ANNUAL REPORT

February 2025-January 2026

BANGLADESH
HEALTH WATCH

Sweden
Sverige

CONTENTS

List of Acronyms	2
Executive Summary	4
Introduction and Project Brief	9
Progress Reports Based on Outcome Indicators	11
BHW's Core Activities	22
Risk Assumptions	26
Annexture 1: M&E Framework table for Feb 2025-Jan 2026	30
Annexture-2: Report on Facility Observation and Patient Feedback	38

LIST OF ACRONYMS

AG	Advisory Group
BDHS	Bangladesh Demographic and Health Survey
BHW	Bangladesh Health Watch
BLAST	Bangladesh Legal Aid and Services Trust
BRAC	Bangladesh Rural Advancement Committee
BSMMU	Bangabandhu Sheikh Mujib Medical University
CS	Civil Surgeon
CHCP	Community Healthcare Provider
C-sections	Caesarean Section
CSO	Civil Society Organization
CIRDAP	Centre on Integrated Rural Development for Asia and the Pacific
CIPRB	Centre for Injury Prevention and Research
DG	Director General
DGDA	Directorate General of Drug Administration
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHRF	District Health Rights Forum
DHRYF	District Health Rights Youth Forum
ED	Executive Director
FCDO	Foreign, Commonwealth & Development Office (UK)
FDA	Food and Drug Administration (USA)
EPI	Expanded Programme on Immunization
FWA	Family Welfare Assistant
FGD	Focus Group Discussion
FY	Fiscal Year
GoB	Government of Bangladesh
HA	Health Assistant
HRF	Health Rights Forum
HO	Host Organization
ICDDR, B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICT	Information and Communications Technology
IEDCR	Institute of Epidemiology, Disease Control and Research
INGO	International Non-governmental Organization
JPGSPH	James P Grant School of Public Health
KII	Key Informant Interview
KPI	Key Performance Indicator
LMIC	Low and Middle-Income Countries
MOHFW	Ministry of Health and Family Welfare
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation and Learning

MP	Member of the Parliament
MPG	Medical Practice Group
MTR	Mid-Term Review
NGO	Non-governmental Organization
NID	National Identity Card
OGSB	Obstetrical and Gynaecological Society of Bangladesh
PhD	Doctor of Philosophy
RC	Regional Chapter
SIDA	Swedish International Development Cooperation Agency
TG	Thematic Group
TOR	Terms of Reference
UHC	Universal Health Coverage
UHRF	Upazila Health Rights Forum
UHRYF	Upazila Health Rights Youth Forum
UNICEF	United Nations International Children's Emergency Fund
WG	Working Group
WHO	World Health Organization

EXECUTIVE SUMMARY

This annual report presents the results achieved during the second year of implementation of the Swedish International Development Cooperation Agency-Sida supported project 'Institutionalizing Accountability in Health Systems to Improve Access to Services' covering the time February 2025 to January 2026. Despite a challenging political context—including prolonged unrest and the 13th National Election—Bangladesh Health Watch (BHW) demonstrated adaptability and strategic consolidation of activities to achieve its planned outputs and outcomes.

The project is implemented through three strategic objectives:

1. Strengthening local-level accountability,
2. Enhancing media engagement for social accountability, and
3. Strengthening national-level advocacy to accelerate Universal Health Coverage (UHC).

Collectively, these efforts contribute to a more responsive, transparent, and citizen-centered health system aligned with Bangladesh's 5th Health Sector Plan and UHC commitments.

Outcome 1: Strengthened Local-Level Accountability

Strengthening accountability at the local level is a critical pathway to improving the quality and responsiveness of public healthcare services in Bangladesh. Health Rights Forums (HRFs) have been empowered to engage constructively with health authorities, monitor service delivery, and advocate for necessary reforms. As influential community-based pressure groups, they play a vital role in promoting transparency, amplifying citizens' voices, and driving improvements in local health services.

The project supported eight Regional Chapters (RCs), mobilizing voluntary Health Rights Forums (HRFs) and Health Rights Youth Forums (HRYFs) to institutionalize citizen-led monitoring and advocacy initiatives with health authorities. During the reporting time, the key interventions that were carried out in 8 regional chapters are shown in the following table:



Multistakeholder meeting at Barguna hospital

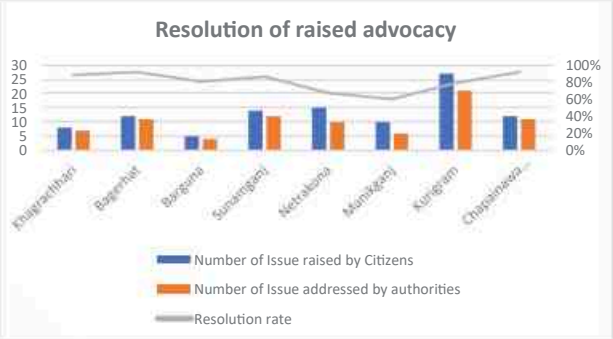
Sl	Activities	Planned	Accomplished
1	Yearly planning meeting	8	8
2	Health Rights forum regular meeting (at Districts and Upazila)	64	64
3	Health Rights youth forum regular coordination meeting	64	63
4	Meeting with Health Authority and Local Administration	32	23
5	Multi-Stakeholder meeting (Face the public)	15	15
6	Community Clinic Coordination meeting	16	13
7	UHFWC Coordination meeting	16	14
8	Coordination meetings with Civil Society Organizations /Local Government/NGOs	16	16
9	District Youth Gathering / Olympiad	8	8
10	Coordination meeting with Youth Forum (District and Upazila)	16	16
11	Capacity building training for HRF & HRYF members	32	24
12	Information board display	8	7
13	Safe motherhood day observance	8	8
14	World Health Day observance	8	7
15	World Population Day observance	8	7
16	Advocacy on Abuse of Anti-Microbial Resistance	8	8
17	Campaign on SRHR at Secondary Schools	24	24
18	Facility monitoring by RC members	30	29
19	Regional level round table on Doctors' Absenteeism	7	7
20	Workshop on Optimizing C-section	3	3
	Total	391	364

Key Outcomes:

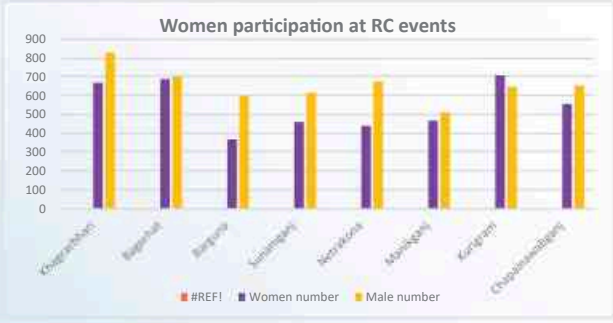
- Deployment of doctors and nurses to fill up the vacant positions in Kurigram and Barguna.
- Installation of citizen charters and complaint boxes in all facilities.
- Reduction of informal brokers in hospital premises in (Kurigram, Manikganj, Netrokona)
- Activation of diagnostic equipment and ambulance services in Netrakona.
- Improved cleanliness, waste management, and ward discipline in Barguna, Sunamganj, Kurigram
- Introduction of structured C-section monitoring systems in three districts (Manikganj, Chapainawabganj and Khagrachhari)
- Increased female participation, particularly in Youth Forums (up to 60% in some districts).
- Development of sustainability mechanisms through partnerships, joint workshops, and volunteer-driven models.

Importantly, the RC model remains fully voluntary—an innovative example of civic ownership where accountability is sustained through social responsibility rather than financial incentives.

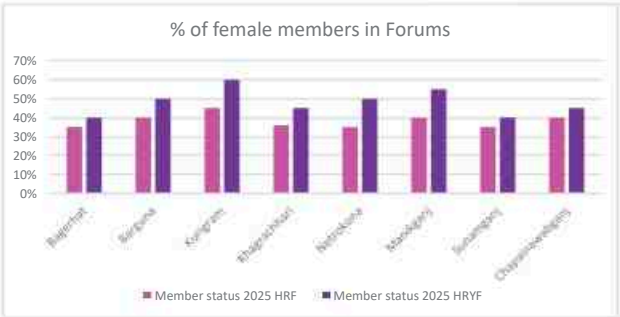
Resolution of raised advocacy issues:
During the reporting period, Health Rights Forums facilitated the raising of 103 citizen-identified issues through advocacy meetings and public hearings across eight districts. Of these, 82 issues (approximately 80%) were addressed by health and hospital authorities. Resolution rates ranged from 60% to 92%, with several districts achieving above 85% responsiveness. These findings demonstrate the effectiveness of HRF-led advocacy in strengthening local accountability and promoting responsive health governance.



Comparative overview of gender-disaggregated participation by region
This bellow figure provides a comparative analysis of the number of events conducted and total participation across regions, highlighting women's engagement as a key indicator of inclusive outreach. The findings indicate sustained efforts to ensure gender-responsive participation in program activities.



The below figure show that in 2025, all eight districts successfully exceeded the organizational provision requiring a minimum of 33% female membership in both Health Rights Forums (HRFs) and Health Rights Youth Forums (HRYFs). Female participation ranged from 35%–45% in HRFs and 40%–60% in HRYFs, demonstrating strong progress toward gender-inclusive community accountability structures. Notably, youth forums show particularly high engagement of young women, signaling positive intergenerational shifts in leadership and participation in local health governance.



Outcome 2: Strengthened Media Engagement and Digital Accountability

Under Outcome 2, the project enhanced media engagement and digital advocacy to promote social accountability in health. Strengthened capacity and involvement of local journalists led to more evidence-based reporting on health issues, improving accountability and responsiveness. As a result, citizens are raising concerns about health rights and service quality more regularly and confidently in public forums. A sustained partnership between BHW and local media has also emerged, positioning journalists as credible watchdogs in the health sector.

Key Results

- 57 print/online reports and 4 TV reports published on absenteeism, drug pricing, dengue, workforce shortages, and PHC financing.
- 64 local advocacy and campaign events and 30 national events covered by media.

- Two Journalism trainings (40 local journalists trained).
- A national workshop on the Health Commission Report engaged 30 members of the Health Reporters Forum.
- 108 youth-produced advocacy videos created; dengue awareness videos reached up to 3,000 viewers on social media.
- 70 female youth members trained in digital advocacy; 60 videos produced by female participants.
- Media engagement has evolved from event coverage to investigative and solution-oriented reporting, increasing policy attention and public debate on health system reform.



District Correspondent training at BLC Niketan

Outcome 3: Strengthened Advocacy for UHC, Quality, and Anti-Corruption

During the reporting period, BHW intensified its advocacy to accelerate progress toward Universal Health Coverage (UHC) through evidence generation, policy engagement, and accountability reforms. District and national consultations on PHC budget allocation increased awareness among policymakers. BHW also supported implementation of High Court directives on emergency medical treatment by developing national guidelines and initiating a pilot with BRAC. In addition, structured dialogues addressed doctor absenteeism and rural retention, and groundwork began for a multi-stakeholder "Pharma Watch" platform to strengthen oversight of medicine pricing. Collectively, these efforts advanced evidence-based advocacy and government engagement for UHC.

Key Results

- High-level validation workshop at DGHS engaging 35 policymakers; district-level consultations at Kurigram engaging 40 local officials.
- Endorsement of equity-sensitive PHC financing reforms by Policy stakeholders.
- Government-endorsed national guideline on emergency medical services aligned with High Court directives.
- Formation of an 8-member thematic group on C-section reduction; monitoring systems introduced in three districts.
- High-level UHC Day policy dialogue (60 policymakers and experts) generated commitments for:
  a. Tax-funded health financing reform.
  b. Gender-responsive PHC strengthening.
  c. District-level UHC pilots.
  d. Establishment of a "BHW UHC Lab."
- Preparatory work for a multi-stakeholder accountability platform on medicine pricing ("Pharma Watch").
- These actions strengthened the bridge between evidence generation, public discourse, and policy reform.



Dissemination of Budget Review of Primary and Secondary Level Health Care Centres in Kurigram District

Other Achievements

- 10th Biennial BHW Report on Corruption in the Health Sector finalized and panned to be launched in April 2026 where 27 experts contributed.
- Policy recommendations submitted to 12 political parties; major parties incorporated health reform priorities into election manifestos.
- SRHR campaigns in 24 higher secondary schools across eight districts, linking adolescents to public health facilities.
- Collaboration explored with key stakeholders including Social Marketing Company (SMC) for safe motherhood initiatives and RDRS for Regional Chapters' sustainability.

