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Decentralized Provision of Primary Healthcare in Rural Bangladesh – a Study of Government Facilities[1]

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Abstract

Bangladesh has made significant progress in health indicators in recent years in spite of her low level of income. This is mainly due to the commitment of the state supported by donors in providing preventive care with respect to child health and family planning. However, there are serious problems related to both access and quality of curative care that hurt the poor most. Infrastructures for service delivery exist at local level in rural areas but they function inefficiently. This paper deals with the systemic weaknesses of decentralized service provision of primary healthcare in Bangladesh and focuses on accountability links between different actors and functions of delegation, finance, performance, information and enforcement. The study is based on facility- and household-based data collected during 2005 in Khulna Division. The main findings of the study are: the health system in rural areas represents deconcentration rather than decentralization of central government functions where inter-sectoral discipline works poorly; local health providers are not accountable to local government, and poor citizens/clients are neither aware of their rights nor are capable of expressing their needs as effective channels do not exist.

Key words: decentralization, accountability, governance, primary healthcare

JEL classification: I12, I18

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Decentralized Provision of Primary Healthcare in Rural Bangladesh – a Study of Government Facilities

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Abbreviations

ACPR	Associates for Community and Population Research
CIDA	Canadian international development agency
DGHS	Directorate of Health Services
DGFW	Directorate of Family Welfare
ECG	Electrocardiogram
EPI	Extended Programme of Immunization
ESP	Essential Services Package
FP	Family planning
GK	Gonoshastha Kendro (peoples´ health clinic)
LGRDC	Local Government, Rural Development Cooperatives
MOHFW	Ministry of Health and Family Welfare
NGO	Non-governmental organization
NS	Nursing supervisor
PHC	Primary healthcare
RMO	Residential medical officer
SSN	Senior staff nurse
UHFPO	Upazila health and family planning officer

Decentralized Provision of Primary Healthcare in Rural Bangladesh – a Study of Government Facilities

I. Introduction

Bangladesh has made significant progress in health indicators in recent years in spite of her low level of income. Life expectancy at birth for both males and females has gone up since the 1980s. Infant/child mortality and fertility rates have also declined considerably. The proximate causes behind these successes are interventions in preventive care that has been possible due to the commitment of the state supported by donors, focused policies and certain institutional innovations (Public Expenditure Review, 2003 P. 70). Problems, however, remain with respect to curative care both in access and the quality of care for the poor (ibid). According to national health policy of Bangladesh, the provision of primary healthcare services is a public responsibility and the government tries to fulfill this role through its own facilities that are geographically dispersed. A well-developed rural health infrastructure exists in Bangladesh compared to urban areas but they are inefficiently operated, and there is a trend of declining use of public facilities in recent years (Cockcroft, A. el al, 2004 and 2007). People rely increasingly for curative care on the private sector that includes different types of actors.

Table 1 Health indicators in Bangladesh

	1980	1990	2000	2004
Life expectancy				
Male	49	55	61	63
Female	49	55	62	64
Under-5 child mortality				
(per 1000 live births)				
Male		47	38	29
Female		37	28	24
Infant mortality		100	66	56
(per 1000 live births				
Maternal mortality (per 100.000 live birth)				380
Total fertility rate		4.3	3.2	3.0
Population growth		2.3	2.0	1.9
Child immunization rate %(Percentage of children 12-23 months)				

DPT	69	83	85
Measles	65	76	77

Source: World Bank data website

Available studies on the problems of the healthcare sector focus on proximate causes such as the absence of doctors, incompetence and indifference of health staff, and corruption related to medical supplies and unofficial fees charged from patients (Cortez, 2006). The underlying causes of inefficiency are actually rooted in the system that lacks both incentives and accountability. This paper analyzes the governance structure in public provision of PHC services in rural Bangladesh. Specifically, the paper focuses on the accountability relationships between the state, line ministry, service provider organization and health workers operating at local level, and analyzes how the decentralized service delivery system works in practice in rural areas.

The analysis is based on facility- and household-based data collected during 2005 in Khulna Division using a conceptual framework derived from theoretical literature on public sector governance and decentralization.

This paper is organized as follows: Section 2 first discusses conceptual issues on governance and decentralization of service delivery. Section 3 provides some background information on national health policies, healthcare infrastructure in rural areas and decentralization of primary healthcare services in Bangladesh. Section 3 presents the results of a survey of 25 health complexes in Khulna Division with respect to different aspects of decentralization of primary healthcare services. Section 4 contains concluding remarks on accountability links and health sector decentralization in practice in Bangladesh.

II. Conceptual issues on institutions of service delivery – decentralization

Primary health care services (PHC) included in the Essential Services Package (See WDR 1993; Ahmad, 2003 and 2007) has been accepted as a public responsibility in many countries as well as in Bangladesh. ESP involves multiple tasks that may be broadly categorized into population-based, community and family-based services and individual-based clinical services with different degrees of measurability, information asymmetry and contestability (see Ahmad 2007 for details on ESP and its goods characteristics). Population based services – immunization, are standardized services, easy to monitor due to its measurability, do not

have heterogeneous preferences, and they are non-information asymmetric. They may not be highly contestable due to heavy costs involved. Family/community-based services – family planning, integrated management of sick children, programs to reduce consumption of tobacco, alcohol and other drugs, dissemination of health and scientific information – are information asymmetric with respect to policymakers and providers while beneficiaries know the level of performance.

Differences in the type of services call for different mixture of institutional arrangements such as market, government bureaucracy and community participation involving the mechanisms of exit, hierarchy/loyalty and voice respectively (Hirschman 1970). Markets, however, function poorly for ESP services. For example, population-based and community-based services have strong element of positive externalities and need promotional approach that markets lack. Provision of clinical services through market institutions (for example, vouchers) is also not efficient in poor countries where clients lack knowledge about the quality and access of services available (information asymmetry). Market institutions, in general, fail to target the poor and achieve equity. Because of market failures, the public sector commonly bears the responsibility of provision of basic services through central bureaucracy that reflects the obligation of the state to its citizens. Government failures, however, occur due to the lack of incentives to improve quality, cost control, and often equity goals are not met (Besley and Ghatak 2003). Given the inefficiencies of market and central bureaucracy in service provision, two kinds of reforms are suggested in the literature. These are:

- Contracting out to NGOs that have similar mission-orientation (non-profit) as the state
- Decentralization of government bureaucracy

As this paper deals with government facilities in rural areas, the rest of this section is devoted to the meaning of decentralization and accountability relationships involved in decentralized health service delivery.

Decentralization of public service provision

Decentralization may be viewed in both narrow and broad terms. In a narrow sense, it means delegation or deconcentration of central government functions to lower levels while the central government exercises authority with respect to policy, finance and administration. In a broad sense, decentralization refers to devolution of central government authority to local levels. It can work in different spheres – administrative, fiscal and political. In administrative decentralization local government bodies are entrusted with daily administration including

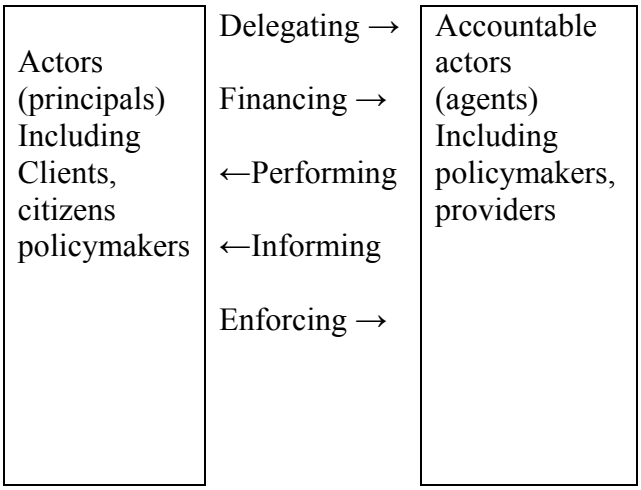
personnel relationships, supply of inputs, etc. On the other hand, fiscal decentralization means that local government bodies have the responsibility and autonomy to disburse and allocate funds to different activities, and to mobilize resources locally either through taxes or user fees for specific services. Decentralization in a political sense refers to civil society participation through local election, and it may be viewed as a goal in itself, a part of democratization processes (World Bank website).

In recent years, decentralization is considered as an instrument in achieving development goals such as improved provision of public services (Mills, et al 1990). It is argued that in a decentralized system service provision may be geared to people´s needs and demands; it can be cost-saving for the central government because local resources may be mobilized; it can be cost effective in the sense that community participation and social accountability ensure good services. However, a full-scale decentralization has certain downside effects: risk of regional inequality and divergence in the quality and access to basic services, loss of economies of scale for standardized, routine and network-based services and the risks of corruption, elite capture and politicization of local bureaucratic structure (Bardhan P. and Mookherjee, D. 2000; Azfar O. et al 2000; Litvack, J. et al 1998; Ahmad, J. et al 2005; World Bank website on decentralization). Moreover, potential benefits of decentralization often depend on the capacity of local government and bureaucracy, the oversight of central government and sound principles of inter-sectoral discipline, and local level democracy where voices of the people are heard. It is important at this point to focus on accountability relationships in public sector service provision, and particularly, its implication for decentralization in the health sector.

Structure of accountability in public provision of primary healthcare (this part is based on WDR 2004)

The fact that state/policymaker assumes the financier role while the provision of services is entrusted to local level institutions, introduces the problem of governance that involves accountability among actors and monitoring. The chain of service delivery involves five functions, four actors, and their roles and relationships with each other. The four actors are citizens/clients, politicians and policymakers, organizational providers, and frontline providers. The four accountability relationships are:

Figure 1: Functions and accountability

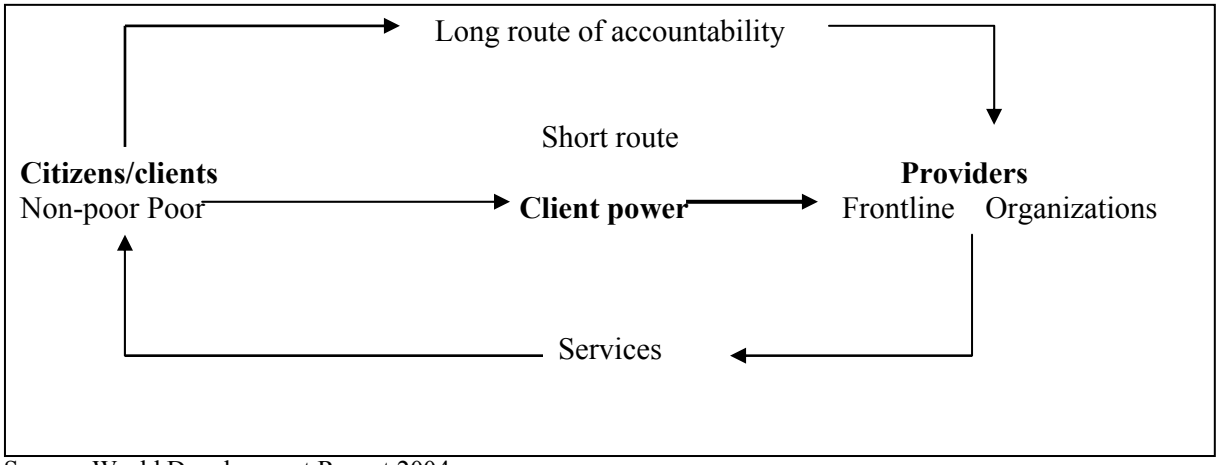


Source: WDR 2004, p. 47

1. of politicians to citizens: voice and politics
2. of the organizational provider to the state
3. of frontline professionals to the organizational provider: management
4. of the provider to the citizen-client: client power

With respect to health services provided by the state, there is usually no direct relationship between the provider and the consumer as it works in the market. The quality and access to services depends on the long route of accountability (Figure 2). It means that state (policymakers/politicians) is accountable to its citizens for the delivery of services, while the political system determines the ability of the people to hold policymakers/politicians responsible. Policymakers delegate the responsibility to health ministry, the organizational provider, who in turn, get the task/s done through frontline professionals – health workers. Since frontline professionals are largely accountable to provider organizations, and not to clients (clients do not pay) there is no direct or short route of accountability. In a decentralized system, clients may exercise more power provided democratic institutions function, and information about the services demanded/delivered reach policymakers and clients. In a weak democratic system, many potential advantages of decentralization cannot be realized, and success in health service delivery will then depend on the commitment of the state together with strong bureaucratic control.

