

## **CHAPTER 1**

### **THE RESEARCH PROBLEM, OBJECTIVES AND CONTEXT**

This thesis focuses on the political dynamics of public policy process that underpin the fundamental understanding of social development initiatives in Bangladesh. My enquiries are guided by a broad, general question: can elite driven development initiative bring social justice in the context of developing countries? The breadth and width of this question has been narrowed down to a sector specific question: do health reform policies benefit the poor? In answering the question this thesis examines the institutional mechanisms of policy making, sources of power of key actors, interests and institutions in implementation and opportunity structures that are on offer for the poor, vulnerable citizens of the society.

Despite the fact that Bangladesh has made a significant achievement in reducing both income and human poverty in recent years, on an average, one percent each year since 1991, almost half of the population still lives in poverty; about 20 percent of total population lives in extreme poverty (GOB 2005, WB 2002). These large numbers of people are deprived of most of the resources that they do require fulfilling certain basic consumption needs, health is one of them. It is observed that as a constitutional mandate, the Government of Bangladesh has invested substantially and initiated numbers of multi-sector and multilevel institutional and programmatic health reforms to improve the health and family planning services in the country, with special attention to the poor (GOB 2006). Observer notices that there has been a proliferation of reform policies in the country in recent years; for example, related with greater policy arena of health sector only, there have as many as 10 influential national policies been put in place since the year 1995 (Islam 2006). Despite the fact that all reform policies and programs have been targeted to improve the health of the poor and women, the health status of the poor in Bangladesh is one of the worst in the world. Still 56 children per thousand die before their first birthday; 80 children per thousand live births die within first five years of their life; 320 - 400 mothers die per 100,000 live births each year; nearly two thirds of mothers in Bangladesh do not receive antenatal care. This grim reality would provoke anyone to ask a very legitimate question: do health reform policies benefit the poor?

This thesis is an effort to answer this question. In answering the question, I take a critical position and bring the politics in as an explanation. Thus, this thesis is about health politics. This is a deconstruction of politics of health reform policy. I try to answer the question by articulating my understanding and analysis of the impact of a particular health reform policy. I argue, the problem of the health care system to improve the health of the poor in Bangladesh remains unsolved not because solutions are not there, rather, it is because the problem has not been understood in the first place. In the hegemony, health has been politically made ‘non-political’ and portrayed as ‘technical’; therefore solutions are also been proposed as a ‘technical fix’ with medical know-how but without addressing the question of power relation, which resulted somewhat improvements in the medical care services, but, little has been done to health of the poor.

Having drawn on the above backdrop, I chose the central question of the thesis as: does the health reform benefit the poor? In order to answer the question, from a bottom-up critical perspective, it aims to understand the impact of the health sector reform on state and society in Bangladesh.

This thesis is built on several assumptions, first, health is political. Second, reform is political, because, it resulted from elite’s drive of power and status to connect the state and society (Mitra 2006); because, it involves restructuring of institutions, and restructuring of institutions creates reconfiguration of power relations in the society (Crook and Manor 1998). Thus, health reform is profoundly a political process. The second leads me to formulate the third assumption: the impact of health reform policy is also political which fall unevenly on the poor.

Based on these assumptions, I argued, root causes of the prevailing problems of the health sector with respect to health of the poor, for which the reform policy is designed, lies in the nature of the politics of the country. I argue that there is democratic deficit in the policy arenas in general, and health sector in particular. Therefore, it has been relatively easy for the hegemonic coalition to persuade and expand their ideas and interest through state policies. This means, the hegemonic policy coalition of health bureaucrats and professionals, donors, political and NGO professionals by manipulating the democratic deficit of the state shapes the problem definition, influences policy goals

and strategies. As a result, when the policy is implemented it reproduces the interests and ideas and unequal power relation of the hegemony as the impact, thus the poor remain marginalized, excluded. I further argue, depending on actor's constellation in the hegemony, elite's interest and embedded institutions the same reform program can produce different types of impacts on different part of a society.

These arguments are developed based on three cornerstones: policy process, policy actors and policy context. In other words, the impact of the reform, more precisely the benefits of the reform for the poor, does depend on the nature of the processes through which policies are made and implemented; the nature of the key actors who make and implement the decision; and the socio political context in which policies are taken and implemented. In fact, these three cornerstones constitute the set of independent variables of this study. Now the question of dependent variable comes in. Since the central research question of this study is '*does health reform policy benefit the poor?*', one can clearly identify that the dependent variable of the research is 'benefit'. This study perceives 'benefit' in comprehensive manner, which is derived from the idea that the reform program is not a mere a 'package of medical services', rather, it contains social, economic and political resources along with medical resources. Therefore, the concept of benefit denotes economic, social and political resources along with health resources. This extended notion of benefit leads to breakup of dependent variable<sup>1</sup> in two: health benefit (refers to medical and economic resources gain) and political benefit (refers to social and political resources gain). I argue that the health and political benefits vary as the three independent variables: process, actor and context change. Since it is a case study, it does not carry any hypothesis for testing; instead, some key propositions, which establish causal association between dependent and independent variables, have been derived by disintegrating the above arguments. I shall briefly introduce the key propositions in this place, all of them are discussed in detail in Chapter 2; they are as follows:

1. The more transparent, accessible the decision making process is the higher the benefit is.

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<sup>1</sup> Health and political benefit have further been disintegrated into seven variables which I shall discuss in Chapter 2.

2. The more public and political actors are in the policy coalition the higher the political benefits are
3. The more the professionals are in the coalition the higher the health benefits are
4. The benefits change as the social, political and institutional context change.

These four key propositions are investigated and examined throughout the text of the case study and presented in chapters from 3 to 7. These propositions are brought back again in the concluding chapter of the thesis in order to evaluate the entire case study.

Investigating the implementation process of health reform, particularly the reform in urban primary health care sector in Bangladesh I show how a far reaching change takes place in the role of state in health care provision and how it impacts the society, particularly poor and vulnerable groups. Having argued this, my aim is to contribute to recent debate in critical discourses on politics of health by answering the question ‘does health reform benefit the poor?’ that may help the empowerment of marginalized, disadvantaged poor in developing countries.

The study concentrates on understanding dynamics at the state and society level that have been developed after introducing reforms, specifically, contracting out of primary health care services to the non-governmental organizations since mid-nineties in major cities of Bangladesh. The search will proceed to examine the ideological lineage of the reform, the process of reform policy formulation and implementation in one hand, and on the other, to analyze the outcome of this reform in two levels: state and society. At the state level, I would see what kind of changes take place in the role of state in relation to health care provision and at the society level, outcomes will further be analyzed in terms of their contribution in gaining access to health care services and control of social-political determinants of their health.

### 1.1. HEALTH SECTOR REFORM: FINDING THE IDEOLOGICAL LINEAGE

In order to understand the impact of the health sector reform one need to understand the nature of the reform first. The nature of the reform, from a critical perspective, includes who promotes the idea, at which historical moment and what is the ideological foundation of the event and the actors behind it.

Health sector reform what is taking place in Bangladesh is not something very unique in the current world. In fact, health reforms have been taking place in many countries over the last two decades or so. Despite the differences among states, in terms of the contextual factors, there has been an enormous pressure for convergence of national health policies and organizations been put by international organizations, such as World Bank and World Health Organization in the last two decades. The same tone of reform agenda also been forwarded by the Alma Ata Declaration on Health for All by the Year 2000 which has been marked as a “global strategy in health and health services development” (Koivusalo and Ollia 1996:111). During the last two decades, after the adoption of HFA 2000 by all WHO member countries, there has been a significant improvement in health development; the growth has not been equal though (WHO 2000). The unequal and inequitable development in health among and within countries invites renewed interest to see how the systems operate in improving health functioning and organization (Hanson and Berman 1994a; Berman et al. 1995; Salamon 1995; Bennet McPake and Mills 1997; Wango’mbi 1998; Harding and Parker eds. 2003). The whole 1990s could be marked as the decade of health sector reform while most of the countries both developed and developing took one or other kind of reform strategies with great enthusiasm. For instance, during this decade, the United States was debating The Clinton Plan- the most significant health reform proposal in several decades. The United Kingdom, the Netherlands, Sweden, and other European countries were implementing new financing and delivery arrangements. Middle-income countries, such as Taiwan, were introducing new health insurance systems; Peru, Chile, Mexico, and Uganda were implementing decentralization of health care and many others to name (Berman and Bossert 2000). This global wave of health sector reforms have multiple causes, the primary one is the emergence of World Bank as the leading international organization concerned with health. The World Bank published its *World Development Report 1993* “Investing in Health” which proposed an agenda focused on state commitment to essential services; an enhanced private sector role in service delivery; resource prioritization based on standardized indicators and comprehensive sector-wide rather than fragmented project-based approaches to health planning (Buse and Gwin 1998, World Bank 1993). In following years, a substantial rethinking and reformulation of health sector strategies took

place in the lower and middle-income countries.

It does not require being critical to observe that globally running health sector reform initiatives are simply structural adjustment measures under cover. They are often complicated and mostly top-down. Connecting to its ideological root - neoliberalism<sup>2</sup> - these reforms can be labeled as neoliberal reform. Clearly, these reforms have come to mean market-oriented interventions in the health sector. Whilst in most countries, the tasks of health related planning, policy and strategy development, and resource allocation are centralized within the Ministry of Health, and health services are delivered through a hierarchical system of hospitals, health centers and health stations, neoliberal health reform suggests change of responsibilities of some or all of these tasks from the central to the lower levels of government or to private sector. In essence, the main idea of neoliberal reforms is the application of market-based solutions for government managed health sector. Neoliberal reform in health sector, however, does not refer to a unified and/or single reform strategy; it may appear in various faces. In reality, it is a package of reform strategies, which has many components, and a country may choose one, some, or all of them. In general, health sector reforms emphasized on the efficiency-oriented agenda of “devolution”, “privatization”, “de-regulation”, “out-sourcing”, “commercialization”, “corporatization”, and “down-sizing” (Dixon and Kouzmin, 1994; Kouzmin et al. 1997). Although there were/are many countries implementing neoliberal health reforms primarily targeted to bring effectiveness and efficiency but the evidence of greater efficiency and effectiveness through privatization or contracting-out of public services remains slim, particularly for developing countries.

**Table 1.1: Global trends in health reform**

<i>Timeline</i>	<i>Focus of the reform</i>
1950 - 1960s	<ul style="list-style-type: none"><li>• Reconstruction and expansion of health care infrastructure by the state</li></ul>
1970 - 1980s	<ul style="list-style-type: none"><li>• Establishment of universal primary health care system under</li></ul>

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<sup>2</sup> I do refer neoliberalism, as Green (1996) denotes, as “an ideology that advocates an economic arena free of government regulation or restriction, including labor and environmental legislation, and certainly, free of government action via public ownership. It advocates a retreat from the welfare state’s publicly funded commitments to equality and social justice. It does view citizenship as consumption and economic production” (Green 1996: 112).

	the auspicious of the state <ul style="list-style-type: none"> <li>• Health For All by 2000</li> </ul>
1990s - to date	<ul style="list-style-type: none"> <li>• Denationalization of health care</li> <li>• Decentralization</li> <li>• Privatization</li> <li>• Public-private partnership</li> </ul>

Though the evidences are not satisfactory enough, hence, Bangladesh, as one of the few less industrialized countries, in the mid nineties, took the challenge to reform its health and population sector, which was the biggest in the postcolonial era. In order to understand the linkage between the global trends of health sector reform and policy and programs that were undertaken in Bangladesh and to grasp the research problem in relation with the context we need to elaborate the greater socio-political context and the situation of health sector in general. I take this point in the next section.

## 1.2. CONTEXT OF THE STUDY

Bangladesh is one of the mostly populated countries having a very low per capita income, around 450\$. It has been trying to rebuild its economy and social status despite the recurrent political crisis and natural disasters. The current literacy rate is 51.2 percent which is significantly low compared to other low-income countries where the literacy rate is about 60 percent (UNESCO 2006). The economy has extensively been liberalized since 1980s and presently influenced by WTO regimes as a signatory. Agriculture, Garments industry and work force in aboard are the main sources of GDP for Bangladesh. 30% of country's GDP accumulated from the agriculture. The economy is still largely dependent on foreign aid; since independence in 1971 Bangladesh has received more than \$22 billion in grant aid and loan commitments from foreign donors, about \$15 billion of which has been disbursed. Major donors include the World Bank, the Asian Development Bank, the UN Development Program, the United States, Japan, the United Kingdom, Germany, Saudi Arabia, and a number of West European countries.

In recent decades, there has been a significant decline in infant, child and maternal mortality in Bangladesh. Control and prevention of diseases, such as measles, poliomyelitis, and diphtheria along with widespread use of ORS for diarrheal diseases have greatly reduced childhood mortality and morbidity. Bangladesh is on the verge of Polio eradication, and has already achieved the elimination goal for leprosy at the

national level. People are living longer; the average life expectancy at birth in Bangladesh had increased to over 61 years now for both sexes (BBS 2005). Despite very important health gains achieved in the past decade, the mortality and morbidity burden in the country, particularly amongst children and women are still unacceptably high. Moreover, increased pace of globalization, escalation of travel, trade liberalization, rapid urbanization, economic crisis as well as environmental threats are also attributing to the growing burden of health problems in the country. Total Fertility Rates (TFR) remained plateaued at a level of 3 per women for the last 10 years. Maternal Mortality Ratio (MMR) - 300/100,000- is still unacceptably high by any standard. Due to increase in number of ageing population, by the year 2025 there will be around 14.6 million people (9% of the total population), the incidence of non-communicable diseases is also expected to rise. Malnutrition continues to be a severe health problem among both mothers and children. There are growing evidences that emergence and resurgence of communicable diseases like Malaria, Kala-Azar, TB, Dengue and non-communicable disease like Diabetes, cardiovascular disease etc. which were once thought to be controlled, are on the rise and thereby putting enormous pressure on the health care system of the country. The possible unfolding of the HIV epidemic is another threat for the country. There are new health threats coming from the arsenic contamination of ground water (approximately 70 million people of the 130 million people of the country are currently at risk). The growing social inequality between different income groups within the society is also adversely contributing to health inequity and inequality between among the countries. Hence, the inequality is also very prominent between rural and urban population. Studies showed that the health status, in all indicators, among urban population is better than that of rural population; but the status of urban poor are worse than the rural population (Islam et al 1997; Arifeen and Mookherji et al 1995). The range of health problems in cities is also greater than that in rural areas.

Major health problems in Bangladesh relate to its health system performance. Notwithstanding the fact that the country, compared to many developing countries, has an impressive, dynamic and innovative network of health care infrastructure across the country, only 40 percent of the country's population can effectively access to basic health care services (Perry 2001). Most of the public health facilities in Bangladesh are under-



utilized, under-performed and underachieved. Traditionally, the country's health sector has evolved in line with primary health care approach for providing basic health care to its population. Given the country's resource limitations, to ensure that high-quality primary health care services for its citizens, particularly for those most in need namely the poorest, least educated and geographically most isolated members of the society is a big challenge for Bangladesh. The constitution of Bangladesh enshrined *health* as one of the five fundamental needs of the people and thereby assigned the responsibility to meet the people's health need, mainly, to the government. Being the bearer of the British colonial legacy, however, Bangladesh, after the independence, inherited an urban-biased, elite-biased and a curative health care system (Osman 2004). In this backdrop, Bangladesh introduced, in 1996, its first major reform programs in health and population sector: Health and Population Sector Program (HPSP). Improved efficiency and effectiveness was the explicit objectives of this reform program. For instance, one element of reform, the sector-wide approach, is intended to generate enhanced coordination among donors and host governments with better efficiency as a goal. This approach stems from concerns that health systems have been functioning unproductively due to poor coordination of donor resources and duplication of service delivery systems (MOHFW 1997a; Buse and Walt 1997; World Bank 1993). Client satisfaction, equity of accesses of services and quality of service delivery are also emphasized in the reform strategies (MOHFW 1997a). From reorganization of the public health bureaucracies to creation of new institutions are included in the reform strategies. As Bangladesh embarks on major reforms, which has been mature over these years, offers an opportune time to study the effect and implications of these reforms on achievement of some major objectives e.g. client satisfaction, equity in access in one hand and community participation, public accountability on the other.

As I mentioned earlier, the health situation is worse among urban poor comparing to rural poor population; and worst in metropolitan cities - where the concentration of population is much higher than the national level. For instance, in Dhaka city the prevalence of illness is higher among the hardcore and moderate poor than that of other cities (Islam et al 1997:219). The urban health care infrastructure in the country consists of a range of care provided from three different sources: (1) government facilities, (2) private facilities

and (3) NGO facilities. In Dhaka and other metropolitan cities, e.g. Chittagong, Khulna, Barisal, Rajshahi, the primary health care is provided mainly by the government run general and specialized hospitals<sup>3</sup>. However, there are few dispensaries and a fewer small-scale hospitals, e.g. maternity hospital, that is run by city corporations. Nevertheless, their conditions and capacities are extremely poor; compared to the demands these facilities are meager. Particularly, access of the poor to these government and local government health facilities is very limited (Islam 1997: 88). In fact, there have not been any major government or private programs aimed specifically at the primary health care needs of the urban poor before the inception of the *Urban Primary Health Care Project* in 1998 under which one of the major neoliberal health reforms took place in the primary health care service sector.

### 1.3. RESEARCH PROBLEM AND RATIONAL

The research problem, which has been derived from the background described in earlier sections, could be stated from two different points of views - practical and theoretical, indeed they are intertwined though. Firstly, the research problem could be organized from the practical point of view. Practical point view is an attempt to identify the problem in the real world.

I already discussed that the health sector particularly the primary health care sector of Bangladesh is facing some serious problems as there is hardly any positive change in health status of the population specially of the poor and women in recent years in one hand; and on the other, the neoliberal policy and institutional reforms that are well underway at the expense of national scarce resources have made no significant achievement in terms of effectiveness, efficiency, service quality and peoples participation.

From the theoretical point of view, the issue at hand offers a very important problem for scientific inquiry. We know, according the classical Weberian conception of state ‘a

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<sup>3</sup> In the context of postcolonial country, the nature of public service organization has to be understood differently. For example, specialized hospitals, in common practice globally, is meant for providing tertiary level health care. However, in Bangladesh it is a kind of hospital which provides from contraceptives to nuclear medicine and in between almost everything. The specialized hospitals in Bangladesh are usually attached to various health education institutes, for example, the largest specialized hospital in Dhaka is *Dhaka Medical College Hospital*. More importantly, specialized hospitals are also the main primary health care service delivery organization for urban population.

monopoly on legitimate violence' clearly indicates that state's existence is dependent on its power over the sources of violence, but that violence has to be legitimate (Weber 1946). This means, legitimacy is the nucleus of the modern state. In modern state, coercion is not only the means to sustain state power over the society, therefore it could be argued that the relative importance of the violence has been reduced over years, but legitimacy remains still stands at the center. There are many factors for which state can loss legitimacy. For example, as Mitra explained, based on Huntington-Gurr argument, that in a changing society social inequality resulted from rapid economic and social change can 'lead to violent protest and crisis and decline of legitimacy' (Mitra 2006: 14). When for any reason, state faces decline in democratic legitimacy, it tries to recover it by introducing many reforms including institutional, symbolic or regulatory and policy changes. Mitra suggests strategic social and economic reforms enhance democratic legitimacy (ibid). In that sense reform is way to bridge the gap between state and the society. Therefore, reform for the state, particularly for those who has deficit, is a way of gaining legitimacy. In order to design and implement the reform it needs resources, knowledge and expertise, however, if we consider state as an actor, its capacity to make rational decision is also bounded, which call for exchange information, knowledge and resources from other social groups. In the course of exchange process, social interests groups interact with state actors and provide their material and nonmaterial inputs to the government. Being engaged in exchange with state actors, coalition of social interest groups also gains legitimacy for their ideas and interest. Therefore, the reform turns to a contesting site for multiple values and interests. However, what unknown about this is which kind of coalition produces what outcome? There are many groups such as military, professionals, bureaucrats, political leaders, social activist who can form the coalition; some of the groups represent relatively a small constituency some represents larger. Since the actor's behavior and preferences are constrained by the institutions which they are embedded in, it is very likely that combination of actors matter with respect to the impact of the reform.

Health sector reform provides us the context in which the above theoretical question can be examined. The general goals of health sector reform in any country are to improve the service provision; improvement of health care management; resource generation and

establishing fairness in health care financing. In other words, health reform formulation and implementation entails changes in the process of resources allocation within the health sector and distribution of benefit and burden across population groups. It is therefore a highly political process involving various actors within the state and in society, whose interests may be affected by the envisioned policy changes (Glassman et al. 1999: 115). Yet, outcomes are inconclusive. In addition, its inner paradoxes and contradictions have not been investigated in a postcolonial context. Therefore, how health sector reform affects state's role in distributing public services and citizens access, entitlements and rights to public services offers and an opportunity for a useful scientific inquiry for its analytical and practical value.

#### 1.4. AIMS OF THE STUDY

Since the thesis is interested to provide some answers to the question: “does the health reform benefit the poor”, it focuses on analyzing the political dimension of *ex ante* effect of health sector reform. More precisely, it is concerned to understand and explore the depth of political nature of health reform process and its consequences, particularly in terms of gain for the poor in a postcolonial country.

Thus, the aim of the study is to understand the process and impact of neoliberal health reform on state and society in a postcolonial context. Bangladesh is a case in point.

I have shown that the present reform regime is ideologically creation of neoliberalism. The impact of health reform, however, is inconclusive and complex. It is also true that there has very little amount of theoretically sound and empirically validated work, particularly considering the stake for the poor, been done on the issue using Asian postcolonial experiences. Therefore, I have been inspired to take up a modest effort to shed light on this obscurity. However, the concepts of ‘state’ and ‘society’ are so broad that the aim would not make sense unless they are defined precisely. The state is perceived and used in this thesis as both an actor and institution simultaneously that control actions and organizations; structures relations between society and the public authority, and structures the relations within society (Skocpol, 1985). The society is conceived as an arena where individual citizens, groups, and forces live, interact, compete and cooperate with each other in organizations and institutions being distinct from the state. It includes

all individual, groups, classes, and organizations beyond the state. Nonetheless, the concept of ‘society’ is used in this thesis, mainly, to denote the poor, marginalized, disadvantaged population of the country.

The aim of the study can be further specified in objectives. The objectives of this thesis are twofold: to contribute to the current scholarly debate on the politics of neoliberal reform in general and health reform in particular; and, to provide useful insights/suggestions to the policy makers, practitioners and activists who are working in ground for the improvement of health of the poor.

Thus, the objectives can be summarized as follows:

***Specific Objectives:***

- (1) To build analytical understanding of the ideological and political factors of neoliberal health reform policy adoption
- (2) To understand the implementation process of health sector reform
- (3) To analyze the impact of the reform on the role of state in health service delivery
- (4) To analyze the impact of reform on the poor in cities in Bangladesh
- (5) To develop suggestion for the policy makers, practitioners and activists so that they can bring changes in the ongoing or yet to come reform programs

In pursuance of the aims and objectives, the study concentrates on addressing one key question: “does the health sector reform benefit the poor?” The question itself is a compound one which needs further elaboration. I argue that the ‘poor’ is a political category, so is the ‘neoliberal reform’. In the first place, the poor are unevenly placed in any society, particularly in Bangladesh. Thus the impact of an intervention, which is also very political in nature, will be uneven, thus political. Therefore, the political spaces: household, community and state, are taken in the study. Moreover, poor, very often are politically excluded and economically exploited by the powerful actors (Webster and Engberg-Pedersen 2002a: 3). But these marginalized and disadvantaged people do not live in isolated ‘island’, rather, are connected with the larger political spaces through their struggle to cope with their conditions and exploit emerging opportunities. Here comes the relevance of the state to lives of the poor. The state controls the distribution of resources,

value of the resources for its subjects. Therefore, I argue, in order to understand if neoliberal health reform does benefit the poor it is not sufficient to concentrate only on the poor as individual citizen. But at the same time, we must look what kind of changes takes place at the level of state in relation to its role in distributing a particular resource which concerns the poor. For example, if the state does withdraw its price subsidy for drugs from pharmaceutical companies, it will affect the poor, indirectly, more than the companies. In other words, changes in the role of state in relation to distribution of service/resources in concern have to be addressed with same importance along with the direct benefit of those services. Therefore, this study takes three spheres of one's engagement: household, community and state into account in answering the said question. I shall discuss the approach and analytical framework in the next chapter, but before that I shall define some key terms which are being used in this thesis in the following section.

## 1.5. DEFINITION OF KEY TERMS

### 1.5.1. State

There is no consensus among different schools of social sciences regarding the definition of state; therefore, I would not introduce the theoretical debate on the conception state in this place. Rather, I will try to go for a definition, however, that is no an easy job too.

The state is a distinct set of institutions that has the authority to make the rules which govern the society. It has, as Max Weber said, 'a monopoly on legitimate violence' within a specific geographic boundary (Weber 1919). There are two difficult aspects of the conception of state which concerns me in relation to the present study: the boundary of state and the interest of state. Broadly, the state theorists can be divided into two broad categories: society-centered and state-centered schools, each of them holds somewhat different ideas about boundary and interest of state. Weberian views suggests that the boundary of state is clearly identifiable as it consists of clearly defined set of institutions while others, mainly Marxists like Althusser and Gramsci argue the distinction between state and civil society is not clear because, they are rather interconnected and integrated one into another (Gramsci 1971 cited in Jessop 2000). Regarding the state interests, according to the Marxian school, state interests is the same as the dominant elite's who

represents the interests of capital. Others, the pluralists view that the state acts in the interests of groups in society. However, there are others, known as statist, for example Skocpol, suggests, state can act autonomously to a reasonable degree (Skocpol 1985). Their main argument is that since the modern state controls the means of violence and social groups are dependent on the state for achieving any policy goals, the state personnel/organization 'can impose, to some extent, their own preferences on the citizenry' (Marshall 1994: 508). Having discussed briefly the main debates on state, we would like to define state, following Skocpol (1985), as an entity that possesses an administration, laws that guide actions, and organizations and institutions that coerce society, structures the relations between society and the public authority, and structures the relations within society (Skocpol, 1985). According to this definition state is perceived as an actor, who takes part in negotiation with other social actors, and at the same time as an institution what controls the actions of all actors including itself. I argue that this definition is more useful to captures the very complex nature of modern state.

### **1.5.2. Society**

According to the Oxford Dictionary of Sociology, society is 'a group of people who share a common culture, occupy a particular territorial area, and feel themselves constitute a distinct and unified entity' (Marshall 1994: 498). This general definition of society seems to have similarities with nation-state. But, in this thesis I would like to follow the idea that society and nation-state is not analytically similar. There are many schools and as many as streams within schools suggest different conceptions of society. It is not the right place to be engaged in that debate. The concept of society, in the Western world, developed in the age of reason, according to that classical view, the society is a distinct entity which is clearly prior to and outside of state (Mayhew 1968). For others, society is an institutional order which embodies a fundamental set of cultural ideas. The core unit of society, however, is individual and the network of their interrelationships. Combining different approaches, for us the term society is conceived as an arena populated by individuals and groups having interactions and networks based on shared cultural beliefs and that is clearly outside of the state. It includes all individual, groups, classes, and organizations beyond the state. Nonetheless, society is not a monolithic entity or space, there are many subgroups within. This thesis, mainly, is concerned of the poor,

marginalized, disadvantaged population of the society.

Although the individual is the organizing unit of the society and act upon his/her rationally chosen ends, but his/her action is constrained by various institutions within the society. These institutions help to establish equilibrium among utility-driven individuals from being conflicting to each other. Household and community are two most important institutions in the society outside of state that affects individual's position and actions in the society most. Polanyi (1977) and Friedman (1992) both argue that human behavior is determined by social cultural relations more importantly than the incentive or utility. They also suggest that household is the basic organizing unit of society through which individuals connect to society and through which market and non-market relations are articulated (Friedman 1992: 50). The other important mediating sphere between individual and society is the community. Then the question is how to differentiate household and community from society. For some, communities are locally based units of a larger society; for others, community refers to some aspect of society, such as its solidarity (that is, communal) or spatial components (Mayhew 1968: 584); in fact, it is both. Community interests are, very often, articulated through community based organization (CBOs) or NGOs. These two institutions: households and community play in between state and individual and act as two separate but interdependent domains of social actions to relate to the state (Friedmann 1992). Thus, the very significance of household and community in relation to their position in the state-society continuum posit them to the foreground in studying the impact of health reform.

### **1.5.3. Health**

Health is political. Therefore, it is very likely that there will be hardly any consensus on the definition of the concept of health. Yet, for the analytical purpose, in this thesis, I would like to take the definition of health that has been accepted by the WHO and the United Nations. The constitution of WHO defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO 1948). Despite a wide acceptance, the definition generated a great deal of criticism since ever it appeared. For example, Sissela Bok (2004) highlighted:

“It has been variously called masterful or dysfunctional, profound or meaningless; defended



as indispensable in its present formulation or seen as needing revision; at times held to have opened the door to medicalization of most of human existence and to abuses of state power in the name of health promotion”

It is interesting, however, to see that the criticism of the definition is not for any kind of logical incoherence or contradictions of its formulation, but most for its political nature. For us, this is not a weakness of the concept of health, rather an acknowledgement of the very political nature of the concept, thus, the phenomena itself; therefore, we would like to accept the definition and work on it. The very political nature of the definition has been further exposed in its declaration that “the enjoyment of highest standard of health is one of the fundamental rights of every human being without distinction of race, religion, and political belief, economic or social condition” (WHO 1948). The definition and declaration of WHO clearly indicates that food, shelter, peace, income, sustainable resources, social justice and equity are basic prerequisites for health; this means, health entails major change in the distribution of power and resources in the society (Signal 1998).

The conception of health with its political dimension forms the crux of this thesis. I argue health is political because it is a precious resource of mankind and it is distributed unevenly among various groups in the society. This means, like any other resources, some have more of it than others (Bambra, Fox and Scott-Samuel 2005). Rissel (1994) showed that the groups without power or feeling powerless experience worse health. Similarly, Labonte (1992) argued that those who have more power are healthier. This clear linkage between power and health established the political nature of health. In addition, the social determinants of health e.g. inequality, poverty are subject to political decisions and are thereby dependent on political action (Bambra, Fox and Scott-Samuel 2004). Finally, we must not forget that there is right dimension of health. Health is acknowledged as human rights in the UN declaration. This right dimension engages individual to be engaged with political spaces; thus, health eventually become a political agenda to be decided about, a political resource to be distributed.

#### **1.5.4. Health System**

The usage of health system as a key term in our study relies on the notion that have been

used by World Health Organization (WHO), the world health authority, for quite a long period of time and many scientific and policy purposes. WHO defines health system as “all the organization, institutions and resources that have been devoted to producing health actions” (WHO 2000:1). In a general sense, the health sector includes “all the activities whose primary purpose is to promote, restore or maintain health” (ibid. 5). By *health action*, WHO defines as “any effort, whether in personal health care, public health services or through inter-sectoral initiatives, whose primary purpose is to improve health” (ibid). The model of health system presented by Grodos and Mercenier (2000:22) encompasses several elements: environment (physical, social, economic, political), health services, specific agents (diseases or health problems) and population (heredity, culture, behavior). An institutional view regards health system functions as the mechanisms of finance, delivery and decision making” in health care (Freeman, 1999:81). Health systems vary in form, function and content. There are three key objectives of a health system irrespective of the country: 1) improve the health of the population they serve; 2) responding to peoples expectations; and 3) providing financial protection against the ill-health (WHO 2000: 8). A range of organizations, institutions such as public and private modern health high-tech services, hospitals, professional medical treatments, traditional health believes, practices and medicine, nursing (home and professional), health insurance, health education and promotion are all part of a health system (Griffith and Mills 1983:52; WHO op. cit:11). Health services are usually distinguished between *curative* and *preventive* services. Curative services are actions aimed at treating an already acquired illness. On the other, the preventive services refer to actions aim at stop the occurrence of ill health (Last 1987: 10) such as child immunization and sanitation. Health prevention is analogous as health promotion, which refers to “the process of enabling people to increase control over and improve their health” (ibid.). Such processes include public policies, measures and actions for healthy life style. Health promotion may be targeted at the individual, the community or whole populations (Harding 2003: 45-46).