Conclusion

Despite contextual challenges, the project achieved substantial improvement toward institutionalizing accountability in targeted health facilities. The integrated model-combining citizen monitoring, media engagement, and policy advocacy-demonstrates measurable improvements in service delivery, governance responsiveness, and policy dialogue. The voluntary, citizen-led structure of Regional Chapters, growing female participation, strengthened journalist engagement, and policy-level commitments toward UHC collectively position the initiative as a scalable model for accountability-driven health reform.

INTRODUCTION

This is the annual results-based report for the Sida supported project titled “Institutionalizing Accountability in Health Systems to Improve Access to Services,” being implemented by The Bangladesh Health Watch-BHW, and covering the period February 2025 to January 2026.

This report provides an update on the yearly progress of all three streams of work, accompanied by a financial report for the reporting period mentioned. However, except for some internal Citizens Forum meetings, the target of the plan was accomplished.

It is noteworthy that during the reporting period, Bangladesh Health Watch (BHW) faced several contextual challenges that delayed the timely implementation of planned field-level activities. Continuous yearlong political turmoil created challenges in following the work plan timeline. Moreover, Safety concerns led some District Health Rights Forum members to withdraw from public activities in a couple of districts. The situation became so serious that BHW had to partially restructure the Health Rights Forum in Bagerhat and Chapainawabganj districts. At the end of the year, new forum members have successfully been onboarded, and field activities have resumed there.

Furthermore, BHW revised its work plan timeline in consideration of the 13th National Election held on 12 February 2026. Due to the prevailing political and law-and-order situation, many national and field-level activities were consolidated and completed during the final week of January 2026 to ensure the achievement of the year’s targets.

Despite these challenges, BHW remained adaptive and responsive, enabling the project to maintain momentum and accomplish its key objectives within the reporting period.

PROJECT BRIEF

Bangladesh Health Watch (BHW) has been implementing the two-year project, “Institutionalizing Accountability in Health Systems to Improve Access to Services,” with the financial support of the Swedish International Development Cooperation Agency (SIDA) since February 2024. This two-year initiative builds upon BHW's earlier project, "Enhancing Responsiveness and Participation in Bangladesh's Healthcare Systems," which was also supported by Sida and lasted three years. While maintaining the emphasis on creating a responsive health system, the new project places a stronger focus on accountability, especially at the local level. It aims to improve citizens' health and productivity in alignment with the objectives of the Bangladesh government's 5th Health Sector Plan.

Goal

The project aims to transform Bangladesh's local health system by fostering a positive policy environment, leading to better and more accountable healthcare access for citizens. It operates at both local and national levels to improve service delivery, accountability, and policy support, helping to accelerate Universal Health Coverage (UHC) in Bangladesh, which aligns with the vision of the government’s 5th health sector plan.

Objectives

The project is designed to meet three strategic objectives:

1. Strengthened Local Level Accountability: Improve the responsiveness and accountability of local health facilities through grassroots engagement and monitoring.
2. Enhanced Media Engagement and Capacity: Equip local and national media to effectively report on and advocate for health service

issues, increasing public awareness and pressure on policymakers.
3. Strengthened Advocacy for UHC: Influence national health policies and practices through targeted advocacy and legal actions to accelerate UHC implementation.

Major Activities

Objective 1: Strengthened Local Level Accountability

- Public Hearings: Organize bi-annual public hearings to facilitate dialogue between communities and health authorities, holding health facility authorities accountable for service quality.
- Facility Readiness Meetings: Host regular meetings between Regional Chapters (RCs) and health facility authorities to address service readiness and improvement needs.
- Service Monitoring: Conduct annual reviews of health facilities by RC members to assess and address service quality issues.
- Youth Forum Engagement: Enhance Youth Forum capabilities to monitor facilities, gather feedback, and conduct awareness campaigns on health rights.
- Awareness building and Campaigns: Implement local campaigns and advocacy initiatives to address absenteeism, service quality, and other pressing health sector issues.

Objective 2: Enhanced Media Engagement and Capacity

- Local Media Training: Train journalists in health reporting and advocacy, enhancing their ability to cover health issues and engage in investigative reporting.
- Media Coverage Expansion: Increase media coverage of health service issues at local levels through consistent reporting and public engagement.
- National Media Alliance: Build strong alliances with national media to report on absenteeism, drug pricing, and Primary Health Care (PHC) funding, and engage journalists in policy dialogues and forums.

Objective 3: Strengthened Advocacy for UHC

- Evidence-Based Advocacy: Conduct advocacy for increased PHC funding by presenting evidence on budget needs versus allocations and proposing policy adjustments.
- Legal Advocacy: Utilize Public Interest Litigation (PIL) to address critical health issues such as antimicrobial resistance and immediate treatment for accident victims, and engage legal experts for effective court enforcement.

Expected Outputs

1. Local Level Accountability: Improved facility management, enhanced public engagement, and better service quality through active citizen involvement and oversight.
2. Media Engagement: Increased and impactful media coverage of health issues, raising public awareness and driving policy changes.
3. Advocacy for UHC: Effective policy changes and legal reforms supporting increased PHC funding and quality improvements in the health system.

Beneficiaries

- Direct Beneficiaries: Citizens of Bangladesh, especially in the eight target districts.
- Indirect Beneficiaries: Health authorities, service providers, RC members, government policymakers, healthcare planners, and media representatives.

Target group of the project

- Government/NGO policy planners, programme managers, service providers, and Civil Society Organizations (CSOs) at central and local levels.

Theory of Change

The project posits that by strengthening local accountability, enhancing media engagement, and advancing advocacy efforts, the health system in

Bangladesh can become more responsive and accountable. This will lead to improved healthcare services and contribute to the broader goal of a productive and healthy population in line with Bangladesh's health sector vision.

PROGRESS REPORTS BASED ON OUTCOME INDICATORS

Objective 1: Strengthened local-level accountability

Regional Chapters (RCs) are designed to function as the main vehicle for instituting stronger local level accountability, with policy advocacy at the central level playing a supportive role. BHW established eight RCs in eight districts in Bangladesh to bring the grassroots voices and concerns of healthcare users and service providers to policymakers. Citizen's forum, namely Health Rights Forums (HRFs) and Health Rights Youth Forums, work to strengthen the local level accountability process in health institutions. These forums with the secretarial support by Host Organizations are further capacitated for sustainability. To utilize RC's capacity to systematically claim local level health accountability, the project undertakes six sets of strategies to contribute to the outcome of influencing health systems to be more responsive and accountable to people (lasting changes).

1. **Multi-stakeholder "public hearing" meetings.** Grassroots people get an opportunity to express and discuss issues related to health services with the government health authority. RCs follow up with concerned government officials on the recommendations and the commitments made during the public hearing.
2. **Authority meeting.** Host Organisations, along with HRFs, arrange a sharing meeting with district and upazila hospital authorities to discuss respective facility readiness issues and needs and what could be done to improve their facilities, including resource mobilization for facility maintenance/improvement.
3. **Citizen monitoring.** Trained RC members along with the Youth volunteers monitor the health service situation and carry out an periodic systematic assessment of facility performance at different tiers and identify specific problems of healthcare services regarding quality, and follow up with relevant authorities to implement recommendations.
4. **Campaign.** RCs implement a well-structured programme for awareness building and campaign at the local level, engaging HRF and Youth Forum members. With strengthened capacity, Youth Forums are able to better support RCs through their participation in local level health initiatives, e.g., campaigns, rallies, and human chains to improve awareness of local populations and support the process to claim accountability of government health facilities at the local level.
5. **Networking and advocacy.** RCs develop partnerships with key stakeholders in the health sector and engage with local Civil Society Organizations network to amplify the voices of marginalized communities. RCs also build network with facility management committees to improve non-clinical aspects of health services.
6. **Media engagement.** BHW engages both local and national-level media. RC's partnership with local journalists has been strengthened and expanded, and journalists' skills for health reporting and advocacy have been enhanced with the purpose of voicing and publicizing citizens' concerns about government services. It also supports national news outlets in publishing investigative reports on the health sector, and producing health-related news and opinion pieces to inform and engage the broader public. The project also facilitates active participation of journalists at different communication platforms, including policy dialogues, discussion forums, and roundtables.



Sabalamby Unnayan Smaity (SUS)
Netrokona

Solidarity,
Kurigram

PROYAS Manobik Unnayan Society
Chapainowabgong

Efforts for Rural Advancement-ERA
Sunamgonj

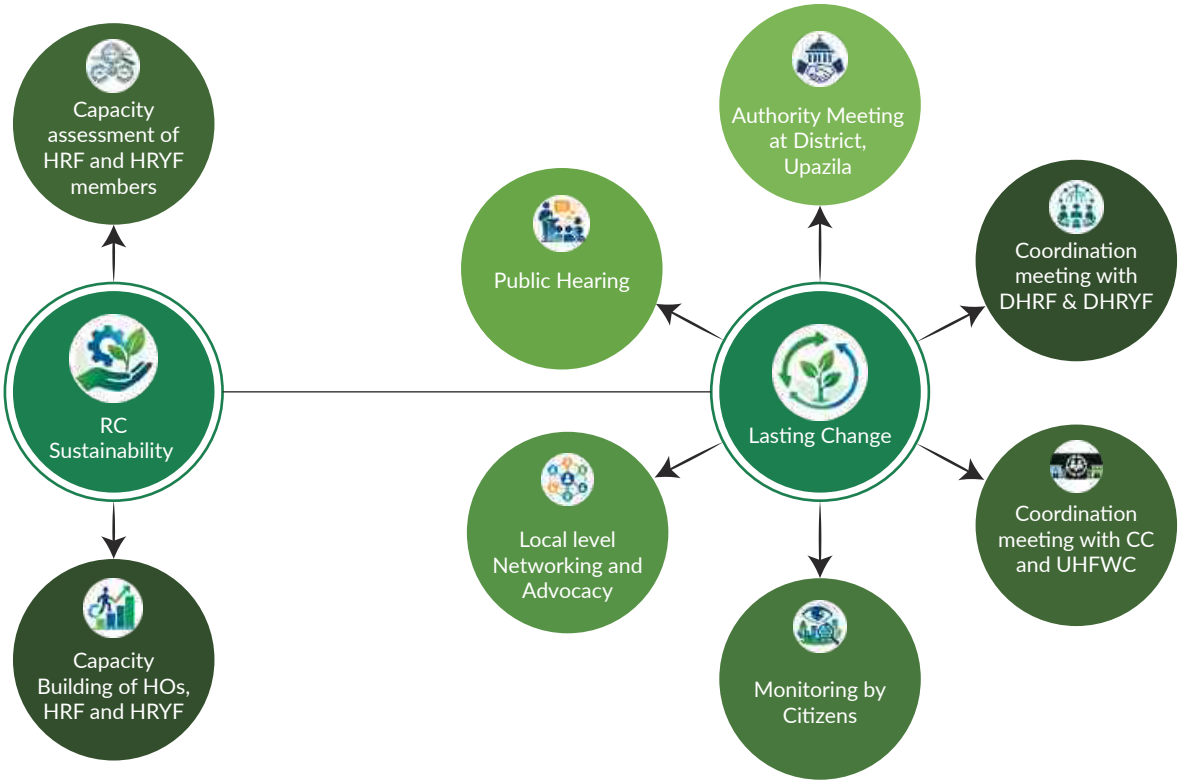
Rupantar
Bagerhat, Khulna

Jago Nari
Barguna, Barishal

BARCIK
Manikgonj, Dhaka

Zabarang Kalyan Samity
Khagrachori, Chottogram

The two-pronged strategies for RC sustainability: Figure 1



1.1 Enhanced Capacity and Ownership of RCs to Demand Local-Level Accountability

Strengthening accountability at the local level is a critical pathway to improving the quality of public healthcare services in Bangladesh. Health Rights Forums (HRF) are empowered to engage with health authorities, monitor health service delivery, and advocate for improvements in local health services.

At the Regional Chapters, The Health Rights Forum and Youth Forum represent a unique model of citizen-led accountability in Bangladesh's health sector because they function entirely on voluntary commitment rather than any financial incentives. Unlike many community initiatives that depend on project-based funding or allowances, these forums are driven by conscious citizens and young people who invest their own time, skills, and social capital to monitor local health facilities, engage in dialogue with authorities, and advocate for improvements in service quality, environment, and accessibility.

regularly monitor local health facilities, arrange dialogue and provide recommendations on the quality, environment and availability of healthcare. The Youth Forum involves young people in raising awareness on health rights, conducting social media-based campaigns, campaigns and voluntary activities following a set annual the work plan.