Figure 2: Routes of accountability



Source: World Development Report 2004

The functions and accountability links (Figure 1) in a decentralized system is explained below.

Delegation: As mentioned above, **t**he long route of accountability suggests that citizens delegate the responsibility of primary healthcare to the state who defines overall national health policies including primary care. The state entrusts the responsibility of achieving the goals to health ministry which then delegates it to local government consisting of elected representatives and appointed bureaucrats. It is the responsibility of local government to get the job done through local providers while remaining accountable to local community.

Finance: Complete fiscal decentralization (autonomy in revenue raising and expenditure allocation) with respect to healthcare services is not possible because some services are of national priority such as family planning, controlling infectious diseases, etc, and it cannot be left to local government discretion. Moreover, local resources may be inadequate for meeting national goals and central government transfer is needed. While transferring resources, central government has to set "minimum requirements for expenditure on maintenance and training in order to assure consistent quality and sustainability" (World Bank website on decentralization). However, local taxes and user fees have to be mobilized with a view to reduce the pressure on central government and to promote active community participation and voice. Regular disbursement of funds is an important condition for efficient service delivery.

Performance: With respect to performance and choice of activities, "local government´s freedom to adapt to local conditions must be balanced by a common vision about the goals of the health sector" (World Bank website). Local government autonomy has to be balanced with overall monitoring by central government. Decentralization policy should clearly define functional responsibilities of different levels of government. Central government should carry out functions such as licensing health professionals, registration and quality control of drugs.

Information: For a decentralized system to work, clients must have easy access to information about local healthcare services. On the other hand, political decentralization based on democratic institutions should also facilitate flow of information from clients to policymakers and local provider organization.

Enforcement: Most decentralized systems have problems with enforcement related to health workers who are generally employed by the health department and are not accountable to local government. In such cases, clients cannot exercise their power through voice. The efficiency of services depends crucially on how the health department sets criteria of performance, acquires information and maintains inter-sectoral discipline.

Concluding remarks on decentralization: While health sector reforms in developing countries focus on decentralization of central government machinery and increased involvement of local level institutions, it is important to underscore the role of central government as well community participation. Central government has diverse functions - overall health strategy and setting priorities; financing; regulation and monitoring, evaluation and inter-sectoral coordination (Parker and Harding 2002). It has an overarching role not only in setting policy goals but also monitoring that the goals are achieved. For this, the long route of democracy both at national and local level should work which means citizen voice and client participation for improved service delivery. In countries with weak democratic institutions, it may be wise to start with an incremental bottom-up approach such as to promote community participation in specific issues. This can in the long run strengthen local level democracy and decentralization as well.

III. Provision of Primary Healthcare Service in Rural Areas of Bangladesh

National Health Policy and health sector reforms

The formal document on national health policy of Bangladesh was first available in 2000. Prior to that, policies related to health issues were part of development strategies envisaged in Five-Year Plans and implemented through Annual Development Plans. Since 1970s the government, supported by donors, focused on family planning, reproductive healthcare and child care services to be delivered by local level government facilities dispersed throughout the country. According to the National Health Policy undertaken in 2000 (based on information available on the MOHFW Government of Bangladesh and Public expenditure review and Five-Year Plan), the government accepts the responsibility of primary healthcare delivery as included in ESP with limited curative care. It guarantees the access and quality of care to the population at affordable prices. First of all, services are to be provided through local level health complexes. One of the goals is also to promote pluralism among service providers, and reliance on NGOs for preventive care and promotional activities.

The recent health sector reform, Health and Population Sector Program (HPSP) has the following components: (cited in Public Expenditure Review, 2003 p. 67)

- Unifying the bifurcated health and family planning service delivery structure.
- Shifting to provision of "one stop" service delivery by phasing out the existing Expanded Programme of Immunization (EPI) outreach and satellite clinics and establishing fixed service points (community clinics).
- Reorganizing the directorates and the ministry through a redefinition of roles, responsibilities, and accountabilities (especially developing integrated support services focusing on human resource management, development, and training; management information systems; behaviour change communication; quality assurance; and procurement.
- Decentralizing thana-level health and family planning services.
- Improving hospital management through delegation and financial authority.
- Enhancing cost recovery (through fee retention and local fee utilization).

Some progress has been achieved with respect to directing more resources to primary healthcare, especially for ESP services and targeting the poor, unification of health and family planning services at upazila level and the adoption of sector-wide programme at the ministerial level. However, inequality in the access to curative remains to be a serious problem (Public Expenditure Review, ibid).

Decentralization in Bangladesh

Bangladesh is described as the most centralized countries in South Asia (World Bank website). A decentralized administrative structure exists but in practice it is an example of deconcentration of government functions rather than devolution. Of the four councils (Figure 3), only Union Parishad has elected representatives. The Sub-district level is the lowest administrative level of government operated by civil bureaucracy and line ministries, and is most important for rural development. The functions of local governments are limited to civic duties, tax collection, law and order and development work. Local governments are largely dependent on the central government for finance, recruitment local level functionaries and major policies regarding the allocation of resources.

Figure 3. Local Government Structure for Rural Areas

Ministry of LGRDC

↓

Local Government Division

↓

Local government

↓

Zila Parishad (District Council)

↓

Upazila Parishad (Sub-district Council)

↓

Union Parishad (Council for a group of villages)

↓

Gram Parishad (Village Council)

Health infrastructure in rural areas and decentralization in primary healthcare sector

Health infrastructure (Public Expenditure Review, 2003)**:** Government health services are provided by a four-tier system of government owned and staffed facilities.

- Union level- health and family welfare centers
- Thana/upazila level – health complex providing PHC and some referral services
- District level – providing both primary and tertiary care through district hospitals

- Medical college hospitals in divisional cities and towns providing tertiary as well as primary care.

Rural areas are served through upazila health complexes and union-level health and family welfare centers. Besides government facilities, NGOs, private practitioners including dispensaries provide primary health care services. Private sector mainly accounts for curative care with out of pocket expenses of clients. The following section considers the extent of decentralization in general and specific to the health sector in Bangladesh.

The three F´s - functions, functionaries and funds:

Functions: While the central government (Ministry of Health) of Bangladesh is involved in policy making, design, allocation of resources, regulation, monitoring and evaluation, actual service delivery functions are entrusted to local level facilities.

Functionaries: Staffing pattern – the Ministry of Health and Family Welfare (MOHFW) operates through two directorates: Directorate General of Health Services (DGHS) and Directorate General of Family Welfare (DGFW). The recent health sector reform (HPSP) envisages an integration of the two directorates but little progress has been made. DGHS and DGFW are responsible for functionaries, and local government has nothing to do with personnel administration in the health sector. Daily management is handled by medical chiefs of facilities without any local government involvement. While all health workers are accountable to the Ministry of Health and their respective Directorates, there are hierarchies of accountability at different levels of government.

Funds: Local service providers are largely dependent on central government funds. There is a provision for user fee for certain services. While some resources are mobilized at local level, they are not used for health purposes (Alam et al 1994).

Client power: The government of Bangladesh recognizes the importance of community participation in decisions with respect to programme planning, cost sharing, service delivery, quality control, IEC, programme monitoring and supervision (Fifth Five-Year Plan, p. 468). However, no clear-cut policies have been taken on these issues. The impact of decentralization may have been less on health than in other sectors such as infrastructure and agriculture, because of the unique features of health services that need government intervention at a national level.

IV. Empirical study of primary healthcare facilities– a survey of selected Upazilas in Khulna Division

Data and methods

The main objective of the survey was to find out what kind of accountability and incentives the health workers face in practice given the current institutional set-up of central-local relationships. The survey was undertaken in 25 Upazila Health Complexes in Khulna Division. Because of resource constraints only one division was surveyed. Khulna Division was selected because of its more developed infrastructure compared to the rest of the country. For each facility three categories of respondents - doctor, administrator and nurse were interviewed. In total 75 questionnaires were filled out by the respondents. The Association for Community and Population Research (ACPR) carried out the fieldwork. The 25 Upazilas under the survey were selected randomly.

Facility-based data on

- General characteristics of the facilities
- Administrative routines
- Fiscal and financial issues
- Community participation

The main objective of the household survey was to explore the opinion of client population regarding the access and quality of primary healthcare services. The study also aims to find out the level of knowledge and awareness among the population about community health services, and how active they are in demanding better services. One thousand households in the vicinity of government healthcare centres were randomly selected (number dependent on catchment population), and from each household, the head of the household and his spouse were interviewed based on a structured questionnaire and in-depth probing.The questionnaire consists of the following parts:

- General characteristics/background information.
- Use of health facilities
- Knowledge and awareness

The results of the household survey are presented in detail in a separate paper. This paper will refer to only some of the results on community participation in PHC services.

Results of facility survey

Results are presented in five sections:

1. General characteristics

2. Administrative decentralization - daily management and personnel issues
3. The role of local government and social accountability
4. Fiscal decentralization
5. Monitoring and evaluation by central government – top-down accountability

1. General characteristics

We interviewed health staff at higher level – administrative heads (20), chief medical officers (21 25 nurses in each facility. In some facilities (9) the chief medical officer is the administrative head that makes the total 66 instead of 75. Out of the 66 respondents 27 were female and 39 male staff. There is high job segregation by sex and health centers are male-dominated even in family planning matters. Chief medical officers and administrative heads are all male, all nurses are female, and only two out of nine medical officers are female (Table 2).

Table 2 Designation of the respondents by sex

	Total	Male	Female
Upazila Health and Family Planning Officer	20	20	
Residential Medical Officer	12	12	
Nursing Supervisor	5		5
Medical Officer	9	7	2
Senior Staff Nurse	20		20
Total	**66**	**39**	**27**

The majority of patients are female from poor households (Figures 3.1 and 3.2). This is corroborated by other surveys as well (Mannan, 2005). This is expected given focus of government policy on family planning and preventive care in rural areas.