#### **1.5.5. Health Sector Reform**

Health sector reform refers “a significant, purposive effort to improve the performance of the health-care system” (Huntington 2004). This is a very broad definition as it includes any actions that improve performance of the health care system of a country. It has been

argued that there is a wide variety of policy mixes that are being denoted as health reforms referring “in a very loose way to a package of policy measures affecting the organization, funding and management of health systems” (Zwi and Mills, 1995:314). However, Berman and Bossert (2000) argue any action to improve health sector performance should not be labeled as health sector reform. According to them, health sector reform should bring ‘sustained, purposeful and fundamental changes’ in the health system (Berman and Bossert 2000). However, I would not elaborate the definitional discussion, because I do subscribe the idea that health sector reform is not a concept that ‘demands a global single definition, nor should we try to be too specific in splitting hairs about what is and what is not reform’ (Cassel and Janovsky 1996 cited in Berman and Bossert 2000). Surely, health sector reform can include a wide range of activities regarding health systems. Five areas of health care are typically addressed in the reform program: financing, payment, organization, regulation and behavior (Roberts et al. 2004). Some reforms initiatives are wide in scope and involve change within several areas of health system structures and operations while others are rather narrowly conceived and with a more limited scope of change (e.g. a new payment scheme is introduced for unemployed). Both types of reforms may cause wave-effects throughout the health care system requiring adaptation and adjustments in their implementation. Health sector reform should be considered as a process that in one hand reflects the social values and political processes of a country; on the other, involves significant transformation of systems and the creation or promotion of actors who will defend their new interests in the political process (Huntington 2004). The *World Health Report 2000* identified five goals of health sector reform: efficiency, quality, equity, client responsiveness and sustainability. To conclude the definition, I would say, as Berman (1995) said, health reforms may vary in content and scope, but share common general features in that most entails changes in the institutional arrangements of the health care system, in the role of the state and the private sector, and ultimately, in the nature and amount of services accessible to different groups of the population.

Cassel (1995) identified six main components of reform programs: (i) improving the performance of the civil service; (ii) decentralization; (iii) improving the functioning of national ministries of health; (iv) broadening health financing options; (v) introducing

managed competition; and (vi) working with the private sector. He also suggested that reform programs should ideally offer “menus” that contain a number of options.

With reference to recent health sector reform program in Bangladesh, clearly, it was the efficiency and effectiveness drive from the key actors, particularly the government and international donor community. Indeed, it was wide in scope, purposeful and fundamental. The reform program set off transformation from vertical to integrated service delivery through unification of health and family planning services under a single management structure (Jahan 2003: 183). The reform in Bangladesh also introduced managed competition through contracting out health services to non-government organizations. In short, it introduced market principles in primary health care sector.

Zwi and Mills (1995), however, point to the fact that adoption of market principles in the health sector emerges as a reaction to the failures of the previous state model, and is not based on policies with proven effectiveness. Hsiao also raised more precise questions about the “effectiveness of using free market principles to structure the health sector” (Hsiao, 1995:134). He also noticed that many countries have defined and undertaken health reforms without considering the facts and context but being motivated by some ideological factors. Like Hsiao (1995), Cassel (1995) also suggests that reforms have to be context-specific. He stresses that political and institutional analysis should be accorded with same importance as epidemiological, demographic, and economic research in designing and instituting reforms. I shall discuss the political aspects of health sector reform in the next chapter.

### **1.5.6. Primary Health Care**

The most comprehensive and least disputed definition of primary health care has been provided by the Alma Ata Declaration<sup>4</sup>. The declaration defined primary health care as:

essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to

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<sup>4</sup> An international conference on primary health care, organized by WHO and UNICEF held in Alma Ata, Kazakhstan in 1978. This was the first of its kind where the world community reached to the consensus and declared that primary health care is the key to attaining a level of health by all peoples of the world by 2000 that will permit them to lead a socially and economically productive life (WHO/UNICEF 1978).

maintain at every stage of their development in the spirit of self-reliance and self-determination ....It is the first level of contact of individuals the families and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The declaration also expressed that the primary health care should address the main health problems in the community and includes promotive, preventive, curative and rehabilitative services. It should include “education concerning prevailing health problems and methods of preventing or controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child care, including family planning, immunization against major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs” (WHO/UNICEF 1978: 16).

Though the definition encompasses a very wide range of activities but what is significant about it is the definition holds the spirit of social justice, community participation, self-reliance and self-determination within it.

In light of the Alma Ata Declaration, as a signatory of the declaration, Bangladesh also adapted *Health For All by 2000* strategy and in accordance with the strategy it reorganized the primary health care services in early eighties. Since then, the main elements of primary health care services in Bangladesh remain as follows (Khan 1988:19):

- (1) Education concerning prevailing health problems and methods of preventing and controlling them
- (2) Promotion of food supply and proper nutrition
- (3) Adequate supply of safe water and sanitation
- (4) Maternal and child health (MCH) including family planning services
- (5) Immunization against major infections diseases
- (6) Appropriate treatment of common diseases and injuries
- (7) Prevention and control of endemic diseases
- (8) Provision of essential drugs
- (9) Promotion of mental health care

### **1.5.7. Democracy, Defective Democracy and Democratic Deficit**

Concepts of defective democracy and democratic deficit are inevitably related with the idea of democracy itself. In fact, the concept of democratic deficit is concerned with the quality of democracy in a system of collective decision making and defective democracy is the concept that captures the quality dimension of democracy in a very sophisticated manner. From this perspective, in order to build my concept of democratic deficit, I would like to introduce a brief discussion on democracy and defective democracy first, and then would connect to the concept of democratic deficit in the following paragraphs.

Democracy as a form of governance emerged because people, while being dependent on each other, do not agree on everything. Democracy stands on the recognition of the fact that there is no single correct solution to political problems and therefore, other people's standpoint may be right and ones own may be wrong. While there is no one best solution, it is reasonable to assume that the more views and premises are considered in a decision making process, the better the policy will be. Moreover, participation not only produces better policies, but also creates better citizen (Aars and Offerdal 2001). Having established on these general premises, to let people take control over their livelihood-decisions and live a well-informed life democracy has been turned out as an effective path all around the globe.

Democracy belongs to the sphere of the political, which is the sphere of collectively binding rules and policies and of the resolution of disagreement about what those policies should be. And at the same time, it certainly entails a variety of individual rights – of free speech, association, the suffrage and so on. But their point of reference is the process of collective decision-making, which is necessarily prior to – because it provides the preconditions and boundaries for – individual choice and action (Beetham 1996). Moreover, democracy is a mode of organizing things that is not confined to the arena of government alone but can be realized wherever there are common rules and policies to be made and disagreement about these rules to be resolved.

Considering the above points, a system of collective decision-making can be regarded as democratic to the extent that it is subject to control by all members of the relevant associations considered as equal. Popular control and the political equality are the key

principles of democracy. These two principles constitute simple but powerful notions, which can be used both to assess how democratic a system of collective decision-making is and as ideals to be realized in practical institutional form. The history of popular struggle for realizing these principles in the mode of governance has developed a set of intermediate concepts i.e. popular authorization and accountability of public officials and the responsiveness and representation of decision-making bodies. It can, therefore, infer three basic criteria for evaluating a collective system of decision-making, be it government bodies or private associations: accountability (to the electorates), responsiveness (to the interests of the electorates) and representation (of the electorates). These three criteria can not be ensured by its own, require number of legal, structural functional and institutional arrangements. The question of defective democracy arises when these arrangements are not done properly. The question of defective democracy points to the fact that not all the countries known as democratic have been able to establish those three criteria in their respective systems of governance.

The concept of defective democracy is developed by Merkel and his colleagues (Merkel et al. 2003, Merkel 2004). The concept has been developed out of the dissatisfaction regarding the popularly used concept *electoral democracy*. The idea of electoral democracy built on minimal definition of democracy, which at least ensures universal right to vote, regularly held free and fair elections where two or more political parties take part (Morlino 2004:10, Merkel 2004: 34). Nevertheless, the concept of electoral democracy overshadows the variation within democracies in one hand, and marketizes a narrower interpretation of democracy itself on the other. Indeed, free, fair and competitive election based on universal suffrage lies in the center of democracy; however, further empirical investigation is necessary to understand to what extent accountability, responsiveness and representation can be achieved only by holding elections. In other words, the quality of democracy requires to be investigated. According to the Freedom House<sup>5</sup> data, in 2001 there were 120 electoral democracies in

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<sup>5</sup> Freedom House is a nonprofit and nongovernmental research and advocacy organization established in 1941 in the US. The organization is working for establishing democratic values all around the world. It has been one of the major sources of worldwide socio-political data to academics, journalists and activists through its annual publications e.g. *Freedom of the world*, *Freedom of the Press*, *Nations in Transition*, which publishes state of democratic rule in the world since seventies (Freedom House 2007).

the world (Freedom House 2007a). Diamond, by using Freedom House data, develops a further classification within these electoral democracies; according to which 58.3% of all electoral democracies have been qualified as liberal democracy where as 20.8% were semi-liberal and 20.8% are illiberal democracies (Diamond 1999 cited in Merkel 2004). The conceptual foundation of these quality labels, however, was not clear. In order to develop a more precise and theoretically sophisticated differentiation-scheme Merkel and his colleagues developed two complementary concept *embedded democracy* and *defective democracy* (Merkel et al. 2003). The later has to be understood in contrast of the former.

The idea of embedded democracy is built on the assumption which suggests modern democracies are embedded in a complex institutional and structural conditions both internally i.e. complex societies and externally i.e. challenging environment. According to Merkel:

“...an embedded liberal democracy consists of five partial regimes: a democratic electoral regime, political rights of participation, civil rights, horizontal accountability and the guarantee that the effective power to govern lies in the hands of democratically elected representatives” (Merkel 2004: 36).

The concept of embedded democracy stretches the conventional definition of democracy which is based on democratic electoralism. It recognizes the primacy of the democratic election as the core, however, simultaneously suggests having institutional guarantee which ensures that democratically elected representatives will rule according to the democratic and constitutional principles during their term in the government (ibid). One of the major contributions of the concept of embedded democracy is that it provides us with the analytical tool to locate precisely the incompleteness or defects of a particular regime.

Putting straight and simple, the concept of defective democracy denotes a situation when ‘one of the partial regimes of an embedded democracy is damaged in such a way that it changes the entire logic of a constitutional democracy’ (ibid). In other words, in a defective democracy the mutual embeddedness between partial regimes gets distorted. One or more of the partial regimes may be disrupted at a particular point of time. Elaborating this argument, depending on which partial regime(s) is impaired, defective



democracies, in between autocracy and liberal democracy, can be differentiated in four types: exclusive democracy, domain democracy, illiberal democracy and delegative democracy (Croissant 2004, Merkel 2004, Morlino 2004). I shall not elaborate the various types of defective democracies in this place; however, a brief introduction can be forwarded. Drawing on Merkel's (Merkel et al. 2003) formulation, it can be said that when one or more groups of adult citizen of a country is excluded from universal right to vote is called exclusive democracy. Similarly, domain democracy is a situation where some specific domains stay beyond the control of democratically elected representatives. In domain democracy the military or multinational companies or some other groups may hold exclusive power. The illiberal democracy is said to have a situation where the power of executive and legislature is weekly controlled by the judiciary, where the rule of law is damaged and constitutional norms has little control over the actions of the government. Civil rights in illiberal democracy are not firmly established. The delegative democracy is the last sub-types of defective democracy. The main feature of this type is limited control of legislature and judiciary over the executive branch of the government. In this condition the checks and balances between three organs of the government are severely damaged.

In summary, I would like to mention that my intention is not to analyze the causes of emergence of defective democracy, rather, I am more concerned to understand the link between quality of democracy and the policy impact it does create on the state and society in a country. However, the concept of defective democracy helps us to focus more precisely on the very quality of the governance of a country. There are two common features, identified by Merkel and Croissant (2004: 205), in all form of defective democracy: weak observation of rule of law and of horizontal accountability; existence of powerful political groups that captures certain political domains and thus exclude certain issues from the policy agenda and restrain the power of the democratically legitimized authorities to make public policies autonomously. This is the situation what is called democratic deficit. In other words, democratic deficit develops as a result of defective democracy when the quality of democracy diminishes.

I shall give a very precise definition without involving the whole range of literatures on the concept of democratic deficit. Nonetheless, I do acknowledge the fact that the term has been developed in the field of international politics, particularly in relation with

politics in European Union. However, I argue that the term can be used in other contexts as well as an analytical concept. My understanding of democratic deficit is built on three landmark works of Milev (2004), Moravcsik (2004) and Scharpf (1996). I shall not elaborate the theoretical debate over the concept here; rather, drawing on above literature I propose the following definition of the concept.

In simple words, the concept of democratic deficit denotes lack of democratic legitimacy of a political institution or organization. Democratic deficit is used to refer to organizations which are democratic to some extent, but are seen to be falling short of fulfilling the principles of democracy in their practices or operation. In other words, it clearly means a situation where the decision making process has been made distanced and unaccessible for its constituencies, the common citizens. The relationship between the governed and governor is the central to the idea of the democratic deficit. The political organization or institution for example government or any supra-government entity like EU or UN may be democratic in some respect i.e. election, but if their decision making system is not transparent, is not easily accessible then it could be said that there is deficit in the democratic practices. The relationship between defective democracy and democratic deficit is very clear, latter is the result of the former. That is to say, deficit may be resulted from any form of defects in the democracy.

#### **1.5.8. Actor**

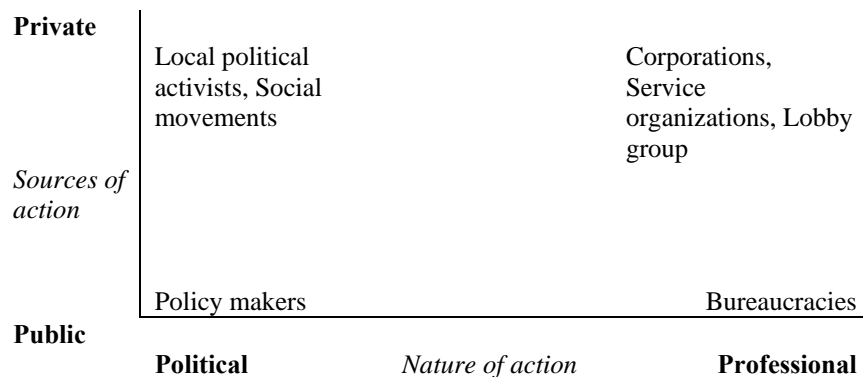
Actor is one of the most commonly used terms in social sciences; however, it does appear to have very little effort to define the concept. Usually it's been used to denote a person, a group of people or organization that performs any kind of action or inaction in relation to public policies. An actor used to have a particular identity with a set of norms, values and practices that distinguishes one from other. Talcott Parsons sees social actor in terms of the interaction one may have to its environment. He perceives social actor as an entity "which chooses between different means and ends in an environment which limits choice both physically and socially" (cited in Marshall 1994). The main marking line between an actor and non-actor is his/her action, if any entity is able to influence public decisions directly or indirectly then that could be said as an actor. It could be any individual, or group of individual, for instance, professional associations. It also could be some

organizations as well, such as state, community and so forth provided they take part with a particular identity. However, one should keep in mind that there is a difference between individual or group actor and institutional actor. The difference proposed by Murphree (1994) is especially relevant to this point, she postulates:

“The concept of actor is a social construction rather than simply a synonym for individual. Nor is an institutional actor a synonym for group. An institutional actor is an entity organized for the interests of some group or set of goals. Groups and individuals are considered within the context of organized institutional arrangements.”

Thus, according to Murphree, the difference between an institutional actor and a non-specified individual or group is that the institutional actor is organized for an interest or purpose of some groups. In other words, an institutional actor represents a larger constituency. There could be some confusion regarding the subscription of *state and community as actor*, because they are also known as *structure*. I argue that, state and community as such is a structure, but when one individual acts on behalf of the state or community with that particular state or community identity which is embodied with a specific set of norms, values then s/he becomes state or community actor. In this study, I am concern about the individuals and organizations who take part in policy and service networks. There are mainly two broad-categories of actors: public and private actors, both of them requires further unpacking.

Figure 1.1: Typology of Actors



In order to understand the relationship between public and private actors, the state should not be treated as a unitary actor. *Public (state) actors* may consist of policy makers, bureaucrats or any individual/organization that have the authority to take any decision on

behalf of the state (Börzel 2000). Local government officials, both political leaders and professionals, are also could be regarded as public actor. However, differences in interest, norms and values between policy makers (political leaders) and the people who are involve in policy implementation e.g. professionals are prominent, thus, public or state actors could be placed under two gross sub-categories<sup>6</sup>: *political actor*, *professional actor*. We can also divide *Private actors*- who do not function on behalf of a state or international organization into two sub-categories: as *for profit*, *economic actors* (e.g. corporations, interest groups) and *not for profit*, *societal actors* (e.g. voluntary organizations, social movements, and advocacy coalitions). Economic actors aim mainly to produce financial wealth and are driven by the goal of maximizing profit. They are less concerned with solving common problems of advancing political agenda. On the other, the societal actors are mainly to address public issues (Börzel 2000). It should be mentioned that public issues are not necessarily always in the general interest of the public good. Private actors also could be divided into political and professional categories. The typology of actors can be generalized on the basis of two more dimensions: *source of action* and *nature of action*. Source of action refers to the origin of authority or power on basis of which an actor acts. Likewise, the nature of action refers to the kind of job an actor used to do. Figure 1.1 depicts the relationship between the actor's action, their source of power and their identity. Drawing on arguments presented in Figure 1.1, it can be said that the actors whose source of action is rooted within their economic power are less concerned about the common citizens, rather they are more interested to make gain out of influencing public policies. For example, pharmaceutical companies may influence the health policy and drugs policy so that they can enjoy government subsidiary or tax-holiday. On the contrary, political groups, parties and social groups are more committed to collective interests mainly because their action derives from their power that they gain from the popular support. In other words, political parties and social groups are dependent on and thus accountable to the larger population for their

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<sup>6</sup> These categories are a kind of broad classification. The objective of this categorization is not to reinforce the old debate of 'politics-administration dichotomy', but to distinguish the actors and their relative preference who are involve in public sphere and act on behalf of the state or state organization for analytical purpose. However, at the same time, we acknowledge that the boundary line between these categories is very thin and they overlap each other often.

power and action. In summary, it is arguable that the policy arena which is dominated by public-political-social actors likely to produce pro-people policy outcomes.

#### **1.5.9. Hegemony**

The concept has been developed mainly by Karl Marx to refer ideal representation of the interests of the ruling class as the universal interest. While according to the classical Marxian tradition state interests are the ruling class interests, there is no difference between state and hegemony (Marx 1848). However, Gramsci made a difference between these two. Gramsci locates hegemony within the non-state level, for him civil society is the vehicle of bourgeois hegemony (Marshall 1994). Gramsci (1988) used the term to connote a congruence of material and ideological forces that enables a coalition of interests to maintain a dominant position in society. This coalition develops over a long period of the historical development that transcends any one class (ibid). Hegemony is maintained through material control over economic resources as well as ideological control over symbols, imagery, and modes of thought. In achieving and sustaining hegemony, Gramsci emphasized the process of consent and compromise rather than coercion; the role of ideology is crucial in this process of achieving consent. Nevertheless, hegemony in Gramscian literature is not viewed as constant or stable; rather in dialectic view which is characterized with contradictions of conflicting interests between within and outside. In addition, it also suggests that the dominant coalition does not have total power over state institutions.

In my study, the concept is used to explain how the dominant coalition universalize their own ideology oriented concept of health, performance of health system and health sector reform by using the state mechanisms and process in Bangladesh society.

#### **1.5.10. Non-Governmental Organization**

The term NGO is one of the most illusive, difficult-to-define concepts in contemporary development discourse. The term has been originated from, used in and abused for multiple arenas. However, in a straight look, we find in the contemporary era some formal and non-formal groups, communities, societies, agencies or organizations engaged in public domain, for some common causes<sup>7</sup> being relatively autonomous of state, they

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<sup>7</sup> Common causes may not necessarily be a 'public good'. There might be some voluntary, private

are known as NGOs. Thus NGOs are non-governmental and voluntary. This is only the common part in the hundreds of definition of NGO because there is a wide range of controversy, complexity and disagreement over a common definition of NGO. The debate arises because of enormous variation in types, functions, funding sources and patterns, nature of membership etc. regarding organizations. Nevertheless, there seems a growing trend of convergence in understanding the phenomena is gradually taking place. The well known studies of the world wide Comparative Nonprofit Project (CNP), by the Center for Civil Society Studies, John Hopkins University developed an inventory of common minimum attributes, which is known collectively as the International Classification of Nonprofit Organizations (Salamon and Anheier 1997). This classification has five defining features, NGOs are: (1) are formally organized; (2) are privately organized; (3) do not distribute earned profit to their members or owners; (4) are independently controlled; and (5) are voluntarily organized (Salamon et al 1999). These features cover most part of the phenomena. However, in the context of developing countries, there is commonness in aims of NGOs, i.e. to work for some social causes, for example, alleviation of poverty, empowerment of women, rural development and so on. In order to reflect this reality in the definition, I do consider a recent formulation made by Marten (2002: 282): “formal (professionalized) independent societal organizations whose primary aim is to promote common goals at the national and international level”. Recognizing the fact that Salamon’s definitional criteria and Merton’s definition both together enough to capture the various dimension of the concept as an analytical category, therefore, the term shall need not further explanation. However, some Bangladesh specific information may be added. The most important criteria which are contrasting to the NGOs of north is that, the NGOs working in Bangladesh, almost all of them, by one way or other, largely depend on foreign donor’s fund for operation (Begum 2003: 71-72). This country specific reality is reflected in the definition put by Richard Holloway (1998:19) “organizations started in Bangladesh, or brought in from overseas that claim to do development work, and usually to do so with foreign money”. This definition mostly covers the main features of maximum number of voluntary and

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organizations working for some ‘public bad’ as well. The organization of Aryan Nations, which generate solidarity across borders among the white people of European descent s an example of NGO pursuing public bad (racism) rather than a ‘public good’ (Ridgeway 1995 cited in Börzel 2000).

nonprofit organization working in Bangladesh. Therefore, at the end, I define NGOs in Bangladesh as privately owned and voluntarily initiated organizations started in Bangladesh or brought in from overseas aiming to do social development work and usually do so with foreign funds.

#### **1.5.11. Contract Out**

Contract out or outsourcing of public services is not a new phenomena; it has been a common way to organize public services for centuries in one form or other (Bryntse and Greve 2002). In recent years, competitive contracting has been implemented in many countries as a policy measure to achieve some degree of deregulation or privatization by involving private actors in the public business. With respect to health care services in developing nations much of the impetus for contracting out has arisen from the perception that suggests publicly provided health services are not effective or efficient. The outcome of the policy has been widely debated though (Deakin and Walsh 1996; Rhodes 1994), but there seems to be a general recognition of contracting out as a specific style of management (Brynste 2000).

In this study *contract out* is considered as a policy for managing public service provision, more precisely, an “arrangement in which a public authority retains ownership or policy control of a function but contracts with a private operator to discharge that function” (Wettenhall 2003). In other word, it’s a mix of public and private actors, interests and endeavors in public service provision. If we look into the particular context of Bangladesh, soon we will see that contract out - in terms of sharing some responsibility by private actors with public actors not new at all. Private organizations have been taking part in many ways in government businesses since long where government is awarding the contract to one or a group of private organization to let them supply some goods or services for a particular need of the government. In that situation the main modalities of the contract are profit making (for the private organization) and cost saving (for the government), but contract out in relation to our study is quite different than these common categories. Profit making or cost saving is not the driving motive for either of the party involved. The main features of the contract out I am concern about in this study are as follows:

- (a) It is about public service provision, primary health care service in particular;
- (b) It is an involvement of private but *not for profit* organization;
- (c) Neither profit nor cost saving but achievement of effectiveness and quality of the service is the main goal;
- (d) Its based on a formal agreement
- (e) Interdependence and mutual collaboration is the mode of transaction

## 1.6. STRUCTURE OF THE DISSERTATION

This dissertation is structured in eight chapters. I will briefly introduce the contents of the chapters in the following:

***Chapter 1: The Research Problem and Context:*** This Chapter 1 provides a general introduction to the dissertation. At first, the chapter presents a brief introduction to the research problem and main arguments of the dissertation. Discussion in the next section moves to locate the research problem at the global level and presents its link to the country specific problem. The Chapter then discusses the context of Bangladesh within which the research problem has been identified. The chapter also discusses the aim and objectives of the study and ends with introducing key concepts that are relevant to explain the research problem.

***Chapter 2: Health Sector Reform: Political Analysis:*** Chapter 2 is to provide the theoretical foundation of the dissertation. This Chapter is divided into three main parts: Review of the Relevant Literature, Analytical Framework and Methodological Position of the Study. The Review of Relevant Knowledge and Research part introduces major current literatures on health politics, health sector reform, and impact of reform and so on. The main purpose of this part is to locate the study within the current theoretical debates that have informed it. The second part of this chapter, presents the Analytical Framework, which is developed on the basis of the literatures discussed in the previous section. And the third part discusses the methodological position of the study and researcher (A detail discussion on methodology and research design is presented in the **Annex 1**).



***Chapter 3: The Socio-political, Economic and Institutional Context of Health Care Sector in Bangladesh:*** This chapter presents the contextual factors that affect the health sector reform in Bangladesh. In doing so, it examined the social and economic conditions and how they affect the health and health sector reform policy. At the same time it also presented the political factors: the nature of the state, feature of ruling elites, position of major political parties on health issues. This chapter also discusses the immediate environment of health care system: the structure, function of the health ministry, national health budget and position of other private players in the health care sector in Bangladesh. Finally the chapter summarizes the interrelation between various contextual factors and the health sector reform program and its impact.

***Chapter 4: Health Sector Reform 1995-2000: Actors, Institutions and Interests:*** This Chapter exposes the political nature of the reform in primary health care sector. It discusses the content and process of reform in Bangladesh. It discusses what is been changed, how reform policy were formulated, who were the key players, who implemented it and how it is implemented, what was the interests of the key players in both formulation and implementation level.

***Chapter 5: Impact on the Role of State in Health Sector in Bangladesh:*** This Chapter Presents two case studies on how reform is implemented in ground. The Chapter provides analysis of organizational and institutional features of two different actors who are implementing the reform process close to communities.

***Chapter 6: Impact on the Role of State in Health Sector in Bangladesh:*** This Chapter discusses the impact of health sector reform at the macro level. It shows how state is moving away from its traditional role to a new role. It also discusses the implication of this change for the poor.

***Chapter 7: Impact on Society:*** This chapter forms the crux of the dissertation. This chapter is organized in seven sections. The first section presents the overall picture of the respondents, their household and communities. Second section discusses the impact of the reform on poor community's usage of health care services. Third section presents the interpretation of the data about how people's health related knowledge and awareness has changes as a result of reform. Fourth section discusses whether the reform has increased

or decreased the people's access to health care services. The fifth section discusses the impact on non-health aspects of health care of poor communities. The sixth section discusses participation and accountability issues. Seventh section presents data and interpretation related with people's collective action.

***Chapter 8: Conclusion: Summary of Findings and Policy Recommendation:*** This Chapter summarizes the findings that are presented in previous chapters and presents the learned arguments of the dissertation and presents the evaluation of the health sector from the perspective of poor communities. This chapter also elaborates arguments and final evaluation about the propositions. At the same time it also suggested some policy recommendation for those who are working in ground and shows some new areas of research.

***Annex 1: Research Design and Implementation:*** In addition to the regular chapters, full length discussion on methodological issues, research design and fieldwork organization is made in the Annex 1.

## 1.7. CONCLUSION

This chapter introduces the reform problem, context and the main theme of the thesis. In order to answer and explain the research problem one needs to, at first look into the existing knowledge and literature. I shall introduce the theoretical debaters by reviewing the literature in the next chapter.

## **CHAPTER 2**

### **HEALTH SECTOR REFORM: POLITICAL ANALYSIS**

Health is political. I argue, power is produced, reproduced from and exercised over health as a product of and factor for greater socio-economic and political context. Moreover, reform itself is also a political process in its own right. Thus, all in all, I argue the health reform is profoundly political. I also argue that since the reform process is political, the impact will also be political. This means, the distribution of impact of the reform will be different on the different groups of the society, within and outside of state. This study is an attempt to explore, analyze and understand this impact. Since the health inequity is very high in Bangladesh, thus I concentrate on to understand how this reform affects the poor - their access to health services, and linkages with political spaces. Therefore, as we already mentioned, the aim of the study is to understand the impact of neoliberal reform on state and society, with a special focus on the poor. The main challenge of this chapter, therefore, is to develop an analytical framework by which we can analyze the health sector reform process and understand the impact on state and society in Bangladesh. In order to do that I would focus on the existing literatures on health politics, health sector reform, implementation research, health impact research and political analyses of health sector reform and literatures on Bangladesh health sector in general. Thus, the main objective of this chapter is to introduce relevant literatures based on which the analytical framework and main arguments are developed. This chapter is structured into three broad parts: review of literature, analytical framework and methodological notes.

#### **2.1. REVIEW OF RELEVANT LITERATURE**

##### **2.1.1. Health Politics: Medicalization, Individualization and Commoditization**

The health politics began with making of the definition of health itself by the WHO. As I have already told in the previous section that the definition of health proposed by WHO, by now accepted by all government in the world, is the first step towards reducing health into a pathological condition of human well being.

Reduction of health into illness, or pathology is deliberately done for the interests of a

particular group of elites in the society. This process is called medicalization (intensively used by Michel Foucault). The process denotes a ‘spread of the medical profession’s activities, such as their increasing involvement in the process of birth and dying’. The term suggests increase of power of medical profession over issues in human’s private and public life.

Bambra, Fox and Scott-Samuel (2006) argues that the process of medicalization of health also created a shift of ‘power over and responsibility for health from individuals, the public and therefore political life, to powerful elites, namely the medical and health professions and the multinational pharmaceutical companies’. Quoting from Scott-Samuel:

“When we conceive of ill-health as episodes of disease manageable by the delivery of healthcare, we are transferring the responsibility for health from society as a whole to an elite possessing what we define as the necessary professional and technical expertise for the management of disease” (Scott-Samuel, 1979).

This medicalization has bearing on my study. Because, when power over and responsibility of health is transferred from the society to a particular group of elite and through hegemony this has been normalized and legitimized in the society, then we can predict that the health policy arena will also be dominated by the experts, professional instead of the political actors. Thus while analyzing the health reform policy, one needs to know who are the actor and which groups they are representing and what is ideology they holding by which they shapes the content of the policy.

Individualization of health is also part of medicalization. It connotes a process by which health has been made separated from its context. There are many researches which show that economic, social and cultural determinants affect people’s health most (Bambra, Fox and Scott-Samuel 2005). However, very often these determinants are ignored in the hegemony. Rather, genetic predispositions, individual behavior, lifestyle are ascribed as the reasons for ill-health. In other words, health has been made limited within individual. For this reason the determinants of health which are outside of the health care system such as housing, income, employment, collective actions, political contexts, are not paid attention in the policy arena. These so called ‘non-health’ issues have to be understood as a factor for and impact of health and thus health care system in any society.