This combination of structured monitoring, constructive engagement with duty-bearers, grassroots advocacy, and purely voluntary participation makes their role distinctive. It demonstrates a rare form of civic ownership where accountability is sustained not by financial motivation but by social responsibility and a shared commitment to equitable healthcare—establishing an innovative and credible model of citizen engagement at the local level. Thanks to their persistent endeavor, the major outcomes that came are given in the following table

Indicators & Outcomes: Outcome 1: Strengthened local level accountability

<table>
<tr><th>Indicators</th><th>Outcome Indicators</th><th>Outcomes</th></tr>
<tr><td>1.1. Enhanced capacity and ownership of RCs to demand local-level accountability.</td><td>1.1.1. Number of lasting changes (6 months) brought about by advocacy/activism events.</td><td>The notable outcomes include-
Improved cleanliness, waste management, and facility discipline in Barguna, Bagerhat, Kurigram, Khagrachari and Netrokona are evident. As a result, patients now experience cleaner, safer, and more organized health facilities, increasing community trust in public healthcare services.
Installation of citizen charters at all selected hospitals, CCs and UHFWCs has led to several important improvements in transparency, accountability, and service delivery. The Citizen Charter clearly displays available services (free and subsidized), service hours, contact information for responsible authorities etc.
Installation of complaint boxes at all target hospitals done and half of them are utilized.
Separate service counters for men and women in all selected hospitals
Staffing of new doctors in Kurigram and staffing of nurses in all selected hospitals
Repair of necessary medical equipment (Kurigram, Manikganj)
Reduced brokers in hospitals (Kurigram, Manikganj, Netrokona)</td></tr>
<tr><td></td><td>1.1.2: Evidence of strengthened regional chapters</td><td>Active engagement of forum members observed:
<table><tr><th>RCs</th><th>% of active members</th><th>% of active members</th></tr><tr><td>Bagerhat</td><td>100</td><td>100</td></tr><tr><td>Barguna</td><td>80</td><td>100</td></tr><tr><td>Kurigram</td><td>70</td><td>90</td></tr><tr><td>Khagrachari</td><td>40</td><td>75</td></tr><tr><td>Manikganj</td><td>40</td><td>70</td></tr><tr><td>Sunamganj</td><td>70</td><td>50</td></tr><tr><td>Chapai</td><td>80</td><td>60</td></tr></table></td></tr>
<tr><td></td><td>1.1.3: Number of initiatives taken up by the forums</td><td>Forums plan, coordinate, and implement activities independently:
Identifying local health problems
Designing need-based programmes
Allocating responsibilities among members
Members actively follow up with authorities to ensure issues are resolved (e.g., broken washroom doors, privacy for adolescent patients, equipment relocation).</td></tr>
</table>

<table>
<tr><th>Indicators</th><th>Outcome Indicators</th><th>Outcomes</th></tr>
<tr><td></td><td>1.1.4: Changes through collaborations with similar organizations.</td><td>• Initiatives across districts include:
• Blood donation campaigns (Bagerhat, Kurigram)
• Hospital monitoring and report publication (Netrokona)
• Equipment procurement and preventive service improvement at community clinics</td></tr>
<tr><td></td><td>1.1.5: Evidence of strengthened ownership of project activities by RC and HO</td><td>• Winter clothing collection and distribution for poor patients (Khagrachari and sunamganj)
• Adolescent health initiatives and forming of sexual harassment prevention committees (Netrokona)</td></tr>
<tr><td></td><td>1.1.6: A strategy for the sustainability of initiatives at the local level was developed</td><td>Forums have developed sustainability mechanisms through:
• Networking with government and CSOs
• Joint technical workshops (workforce retention, rational use of cesarean sections)
• Volunteer-driven activities with shared costs/responsibilities
• Local partnerships for continuous health campaigns and monitoring
• Embedding accountability mechanisms into routine health facility operations</td></tr>
<tr><td></td><td>1.1.7: Increased percentage of women in the Forums.</td><td>The engagement is strongest among younger members, suggesting that youth platforms are more successful in including women compared to broader district forums. Indicates improved women's participation, especially in youth forums
<table>
<tr><td>Districts</td><td>HRF</td><td>HRYF</td></tr>
<tr><td>Bagerhat</td><td>35%</td><td>40%</td></tr>
<tr><td>Barguna</td><td>40%</td><td>50%</td></tr>
<tr><td>Kurigram</td><td>45%</td><td>60%</td></tr>
<tr><td>Khagrachhari</td><td>36%</td><td>45%</td></tr>
<tr><td>Netrokona</td><td>35%</td><td>50%</td></tr>
<tr><td>Manikganj</td><td>40%</td><td>55%</td></tr>
<tr><td>Sunamganj</td><td>35%</td><td>40%</td></tr>
<tr><td>Chapainawabganj</td><td>40%</td><td>45%</td></tr>
</table></td></tr>
<tr><td>1.2. Improved local level citizen-led facility monitoring and public hearing.</td><td>1.2.1: Lasting changes from recommendations captured during public hearing (gender desegregated data)</td><td>• Barguna: Allocation of rooms for districts hospital's helpdesks, cleanliness, improved patient attendant management, In time Community clinics opening,</td></tr>
</table>

<table>
<tr><th>Indicators</th><th>Outcome Indicators</th><th>Outcomes</th></tr>
<tr><td></td><td></td><td>

Kurigram: Recruitment of doctors/nurses, activation of X-ray/ultrasound, reduction of brokers, separate counters for men and women, privacy improvements, operational ambulances
Netrokona: Improved food quality, cleanliness, oxygen mask use, emergency ward services, adolescent registration, complaint mechanisms
Khagrachari: New building construction, staffing improvements

</td></tr>
<tr><td></td><td>1.2.2: Number of issues raised and addressed in health facilities that use recommendations from RC monitoring.</td><td>
<table>
<tr><th>RCs</th><th>Number of Issue raised by Citizens</th><th>Number of ssue addressed by authorities</th></tr>
<tr><td>Khagrachhari</td><td>8</td><td>8</td></tr>
<tr><td>Bagerhat</td><td>12</td><td>11</td></tr>
<tr><td>Barguna</td><td>04</td><td>04</td></tr>
<tr><td>Sunamganj</td><td>14</td><td>12</td></tr>
<tr><td>Netrakona</td><td>15</td><td>10</td></tr>
<tr><td>Manikganj</td><td>10</td><td>4</td></tr>
<tr><td>Kurigram</td><td>27</td><td>21</td></tr>
<tr><td>Chapainawabganj</td><td>12</td><td>11</td></tr>
<tr><td>Total</td><td>102</td><td>81</td></tr>
</table>
</td></tr>
<tr><td></td><td>1.2.3: Lasting changes from the monitoring recommendations identified</td><td>

Hospitals in all eight districts implemented changes based on RC feedback, including:
Staff behavior improvements
Functional citizen charters and complaint
Preventive services at community clinics (antenatal counselling, medicine lists, service schedules)
Manikganj: Improved patient care: indoor rounds by doctors, better food, ambulance services, Facility discipline: opening/closing on time, waste management, ward cleanliness

</td></tr>
<tr><td></td><td></td><td>

Sunamganj: Transparency and accountability: staff ID cards, complaint boxes, citizen charters, reduced brokers
Chapainawabganj: Community engagement: routine meetings, resource mobilization, awareness campaigns

</td></tr>
</table>

<table>
<tr><th>Indicators</th><th>Outcome Indicators</th><th>Outcomes</th></tr>
<tr><td>1.3. Increased strategic activities by CSO and other interest groups to reduce absenteeism and increase gender equity in the health service</td><td>1.3.1: Evidence of increased capacity and knowledge of CSO and interest groups to work on absenteeism and gender equity and Number of scalable mechanisms to reduce absenteeism identified and publicized.</td><td>Health Rights Forums actively advocating for doctor retention issues with health authorities at regular meetings-
Technical workshops conducted with doctors and other health providers, aligning community priorities with system-level needs
In Public hearings and follow-up meetings, issues raised regularly by forum members to track staff presence and service delivery
Recruit additional staff (reducing absenteeism)
A total of 12 reports have been published in local media about doctors absenteeism
2 Television reports on doctors absenteeism aired.
Hospital Staff ID cards to reduce unauthorized intermediaries (Netrokona, Barguna)</td></tr>
<tr><td></td><td>1.3.2: Evidence of changes towards more gender friendly health services.</td><td>There is a positive trend in female participation in different advocacy and campaign events.
<table>
<tr><th>RCs</th><th>Total events</th><th>Total Participation</th><th>Women number</th><th>Male number</th></tr>
<tr><td>Khagrachhari</td><td>49</td><td>1497</td><td>668</td><td>829</td></tr>
<tr><td>Bagerhat</td><td>47</td><td>1392</td><td>687</td><td>705</td></tr>
<tr><td>Barguna</td><td>43</td><td>966</td><td>368</td><td>598</td></tr>
<tr><td>Sunamganj</td><td>47</td><td>1075</td><td>460</td><td>615</td></tr>
<tr><td>Netrakona</td><td>43</td><td>1114</td><td>439</td><td>675</td></tr>
<tr><td>Manikganj</td><td>44</td><td>980</td><td>468</td><td>512</td></tr>
<tr><td>Kurigram</td><td>49</td><td>1355</td><td>708</td><td>647</td></tr>
<tr><td>Chapainawabganj</td><td>46</td><td>1207</td><td>555</td><td>652</td></tr>
</table></td></tr>
</table>

Outcome 2: Strengthened media engagement and capacity to promote social accountability in health

Under Outcome 2, the project strengthened media engagement and digital advocacy to promote social accountability in health. Strengthening the capacity and engagement of local journalists has led to more evidence-based reporting on local health issues, helping to improve accountability and responsiveness in the health sector. As a result, citizens voice on health rights and service quality have raised regularly and community members now feel more confident raising their concerns during public hearings and forums. Over time, a strong and ongoing partnership has developed between BHW and local media, with journalists increasingly recognized as credible watchdogs in the health sector.

During the reporting time, a workshop titled "What's in the Health Commission Report" was conducted with 30 members of the Health Reporters Forum. The session enhanced journalists' understanding of key reform recommendations and directly contributed to increased media coverage on health sector reform issues. Besides, District-Level Health Journalism Trainings (23–24 July & 6–7 August 2025)

Two district-level trainings were held for 40 journalists from 8 districts. These sessions strengthened their skills in investigative and solution-oriented reporting and resulted in the development of actionable reporting plans tailored to local health challenges.

Thanks to the journalist trainings, 57 reports were published in leading outlets such as The Daily Star, Prothom Alo, and Jamuna TV, highlighting service gaps, doctors' absenteeism, health financing issues, and dengue-related challenges. Digital engagement expanded through 108 youth-produced advocacy videos and webinars reaching over 500 participants, with dengue campaign videos receiving up to 3,000 views.

Outcome 2: Strengthened media engagement and capacity to promote social accountability in health

Indicators	Outcome Indicators	Outcomes
2.1. Increased role of local journalists to voice and publicize citizen's concerns about services in government health facilities	2.1.1: Number of media reports on health issues at the local and national levels published	- National-level reports: A total of 18 reports published at the national level. - Local/district-level reports: 36 reports have been published covering issues like workforce gaps, limited vaccination services, unauthorized pharmacies, and dengue outbreak etc. - TV reports: 04 tv reports have been published
	2.1.2: Number of events covered by media to engage and report on citizen's concerns	- 57 reports were published in leading outlets such as The Daily Star, Prothom Alo, and Jamuna TV, highlighting service gaps, doctors' absenteeism, health financing issues, and dengue-related challenges - 64 local level and 30 national events were covered by different print and electronic media.
	2.1.3: Actions instigated by health reports	- Reports highlighted systemic challenges, regulatory weaknesses, and resource gaps. - Media coverage initiated public debates and discussions on health sector reforms. - Enhanced accountability by drawing attention of policymakers to implementation challenges.
2.2. Strengthened digital media usage and increased social media presence to showcase RC activities and achievements	2.2.1: Evidence of improved social media engagement.	- Health Rights Youth Forum produced 108 advocacy videos on health awareness and rights after social media training (October–November 2025).

Indicators	Outcome Indicators	Outcomes
	2.2.2: Evidence of increased use of digital media (webinar).	• Youth participants continue to produce content with expert mentorship support. • Youth Dialogue Webinar (2 February 2025): 3 districts participated; 500 views on Facebook Live/Zoom; discussions on absenteeism, high medicine prices, and governance. • Dengue Awareness Webinar: Led by public health experts and officials; shared evidence-based strategies, operational gaps, and the need for coordinated national response.
	2.2.3: Evidence of improved social media engagement by females.	• In the social media campaign for dengue awareness, 4 female experts' opinions have been taken. Moreover, a two-day-long online training session was conducted for social media advocacy, where 70 female youth members were actively present in the training. Also, 60 health awareness videos have been collected from the female participants.