We asked the respondents about the number of staff of different categories currently working, and the size of the catchment population covered by the facility. We found a great discrepancy in their responses (Figure 3.3) especially between UHFPO and other groups with respect to the number of family planning workers. It appears that family planning services and general health services are still operating in a bifurcating manner in spite of the integrated approach of health reform. There is also a lack of knowledge about the size of the population they serve. In 50% of the cases, even the facility heads did not know. For the facilities for which information was available, a wide variation in the size of the catchment population was observed. It ranges from 15000 to 320,000 with an average of about 170,000.

The findings suggest that at least one third of the facilities suffered from inadequate service providers. There are, however, differences in responses with respect to adequacy of health staff. Supervisor nurses reported the highest percentage of shortfall of health workers, while

Table 3 Catchment Population reported by Facility Head (UHFPO)	
1. Abhoynagar	248000
2. Chowgacha	
3. Debhata	120000
4. Kalia	
5. Damurhuda	
6. Kaliganj	
7. Fakirhat	
8. Keshobpur	250200
9. Kalaroa	200000 (RMO)
10. Gangni	
11. Jibbonnagar	
12. Mongla	146051
13. Manirampur	402247 (RMO)
14. Khoska	13000
15. Paigacha	259333
16. Mohammadpur	
17. Maheshpur	30000
18. Rampal	
19. Rupsha	
20. Sailkupa	36000
21. Shalikha	15000
22. Tala	320000
23. Terokhada	
24. Sreepur	
Average Total	**169916**

UHFPO reported the least shortfall. The upazilas that are reported to lack health staff are Kalia, Kalaroa, Jibbannagar, Manirampur, Mohammadpur, Terokhada and Sreepur. Information available from our household survey confirms that these upazilas suffer from poor infrastructural facilities that can create disincentive among health workers to be stationed there.

2. Administrative decentralization

Under administration, we considered both daily management of inventories, medical supplies, work routines, and personnel management including recruitment, transfer, promotion, salary and dismissal. Daily management is supposed to be the responsibility of the chief of the facility who then delegated it to others. The majority of respondents (over 70%) named store-keeper and residential medical officer as responsible for daily management of inventories, while store keeper and pharmacist for medical supplies. According to the respondents, daily work routine was managed by UHFPO (74%) and RMO (19.7%). However, there is a difference of opinion among the respondents in a given facility. Only in 8 out of 25 facilities all three respondents have similar answer.

On the average of all facilities with respect to recruitment, transfer and promotion, highest responses were recorded for the Directorate of Health followed by civil surgeons, whereas highest response in matters of salary was received by UHPFO which we consider as a strange result. Further investigation will be made to clarify the matter.

The respondents differ in their opinion about who decides about recruitment, promotion, transfer, salary and termination of job. Such differences may arise due to the fact that they have different designations, and their work conditions are decided by different authorities. The problem is however, with the same category of respondents giving different answers. For example, in the case of appointment of 23 UHFPO, there are four different answers from 14 persons and multiple responses from 6. Similar is the case for other categories of workers as well as other issues (Tables 5-9).

Table 4. Personnel Management by Different Authorities (% of total responses from all facilities)

Personnel management→ Authorities↓	**hiring**	**firing**	**salary**	**promotion**	**transfer**
Ministry of Health	24.2	21.2	16.7	22.7	10.6
Directorate General/ Deputy Director	48.5	37.9	4.5	51.5	57.6
Civil Surgeon	34.8	33.3		33.3	

Director of Nursing Services	18.2	19.7	25.8	25.8
Appointing Committee	18.2	10.6	4.5	
Public Service Commission	3.0			
Upazila Health Officer FPO			72.7	
Revenue Board			3.0	
Note: Multiple responses and figures do not add up to 100.				

Table 5. Responses with respect to appointment by categories of respondents

Authorities responsible	Respondent designation						
	UHFPO	RMO	NS	MO	SSN	Other	Total
MOHFW	5	1		3	1		10
DoH	5	3	3	3	1		15
Civil surgeon	3	2			4		9
DNS			1		7		8
Appointing Committee	1	1					2
Public Service Commission							
Do not know				2			2
Multiple answers	6	5	1	1	7		20
No reply	3	1		5			9
Total	23	13	5	14	20		75

Table 6. Responses with respect to promotion by categories of respondents

Authorities responsible	UHFPO	RMO	NS	MO	SSN	Other	Total
MOHFW	4	2		3	2		11
DoH	11	8	1	3	5		28
Concerned authority		1		1			2
DNS			4		10		14
Appointing Committee	2						2
Do not know							
Multiple answers	3	1			3		6
Do not know				2			2
No reply	3	1		5			9
Total	23	13	5	14	20		75

Table 7. Responses with respect to Transfer by categories of respondents

Authorities responsible							
	Respondent designation						
	UHFPO	RMO	NS	MO	SSN	Other	Total
MOHFW	1	2		1	1		5
DoH	9	2	1	6	1		19
Civil surgeon	1	1			1		3
DNS			3		11		14
Other	1		1				2
Multiple answers	8	7			6		21
No reply	3	1		5			9
Do not know				2			2
Total	23	13	5	14	20		75

Table 8. Responses with respect to Termination by categories of respondents

Authorities responsible							
	Respondent designation						
	UHFPO	RMO	NS	MO	SSN	Other	Total
MOHFW	4	2		2	1		9
DoH	3	1	2	3			9
Civil surgeon	2	1	1	1	3		8
DNS			2		7		9
Appointing authority	6	1					7
Other				1			1
Do not know				2	2		4
Multiple answers	5	7			7		19
No reply	3	1		5			9
Total	23	13	5	14	20		75

Table 9. Responses with respect to salary by categories of respondents

Authorities responsible							
	Respondent designation						
	UHFPO	RMO	NS	MO	SSN	Other	Total
MOHFW	2	1		3	4		10
DoH	1			1			2
Civil surgeon							
UHFPO	**16?**	**10?**	**4**	**2**	**15?**		**47?**
Revenue Board	1			1	1		2
Other	1						1
Multiple answers		1	1				2
Do not know				2			2
No reply	3	1		5			9
Total	23	13	5	14	20		75

3. Political decentralization- social accountability

The implications of political decentralization are that locally elected bodies will be accountable to people for the delivery of local services including primary healthcare according to the legal and judicial framework of the country, and to dispense this responsibility they are supposed to interact with health management agencies and service providers. In Bangladesh, except in a few cases (See World Bank Report on accountability in GK service provision), political decentralization in the sphere of provision of healthcare services does not work There are two reasons for this: first local government does not have the autonomy with respect to finance, design of healthcare programme, allocation of resources to different activities and personnel administration. Secondly, local elections are fought on issues other than service delivery. Under these circumstances, there is no positive role played by local politicians in healthcare provision in the community.

However, this does not mean that they do not intervene. They intervene for their own personal gain not to serve the general interest. According to our survey, 15% of the respondents in six upazilas reported intervention by local government that has been considered as a negative feature. Out of the 10 respondents who reported of pressure by local government, 5 are UHFPO, 3 RMO and 2 senior staff nurse. However, in majority of cases (56 out of 66) no involvement of local government in personnel administration is reported. The Upazilas experiencing local government interference are Fakirhat, Keshobpur, Kalaroa, Mongla, Sailkupa and Tala. The health facility in Keshobpur is influenced by both union and upazila councils, whereas in Fakirhat, Kalaroa, and Tala union council is involved, and in Mongla, and Sailkupa upazila council is involved. These upazilas are known to be conflict-ridden areas (shrimp culture and *Nakshal* anarchist party), and politicians get involved in health-related injuries.

Table 10. Daily management influenced by local government

Yes	No	Upazila Council	Union Council
10	56	4	6
Designation of respondents by answers yes and no			
		Yes	No
UHFPO		5	15
RMO		3	9
Nurs. Sup.			5
MO			9

Sr. st.nurse	2	18
Total	**10**	**56**

UHFPO, RMO and SSN mentioned that politicians and local level bureaucrats exert pressure for different purposes such as to admit patient and allot seats, to issue certificates of illness or injury, to run administration and provide services according to their choice. Service providers are reported to be intimidated in case of non-compliance.

Client involvement and social accountability

One aspect of political decentralization is taking client opinion into account and reporting to higher authority. Thirty five respondents (53%) answered yes and 31 (47%) no to the question on patient report. Among the yes respondents the majority is UHFPO, and among the no respondents the majority is UHFP and medical officer. It is not clear how keeping patients´ records it affects their behaviour as service providers. It appears to be a routine job.

According to our household-based data, very poor households depend either on government health facility that is supposed to provide affordable care or on low-cost traditional practitioners. For curative care, traditional practitioners are preferred because of easy availability and low cost. Women tend to use more of this partly due to constraints related to travel cost and time needed to go government facility. Other studies support these findings (CIDA, 2004, Mannan, 2003). Our findings on the level of satisfaction with government facilities are more positive than most studies (CIDA 2004; Cockcroft, A. et al, 2007) especially with respect to the attitude of health workers, except Mannan´s study which indicate high level of satisfaction with the attitude of health staff. Dissatisfaction is mainly expressed for the availability of medicines in all studies including ours.

We have observed a serious lack of knowledge and awareness among the respondents about what they can expect to receive from government facilities in terms of treatment, preventive care, medical supplies, and associated expenses. Seventy seven per cent of male respondents and 57% of female respondents do not know about which services are supposed to be provided free of charge.

People are generally submissive and do not complain about poor access and quality of services. This is mainly due to poverty and lower socio-economic status compared to the health providers. We received very poor responses to questions related to social accountability

such as expression of discontent or waging formal complaint. This is somewhat contrary to findings from other studies that record high level of dissatisfaction (and increasing) with government health services (CIDA 2004). These studies find that the expression of complaints is highly correlated to education and residential status of respondents. Urban and educated people tend to complain more than the rural poor. The respondents (clients) in our study are very poor and reside in rural areas that may explain their passive attitude.

4. Fiscal decentralization

There are large variations in the knowledge among the respondents on financial matters. Thirty percent of them did not know where the fund came from and nearly 40 percent had no knowledge about how often funds are disbursed by central government. But the majority (65%) reported that funds came from the Ministry of Health, and the respondents are mainly UHFPO and head nurses. Variations in response with respect to regularity of disbursement are observed. Nearly 80% of the UHFPO and MO consider that they have discretion (not other staff) in fund utilization at local level because of their position. It is not clear if it is meant for all kinds of expenditure or some specific heads.