Similarly, in connection with individualization health has been made a commodity like any other commodity through the process of commoditization. The commoditization is 'the process whereby everything becomes identifiable and valued according to its relative desirability within the economic market (of production and consumption)' (de Viggiani 1997 cited in Bambra, Fox and Scott-Samuel 2005). Commoditization of health has been started since the industrial revolution and which has given a new impetus, after a shorter period welfare-regimes, since 1980s. This commoditization is compatible with capitalism. Thus the pharmaceutical companies, insurance companies, health professionals are the promoters of this principle as opposed to other social rights movements which consider health is fundamental human right.

Thus discussion on politics of health gives us the potential dominant coalition in the health policy arena or the nature of the hegemony. The health professional, researchers, epidemiologist, neoclassical economist, pharmaceutical companies and political elites those who represent these interests would form the dominant coalition in the area of health policy. And this whole coalition is guided by neoliberal ideologies and values.

Having discussed the nature of the health politics, I argue this hegemony should be questioned in order to understand the impact of the health sector reform and an alternative construction of health and thus the impact of health reform should be made. On the basis of this argument, I would expand the boundary of my analysis beyond the boundary of the health center and include social, economic and political aspects of human life where a health reform can have an impact.

### **2.1.2. Neoliberalism - The Ideology of the Hegemony**

As I already mentioned that the ideology is the main instrument through which the dominant actors legitimizes their interests, therefore one needs to explore the ideology behind the recent health sector reform paradigm. It has already been showed in Chapter 1 that the present reform is originated from the neoliberalism; however, in order to make this linkage more clear and to connect it with the health politics, it requires further elaboration.

Neoliberalism can be understood as an ideology, a policy and governmentality (Larner 2000). I will, however, limit myself not discussing all of these interpretations in this

place; rather, a general portrait, combining all of three aspects, of the tenets of neoliberalism is presented in the following.

Neoliberalism as an ideological doctrine emerged during the late seventies and became very influential among academics and politicians in industrially advanced countries, especially in the USA and Great Britain. In general, the main proposition of neoliberal school is that market is a better way of organizing economic activity because they are associated with competition, economic efficiency and choice, thus, states should turn to markets and it should ensure free play of market forces being stayed away from interfering them (Bevir and Rhodes 2001). Similarly, when the ideology comes to policy, it suggests a 'shift from Keynesian welfarism towards a political agenda favoring the relatively unregulated operation of markets' (Larner 2000). For the policy actors, argument is, paraphrasing Larner, due to the globalization of capital new forms of production relations and financial systems emerged. In order to cope with this new situation governments have to adopt privatization and deregulation policies. This pro-market move, as a result, has led governments to abandon their commitment to formulate policies to ensure full employment, social welfare system; and instead, forced them take policies to achieve economic efficiency and international competitiveness (Larner 2000: 4). Therefore, it can be argued that as a neat result of embracing the neoliberal policy, the welfare state rolled back from providing the public services for the citizens. However, this shift in policy, as analysts showed, associated with emergence of particular political actors, for examples Thatcher and Regan, and political ideology. This policy was intellectually supported and popularized by multinational corporations, international organizations such as the IMF and the World Bank (Marchak 1991). However, we should keep in mind that there are many variants within the neoliberal tradition at both theory and policy level.

There are many critics of neoliberalism, we are not going to review them all by name here; yet, the main concerns are taken care of.

In many sense, the expansion of market relations is problematic. Particularly, deregulation and privatization are seen as giving power away from democratically elected governments committed to guarantee universal service provision, towards private sector

concerned primarily with profit (Larner 2000). As a long term effect of this shift from public to private sector can damage the foundations of both national economies and social solidarities.

Neoliberal reform refers to the reform in the role of state as a whole, more precisely, pro-market change in the structure, process or personnel of the public sector. The emphasis of the neoliberal reform is on the attainment of efficiency, effectiveness and economy. Referring to the reform in public service provision, it means encompassing managerial thinking and market mentality. In this view, public administration is regarded as a 'provider of services to citizens who were redefined as consumers and clients' (Christensen and Lægreid 2002: 17).

The neoliberal reform movement, collectively branded as New Public Management (NPM), began to develop in the late seventies and early eighties. The early attempts were carried out by the Margaret Thatcher government in the UK and the Reagan government in the USA. Later, national governments of OECD and many others joined.

The main feature of NPM is its emphasis on economic norms and values. NPM presumes the actors in the political-administrative system behave rationally; preferences are made out of strategic games between rational actors who intended to make the political-administrative system more efficient, streamlined and consistent (Boston et al. 1996: 3; Evans et al. 1996). These assumptions grew out of its deeply rooted connection with economic theories such as public choice theories (Buchanan and Tullock 1962), principal-agent models (Stiglitz 1987, Walsh 1995, Lane 2000), and transaction cost models (North 1990, Patashnik 1996). In this view, NPM is one-dimensional and simplistic which plays down the importance of public sector ethics and institutional-cultural factors of the public sector. Another important feature of NPM is it sought to separate policy making from policy implementation through devolution and contracting out. According to this view, policy makers make policy and then delegate its implementation to the managers and hold them accountable by contract (Christensen and Lægreid 2002).

The main components of NPM are: hands-on professional management, which allows manager with more discretionary power; explicit standard for performance; a greater

emphasize on output control; contracts; devolution: disaggregation of units and private sector management techniques. NPM promises to integrate these themes, linking efficiency and accountability together (Minogoue et al. 1998).

It is important to note that the NPM has two opposite tendencies within itself: the centralizing tendencies inherent in contractualism and the devolutionary tendencies of managerialism. The first set of ideas stresses on the primacy of political leadership over the bureaucracy. This concentration of power call for centralization, coordination and control and contractual arrangements are the main device to achieve this goal. On the other, the second set of ideas focuses on the need to reestablish the primacy of managerial principle in the bureaucracy (Kettl 1997 cited in Christensen and Laegreid 2002). This emphasis on enhancing the capacity of managers to take action essentially demands attention to decentralization, devolution and delegation.

However, when it comes to the question of implementation of neoliberal reform, there seems to have little evidence that NPM reform policies produce uniform and desired outcomes (Christansen and Laegred 2001). But what happened, in most of the cases, is - fragmentation of service delivery and thereby weakening of the political control of the state without establishing proper markets. The consequences of neoliberal reforms have appeared to be a paradox. On one hand, due to the inbuilt economic rationalist prescriptions of neoliberalism for service delivery the social fabric of many countries began to fray and on the other, citizens find a mode of mobilizing resources from both state and non-state actors in a more creative, inclusive and autonomous way (Bogason 2001). Since neoliberal policies are differentially applied, effects and implications of this reform has not been the same among countries, e.g. developing and developed countries. For example, a study on New Zealand shows, neoliberal reform caused social and spatial polarization within the society (Boston, Dalziel and John 1999). While a sector specific review on Latin American neoliberal health reform programs found that the reform did not attain the intended goals and the principal beneficiaries were only transnational corporations, consultant firms and the WB staff (Homedes and Ugalde 2005: 92), a general review of the neoliberal reform on the same region reports a mixed of negative and positive outcomes (Weyland 2004: 151). Even among the developing countries the outcome also varied widely, particularly, in a postcolonial setting they are more



inconclusive, ambiguous and paradoxical (Hadiz and Robison 2005).

The inconclusive and paradoxical outcomes of the reform are largely attributed to its focus on 'universal' model. This means, by putting emphasis on a universal market-based-model of service provision neoliberal reform ignores the economic, cultural and political variations within and among countries. The context of a particular society within which the reform is being implemented has remained neglected to the reform designer and supporter. Here, the notion of context includes culture, history, values and, most importantly, the nature and structure of the respective state. However, the nature and structure of the state not just acts as only a passive contextual factor, rather, determines the capacity of a state to organize, mobilize, use and distribute resources in order to keep the reform process going (Leftwich 2000). Thus, the contextual factors, particularly the structure and nature of the state should be tackled in relation to its role in the reform process.

Interesting to see that although various aspects of neoliberal ideology and respective reforms, their causes and outcomes, particularly the implications for state, have come under scrutiny from a wide band of scholarship (Hood 1991; Jessop 1999; Keating 2001; Osborne and Gaebler 1992; Marsh and Rhodes 1992; Rhodes 1997; Thomson et al. 1991; Peters 1999; Kooiman 1993; Mayntz 1998; Weyland 1998; 2004) since 1990s but most of them are based on the experiences of advanced industrial countries; African and Asian states have largely been overlooked in this discourse. The differences that exist between European and non-European states due to their different historical development, culture of the population, structure of the economy and politics around the state suggest that they should be treated differently; particularly the states that emerged from the colonial legacies reasonably demand special attention.

Postcolonial state, in relation to the role of state in development process, as an analytical category has long been enjoyed special interests among the scholars from both developing and developed countries (Miliband 1969; Ali 1971; Alavi 1972; Shivji 1976; Migdal 1988; Mitra 1990; Loomba 1998). Hamza Alavi rightly claimed that due to the historical specificities of postcolonial states needed to be conceptualized and understood very differently from the states that emerged in Europe following the bourgeois

revolutions (Alavi 1972: 59). In brief, the main thesis of postcolonial state is that had these states not grown out of the indigenous society; rather the state structure were imposed by the colonial rulers and imported from their 'mother' European societies (Leftwich 2000). Its institutions and procedures were devised and deployed to serve the causes of colonial rulers. After being freed from the colonial relations, the newly independent nations inherited an overdeveloped state where not the bourgeoisie class but a bureaucratic-military apparatus had been in the effective control of state power (Alavi 1972). These bureaucratic-military elites eventually control and regulate the growth, development and actions of indigenous social classes. Therefore, it is very likely that the state's role towards common masses of postcolonial societies will be largely determined by the preferences and interests of actors from this bureaucratic-military oligarchy which is quite different from that of west European advanced industrialized states. Nevertheless, how the advent of neoliberal ideology has been adopted in and responded to by these postcolonial states and how this process of interaction affected the social-political-economic domain of the society, particularly of the most vulnerable poor- who lives out of the network of bureaucratic-military elites, are still remained relatively unexplored but important areas of interest. The focus of the dissertation is a modest effort to shade lights over these areas by explaining the consequences of the adoption of neoliberal reform strategies in health care service provision in Bangladesh.

Considering the above discussion on the concept of neoliberal reform and implementation experiences we can formulate following primary assumptions about the consequences of neoliberal reform:

- (a) neoliberal reform can increase the social and spatial gaps between different groups, and between regions within the country;
- (b) main beneficiaries of the reform are very likely to be the powerful actors who promoted the reform than the people for whom the reform was designed;
- (c) neoliberal reform can erode the quality of democracy by opening opportunities for external restrictions on democratic choice and governmental decision making; and
- (d) the reform can consolidate democracy by putting socioeconomic and political

elites at ease which prevents them from using undemocratic extra-constitutional means to protect their core interests

- (e) due to the differences in the context the reform can produce different outcome
- (f) the nature and structure of the state and the politics around it can affect the impact of the reform

I already mentioned that the impact or outcome may vary across the sector, country, and context, therefore, it would not make sense to make generalization at this level, yet, the above assumptions can guide us to formulate hypothesis for investigation in ground.

### **2.1.3. The State and the Health Sector**

In the above discussion I have made it clear that the neoliberal reform is about the reforming the structure, function and scope of the state in public service provision. At the same time, I also argued that the nature of the state and the politics around the state is the two important factors that may affect the outcome of the reform. Therefore, before moving further we need to understand the role of state in the health sector.

Ensuring an effective health care service provision for the citizens is regarded as one of the prime responsibility of the state until today in both developed and developing countries. Yet, the gaps in health status both among and within developing and developed countries suggest that not all the states perform the responsibility in same manner; have they wanted to do so nor they can. Actually, how a state will organize its health care system, particularly the health care delivery system, depends on the country's specific historical, political and socio-economic conditions. It also reflects the ruling elite's views on role of state in promotion of health care. Despite a wide variation in the distribution of tasks and responsibility between public and private sector, all countries continue to have significant state involvement in the health sector. It is argued that the nature of the goods and services also determines whether state or private sector will involve in provision of respective goods and service.

Table 2.1: Types of goods

	<i>Rivalry in consumption</i>	<i>Non-rivalry in consumption</i>
Excludable	<b>Private goods</b> e.g. house, foods	<b>Toll goods</b> e.g. motorways, bridges
Non-excludable	<b>Common goods</b> e.g. rivers, grazing land, forest	<b>Public goods</b> e.g. defense, law and order, public health

As we can see in Table 2.1, according to the typology based on two very crucial features - excludability and rivalry- of goods consumption, there are four types of goods and services: private goods, toll goods, common goods and public goods (Levacic 1991: 39). This taxonomy of goods determines whether market or state will provide an allocatively efficient quantity of each goods. In the case of private goods there are no significant amount of externalities with their production and consumption and thus the market can be efficient. A competitive market will produce a socially efficient quantity of private goods. But for public goods, market will not provide a sufficient quantity because people can obtain the non-excludable benefits of public goods without paying for them. For instance, vaccination for infectious diseases is a public good of which not only the infected person but the whole society can have the benefits. Similarly, other components of primary health care services have also the public goods character which provides less incentive for market involvement. Moreover, since the main targets of the primary health care services are the poor, it's very likely that market will not take care of them. Therefore, it is clear that for collective goods (common, toll and public goods), such as primary health care, state involvement of one way or another is required in order to ensure socially optimal resource allocation.

In addition to the above theoretical reasons, the specific context also does provide significant impetus for state to be involved in health sector. For instance, the case of developing countries, it is argued that due to the underdeveloped markets and the absence of a strong entrepreneurial class, there is hardly any alternative except the state. There are great variations in the role of state in health sector in different countries at different point of time. However, based on Martinussen (1997), six types of role for state in health sector can be identified:

- (a) Establishment of general judicial and institutional preconditions for production and exchange of health services, including a legal framework for enforcing customer's rights, contracts, etc.
- (b) Formulation of health policies and inter-sectoral coordination
- (c) Procurement of material infrastructure, including equipments, human resource development, hospitals, roads
- (d) Procurement of health services produced by private sector
- (e) Operational control over private sector providers
- (f) The state's direct participation in the production of health services

The aforesaid roles of state in health sector can be seen in three broad categories: *state as regulator, state as financier state as buyer of service and goods and state as producer of services and goods*. In fact, state plays all of the roles, however, in different proportion in different sub-sectors of health. As we have already noticed that there have been a lot of debates on the states role in all these areas. The main argument of these controversies, however, is: there is no automatic guarantee that state's involvement will achieve socially efficient allocation of resources; nor it does guarantee distribution of welfare according to subjective principals of social justice, especially when the net effect of uncoordinated policies is taken into account. Much of this lack of coordination is inevitable, because of the politics surrounding the government policy making. It is argued, since the state decision making is done by self-seeking and calculating politicians and other actors, who form coalitions to control the allocation of resources in accordance with their own narrow interests, the allocation of resources will not be even, socially efficient.

Health sector reform, usually, known to be the process to make this resource allocation socially efficient through negotiations with actors within and outside the state in determining the exact nature of health care provision and how to finance it and who will do what (Rosetti 2001).

In summary of this section, it can be said that there are variations in the role of state in health sector; however, in developing countries like Bangladesh, the state continues to be the most important player. The state's role is important to ensure socially efficient

allocation of resources in the health sector, thus changes in the role of state will affect the level of social justice. In other words, the level of benefit obtained by the poor is largely depends on what kind of role state is playing. Yet, there is no specific form of role that will benefit the poor more than the other; rather it depends on the particular context. Thus, this study is aimed to analyze the consequences of the changes of the role of the state brought by the neoliberal reform program. A brief discussion follows on the concept and approaches of health sector reform.

#### **2.1.4. Politics of Health Sector Reform**

Reform means change. Public sector reform is a way to reorganize and reconfigure the relationship between various actors, institutions and organization in response to certain societal crisis. Any reform involves restructuring of institutions. The restructuring of institutions creates looser and winner in the society, thus, brings changes in power relation at different levels from the government bureaucracy down to the household (Signal 1998). In this perspective, it can be argued that health sector reform is an inherently political endeavor. Yet, the political nature of health sector reform has rarely explored.

Before I move into the discussion on the politics of health sector reform, I would like to make it clear that what actually the term ‘politics’ means in this thesis. We know that the definition of politics is in itself a political act (Leftwich, 1984). This will be very clear if we look how different political ideologies and schools of thought in political science view the concept of politics (Marsh and Stoker, 2002). For example, while the rational choice theory conceives politics, mainly, as actions to conduct and management of community affairs, the behavioralist and institutionalist view politics primarily associated with the art of government and the activities of the state (Bambra, Fox and Scott-Samuel 2005). However, I am not following either of them; rather, for me politics is *all the activities of conflict, cooperation, and negotiation involved in the use, production and distribution of scarce resources whether material or ideal in all areas of social existence* (Leftwich: 2000: 5). In other words, according to this definition, politics is a term that can be used to explain any power-structured relationship (Millet 1969 cited in Bambra, Fox and Scott-Samuel 2005). Therefore, political analysis of any event, issue or phenomena

entails analysis, in one hand, of activities of government, elite and state agencies and on the other hand it includes peoples and non-state actor's organizations, struggles and movements and interactions in order to influence the use, production and distribution of scarce resources related with the concern phenomena; health sector reform is a phenomena in point in this thesis.

Health sector reform entails changes in the resource allocation and distribution of financial burden across population groups within and outside the health sector. Population groups in society compete for health resources and services with different values and expectations about the role of the state, as well as their entitlements in access to public services and resources. It, therefore, turns to a highly contesting political arena, mobilizing many groups within the state and society, whose interests may be affected by the envisioned changes (Rosetti 2001). Although health reform is a process where both state and societal actors engage in political struggle, the state remains as the key player in formulating and implementing the reform. But, one should not forget that state is not a monolithic actor with a unified single policy objective. In fact, there are many groups within the state e.g. legislators, bureaucrats, might have competing policy preferences about the goals and strategies of a health reform. This means, the strengths of various groups within the state affect the policy content and thus distribution of outcome of the reform. At the same time, reform process draws various societal groups from the society as well, who try to influence the key decision maker by employing various strategies. In other words, health reform process opens an arena where continuous negotiation between the state and societal actors takes place.

According to the public choice tradition, the state actors, particularly the policy makers need the political support of the key societal groups, for example, professional organizations, media, trade unions, business communities, etc. In order to secure the support among these groups the political actors distribute resources, services, jobs and subsidies and make regulations favoring specific interest groups. The reform policy is one of many ways of distributing public goods and services for political support. However, this 'exchange of public goods and services for political support among public officials and groups and individuals in society takes various forms depending on the political system in which it operates' (Rosetti 2001). Therefore, the political context,

political institutions, actors and their interests emerge to the foreground of any political analysis of health sector reform.

The politics of health and health sector reform is paid enough attention neither in political science nor in public health literatures. There are, however, several important attempts done by scholars from different schooling background (Reich 1994; 1996; 2002; 2002a; Navaro and Shi 2001; Bambra, Fox and Scott-Samuel 2005; Scott-Samuel 1979; Signal 1998; Walt 1994; Immergut 1992; Rosetti 2001 and OECD 1995). One of the early significant contributions come from the Ellen M. Immergut (1992) in her groundbreaking work *Health Politics Interests and Institutions in Western Europe*, where she showed how different political institutions shape the health policies in West European countries particularly in Sweden, Switzerland and in France. In a very influential cross-country study OECD (1995) also showed that “reform packages have taken different shapes even for countries having similar problems” (OECD, 1995:37). However, these studies focused on macro aspects of politics and didn’t focus on the very the dynamics of the reform process itself.

The dynamics of the health reform policy is explained in great detail in Reich’s works (1994; 1996; 2002; 2002a). He suggested that every reform, thus, health reform policy is to be understood within its political context; because, any policy change needs to be approached through politics. It also suggests engagement in and across policy arenas called for management of the political process (Reich 2002). He also emphasized to identify the key actors, their power-base and their strategies to influence the reform policy. He noticed that the every reform has a promoter, supporter, follower and resister. These actors and their interactions should be analyzed. Reich is not alone in the group, most of the analysts take a pluralists position to explain the reform process.

Rosseti (2001), argued that the health policy reform is affected by three important factors: political context, policy process and reform management teams (located in the bureaucracy). In a comparison between Columbia and Mexico, Rossti showed that the formation, characteristics of the change team is very crucial for the reform implementation because this teams acts as the policy node between the state and society. Since Rosseti’s work was focused on the role of change team in explaining variations in



the political feasibility of reform policy, ignores the impact of the reform policy.

Bambra, Fox and Scott-Samuel (2005) argue that in analyzing the political aspects of health one should focus on the health inequalities in the society first. They also suggest social determinants of health; the nature of the political context, the economic system of the country has also affect the content and outcome of the policy.

In summarizing the above discussion, we can say that the political context, institutional context, the nature of the state, the nature and constellation of the key actors, the relationship between state and social actors, their interests, strengths and locations are the curial areas to be examined by which the reform policy process itself and the outcome is largely determined. Despite the great contribution made by the above-reviewed literatures there is significant vacuum in the political analysis of health. Most of the existing literature focuses on the policy formulation process, and ignored the implementation and ultimate impact of the policy. Moreover, very of the study are informed with theories of political science. Thus there is a clear niche to have another study informed with political theories focusing in order to understand the political on both the process and impact on state and society in great detail. However, we need to have an analytical framework to guide our study; we shall discuss the analytical framework in the next section, but before that I would like to discuss the theoretical approach of the study in the following in brief.

#### **2.1.5. Approaches to Study the Impact of Health Reform**

I have mentioned that the main attempt of this study is to provide an answer to the question ‘does health reform benefit the poor?’ In order to do so, this thesis seeks to understand what happened in and after implementation of the reform policy. In this section, I shall discuss the particular theoretical approaches from which I seek to explain the research problem of this study. But, at the outset, I want to put two arguments on board, which will set the boundary for the analytical framework.

First, the term ‘benefit’ is not only to mean ‘health benefit’ in this thesis. In the main stream public health research benefit is perceived as health benefit while health itself is defined in terms of absence or presence of physical illness. In contrast, health is defined in this study as resource by which human being can attain complete physical, mental and social wellbeing. For me, it is a resource that enables individual to live disease-free life

and to take control of decisions that affect her/his life. At the same time I also argue for an expanded conception of the term benefit to include economic, social and political resources along with health resources. However, in the context of reform in primary health care in Bangladesh, the expanded conception of benefit of the reform is presented in two major dimensions: political benefit and health benefit. With reference to health reform, the economic and health resources are considered together under the health benefit and social and political resources are considered under the political benefit. Therefore, the health benefit will be measured in terms of access to and usage of health care services by the poor household; and the political benefit will be measured in terms of awareness, responsiveness, rights, participation and accountability.

Secondly, I argue that the impact of implementation of health sector reform policy can not be understood well by separating the implementation process from the policy formulation process. Departing from the linear view of reform policy which suggests agenda setting, decision making and implementation is linearly connected three distinct sub-processes of policy process and either of them can be evaluated distinctly from others, I am conceiving the policy process as an interactive process (Thomas and Grindle 1990: 1164 -1167). The interactive model suggests that the implementation of reform is interconnected with other two phases: agenda and decision making. The main assumption of this model is ‘a policy reform initiative may be altered or reversed at the any stage of its life cycle by pressures and reactions from of those who oppose it’ (ibid). Contrasting to the linear model, the interactive model assumes policy reforms as a process in which interested parties can exert pressures for changes at many points. On the basis of the interactive model of policy implementation, I would argue, implementation is a continuous process, thus the impacts change as process of implementation proceeds.

#### *2.1.5.1. Top-Down vs. Bottom-up Approach*

The study deals with two goals: understanding the reform process and understanding the impact of the reform process. However, it should be clear from the very beginning it is neither a Health Impact Assessment (Scott-Samuel 1998) nor a Cost-Benefit Analysis of health program (Birch and Donaldson 1987). It is a political analysis of health policy reform.

In studying policy process and its impact, there two approaches: Top-down and Bottom-up. In fact, these are two broad perspectives from where the relationship between dependent and independent variable is viewed or the research problem is addressed.

There has been a methodological debate going on in the Political Science and policy literature on how to structure the empirical study: should we start from the problems as stated by the top (formal head of the organization e.g. director, president) or should we start from the problems as perceived from the bottom (e.g. the end user, client or target people). There is no generally acceptable answer to this question; both sides have quite few valid arguments. The classical implementation research (Pressman and Wildawsky 1973) was done in top-down approach that followed decision maker's perspectives. The top-down researches focus on the formally stated goals, targets, chain of commands rules regulation and seek answers why goals and targets are not attained. This approach is criticized for being unrealistic in focusing on the implementation of formal goals as formulated in the program document or in law. The approach has problems in understanding the implementation process as a linear process. On the contrary, the bottom-up approach focuses on the client or users or affected people or community. It reconstructs the groups and maps the network of relationships within them and the organization; and it seeks to understand their rational and motives for action (Bogason 2000). The bottom-up approach takes into account the expected and unexpected consequences of the implementation.

In relation with this study, to understand the impact of reform in primary health care sector in Bangladesh, I employed the bottom-up approach which guides me to structure the empirical study and set the direction of the study. Since I am interested to know the political nature of the impact of neoliberal health reform, this bottom-up approach helps me to understand the institutional setting in which the poor lives and interact with other state and societal actors and institutions.

#### *2.1.5.2. Performance-oriented vs. Process-oriented Approach*

Solving the question of viewpoint, from which direction I am approaching the research problem, is not enough; there is even more important issue to be solve before move on to the analytical framework. At this level, the next question is what I am going to study

exactly in the name of studying impact of health reform. There could be many things to study e.g. organizations, people, their relationships and etc. It has been seen that, the literature on health reform in developing countries mainly concerned with issue of performance only, and neglect the process through which the performance is attained (Shiffman and Wu 2003). Most of the public health literature is preoccupied with this performance: efficiency and effectiveness. Indeed, performance is important, but not sufficient alone. Shiffman and Wu argued that in order to evaluate a reform policy it is not enough just to know if the reforms are 'achieving what they were intended to accomplish, but also how they were enacted at the first place'. Therefore, I argue that the process through which the reform policy is enacted and implemented is as important as its consequences. Thus, in this study, I take a process-oriented approach which allows me to examine not only the impact but also the process by which that impact is produced. It suggests to ask questions like who made the decision, who set the agenda, did parliaments and legislatures debated over it, whose voices were heard, was poor represented in the decision center? In short, the process-oriented approach provokes the researcher to go deep into the reform process.

#### *2.1.5.3. State-centric vs. Society-centric Approach*

The reform policy implementation can be viewed from two more different perspectives: state-centric approach and society-centric approach. State-centered approaches focuses on the structure, functions, rules and resources of the state in relation to the respective reform policy. It does explain the success or failure of the reform policy implementation taking the state as the central variable. However, on the other hand, the society-centered focuses on the groups, community to whom the reform is targeted to. The society-centered approach explains the implementation in relation with participation of social actors in the process. It evaluates success or failure of the reform from the community's point of view. In this study I analyze the reform process and examine its impact from society-centered approach. Therefore, I take the views and opinion of the poor communities about the health care services they are receiving from the newly established service provision.

In summary of this section, I would say, among the aforesaid top-bottom, performance-

process and state-society approaches, I adopted bottom-up, process-oriented and society-centered approach to organize my empirical focus, to determine the focus of my research and to identify the perspective of my analysis and explanation. However, I would not consider these top-bottom or state-society and performance-process approaches as dichotomous as they seem to be; I would argue that these relations are rather complementary to each other. Therefore, despite of having a position the other aspects of relevant approaches have also been given due attention in course of the study. In the following I shall discuss in brief the theories which lay the foundation of the political analysis of the health reform process.

#### **2.1.6. Explanatory Paradigms**

In this section I shall discuss the main political theories, which provides the conceptual linkages between various variables in one hand, and on the other hand, the analytical argument and locates the study within the larger debates in Political Science. This explanatory paradigm is built on three different political theories to be applied for three different levels of analysis. They are: Pluralism, Neo-Institutionalism and Neo-Marxism.

As we already know that this thesis is attempted to analyze the health reform process on the one hand, and to understand the impact of this reform process on state and society. I will employ pluralism for analyzing the key actors and their interests, neo-institutionalism to analyze the institutional context and factors within which the reform takes place and neo-Marxism for explaining the variations of impact of among various communities and actors.

##### *2.1.6.1. Pluralism - The Interest Group Approach*

Pluralism suggests public policy is made according to the interests of a range of groups who compete with each other in order to influence the policy process (Latham 1952; Dahl 1961). The main argument of pluralism is that group wields significant amount of power and therefore are important in determining policy outcomes (Smith 1976 cited in Smith 1993: 15). Pluralists suggest that power is distributed equally, the state is neutral and that access to the state is relatively open.

With regard to analyzing public policy, according to this theory, a group's influence on

the policy depends on the resources it has available, and variations in resources lead to one group having greater influence than other. Thus, this approach moves on to identify various interest groups in a policy arena, determine their interests, resources and strategies they employ to influence each other and the policy makers in the government. Truman (1951: 267-9) suggests that the access groups have to government depends on: the social position of the group; the extent to which it is organized; and the skills and organization of the leadership. Pluralists also stress the importance of the size of the organization and the degree of mobilization, and the level of group's legitimacy. It is a micro level theory; that is, it explains the influence of individuals and groups on the political process.

The main problem of the pluralist's view is that it considered distribution of power among the groups is equal. But at the same time, contradict with their idea of resources, which allows unequal resource possession to different groups, thus unequal power. It also fails to consider the structural and ideological context within which policy is made (Smith 1993: 25). They also fail to recognize the ability of the state actors to make policy independently of groups. The influence of the group does not derive solely from their resources but from the organization of government.

Health reform initiative is likely to affect the interests of many groups in state and society. According to the pluralist view, policy makers will determine reform components according the level of support they may obtain in exchange for it. It is very likely that this political cost-benefit analysis would lead to very little policy change, as entrenched interests would press for the continuation of the status quo. And it is also likely that the reform will not suggest 'a more equitable distribution of public resources, as powerful groups would effectively oppose it' (Rosseti 2001: 31). A pluralist approach would thus always expect incremental changes negotiated between the state and the strongest coalition in society. For example, the intimate follower of the pluralist view, the World Bank (1993), advocates for policy interventions that allow gradual relocation of resources in order to secure the main support base. Although the interest group approach helps to understand the dynamics of interest group competition or distributional politics in a liberal well established democracy, but fail to explain the situation of a transitional democracy where groups are not well organized and policy makers can introduce a

reform without taking care of interests of powerful groups in the society. For instance, we can take the case of drug policy of Bangladesh. The policy was introduced and sustained in spite of a tremendous resistance from professional groups, business groups, multinational corporations (Chowdhury 1995). Applying pluralist approach on drug policy making in Bangladesh, Reich (1994), identified the key interest groups in the health sector that may mobilize support or opposition for a health reform initiative. He suggested coalition-making of relatively less powerful groups and interest mobilization can be used as a means to ensure a more redistributive outcome of the health reform processes. He noticed that the political context, particularly the nature of the regime largely determines the relative strength of the interest groups. In other words, the resources of the groups and the boundary of their activities, thus their success or failure is dependent not only on their own resources but also on the greater institutional contexts within which the interplay of the groups take place.

#### *2.1.6.2. Neo-Institutionalism*

Neo-Institutionalism acknowledges the crucial role of institutions in political life and argues institutions constitute and legitimize political actors and provide them with consistent behavioral rules, conceptions of reality, standards for assessment, effective ties, and endowments and thereby with capacity for purposeful action (Howlet and Ramesh 1995: 26-27).