Outcome 3: Strengthened advocacy work to accelerate the implementation of Health Care, improve quality of health and reduce corruption

During the reporting period, BHW strengthened its advocacy to accelerate government action toward Universal Health Coverage (UHC) by generating evidence, engaging policymakers, and promoting accountability reforms. Through district and national-level consultations on PHC budget allocation, around 75 policy stakeholders became more aware of equity gaps in financing and service delivery. Evidence from budget analysis and field consultations was shared with DGHS and other national actors to support more equitable resource distribution. BHW also advanced implementation of High Court directives on emergency medical treatment through development of national guidelines and initiation of a pilot with BRAC. In addition, structured dialogues on doctor absenteeism and rural retention were conducted, and preparations are underway to form a multi-stakeholder platform on medicine pricing ("Pharma Watch") to strengthen accountability and policy oversight. Together, these actions have reinforced evidence-based advocacy and government engagement to advance UHC implementation.

Outcome 3: Strengthened advocacy work to accelerate the implementation of Health Care, improve quality of health and reduce corruption

Indicators	Outcome Indicators	Outcomes
3.1. Public opinion created, and policy makers mobilized to accelerate UHC implementation	3.1. Number of commitments of policy stakeholders for increased allocation in Primary Health Care (PHC)	High-Level Consultative Meetings and Workshops: • A dissemination workshop was organized at the Directorate General of Health Services (DGHS), where key findings were presented to government officials and relevant stakeholders. The workshop provided an important platform for technical dialogue, validation of findings, and constructive engagement with policymakers with their feedbacks. • Validation Workshop on Health Budget Analysis (DGHS, 22 Jan 2026) engaged ~35 national-level policymakers and technical experts. • At local level, dissemination and validation workshop at district-level (Kurigram, 1 July 2025) engaged ~40 local-level health policy stakeholders. • Outcomes as commitments Demonstrated by policymakers: • Policymakers endorsed incorporation of equity-sensitive recommendations and reform-oriented strategies in final reports. • Recognition of systemic inequities (vacancy-related savings, underutilization of funds, decentralization issues) and agreement to consider these in future budget allocations. • Increased awareness and commitment among national and local policy stakeholders to address equity challenges in PHC financing and support evidence-informed allocation for UHC.
3.2. Use of legal provisions for improving quality of health services	3.2.1 Evidence of better awareness of High Court directives on the reduction of unnecessary Caesarean Section and emergency medical treatment facilities.	**Emergency Medical Treatment Facilities:** • -Government-endorsed national guideline on emergency services aligned with 2018 High Court directives circulated in April 2025. • Technical review, agency selection, and formal agreement signed with BRAC Health and Road Safety Programmes to pilot implementation from 1 March 2026.

Indicators	Outcome Indicators	Outcomes
	3.2.2 At least one Public Interest Litigation (PIL) lodged, written petition and follow-up in partnership, e.g., with a legal organization.	• A series of meetings with Obstetrical and Gynaecological Society of Bangladesh (OGSB) was done. A meeting with senior OBGYANs held where it was decided that a thematic group will be formed. Later, the thematic group was formed.
3.3. Increased commitment of policy stakeholders to address corruption issues related to absenteeism and medicine prices	3.3.1: Discussions on the two issues in national and local media and at policy levels	**Discussions and Awareness:** • C-section workshop organized in Manikganj, Chapainawabganj & Khagrachhari. In Manikganj, the private clinic authority regularly submitting C-section and NVD report to civil surgeon. A meeting with SMC was held for future partnership for conducting Mother gatherings. Moreover, a series of mother gatherings is supposed to be held in March. • A high-level policy dialogue was organized on UHC Day 2025 (Dhaka, 18 December 2025), engaging approximately 60 senior policymakers, economists, academics, and media representatives to review progress toward inclusive Universal Health Coverage and address rising out-of-pocket expenditure. The dialogue generated concrete commitments, including endorsement of tax-funded health financing reform with explicit benefit packages, prioritization of gender-responsive and equity-focused PHC strengthening, piloting UHC implementation at district level, and establishment of a “BHW UHC Lab” to translate policy dialogue into sustained research, advocacy, and reform-oriented action.
	3.3.2: Policy recommendations in the area of absenteeism and medicine pricing.	• Structured Regional dialogues held between Jan–May 2025 with district and upazila health managers and medical officers across eight districts. The dialogues were jointly organised by BHW and Civil Surgeon Offices.
	3.3.3: A possible accountability platform formed on absenteeism collaborations reducing medicine prices strengthened.	• As part of a study, A comprehensive report has been prepared to support evidence-based policy advocacy on rural doctor retention. The report synthesizes findings from regional workshops and national-level stakeholder interviews to present a strategic and actionable roadmap. Insights from the regional workshops highlight professional and policy-related factors influencing rural postings, the availability of compulsory facilities, and the key reasons motivating doctors to remain in rural areas.

BHW'S CORE ACTIVITIES

BHW'S BIENNIAL REPORT

The BHW report titled "**Corruption in the Health Sector in Bangladesh**" is currently in its final drafting and synthesis stage, marking the culmination of an extensive, multi-layered research and consultation process. The report is being developed with the active engagement of approximately 27 authors and technical contributors, including public health experts, health economists, governance specialists, legal analysts, and field researchers. This multidisciplinary team has ensured that the analysis reflects diverse perspectives and is grounded in both empirical evidence and field realities.

This continuity demonstrates BHW's institutional credibility, technical leadership, and sustained contribution to evidence-informed health sector reform in Bangladesh. The report is planned to be launched in April 2026.

BHW's recommendation for different political parties' Election Manifestos

Bangladesh Health Watch (BHW), as a national civil society platform, has undertaken strategic and proactive engagement with key political stakeholders to ensure that health is positioned as a national priority in the forthcoming election. Through formal in-person consultations with the Bangladesh Nationalist Party (BNP), the National Citizen Party (NCP), and other major political parties, BHW strongly advocated for the integration of its policy recommendations into their respective election manifestos. These recommendations emphasized advancing Universal Health Coverage (UHC), increasing public sector health expenditure, strengthening primary healthcare systems, enhancing accountability and transparency, promoting meaningful citizen participation in the health sector, and expanding and retaining the health workforce.

As a result of sustained advocacy, constructive dialogue, and evidence-based policy engagement, major political parties incorporated these priority health issues into their manifestos. Furthermore, BHW formally submitted its recommendations to 12 political parties, contributing to the development of broader political consensus on health sector reform and reinforcing the recognition of health as a central pillar of national development.

Discussion on recommendations for women's health proposed by the Women's Affairs Reform Commission

Bangladesh Health Watch organized a discussion meeting on June 29 at the BRAC Tower conference room in Mohakhali to deliberate on the women's health recommendations proposed by the Women's Affairs Reform Commission. The dialogue created a platform for policymakers, public health experts, and civil society representatives to critically review the proposed reforms and build consensus on actionable priorities. Participants emphasized the urgent need to translate the recommendations into concrete policy commitments to ensure equitable and quality healthcare services for all women. The keynote paper, presented by public health expert Dr. Halida Hanum Akhter, highlighted key gaps and strategic opportunities identified in the Commission's report, guiding stakeholders toward coordinated advocacy and policy follow-up. The meeting strengthened collective commitment to advancing women-centered health reforms and integrating these priorities into national health planning processes.



Women Health Commission Report Discussion event at Brac Tower

Programmes focusing on SRHR and Safe motherhood

During this reporting period, BHW carried out an integrated program on SRHR.

i) **Thematic group on C-section:** Bangladesh Health Watch formed an 8-member thematic group with veteran OBGYNs, holding its first meeting on 17 December 2025, to advance the promotion of natural vaginal delivery. The formation of this expert platform is expected to generate evidence-based recommendations to address the rising rate of unnecessary cesarean sections and improve maternal health outcomes. Through technical guidance, policy advocacy, and professional engagement, the group will work toward strengthening clinical practices, increasing awareness among healthcare providers and mothers, and promoting safe, respectful maternity care. So far, 3 Regional level Workshops have been organized in collaboration with respective civil surgeon offices at Manikganj, Khagrachhari and Chapainawabganj. As, instant outcome of the workshop a monitoring and reporting system was introduced at those districts where both government facilities and private clinics are providing monthly data of C-section and NVD to the Civil surgeon office.



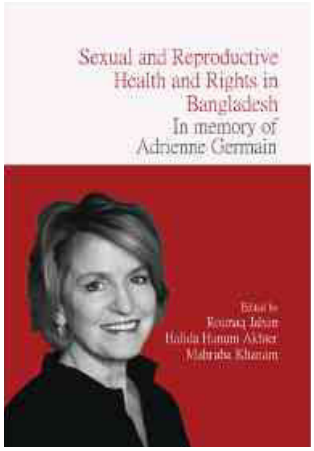
C-section workshop at Chapainawabganj

ii) **SRHR School Campaign:** In eight Regional Chapters, District Health Rights Forums (DHRFs) under Bangladesh Health Watch conducted SRHR campaign programs in 24 higher secondary schools. The initiative improved adolescents' knowledge of sexual and reproductive health, menstrual hygiene, and rights, while helping reduce stigma and common myths around sexuality. Students gained greater confidence to discuss sensitive issues and seek reliable information. The program also successfully linked students with adolescent-friendly services at UHFWCs, Upazila Health Complexes, and District Hospitals, increasing awareness of available counselling and clinical support. Engagement of government doctors and health education officers strengthened collaboration with public health facilities and enhanced the credibility and sustainability of the initiative.



Campaign on SRHR at secondary school

iii) During this reporting period, BHW published a book documenting the proceedings of the conference "***The Emerging Challenges to Sexual and Reproductive Health and Rights (SRHR) in Bangladesh***," held in Dhaka on 3 December 2022 in honor of Adrienne Germain. The volume brings together the insights of distinguished national and international experts, policymakers, advocates, and



practitioners who addressed key SRHR challenges, including maternal health, adolescent rights, climate change, and legal barriers affecting women's access to care.

BHW has widely disseminated this publication—sharing copies across its national networks, with academic and policy stakeholders in Bangladesh, and internationally, including distribution among Adrienne Germain's friends and family in the United States. The book is also made available through https://www.rokomari.com/book/471032/sexual-and-reproductive-health-and-rights-in-bangladesh-in-memory-of-adrienne-germain ensuring that it serves as a resource for researchers, academics, policymakers, and advocates committed to advancing SRHR.

Working Group meetings

During the reporting period, Bangladesh Health Watch (BHW) convened a series of Working Group (WG) meetings to provide strategic oversight, review program progress, and guide institutional development.

- **The 21st WG meeting**, held virtually on 2 July 2025, focused on program updates, progress on the Biennial Report 2025, discussions on initiating a Public Interest Litigation (PIL) on drug pricing, review of the BHW Company Constitution, and sharing of the draft funding concept note for the next phase.
- **The 22nd WG meeting**, held on 16 November 2025 reviewed BHW's registration process, and the extension of the Sida-funded project. Recognizing the evolving scope of BHW's work and the need for broader expertise and representation, the meeting further decided to reform the Working Group. This reform will include the inclusion of new members to enhance technical capacity, strengthen governance, and ensure more inclusive and dynamic leadership moving forward.
- **In addition**, on 14 October 2025, the Working Group held a strategic meeting with Dr. Ziauddin Hyder, Advisor to the Chairperson of Bangladesh Nationalist Party (BNP), to advocate for prioritizing health sector reforms and incorporating BHW's recommendations into future policy and manifesto commitments.

Collectively, these meetings strengthened governance oversight, advanced policy engagement, and ensured alignment of BHW's strategic direction with national health reform opportunities.

Donor meetings: Meeting with Sida

During the reporting period, BHW convened several important meetings with representatives of Sida to strengthen collaboration and ensure effective implementation of planned activities. A meeting was held with Mr. Felix Helgesson, Second Secretary, Embassy of Sweden, Bangladesh, on September 28, 2025, at the 10th Floor of BRAC Tower. The discussion focused on a presentation of the District Health Budget Analysis, updates on the approved Work Plan and Budget, and guidance during his leave period to ensure continuity of coordination. A subsequent meeting took place on December 10, 2025, to follow up on progress and strategic priorities. On December 12, 2025, BHW presented the final report on Doctors' Retention in Rural Settings, highlighting key findings and policy recommendations.