Table 11. Knowledge about Allocation of funds by period

	No.	%
Monthly	1	1.5
Quarterly	28	42.4
Semi-annually	7	10.6
Annually	4	6.0
Do not know	26	39.3
Total	**66**	**100**

Table 12 Knowledge about Sources of funds

	No.	%
Ministry of Health	43	65
Local Government taxes	1	1.5
Others	2	3.0
Do not know	20	30
Total	**66**	**100**

5. Monitoring and evaluation

Standard auditing system is reported to exist, and it is carried out mainly by the Ministry or Directorates and special auditing teams. Free services are reported to be provided for consultation fee, medicines, hospital bed and food. Some differences in response with respect to lab test, ECG and X-ray is observed which means sometimes patients are charged and sometimes not. There are differences in response on specific terms of reference regarding patients and services provided. On the whole, less than 50% get specific instructions. While nearly 100% reported that monitoring is done, there are differences in responses with respect to how often it is done and about specific indicators of monitoring. Evaluation is mainly done by civil surgeons, while 19% mentioned the Department of Health (See additional figures in appendix).

IV. Concluding remarks on accountability relationships and decentralization in practice

The framework developed in Chapter 1 above may be used for understanding the accountability links under the decentralized system in Bangladesh. The main elements in accountability are delegation, finance, performance, information and enforcement with the involvement different stakeholders – citizens, state, line ministry, health management, frontline providers and clients.

Delegation: According to national health policy of Bangladesh, state assumes this responsibility even though citizens do not actively hold the state responsible because of the weak democratic tradition in the country – citizens do not know about their rights, and health issues seldom become an electoral issue. In spite of this, due to strong commitment of the state to the goal of reducing population growth, provision of family planning, and childcare services, some of the objectives envisaged in national health policy have been fulfilled. Part of the reasons behind the success is the ability of the state to establish a compact with the organizational provider, the Ministry of Health and Family Welfare which in turn has delegated .the responsibility to local level health complexes under which the frontline professionals work.

It should be mentioned that many of the activities are population-based, related to public health, (such as immunization), and are not transaction and information-intensive and also non-discretionary. They can be easily administered through centralized but de-concentrated

bureaucracy. Promotional activities like family planning services, however, are community-based and involve more transaction, information and discretion of service providers. The success of Bangladesh in this area is largely due to the design of the programme that characterizes clear goals, targets, and agents of change such as NGOs, door-to-door field workers, etc.

The most difficult-to-provide services are involved in curative care. They are highly transaction-intensive (doctors meet patients many times), information-intensive (both patients and doctors need to have information about each other) and treatment depends on the discretion of doctors. Available studies including this study confirm the difficulties in providing curative care in Bangladesh. A large majority of the population relies on private doctors, and according to our study the very poor seek help first from traditional practitioners followed by public facilities mainly due to low cost involved.

The inability of government facilities to meet the demand for curative care appears to be related to systemic failures. In the present system, there are no accountability links between local government and local providers and the former is virtually unaccountable to local community especially with respect to healthcare issues. Our investigation indicates that client interaction (both long and short routes) is highly limited.

Finance: As mentioned above, most of the primary healthcare services included in ESP is supposed to be provided at affordable price and free of charge to the very poor. Health service expenditures at local levels are financed through government transfer, and local government functionaries (union level elected bodies and upazila-level bureaucrats) have no say about the size and allocation of funds. Our survey, however, indicates that UHFPOs have some discretion over heads of expenditure. In Bangladesh, local governments have some power to mobilize resources. However, it has been found by empirical studies on decentralization that local resources are used for schools, roads, irrigation, community centers but not health for which central government is responsible. While community members discuss how local resources are used and should be used, health is not a subject of discussion (Alam et al. op. cit). Our survey indicates inadequacy of staff, irregular funding and uneven geographical distribution of health facilities.

Performance: With respect to performance and choice of activities, local needs are to be balanced with national priority. National health policies of Bangladesh focus on ESP services with strong emphasis on preventive care and limited curative care. As mentioned above, decentralized government facilities have succeeded in providing preventive care but local needs of basic primary care are not satisfactorily met.

Information: In a decentralized system free flow of information is important. Our survey confirms that channels of information do not work. First of all, people do not voice their opinions. One major problem is the lack of knowledge and awareness among the rural poor about their basic rights and how to exercise them. On the other hand, local government has no incentive to acquire information either from the client population or health providers since the accountability link with the population does not work. Since the central government has the overall responsibility of primary healthcare services, the initiative for collecting information should come from the relevant central agency, Ministry of Health. It has been pointed out in several reports that a vast amount of information exists in Bangladesh that has not been utilized properly to improve service delivery (Public Expenditure Review, 2003).

Enforcement: In the absence of local government responsibility to ensure efficient PHC services, intergovernmental discipline assumes crucial importance in service delivery. Health workers in Bangladesh are employed by different directorates and they are supposed to be accountable to respective ones. Our survey indicates that health workers have no clear idea about their relationships with employers on various issues. The accountability link between the management organization and frontline providers is also blurred and overlapping. In daily management, differences in staff opinion reveal unclear division of responsibilities.

In cases where bottom-up accountability does not work, efficiency in service delivery depends crucially on how the health department sets criteria of performance, acquires information and maintains inter-sectoral discipline. There are gross weaknesses in the utilization of the system of monitoring and evaluation. Most monitoring is focused on input indicators- inventories of drugs, other medical supplies and annual auditing. It should be noted that monitoring and evaluation of curative care is more difficult than preventive care, and is highly dependent on local level information. On the whole, while PHC service facilities in Bangladesh are brought down to local level it does not work like a decentralized system because of the lack of participation of local government and the community. Administratively, it is a deconcentrated

system with weak inter-sectoral discipline that adversely affects service provision in curative care.

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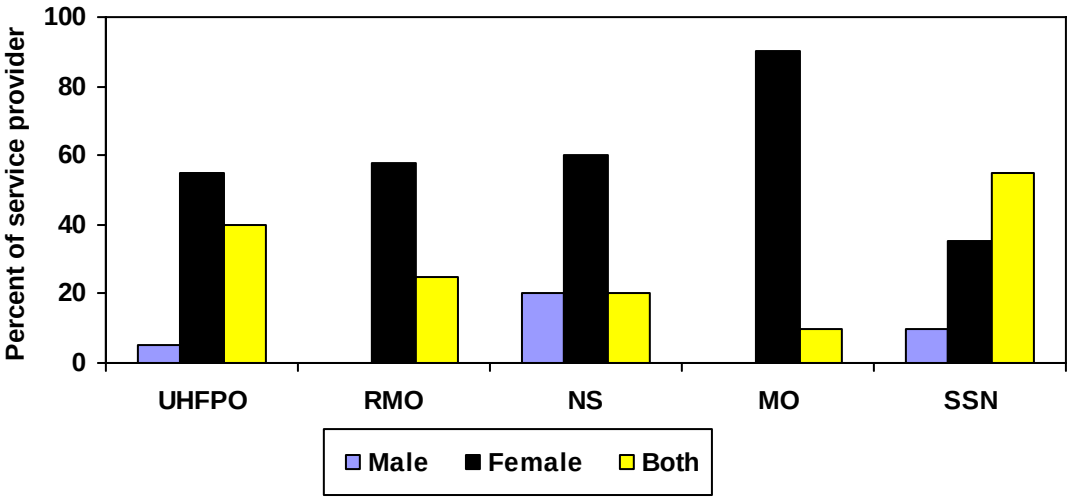
Appendix

Figure 1 Gender specific patient groups of the health workers



Inference: Most of the patients are female and only poor people visit to the Upazila health complex.

Figure 2 Patient groups of the health workers

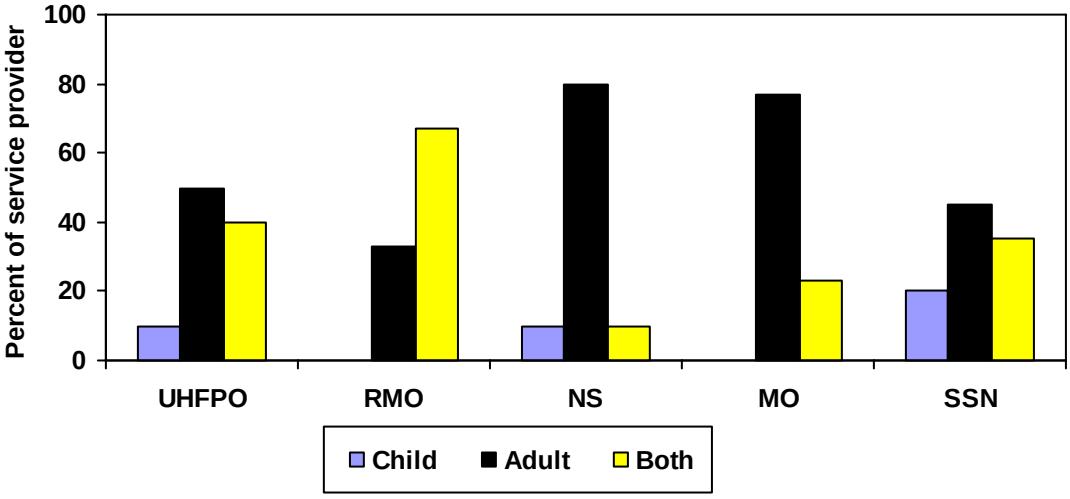


Figure 3 Variations in response regarding Filled-in Positions of Different Categories of Health workers

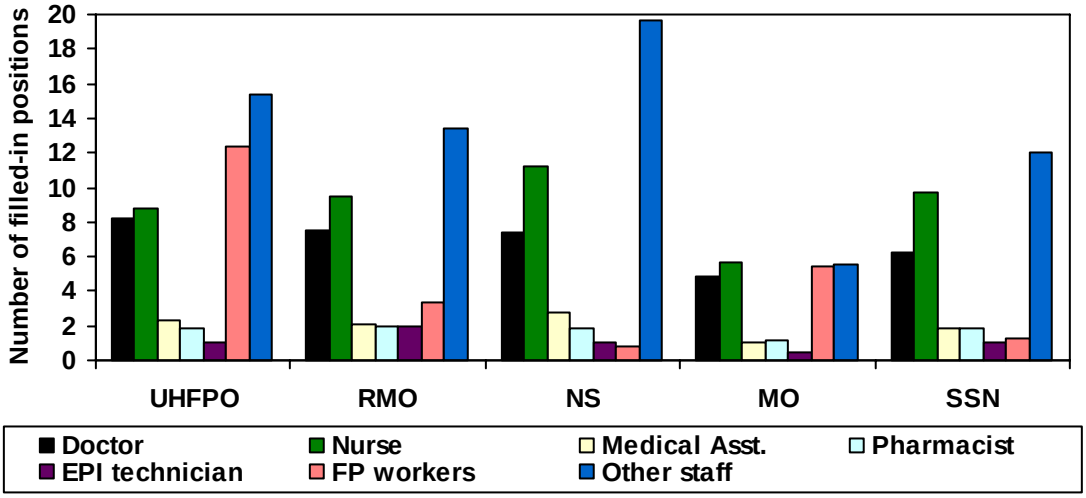


Figure 4 Percent of Facilities Not Having Health Staff as Reported by Different Respondents