The neo-institutionalism perspective acknowledges the role of individuals and groups in the policy process. It argues that policy preferences and capacities are to be understood in the context of the society in which state is embedded. March and Olsen argues for the autonomy of the political institutions from the society in which they exist. They also suggest that the unique pattern of historical development of a society imposes constraints on choice of state and societal actors (March and Olsen 1984: 738). Mitra forwarded a more precise note, he argues, institutions like 'state and constitution within which societies are embedded provide an overarching framework that acts as the boundary condition to completion, collaboration and conflict between the concerned actors' (Mitra 2006: 13). Thus, it could be said that, in relation to policy reform, the state and society both can act independently in accordance of their own interests, preference but within a

set rules, norms and a system of symbols through which both can give meaning to their actions. Stephen Krasner has come up with some useful insight of neo-institutionalism regarding policy process as:

“an institutional perspectives regards enduring institutional structures as the basic building blocks of the social and political life. The preferences, capabilities, and basic self-identities of individuals are conditioned by these institutional structures. Historical developments are path dependent; once certain choices are made they constrain future possibilities. The range of options available to policymakers at any given time is a function of institutional capabilities that were put in place at some earlier period, possibly in response to very different environmental pressures” (Krasner 1988, cited in Howlet and Ramesh 1995: 27).

If we take Krasner’s account in understanding the reform within the framework of policy process, it would be worth saying that social and state actors have their separate interests, capabilities and preferences but they are conditioned by the institutional structure. They can form any type of coalition but that will be within the set norms, values and legitimate environment. Group can participate in the policy process but what will be their role depends on their interpretation of problem, history and their identities. Their choices of available options are constrained by historical path dependence and the context they both are embedded in.

With regard to health sector reform, this approach examines the effect of institutional structures on policy process and outcome. It focuses on aspects of institutions such as the organizational structure, the formal rules of operation, the processes used and the ideas built into them (Signal 1998: 258). It also looks into the effect of institutions like government departments and Parliament. Despite criticism of the looseness of some of concepts, the new institutionalism's has much to offer to analyze the influences of institutions on health reform, particularly given that government is the key player in health reform. The study of Immergut (1992) can be reviewed as an example of institutional analysis of health reform. Comparing the health reform processes in France, Sweden and Switzerland she concludes that their different institutional contexts explain why the outcome of their health reform process was so different, despite the fact that these countries shared common goals and had same kind of policy content at the beginning of the reform process.



However, relation between the institutional framework and the outcome of policy reform is not always as clear as it may appear. Studying different types of political regime in Latin America, Remmer (1990) showed that there did not seem to be any empirical relation between institutions and the state's capacity to promote policy change. He also noted that the content of policy reform cannot be automatically associated with a specific institutional arrangement. One more thing, which is not addressed in the institutional theory, is the uneven power relation between actors within institutional framework and its influence on the outcome of a reform.

#### *2.1.6.3. Neo-Marxism*

The power issue is systematically addressed in neo-Marxism. The sources of uneven power relation rooted in the broader political and economic structure of the society. Neo-Marxism allows us to place health reform within its broad political and economic context and take them as explanatory variable for reform outcome. It builds on the work of Karl Marx. The classical Marxist view, as Milliband (1969: 23) pointed out, the ruling class of capitalist society is the class which owns and controls the means of production and is able to use the state as its instrument to dominate the society. The dominant position of this bourgeoisie enables them to exploit the proletariat, which results in continual class struggle. The contradictions of class are seen as imprinted in the operation of all societal institutions (Alford and Friedland 1985). The role of the state in capitalist society has been much debated by neo-Marxists, but there is a growing consensus that the state is relatively autonomous from capital (Poulantzas 1973: 54).

Neo-Marxists identified organized capital, organized labor and political parties as three key political groupings (Signal 1998). With regard to policy reform, support from these groups is crucial. Like all policies of the government, health reform also requires support from the business, trade unions and political parties. Government's capacity for ensuring redistribution of reform outcome, however, is determined by the capacity of the economy.

Analyzing the National Drug Policy implementation in New Zealand, Signal (1998) argues that despite the redistributive policy goals, the reform was not fully implemented due to lack of support from the business and the limited state capacity for economic

pressure.

Having discussed three major theories of social sciences in above sections, I would like to articulate their analytical linkage in order to postulate arguments for the following analytical framework. I have introduced them without indicating any apparent relation among them. Also, in the academic discourse those theories are considered, to a greater extent, competing to each other. I argue, however, they can be used in complementary manner. These three different theories can provide three major explanatory variables for the same study to be looked upon.

It is seen that afore-mentioned three theories are concern of three different levels - interest, institution and class- of political structure of the society. Alford has, however, argued that each successive level of political structure 'sets limits upon the other levels, but does not completely determine structures within them' (Alford 1975: 153). Elaborating his argument further on, it can be said that the very class nature of society influences the development and characteristics of institutions and the types of interest groups and their power-base, but does not fully determine either. Similarly, it also can be argued that the nature of institutions draw the boundary line on the capacity of various interest groups, but does not determine how they will act, as this is done according to the principles of interest groups. This means, despite the noble objectives of interest groups and individuals, political institutions and the basic-structure of the capitalist society may restrict their capacity for reform. Again, putting the same argument, it can be said that the capacity of progressive institutions is confined by the very nature of the capitalist state. I shall take these arguments in building the analytical framework in the next section.

## 2.2. ANALYTICAL FRAMEWORK

An analytical framework is a useful way to organizing the key arguments, formulating hypotheses and establishing links between empirics and explanations. Social science researchers very often advocate for analytical framework for two reasons. First, an analytical framework helps to draw "limited generalization" from small-n case studies (Ragin 1987). Second, it assists using previous research to reduce complexity of a phenomenon under investigation (Scharpf 1997). With regard to my study, the analytical framework is constructed to guide the research aiming at generation of knowledge about

health sector reform in Bangladesh systematically.

Before start constructing the analytical framework, I forward one very important observation on contemporary public health research. In this study I am interested to know if the neoliberal health reform benefits the poor. However, ‘how government health policy/program benefits the poor’ - as a research question is not new among public health researchers. But, my position is distinct from them. Let me explain how.

In the mainstream public health research the impact of reform on poor is very often addressed within the framework of ‘equity’ question. Indeed, the question of equity is political, and it captures the discrimination between poor and rich, powerful and powerless. However, the equity studies (e.g. Wagstaff and Doorslaer 1998; ISEqH 2006) are preoccupied with analyzing the distribution of cost only. In other words, it emphasizes analyzing the comparison of the shares in cost and benefit between rich and poor groups of population. To be more precise, this approach mainly, if not only, focuses on the financial analysis of the distribution of cost and benefit between poor and rich. I argue the mainstream equity research is insufficient for two reasons: firstly, it’s preoccupation with distribution of financial benefit and burden. In fact, this approach reduces the entire intervention/reform only in digits, which ignores the very dynamics of the process emerged from the interaction among the engaged actors. The second reason is: it’s preoccupation with rich-poor comparison. From an ethical point of view, I would say, the status of the poor should not be qualified or evaluated in comparison with the rich. My point is that the status of the poor can be evaluated by their own status. The higher share of poor in benefit comparing to the rich does not necessarily mean that benefit is sufficiently beneficial to the poor. Thus, the comparison is not enough; rather, an independent study on the status of the poor is also very important to demonstrate the detail of the phenomena.

### **2.2.1. Two-level Analysis<sup>8</sup>**

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<sup>8</sup> The idea of two-level analysis is borrowed from Robert Putnum’s (1988) groundbreaking *two-level game* theory. Despite the fact that Putnum developed his model in explaining the relationship between domestic politics and international relations, the abstraction of the model, I argue, has the relevance to explain the relationship between state and community in relation with public policy implementation. I also argue that state and society is entangled as far as the impact of a particular public policy is concerned.

This thesis is concerned to know if the neoliberal health reform does benefit the poor in a country like Bangladesh. In order to answer the question I decided to study the *ex ante* effects of implementation of health reform on all domains - household, community and state- of social actions, related to life and livelihood of the poor in cities in Bangladesh. I already argued (Pls. see page 11, Chapter 1 for detail discussion) that the impact is to be analyzed in two dimensions: state and society. Society level impact is further disaggregated in household and community levels. In order to capture the impacts on all domains of social action, analysis is conducted in two levels: macro and micro, having assumed their interconnectedness with clear distinct boundary of each.

#### *2.2.1.1. Macro-level Analysis*

The objective of the macro-level analysis is to understand the impact of reform on the role of state in health care. Since it is a national level change by which national level institutions and all citizens are likely to be affected at various degrees, I argue a national level analysis would make more sense. To be more precise, the state level impact will affect life and livelihood of all poor in whole country. Therefore, for this level the unit of analysis is the whole country, the entire reform program. The Urban Primary Health Care Project (UPHCP) is the case in point.

#### *2.2.1.2. Micro-level Analysis*

The objective of micro-level analysis is to understand the impact of reform on the society. In this part I would like to answer, what kind of benefit an individual is obtaining from the new health service system. However, in a primordial society like Bangladesh, individual benefit is better understood in relation with the household and community. Therefore, society level impact is further disaggregated in two dimensions household and community. For this level the unit of analysis is the household.

A combination of both levels of the analysis is presented in the conclusion of this thesis.

### **2.2.2. Conceptualizing the Relation between Reform and Impact**

In this section, I figure out the causal relationship between the reform and its impact based on the literatures what I introduced in previous sections. This study is concerned with neoliberal health reform and its impact on state and society. I already defined what

the term ‘health reform’ means in this thesis. But the term ‘impact’ has not yet been defined. I shall take it now, before moving to outline the relationship.

Very often *outcome* and *impact* is used interchangeably, but a distinction must be made between them. The Oxford Advanced Learner (Wehmeier, 2000) defines the term *impact* as “the powerful effect” (p. 649) and *outcome* as “a result or effect” (p. 899). These definitions make the two terms indistinguishable. As Green and Kreuter (1991) noticed, however, usage varies among disciplines; those in the health field tend to use these terms in diametric opposition to those concerned with the evaluation of non-health matters. For example, Börzel, in the field of implementation studies, drawing on Easton’s system theory, distinguishes impact from outcome (Börzel 2000: 3). She suggests that impact is *the effect of the policy on the socio-economic environment* while outcome is *the effect of the policy measures on the behavior of the target actors*. On the other side, in the public health literature the term *impact* refers to the *immediate effect* of a health program, process, or policy, while the term *outcome* refers to the *distant* or *ultimate* effect (Scott-Samuel 1998). Since I took a clear departure from the Health Impact Assessment and our analysis is apolitical analysis of health policy implementation, it is more appropriate to use the definition forwarded by Börzel (2003), however, with a modification. The change I am suggesting to Börzel’s definition is incorporation of the meaning of outcome within the concept of impact. This means, for us *impact* refers to *the effect of the policy on the behavior of the target population and socio-political-economic environment they live in*. This definition allows me to focus on both micro and macro levels on the one hand, and health and non-health matters on the other.

Theoretically, the relation between the health reform and its impact can be understood on the basis of system framework (Easton 1965):

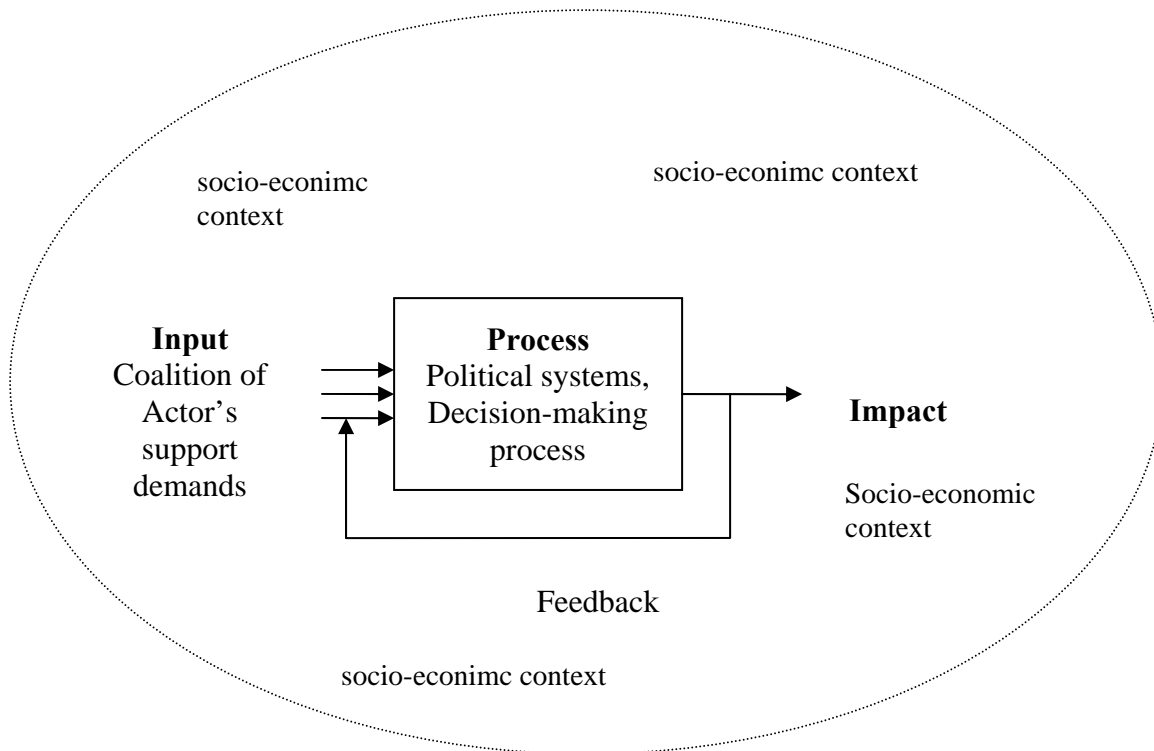


Figure 2.1: System framework for analyzing impact of health reform

Figure 2.1 shows the simplified version of the causal relationship between health reform and its impact. The main assumption behind this model is that outcome is mainly determined by the input. Indeed, not only by the input, there is a process i.e. political institution, government processes through which the input is processed or entertained, thus this process also matters. At the same time, the source of input and the legitimacy of the output depend on the socioeconomic and cultural structure of the society. With respect to health sector reform in Bangladesh, the above framework can provide some explanatory insights which suggest that the impact of the health sector reform will be determined by: (a) *Constellation of actors*: who are they, what is their ideology, what are resources they put in; (b) *Nature of the process*: the nature of the political system, institutions, decision-making process; (c) *the socio-economic structure of the society* : including the historical development, dominant values and norms of the society. The great problem that lies in this model is that it assumes the input-output relation linear, as if one can measure how much output one can earn at the cost of a certain amount of input. In fact, this is the mechanistic view of the society. Since health reform is a political

process, does not follow the linear path. The relations among input process and output are not that step-wise, rather it is continuous and intertwined. Thus, in order to overcome the limitation of the system model I would offer an alternative model for analyzing the impact.

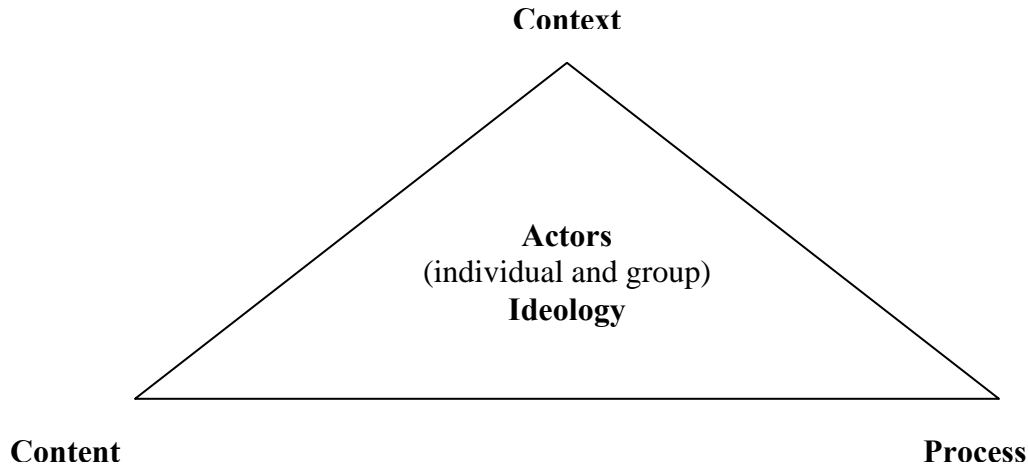


Figure 2.2: Model for Analyzing the Health Reform  
*Adopted from Walt and Gilson 1994*

As we can see the Figure 2.2 provides the relation among process, content and actors and context and ideology. Although, actors themselves reflect the ideology they subscribe to, however, a special focus is given in this model. This model is not alternative to the other one, however, is able to indicate the independent variables by which the impact is determined. Clear enough, these **independent variables** are *actor's constellation, political and socioeconomic context, decision making process and ideology and content of the policy*.

With regard to the relation between health reform and its impact, reform is an intervention and impact is its effect, in other words, they are causally connected. However, our aim is not to *measure* the cause and effect relationship, but to *understand* in its detail. Now the question is what are the variables by which I can measure or trace the effect of the reform? Since this study is dealing with political aspects of health reform, I need to select the variables which are able to capture both health and political aspects of the impact.

Health reform is not mere an offer of *new* 'service package' instead of the *old*. Reform brings changes in the institution, organization and behavior of the concerned individuals.

It is profoundly political. Thus, it is obvious that any health reform program will have some direct or indirect impact on the socio political environment in addition to its health impact. In light of the Ottawa Charter of Health Promotion 1986, I argue, ideally the health reform is aimed at enabling people to take control over and to improve their health (WHO 1986a). In other words, *to take control over health* requires changes in institutional and organizational level - that is the political part of the impact. And, *to improve health* indicates the health aspects of the reform. All in all, my point is, a health reform does produce both health and socio-political and economic impact. Now the task is to devise variables to trace these health and social, economic and political impacts.

Since I am doing political analysis of impact of the health sector reform on poor, thus I do focus on those aspects of health reform from which the poor are deprived of; in other words which have implications for: (a) human agency - the capacity to make informed decisions; and (b) changing uneven for power relation.

The objective of the reform in urban primary health care in Bangladesh was to improve the health of the urban poor and reduce preventable mortality and morbidity, especially among women and children, by increasing access to PHC services. Considering the official objective of the reform program of Bangladesh in coordination with aforementioned two aspects and objectives of my study, I want to take following set of **dependent variables** for understanding the impact of the reform:

- *Usage of health services*
- *Health knowledge and awareness*
- *Access to health services*
- *Responsiveness of health services*
- *Participation of community in health service provision*
- *Accountability of health service provision*
- *Collective actions*

In the above list of dependent variables, the first three are to capture the health benefits and the last three are to capture the political benefits of the reform. In the middle of these two the fourth variable i.e. responsiveness of the health system represents both health and political benefit of the reform.



Then the question is: why I chose this set of variables<sup>9</sup> for understanding the impact of the health reform? What is the relation between reform and these variables? I shall answer these questions in the following.

I have already mentioned, having departed from the conventional position of ‘health benefit’, I took an expanded notion of the term which includes social, economic, and political benefits in addition to health benefits of health reform to a community. This suggests having a set of variable which can reflect the health and political benefits of the reform program of a community. Since my focus is the urban poor community, variables require further sensitization of the context and target population. At the same time, as I have mentioned earlier that I am using a process-oriented approach in combination of the performance-oriented approach, the variables should reflect status the performance and process of the health reform. Having taken all these issues into account, I have selected the above set of variables to study the impact of the health reform in Bangladesh.

### **2.2.3. Key Propositions**

I argue that due to the system of defective democracy in consecutive regimes after the independence in Bangladesh there is democratic deficit in the policy arenas in general, and health sector policy in particular. Therefore, it has been relatively easy for the hegemonic coalition to persuade and expand their ideas and interest through state policies. This means, the hegemonic policy coalition, by manipulating the democratic deficit of the state, shapes the problem definition, influences policy goals and strategies. As a result, when the policy is implemented it reproduces the interests and ideas and unequal power relation of the hegemony as the impact, thus the poor remain marginalized, excluded. Elaborating this main framework of argument I formulated the following propositions that are to be examined with empirical data organized under case study. Once again, the following propositions are not to establish the quantitative association between the sets of independent and dependent variables, rather they are to guide the interpretation, explanation of the various dimensions of impact of the reform

- (1) *The more public, political the actors are the higher the political benefits are:* I argue that the quality and quantity of benefit is primarily determined by the

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<sup>9</sup>Definitional discussion on all these variables is made in detail in respective sections of Chapter 7.

actors who are making the policy. This means, if the members of dominant coalition come from democratic institutions or representative institutions (e.g. political parties, parliaments, social movements) the impact will be more contributing to enhancement of human agency and reduction in power relation gap. In other words, the source of power and the nature of action of the involved actors in dominant coalition determine what kind of benefit an intervention will produce. If the actor's source of power lies in the hand of mass people and if they have to act in public spaces, it is likely that the reform program will produce higher political benefit for the people in general and the poor in particular.

- (2) *The more private, economic and professional actors are the higher health the benefits are:* I argue, the benefits of the health reform depends on the perception of 'benefit' of actors. This is to say, the actors choose reform measures according to their beliefs, values and norms. Therefore if the actors come with health professional and/or economic background it is likely that they will choose reform measure which can produce medical and economic benefits in relatively shorter period of time.
- (3) *The more transparent and accessible the decision making process is the higher the benefit is:* I argue, the nature and quality of benefit is highly related with the nature of the decision making process. This means, if the decision making process is highly centralized, less deliberative and less transparent it is very likely that the impact will be very limited in terms of its low impact on all aspects human agency and unequal power relation. Rather it will produce the hegemonic unequal power relation and vis-à-vis.
- (4) *Benefit changes as context changes:* This is to argue that if the socio economic context changes significantly the amount and nature of benefits will be affected. In other words, the same reform program can produce different outcome in different context.
- (5) *Benefit changes as the content of the policy changes:* This is to argue that the policy content sets the objectives, goals and the strategy for implementation, thus any change in the content will obviously affect the impact of the reform. The

content also reflect the values, ideologies of the actors which symbolized in the policy document, thus any changes in the content implies changes also took place either/and actors, context or ideology, which will be resulted on the impact.

- (6) The hegemonic ideology affects the perception of key actors in formulation and implementation phases, the definition of the problem and the standard of the performance to be evaluated. Therefore, benefit of the reform change as the hegemonic ideology changes.

Based on these propositions the study proceeds by asking following research questions that guided the research design and data collection process.

#### **2.2.4. Research Questions**

This study, as far as the research objectives are concern, is **inductive, investigative, and explorative** (Yin 1994: 39-41) in nature, therefore it does not aim to test one or more stated hypothes(e)s. There are several reasons for that. First is the lack of comprehensive theory on health sector reform. Though there is a growing body of literatures explains health policy making in present world but few have focused on the causal relationship between types of reform and its health and non-health impacts. Infact, analysing the impact from political perspective is almost absent in the academic discourse. Second is the interplay and influence of complex internal and externall socio, economic and political forces on the phenomena.

Having considered the above two reasons and objectives and approaches of my research, instead of formulating hypothesis I structured several research questions that has guided me to collect emperical data, explain the phenomena in line with my objectives.

The central question of the study is: *does the health reform benefit the poor?* It is a very broad and general question which requires more specific focus. Therefore, taking the context and specific reform program into account, the question is rephrased as the **main research question** of this study:

*Does the contract out of primary health care services to NGOs benefit the poor in cities in Bangladesh?*

As I have already argued that in order to answer this question one needs to know what

happened at the state and community level concerning the health of the poor after contracting out the primary health care services to the NGOs in Bangladesh. I have also argued that the implementation/ impact largely depend on the formulation phase. So we also need to know how the policy was made in the first place. In order to know detail of the back ground of the reform process following set of questions were asked:

- (1) What were the political and socio-economic factors for neoliberal health reform policy adoption?*
- (2) Who were the key actors in the formulation phase?*
- (3) What were their interests?*
- (4) What were their sources of power?*
- (5) What was relationship among the key players?*

Following the background information, I focus on the implementation process. Implementation is a continuous process. I argue, the implementation process mostly depends on the reform managers, the rules, regulation in the implementing agencies, leadership of the implementing agencies and political, technical and economic resources (Rosseti 2001; Thomas and Grindle 1990). Therefore, I asked another set of questions:

- (1) What is the nature and structure of the reform implementing agencies?*
- (2) What is nature and structure of contract awarded organization?*
- (3) What is the system of monitoring of implementation?*
- (4) Who provided the finance for implementation?*
- (5) Who provided other political and technical resources?*
- (6) Who supported the implementation?*
- (7) Who opposed the implementation?*
- (8) Was there any conflict between various actors?*

After gathering information about the implementation, I proceeded to the central part of the research, the impact of contract out. Impact is to be studied in two domains: state and society. Thus, at this level the question was:

- (1) What is the present role of central government in primary health care?*
- (2) How it was before the reform takes place?*
- (3) What is the role of local government and how was it during pre-reform period?*

In order to know the detail health and non-health impact on the society I focused on the household and community level. A survey was conducted for the household level information, and other instruments like interview, FGD were also conducted for tapping information from various stakeholders. However, following were the main questions that I asked for the impact on the society:

- (1) *Does the new service provision increase the access of the poor?*
- (2) *Does the new service provision increase the usage of services by the poor?*
- (3) *Does the new service provision increase the health knowledge and awareness of the poor?*
- (4) *Does the new service provision increase responsiveness of the service providers for the poor?*
- (5) *Does the new service provision increase or create opportunities for the poor to participate in health system?*
- (6) *Does the new service provision create opportunities for ensuring social accountability of the decision makers to the poor?*
- (7) *What are factors that make difference in obtaining health benefit among poor?*
- (8) *What are factors that make difference in obtaining non-health benefit among the poor?*

Finally, I focused to know views of the stakeholders regarding the problems of the new service system: *What are the weaknesses of this system and how it can be removed?*

Indeed, these were the main research questions, each of them were further divided into follow-up and complementary questions. These questions are investigated, explained and answered in course of the presentation of the case study in following chapters. I will put a short note on how I structure the research and organized the data collection activities in the next section; a detail of methodology including case selection, sampling of respondent is discussed in the *Annex1*.

### 2.3. METHODOLOGICAL NOTES

There are three critical issues to the study of any social or political event, policy or institutions: theoretical, conceptual and methodological (Classen 1999). This section deals with the methodological issues.

This is an inductive research. This is an explorative research. The aim is to generate hypothesis, not to test any. However, I have tried to make a reasonable combination of both. This study is multidisciplinary in nature; on the one hand it focuses on the dynamics of a political process - health reform policy under which I am looking into how policies are made, who are actor what are their source of power, how they attain legitimacy, how state response. And what more, I am examining the impact of such policy reform on state and society. Therefore, it is, indeed, a research of core political science and at the same time a public health system research. This multidisciplinary nature of the research topic has been reflected in its methodological structure. Being informed by Groods and Mercenier (2000) the study combines both analytical and health system research. Whilst the analytical approach focuses more on the interplay of actors and their preferences, the health system research addresses the whole system and interactions between actors and environment. Thus, multi-methods involving combination of quantitative and qualitative techniques in data collection and analysis are used in identifying, describing and explaining the research question.

### **2.3.1. The Paradigmatic Approach behind the Methodology**

The paradigmatic approach, as Patton (1990) illustrates, behind the methodology can be characterized as paradigm of choices which recognizes different methods that are appropriate for different situations. As such paradigms<sup>10</sup> are important theoretical constructs for illuminating fundamental assumptions about the nature of the reality. However, at the pragmatic level of making specific methods decisions, the emphasis on strategic choices helps to convey the idea that there is a wide range of possibilities when selecting methods. This is a fundamental remark concerning the investigation of politics. The present study holds the view about the nature of 'world' as the constructivism featured. The study has largely been influenced in its paradigmatic decision by the work of Labonte and Robertson (1996) who have presented convincing results using constructivism as the leading paradigm in community-based health promotion programs

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<sup>10</sup> A paradigm (Kuhn 1970) is defined as a worldview and as such, is generally believed to be more or less exclusive. Paradigms are composed of multiple belief categories, particularly, ontological (the nature of the reality), epistemological (the relation between the observer and the reality) and methodological (the way of approaching reality) assumptions are at the center (Labonte and Robertson 1996).

and claimed that constructivism has potential to resolve tensions between research and practice in health promotion, and in addition it is inclusive of knowledge generated by conventional paradigms.

The core idea of constructivism is relativism (Bogason 2001), which means that what we take to be objective knowledge or truth is relative; result of observer's perspective. Knowledge and truth are created, not discovered, by human mind (Lincoln and Guba 1985). Lincoln and Guba (1985), the pioneer of constructivist paradigm, used it as a wide ranging framework, most importantly they also have used the approach as methodology, however, they acknowledge that constructivist, interpretative, naturalistic and hermeneutical are all similar notions. The act of inquiry begins, as Lincoln and Guba inform, with issues and/or concerns of participants and unfolds through a "dialectic" of iteration, analysis, critique, reiteration, reanalysis and so on that leads to a unified reconstruction, which is then once more evaluated for its "fit" with the data. The ontology of constructivism is 'realities exist in the form of multiple, mental construction, local and specific in nature and dependent on their form and content on the individual person or groups holding the construction' (Guba 1990). The epistemology is transactional and subjectivist and in the methodological question it is hermeneutical and dialectic, however, constructivist paradigm can include both quantitative and qualitative methods, allowing a selection of methods appropriate to the research questions in concern.

The study at hand is concerned of, referring to the paradigmatic position, in essence, three core aspects - structure, process and action of a social phenomenon at which different categories actors construct realities with their own identities, beliefs, norms values and corresponding preferences. The study attempts to explain the process of construction, negotiation among actors and the institutions through which negotiation takes place on the one hand, and the outcome the process produces on the other. Since the study is investigating what kind of benefit, if any, poor people render from the reform policy, which is a political question, the perspectives of the poor people form the backbone of the study.

### **2.3.2. Research Design: Case Study**

Research design depends the central research question, the research topic and meta theoretical background of the study. Since the main objectives of the research is to

understand the if the poor does render any benefit from the neoliberal health form and in order to build that understanding the study aims to analyze the impact of health reform on state and society. Therefore, it is clear that the research question demands a research design which can capture and explain a political phenomenon that is embedded in its socio-political context. Yin (1994) suggests that when the context has great deal of influence on the main causal relationship within the research question or the boundary between the researched phenomena and the context is not clearly distinct case study is the appropriate design for that.

It is already explained that the study is influenced by the constructivist, heuristic and interpretative perspectives. The study in effect is a political interpretation of health reform policy; it is the deconstruction of health politics. These tendencies clearly demonstrate the necessity of having a holistic and qualitative research design. The case study has an important position in the discipline of political science as a qualitative , holistic research design (Gerring 2004: 341). Moreover, the objective of this study is not to test any theory or hypotheses derived from theories; rather, it is dedicated towards building a new theory of health politics. Methodologists argue that the ‘case studies have powerful advantages in the heuristic identification of new variables and hypotheses through the study of a particular case(s) in the course of field work (George and Bennet 2005: 20). Similarly, Vaus (2001: 223) also suggests that case study helps to develop and refine propositions. In addition, another important objective from methodological point of view is, this study intends to contribute in strengthening the dialogue between qualitative and quantitative methodological divide. Although, case study is popularly known as a qualitative method, however, I tried to minimize the gap with quantitative approach by accommodating quantitative data collection techniques within the case study framework.

The aim of the study is to ‘understand’ a process and to ‘examine’ the impact of the process. In connection with the aim, it is clear that the research design should be a combination of two approaches: understanding and evaluation. Case study is a holistic, in-depth study of a phenomenon, which is capable of accommodate both ‘understand’ and ‘examine’ dimension of aim of the study.