Donor meeting at BRAC Tower

RISK ASSUMPTIONS

Several categories of risks impacted on the project execution and deliverables during the reporting period. These risks were closely monitored by the BHW Secretariat team during their periodic team meetings and the activity plan rescheduled. Opinions from the forum members and HOs were also collected through coordination meetings. In case of this unanticipated risk, or a risk which the Program Director informed the Convener and the Working Group members and actions taken accordingly. The risks and mitigation strategies are listed below:

	Risk Factors	Level	Probability	Impact		Mitigation strategies
				Financial	Performance	
A	**Political Risk**					
1	2026 Election and/Elected political government's approach may slow down or hamper government response to BHW efforts	High	High	Low	Medium	i. It was anticipated that the announcement of an election date could arise challenges to the implementation of field activities due to law-and-order situation. However, BHW rescheduled the work plan and accomplished all outdoor events before December 2025, only inhouse meetings were held in January 2026. ii. BHW is optimistic that the present elected government has clear commitment for health in their election manifesto. BHW strongly advocated for the integration of its policy recommendations into their respective election manifestos and planned to continue to highlight Bangladesh's commitment to SDGs through national and social media. Activism will be undertaken to remind new government of its commitment to SDGs.
B	**Reputational Risk**					

	Risk Factors	Level	Probability	Impact		Mitigation strategies
				Financial	Performance	
3	Negative mainstream and/or social media coverage/comments may damage the trust of local and national level stakeholders: Media reports on BHW activities may attract irresponsible /unprofessional/ untruthful comments or may be used to spread misinformation about BHW/the project which in turn may result in local/ national level repercussions	High	High	Low	Medium	i. No such risk is found.
C	**Safeguarding Risks**					
4	Staff security and safety: Travels by BHW team members and regional chapter members may be affected by adverse weather/travel conditions or political disturbances. Special measures may need to be taken to ensure the security of team members while traveling and during their stay at a particular place	Low	Low	Low	Medium	There were number of risks projected about field visit. But Field visits were done cautiously. However, during the political unrest situation, staff especially the females did very few field visits. BHW Secretariat used online facilities to ensure field activities run as planned.

	Risk Factors	Level	Probability	Impact		Mitigation strategies
				Financial	Performance	
D	**Delivery/Operational Risks**					
5	Vested interest groups may see BHW as an adversary: Topics taken up through the project, including absenteeism, PIL-related activities etc. may hurt vested interest groups which may undermine/ negatively influence BHW's position by mobilizing powerful quarters within/outside the government.	Medium	High	High	Medium	i. No such risk is yet to be faced. If it is found, BHW will take measures with the assistance of local administration and the civil society forum members who are influential at their community.
E	**Fiduciary Risks**					
7	Contractors may not deliver timely or with quality: The project will outsource a number of activities, e.g., research, campaign design etc. The contractors may in some cases fail to deliver the products in time and/or with quality.	Low	Medium	Medium	High	i. No such risk is found yet in this reporting time.

	Risk Factors	Level	Probability	Impact		Mitigation strategies
				Financial	Performance	
F	**Natural Disasters**					
8	Bangladesh is a flood and cyclone prone area as it is situated two large river deltas. Each year, large part of its areas flooded during the monsoon. This situation may hinder regular project activities.	High	High	Low	Low	i. This year no notable natural disaster happened that may hinder regular activities.

ANNEXURE 1
M&E FRAMEWORK TABLE

Project title: Institutionalizing Accountability in Health Systems to Improve Access to Services

Duration: February 2024 – January 2026

M&E Framework Table for Feb 2025 – Jan 2026

Outcome	Outcome Indicators	Output indicator	Baseline	Target: (2024) Year 1	Year 1 Achievements: 1st Feb 2024 to 31st Jan 2025	Target: (2025) Year 2	Year 2 Achievements: 1st Feb 2025 to 31st Jan 2026	Remarks: (Include reasons for any deviations or why not achieved)
Overall Outcome: **More responsive health system that delivers accountable health care to citizens of Bangladesh to achieve Universal Health Coverage**								
Outcome 1: Strengthened local level accountability								
1.1. Enhanced capacity and ownership of RCs to demand local-level accountability	1.1. Number of lasting changes (6 months) brought about by advocacy/activism events. Evidence of strengthened regional chapters Number of initiatives taken up by the forums Changes through collaborations with similar organizations. Evidence of strengthened ownership of project	1.1.1. Health Rights forum regular coordination meeting (District and Upazila)	Baseline: 32	Target: 16	16	Target: 64	88	Overachieved. An additional 16 meetings are held between HRF and HRYF An additional 8 planning meetings in RC areas have also been arranged
		1.1.2. Health Rights Youth forum regular coordination meeting (District and Upazila	Baseline: 32	Target: 16	19	Target: 64	63	Achieved One meeting was postponed due to political unrest
		1.1.3. Number of meetings with facility authorities at local level organized by RCs	Baseline: 48	Target: 16	19	Target: 32	23	Not achieved. The deviation occurred because previous authority members were transferred following the July changes. It took time to build relationships with newly appointed members in some RC areas
		1.1.4. Number of public hearing (PH) meetings organized by Regional Chapters (RCs)	Baseline: 24	Target: 16	10	Target: 15	15	Achieved
		1.1.5. Community clinic coordination meeting	Baseline: 8	Target: 24	21	Target: 16	13	Not achieved The committee could not continue regular activities after the July movement. Political changes, new authority members, and forum restructuring disrupted the meetings

Outcome	Outcome Indicators	Output indicator	Baseline	Target: (2024) Year 1	Year 1 Achievements: 1st Feb 2024 to 31st Jan 2025	Target: (2025) Year 2	Year 2 Achievements: 1st Feb 2025 to 31st Jan 2026	Remarks: (Include reasons for any deviations or why not achieved)
	activities by RC and HO - Number of independent initiatives deployed by RC - Reduced turnover of the members A strategy for the sustainability of initiatives at the local level developed	1.1.6. Union Health and Family Welfare Center Coordination meeting	Baseline: 08	Target: 16	15	Target: 16	14	Not achieved. Two planned meetings at the Union Health and Family Welfare Centre were not held due to the absence of management committee members. Disruptions following the July uprising and the need to rebuild working relationships affected the meetings during the reporting period
		1.1.7. Coordination meeting with civil society/local government organizations/ NGOs	Baseline: 08	Target: 16	12	Target: 16	16	Achieved
		1.1.8. Online based meeting with RCs	Baseline: 08	Target: 4	5	Target: 8	08	Achieved
		1.1.9. Number of awareness and campaign at local level assisted by HOs Knowledge on SRHR at selected school	Baseline: 16	Target: 16	29	Target: 48	62	Overachieved On Safe Motherhood Day, campaigns were organised in eight areas. Additionally, World Health Day and World Population Day were observed, with campaigns conducted in seven areas. Discussion meetings and workshops were jointly organised in eight areas to mark Antibiotic Resistance Prevention Week. In addition, Health Olympiads were held in eight areas to engage young students
		1.1.10. An Action Plan for post project sustainability at the local level was developed	Baseline: XX	-	-	One Action Plan	-	In process

Outcome	Outcome Indicators	Output indicator	Baseline	Target: (2024) Year 1	Year 1 Achievements: 1st Feb 2024 to 31st Jan 2025	Target: (2025) Year 2	Year 2 Achievements: 1st Feb 2025 to 31st Jan 2026	Remarks: (Include reasons for any deviations or why not achieved)
1.2. Improved local level citizen-led facility monitoring and public hearing.	1.2. Lasting changes from recommendations captured during public hearing (gender desegregated data) Number of health facilities that use recommendations from RC monitoring. Lasting changes from monitoring recommendations identified	1.2.1. Number of independent monitoring of facilities conducted by RCs	Baseline: 00	Target: 8	8	Target: 30	29	Achieved Could not be achieved in one RC area due to political unrest
		1.2.2. Independent facility monitoring of 8 DHs and 08 UHSs is biannually conducted by youth volunteers	Baseline: 16	Target: 8	8	Target: 8	8	Achieved
		1.2.3. Percent of surveyed citizens who report overall satisfaction in healthcare	Baseline: 00	Target: 60%	-	Target: 60%	53%	Not achieved Institutional changes following the July uprising affected service delivery during the reporting period, which may have influenced citizens' satisfaction
		1.2.4. Number of workshops to train HO and HRF members on social accountability methods and tools	Baseline: 8	Target: 8	5	Target: 16	8	Achieved The orientation with Health Rights Forum members and the training programme on Social Accountability Methods and Tools are combined into one package. So there was no need to separate the training
		1.2.5. Capacity building for youth forums in 8 RCs on (Volunteerism, Rights to Information, Gender etc.)	Baseline: 32	Target: 8	8	Target: 16	16	Achieved Title: Social Accountability and Community Mobilisation

Outcome	Outcome Indicators	Output indicator	Baseline	Target: (2024) Year 1	Year 1 Achievements: 1st Feb 2024 to 31st Jan 2025	Target: (2025) Year 2	Year 2 Achievements: 1st Feb 2025 to 31st Jan 2026	Remarks: (Include reasons for any deviations or why not achieved)
		1.2.6. Capacity development workshop for DHRF and YHRF on social accountability methods/RTI tools	Baseline: --	Target: 8	8	Target: 8	8	Achieved. Title: Social Accountability and Advocacy.
		1.2.7. Percent increase in retention rate of Forum members	Baseline: 70%	Target: 90%	85%	Target: 95%	75%	Not achieved Most RC Forum members remained the same; however, one area underwent a complete restructuring with a new committee following the change in regime. Additionally, staff reshuffling among the health authority required time to rebuild relationships with the newly formed members
1.3. Increased strategic activities by CSO and other interest groups to reduce absenteeism and increase gender equity in the health service	1.3. Evidence of increased capacity and knowledge of CSO and interest groups to work on absenteeism and gender equity Number of scalable mechanisms to reduce absenteeism identified and publicized. Evidence of changes towards more gender friendly health services. Increased percentage of women in the Forums.	1.3.1. Number of awareness and advocacy events on absenteeism organized by RCs	Baseline: XX	Target: 08	01	Target: 7	7	Achieved Hold a planned workshop in 7 areas in collaboration with CS and prepare a report for National advocacy
		1.3.2. Number of actionable recommendations transmitted (through multiple channels) with facility authorities and policy stakeholders	Baseline: XX	--	05	XX	102	Achieved.
Outcome 2: Strengthened media engagement and capacity to promote social accountability in health								

Outcome	Outcome Indicators	Output indicator	Baseline	Target: (2024) Year 1	Year 1 Achievements: 1st Feb 2024 to 31st Jan 2025	Target: (2025) Year 2	Year 2 Achievements: 1st Feb 2025 to 31st Jan 2026	Remarks: (Include reasons for any deviations or why not achieved)
2.1. Increased role of local journalists to voice and publicize citizen's concerns about services in government health facilities	2.1. Number of media reports on health issues at the local and national levels published Number of events covered by media to engage and report on citizen's concerns Number of actions instigated by health reports	2.1.1. Number of journalists trained on health accountability and reporting at National Level	Baseline: 25 (Person)	27	27	Target: 25 (Person)	30	Overachieved
		2.1.2. Number of investigative reports and newspaper articles published at national dailies	Baseline:16 (Number of Reports)	Target: 10	21 (Reports have been published)	Target: 10	15	Overachieved
		2.1.3. Capacity building training of local journalists	Baseline: 08	Target: 08	8 (40 journalists were trained)	Target: 08 RCs (40 people)	8 (40 journalists were trained)	Achieved.
		2.1.4. Number of media reports publish in two years.	Baseline: 96	Target: 10	Original Submitted: 21 Revised: 37 reports have been published	Target: 15	17	Overachieved.
2.2. Strengthened digital media usage and increased social media presence to showcase RC activities and achievements	2.2. Evidence of improved social media engagement. Evidence of increased use of digital media (webinar). Evidence of improved social media engagement by females.	2.2.1. Orientation/training/ workshops on social media platform usages for HRF and HRYF	Baseline: Original Baseline: 04	Target: 02	2	Target: 02	8	Overachieved Instead of two training sessions for all RCs, the training was held in eight RCs individually.
		2.2.2. Webinars on Absenteeism, Health Governance, High Price of Medicines, Anti-microbial resistance, etc.	Baseline: 03	Target: 04	03	Year 2: 04	02	Not achieved. However, instead of the planned webinars, a social media campaign on dengue awareness was organized. As part of this campaign, 10 public health experts were interviewed, resulting in 10 separate pieces of video content. The contents received a total of 1,000 views, with 40% female engagement. The shift allowed continued public engagement and a wider reach online