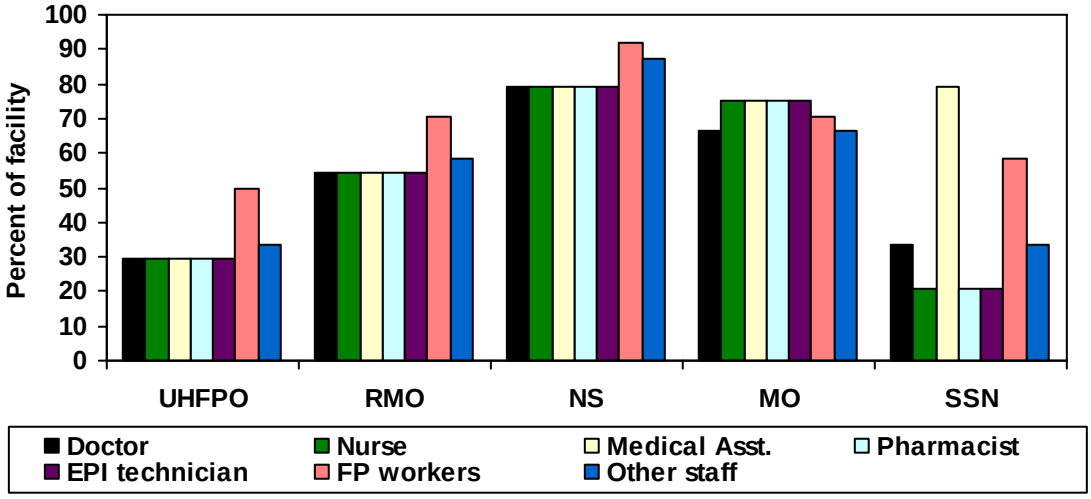
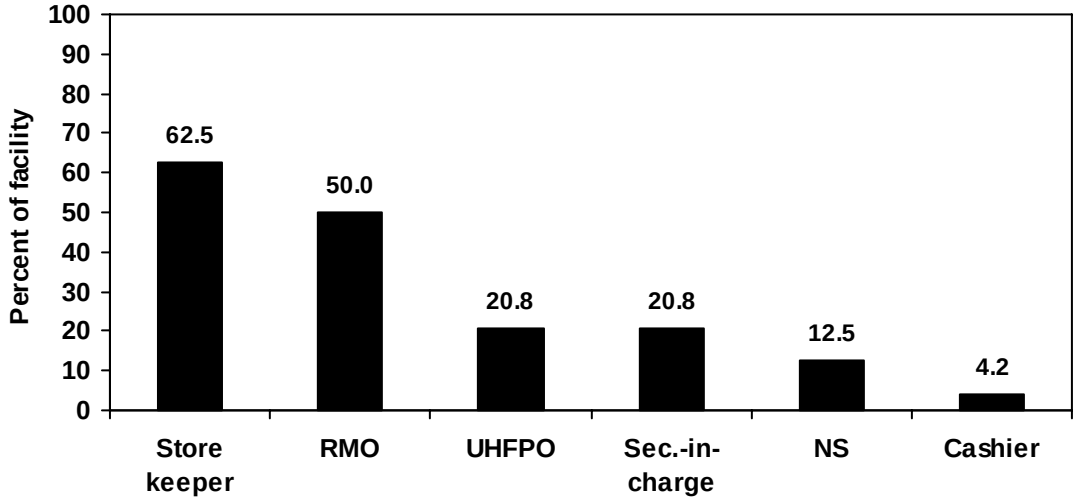


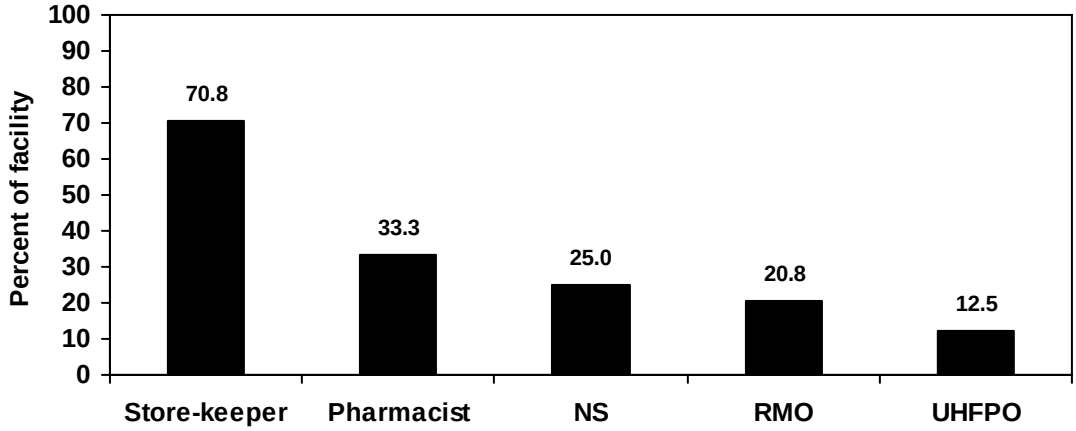
Figure 5 Percent of facilities mentioned regarding the responsibilities of daily management of inventories



Note:

- 43.9% of the respondent said that Store-keeper is responsible for daily management of inventories
- 27.3% of the respondent said that RMO is responsible for daily management of inventories
- 10.6% of the respondent said that Section-in-charge is responsible for daily management of inventories
- 7.6% of the respondent said that UHFPO is responsible for daily management of inventories
- 4.5% of the respondent said that NS is responsible for daily management of inventories
- 4.5% of the respondent don't know/refuse to give answer regarding daily management of inventories
- 1.5% of the respondent said that head-asst.-cashier is responsible for daily management of inventories

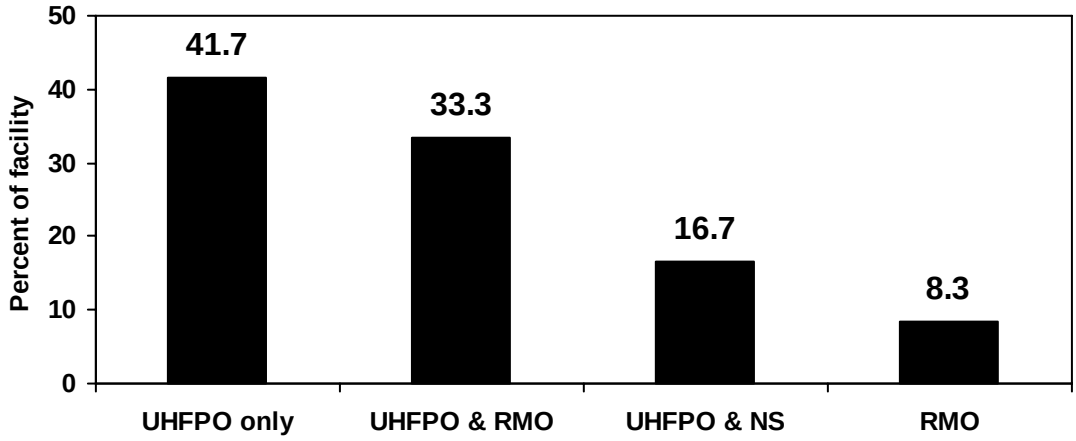
Figure 6 Percent of facilities mentioned regarding the responsibilities of daily management of medical supplies



Note:

- 53.0% of the respondent said that Store-keeper is responsible for daily medical supplies
- 21.2% of the respondent said that Pharmacist is responsible for daily medical supplies
- 12.1% of the respondent said that NS is responsible for daily medical supplies
- 7.6% of the respondent said that RMO is responsible for daily medical supplies
- 4.5% of the respondent said that UHFPO is responsible for daily medical supplies
- 1.5% of the respondent don't know/refuse to give answer regarding daily medical supplies

Figure 7 Percent of facilities mentioned regarding the responsibilities of daily management of work schedule for the Health Workers



Note:

- 74.2% of the respondent said that UHFPO is responsible for daily management of work schedule
- 19.7% of the respondent said that RMO is responsible for daily management of work schedule
- 6.1% of the respondent said that NS is responsible for daily management of work schedule

Figure 8 Responsibilities of Authorities at Different Levels with Respect to Personnel Administration

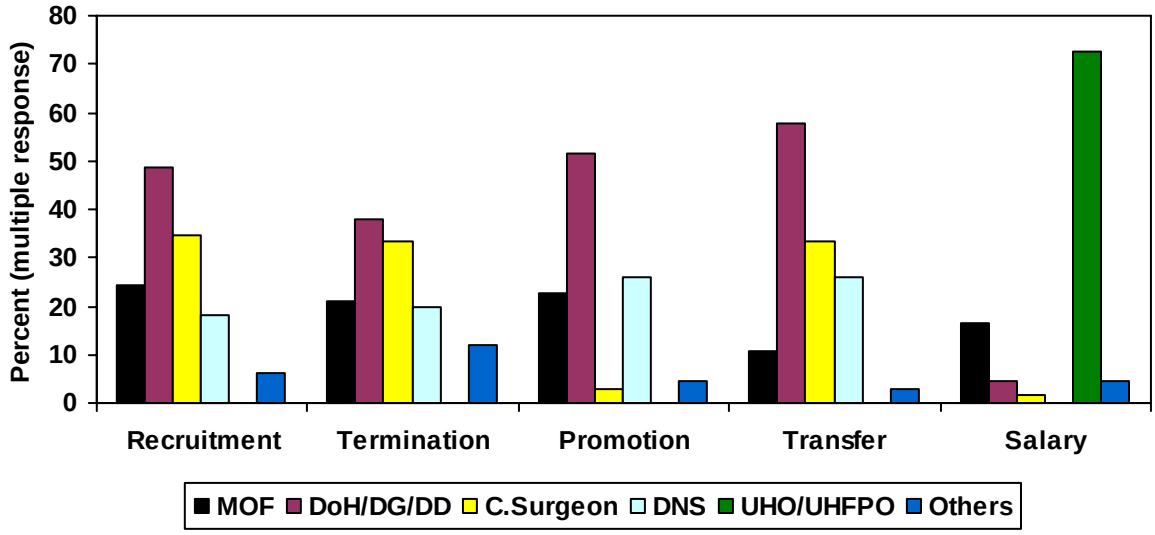


Figure 9 Percent of facilities influenced by the local politicians and officers from local government for day-to-day management