While employing a qualitative and interpretative research design, for the researcher, at



the very beginning of the research design has to think two important questions how data will be collected and how that data will be interpreted. Regarding the data interpretation, not only the 'how' but a complementary "who" question can not be overlooked either. It is so because, the knowledge is relative; it also becomes a part of the relationship between individuals who in the process may continuously change the content of that knowledge; it is discursively created and thus local. If it is so, the role of source, collector, and interpreter of the data overlaps; they always influence each other and thus shared knowledge. In this situation the issue of inter-subjectivity comes fore. Inter-subjective consensus on the interpretation of the reality needs to be logically and empirically established (Mitra 2005). King, Keohane and Verba (1994) reports, in their explanation of the methodological implications of contrasting perceptions of reality, that the same event might have different meanings. With regard to the research questions, the main focus of the study concerns about the process through which the poor gain health and political benefit in relation to the health environment they live in. It recognizes that the way poor construct their health reality has to be counted from their own perspective. This is the demand side of the phenomena, but on the other, the construction by the actors of the supply side has to be considered as well. Therefore, the actors who are directly involve with communities in service delivery, how they views their job, responsibility, beliefs and their relationship with the community also one of the core part of the knowledge they produce and share with other actors vertically and horizontally. As we know that the elite's - political and administrative, strategy is one of determining factors for shaping the relationship between the service providers and receivers, thus their views, perceptions, actions, interests also provide the causalities to the study. In order to establish consensus of understandings of the realities among these three main categories of actors and observers the study borrows the way Mitra (2005:6) has set in his work, that is, "to engage actors and observers both by focusing on the discourses that connect them".

Having the above discussion kept in mind as the frame of reference, the study adopts an embedded case study design (Yin 1994, Vaus 2001). As I reported earlier, the study focuses on the 'process' (implementation of new health service regime) and the 'impact' of that process on the poor communities. The notion of 'process' in the present study is to

be understood as the dynamic interplay of public and private actors and the, structure and institutions which they are embedded in. It also includes the influence of socio-economic and political context. Therefore, the data regarding the formal structure of reform implementing agencies, their functions, formal and informal relationships -vertical and horizontal, and the rules, norms and values by which their relationship is determined is a major target of the research design. To capture this part of the data along with *document and official discourse analysis*, mainly, qualitative methods e.g. *in-depth interview*, and *focus group discussion* has been employed in the study. For the other aim of the study, impact study method is been applied. This part largely owes to the health research schools.

In order to capture the reality at the communities level that has been created and/ or reproduced due to the inducement of health system changes, the focus has given to the information of individual and household morbidity pattern, health seeking behavior, health expenditure, sanitation, food habit, their perceptions, values, beliefs, experiences of encountering service providers at their door step and service center and interactions with the rules of the game and the health related power structure (Ostrom 1990).

Since the study is concern with analyzing health reform from political perspective, it focuses on to explore the power relation surrounding the concept of health, distribution of health resources and the role of state. Therefore along with interview with key players in the health sector, institutional analysis and analysis of key documents like constitution, ordinances have also been made. I shall discuss detail of data collection strategies, case selection in **Annex 1**.

## 2.4. CONCLUSION

Health and health reform is political. Thus the consequences are also political. It has been seen in the literature that there is no straight answer if the neoliberal health reform does help the poor. In some cases result were mixed, some cases negative. Thus, analytically neoliberal reform offers a challenge to be understood. This study takes that challenge and analyzes the phenomena in the context of urban primary health care reform in Bangladesh. The next section is the beginning of that deconstruction of politics of health reform.

### **CHAPTER 3**

## **HEALTH CARE SYSTEM IN BANGLADESH: SOCIO-ECONOMIC, POLITICAL AND INSTITUTIONAL CONTEXT**

Health reform policy is a political arena, participated by various actors from state and society. A continuous negotiation goes among them at different levels. Every actor in that negotiation behaves on the basis of their preferences and always tries to maximize the achievement of their preferences by employing rational strategies (Hall and Taylor 1996: 944). This means, preferences and strategies are two building-blocks of actor's position in the entire policy game. Mitra (2006), however, argues that institutions like, the state and constitution 'provide an overarching framework that acts as the boundary condition to the negotiation between the concerned actors'. In other words, actor's preferences and strategies are shaped by the state and constitution. I would like to expand this argument little further. I would argue the basic-structure of the society which includes not only the nature and the structure of the economy but also the cultural traits, historical development of a particular society greatly influence the development and characteristics of institutions. Putting it differently, actor's preferences and strategies are shaped by institutions, and institutions are the product of the larger social and economic structure of the society. This is the argument which leads me to look into the contextual factors in relation to reform in urban primary health care in Bangladesh.

Therefore, the purpose of this chapter is to present the contextual factors that affect the health sector reform in Bangladesh. In doing so, I narrated the social and economic condition and how it affects the health and health sector reform policy. At the same time, I also presented the political factors: the nature of the state, feature of ruling elites, position of major political parties on health issues. This chapter also discusses the immediate environment of health care system: the structure, function of the health ministry, national health budget and position of other private players in the health care sector in Bangladesh. Finally the chapter summarizes the interrelation between various contextual factors and the health sector reform program and its impact.

### 3.1. SOCIO-POLITICAL AND ECONOMIC CONTEXT OF HEALTH CARE

#### 3.1.1. History and Geography

Bangladesh is a small (area: 147, 570 sq. km) low-lying, riverine South Asian country lying north of the Bay of Bengal, on land it borders India and Myanmar. Nepal, Bhutan, Pakistan and China are other close neighboring countries. Formed by a deltaic plain at the confluence of the Ganges (Padma), Brahmaputra (Jamuna), and Meghna Rivers and their tributaries, Bangladesh's alluvial soil is highly fertile but vulnerable to flood and drought.

The area what is now known as Bangladesh, once the eastern part of a greater region called Bengal, has a rich historical and cultural past. The relics of Buddhist monasteries provide evidence of civilizations dating back to 700 BC, and there are claims and evidences of social structures from around 1000 BC. Bengal became a wealthy centre of trade and industry under the Mughal Empire during the 16th century. European traders had arrived in the late 15th century and eventually the British East India Company took control over the region by the late 18th century, from which the British Raj extended their rule over the subcontinent. In 1947, after a long anti-colonial movement, the British left with dividing subcontinent in two separate States: India and Pakistan on the basis of religion majority. The region of Bengal was also divided along religious lines into two: east and west and the eastern part formed one of the two major territorial units of the newly independent Pakistan. East Pakistan was dominated and ruled by the military-bureaucratic oligarchy of Pakistan from the very beginning of independent Pakistan. The relation between two parts was never been smooth because of economic and political exploitation by the West Pakistan which in turn led to popular uprising and demand for equal rights under the guidance of Awami League led by Sheikh Mujibur Rahman from East Pakistan. And as a result of continuous popular movement and a shorter period of arms struggle, Bangladesh achieves the independence on 16 December 1971. The post-independence situation of Bangladesh politics and society, particularly the major features relevant to explain the health sector reform, will be discussed in the following section.

#### 3.1.2. Society and Social Structures

A short analysis of common features of society and social structures in Bangladesh is necessary for understanding the impact of health reform on state and society.

Demographic characteristics are the essential elements of a society; therefore, it requires depicting the current status of the population of the country. Presently, the total population of Bangladesh is 138.8 million of which 62.5% are grown adult, children and adolescents form 30% of the population (GOB 2006). There are 17.3 million of teenagers in the country. Male female sex ratio in the total population is 1.05. Population is growing at a rate of 1.6 per annum. The mean age of the population is 22.2 years for both sexes. Life expectancy is 62.46 years for both sexes. 98% of the total population is Bengali while the rest constitutes with small ethnic groups living in different parts of the country, mostly in hilly areas including Chittagong Hill Tracts, and non-Bengali Muslim. 88% of the total population is Muslim, 10.5% Hindu and 1.5% Buddhist, Christians and animists. The literacy rate is (among the population of 15+) is 53.1% (male 53.9% and female 31.8%).

Although the contribution of agriculture in GDP is decreasing over years, from 50% in 1972-73 to 20.5% in 2005, agriculture laborer form the largest category in the total work force of the country, more than 20 million people employed in agriculture (World Bank 2006, Abdullah 2000, Sen 1994). Besides, industrial workers, service sector workers, tea garden laborers, garment workers form the working class in Bangladesh. The total size of the working class is 30 million (Sen 1994). However, recent growth in garments industry caused changes in the working class composition. According to the 1990-91 labor force Survey, 7 million people work in garments industries most of which are based in big cities like Dhaka and Chittagong. 85% of these huge workforces are women (Abdullah 2000). The number of white colored employees in the country is about 5.6 million (Sen 1994). Beside the working class, the growth of capitalist class has been very slow which led formation of numerous intermediate strata in rural and urban population (Gankovsky 1974).

In general, society in Bangladesh is not rigidly stratified; rather, it is relatively open, and diffused comparing to its south Asian neighbors. Social class distinctions are mostly functional, however, with a considerable mobility among classes (ibid). However, traditional stratification has not been wiped away, still exists. Bhuyian (2004) notices that, in urban Muslim society, there are two broad class divisions: *Ashraf* (high class) and *Atraf* (low class). High class constitutes with elites who have economic, political and

social power positions. These elites mainly work in civil and military bureaucracy, owner of old industrial houses. On the other, all members of the society except high class belong to the *atraf* (low class). Members of this group are involved in petty trading, support services and other low paid jobs. Kinship and patron-client relationship are two modes of social relationship determine most of the interpersonal and inter-group interactions in both public and private domains in Bangladesh society. The inferior position of women in social status shows the patriarchal nature of the society; however, situation has started changing since mid eighties with increased employment of women in garment industries.

In summary, two issues bear high relevance in understanding and locating the research problem within the social context. First, urban society is broadly divided, where the poor are considered as *atraf* and the elites - the policy makers are known as *ashraf*. Secondly, the inferior position of women in the society. Women are neglected within and outside of the family.

### **3.1.3. Politics and Administration**

Since the independence, the polity of Bangladesh has gone under several significant transitions. The first government after the liberation was formed by the Bangladesh Awami League and took parliamentary form of government, which survived following three years only. The Awami League regime due to its internal weaknesses and external factors gradually became authoritarian in nature and fall back to presidential form of government (Haque 2002; Sobhan 1993: 20). This first phase of the newly independent state ended up with the violent overthrow of the Awami League regime by a small group of army personnel in 1975. Since then the state power has shifted from one group of elite to another through *coup d'état* than by elections (Crow 1990: 1994). After the assassination of Sheikh Mujib, from 1975 to 1990, three regimes took over the state power and held four general elections - presidential and parliament. The national elections, however, did not play any role in changing the regimes; rather they were much about a way of legitimization of unconstitutional capture of state power (Huque and Hakim 1993). It could be said, as Khan (2000: 109) observes, that the country was under direct or indirect military rule from 1975 to 1990 and during this period a presidential form of government was practiced. The country again, after a long populist movement

and violent incidences, moved from totalitarian regime to democratic regime since 1991 and reinstalled the parliamentary form of government.

Having spelt out the brief political history of the post-independence Bangladesh, I would like to reflect more deeply on the nature of the post independence state in Bangladesh.

#### **3.1.4. The Nature of State**

In analyzing the nature of state in Bangladesh we shall actually be looking into the structure of the relation among political elites and/or social forces, and the institutional ways by which the distribution of political power among dominant and dominated are regulated and controlled (Mouzelies 1990:60) at the level of polity. In doing so Hamza Alavi's classic formulation regarding the nature of the postcolonial state could be a useful start, however, with some reservation. In his influential article, 'The State in post-colonial societies: Pakistan and Bangladesh' (Alavi 1972: 59-81) analyzed the characteristics of dominant elites, the power-relation among them and their role in national level decision making in Bangladesh. According to him, postcolonial state inherits an overdeveloped bureaucracy that was designed and built to meet the need of the colonial regimes. He argues, with example of Pakistan and Bangladesh, that the colonial rulers developed 'a powerful bureaucratic and military apparatus' in order to 'subordinate the native social classes' which remained powerful even after the independence. In this case, state plays a mediatory role among three dominant classes: the civil bureaucracy, military bureaucracy and native bourgeoisie – who emerged mostly from the land-owning classes. While political parties in this post colonial states represents the native bourgeoisie remained as a weaker partner compared to other two, nevertheless, these three groups were closely interlinked but, to a greater extent, interdependent to each other. The main points which came out of Alavi's arguments as relevant to analyze the situation in Bangladesh are military and bureaucracy remained as the most powerful and relatively autonomous group in national policy making; the contradiction between urban-based bourgeoisie and rural-based petit bourgeoisie weakens the consolidation of political parties and thus the post-independence state building. Sobhan (1993), however, illustrates Alavi's line of argument in more detail where he suggests that the post-liberation Awami regime suffered from its inner inherited-contradiction (Sobhan 1993: 21).

Betrocci, applying Kalecki's (1972) conceptual schema of 'intermediate regime', identifies the state in Bangladesh with dominance of four major groups: the civil bureaucracy, the military, the civilian political parties and the rich peasant elites (1982: 991). He suggests that the members of these 'institutional groupings' are 'cooperatively linked to one another by bonds of kinship, status and material interests'. Jahan also persuaded similar kind of arguments (Jahan 1980: 163). However, Betrocci also identified several other important groups such as industrial proletariats, urban in-migrant poor, middle-to-poor and landless laborers as potential political forces who usually possess no immediate threat to the established class relations among the privileged groups, however, can 'form a vast reservoir of political activism that may be drawn into whatever movements a given constellation of political forces may engender from time to time' (Betrocci 1982: 991).

From a different perspective Sobhan, noticed that the state apparatus in Bangladesh is largely dominated by a powerful class, comprises of members from civil service, business, professional and rural elite who has been mobilized around the aid regime (Sobhan 1982: 202-3) as a political product of continuous heavy<sup>11</sup> foreign-aid dependence of the Bangladesh economy. He comments that these groups may not constitute an autonomous ruling class rather they are dependent on 'external patronage provided through the aid regime' (ibid).

To sum up the above discussion, it can be said that in Bangladesh, until very recently the military, the civil bureaucracy and the civil political parties and rich peasants are the most influential group regarding national policy making. The relative importance of one group over other changes as regime changes from time to time. Kochanek (1996) suggests that these elites and organized groups – who can influence political process, include student

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<sup>11</sup> Foreign aid constitutes a major part of the national economy in Bangladesh. Historical revelation shows that the Bangladesh government's dependence on foreign aid was initially a historical inheritance (Sobhan 1982). It has been noted that on average, before 1991 foreign aid contributed about 60% of the total Annual Development Program of Bangladesh government. For several international and national level policy changes, however, dependence on foreign aid has been reducing since 1991. The share of foreign aid in Annual Development Program drops down from 60% in 1991 to 43% in 2002; estimates show that foreign aid (project aid, commodity aid and technical assistance) shared 5.6% of the GDP in 1991 which fell to 3.2% in 2000 (CPD 2005). Nevertheless, despite a downward trend of aid-reliance, foreign aid still continues to influence significantly country's macroeconomic balance and thus the donors and the 'constituencies' that formed around the aid regime remain influential in the policy process of the country.



community, trade unions, businessmen, middle-class professionals are urban based. He also observes that social organizations are based on patron-client relationships dominated by the rich peasants in the countryside. The growing number of agriculture day-laborers, near-landless population, however, are being gradually mobilized by non-government organizations but ‘they remain highly localized, non-political and primarily concerned with poverty alleviation’ (Kochanek 1996: 704).

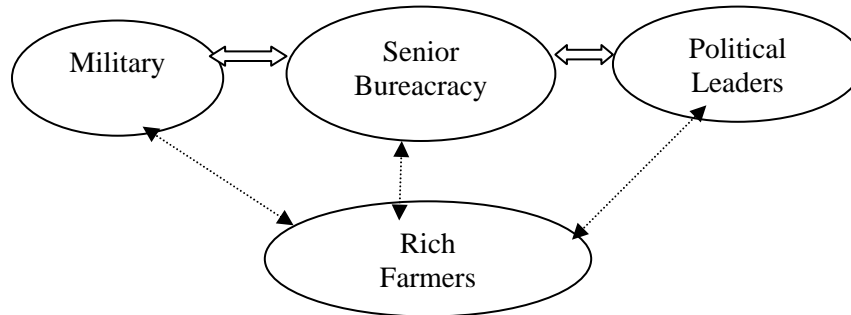


Figure 3.1: Relationship among ruling elites, before 1990  
Adapted from Blair 2000

Figure 3.1 depicts the relationship among the ruling elites. It is important to note that these intermediate classes formation has largely been dependent on state patronage distributed from the resources obtained from foreign aid. Patron-client relation remained the basis of distribution of power among them and thus they have been accountable to none but themselves (Kochanek 1996). It has been observed that during any particular period any two of the bureaucracy, military and political parties ‘dominated the politics at the macro level’; sometimes a combination of military and bureaucracy (1975-79 and 1982-90) while on the other occasion alliance of bureaucracy and political parties (1972-75 and 1979-81) governed the country (Blair 2000: 190). However, neither of the coalition has been interested in encouraging the masses or organized groups to participate in the political process. As a result, modern associations to represent various social forces have been ‘rudimentary and insufficiently organized and coherent to do more than sporadically intervene in the political process’(ibid). At the same time institutions of modern democratic state such as functioning representative parliament, independent judiciary has not been established. Therefore the legitimacy of the regime, if not the state itself, among the mass has never been out of question. As a result, the state couldn’t grow

properly and remained weak. The nature of the state, however, has been started changing substantially since 1990 after the fall of eight-years-long Ershad's<sup>12</sup> totalitarian rule. Since then there has a consensus been achieved among powerful elites over taking election as the means of change of the government. Since 1991 not only change in the totalitarian regime but also a reshuffling of power relations among the ruling elite took place and more importantly, some new actors became influential in the policy process of the country. Blair (2000) noticed, in the new phase of the country's political and economic development that has started from 1991 two new actors: business community and NGOs emerged. However, Blair missed to notice the enormous growth in size and influence of media. Thus, I argue that the political change in 1991 actually brought three more additional actors: business, NGOs and media into the political space. Being informed of the potential conceptual overlapping among these three categories, however, in this place I consider business as profit oriented trade and industry sector while the NGOs are broadly regarded as private, voluntary and non-profit development organizations. Media broadly refers industry which includes all forms of printing, audio, visual, digital information industry. Indeed, media may also be a part of business community but for analytical reasons, here I consider them separately. I do acknowledge that these three actors do not have one unified interest-scheme for their respective groups. Yet, in a wider context from a comparative or relational perspective, I argue, can be identified as category of actors who are separate from each other in terms identity and interest. In the following I discuss the development of these new actors in brief.

Business was a very marginal actor in the early years of independent Bangladesh, however, economic liberalization policies that have been taken by the successive governments since 1975 gradually helped the emergence of indigenous entrepreneurship

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<sup>12</sup> The first government of Bangladesh led by Awami League was overthrown by a group junior officer's coup in 1975 and the administration brought to power survived only two-and-a-half months before being overthrown by a second coup and as a result of which General Ziaur Rahman – the then army Chief of Staff took the charge of the government. The Zia regime survived following six and a half years. Zia was assassinated by another unsuccessful coup in 1981. After Zia, a very short period of civilian rule of Abdus Sattar took hold of the government. But in March 1982 the then Army Chief of Staff Lt. General Ershad came into power and continued to remain in power until 1990 despite a strong opposition from major political forces. Finally, in December 1990 on the face of huge mass agitation, the government of General Ershad resigned. Since 1991 parliamentary form of government has installed replacing the autocratic presidential form of government and until 2005 government has changed three times on the basis of regularly held reasonably free and fair election.

and eventually placed the business community as an important actor in the politics of the country (Blair 2000; Kochanek 2000). Particularly the explosive growth of finished garments export in the early 1990s made the nascent business community an undeniable actor in the political space (Blair 2000). An estimate shows that the export of ready-made garment product rose from virtually nothing in the mid 1980s to more than US \$ 2 billion by the later 1990 to become the lead industry, with some three fifths of all exports by value in 1996-97 (Economist 1998 cited in Blair 2000: 193). The business community usually used two ways to enter into the politics – ‘directly contributing political parties and through directing money to individual rent-seekers within the various state and political sectors particular’ (ibid). Kochanek (1993; 1996 and 2000) portrayed the quite clearly that the business community is an important actor, indeed, not on the level of bureaucracy, military and political parties, yet active and influential.

NGOs as a form of civic organization are not new in Bangladesh. The origins of some NGOs began in the late 1970; however, their expansion and legitimation as influential actor in socioeconomic and political development began largely in the mid 1980s (Haque 2002: 414). NGOs they have expanded in numbers, activities and coverage enormously since mid 1980s. Some observers suggest that there were more than 1300 NGOs, almost all of them were directly or indirectly foreign aid assisted, by the late 1990s. These NGOs covered some 24 million of people as beneficiaries 78% of them living in rural areas (Begum 2003: 66-67; Blair 2000: 195). There are several federations under which these NGOs are organized, for example, Federation of NGOs in Bangladesh, Association of Development Agencies of Bangladesh are few to name. The main strength of NGOs is their linkage to the international donor organizations on the one hand and on the other their thousands of beneficiaries usually organized in groups in the countryside. NGOs influence politics through their federation by negotiation, influencing government policies through their international donors and by encouraging beneficiaries to take part in the local government election in the rural area (Westergaard 2000).

Bangladesh experienced a media boom following the democratic change after the fall of Ershad regime since 1991. Though freedom of speech, expression and media is enshrined

in the constitution<sup>13</sup> as one of the basic civil rights, however was subject to strict government control and censorship until 1990. There are several laws, for instance, Special Power Act 1974 and Printing Presses and Publication Act 1973, by which governments were used to control the freedom of press. But the interim government of justice Shahabuddin, who came into power only for a short period of time to arrange national parliament election 1991 with the consensus of main political parties, took initiative to scrap some provisions (Sections 17, 18 and 19) of the Special Powers Act 1974. These provisions were against freedom of speech and expression in general and freedom of press in particular (Hasan 2004). The installation of democratic regimes, elimination of some legal tools and the liberalization of overall economy since 1991 caused a sharp increase in the number of newspapers and electronic media in the country. It has been seen that there were some 90 daily newspapers published in Bangladesh, the

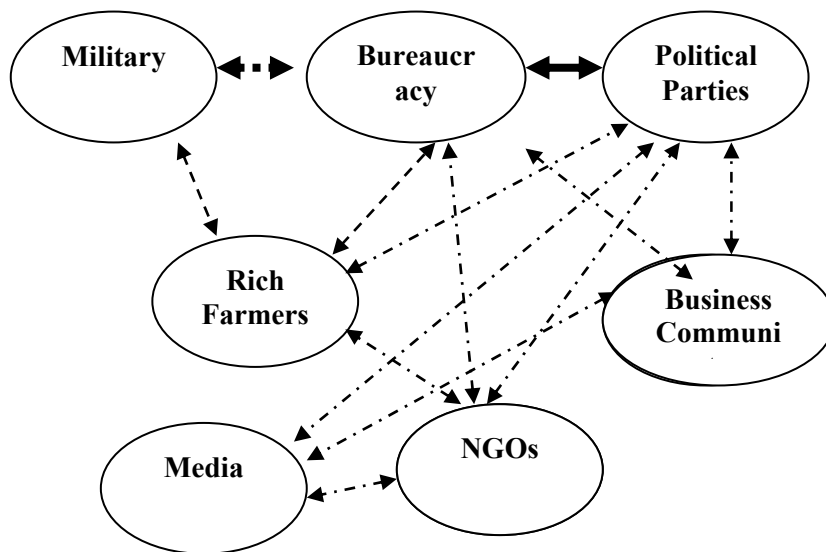


Figure 3.2: Power elites and their relationships, after 1991  
Adapted from Blair 2000

number rose to 282 in 2002 and 346 in 2004. At present approximately 1566 newspapers

<sup>13</sup> Article 39(1) and 39(2) of the constitution of Bangladesh ensured the freedom of thought, conscience, freedom of speech, expression and press, however, the constitution preserved a room to maneuver for the government according to their need as it made the 'freedom' "Subject to any *reasonable* restrictions imposed by law in the interests of the security of the State, friendly relations with foreign states, public order, decency or morality, or in relation to contempt of court, defamation or incitement to an offence" (GOB 2004). This statement of the government gave the government to impose restrictive laws on the media.

and periodicals are published from Bangladesh in Bengali and English. Indeed, not all of them publish regularly, only 20 -22 dailies are published regularly (Hasan 2004). Besides newspapers there are six private and one public television and several radio stations are on broadcasting. The relative importance of media in the political space has increased recently because media houses are, generally financed by one or the other big business houses on the one hand. On the other, firstly, for last one decade or so the two main political parties, Bangladesh Awami League and Bangladesh Nationalist Party, who were in government in 'democratic' era failed to make the parliament a effective institution for governance therefore the accountability of public officials has eroded severely. The media, during these years of political inefficiency, played an important role to make the ruling elite's irregularities public and thus achieved higher level of public confidence. Moreover, while corruption in all sectors of state organs made citizens increasingly disappointed with the behavior of political parties, media, both print and electronic, played a reasonable role in favor of common citizen and to a significant extent has been able to question the authority and thus gained public confidence. Since the political parties are largely dependent on growing urban middle class voters, they also do care media because urban middle class are the main subscriber of the media.

Figure 3.2 presents the new reality of Bangladesh political landscape that emerged after 1990s, which suggests that the strong relationship among traditional powerful groups like military, bureaucracy and political leadership still exists and dominates, however, the equation has changed a bit because of the strong presence of business community, NGOs and the media in general.

To conclude the discussion of this section, we could say that the though state institutions remained weak in Bangladesh, yet some new players like business community, NGOs and media became strong in course of history along with the traditional actors: bureaucracy, military, political leaderships and rich peasants. Indeed their role and relative importance in the polity has changed a lot from the earlier days, particularly the role of military has been somewhat reduced from earlier 'most powerful' to 'powerful' status. One more important development occurred that deserves attention is the new actors are coming from the society. Unlike the military or bureaucracy or political parties, NGOs or business or media are not directly connected with the government. Importance

of these new actors implies, in a simple meaning, non-state actors are on rise. In general, what Jahan (1980) observed some twenty years back about the political development of Bangladesh, is still valid for the current situation, political elites in Bangladesh ‘failed to take any substantive policy to create a just social order and give citizens a sense of participation in the political system’ (Jahan 1980: xii). In following section I shall give a brief account of the nature and quality of democracy in Bangladesh.

### **3.1.5. The Nature and Quality of Democracy**

In this section I shall try to portray the nature and quality of democracy in Bangladesh. One should keep in mind that this discussion is not about history of political development, rather, more focused on the political institutions and practices so that we can understand the present quality of the democracy. I have discussed the conceptual issues related with democracy and quality of democracy in Chapter 1, thus, in this place I shall present a brief situation analysis only and the discussion would cover only recent period of political rule, from 1991 to 2005.

Evaluating the quality of democracy in Bangladesh, I am departing from minimalist definition of democracy, rather, taking on the concept of embedded democracy which suggests that liberal democracy consists of five partial regimes: a democratic election, civil rights, political rights of participation, horizontal accountability and the supremacy of democratically elected representatives (Merkel 2004). Putting it simple, the quality of democracy depends on five parameters - free, fair and competitive election, supremacy of the constitution, rule of law, effective parliament and presence of free media and civil society.

After the resignation of military ruler Ershad in the face of eight years of popular protest and agitation Bangladesh started its new phase of democratic rule. From 1991 to 2005 changes of state power took place through free, fair and competitive elections. But ‘successive regimes failed to promote economic prosperity, social justice and people’s welfare’ (Jahan 2000a: 26). The most important feature of this ‘democratic period’ is the growth of pervasive corruption and abuse of public offices for private gain (Khan 2003: 398, TIB: 2000). Observance of rule of law was neglected; no effective measures were taken to free judiciary from the control of executive branch by all successive regimes

(Barman, Rahman and Siddiqui 2003). Political opposition has been brutally by using state power by all regimes. This intolerance led degeneration of political competition to deadly confrontation. Parliament has never been able to perform as the central forum for negotiation and resolve policy differences amongst political parties (Jahan 2000a, Barman, Rahman and Siddiqui 2003). Politicization of bureaucracy continued in increased rate since 1991 (Bhuiyan 2004). Neither parliament nor the judiciary has been able to hold the executive branch accountable. No effort was taken to democratize the decision making process at neither the central government level nor it was decentralized to the local governments. However, during this period media has been increasingly strong and enjoyed reasonable freedom. All in all, it is very clear that the democracy that has been practiced in Bangladesh for last 15 years fell far short of what is called liberal democracy. Scholars have rightly observed this situation and identified Bangladesh in the list of illiberal democracy (Croissant 2004: 165, Merkel 2004: 51).

To conclude this very brief account of the quality of democracy in Bangladesh clearly establishes that the ruling elites has failed to establish and institutionalized democratic governance. And this failure created a chronic deficit of democratic legitimacy of ruling class in Bangladesh.

### **3.1.6. Profile of the Economy**

Bangladesh is one of the most densely populated countries in the present world; the World Bank estimate shows, in 2005 the total population rose to 141.8 million having a per capita income of US\$ 470 (World Bank 2006). According to the same source of World Bank data, the average annual population growth rate during the period 1999 - 2005 is 1.9 while during the same period the labor force grew at an average rate of 2.2. Country recorded 5.4% growth of GDP in 2005.

Table 3.1: Post independence Annual Growth Rates in different sub-periods

<b>Sub-period</b>	<b>Average annual growth rate of GDP</b>
1975 - 80	4.2 percent
1980 - 90	4.3 percent
1990 - 97	4.7 percent

*Source: World Bank 1995; World Bank 1999 cited in Khan 2000: 248*

The economic performance of the country has gone through several transformational

phase over more than three decades of its existence. A significant shift took place in the economic policy in 1975 and since then country has moved towards a market driven economy from a state driven one. All the successive regimes after 1975 have tried hard to reduce the involvement of the state in trade and industry and encouraged private sectors to fill that gap, however, appeared to have brought results at much lower level than it was expected. The economy has extensively been liberalized since 1980s in an effort to integrate in the world economy and in doing so Bangladesh became member of several regional and global trade regimes such as SAPTA (South Asian Preferential Trade Agreement) and WTO. However, Bangladesh has achieved a faster growth rate of GDP than did during pre-independence era. Khan (2000) suggests that the growth of GDP between 1950 -70 was 3.2 percent per year which Bangladesh passed behind immediate after the independence. Table 3.1 presents the average annual growth rate of GDP in different periods after independence. The World Bank sources notice that Bangladesh achieved an average growth of GDP 5.4 % per year over the fiscal year 2001-05 which is the highest since independence (World Bank 2006a). The acceleration of growth has been mainly credited to the contribution of the accelerated private investment, which grew at an annual average rate of 10%, increasing its share in GDP from 16% in 2001 to 18.5% in 2005 (ibid). Bangladesh economy has been benefiting from continued strong export growth, garment export being the top, and large remittance inflows.

Table 3.2: The structure of the economy (% of GDP)

	1985	1995	2004	2005
Agriculture	32.8	26.4	21.0	20.5
Industry	21.4	24.6	26.6	28.0
<i>Manufacturing</i>	14.2	15.3	16.1	17.0
Services	45.8	49.1	52.4	51.5

*Source: World Bank 2006*

Table 3.2 presents the structure of the Bangladesh economy. The contribution of the agriculture sector has been reducing over the years; on the other, the contribution of the industry and service sector have been growing. The economy is still largely dependent on foreign aid; since independence in 1971 Bangladesh has received more than \$22 billion in grant aid and loan commitments from foreign donors, about \$15 billion of which has been disbursed. Major donors include the World Bank, the Asian Development Bank, the UN Development Program, the United States, Japan, the United Kingdom, Germany,



Saudi Arabia, and a number of West European countries.