Outcome	Outcome Indicators	Output indicator	Baseline	Target: (2024) Year 1	Year 1 Achievements: 1st Feb 2024 to 31st Jan 2025	Target: (2025) Year 2	Year 2 Achievements: 1st Feb 2025 to 31st Jan 2026	Remarks: (Include reasons for any deviations or why not achieved)
Outcome 3: Strengthened advocacy work to accelerate the implementation of Health Care, improve the quality of health and reduce corruption ipsum								
3.1. Public opinion created, and policy makers mobilized to accelerate UHC implementation	3.1. Number of commitments of policy stakeholders for increased allocation in Primary Health Care (PHC)	3.1.1. High-level consultative meeting on PHC allocation	Baseline: 00	Target: 01	-	Target: 01	02	Overachieved (Additional thematic Group meetings held)
		3.1.2. Number of policy stakeholders at national levels that are aware of equity issues related to PHC budget and expenditure	Baseline: 0	Target: 50 (Person)	-	Target: 50 (Person)	70	Overachieved. (Two rounds of events at DGHS) .
		3.1.3. Round table discussion on PHC allocation with national-level stakeholders	Baseline: 0	Target: 02	-	Target: 02	0	Not achieved. Not achieved due to delayed approval from DGHS; however, it is planned to be conducted in the current phase.
		3.1.4. Number of policy stakeholders at local levels that are aware of equity issues related to PHC budget and expenditure	Baseline: 0	Target: 100 (Person)		Target: 50 (Person)	40	Not achieved. The target was set high relative to the limited number of relevant policy stakeholders available at the local level

Outcome	Outcome Indicators	Output indicator	Baseline	Target: (2024) Year 1	Year 1 Achievements: 1st Feb 2024 to 31st Jan 2025	Target: (2025) Year 2	Year 2 Achievements: 1st Feb 2025 to 31st Jan 2026	Remarks: (Include reasons for any deviations or why not achieved)
3.2. Use of legal provisions for improving quality of health services	3.2. Evidence of better awareness of High Court directives on the reduction of unnecessary Caesarean Section and emergency medical treatment facilities. At least one Public Interest Litigation (PIL) lodged, written petition and follow-up in partnership, e.g., with a legal organization.	3.2.1. Number of policy stakeholders that are aware of PIL issues and pending judgments and committed to influence process into action	Baseline: x	Target: 60 (Person)	-	Target: 60 (Person)	140	Overachieved In several events related to C-section and post-crash care.
		3.2.2. Increase in number of issues on which court judgements sought	Baseline: 2	Target: 02	-	Target: 02	00	Not achieved. No new PIL was initiated during the reporting period.
3.3. Increased commitment of policy stakeholders to address corruption issues related to absenteeism and medicine prices	3.3. Discussions on the two issues in national and local media and at policy level Policy recommendations in the area of absenteeism and medicine pricing. A possible accountability platform formed on absenteeism and collaborations, reducing medicine prices strengthened.							Note: Structured regional dialogues were held between January and May 2025 with district and upazila health managers and medical officers across eight districts to discuss doctor absenteeism and rural retention. Based on these consultations and national stakeholder interviews, a comprehensive report has been prepared to support evidence-based policy advocacy on rural doctor retention, highlighting key professional and policy factors influencing rural postings and proposing a practical roadmap for action. A national-level policy dialogue is planned in the current phase of the project, and the findings will also be shared with the donor consortium. In addition, preparations are underway to establish a multi-stakeholder platform on medicine pricing ("Pharma Watch") to strengthen transparency, accountability, and collaboration in addressing concerns about medicine prices. These are planned activities of the AC Coalition.

ANNEXURE 2

ENHANCING HEALTHCARE SERVICES THROUGH FACILITY OBSERVATION AND PATIENT FEEDBACK

ENHANCING HEALTHCARE SERVICES THROUGH FACILITY OBSERVATION AND PATIENT FEEDBACK

by Mahruba Khanm, Dr. Imrul M Sifat

Table of Contents

Acknowledgement 1
Introduction 2
Objective 2
General Objective 2
Specific Objectives 2
Process of information gathering 2
Key Indicators 3
I. Facility Observation Indicators (Direct Observation) 3
II. Patient Exit Interview Indicators (Face to face at Exit Point) 4
Key findings 4
I. Direct Observations 4
Facility Readiness & Infrastructure 4
A. Cleanliness & Hygiene Standards 4
B. Clinical Services & Diagnostics 5
C. Patient Amenities (Food & Water) 5
D. Workforce profile of the Institution / Human Resources 5
E. Governance & Accountability 9
F. Grievance Redressal & Transparency 9
II. Patient Exit Interview 10
G. Patient Satisfaction 11
H. Waiting Times 12
Discussion/ Overall observations 13
Recommendations 14
Conclusion 14

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Enhancing healthcare services through facility monitoring and patient feedback

Introduction: Despite structural growth in Bangladesh's healthcare system, persistent challenges—such as inequity, poor accountability, and limited responsiveness—continue to affect the quality and accessibility of services, particularly in rural areas. To address these issues and enhance social accountability in health, Bangladesh Health Watch (BHW), with support from SIDA, initiated a project to make healthcare systems more responsive and participatory. As part of this effort, Regional Chapters (RCs) were established across eight regions, forming Health Rights Forums (HRFs) and Health Rights Youth Forums (HRYFs). These Forums empower communities to advocate for their health rights, monitor local services, and promote inclusive health governance.

Under the second phase of the project, "*Institutionalising Accountability in Health Systems to Improve Access to Services*," BHW undertook activities to document local services, assess the implementation of activities by the Regional Chapters, and identify gaps for improvement.

Objective

General Objective: To institutionalise social accountability mechanisms within Bangladesh's health system by strengthening community-led, e.g., RCs, HRFs, and HRYFs, monitoring, engagement, and evidence generation to improve access, equity, transparency, and responsiveness of healthcare services.

Specific Objectives

1. To systematically document the status, functionality, and performance of selected public healthcare facilities across eight regions.
2. To assess the implementation progress and effectiveness of activities carried out by the Regional Chapters.
3. To identify service delivery gaps, governance challenges, and accountability bottlenecks affecting access and quality of care.
4. To generate evidence-based recommendations to inform local and national-level stakeholders for improving participatory health governance and service responsiveness.

Process of information gathering

1. ***Facility assessment:*** Health facilities across the eight catchment areas were visited for observation. One facility from each type—Upazila Health Complexes (UHCs) and District Hospitals (DHs)—was assessed per area. The assessment focused on key aspects of service delivery, documenting challenges, gaps, and the general functioning of the facilities. Appropriate authorities were contacted in advance to schedule visits, and assessments were carried out without disrupting routine operations.
2. ***Exit interviews with patients:*** Adult patients (aged 18–69 years) who had received health services were interviewed upon exiting the facility to collect information on their experiences and satisfaction. A total of 300 exit interviews were conducted across the eight catchment areas. Numbers were proportionally distributed among the two facility types.

Development and use of data collection tools: Two checklists were prepared for consistent information collection: one for facility observations and one for face-to-face exit interviews with patients. Data were collected using the Kobo toolbox. These tools were designed to gather clear and structured information on service delivery, patient satisfaction, and facility management.

Training of youth volunteers: BHW Regional Chapters engaged youth volunteers in data collection. Volunteers (2–6 per Regional Chapter, depending on facility accessibility) were trained in a day-long online session covering: project objectives, target populations, and methods for information gathering using the prepared checklists. This capacity-building activity aimed to enable volunteers to conduct repeated information checks efficiently and accurately.

Information analysis: Information collected from facility observations and exit interviews was compiled and presented in tables and charts. Key aspects such as general satisfaction, technical quality, interpersonal interactions, communication, financial considerations, time spent with the doctor, and accessibility were summarised to highlight patterns and identify areas needing attention.

Duration: The facility assessments and exit interviews were conducted over a period of three months from November 2025 to January 2026, coordinated across the eight catchment areas of the BHW Regional Chapters.

Key Indicators

To assess changes associated with Regional Chapter (RC) activities, a structured set of indicators was applied across selected facilities. The exercise included:

1. **Direct observation** to understand supply-side functionality.
2. **Patient exit interviews** to capture user experience.

Each key indicator included several sub-indicators to allow a detailed assessment of strengths and gaps.

I. Facility Observation Indicators (Direct Observation)

The following indicators were assessed through on-site observation, document review, and interaction with facility representatives:

A. Cleanliness and Hygiene Standards

B. Clinical Services and Diagnostic Availability

C. Patient Amenities (Food and Drinking Water)

D. Workforce Profile / Human Resources Availability and Vacancies

E. Governance and Accountability Practices

F. Grievance Redressal Mechanisms and Transparency Measures

These indicators primarily reflect structural readiness, service availability, and institutional accountability mechanisms.

II. Patient Exit Interview Indicators (Face to face at Exit Point)

The following indicators were assessed through structured face to face interviews with patients at the time of exiting the consultation room:

G. Patient Satisfaction with Services Received
H. Waiting Time for Consultation and Services

These indicators capture user-reported experience and perceived responsiveness of care.

Key findings

I. Direct Observations

Facility Readiness & Infrastructure

Data from this facility monitoring cycle across the eight divisions highlight a clear gap between the physical growth of healthcare facilities and the actual functionality of services provided. While infrastructure such as buildings, equipment, and staffing positions has been established, the effective operation of these facilities is often constrained by weaknesses in governance, delays in decision-making, and unequal distribution of resources. In other words, although the "hardware" of the system exists, the "software" including management, service delivery processes, and accountability mechanisms remains underdeveloped.

This section provides a detailed overview of the physical conditions and the availability of services in the monitored facilities.

A. Cleanliness & Hygiene Standards

The findings (Table-1) show that out of 15 assessed facilities (8 District Hospitals and 7 Upazila Health Complexes), toilets and washrooms were found clean in only 2 facilities, making this the most critical gap. In contrast, trash bins were available in 14 out of 15 facilities, and hospital premises and stairs were clean in 13–14 facilities, indicating that visible areas and basic infrastructure are largely in place. Cleanliness of ward beds was maintained in 11 out of 15 facilities, and ward areas were clean in 10 out of 15 facilities, though inconsistencies were more evident in some District Hospitals.

Overall, the figures suggest that while structural elements of hygiene are present, routine sanitation management—particularly in toilets and washrooms—remains a significant weakness (13/15).

Table 1: Distribution of cleanliness & hygiene status by type of facility and the indicators

Area of cleanliness	Manikganj		Borguna	Khagrachari		Bagerhat		Netrokona		Kurigram		Sunamganj		Chapai nawabganj	
	DH	UHC	DH	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC
Cleanliness of Ward Beds	✗	✓	✓	✓	✗	✓	✗	✓	✓	✓	✗	✓	✓	✓	✓
Cleanliness of Hospital Ward Areas	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✗	✓	✓
Cleanliness of Toilets and Washrooms	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗
Availability of trash bins	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Cleanliness of available trash bins	✗	✓	✗	✓	✗	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓
Cleanliness of hospital stairs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Cleanliness of Hospital Premises	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓

* ✓ = Clean/ Available ✗=Not Clean/ Not Available

B. Clinical Services & Diagnostics

Table 2 shows that while all facilities ensured sample collection during office hours and most displayed test and fee information (15/16), fewer provided information on available medicines (10/16), indicating a key area for improvement in patient access to essential service details.

Table 2: Clinical Services & Diagnostics status

Sub Indicators	Manikganj		Borguna	Khagrachari		Bagerhat		Netrokona		Kurigram		Sunamganj		Chapai nawabganj	
	DH	UHC	DH	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC
Sample collection during office hours	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Displayed Information on Available Tests	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Display of Diagnostic Test Fees	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓
Displayed Information on Available Tests Medicines	✗	✓	✗	✓	✗	✓	✗	✓	✗	✓	✓	✓	✓	✓	✓

C. Patient Amenities (Food & Water)

Table 3 shows that availability and adherence to hospital meal menus were inconsistent, with only a few facilities (6/16) meeting both criteria. Safe food handling was observed in about half of the facilities (8/16), while safe drinking water was available in most UHCs (7/8) but less consistently in DHs (4/8), highlighting gaps in basic patient support services.

