

Case study



Bangladesh

Modelling WASH in community clinics



Context

By 1996, Bangladesh was well behind its goal of achieving health for all by 2000. To address those shortfalls, the Government of Bangladesh (GoB) established community clinics (CCs), one stop health centres (HCs) for every 6,000 people across the country. The CCs aimed to meet community health needs – such as family planning, nutrition services, childcare, overall antenatal and postnatal care, free basic medicines, primary care and referral – under one roof and within a half hour walking distance from their homes, even in remote areas.

The CCs are situated at the ward level (smallest local government administrative unit in Bangladesh) under the Union Parishad (lowest tier of local government), and are managed by Community Groups (CGs) and Community Support Groups (CSGs), with representation from local communities and Local Government Institutions (LGIs). The CCs are a unique Public Private Partnership initiative in Bangladesh, where the community provides the land, the government constructs the infrastructure, provides medicines and operational costs, and the local community manages it on a voluntary basis.

▼ Banoara receiving medicine from CHCP Shongita Parvin at Noapara community clinic. Noapara Gangni, Meherpur, Bangladesh. October 2019.



Barriers

The barriers to progress on WASH in HCF were due to several reasons:

- **Lack of clarity on roles and responsibilities for WASH in CCs.** Although CGs were responsible for the overall management of the CCs, in many cases, the roles and responsibilities were not clear even to the local government. In addition, CGs and CSGs at the local level were often not organised or adequately informed, leading to limited participation of CGs.
- **Issues around O&M resulted in an absence of, or poor quality, WASH facilities** as well as other aspects of CC infrastructure (such as roofing). This was in part caused by a lack of budget allocation for O&M and exacerbated by environmental challenges such as arsenic in the water supply, flooding or salinity.

The poor condition of the infrastructure neither inspired the community to seek services nor motivated the service providers (especially women healthcare workers) to provide healthcare.
- **Remoteness and an inadequate supply of medicine** for the population meant that the operation of the CCs was irregular.
- **Inadequate capacity of LGIs** on how to manage and monitor WASH in CCs, along with no accountability for budget allocation, sometimes led to duplication of funds.
- **Advocacy** was needed to support the health engineering department (HED) and fund the CC improvements.
- **Population growth meant that CCs were overwhelmed.** Each CC was built to serve 6000 people, however in reality, the clinics served more than this.

Approach

WaterAid Bangladesh started work on WASH in HCF in 2016, after the Bangladesh Ministry of Health (MoH) carried out a survey – with support from WaterAid Bangladesh, UNICEF and the WHO – which revealed the nationwide lack of WASH in CCs. WaterAid Bangladesh modelled improvements in CCs in two districts, Tahirpur upazila (subdistrict) of Sunamganj district and in Meherpur sadar upazila of Meherpur district, working with development partners, the local health directorate office and a directorate of the health department.

In 2017, WaterAid Bangladesh along with local partner SKS Foundation, facilitated the capacity and skill development of both the CGs and the duty bearers responsible for the CCs. The training for the CGs covered roles and responsibilities, basic financial management, reporting and organisation of monthly meetings. The duty bearers training for the local government institution covered roles and responsibilities, and allocation of funds from national and local government for O&M. WaterAid worked with both levels of government to advocate for funds to be allocated for O&M.

WaterAid Bangladesh created a model at the CC level so the government could replicate this across CCs to have significant impact. To assist scale up, WASH guidelines for the CCs were developed by WaterAid Bangladesh and endorsed by the GoB.

Evidence of change

The evidence is compelling, with the average flow of patients visiting the CCs in the districts in the intervention increasing by 30%.¹¹ Previously, the community lacked clarity on the remit of CCs and would travel instead, at their own cost, to the district health centres to seek care. After the intervention, the CCs were more popular and contributed to overall community health services – further improving the confidence of the stakeholders. The service provider and the CHCP were observed to be more likely to stay in the CCs for their entire workhours. Previously, providers were forced to leave the clinic if they needed to drink water or visit the toilet.

An accessibility audit led to the introduction of inclusive WASH facilities. The interventions described above contributed to around 300 women giving birth at the CCs in the last three years compared to none before as suggested by HCF recorded data.

Through capacity building in the districts, the CGs were empowered to start monitoring the work schedule, service quality, medicine disbursement, patient flow, governance, infrastructure and repair issues, monthly meetings, and community participation. The GoB adopted the model and incorporated this in their updated or new CC designs.



► Nurses working in the Fulchari Health Complex, Gaibanda, Bangladesh. 10 March 2022.



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11. WaterAid India (2020). *Social Accountability and System Strengthening for water, sanitation and hygiene in South Asia*. Available at: [wateraidindia.in/publications/social-accountability-and-system-strengthening-for-water-sanitation-and-hygiene-in](https://www.wateraidindia.in/publications/social-accountability-and-system-strengthening-for-water-sanitation-and-hygiene-in) (accessed 8 Mar 2022).



WaterAid/Farzana Hossen

▲ Nahida Aktar works at the Saharhati CC as a CHCP. Gangni, Meherpur, Bangladesh. 2019.

▶ Nahida Aktar is measuring the blood pressure of Sabina Khatun at the Saharhati CC, Gangni, Meherpur, Bangladesh. 2019.



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Key lessons

- The key to success is to work at all levels of the health system. WaterAid Bangladesh started at the primary level and then moved up to the secondary and district levels.
- Coordination and contribution of all relevant stakeholders strengthens accountability and ownership among key actors. Capacity building of both communities and duty bearers helps with the overall coordination.
- WASH is often overlooked, so it is vital to bring it to the attention of other services, such as maternal care and the care of older people.
- It is important to understand all components of the system and how they function.
- When working with CCs, the wider community needs to be engaged to understand their roles and responsibilities. Following training and support from WaterAid Bangladesh, the community mobilised funds and helped monitor the project.

Conclusions and recommendations

For successful CCs with functioning WASH services, we need to engage communities and LGIs from the start.

Coordination and contribution of all relevant stakeholders helped in strengthening accountability and ownership among key actors. Capacity building at both ends – strengthening communities and duty bearers – helped in the overall coordination.

The WASH improvements enabled the other aspects of the CC to function properly, including monitoring and reporting – which improved accountability of the CCs. For example, all CHCPs have been given a laptop from the government and so reports are now online, which has led to improved communication and transparency.

Finally, making information public and increasing transparency regarding service outputs and medicine stocks helped build trust in the CCs overall.