Table 3.3: Average annual growth rate in major economic indicators

	1985-95	1995-2005	2004	2005
GDP	4.0	5.3	6.3	5.4
GDP per capita	1.7	3.2	4.3	3.6
Exports of goods and services	10.3	9.2	12.5	11.9
Imports of goods and services	5.6	4.7	10.6	10.7
<b>Sectoral growth</b>				
Agriculture	2.2	3.7	4.1	0.3
Industry	6.3	6.8	7.6	8.5
<i>Manufacturing</i>	6.3	6.7	7.1	8.4
Service	3.7	5.3	5.7	6.1

*Source: World Bank 2006*

Table 3.3 presents a general picture of the dynamism within the economy of Bangladesh. Despite an increase in the per capita GDP at around 4% in recent years, almost half of the population still lives in poverty. An estimate based on the Household Income and Expenditure Survey of the Bangladesh Bureau of Statistics shows poverty declining from 58.8% in 1991/92 to 49.8% in 2001 (BBS 2001). This data also suggests a modest reduction of income poverty at rate of around one percent each year during this period.

To conclude this section, we can say that the economy of Bangladesh has overcome its long stagnation of 1980s. However, poverty still remains at a very high level and inequality among population quintiles is increasing. Economy is largely depends on the growth in garment industry and remittance inflow. Foreign aid still continues to be a major source of government's development expenditure.

Since this study specifically focuses only on the reform that were undertaken to improve the health of the urban poor, one needs to have an understanding of the overall context of urbanization and state of service delivery in urban areas in Bangladesh, which is presented in the following.

### **3.1.7. Urbanization and Service Delivery in Urban Areas**

Despite of being a predominantly rural country, urbanization is taking place very fast in Bangladesh in recent years. Urban population is growing twice as fast as the rural

population. In 1974 only 8% of the population was living in urban areas which increased three times in only two decades and reached to 24 million people in 1996 (20% of a total of 122 million). The rate of urban population growth between 1975 and 1995 was quite high; 6% per annum. The urban population grew to 35 million in 2005, which is around 25% of the total population of the country (United Nations 2006).

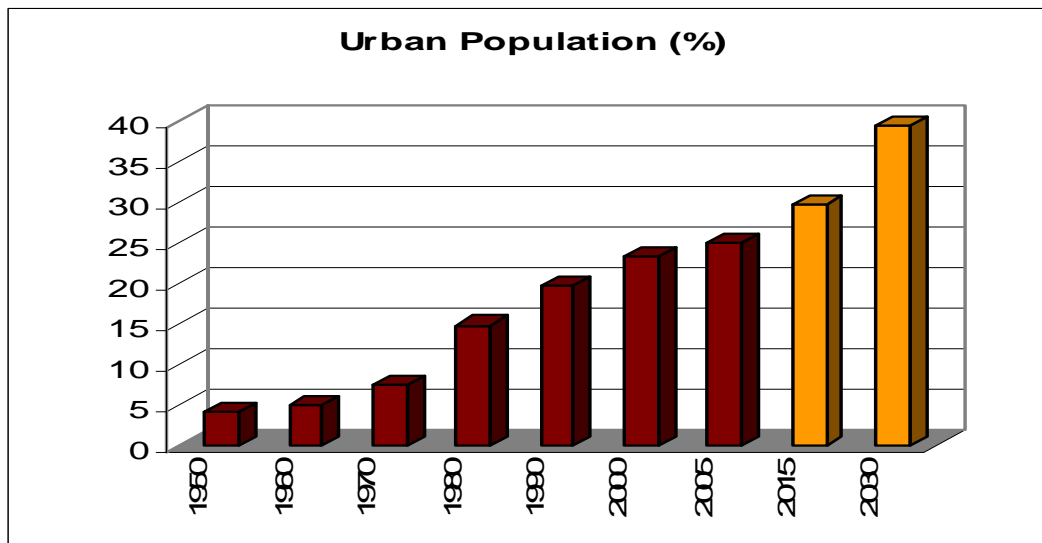


Figure 3 3: The trend of urbanization in Bangladesh  
*Source: United Nations 2006*

Figure 3.3 shows the urbanization trend in Bangladesh. The projection in the figure is based on the estimate of the United Nations Population Department which suggests that the urban population will reach 80 million in 2030. The Figure 3.4 presents the growth of urban population in comparative perspective within the national population landscape.

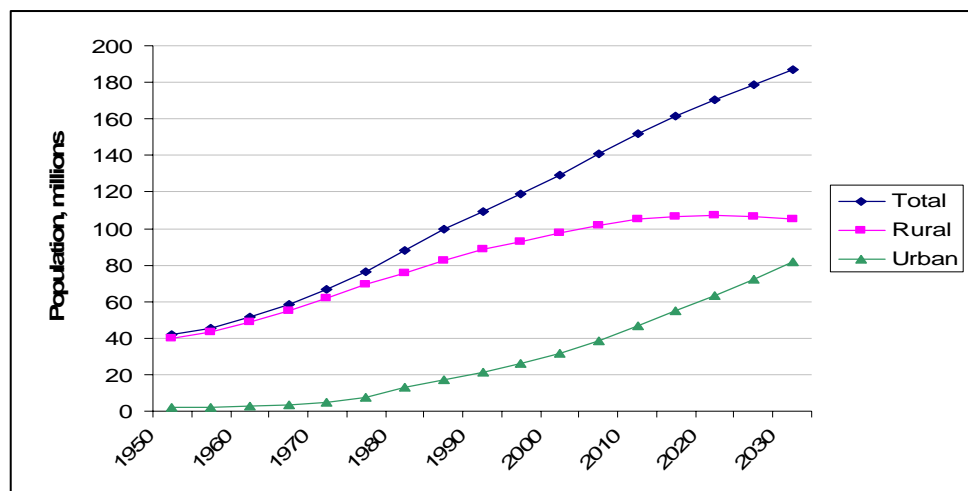


Figure 3.4: Comparison of the size of urban, rural and total population  
*Source: United Nations 2006*

There are four very large urban centers: Dhaka, Chittagong, Khulna and Rajshahi which are called metropolitan cities. Besides, there are 20 cities with population of over 100,000 each. The 4 largest metropolitan cities have 50% of all urban population (Islam 2002). Another 40-45% of the urban population is absorbed in rest of the 200 pourashavas. The present urban growth rate is around 3.47, one of the highest in the world (United Nations 2006).

Migration from rural and small town is the main cause of this rapid urbanization. Urbanization in Bangladesh is more poverty driven than fostered by industrialization; thus, most of these migrants are poor, adding only to the vast number of poor population. According to Islam (2002) 44% out of 30 million urban population is poor. The contribution of urban economy to the GDP is increasing. It was around 25% during 1950. Currently, it contributes more than 50% to GDP (Chowdhury 2006).

Historically public organizations of central and local government have been providing the citizens with public services. All though central government controls the major and important part of the urban services e.g. primary and secondary education, public hospitals and power, but the local government also takes part in some important service provision e.g. waste collection and management, primary health care, roads construction, water etc. Nevertheless, growing pressure of rapid urbanization, resource constraint, environmental deterioration and poor management have made the task of effective service delivery difficult for urban authorities in Bangladesh. Moreover, it has been observed that urban local government bodies have been weakened considerably over the years due to the interference of the central government in the affairs of the former. Researchers suggest that extreme control from and dependence on the government's ministries made urban local government bodies unable to cope with multifarious responsibilities endowed upon them (Islam and Khan 2000). In spite of being constrained for financial and institutional reasons, urban local governments bodies try to deliver utility services to their subjects, however, could not achieve citizen's satisfaction much (Proshika 2002).

To conclude the discussion on the political and socio economic contexts in the above

section, it is fair to say that the polity and economy of the country has gone through several important trajectories over past decades which has left their marks on the development of the health system in Bangladesh. The history of political development shows that country is gradually moving towards consolidation of democratic institutions. At the same time, the economy has also come over its early experimentation and stagnation and has settled on a reasonably steady path of growth. The transition of economy and politics has led to the emergence of some new actors in the policy process. Urban centers are becoming more and more important day by day for its higher contribution to the national economy. But the state of urban governance has still remained in the deep misery. Like all other public services health, particularly the health of the poor has been an issue of great concern until today. The following section focuses specifically on the health care system of Bangladesh.

### 3.2. HEALTH CARE SYSTEM: INSTITUTIONS AND ORGANIZATION

In order to understand the dynamics of the reform in urban primary health care and its impact one needs to have an idea of the entire health care system. It is very essential to know the institutes, organizational structure, and its resources to make sense of the reform process. Therefore, following subsections shall take each of the issue sequentially.

#### 3.2.1. Pre-independence Development of Health Care Services

The root of the present health care system of Bangladesh dates long back to the nation's century-old history, thus, the evolution of the health care services should be studied in line of the historical development.

During the pre-colonial era there was no formal, organized 'health care services' as such in the subcontinent, although Indian system of medicine goes back to several centuries before the birth of Christ (Rao 1968). The existence of *Ayurveda*<sup>14</sup> - the ancient Indian

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<sup>14</sup> *Vedas* are the earliest sacred books that contain religious and other teachings and philosophy of life propounded by the ancients of the Indian sub-continent from time immemorial. The Vedas are four in number, i.e. *Rigveda*, *Samaveda*, *Yajurveda* and *Atharvaveda*. The Indian system of medicine is said to have roots in the Vedas. The term Ayurveda, literally means knowledge of life, was given to the ancient Indian system of medical sciences. Ayurveda is strictly not a Veda like the four Vedas, however, is considered to be a branch of the fourth Veda, the Atharvaveda. The teachings of Ayurvedic medical knowledge have been compiled in two important ancient literatures - *Charaka Samhita* and *Sushru Samhita*.

system of medical science - since the pre-historic age shows that there were medical services in one form or the other. The practicing physicians in Ayurvedic science were called as *Vaidyas* who were main source of health care. During the middle age, after the Muslim's invasion, a new system of medical science and related health care practices called *Unani*<sup>15</sup> had been introduced. Although introduced by Arabs, Unani soon took firm roots in the society and flourished very quickly with the princely patronage from the Mughal court (Husain 1998). During Mughal, the *Hekeems* - the Unani physicians gained significant political influence for their intimate relation with the Court. Despite significant development of medical knowledge during the pre-colonial era, no strong evidence of organized health care service is found. However, the influence of the system of traditional Ayurvedic and Unani health care faded out with the invasion of European colonial rulers in the subcontinent.

The modern system of health care services is rooted in the British colonial rule in India. The British East India company and other early colonizers brought doctors and medicine with them from their homeland (Rao 1968), yet, were not enough in numbers. Thus, the British took initiative to establish Indian Medical Service in 1714 on a very limited scale (Osman 2004: 72). The real establishment of modern health service began with the promulgation of the Quarantine Act 1825, which 'marked the start of public health movement in India' (Rao 1968: 56). Before the Quarantine Act, the colonial administration introduced 'The Local Self Government Act 1816', which allowed the extension of some health facilities in the small towns. The purpose of this kind of health service establishment was mainly to protect the British officers working in the countryside. There were some other important acts like Vaccination Act 1880, the Birth and Death Registration Act 1896, the Epidemic Diseases Act in 1897 enacted by the Government of India that paved the foundation of health care services in the subcontinent. In 1919 the departments concerned with public health and sanitation were

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<sup>15</sup> Unani system of medical science owes its origin to Greece. The fundamentals of Unani Medicine are based on the teachings of Hippocrates (460-377 BC). Arabs took the knowledge and enriched enormously with the inclusion of knowledge of the contemporary world. The Unani system received great impetus during the reign of the Abbasids. In India, Unani system of medicine was introduced by Arabs. When Mongols destroyed Persian and Central Asian cities scholars and physicians of Unani Medicine fled to India. During the 13th and 17th century the Delhi Sultans and the Mughal Emperors provided state patronage to them. However, during the British rule, Unani system suffered a setback and its development was hampered due to withdrawal of governmental patronage (Husain 1998).

transferred to the provinces. This was the first initiative of decentralization of the Health Administration. Despite a gradual expansion of health care services it was solely devoted for 'a few, neglecting the vital interests of vast majority' (GOB 1987 cited in Osman 2004: 72). In 1940, the colonial government formulated a drug policy that established the supremacy of allopathic medicine based health care over the traditional health care practices. During the Second War a detailed survey on country's medical and health services was conducted by the Health Survey and Development Committee, popularly known as the Bhore Committee. The committee recommended a far-reaching reform proposal for the entire health system including building an integrated health care service, based on the principals of equity and community participation, and making them available to the communities (Osman 2004; Rao 1968). However, the British Government did not have time to implement the recommendations of the Bhore committee as the colonial rulers left the subcontinent in 1947, immediate after the publishing of the report.

During Pakistan era the government made no significant effort to improve the health care service in the country, nor did take attempts to implement the Bhore Committee recommendations (Zaidi 1987). Pakistan was also carrying the colonial tradition of emphasizing on curative cares and urban needs in the organizing of health care services. Osman, reviewing the Five Year Plans of successive governments of Pakistan identified two features: first, the plan was biased to urban elites because the most of the budget allocations was directed to the hospital services and hospitals were mostly in district towns. Secondly, the plan neglected the preventive health care and emphasized the curative care. However, a major attempt came into being in 1961 while the government of Pakistan introduced a scheme for setting up Rural Health Centers in the rural areas. Under this program, one Rural Health Center (RHC) was planned to provide comprehensive health care services for every *thana*<sup>16</sup> and three sub-centers were envisaged to be attached to each RHC. During the same time, the government also launched three very important and long-term public health projects, i.e. malaria

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<sup>16</sup> *Thana* is a small administrative unit of, on average, an area of 255000 people. At present in Bangladesh there are 507 Thanas (BBS 2005). A Thana is composed of several *Unions* and a *union* is made up of several villages. Very recently, government has renamed thana as Upazila. Upazila means sub-district.

eradication program, family planning program and small pox eradication program. By the year 1970, 140 RHC were built (Khan 1988: 16).

### **3.2.2. Post-independence Development of Health Care Service Structure**

Bangladesh inherits a health care service structure that was predominantly elite-biased, urban-focused and curative-care-oriented (Khan 1988; Osman 2004). There were only 8 medical colleges, 1 post graduate institute, 37 T.B. clinics, 151 rural health centers and 91 maternity and child welfare centers spreading over the country in 1971 (Osman 2004: 76). These inherited health care infrastructure was embarrassingly insufficient to tackle the growing health problems, particularly the increasing incidence of communicable diseases, malnutrition and population growth, in the early post-war period. However, the new government of Bangladesh took the public health issue as one of the priority areas for reorganization and expansion. Thus, in 1972, government approved the Thana Health Complex Scheme. Government launched the First Five Year Plan (1973 - 78). The plan highlights government's mission to establish a health care network consisted of comprehensive preventive and promotive health care services in rural areas (GOB 1973). However, the government could not achieve much of its projected goals of development of the network of THC because of financial and construction difficulties. In 1976 government revised the program and plan to build 356 THCs one in each thana and 1068 sub-centers at the union level (Khan 1988: 17).

In brief, the period from 1971 to 1980, in relation to health care service, could be said the *reorganization and reconstruction phase*. The focus of this phase was, mainly, to build the physical infrastructures like hospital and health centers, expansion of beds, procurements of modern equipments etc. all around the country. Along with infrastructural expansion, government initiated some significant attempts to reorganize several service provider agencies. For example, Malaria Eradication Board was abolished and the work force and activities of the board were integrated in the THC. Khan shows that by the end of 1980 construction of 84% of total 356 THCs were completed but only with a 34% of operational beds being placed (Khan 1988). Government take another important attempt to integrate government's family planning services with health services in 1974, however, the attempt was abandoned with change in the government in 1975 and

new Division of Population Control and Family Planning was created under the Ministry of Health and Family Welfare. Later on, government established Directorate of Population Control and Family Planning by merging some autonomous organizations such as National Population Board, National Post-partum Program. The government launched Health for All 2000 program in 1980-81 being a signatory of the Alma Ata Declaration of 1978. During this period, in accordance with the global change in the health policy focus and considering national situation, government made a significant move toward primary health care from the hospital oriented curative care. Government set a three-tier health care service structure for the people living in the rural area, which include household level domiciliary services, union level institutional services and thana level institutional services.

Having built the physical infrastructure and organizational structure in the first fifteen years of health care service provision, Bangladesh has moved into new phase since 1985. The present structure of health services in Bangladesh, however, more or less is following the one that has been established in those days.

### **3.2.3. Institutional Framework of the Health Care Services**

Institution, in a broader sense, is perceived as the formal and informal rules, regulation, and structure by which the actor's behavior is controlled. In order to understand the organizational dynamics within the state bureaucracy we need to understand the institutional framework within which it operates because institution 'affect individual action and collective outcomes by conditioning both the distribution of power and the definition of interests' within society (Hall and Taylor 1994: 3).

The health care service in Bangladesh is a mix of public and private sectors, however, the actions and activities in both sectors are subject to the regulatory provisions set by the government from time to time. The main sources of the laws, rules, and regulations are the Constitution, Rules of Business and various Acts/ Ordinances and Parliamentary provisions.

The constitution of the Peoples Republic of Bangladesh acknowledges right to health as one of the fundamental rights of the citizen According to the constitution [Article 15(a)] it is one of the fundamental responsibility of the state to ensure the 'provision of the basic



necessities of life, including food, clothing, shelter, education and medical care' ( GOB 2004). The same article of the constitution also mentions that the state shall adopt effective measures to reduce disparity in health care progressively. The constitution has further emphasizes [Article 18(1)]. Therefore, it is very clear that the constitution has provided the basic framework to protect, promote and respect health care for every citizen of Bangladesh.

Under the constitution, there have several acts and ordinances to regulate, control and coordinate health care services existed in Bangladesh. Osman (2004) classified the existing health related acts and ordinances categories into four different categories: communicable diseases control acts, drug control acts, medical education acts, health practices acts and environmental health acts. Several important acts were enacted by the colonial governments, but continue to be in effect. Not all acts and ordinances are equally important to regulate the affairs of health care services, but some. For instance, The Drug Ordinance Act 1982 dramatically changed the availability and quality of drugs essential for meeting the health needs of the country (Reich 1994). On the other, the Medical Practice, Private Clinics and Laboratories Ordinance 1982 laid down the regulatory framework for the health care service provision in the private sector.

Beside various acts, the Rules of Business is another very important institution. The Rules of Business is the legal instrument that is made to delineate the main responsibilities of government Ministries. According to Schedule I attached to the Rules of Business, the Ministry of Health and Family Welfare is in command of discharging functions related to providing health services; health and family planning, policy-making, education, training, research; regulating medical profession and standards and administering health care organizations (GOB 1997). Along with various laws, rules and regulations there are some policies like National Health Policy 2000, National Population Policy 2001, National Drug Policy 1982, National Food and Nutrition Policy 1997 that have been made from time to time (GOB 2000, 2003a). These policies have also important bearings on the structure of health care sector.

In summary, we can say that laws and policies do not ensure effective health care system automatically; rather, what is important is their effective implementation. The effective

program implementation largely depends on the organizational structure and the service delivery mechanism is in place. We will take existing organizational structure and service delivery mechanism in following sections.

### **3.2.4. Organizational Structure of Health Care Service**

Health care services in Bangladesh are delivered by public, private (for profit), non-government organizations and traditional sectors<sup>17</sup>. Allopathic medicine based modern health care services is more popular than traditional health care, even in rural areas of Bangladesh (Khan 1984). However, currently only 40% of the population has access to the modern primary health care services beyond immunization and family planning (Perry 2000: 10). Having taken the mixed nature of the health care system in to account, I would discuss the organizational structure of the health care services separately.

#### *3.2.4.1. Public Sector*

The public health care system is organized under the overall supervision of the Ministry of Health and Family Welfare. The organization structure of the services is designed in alignment of the administrative set up of the country. The entire area of Bangladesh is divided into 6 administrative divisions. Each division is further divided into districts; there are 64 districts and 460 *upazilas* (sub-districts). *Upazilas* are the lowest administrative unit of the central government. Each upazila consists, on an average, of 10 unions; and a union consists of 10 villages on an average. An average size of Union, in general, used to have a population of 20,000 - 25,000.

The organizational structure of the public health care system in Bangladesh is highly centralized. At the central level, the Ministry of Health and Family Welfare is the highest government authority headed by a Cabinet Minister, responsible for to implement, manage, coordinate and regulate national health and family planning related all activities, programs and policies. The Secretary is the administrative head of the ministry who is assisted by huge number of cadre and non-cadre civil servants. The MOHFW is the

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<sup>17</sup> We are informed that there is significant conceptual difference between ‘traditional health care’ and ‘alternative health care’. We, however, would not like to be engaged in that debate in this place. Rather, we are considering these two concepts, for our current analytical purpose, synonymous. Without making any normative judgment, we regard the traditional health care services as all sources of health care services except allopathic system of health care.

second largest ministry, in terms of its manpower, in Bangladesh (Osman 2004). The ministry is divided into two wings: Health Wing and Family Planning. Each of the wings is administrative through separate Directorates under the ministry. The head of the Directorates are the Director Generals. There are hundreds of employees under each of the DG. The detail organogram of the ministry is shown in the Annex 2.

The Directorate General of Health Services (DGHS) is the key agency to implement the national health policies and programs. It also provides input to the government for making or changing health related decisions. The directorate is in charge of a wide range of activities from procurement of material and manpower to supervising medical schools. The DGHS is assisted by nine functional Directors and under each of them there are several Deputy and Assistant Directors. Until recently, the strength of the DGHS, in total, was 702 (Osman 2004).

Like the DGHS, the Director General of Family Planning is has also similar kind of organizational structure that is dispersed in a pyramidal fashion from the national level to the grassroots. These two wings have been running separately with their own cadre of workers from the top to the grassroots for three decades. We already know that this bifurcated organizational structure was created in late 1975 when a Population Control and Family Planning Division was created within the Ministry Health and Population Control.

In addition to the DGHS, the Directorate of the Nursing Services and Directorate of Drug Administration are attached to the Health Wing of MOHFW. These Directorates have their own office, separate workforces and are assigned to perform various health care related activities.

The 'Division' is a regional unit of government administration in between the center and the local. In fact, in program implementation this level has little role to play. The main responsibility of the Divisional Directors office is to coordinate staff and activities within the division. From the program implementation point of view, the 'District' is very important, in fact this is the level from where the health care services in the small district towns and rural areas are controlled, managed and supervised. The Civil Surgeon is the chief of the district health service. He runs both fixed-site and out-reach health care

services in the district. The district health administration is responsible for supervising and coordinating, on average, 17 Upazila Health Complexes. The Upazila (*Upazila* means sub-district, previously it was called *Thana*) level health care service is organized around the Upazila health Complex - a 30 bed primary care hospital with a very limited secondary level health services. The upazila health complex is administered by the Upazila Health and Family Planning Officer. At present, there are 406 Upazila Health Complexes in the country. On paper, the upazila level health and family planning services are integrated. Upazila Health Complex is organized with three functional components - out-patient department, 31 bed in-patient service including 6 bed for maternal and child care and domiciliary health care section staffed with field workers. The Union Health and Family Welfare Center is at the bottom of the government health care structure. At present there are 4200 union health centers. Some of them, about 1300, are administered by Medical Officers and rest are run by Medical Assistants who are assisted by 15 health and family planning personnel in managing the static health facility and rendering domiciliary services.

We can conclude this section by saying that the government health care services structure is highly centralized, all power to make any substantive decisions lies at the top, the field level organizations are delivering the services decided at the top.

However, public health care services are not enough to serve the entire population, NGOs and private service providers are also delivering health care services to the citizens.

#### *3.2.4.2. Private Sector*

At the onset, I would like to make it clear that, in this place, the 'private sector' is to refer the private business sector - it may be a large business house or may be an individual health care provider. In this thesis by private sector we intent to mean private business sector distinct from private voluntary or charitable or not-for profit organizations.

The private sector is of paramount importance in the context Bangladesh. While only 40% of the population has access to government primary health care services, the majority of the population is jointly served by the private sector both profit and non-profit together. In this section I investigate the structure of the private health care market in Bangladesh.

The private sector in health care comprises of various types of service providers ranging from physicians trained in modern medicine and surgery to practitioners of homeopaths, ayurvedic, unani, unskilled village quacks and traditional healers like *Kabiraj* and *Ojha*. Illustrating the contribution and role of private profit sectors in country's health care is very difficult because of unavailability of reliable and systematic data. There are two influential documents on the issue published by the World Bank (2003 and 2005), but the problem is both of the study made no differentiation between for profit and non-profit private actors. Thus, the contribution of private business sector remained obscure. Nevertheless, both of the study provides some very important insights of the structure of the private actor's participation in the health care services in Bangladesh from which can one draw some idea about the business sector, imprecise though. The Bangladesh Bureau of Statistics conducted the most important study, namely the 'Survey of Private Health Service Establishment 1997-98' that is exclusively dedicated to the private business sector's participation in the health care market (BBS 1998). The survey reports that there are 158 hospitals, 455 clinics/nursing homes and 1042 pathological laboratories in Bangladesh (until the survey period 1997-98). The survey also reports that most of the private health care establishments, 87.4% are urban based (BBS 1998). There are differences between public and private health care service providers in many aspects, however, similarities are also not rare; for example, both public and private providers offer tertiary care only in the metropolitan cities whereas secondary care is offered in district towns and first level care is at the *upazila* level (World Bank 2005).

Table 3.5: Estimated Number of Public and Private Health Facilities in 1997

	Government	Private		
		Total	Registered	Unregistered
Hospitals	645	158	126	32
Hospital Beds	29106	11371	-----	-----
Clinics/ Nursing home	----	455	314	140
Nursing home Beds	----	5,158		
Total Inpatient Facilities	645	613	440	172
Laboratories		1,042	582	172

Source: BBS 1998

Table 3.5 presents an overall state of the private sector health care services in Bangladesh in comparison with the public sector. Before I go into more detail, it would be better to have an idea of the context of and factors for development of private sectors in the health

care services in Bangladesh.

As I described in earlier section, the social and business sectors have gradually been open for private investment since the political change of 1975. This is also hold true for the health care sector. In fact, not only the change in the political power, but also the failure of state to ensure basic health care for all resulted into increased participation of private sector. Islam (2005) reports that dysfunctional public health care system and over patient burden were the main impetus for the growth of private sector. It has been noted that during the period from 1972 - 2000 the government revenue expenditure on health and population sector was in between the range from 4% to 7% of total government revenue expenditure in different years (BBS 2005). On the other hand, this government allocation covers only 0.4% - 0.7% of GDP of different years. What this figures tell us is that the government health care system has been in severe resource constraints since the independence, and that has deteriorated further with managerial inefficiency, corruption, misuse and so on. Therefore, it is convincingly arguable that all symptoms of state failure in health care sector started popping up since the late 1970s. However, the business sector, in general, was too weak to put lot of investment in the health care sector though demand was high. Although there was no restriction on private sector investment in the health care sector, not even during the 'socialistic' years after independence when all financial, industry and trade were taken under state control, the number of private hospitals and clinics were not that many until recently. Of course, there were some large hospitals and clinics all around the country run by missionaries, charitable trust and individuals, but health care as a business enterprise was rare. One estimate shows, in 1981 there were only 164 private clinics and hospitals in 1984, which jumped to 712 in 2001 (BBS 2005). The rapid growth of private sector involvement in the health care started since 1980s as a part of macroeconomic liberalization program that were undertaken to implement the prescriptions of Structural Adjustment Policy (henceforth SAP). Among many agendas of SAP, there were three important recommendations, which are relevant to explain the private health care service industry in Bangladesh. SAP calls for gradual reduction of the role of the state in the economy through denationalisation, privatisation, deregulation and liberalisation. Moreover, SAP also recommends for privatisation of health delivery system along side the gradual reduction

of subsidies from the government-financed health system.

Bangladesh started implementing SAP recommendations in 1980 when they came as part of the conditions that were attached to a US\$ 800 million loan provided by IMF. The military governments of 1980s, particularly the Ershad regime, were the 'golden era' for the SAP implementation. New Industrial Policy 1982, Trade and Industrial Policy 1984-86, Import Liberalization Program 1986-87 etc. are the key policy documents through which government liberalized the entire economy. As part and consequences of this liberalization program private sector's participation in health care market grew very rapidly in 1990s (Islam 2005; BBS 1998). As study reports that the number of private health care facilities started to grow rapidly after the comforting the rules-regulations and conditions for setting up private hospitals, clinics and laboratories (Khan 1996 cited in Osman 2004: 83). I shall conclude this section on private sectors involvement in health care sector by depicting following important feature of the private health care service structure of Bangladesh:

1. Private sector health care services are urban cantered, more specifically Metropolitan city-centric. Survey shows that of total 2003 health establishment 87.4% is urban based while highest number of health establishments is found in Dhaka (46%) and the next highest number, 19.3%, in Chittagong (BBS 1998: 11).
2. The nature of private sector's participation in the health sector has changed in recent years, now the private sector is not only a health service provider but also producing health professionals from the medical colleges established in the private sector. At present, there are 22 private medical colleges are in operation in the country which are expected to produce, on average 800 doctors per year (MOHFW 2003a).
3. Private sector is more interested in tertiary and secondary level health care. Institutional establishments for primary health care are not available in the private sector. Private sector is more important in specialized care. Therefore, preventive care stayed out of the area of interest of private health care.
4. Along with local players, there are some big regional players like Escort Hospital Group (India), Appolo Hospital Group (India), Bamrunngrad Hospital (Thailand) are few to name big health care service providers are investing in the local market. However,

these hospitals are particularly for specialized health care and the price of the service out of reach of majority population.

#### *3.2.4.3. NGO Sector*

In a situation while state and market both fail to provide the services to the people needed most, it is very likely that some other alternative form of service provision grows there. This is exactly what happened in the case of Bangladesh, particularly in the health care sector. In fact, Bangladesh has been a perfect breeding ground of NGOs for more than two decades. Currently, Bangladesh has one of the most dynamic NGO sectors in the developing world (Perry 2000). These NGOs range from large international organizations (for example: Save the Children, CARE) to large national NGOs (such as Family Planning Association of Bangladesh, BRAC) to hundreds of local small NGOs. Perry reports that there are 4061 NGOs working in the broader health sector<sup>18</sup> (Perry 2000). One should keep in mind that this figure does not mean that they are exclusively working on health and population sector. The areas of activities and number of NGOs working in each area of activity are AIDS prevention including STD, 227 ; arsenic mitigation 257; child survival 98; disable 138; health and nutrition 700; MCH&FP 422; prevention of drug addiction and abuse 168; reproductive health including adolescent reproductive health 170; water and sanitation 674 (Fariduddin 2001). According to the Bangladesh National Health Accounts, in 1996/97, total National Health Expenditure (NHE) in Bangladesh accounted Tk. 54700 million, of which non-profit organizations and NGOs accounted to 3% (MOHFW 2004). The number of NGOs and their contribution in the National Health Account clearly shows that NGOs have emerged as a significant actor in the overall development program, and specifically in the health sector of Bangladesh. Before discussing NGO activities in the health sector of Bangladesh, I shall present a brief account of the growth of NGOs in Bangladesh in general.

There are many geo-political and economic reasons worked for the growth of NGOs in

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<sup>18</sup> There is no consensus regarding the actual number of health NGOs working in Bangladesh. A government source shows that there exist 300 NGOs in the health sector (MOHFW 1997) while another study reports there are 250 NGOs providing health and population services (Masud 1993). According to the National Health Account Survey, among the NGOs registered with Department of Social Welfare (24,000) approximately 3370 NGOs are registered as health NGOs, of which 330 are active in health, nutrition and population sector (MOHFW 2004).



Bangladesh. Begum (2003) identifies six important reasons. They are: 1) tradition of voluntary activities; 2) post-war (independence) reconstruction; 3) dissatisfaction of donor agencies with public organization; 4) government's failure in implementation of reform; 5) increase in foreign aid; and 6) success of NGOs in sector development. These reasons reflect the contextual factors of the emergence of NGO sectors comprehensively. In other words, it is very clear that after the liberation war in the war-torn country the government initiatives and resources were not adequate at all. At the same time demand for public services grew as the population grew over years but no subsequent growth recorded in the government allocation. Therefore, the unmet demand for adequate services i.e. education, health grew continuously. On the other side, government inefficiency, bureaucratic rigidity, corruption and change in post-cold war international politics and globalization formed the pull factor for establishing an alternative institutional channel to provide services and resources to the majority of the population.