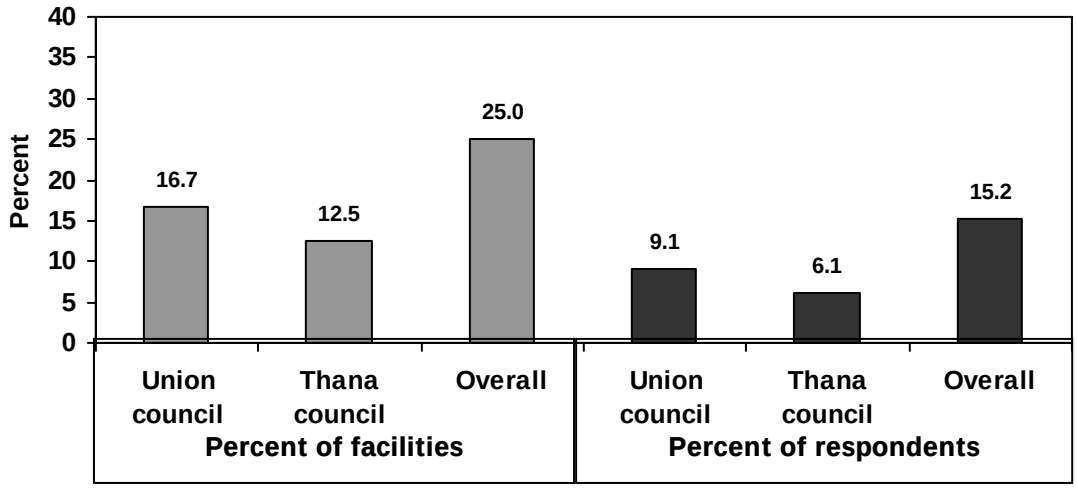


Figure 10 Percent of SPs know the funding source of the health facilities

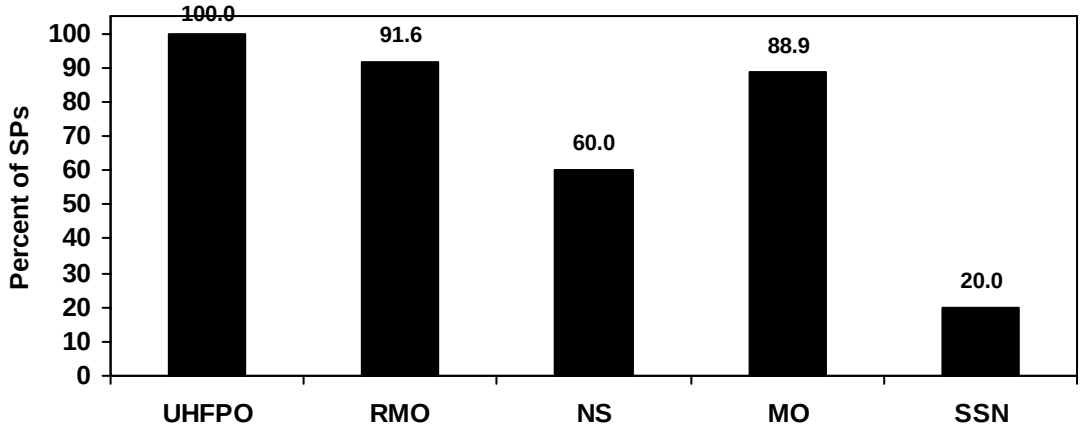


Figure 11. Keeping client record by Service providers

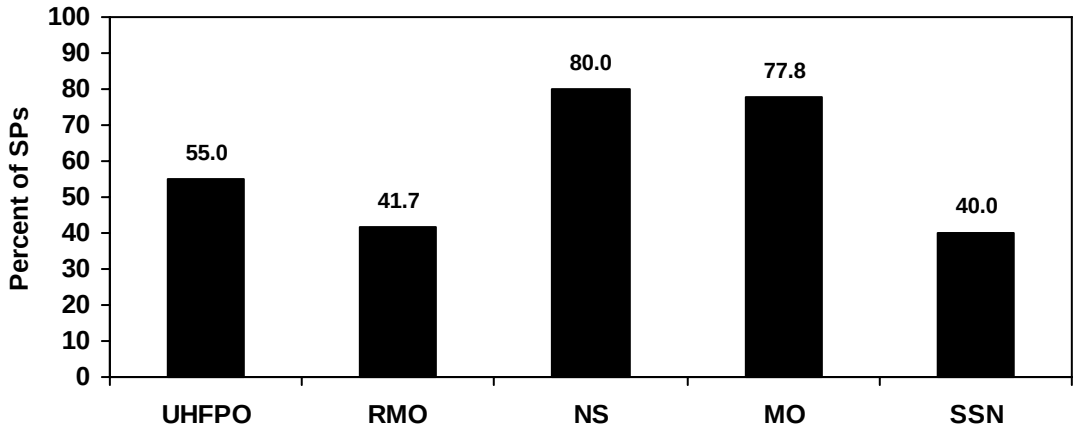


Figure 12 Percent of SPs know the funding period of the health facilities

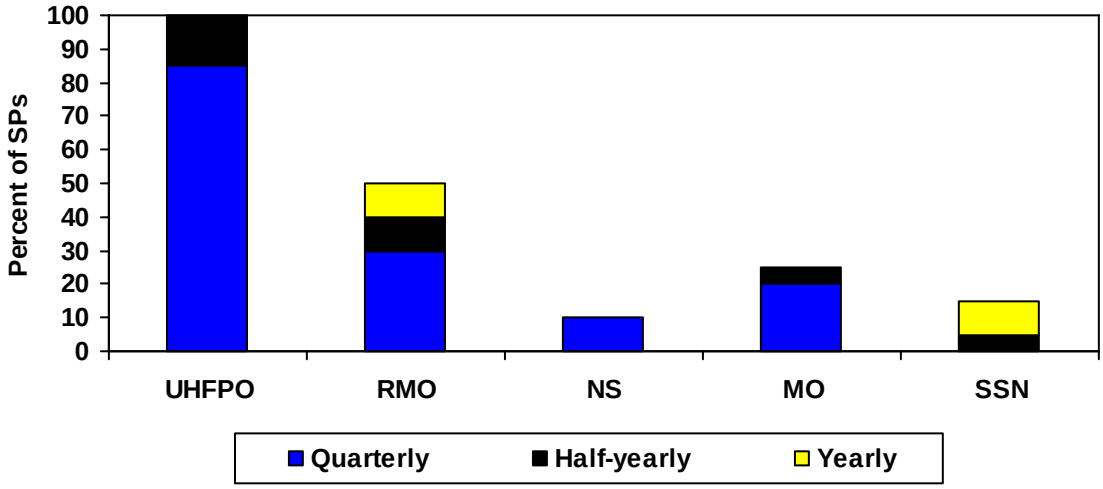


Figure 13 Percent of SPs mentioned that they received regular disbursement of fund according to the schedule

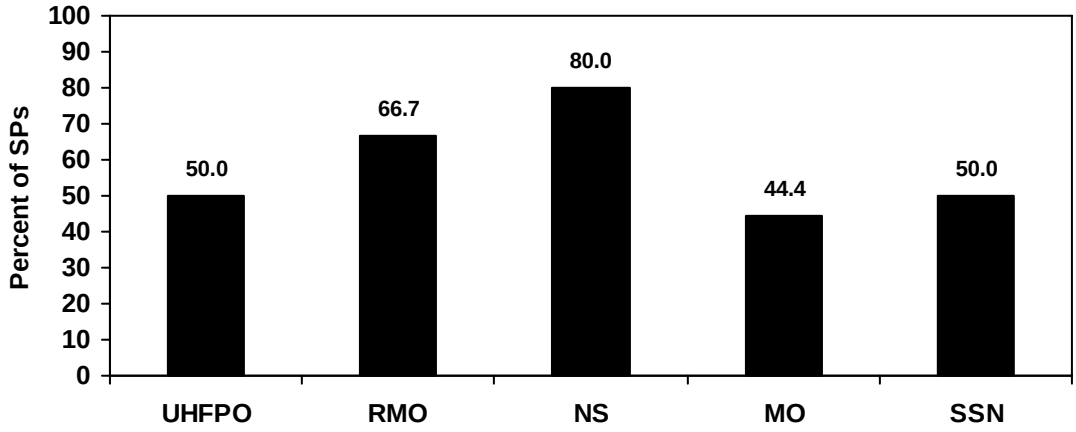


Figure 14 Percent of SPs mentioned regarding delay periods of irregular fund disbursement according to the schedule

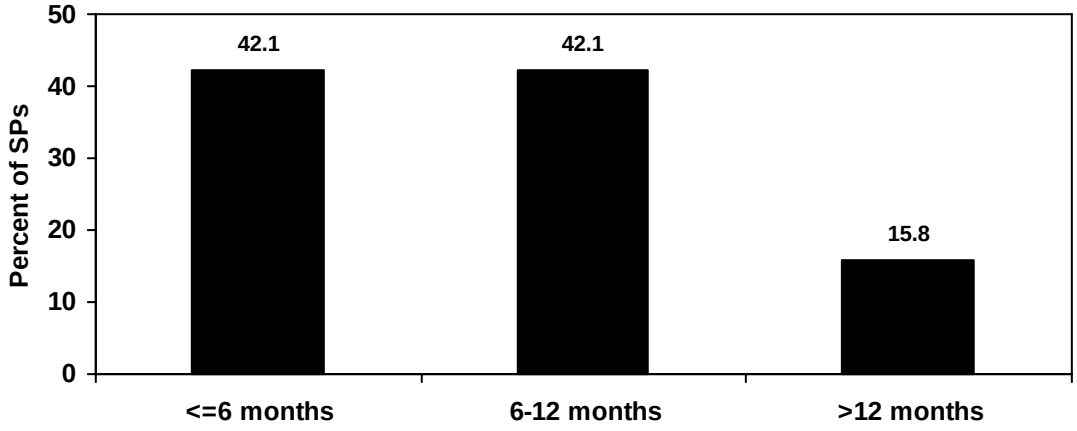


Figure 15 Percent of SPs discretion of fund utilization at local level

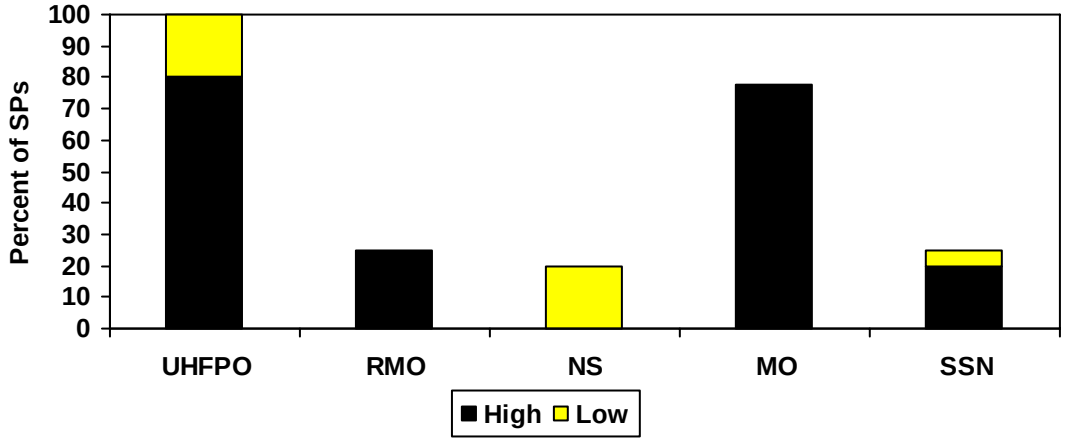
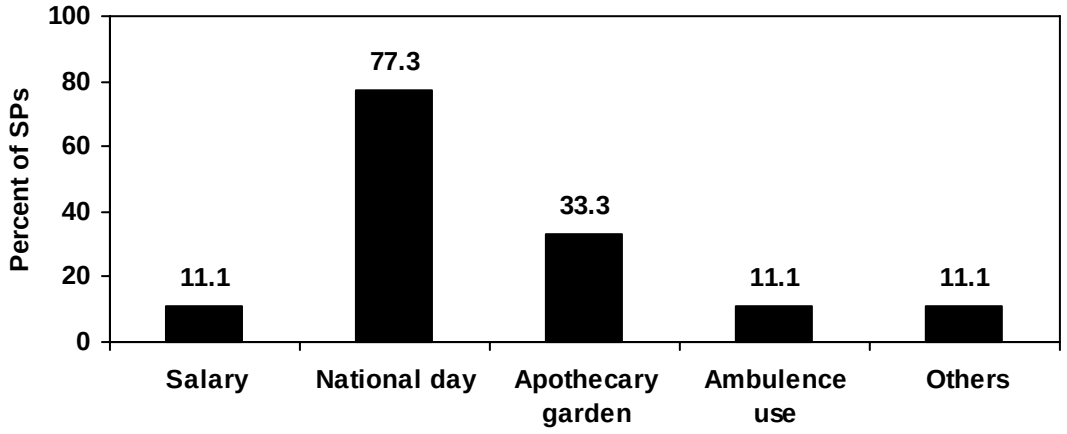


Figure 16 Distribution of special fund mentioned by 14% SPs (multiple responses)



Note: National day was for population and immunization days.