Table 3: Patient Amenities (Food & Water) by the name of facility

Sub indicators	Manikganj		Barguna	Khagrachari		Bagerhat		Netrokona		Kurigram		Sunamganj		Chapai nawabganj	
	DH	UHC	DH	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC
Availability of patient meal menus in hospitals	✗	✗	✓	✗	✗	✓	✗	✓	✗	✓	✓	✗	✗	✓	✓
Adherence to hospital meal menus	✗	✗	✓	✓	✗	✗	✗	✓	✗	✓	✗	✓	✓	✓	✓
Safe food handling in hospitals	✓	✓	✗	✗	✗	✗	✗	✗	✗	✓	✓	✓	✗	✗	✓
Availability of safe drinking water	✗	✗	✓	✗	✗	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓

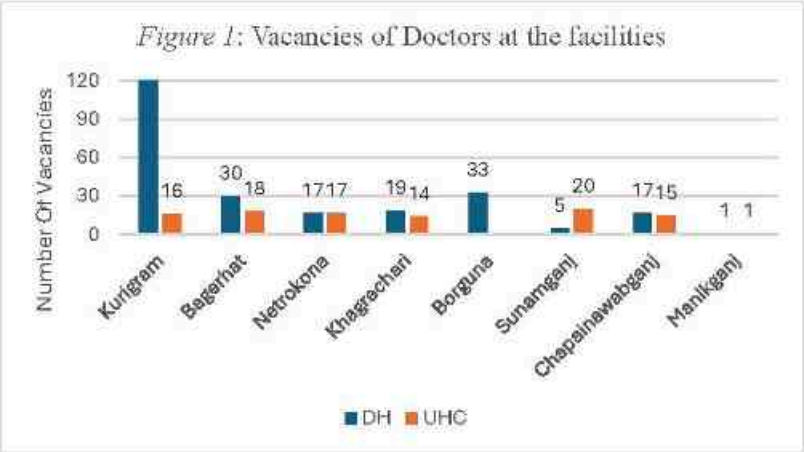
* ✓ = Available ✗= Not Available

D. Workforce profile of the institution / Human Resources

Vacancies of Doctors:

Figure 1 shows that doctor vacancies are highest in Kurigram DH (120) and notably high in Barguna DH (33) and Bagerhat DH (30), while UHCs generally have far fewer vacancies. Some districts, such as Manikganj, have minimal shortages (1 vacancy each in DH and UHC), indicating uneven distribution of medical staff across regions.

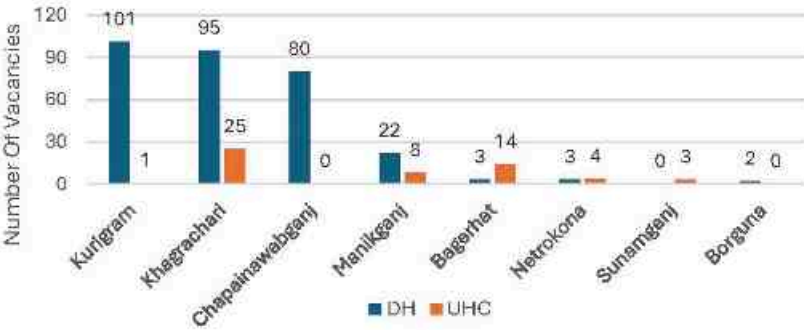
Figure 1: Vacancies of Doctors at the facilities



Vacancies of Nurse:

As shown in Figure 2, nurse vacancies are concentrated mainly in District Hospitals (DHs) across most districts. Severe shortages are observed in Kurigram (101 in DHs vs. 1 in UHCs), Khagrachari (95 vs. 25), and Chapainawabganj (80 vs. 0). Manikganj shows moderate vacancies in both DHs (22) and UHCs (8). In contrast, Bagerhat and Netrokona report relatively low DH vacancies (3 each), though UHC shortages are slightly higher. Overall, vacancies are more pronounced at the district hospital level.

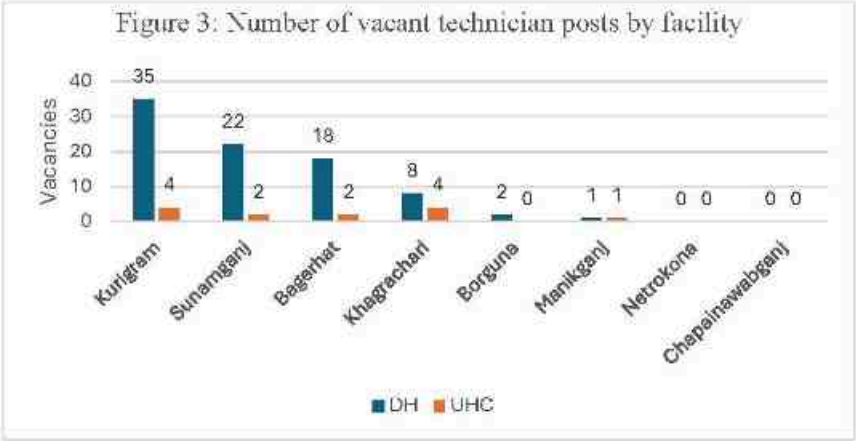
Figure 2: Number of vacant nurse posts at facility



Vacancies of Technician:

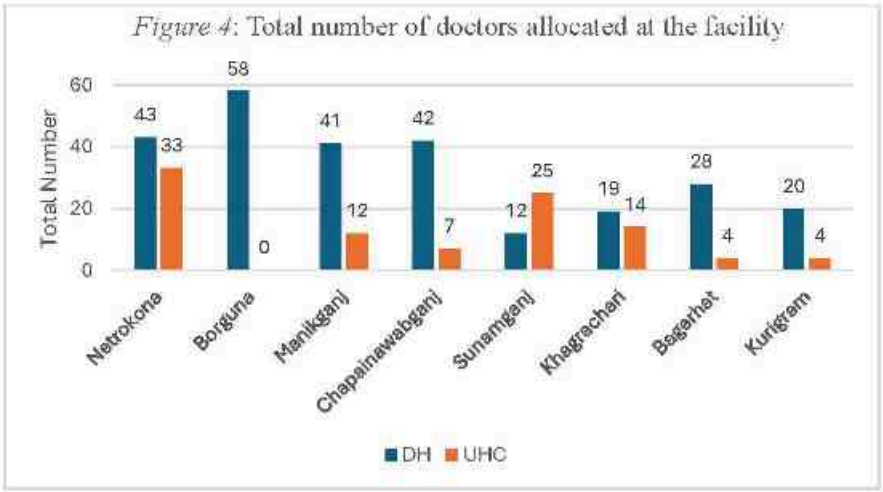
As shown in *Figure 3*, technician vacancies are generally higher in District Hospitals (DHs) than in Upazila Health Complexes (UHCs). Kurigram reports the highest shortages (35 in DHs and 4 in UHCs), followed by Sunamganj (22 and 2) and Bagerhat (18 and 2). Khagrachari shows moderate vacancies (8 in DHs and 4 in UHCs). In contrast, Borguna and Manikganj report minimal shortages, while Netrokona

and Chapainawabganj show no vacancies in either facility type. Overall, vacancies are more concentrated at the district hospital level.



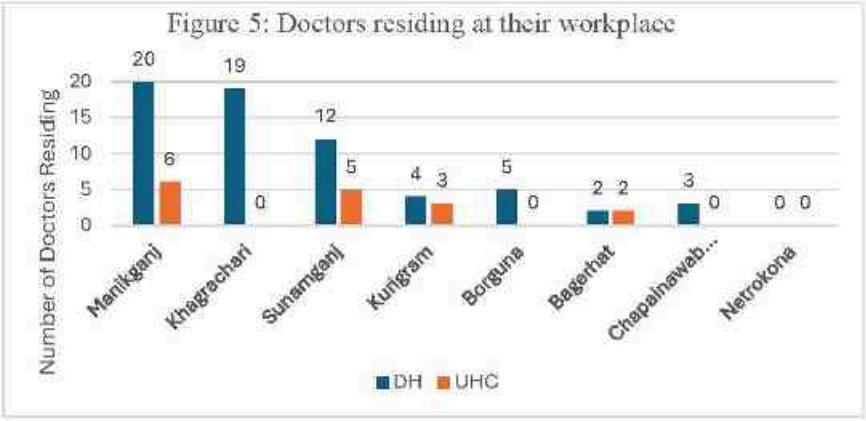
Total number of Doctors:

As shown in Figure 4, the total number of doctors is higher in District Hospitals (DHs) than in Upazila Health Complexes (UHCs) in most districts. Borguna (58), Netrokona (43), Chapainawabganj (42), and Manikganj (41) report comparatively higher numbers of doctors in DHs, while UHC numbers remain substantially lower, including no doctors in Borguna. Sunamganj is an exception, where UHCs (25) have more doctors than DIIs (12). Khagrachari shows a relatively smaller gap (19 in DIIs and 14 in UHCs). Overall, doctor distribution is concentrated at the district hospital level, with notable inter-district variation.



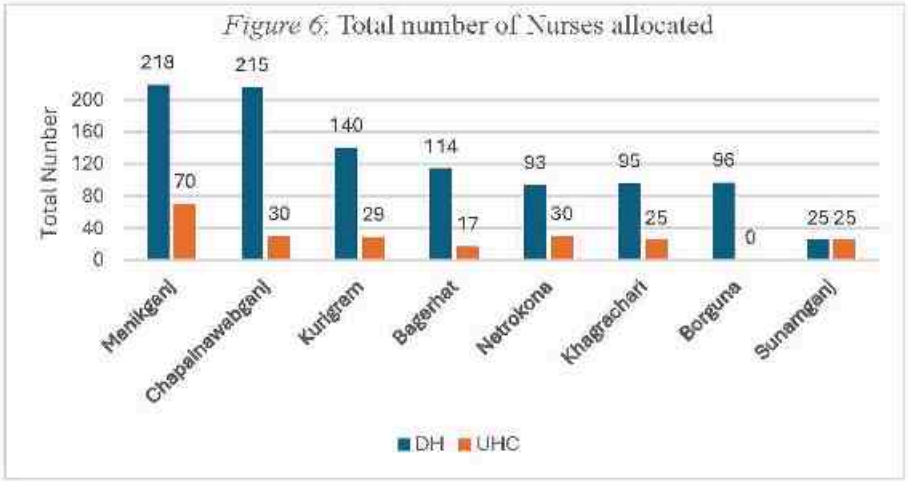
Doctors residing:

Figure 5 shows the number of doctors residing at the workplace in District Hospitals (DHs) and Upazila Health Complexes (UHCs) across the eight districts. Overall, more doctors were residing in DHs than in UHCs. The highest numbers at DHs were reported in Manikganj (20), Khagrachari (19), and Sunamganj (12). In contrast, residence in UHCs was limited, with the highest in Manikganj (6) and Sunamganj (5), while several districts reported none. No doctors were residing at either level in Netrokona (0, 0).



Total Nurse:

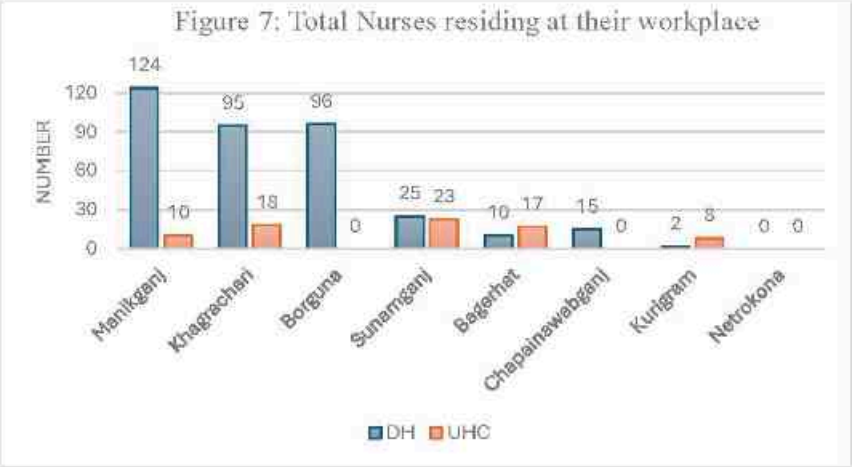
Figure 6 shows the total number of nurses in DHs and UHCs across the eight districts. In all districts, the number of nurses was substantially higher in DHs than in UHCs. The highest numbers of nurses in DHs were reported in Manikganj (218) and Chapainawabganj (215), followed by Kurigram (140) and Bagerhat (114). In contrast, UHC-level numbers were comparatively low, with the highest in Manikganj (70), while Borguna reported no nurses at UHCs (0). Overall, nurse distribution is heavily concentrated at the district hospital level.



8

Nurses residing:

Figure 7 shows substantial variation in the number of nurses residing at their workplace across districts, with a pronounced gap between DHs and UHCs. Residence is notably high in DHs in Manikganj (124), Khagrachari (95), and Borguna (96), while corresponding UHC figures remain comparatively low (10, 18, and 0 respectively), indicating a significant imbalance. In contrast, overall residence is very low in Chapainawabganj (15 in DH; 0 in UHC), Kurigram (2 in DH; 8 in UHC), and Netrokona (0 in both), suggesting critical shortages in on-site availability. These disparities highlight districts and facility types where targeted residential or retention interventions are most needed.