NGOs working in the health sector widely vary in their size, approach to the community, location, funding sources and activities, which made it difficult to draw a general picture covering the whole range of activities and role in health sector. However, I will try to elaborate our argument categorizing NGOs, based on two factors: their place of origin and place of work, into three groups: International National and Local NGOs. WHO study (Fariduddin 2001) reports that among 913 NGOs active in health sector 59 are international, 62 are national and 792 are local. Most of the international NGOs work through their local partners - it might be local NGOs or government/local government organization. While only some of the international NGOs like CARE, Marie Stopes, Concern Bangladesh have their own branches at best at the district level with their head offices in the capital city, most, if not all, of national NGOs have established own branches in rural areas and built strong organizational network from village level to the head quarter in the capital. Among many national NGOs, Bangladesh Rural Advancement Committee (BRAC) - the largest national non-governmental organization, Ganoshstha Kendra (GK) and Grameen Bank are few to name that has a significant share in the health sector. In general, local NGOs work within a smaller geographical area, for example, Uttaron works in Satkhira and Khulna districts whereas Banchte Sheka works only in Jessore district. Scope of function and local NGOs usually limited to

preventive services and their size of the workforce varies from 10 to 100 or more. On the other, national and international NGOs have strong organizations and management capacity and they do provide both preventive and curative health care. All of the national NGOs are funded by international donor agencies; in contrast, many local organizations run on their own. In recent years NGOs have been a very important medium for channeling foreign aid inflow to the country. In fact, donors have increasingly been interested to provide their aid through NGOs in recent years. One estimate shows that in 1972/73 the proportion of total foreign aid to Bangladesh disbursed through NGOs was about only 1% while in 1980s it was increased to about 16.39% (Aminuzzaman 1998). The number of NGOs receiving foreign funds is also increasing. The total number of foreign fund receiving NGOs increased from 494 in 1990 to 1245 in 1998 (Begum 2003).

The involvement of NGOs in the health sector is very wide and diverse. In effect, they have found ‘an important niche for themselves in the provision of local health services’ (Perry 2000:57). This is so because of their expertise in respect of social mobilization, linkage and targeting the poor, skills and efficiency. In addition, there is general perception that they provide relatively high quality services at a reasonable price and they have been able to develop effective partnerships with local communities. In deed, these claims are not without being challenged; counter arguments are quite strong as well. However, the fact is NGOs are growing in terms of their program and area coverage, size and resources, and thus their political influence every year.

#### *3.2.4.4. The Informal sector*

The scenario of the health care sector of Bangladesh will remain incomplete if one does not pay adequate attention to the informal sector of service providers. The informal sector<sup>19</sup> includes allopathic practitioners with medical school graduation certificate and government registration, *palli chikitshok* (village doctors with a very short and basic training in health care), quacks (without any institutional training and government

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<sup>19</sup> The idea of ‘Informal sector’ is taken from Informal-sector theories of Economics. There are many versions since its first formulation in 1971. The concept is mainly used in Economics to explain poverty and inequality in the Third world, focusing on difference between large and small-scale enterprises in terms of their productivity and employment. Drawing on the basic, with regard to health sector, Informal sector refers to self-employed, one-person enterprises, traditional and domestic health care services. Thus, it includes local private practitioners, traditional healers, and pharmacists and so on.

license). The sector also includes *kabiraj* (traditional healers), *hekim* (doctors trained in unani system of medication), local pharmacist (most of them are without any formal training in pharmacy, vendor of the drugstore) and homeopaths. One study shows that the local non-credentialed private practitioners are the most common source of first contact care in Bangladesh (USAID 1995). Claquin estimated in 1981 that there was approximately one self-employed private health care practitioners per 1000 population in the rural Bangladesh (Claquin 1981). There is no recent study to reflect on the present situation, however, it is very likely that the situation has been continuing, more or less, in similar fashion. Thus, if I take this estimate, the number of private health care practitioners comes around 220,000. There are many subgroups within this group; the quacks- those who use allopathic drugs including antibiotics without having any license- is the largest among all private health care provider groups of the country. They constitute 38% while the homeopaths 24% and Medical school graduates only 3% of the total rural private health care providers (Perry 2000). Other practitioners include traditional birth attendants, ayurvedic and unani practitioners and spiritual healers. Moreover, Bangladesh has an extensive array of local shops and pharmacies where drugs and other health related products are sold. According to some sources, there are about 85,000 retail drug shops around the country (Mookherji et al. 1996). The important feature that makes these drug outlets different from that of other countries is these shops not only sell drugs or health-products but also provide health advices and treatments. Many physicians used these pharmacies as their service center. These drug outlets serve also as the main source of family planning products. One should keep in mind that almost all drugs are sellable over the counter. Therefore, these shops act as both the physician's practicing office and retail outlet for drugs, family planning and health-products simultaneously.

### 3.3. CONCLUSION

To sum up the discussion on the socio-economic and institutional context and organizational structure of the health care sector of Bangladesh, it could be argued that following important points came up:

1. The health care sector functions within a broader context in which social, economic

and political changes causes the changes in the health care service structure as well. The trajectories of the political history indicates changes in the nation's vision, goals and development policy and in response to that the health policy has also changed from time to time.

2. The establishment of modern health care service structure made by the colonial rulers, however, the conversion of the pre-colonial health care structure into 'modern' health care structure was driven by the political purpose of the colonial governments. However, the indigenous conception of health and health care system was politically defeated by the colonial governmentality and thereby a 'scientific' allopathic system of health care imposed, patronized and eventually established. Every invasion causes conflict in health care system and new actors emerged with state/ruler's patronage.

3. The postcolonial state structure gave rise of civil and military bureaucracy to determine the goal of all government policy so did happen to health care. Therefore, the early health care structure was devoted to serve only the urban elites. In independent Bangladesh, the emerging middle class petty bourgeoisie tried to expand health services to their rural constituencies, however, due to change in regime and inner contradiction of the ruling elites that initiative did not succeed.

4. The changes in the political economy caused emergence of new actors such as business communities, NGOs and media in policy arena. Besides, some new intermediate groups such as professional organizations, students union and trade earned significant political power.

5. Due to the long dependence on foreign-aid a coalition of actors formed around the aid-regime based on patron-client relation at the policy level in Bangladesh who holds significant political power to determine policy outcome.

6. Government is the largest single actor in health care sector with its regulatory authority and country wide service network; however, there is conflict between two rivals - health and family planning wings- within the health ministry that influence government's selection of policy options.

7. Private sector is growing and increasingly become influential. However, the informal

sector is shrinking. Similarly, power, influence and market of the traditional non-allopathic providers are also decreasing. On the contrary, local and international big capital is being invested in the health care sector, but poor are excluded from this expanding market.

8. NGOs hold a strong position in the total health sector. They are growing in number and resources every year. These actors with donor's confidence and their own operational advantages became influential in the health policy arena.

It is clear that the health policy arena has become much more complex than before. Groups from within the government, private business communities, donors, NGOs, professional organizations, civil and military bureaucracy are now the key set of players in the health sector. Nonetheless, their behavior has not been entirely controlled but limited by the over arching framework of the law and constitution. I argue, contextual factors can tell us only who are the possible key actors, how they became powerful and what is their source of power, on the other hand institutions like constitution, rules of business and laws provides the boundary for their action but can not explain particular action of a particular actor. In this regard, new institutionalism can provide insight, which suggests individual action is the outcome of his/her rational calculation of strategies. However, one's strategic selection of preference is very often determined by her/his position in power relation, "image of the problem", and interest and role perception (Kingdon 1984; Baumgartner and Jones, 1991). With regard to the health reform policy in Bangladesh, we need to examine how these factors were played out in ground.

## **CHAPTER 4**

### **REFORMS IN PRIMARY HEALTH CARE SERVICE DELIVERY: FACTORS, ACTORS, INTERESTS AND INSTITUTIONS**

Primary health care has been a central focus of health planning and resource allocation for last two decades in Bangladesh. In the previous chapter I have shown how primary health care becomes the focus of the government health policy since launching the HFA 2000 in 1980s. In recent years, on an average 65% of total government annual health expenditure is being devoted to primary health care. However, the irony is that urban primary health care has always been neglected. No significant initiative was taken until 1998. In fact, there have not been any government or private programs aimed specifically at the primary health care needs of the urban poor. In response to this situation The Government of Bangladesh through the Ministry of Local Government, Rural Development and Cooperatives (MOLGRD&C) initiated the primary health care reform program- Urban Primary Health Care Project. The reform initiative got into agenda in 1997, however, finally got approved in 1998. The main change of the reform was to contracting out of primary health care service provision to NGOs. The Asian Development Bank (Loan), Government of Bangladesh, UNFPA and Nordic Development fund (NDF) jointly financed the project. This five-year long US\$60 million project attempted to develop basic primary health care services for 9.5 million urban poor populations living in four city corporations (Dhaka, Chittagong, Khulna and Rajshahi), representing 41 percent of total urban population in Bangladesh (ADB 1998).

This chapter exposes the political nature of the reform in primary health care sector. The main purpose of this chapter is to analyze and understand the political dimension of health policy reform. In doing so, it discusses the policy making process, content and process of implementation in Bangladesh. It discusses what is been changed, how reform policy were formulated, who were the key players, what were their power-bases, who implemented it and how it is implemented, what was the interests of the key players in both formulation and implementation level. This chapter is divided into two parts. In the first part I will focus on the policy formulation phase and the second chapter will analyze the implementation process. And, finally a synthesis of these two phases is presented.

#### 4.1. PUBLIC POLICY MAKING PROCESS IN BANGLADESH

The said reform program- The Urban Primary Health Care Project, or other development related public policies are made within the framework of Annual Development Program of the government of Bangladesh. In fact, government's all development investment plans come through the Annual development Plan. Thus it can be said that the ADP formulation process is the policy formulation process for the government of Bangladesh. The UPHCP had been formulated through the ADP process. Thus in the following I shall briefly describe the ADP formulation process.

The process of formulation of public policies in Bangladesh involves two broad stages: agenda formation and policy framework formation.

The agenda formation stage involves identification of the policy problems, ideas and issues and place them on the agenda of the government. Osman (2004) observes that policy ideas and issues are originated from external and internal sources. Regarding health sector in general, it is seen that most of the policy ideas come from the global actors like WHO, WB, UNIFPA and so on. With reference to the UPHCP the technical ideas were originated from ADB, WHO and UNFPA sources (Interview with former DPD of UPHCP). However, internal sources like DGHS, DGFP were also involved in agenda formulation stage as the MOLGRD&C formally asked opinions from these government agencies before finalizing the policy framework. Indeed, the most active actor at this level was the lead initiator of the reform - MOLGRD&C, particularly the Local Government Division. However, former CHO of DCC also reported that he took part two consultation meeting with the LGD in early phase of the project.

Policy framework formulation stage is very important part of the entire policy process. This is the stage where appropriate alternatives are chosen from a set of available alternatives in order to deal with the policy problems. This is the decision making stage.

Bangladesh Planning Commission is the central planning agency for the government which responsible for development of the policy framework. The commission initially receives a set of objectives and guidelines for preparing sector specific plan from the

National Economic Council (NEC)<sup>20</sup>. The Planning Commission then circulates the guidelines among the line ministries. Every ministry has a Planning Cell (PC) which prepares the development plan for the respective ministry. With the approval of the concern minister the DPC send the plan to the Planning Commission again.

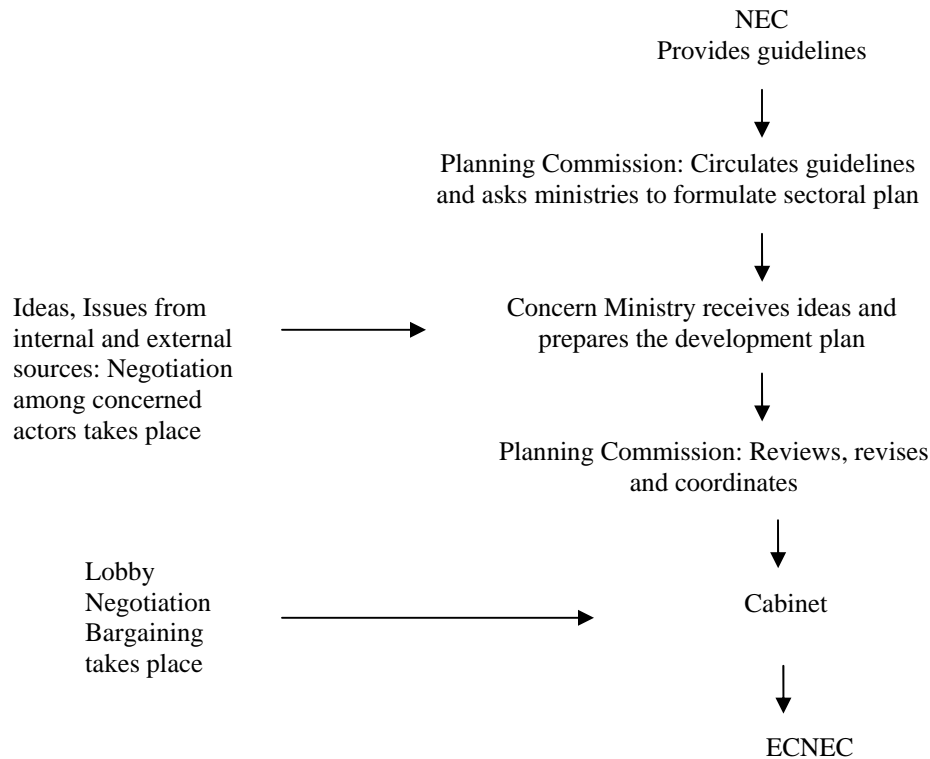


Figure 4.1: Policy formulation process in Bangladesh  
Adopted from Osman 2004

The Planning Commission then reviews, revises and coordinates the plan with national plan and other sectoral plans. After being prepared by the Planning Commission, the plan has to be placed to the approval of the Cabinet. And then Cabinet sends the specific plan

<sup>20</sup> National Economic Council (NEC) is the highest political authority for taking decisions regarding any kind of development investment reflective of long-term national policies and objectives. The NEC consists of all members of the Cabinet and is chaired by the head of the government, i.e the Prime Minister. The NEC meets as and when required, The most common functions of the NEC are to provide guidance at the stage of the formulation of Five Year Plans, ADP including all national economic policies; finalize and approve plans, program and policies; review progress of implementation of development programs.



or project to the Executive Committee of National Economic Council<sup>21</sup>. The entire policy framework process is depicted in the Figure 4.1.

It is clear that the policy formulation process in Bangladesh is linear, sequential. However, in practice it is not that simple. Particularly at the stage where the respective ministry prepares plans and projects for the ministry great deal of negotiation takes place. Although the Minister is the head of the ministry and a political actor, but he has little influence on the technical aspects of the plan because the planning cell is fully dominated by the bureaucrats and technical experts. Similarly final bargaining takes place in the cabinet. However, it is also evident that there are no formal institutions for allowing citizens or civil society members to give their opinion regarding the plan or policy. Even the members of parliament have no formal opportunity to take part in the policy process.

#### 4.2. HEALTH SECTOR REFORM: REVIEWING THE PAST

Before going into analyzing the primary health care reform program, I would like to give an overview of the past initiatives in order to establish the linkage between the present to past so that one can understand the entire process better.

In Bangladesh, health reform is not very new; it has been carried out at different point of history with different objectives and strategies by different government. I have already discussed the historical development of the health care system in Chapter 3 at length, thus, in this section I will only focus on specific attempts that were under taken to bring structural, behavioral and/or institutional changes in the health care system after independence. With regard to the history of development of health system in and political economy of Bangladesh 1990 is a landmark year. Therefore, the review of the past reform efforts is divided into two broad parts: reform before 1990 and reform in 1990.

##### 4.2.1. Reform before 1990s

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<sup>21</sup> The Prime Minister is the chairperson and the Finance Minister is the alternate chairperson of the ECNEC. The members include Ministers for Local Government and Rural Development and Cooperatives, Education, Food, Water Resources, Industries, Commerce, Post and Telecommunications, Agriculture, Science and Technology. The relevant ministers whose subjects are taken up are also members. The cabinet secretary, principal secretary of Prime Minister's office, secretary of External Resources Division, secretary Planning, secretary of Implementation, Monitoring and Evaluation Division, Governor of Bangladesh Bank, the relevant members of the Planning Commission and secretaries are required to assist ECNEC. This is the highest body of making decisions regarding development plan, program and project. It also monitors of implementation of such projects.

Bangladesh inherited a colonial regime introduced health care system that was biased to urban population and curative care. There were little efforts to expand health care from urban centers to country side during Pakistan-days. However, during Pakistani regime, in the late 1960s government introduce Thana Health Complexes and the Union Health Centers with components of primary health care services (Akther 2004). During the same time, government introduced family planning program and integrated a privately run population program with government health care facilities (Ahsan and Thwin 1998); yet, it was integrated at the field level but the central administration of the program was under control of an autonomous board. This separate structure continued for the entire 1970s. After independence, Government took some attempts to integrate government's family planning services with health services in 1974; however, the attempt was abandoned shortly. In 1975, government established Directorate of Population Control and Family Planning by merging some autonomous organizations such as National population Board, National Post-partum Program. This reform in the service delivery system produced transfer of maternal and childcare services from the Health Services to the Division of Population Control and Family Planning. Government also forms a high power overseeing authority, namely National Population Council, involving multi-sectoral agencies including Health Division (Khan 1988: 26). During 1980s, nothing much was done in the health sector. Government took some *ad hoc* measures, implemented some pilot projects from time to time, but no nation-wide program was on the board. However, as part of administrative decentralization policy of the government, the health and population services at the upazila level were made integrated, which was called as 'functional integration' in 1984, since the administrative decentralization policy was aborted after some years - the health sector also went away. Actually, there were no substantive health sector reform efforts until very recently.

#### **4.2.2. Reform in 1990s: Adoption of Neoliberal Principles**

The 1990s is the most vibrant era in the history of health sector development in Bangladesh. Commenting on this phase of reform in Bangladesh, some observers rightly noticed: "the most far-reaching health and population sector reforms in the post-colonial era" (Shiffman and Wu. 2004).

Bangladesh introduced the Health and Population Sector Program (henceforth HPSP) - a nationwide, five-year (1998-2005) health sector reform program, with an approximately US\$ 3 billion budget, following its first Health and Population Sector Strategy (henceforth HPSS). The overall goal of the HPSP was to ensure universal access to essential health care services of acceptable quality in order to reduce infant, maternal mortality and morbidity rate; improve the nutritional status and reductions in fertility rate. Under this program, a range of policy and organizational changes were proposed. The reform was designed on basis the principles of Sector Wide Approach<sup>22</sup>.

This thesis deals with reform in urban primary health sector which was initiated under the banner of Urban Primary Health Care Project (henceforth UPHCP) during the same period as HPSP. The UPHCP is closely linked with the inception of HPSP; in fact, it is very difficult to understand the former without having an idea of the later. Thus in this section I shall present in very short review of HPSP.

#### *4.2.2.1. Context, Factors and Actors*

In the face of donor's threat for stop funding (65% of annual development budget for health is dependent on external aid), lack of coordination in aid utilization, failure of existing project funding mechanism, low effectiveness in project implementation and, above all else, the change in the regime contributed together to prepare the stage for a fundamental reform in the health care system in Bangladesh during 1996-97 (Buse and Gwin 1998; Buse and Walt 1997; Schiffman and Wu 2004); MOHFW 1998a). All these factors led government with active involvement of donor community, particularly the World Bank, to device the reform policy, named Health and Population Sector Strategy, in 1997 and the implementation of this policy is the Health and Population Sector Program.

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<sup>22</sup> Sector Wide Approach (SWAP) has been popular among donors since early nineties as a strategy to increase aid effectiveness by establishing better coordination in a aid-dependent context where numerous projects, sponsored by different donors with their particular agendas and funding process, are implemented with little coordination and coherence. The main objective of the SWAP is to improve the overall performance of a social sector (e.g. education, health) in a country. It often includes sectoral reforms and coordinates resources from various local and global sources. In principle, the SWAP encourages ownership of the national government. Researchers, however, showed that, in effect, SWAP provides the donors with more control over the national government's resource allocation process (Buse 1999; Buse and Walt 1997).

With respect to HPSP, the government and the international donor community are the two key players who controlled policy and program formulation. However, neither the government nor the donor community represents a single unified body of actors. There are several groups within both the government and the donor community. Within the government of Bangladesh, the Ministry of Health and Family Welfare, is the main player in the whole reform process as it is the apex government organization to regulate, control and finance health care system in Bangladesh. The ministry is headed by two political leaders - the minister and the state minister, however, the permanent bureaucrats of the ministry perform main role in policy formulation. Also, within the ministry, there are two implementing agencies: Health and Population wing. The health wing supported the reform but the population did not as they stood to lose power over project and commodity aid for the family planning services. Besides the MOHFW, there were other government agencies who were also involved in the reform many of whom resisted the policy particularly some senior level bureaucrats the Planning Commission. Because, they thought 'it would transfer all the power to negotiate the program with the donors from themselves to the MOHFW' (Jahan 2003: 184).

Besides donors and state actors, there were several social groups also influenced the HPSS. For example, Bangladesh Medical Association<sup>23</sup> and Bangladesh Civil Service (Health) Association<sup>24</sup> - the two key professional's organization played important role in design and implementation of the HPSS. Moreover, civil society organizations were also provided with opportunity to have their say in the policy process. NGOs like BRAC, Nijera Kori, Mohila Parishad, Nari Pokkho, and VHSS, participated in the consultation process with government. Indeed, there was opposition as well among the civil society organizations, for example, UBINIG a local NGO criticized government's approach to the health reform and mobilized opposition, however, failed to make any impact (Akther 2002, 2004).

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<sup>23</sup> Bangladesh Medical Association is the national association of the physicians in Bangladesh. At present, it has 32,000 members. BMA has 67 district chapters working all over the country. It has been established mainly to look after the interests of the physicians as well as the interests of the medical professional community in general. The organization holds regular election and an elected body of 41-member Central Executive Committee runs the association (BMA 2006).

<sup>24</sup> This is the organization of doctors who are employed in the government health services.

#### *4.2.2.2. Content of the reform*

The reform program was designed on the basis of following principles which was outlined by the donors and GOB together in a meeting held in Paris in September, 1995 (GOB 1995 cited in Jahan 2003; Barkat et al. cited in Schiffman and Wu 2003):

- Financial sustainability
- A shift from project-based planning
- A shift from project-based planning to sector-wide planning, management and financing;
- A shift from vertical to integrated service delivery through unification of health and family planning services under a single management structure;
- A shift from bureaucratic/technocratic to participatory planning through involvement of communities and stakeholders in policy and program formulation, implementation and monitoring;
- A shift from centralized planning and management towards decentralization;
- A shift from the public sector being the primary provider to partnership with private and NGO sectors;
- Maintaining a basic services package in the public sector and addressing the health needs of vulnerable groups;
- A shift from separate women's projects in which gender equity was addressed, to a gender-mainstreaming approach

Using these principles as the frame of reference, the Government of Bangladesh outlined the plan of action for HPSP in 1996-97, which went to implementation in 1998. The HPSP included: unification of the health and family planning directorates-general; decentralization of power from the top to the lowest levels; the phasing out of a project-based system in health planning and the creation of a sector-wide approach; a re-orientation of the health and family planning systems toward client service; the ongoing pooling of funding among donors; the mainstreaming of gender into health planning; and the adoption of an Essential Service Package of health services for the poor (MOHFW 1998; Schiffman and Wu 2003).

In order to implement the plan of action the GOB set the main goal of HPSP as to achieve

reduction in: maternal mortality rate, infant mortality rate mortality for children under 5, communicable diseases and unwanted fertility and total fertility rate through client-centered provision and utilization of the Essential Services Packages plus selected services. HPSP also aimed to achieve improvement in life expectancy for females and males, the age of birth of the first child, nutritional status of child and mother and healthy life style (MOHFW 2004). With respect to service delivery system, the main thrust of HPSP was placed upon the Essential Service Package (ESP).

In addition to the main goals and output, HPSP proposed several innovative landmark activities:

- Establishment of Community Clinics (one for every 6000 thousand people)
- Provision of Comprehensive Obstetric Cares
- Provision of STD/HIV/AIDS care and counseling services at all level of care
- Ensuring the accountability process through performance evaluation of health care providers
- Improvement in accounting and financing for the sector

Review of the content of the reform proposal shows that HPSP recommended several fundamental changes in management and delivery of health services in Bangladesh. However, we know a good proposal is not enough to implement it through. Implementation of reform is a complex, dynamic and political process, which deserves to be subject of a separate study in its own right. In the next section, we shall take short look at the implementation phase of HPSP in Bangladesh.

#### *4.2.2.3. Implementation of HPSP: 1998–2003*

The reformers were able to manage full political commitment from the highest level of the government by 1998; however, it was a big challenge to materialize the commitment into specific administrative decisions and actions. As I mentioned earlier that heavy bureaucratic resistance was expected, mainly from the senior civil servants within the ministry who felt threatened to loose their power from the new system. Government took several initiatives to manage the whole reform process, for example, two new units were created, the Program Coordination Cell (PCC) and the Management Change Unit (MCU). These two small units acted as the hub for the whole transformation process and were

resourced with high-profile reform minded government officials. Schiffman and Wu (2003) observed, “the two units evolved into bodies fully beholden neither to donors nor to the Ministry, wielding considerable power over the reform process.” Because of the work of the MCU and PCC, having been supported continuously by the donor community and pro-reform elements within the Ministry itself, the implementation of HPSP advanced considerably over the period 1998–2001.

Performance monitoring reports showed that government and donors were happy with the way reform preceded for the first three years of HPSP. Significant progress was made in the area of unification of the health and population service structure; the devolution of authority to line directors within the Ministry, the establishment of a sector-wide planning process to replace the previous, fragmented approach. Reviews also noticed that challenges existed, but that most of the reforms were moving forward (APR report, 1999, 2000, 2001).

Despite significant attainment in implementation of HPSP, the program was almost abandoned after the change of the regime in October 2001. The new leadership made a reassessment of the contribution of HPSP and revealed that there were many limitations in design and implementation of HPSP (MOHFW 2004: 16; MOHFW 2005: 4), therefore, they decided to design a new program.

#### *4.2.2.4. Political Analysis of the Rise and Fall of HPSP*

Analysis of HPSP reveals the very political nature of the health reform policy process in Bangladesh. As we can see there was no shortage of financial resources, no strong opposition from the main interest groups and the reformers enjoyed support from the highest level of the government, even though the policy was abandoned when the regime changed. But interesting to see that there was no ideological difference between the previous and new government. So the question is why the reform was abandoned. Two complementary explanations can be offered focusing on two variables: political culture, resistance from the civil service. According to the political culture of Bangladesh it is very normal that one new government throws away government policy decisions taken by previous government. Researchers observe that the culture of intolerance permeates every level of the polity, which holds the nation hostage to confrontational style of

politics and gradually making the democratic process unworkable (Sobhan 2004; Islam 2003). Davis and McGregor (2000: 56) notes that this confrontational political culture has its roots in the patron-client relation where ‘the state is seen to organize the delivery of development resources so as to act as the patron of last resort, thus securing micro-level patron-client relations’. I argue while the state becomes ‘patron state’, the ruling elites used it as the ultimate source of their patronage. Thus, when a new party comes into government power it shuffles, cancels or changes previous government’s policies and programs so that it can distribute state resources to its own clients.

Bureaucratic resistance from within the MOHFW is another explanation. Mr. Abedeen (pseudo name), retired Additional Secretary of the MOHFW, commented, “the change in reform policy was a political decision. By changing the program component, the new leadership bowed down to the elements of civil service whose vested interest would have been lost due to unification and budget reform.” (Source: Field Interview of Key Informants, conducted in 2005). Although the HPSP could not survive regime change, but one of its envisaged goals - improvement of the primary health care of urban areas- was taken up by another set of actors in different style for implementation which come into implementation as a program, namely Urban Primary Health Care Project in 1998.

#### 4.3. REFORM IN URBAN PRIMARY HEALTH CARE SECTOR

Urban Primary Health Care Project is the largest and fundamental reform initiative particularly targeting the health of urban population in Bangladesh since ever its inception. In this part, I shall answer mainly two questions: why the reform policy was taken and how it is implemented. The answer of the first question includes the context (through which the image of the problem is constructed), factors, key actors and their interests and their power-base. And, the second question is addressed by informing the process of implementation.

##### 4.3.1. Context of the Reform

The reform in the urban primary health care sector took place in a context where the urban population of Bangladesh are growing rapidly. In 2001, 23 percent of the total population of Bangladesh was urban; by 2010, the urban population is expected to account for 33 percent of the total population, growing annually at a rate of 5.8% (Perry



2000).

The health status of the urban poor is worse than the rural poor, because they are particularly affected by environmental hazards, such as crowding, inadequate sanitation and solid waste disposal, exposure to industrial wastes, accidents and violence. As a result, rates of child mortality among urban slum dwellers have been consistently higher than among the rural population as a whole. The Infant Mortality Rates are 110, 87 and 180 per 1000 live births among national, urban and urban poor respectively (UNICEF 2001). But there was no health care program specifically aimed this urban poor.

Traditionally the health care in urban area is provided from three sources: government, NGO and private. However the mandate for providing primary health care in urban areas is vested on respective city councils. But the city councils, namely, City Corporation for metropolitan cities, did not have adequate health care facilities. For example, while there is 1 Union Health and Family Welfare Centre for 20,000 rural populations, in urban areas there is 1 dispensary for every 132, 000 people. Of course, there are tertiary level hospitals and private clinics to provide primary health care in the urban area, but access of poor to those facilities are very limited, if not entirely denied.

It is quite clear from the above situation-analysis that there was undeniable need for an elaborated and pro-poor health care service provision for urban areas; however, we know, with respect to public policy, mere need is not enough to drive actors making decision. There were several other factors for which helped ripening the context.

#### **4.3.2. Key Factors of the Reform**

##### *4.3.2.1. Inadequate capacity of city corporation*

Urban health services are the responsibility of the respective city councils. The Municipal Administration Ordinance of 1960, The Pourashava Ordinance of 1977 and the City Corporation Ordinance of 1983 clearly assigned the responsibility to provide preventive and limited curative care for the citizens to the city corporations and municipalities (MOHFW 2004). However, it does not have the adequate capacity to perform the assignment. For example, Dhaka City Corporation, it had only 3 maternity centres and 17 dispensaries for its total around 4 million poor populations; for Chittagong, the numbers

of dispensaries is 19. The City Corporations have been disabled for not only poor physical infrastructure but also manpower. City corporations are lacked of capacity to plan, finance, budget and supervise primary health care services (ADB 1998). Therefore, in order to overcome the infrastructural inadequacy and lack of technical capacities, inception of a new program was inevitable.

#### *4.3.2.2. The political context*

The political context - the leadership, political will and relative autonomy of the regime - is a crucial factor for any kind of reform, so to health sector. The World Bank on how to reform health system in developing countries recognized: "...broad reforms in the health sector are possible when there is sufficient political will..." (World Bank 1993: 15). In 1996, Bangladesh Awami League -one of the major political party- assumed power and formed government after 20 years. The new government was in dire need to create a visible difference in the area of public services to consolidate its support-base among the urban constituencies<sup>25</sup>. Health sector is an arena where, on the one hand government can reach the people quickly, on the other it helps to distribute patronage to a strong professional group among the urban middle class who are directly related with health sector; thus any change in the health system would likely to have visible impact. Moreover, during the election campaign in 1996, Bangladesh Awami League promised in its election manifesto:

"...to build up health complexes and modern hospitals at union and thana and city levels respectively will be completed. Low-cost modern health care facilities will be extended to the poor and destitute..." (BAL 1996)

Moreover, any development project, which involves infrastructural construction, employment of new workforce and other supply-contracts, is very attractive for the ruling party in a context where patron-client relationship is the central mode of transactions in both public and private sphere (Kochanek 1996). Therefore, a great deal of enthusiasm and interests motivated the government actors to initiate a project like UPHCP.