Figure 17 Percent of SPs responses regarding whether they have standard auditing system

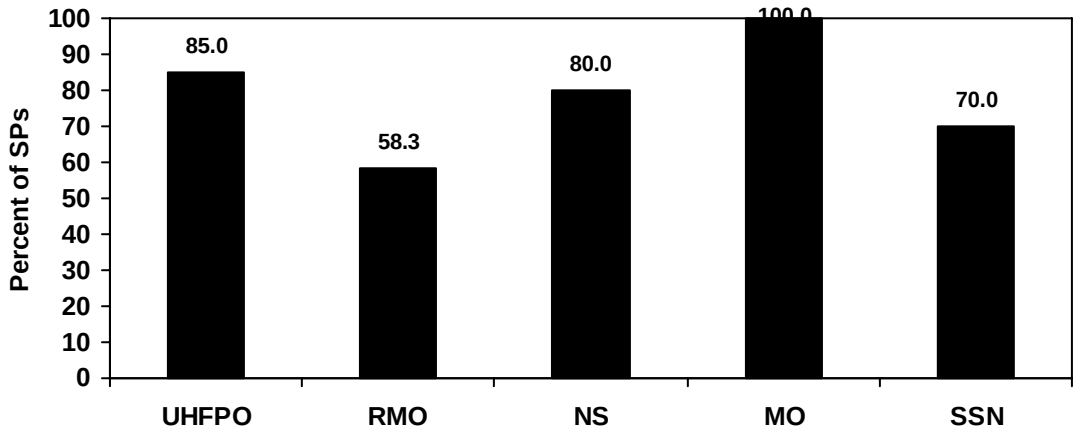


Figure 18 Percent of SPs responses regarding the auditing operation

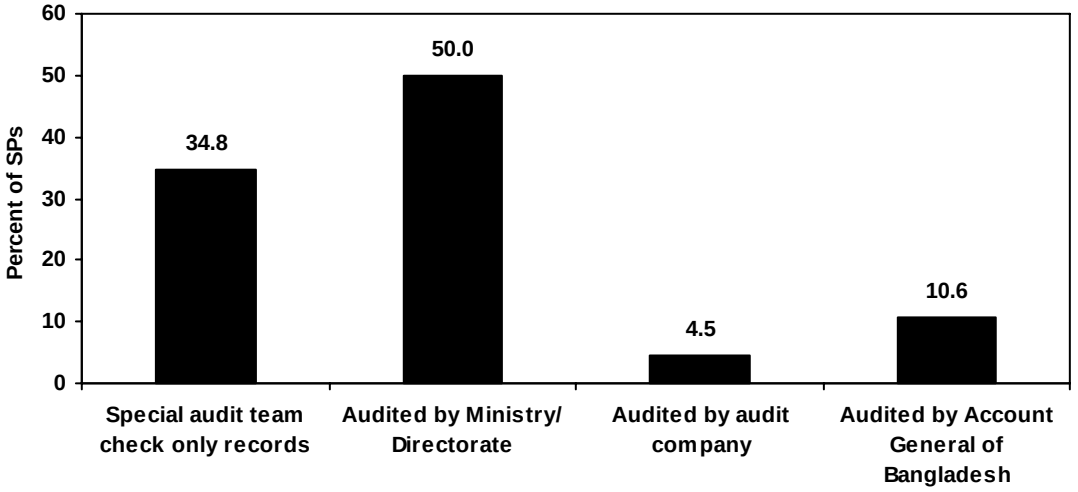


Figure 19 Percent of SPs mentioned regarding free services for specific service given by the facilities

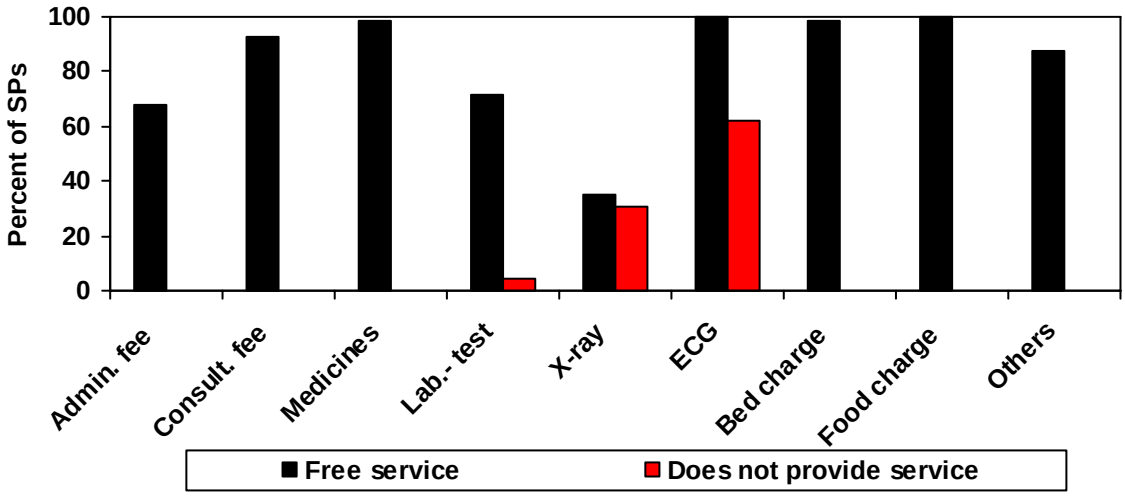


Figure 20 Percent of SPs responded that they have specified terms of references regarding patients and health care services

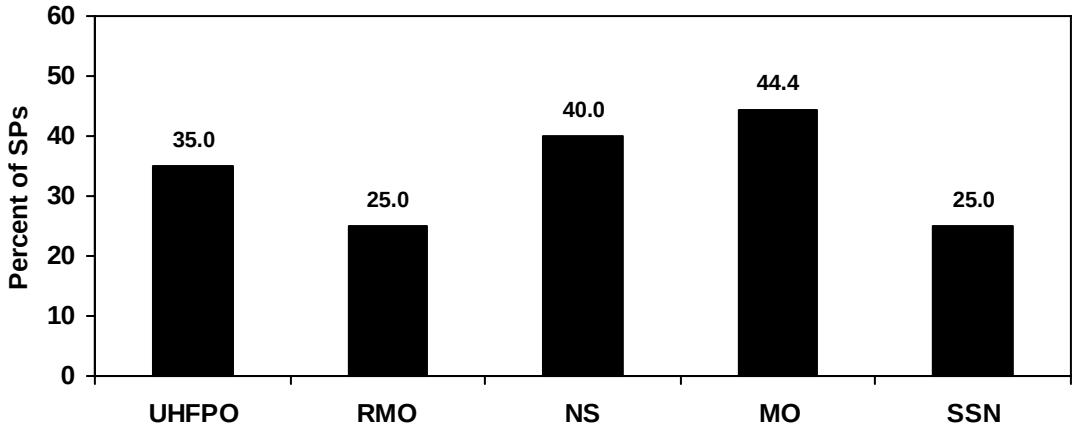


Figure 21 Percent of SPs responded how health center monitored

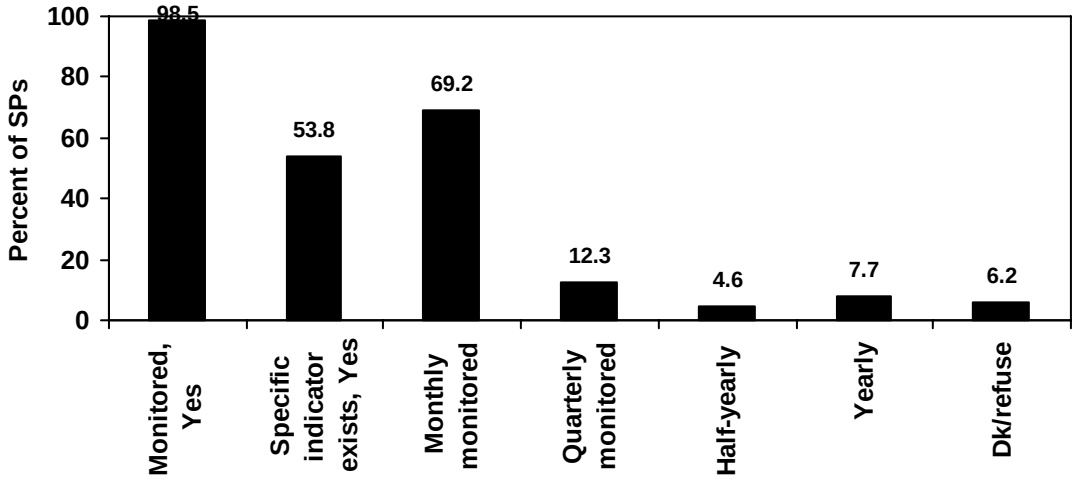


Figure 22 Percent of SPs responded by whom their performance monitored (multiple responses)

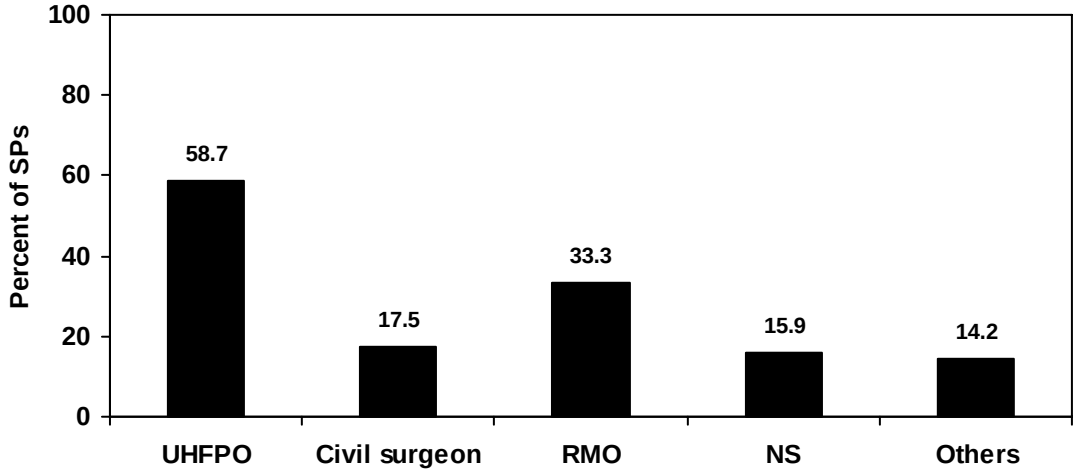


Figure 23 Percent of SPs reported to whom to evaluate their performances (multiple responses)