E. Governance & Accountability

Table 4 shows the presence and absence of brokers (dalal) in DH and UHCs across the selected districts. The findings indicate that brokers were absent in most facilities in Manikganj (DH, UHC), Borguna (DH), Bagerhat (DH), Netrokona (DH, UHC), Kurigram (DH), and Sunamganj (DH, UHC). However, the presence of brokers was reported in several facilities, including Khagrachari (DH), Bagerhat (UHC), Netrokona (UHC), Kurigram (UHC), and Chapainawabganj (DH). Overall, the table suggests that while broker presence is not universal, it remains evident in a number of facilities across different districts.

Table 4: Broker (Dalal) Presence

Status	Manikganj		Borguna	Khagrachari		Bagerhat		Netrokona		Kurigram		Sunamganj		Chapai nawabganj	
	DH	UHC	DH	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC
Absent	✓	✓	0	✓	✓	0	0	0	0	0	✓	✓	✓	0	✓
Present	0	0	✗	0	0	✗	✗	✗	✗	✗	0	0	0	✗	0

✓ = Broker absent at the facility; ✗ = Broker present at the facility; 0 = No data available.

F. Grievance Redressal & Transparency

Table 5 presents the status of complaint boxes, information desks, and citizen charter display across District Hospitals and Upazila Health Complexes in the selected districts.

Overall, most facilities reported active complaint boxes and information desks, particularly in Sunamganj, Bagerhat, Kurigram, and Chapainawabganj (UHC), where all three accountability mechanisms were functional. In contrast, Netrokona (DH and UHC) had no complaint boxes or information desks, although the citizen charter was displayed in both facilities. In Manikganj and Chapainawabganj (DH), complaint boxes and information desks were present but inactive, indicating partial implementation. Khagrachari showed variation between facilities, with the DH lacking an information desk and the UHC not displaying the citizen charter. Borguna DH had inactive complaint boxes and no information desk, while data for Borguna UHC were not available. These findings suggest that while citizen charter display is relatively consistent across facilities, the functionality of complaint boxes and information desks varies by district and facility type.

Table 5: Complaint Boxes, Information Desk, Citizen Charter

District	Facility	Complaint Box Status	Information Desk Status	Citizen Charter Displayed?
Manikganj	DH	⚠	⚠	✓
	UHC	⚠	✓	✓
Khagrachari	DH	✓	✗	✓
	UHC	✓	✓	✗
Sunamganj	DH	✓	✓	✓
	UHC	✓	✓	✓
Bagerhat	DH	✓	✓	✓
	UHC	✓	✓	✓
Kurigram	DH	✓	✓	✓
	UHC	✓	✓	✓
Netrokona	DH	✗	✗	✓
	UHC	✗	✗	✓
Chapainawabganj	DH	⚠	⚠	✓
	UHC	✓	✓	✓
Borguna	DH	⚠	✗	✓
	UHC	N/A*	N/A*	N/A*

Status Key: ✓ **Active:** Present and Functional.
⚠ **Inactive:** Present but Not Functional. ✗ **Absent:** Not Present.

II. Patient Exit Interview

To complement the facility observations, structured face to face patient exit interviews were conducted with service users at the time of leaving the consultation room. The objective of this component was to assess whether observed improvements in facility conditions and governance mechanisms were reflected in patients' actual experiences of care, so that managers can identify service delivery gaps, prioritise responsive actions, and refine interventions based on user-reported evidence. The interviews captured real-time feedback on service quality,

provider behaviour, responsiveness, and waiting time, thereby providing a user-centred perspective on service delivery outcomes.

G. Patient Satisfaction

Table 6 presents the number of patients who answered "Yes" to different questions about their experience of care (Table 6). The findings for each aspect are interpreted below, with the numbers shown in brackets for easy reference to the table.

- ***Timely availability of healthcare providers:*** More patients in Manikganj and Chapainawabganj reported that providers were available on time (e.g., 20 in Manikganj DH and UHC; 19–20 in Chapainawabganj DH and UHC). In contrast, lower numbers were seen in Kurigram (12 in DH) and Borguna (12 in DH), suggesting possible delays in some facilities (Table 6).

- ***Adequate time given during consultation***: Patients in Manikganj, Chapainawabganj, and Khagrachari UHC more often felt they were given enough time (mostly 18–20). However, very low numbers were reported in Bagerhat UHC (2) and Borguna DH (10), indicating that some patients may feel rushed during consultation (Table 6).

- ***Attentive listening by providers:*** Positive responses were high in Manikganj and Chapainawabganj (19–20). Lower numbers were observed in Bagerhat DH (7), Borguna DH (9), and Kurigram DH (11), showing that listening and communication may need improvement in those areas (Table 6).

- ***Sincerity of healthcare providers:*** Most districts reported good perceptions of provider sincerity, especially Manikganj, Chapainawabganj, Sunamganj, and Khagrachari (mostly 19–20). Lower responses were found in Bagerhat DH (12) and Borguna DH (10) (Table 6).

- ***Privacy during examination:*** Privacy was generally rated positively in many districts (often 20 in Manikganj, Chapainawabganj, Sunamganj, and Netrokona). However, lower numbers were reported in Kurigram DH (12) and Borguna DH (17), suggesting some gaps remain (Table 6).

- ***Impact of cost on service use***: In some districts, more patients said cost affected their use of services, such as Netrokona DH (17) and Manikganj UHC (20). In others, such as Khagrachari UHC (4) and Chapainawabganj UHC (4), fewer patients reported cost as a concern (Table 6).

- ***Overall satisfaction with services:*** Even when patients rated providers positively, overall satisfaction with the facility was low in several districts. Very low numbers were seen in Netrokona (3 in DH; 2 in UHC), Sunamganj (4 in DH; 6 in UHC), and Chapainawabganj (1 in DH; 0 in UHC). Manikganj showed comparatively higher satisfaction (20 in DH; 18 in UHC) (Table 6).

The results show that while many patients appreciated provider's behaviour (such as sincerity and privacy), overall satisfaction with services remained low in several districts, suggesting that other service-related issues may be affecting patient experience (Table 6).

Table 6: Patient satisfaction in receiving the services by type of facility

District	Facility	Timely availability of healthcare providers	Adequate time provided by healthcare providers	Attentive listening by healthcare providers	Sincerity of healthcare providers	Privacy protection during health examinations	Impact of cost on healthcare service utilisation	Satisfaction with services at the centre
Manikganj	DH	20	20	19	20	20	16	20
	UHC	20	16	20	20	20	20	18
Khagrachari	DH	19	18	19	19	20	11	5
	UHC	20	20	20	19	20	4	20
Sunamganj	DH	19	20	18	20	20	14	4
	UHC	18	20	20	20	20	5	6
Netrokona	DH	15	16	17	19	20	17	3
	UHC	13	16	16	18	20	14	2
Bagerhat	DH	15	8	7	12	17	3	12
	UHC	17	2	9	10	18	10	12
Kurigram	DH	12	8	11	15	12	4	4
	UHC	17	15	13	16	10	12	10
Chapai nawabganj	DH	19	20	20	20	20	10	1
	UHC	20	20	19	20	20	4	0
Borguna	DH	12	10	9	10	17	3	5

** Note: Values represent the number of respondents who answered "Yes"*

II. Waiting Times

Table 7 presents the distribution of patient waiting times across DH and UHCs in the selected districts. Waiting times of 30 minutes were commonly reported across most facilities, including Manikganj (DH 16%, UHC 17), Kurigram (DH 18, UHC 12), and Borguna DH (11). Shorter waiting times of 15 minutes were more frequently observed in Khagrachari (UHC 17, DH 10) and Chapainawabganj (DH 14, UHC 7). Longer waiting times (60 minutes or more) were notably higher in Bagerhat DH (17) and Netrokona DH (8) compared to several other facilities where such delays were minimal or absent. In some UHCs, including Khagrachari and Sunamganj, no respondents reported waiting 60 minutes or more (0).

Overall, the findings indicate that a 30-minute waiting time is most common across districts, while prolonged waiting (60+ minutes) is concentrated in a few specific facilities.

Table 7: Waiting times to receive the services from the facility

Waiting time (in minutes)	Manikganj		Khagrachari		Sunamganj		Netrokona		Bagerhat		Kurigram		Chapai		Borguna
	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH	UHC	DH
15 Minutes	0	0	10	17	8	8	5	6	0	2	0	7	14	7	6
30 Minute	16	17	7	3	10	12	7	8	3	10	18	12	6	12	11
60+Minutes	14	13	3	0	2	0	8	6	17	8	2	1	0	1	3

Discussion/ Overall observations

This facility monitoring across eight districts provides a mixed picture of public healthcare services. While basic infrastructure and service structures are largely in place, important gaps remain in functionality, human resources, patient amenities, and accountability mechanisms.

First, in terms of cleanliness and hygiene, visible areas such as premises, stairs, and availability of trash bins were generally satisfactory in most facilities. However, toilets and washrooms were clean in only a very small number of facilities (2 out of 15). This indicates that routine maintenance and supervision are weak, especially for less visible but critical areas. Poor sanitation in toilets can directly affect patient dignity, infection control, and overall perception of care.

Second, clinical services and diagnostics appear structurally available. Sample collection during office hours and display of test information were reported in almost all facilities. However, information on available medicines was not consistently displayed. Lack of clear information about medicines can create confusion, increase out-of-pocket expenses, and reduce transparency.

Third, patient amenities such as food and safe drinking water showed considerable variation. Only a few facilities met both criteria of meal availability and adherence to the menu. Safe drinking water was more available in UHCs than in DHs. These findings suggest that supportive services, which are essential for inpatient care and patient comfort, are not given equal priority across facilities.

Human resource distribution remains one of the most critical challenges. Doctor, nurse, and technician vacancies are substantially higher in District Hospitals compared to Upazila Health Complexes in several districts. In some districts, vacancies are extremely high, particularly for doctors and nurses. Although the total number of doctors and nurses is higher in DHs, residence at the workplace is uneven and low in some areas. This indicates both distribution and retention problems. Facilities with high vacancies and low residential presence may face disruptions in service continuity and emergency response.

Governance and accountability mechanisms show partial implementation. Brokers (dalal) are still present in some facilities, indicating weaknesses in service transparency and control systems. Complaint boxes and information desks are available in many facilities, but some are inactive or absent. While citizen charters are widely displayed, the functionality of grievance redressal systems varies. This suggests that accountability structures exist on paper but are not fully operational in all settings.

Patient satisfaction findings reveal an important pattern. In several districts, patients reported positive experiences in terms of provider behaviour, respectful treatment, and privacy. However, overall satisfaction with services at the facility was low in a number of districts, even when interpersonal aspects were rated positively. This suggests that structural and systemic issues—such as waiting times, shortages, service delays, or cost concerns—may be influencing overall perception of care more than individual provider behaviour.

Waiting time analysis shows that 30 minutes is the most common waiting period across facilities. However, prolonged waiting times (60 minutes or more) are concentrated in certain District Hospitals. This again reflects pressure on higher-level facilities and possible inefficiencies in patient flow management.

Overall, the findings highlight a clear gap between infrastructure and effective service delivery. Physical structures, equipment, and formal accountability mechanisms are present in many cases. However, routine management, workforce distribution, sanitation maintenance, and functional grievance systems

remain uneven. Strengthening these "management and accountability" components is essential to translate infrastructure into quality care.

Recommendations

- *Improve routine sanitation management:* Assign clear responsibility and regular supervision for toilet and washroom cleaning, with simple monitoring checklists and public display of cleaning schedules.
- *Address critical human resource gaps:* Prioritise filling doctor and nurse vacancies in high-shortage districts and introduce incentives for residential stay at facilities, especially in District Hospitals.
- *Activate grievance systems:* Ensure complaint boxes and information desks are functional, regularly monitored, and publicly reported to build trust and reduce broker influence.
- *Strengthen patient support services:* Standardise hospital meal services and ensure safe drinking water in all facilities as minimum service standards.
- *Improve patient flow management:* Introduce simple queue management or triage systems in high-volume facilities to reduce prolonged waiting times.

These actions are practical, low-cost, and can be implemented within existing administrative structures.

Conclusion

There are improvements in the number of health facilities and some aspects of patient care, but service quality and patient experience still vary across districts. Issues such as staff shortages, gaps in cleanliness, weak complaint systems, and limited patient amenities continue to affect satisfaction. Programme designers should focus on strengthening management, ensuring staff presence, improving feedback systems, and monitoring basic services. Continued monitoring of these areas will be essential to track progress and ensure that the intervention makes healthcare more responsive, accountable, and patient-centred.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