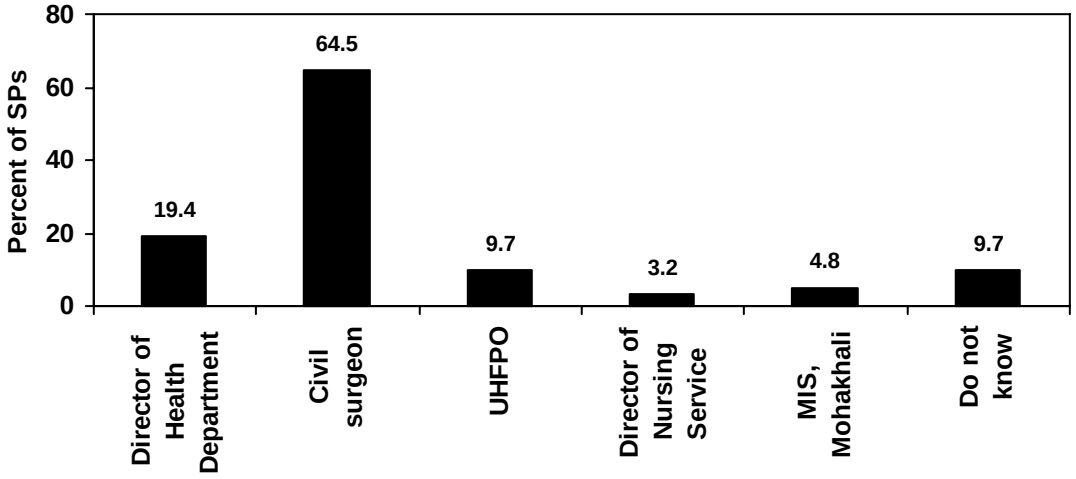
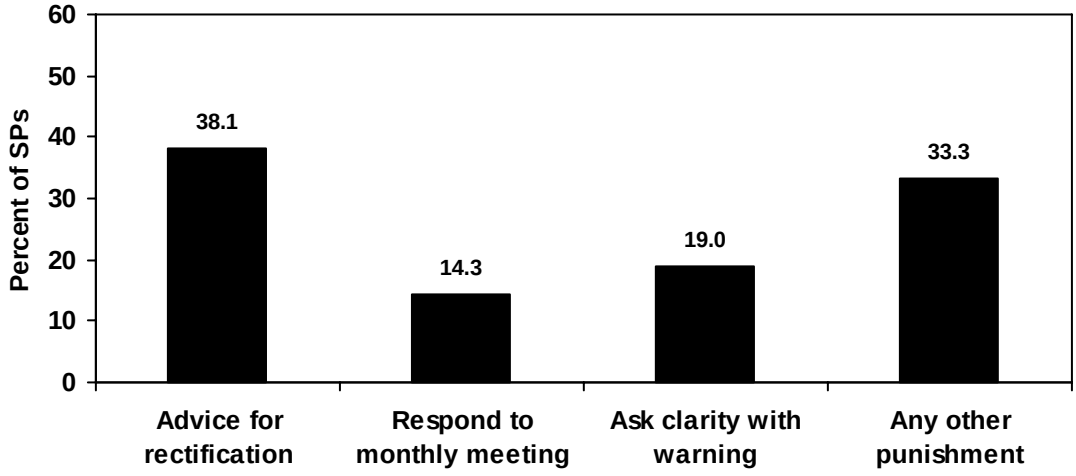


Figure 24 Percent of SPs reported regarding types of punishment if performances is not satisfactory (multiple responses)



Questionnaire

Institutional Problems in the Primary Healthcare Sector of Bangladesh – a survey of government facilities

Conducted by Associates for Community and Population Research (ACPR)3/10, Block A, Lalmatia, Dhaka-1207

IDENTIFICATION	
DIVISION _____	
DISTRICT _____	
UPAZILA _____	
CLUSTER NUMBER.....	
NAME OF RESPONDENT_____	
SEX OF RESPONDENT (MALE = 1, FEMALE = 2).....	
NAME OF FACILITY _____	
TYPE OF FACILITY (GOB = 1, NGO = 2, PRIVATE = 3)	

INTERVIEWER VISITS				
	1	2	3	FINAL VISIT
Date				Day Month Year
Interviewer's name				Code
Result*				Result code
NEXT VISIT: DATE				Total no. of visits
TIME				

*RESULT CODES:

1 COMPLETED 4 REFUSED
2 NOT AVAILABLE 6 OTHER _____ (SPECIFY)
3 POSTPONED

SUPERVISOR/FIELD EDITOR	QUALITY CONTROL OFFICER	OFFICE EDITOR	KEYED BY
NAME _____	NAME _____		
DATE _____	DATE_____		

SECTION I: CHARACTERISTICS OF THE FACILITY

Time start

Hour Minute

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
101.	What is your name?	Name:_____	
102.	What is your designation? Verbatim:_____		
103.	What kind of care does the facility provide?	Curative care..... 1 Preventive care ..... 2 Both curative and preventive care 3	
104.	Are majority of your patients male or female or both?	Male ..... 1 Female ..... 2 Both 3	
104a.	Are majority of your patients rich or poor or both?	Rich..... 1 Poor..... 2 Both 3	
104b.	Are majority of your patients children or adults or both?	Children ..... 1 Adults..... 2 Both 3	
105.	What is the approximate size of the catchments population?	Population.....	
106.	How many doctors, nurses, medical assistant, pharmacists, EPI technicians and family planning workers in this facility? **(IF NONE WRITE 00)**	Doctors..... Nurses ..... Medical assistants..... Pharmacists..... EPI technicians ..... Family planning workers..... Other staff..... (Specify)	

SECTION 2: MANAGEMENT ROUTINES

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
201.	Who is responsible for the daily management regarding work schedules? Verbatim:_____		
201a.	Who is responsible for the daily management regarding inventories? Verbatim:_____		
201b.	Who is responsible for the daily management regarding medical supplies? Verbatim:_____		
202.	Is daily management influenced by the local government (thana and union councils) and/or central government organisations (TNO, Ministry of Health)?	Yes..... 1 No..... 2	→ 203
202a.	By whom?	Thana council ..... 1 Union council ..... 2 TNO ..... 3 Ministry of Health..... 4	
202b.	In what way is management influenced? Verbatim:_____		
203.	Who makes the decisions regarding: Hiring of personnel:_____ Firing of personnel:_____ Salaries:_____ Promotions:_____ Transfer of personnel:_____		
204	Are personnel routines (hiring/firing/salaries) influenced by (thana and union councils) and/or central government organisations (TNO, Ministry of Health)?	Yes..... 1 No..... 2	→ 205
204a	In what way? Verbatim:_____		
205.	Do you undertake regular patient studies/evaluations (demand, composition, opinion) and report to the Ministry of Health?	Yes..... 1 No..... 2	→ 301
205a.	Would you please give a copy of the most recent report?	Yes..... 1 No..... 2	

SECTION 3: FISCAL DECENTRALIZATION

Try to get a copy of the (detailed) budget for the health complex.

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
301.	How are funds allocated?	Monthly..... 1 Bi-monthly ..... 2 Quarterly ..... 3 Semi-annually ..... 4 Annually..... 5 Do not know..... 7	
301a.	From where do the funds come?	Central government/Ministry of health ..... 1 Local government (taxes) ..... 2 Donors..... 3 User fees ..... 4 Other_____ ..... 5 (Specify) Do not know..... 7	
302.	Are the disbursements regular?	Yes ..... 1 No..... 2	→ 303
302a	How long is the delay?	After months	
303.	How much discretion do you have over fund utilisation at the local level?	A lot ..... 1 Some ..... 2 Little..... 3 None..... 4 Cannot tell..... 7	
303a.	Who makes the decision about utilisation of funds – health providers or management or both? Verbatim:_____		
304.	Are the funds earmarked for special purposes?	Yes ..... 1 No..... 2	→ 305
304a.	For what are funds earmarked? Verbatim:_____		
304b.	Who controls the earmarked funds?		

	Verbatim:_____ _____		
305.	Is there a standardised auditing system?	Yes ..... 1 No..... 2 →	306
305a.	Do you follow it?	Yes ..... 1 No..... 2 →	305c
NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP**
305b.	Please provide the auditing guidelines/latest audit report?	Yes ..... 1 No..... 2 →	306
305c.	Why do you not follow the system? Verbatim:_____ _____ (Skip to 306)	☐☐ ☐☐	
305d.	How the auditing is carried out? Verbatim:_____ _____	☐☐ ☐☐	
306.	Are medicines and other supplies free for the patients?	Yes ..... 1 No..... 2 →	307
306a.	What are those?	Medicine .....A Injectables .....B Check up .....C Food .....D Other_____ .....X (Specify)	
307.	Now please state average official fees for treatment at this facility	Taka 1. Admission fee ..... ☐☐ 2. Consultation fee ..... ☐☐ 3. Medicine ..... ☐☐ 4. Bood/urine/stool test ..... ☐☐ 5. X-ray ..... ☐☐	

		6. ECG ..... ☐☐ 7.Bed charge ..... ☐☐ 8. Food ..... ☐☐ 9. Other_____ ..... ☐☐ (Specify)	

SECTION 4. PERFORMANCE, MONITORING AND EVALUATION

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
401.	Do you have clearly specified terms of reference (Are there clearly stated objectives for the health centre regarding number of treated patients, types of care (preventive e.g. immunizations, curative)?	Yes ..... 1 No..... 2	
402.	Is the performance of the health centre monitored?	Yes ..... 1 No..... 2	→402b
402a.	Why the performance of the health centre is not monitored? Verbatim:_____ _____	☐☐ ☐☐	
402b.	Are there specified indicators to measure the performance of the health centre?	Yes ..... 1 No..... 2	→403
402c.	Please give a copy of the indicators with clear descriptions?	Yes ..... 1 No..... 2	
402d.	How often is performance monitored?	Quarterly ..... 1 Semi-annually ..... 2 Annually..... 3 Bi-annually..... 4 Other _____ ..... 6 (Specify)	
402e.	By whom is the performance monitored? Verbatim:_____ _____	☐☐ ☐☐	
402f.	To whom is a performance report sent? Verbatim:_____ _____	☐☐ ☐☐	
402g.	What happens if performance is not satisfactory? Verbatim:_____ _____	☐☐ ☐☐	
403.	**INTERVIEWER: Before leaving (the respondent) check the questionnaire carefully; After thorough checking, stop interviewing and then Thank him sincerely for sparing his valuable time with you.**		

Time finished Hour ☐☐ e ☐☐