#### *4.3.2.3. Influence of International Regime*

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<sup>25</sup> Urban areas are more attractive to political parties for their relatively higher proximity to media than country side.

It is now well accepted that because of the process of globalization health has increasingly become a global issue (Kohlmorgen 2006). Like other policy areas, health reform policy in Bangladesh is highly influenced by contemporary international regimes. Schiffman and Wu (2004) noticed association between World Bank's agendas, such as Essential Services Package, private sector involvement in service delivery, and reform proposal in Bangladesh. Not only the World Bank, many other international organizations like WHO, UNFPA, USAID also shaped poor countries health policy preferences (Buse and Gwin 1998; Buse and Walt, 1997; Schiffman and Wu 2004). The Bank and WHO not only provides health knowledge but also influence the debate over the standard of the health system. This health and health system related global discourse also influenced the key decision makers in Bangladesh. Moreover, the gender advocates - researchers, NGOs and other activists being persuaded by the ICPD 1994 and Beijing 1995 conferences, advocated to the government for comprehensive sexual and reproductive health care services for the increasing urban population, particularly for the vulnerable groups (Jahan 2003: 185; Schiffman and Wu: 2004: 1551). As a result of influence of women activist's advocacies the reform policy included a special component 'services against violence against women' in the service package. What more, the World Bank promoted, New Public Management induced concepts like 'public-private partnership', 'contract out' were also find their way in the UPHCP.

#### *4.3.2.4. Influence of HPSP*

I have mentioned in the previous section that the HPSP and UPHCP were launched more or less in the same period. In fact both of them were under the grand strategy - HPSS. In HPSP government identified ESP as the main component for the primary health care services. But in urban areas, there were very few infrastructures and workforces to deliver ESP. Therefore a separate program was needed to be placed in the ground to deliver ESP for the urban poor.

#### *4.3.2.5. Influence of NGOs*

Prior to the UPHCP, there was another large project named Urban Family Health Partnership (UFHP), which was funded by USAID and managed through contracted NGOs. This project recorded reasonable success (Mitra and Associates & Measure

Evaluation 2003). The success in providing health care to the urban populations, work experience on the one hand, and the growing influence of the NGO sector in public policy making on the other gave NGOs strength to lobby for a larger project where they will have a stake.

#### *4.3.2.6. Rivalry between International Players*

It is well known that there has kind of rivalry existed among the international donors in terms of their struggle to influence public policy. The World Bank came to the fore as the leader of the donor community in relation with HPSP. ADB the regional leader also participated in the HPSP funding, but remained in low profile. On the other, USAID also ran its own program through NGO Service Delivery Program (NSDP). So it was important for ADB to have some program where it could assert its monopoly of dominance and show others that it is an 'ADB program'. Mr. Karim (pseudo name, he preferred not to be quoted by his original name), who worked as Social Infrastructure Consultant for the ADB during 1997-98, commented, "for ADB it was a prestige issue to find some project in the health sector where it can display its own dominance" (Key Informants interview, conducted in 2005 in Dhaka). The government proposal for UPHCP gave them the opportunity they were looking for.

In short, these factors are intertwined; and in combination they matured the context to design a program like UPHCP.

### **4.3.3. Key Actors, Interests and Power**

No reform program takes place in vacuum and/or overnight. It involves great deal of negotiation among various actors drawn from global, national and local context at various levels. In this section I will limit the discussion among the key players only. In this place, players or actors refer to the individuals, groups and organizations that have an interest in a policy and the potential to influence related decisions; the individuals and groups that could be affected - helped or hurt - by the reform (Reich 2002).

#### *4.3.3.1. Local Government Division, MOLGRD&C*

Regarding the UPHCP, the Local Government Division of the Ministry of Local Government, Rural Development and Cooperatives (henceforth MOLGRD&C) is the

most important player. According to the 'Rules of Business' of the government, health service is beyond the jurisdiction of MOLGRD&C (GOB 1997). Since the health service provision in urban areas is the responsibility of the local government bodies and local government bodies, including City Corporations, are regulated by and financed through the MOLGRD&C, they appeared as the key player in the urban health related policy arena. In fact, the UPHCP project is designed and prepared by the MOLGRD&C; therefore, the Local Government Division (LGD) of the MOLGRD&C is the formal executing agency of the project (GOB 2004a). There has been a long history of tag of war between the Ministry of Health and Family Welfare and Ministry (MOHFW) of Local Government, Rural Development and Cooperatives (MOLGRD&C). Traditionally it is the MOHFW who provides health care services, so they were totally against of the move, they did not wanted to let other ministry to do their job. There was serious bureaucratic resistance within the MOHFW to allow MOLGRD apply for this project. In fact, the bureaucratic resistance from the MOHFW kept the UPHCP for about two years in the shelf. In order to resolve this conflict, the government, through an ordinance, delegated the principal authority for health and family planning activities in urban areas to the MOLGRD&C in late 1996 (Perry 2000). Even until now, the relationship between these two ministries is not warm enough. Hence, in order to avoid further conflicts and foster cooperation and better understanding among the primary health care providers in the urban areas, government established Primary Health Care/EPI Coordination Committees through out the county down to upazila level under the supervision of a national level inter-ministerial committee (Hossain et al. 1999; Uddin et al. 1998).

With regard to interest and power, indeed there involves great deal of material and non-material resources in the project which is a key motivation for the bureaucrats and political leaders. As I discussed previously, the patron-client relation is the main mode of transaction, therefore the distribution of state resources among own client is the main interests. One thing I should mention at this level that, in Bangladesh the MOLGrd&C is the largest government ministry and traditionally the Secretary General (regarded as the second most important person in the party hierarchy, next to the party president) of the party in power (does not matter which party is in power) is given the charge of the Ministry. It can be argued that in order to keep running all the channels of patronage

distribution among the party cadres it is necessary to have as many as resource-sources open for the party leaders. Any kind of development project is primarily regarded as the source of resources in Bangladesh (Sobhan 1982). Thus the interests of the political leaders are very clear. Secondly, the bureaucrats also reproduce the same patron-client relation within their jurisdiction. For example, in the PIU office in Dhaka, among 27 personnel 5 have found keens in the LGD secretariat. What it implies is that the bureaucrats are also involved in nepotism.

The LGD has the ultimate say in the project. It has the regulatory power, decision making power and at the same time material power to implement its decision.

#### *4.3.3.2. Donors (ADB, NDF and UNFPA)*

In general, donors were the main players of the health sector reform in Bangladesh. In fact, donors have been involved in the health and population sector since mid seventies. Buse identified, there were 18 bilateral and multilateral donors in the health and population sector in Bangladesh during 1992-96 (Buse 1999). The donors were organized in a consortium led by the World Bank; however, not all the members equally participated in UPHCP.

The ADB is the main financier in UPHCP. Bank committed to give, at the first phase US\$40 million, which is 67% of total project cost, as loan at a rate of 1% per annum (ADB 1998: 8). The project proposal that were submitted by the Government of Bangladesh matched with several objectives of the ADB. It covers primarily the women in development sector of ADB. The project also covers poverty reduction and social infrastructure sector of the Bank. The resident mission of the Bank in Dhaka was interested to sell the loan to the GOB so that it can have a long relation with government. The other major donors, like NDF (Nordic Development Fund<sup>26</sup>), were new in the urban sector. They were interested to fund because of the project objectives, such as women and child health, which were in compliance with the objectives of their own organizations. NDF initially committed to provide US\$ 3.5 million as grant. The UPHCP was the

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<sup>26</sup> Nordic Development Fund was established in 1989 by five Nordic countries - Denmark, Finland, Iceland, Norway and Sweden with the aim of promoting economic and social development in developing countries. The Nordic countries provide regular contributions to replenish the fund. The member states appoint the members of NDF's board of directors and control committee (SIDA 2006).

biggest funding from NDF to Bangladesh since its inception. UNFPA has a large stake in the project, thus the appeared as a key actor in the whole project negotiation. UNFPA was interested because of the reproductive health care component of the Project. The UNFPA is committed to support women and child rights particularly their health rights and ensuring quality reproductive health care globally.

The ADB has material power as it controls the largest part of the funding. At the same time it retained some decision making power, such as recruitment of international and national consultants, procurement firms. In addition, it has also some discursive power as it produces guideline for best practices in procurement and so on. The NDF has both material and decision making power. However, the UNFPA has discursive power as it is seen as the authority in reproductive and population health. It also has some decision making power and quite significant amount of material power.

#### *4.3.3.3. Ministry of Health and Family Welfare*

Although the MOHFW lost the battle with the MOLGRD&C regarding the control over UPHCP, still posses a big stake in the project. The UPHCP project delivers ESP services, in which immunization and family planning services are two key components and supply of these two services i.e. vaccines and contraceptives are to be collected from the Directorate of Extended Program of Immunization and Directorate General of Family Planning - both of them are subordinate agencies under the MOHFW (Uddin et al. 1998). Therefore, the project remains largely dependent on the cooperation from MOHFW. Moreover, according to the “Medical Practice and Private Clinics and Diagnostic Laboratories Ordinance 1982”, the DGHS is responsible for licensing and inspection of all private facilities before they start providing services (World Bank 2004). Therefore, all health care centers under UPHCP, no matter who operates, have to have license from the DGHS. So, due to the institutional advantage, MOHFW remains as an important actor in UPHCP policy domain.

Thus it is seen that the DGHS of MOHFW has legal and material power. DGHS is also member of project Coordination Committee; this means it has decision making power as well.

#### *4.3.3.4. Dhaka City Corporation*

With respect to UPHCP, Dhaka City Corporation is the ‘main implementing agency’ (ADB 1998; GOB 2004a). According to the Project Administration Manual (henceforth PAM), the Dhaka City Corporation is supposed to act as the key coordinating agency for the whole project. The Chief Health Officer of the Dhaka City Corporation (henceforth DCC) is the Chair of the Project Coordination Committee. Moreover, the Project Implementation Unit - the independent project implementation secretariat is located in the DCC premise. A good number of physicians and professional like accountants has joined in the project office from DCC health and other department. Traditionally, the Mayor of DCC is used to be a very influential political leader. During the project negotiation the Mayor was the president of Dhaka city branch of the ruling party of that time, which gave the DCC a comparative advantage over other actors in the policy domain.

The DCC has material power as it provided land for the project; nonmaterial power by which it mobilizes community people to donate land. It has also some degree of decision making power.

#### *4.3.3.5. Health Department of Dhaka City Corporation*

The Health Department of Dhaka City Corporation is an important actor. Health Department is one of the 17 departments of Dhaka City Corporation. The department is headed by the Chief Health Officer. The central health department is being reinforced at the zone<sup>27</sup> level by zonal health departments. Each zonal health department is headed by a medical doctor, designated Assistant Health Officer (AHO) who is responsible for planning, implementing and monitoring the primary healthcare services at the zone level (Khatun et al. 2000). However, the capacity - in terms of human and physical resources, of the city corporation to serve the huge urban population was inadequate. “The Health Department, along with the Mayor, made strong lobby to the Ministry during the project-planning phase to get a big stake in the project,” one Health Officer of the DCC said in

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<sup>27</sup> The entire Dhaka City Corporation area is divided into 10 administrative units, namely Zones. The zones are further divided into a number of wards; ward is the lowest administrative unit of the corporation. An elected Ward Commissioner represents a ward in the corporation. The average number of wards per zone is 9, and the average size of population per ward is 50,000 (range 40,000-60,000). Each Zone is headed by a Zonal Executive Officer (ZEO) who is responsible for the implementation of development projects and maintenance work in the zone.



the interview. The then Mayor (Mr. Mohammad Hanif) and the then Minister of the MOLGRD&C were close colleague and belonged to the same political party, Bangladesh Awami League for many years. Finally, they succeeded to ensure a major stake in the project. Project took 'building the capacity of the city corporation and their partners to plan, finance, budget, monitor and supervise urban PHC services' as one of its main objective (ADB 1998). In the management of the UPHCP, the CHO of the DCC were given the post of Coordinator of the national level Coordination Committee. However, a group of Health officers also resisted the move, as they were not sure what kind of role they will be given in the new project, but the resistance was negotiated by putting provisions to offer national and international level scholarship and training for the Health Department. However, discontents and silent conflict arose again.

The health department of DCC has some degree of decision making power.

#### *4.3.3.6. City Corporations*

City Corporations, particularly the four large city corporations appeared as the advocate for the project because the project entailed a huge resource-inflow to the respective cities through the corporation. For city corporations, each Mayor was appointed Chair of the Partnership Committee of respective city corporation. Mayor and other political officials of the corporation were very happy as the project provided them with an opportunity to show their constituencies the project as a success. The Chittagong City Corporation (henceforth CCC) was more active than others were, and lobbied for a special provision in the project so that the corporation itself can get a large part to implement itself. Being the member of the then ruling party, the Mayor of CCC managed to influence the project planner and got two contracts for the CCC without participating in competitive bidding.

The city corporations in general have low degree of decision making power.

#### *4.3.3.7. The Private Sector - profit and non-profit*

From the very beginning of the project, NGOs strongly supported the project idea. "It was known to the NGO community that the project is going to offer some special opportunity for the NGOs. NGOs were consulted during the project-planning phase several times, and the donors were also interested to involve NGOs in service delivery"

Mr. Zahidul Islam, an NGO project manager was explaining the NGOs position at the beginning. At the same time, NGOs impressive performance in the USAID funded Urban Family Health Partnership that ran for more than five years gave themselves confidence to put their demand on the board. Association of Development Agencies of Bangladesh (ADAB) - the apex umbrella organization of the majority NGOs and Health NGO Forum were consulted with the project planners. The ADAB also contacted through the political channel as well. Finally, project adopted a strategy, which is targeted to involve NGOs in the service delivery process. The project, forwarded the idea of Partnership Agreement (we will discuss it at length in next section) which is actually a strategy to source out the service delivery to the NGOs. Moreover, neither the government ministry nor city corporations were in a position to establish a service infrastructure in all urban areas, given the extremely bureaucratic nature of government decision making. Therefore, claims made by NGOs appeared legitimate and seemed appropriate solution to all parties.

On paper, the project was open for both profit and not-profit private sectors actors. However, there was no significant response among the private business sector was observed. Therefore, as such private business sector had not played any vital role in any phase of the project. The NGOs have material and non-material resources.

#### *4.3.3.8. Bangladesh Medical Association(BMA)*

Bangladesh Medical Association - the apex body of medical doctors of the country was not happy with the move of the project since the beginning. Dr. Zahid Hossain the present (2005) Secretary General of BMA said, “The UPHCP project is a half-hearted initiative of the government. It does not provide complete preventive care at the service centers. The project built many buildings but did waste the opportunity as it only provides limited services. At the end patient has to go to other government hospitals” (Interview, conducted in 2005). His comment reflects the general attitude of the doctor’s community to the project though a large numbers of them have been working under the project. In fact, “since the moment project slipped away from the jurisdiction of MOHFW to MOLGRD&C, a silent non-cooperation from the doctor’s community was observed” a Senior Assistant Secretary of the MOLGRD&C commented (Mr. Hasib Ahmed, Interview, conducted 2005). The BMA did not oppose the project formally and

openly but showed reluctance. However, they remained important for the project as it is for the health sector in general. The BMA has non-material power.

We know that the actor's behaviors are shaped by structural economic, social and political conditions. This means, actor's capabilities to exercise power is conditioned by his/her structural position (Kohlmorgen 2006: 4). Thus, summarizing the above narration on different actor's actions<sup>28</sup> and their sources of power in regard to the UPHCP I would like to present following actor-power matrix<sup>29</sup>:

Figure 4.2: Actor-power matrix

<b>Actors</b>	<b>Discursive power</b>	<b>Decision-making power</b>	<b>Legal power</b>	<b>Material power</b>	<b>Non-material power</b>
<i>Leader</i>	ADB	LGD, MOLGRD&C ADB	LGD, MOLGRD&C	LGD, MOLGRD&C ADB	
<i>Supporter</i>	UNFPA WHO	UNFPA NDF, DCC	Cabinet	UNFPA, NDF NGOs. DCC	WHO UNFPA, CC
<i>Resister</i>	NGOs	DGHS, MOHFW, Health Department			DGHS, MOHFW BMA NGOs

In summary of this section, it is worth saying that complex interactions among various government and non-government, political and social actors built the intertwined project environment upon which large part of project's components were selected. What is clear from the above matrix is that the policy is largely dominated by the government bureaucrats, donors and city level political leaders. NGOs emerged as the immediate beneficiary of the reform, however, there were only few NGOs who questioned the propositions of the reform, but since they were few in numbers and their resources base were not strong, failed to make their voice heard by the key players. What is more, the actor-matrix shows the involvement of political institutions such as cabinet, parliament and political parties were absent. Communities or the beneficiaries or researcher-

<sup>28</sup> Actions are categories into three broad types: leaders, supporters and resisters based on Bately and Larbi 2004

<sup>29</sup> Actor-power matrix is developed on the basis types of power proposed by Kohlmorgen (2006: 4) which suggest four types of power: discursive power (the ability to frame and influence discourses), decision making power (the ability to be involved in decision making in formal setting), legal power (the ability to exercise power on the basis of legal authority and law), resource based power (actors disposal over material e.g. money and non-material e.g. information resources). I, however, present material and non material resource-base power separately.

academics were also absent. This absent of social actors has been reflected in the proposal as it did not include any provision for ensuring community participation in the reform policy.

#### **4.3.4. Reform Content**

In the following section I shall concentrate on the subject matter of the reform policy. In other words, I discuss the officially stated objectives, scope/coverage, services, funding, organization and management of the Urban Primary Health Care Project (UPHCP) in the following section.

##### *4.3.4.1. Objectives*

According to the Project Administration Memorandum (ADB 1998), project's primary objective is to improve the health of the urban poor and reduce preventable mortality and morbidity, especially among women and children, by increasing access to PHC services. Another important objective of the project is to strengthen the capacity of local governments to manage, finance, plan, evaluate and coordinate health services.

In short, the primary objective of the project is increase the access of urban poor to primary health care services. In order to do so the project planned to construct 190 new primary health care centers near slums and other densely populated, low-income area, each of which is for a catchment area of approximately 50,000 persons (ADB 1998). In addition, to the health care centers, outreach services are provided at the temporary sub-centers in the general vicinity of the primary health care centers. The most important change that the UPHCP introduced in Bangladesh is - contracting out of the operation of these primary health care centers to NGOs. The UPHCP is one of the first in Asia in which government contracted out the primary health care services to NGOs (Perry 2000). The secondary objective of the project is to develop capacity of City Corporations in health service management. In order to do so, the UPHCP planned to develop a multidisciplinary PHC management team, which will be gradually absorbed with the City Corporations health department. In addition to this, numbers of trainings, workshops, fellowships have been offered to the City Corporation health department's officials.

#### *4.3.4.2. Services*

The UPHCP offers a package of primary health care services, which includes immunizations; micronutrient supplementation; family planning services; antenatal, obstetrical and postnatal care; case management of pneumonia and diarrhea in children; case management of reproductive tract infections and tuberculosis in adults; first aid and initial psychological support for women who have been victims of violence; and related health education. A closer look of the services offered by the UPHCP reveals that the project actually offering the same service package namely ESP - that is designed by the HPSP, to the urban population.

#### *4.3.4.3. Funding*

In the original plan, the UPHCP is estimated to cost US\$60.0 million equivalent including physical and price contingencies and service charges during implementation. The Asian Development Bank provided US\$40.0 million as loan, which is 67% of total project cost and comprises US\$13.0 million in foreign exchange and \$ 27.0 in local currency. The loan is repayable over 40 years with a grace period of 10 years and with a service charge at the rate 1 percent per annum. The Nordic Development Fund shared US\$ 3.5 million, which is 6% of total project cost, for medical equipment, contraceptives and essential drugs and consulting services for the partners. The UNFPA provided \$1.0 million grant assistance for contraceptives and health education materials. The Government of Bangladesh has provided 26% of the total project cost, which is \$15.5 million equivalent (ADB 1998: 8). This initial financing plan has changed twice as project duration extended in 2003 and 2004.

#### *4.3.4.4. Organization and Management*

The ADB approved Project Administration Manual (PAM) provided the layout of the organization and management structure of the UPHCP. Organization and management of the project is an important component of the project as it assembles the implementation process. The project is implemented through four separate but interconnected bodies of decision-making: The Project Steering Committee, Project Coordination Committee, Partnership Committee and Project Implementation Unit (Please find the organogram in the Annex 2).

**The Project Steering Committee:** This is the highest policy making body for the project. According to the PAM (ADB 1998), Local Government Division of the MOLGRD&C is responsible to form the Steering Committee drawing members from MOHFW, the NGO Affairs Bureau, Directorates of Women Affairs, planning Commission, Implementation and Monitoring Division, NGOs and each city corporations. The main task of the committee is entrusted with overall responsibility for overseeing and setting policies for the project. The Secretary of the Local Government Division heads the committee. The Steering Committee supposed to meet at least every six months.

**Coordination Committee:** The Coordination Committee consists of four chief health officers from involved city corporations, representatives from DGFW, DGHS, and LGD. The Project Director is the secretary of the committee. It should meet at least quarterly. The Chief Health Officer of the DCC is the Chair of the committee. The key responsibility of the coordination committee includes implementation of overall policies; review progress of the project and decide on solutions of the problems encountered; ensure close cooperation between the city corporations and government agencies such as MOHFW and oversee the day-to-day operations of the project.

**Partnership Committee:** Partnership Committee is the main coordinating body at the city corporation level. Within three months of project approval, each city corporation is supposed to establish a partnership committee. The main responsibility of the committee is to implement the project activities including the execution of the project. This committee is to ensure the transparency of the bidding process, determine the maximum level of user fee and mediate the disputes between parties of partnership agreement (contract awardees). The partnership committee is chaired by the Mayor and include Chief Health Officer, the Deputy Project Director, the Civil Surgeon, and representatives from organizations representing NGOs and other form of private sector groups. The committee meets at least quarterly.

**The Project implementation Unit:** The Project Implementation Unit (henceforth PIU) is the most crucial part of the whole organization and management structure of the project. In fact, PIU is the central organizational unit that manages the reform in the ground. PIU

regulates, monitors, and supervises all day-to-day activities related to reform implementation through partners and city corporations. A full time Project Director (PD), with four Deputy Project Directors (henceforth DPD), heads the office. The PIU is stationed at the premise of Dhaka City Corporation *Nagar Bhaban*. The PIU has four branches in four city corporation, each of them run by a DPD. The PIU consists of a small team of multidisciplinary work-force; in March 2005, there were all together 15 persons working in the PIU including the PD. According to the PAM, the principal responsibilities of the PIU are: procurement; disbursement and accounting; logistic management, monitoring and scheduling of project activities; organization of research activities, local trainings; oversight of benefit of monitoring; evaluation; development of programs for international fellowships and study tour; reporting and provide suggestions to the partners if necessary (ADB 1998). The Local Government Division will create the PIU with administrative order and recruit key personnel albeit with ADB approval.

The afore-mentioned organizational forums are to regulate, monitor or supervise implementation activities; but partners are the main organizations who deliver services to communities. Putting it differently, these partner organizations are the reform implementers. Thus, the real change in the service regimes took place at the bottom through partners, which will be discussed in the following section.

#### **4.3.5. Reform Implementation Process**

The UPHCP went into operation, officially, on 30<sup>th</sup> March 1998. But it took long to get into real operation. The former Deputy Project Director Dr. Jahangir said, “the main reason of delayed operation was delay in building health centers in all of four cities, particularly in Dhaka. We had great difficulties in acquiring land for building health centers” (Interview conducted in 2004). Nevertheless, the first phase of the project ended on 30<sup>th</sup> June 2003 and then got extension in two slots, first up to 31 December 2004 and then again extended up to 30<sup>th</sup> June 2005. Since 1<sup>st</sup> July 2005 the Project has been renamed as UPHCP -II and started another cycle 5-years life. The UPHCP-II has added another 2 city corporations and 6 *pourashava* in his working area. However, we shall not include the UPHCP-II in the scope of our study (MOLGRD&C 2005).

#### 4.3.5.1. *How Does Reform Works on the Ground*

The main strategy to implement reform in service delivery is to contract out to NGOs. Contracting out of public services to private sector often referred as NPM endorsed tools. The PAM (ADB 1998) named this contracting out as *Partnership Agreement*. The project envisioned to contract out delivery of primary health care services to NGOs, private for-profit sector groups or providers associations using Partnership Agreement based on competitive bidding. Each Partnership Agreement does correspond to a specific area in a city known as Partnership Agreement Area (henceforth PAA) consisting of approximately 500,000 populations, appointing an agency or a group of agencies as the partner to deliver services. The project initially decided to finance 16 Partnership Agreements - 10 in Dhaka, 3 in Chittagong, 2 in Khulna and 1 in Rajshahi (ADB 1998: 11). Two PAAs in Chittagong were left for the CCC to run the delivery system but with equipment and supplies provided under the project. Apart from the contracting out the delivery, the project also envisioned contracting out the monitoring and evaluation functions to an independent firm. Although in principle, the bidding was open for all private sector participants from home and abroad, but finally, 11 local NGOs or group of NGOs were awarded contract to deliver in 14 PAAs in four city corporation areas. Besides, one private firm was given the contract to carry out monitoring and evaluation function.

According to the project document, the Partnership Agreements (PA) approach offers many potential advantages including the following (MOLGRD&C 2005: 7):

- (a) The PA approach helps achieving tangible results where payment is linked directly to measurable accomplishments. Contractors who fail to meet certain standards of performance might have their contracts terminated.
- (b) The PA approach, using competition, helps to improve quality and promote efficiency. Contractors have a clear motivation to contain their costs, while under strict supervision is maintained to ensure quality and quantity of services as per the agreed standards;
- (c) The PA approach allows for greater flexibility in responding to new requirements and changing circumstances.



The project proforma made it very clear that the driving values behind introducing the contracting out approach (which is otherwise called PA approach) was *efficiency*. The other values such as equity, participation and empowerment was not the central-focus, came to complement the efficiency drive.

At present (April 2005) the UPHCP is providing 73 service components under 6 major elements of ESP to urban population through 120 City Health Centers (CHC) 17 City Maternity Centers (CMC) and 673 Satellite Clinics of 12 partners in four city corporation areas (UPHCP 2005).

#### 4.3.5.2. Types and Nature of the Partners

The UPHCP operates in 16 partnership agreement areas through its 13 partners including Chittagong City Corporation (CCC). Among the 13, all but CCC are NGOs. Specifically they are health NGOs, which means the focus of their work is to provide health services to their constituencies. Three NGOs - Bangladesh Women Health Coalition, Unity Through Population Services and Progoti Samaj Kollayan Prothishthan (PSKP)- run two partnership areas each (Table 4.1).

Table 4.1: List of UPHCP Partner Organizations

City	Partnership Area	Name of Partner Organization	Assigned working area (No. of wards in respective city corporation)	Type of Organization
Dhaka	PA 1	Bangladesh Women Health Coalition (BWHC)	82, 83, 86, 87, 88, 90	Health NGO
Dhaka	PA 2	Bangladesh Women Health Coalition (BWHC)	66, 67, 68, 69, 70, 71, 72, 73, 79	Health NGO
Dhaka	PA 3	Bangladesh Association for Prevention of Septic Abortion (BAPSA)	58,59,60, 63, 64, 65 and areas under Kamrangir Char ward 2, 3 & Nawab Char	Health NGO
Dhaka	PA 4a	Population Service and Training Center (PSTC)	28,29, 31,32,33, 34	Health NGO
	PA 4b	Shimantik	24, 25, 26 and 35	General NGO
Dhaka	PA 5	Naree Moitree	49, 52, 54, 55, 56, 57	Women Organization
Dhaka	PA 6	Marie Stopes Clinic Society	44, 45, 46, 47 and Basila area	Health NGO
Dhaka	PA 7	Unity Through Population Services	10, 11, 16, 41	Health NGO
Dhaka	PA 8	Progoti Samaj Kollayan	6, 7, 8	General

City	Partnership Area	Name of Partner Organization	Assigned working area (No. of wards in respective city corporation)	Type of Organization
		Prothishthan (PSKP)		NGO
Dhaka	PA 9	Unity Through Population Services	1, 19, 20, 21 and Bailjuri, Faydabad, Ashkona and Uttarkhan areas	Health NGO
Chittagong	PA 1	Chittagong City Corporation	1,2,4,5,6,7,8,9,17,21,25,26,30,31,34,35,36,37,38, 39,40,41	Local Government
Chittagong	PA 2	Mamata	3, 14, 22, 24	General NGO
Chittagong	PA 3	Chittagong City Corporation	11,12, 16, 18, 19, 20, 23, 27, 28, 32, 33	Local Govt.
Khulna	PA 1	Progoti Samaj Kollayan Prothishthan (PSKP)	7, 8, 9, 10, 11, 13, 14, 15	General NGO
Khulna	PA 2	Population Crisis Control & Mass Education Committee (PCC&MCE)	16, 17, 18, 21, 23, 25, 26	Health NGO
Rajshahi	PA 1	Ananya Samaj Kallayan Sangstha (ASKS)	1, 2, 3, 12,13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30	General NGO

Source: UPHCP 2004; UPHCP 2005

Among 11 Partner NGOs 6 are particularly specialized in providing health services while 4 general NGOs (the term general NGO refers the organization has various program components such as education, women empowerment, micro-credit etc., health is one of them; the organization does not largely depend on the health programs for its existence). Only one organization *Naree Moitree* is particularly women organization - the organization takes various program for the development of women. Chittagong City Corporation has been running two partnership areas in Chittagong city, however, they were awarded contract without taking part in the competitive bidding.

According to the bidding document (GOB 2005), in order to qualify for being awarded the contract, the bidding organizations needed need to meet the following minimum qualifying criteria:

- Evidence of having implemented projects with a total annual value equal to US\$ 100,000 or more for each of the previous five years, by the lead agency or in aggregate in case of a joint venture;
- Evidence that shows the organization has sound financial accounting practices;
- No consistent history of litigation or arbitration awards against the Bidder or

associated organizations;

- (d) Minimum eight years experience of working with health systems and related activities, with at least five of these years in Bangladesh by the principal bidder;
- (e) Registration either from Registrar of Joint Stock Company or Directorate of Social Welfare or NGO Affairs Bureau of the Government of Bangladesh, entitling bidder to work in Bangladesh. This requirement would apply only to local bidders. Foreign bidders might be requested to be registered with a similar agency in their home countries and with an agency stated above of the Government of Bangladesh in case they are awarded the contract.
- (f) Have gender balance in human resource composition.
- (g) ADB member country national
- (h) Minimum staff for different levels of facilities are required

This set of minimum criteria determined the nature of the partners. The annual project size of USD 100,000 was a big bar for the local NGOs, as most of the local NGOs do not have that size of project. Therefore, the players who got the contract finally, they have been in the health sector for quite long time. For example, PSTC, the organization was initially formed to provide training to family planning workers. They also work as partner of USAID funded Urban Family Health Partnership. BWHC is a local NGO, however, formed as local chapter of International Women's Health Coalition. Marie Stopes Clinic Society is of same nature, it is also, formally, a local NGO with local board of members; but in fact, is a franchised organization of their international society. While the bidding was open to the private sector, however, it is very difficult to find any organization among private for-profit sector health care providers who have eight years of experience of working in health system. Yet, there were two participants from the business sector in the bidding, who were subsequently screened out at the very first stage of bid processing. Finally, no business organization was awarded any contract.

#### *4.3.5.3. Present Architecture of Service delivery*

The partners have been given the central role in the whole UPHCP as they are the service providers. However, they are connected in many types of relation with various actors within and outside of the project. These actors include City Corporation, donors, Figure

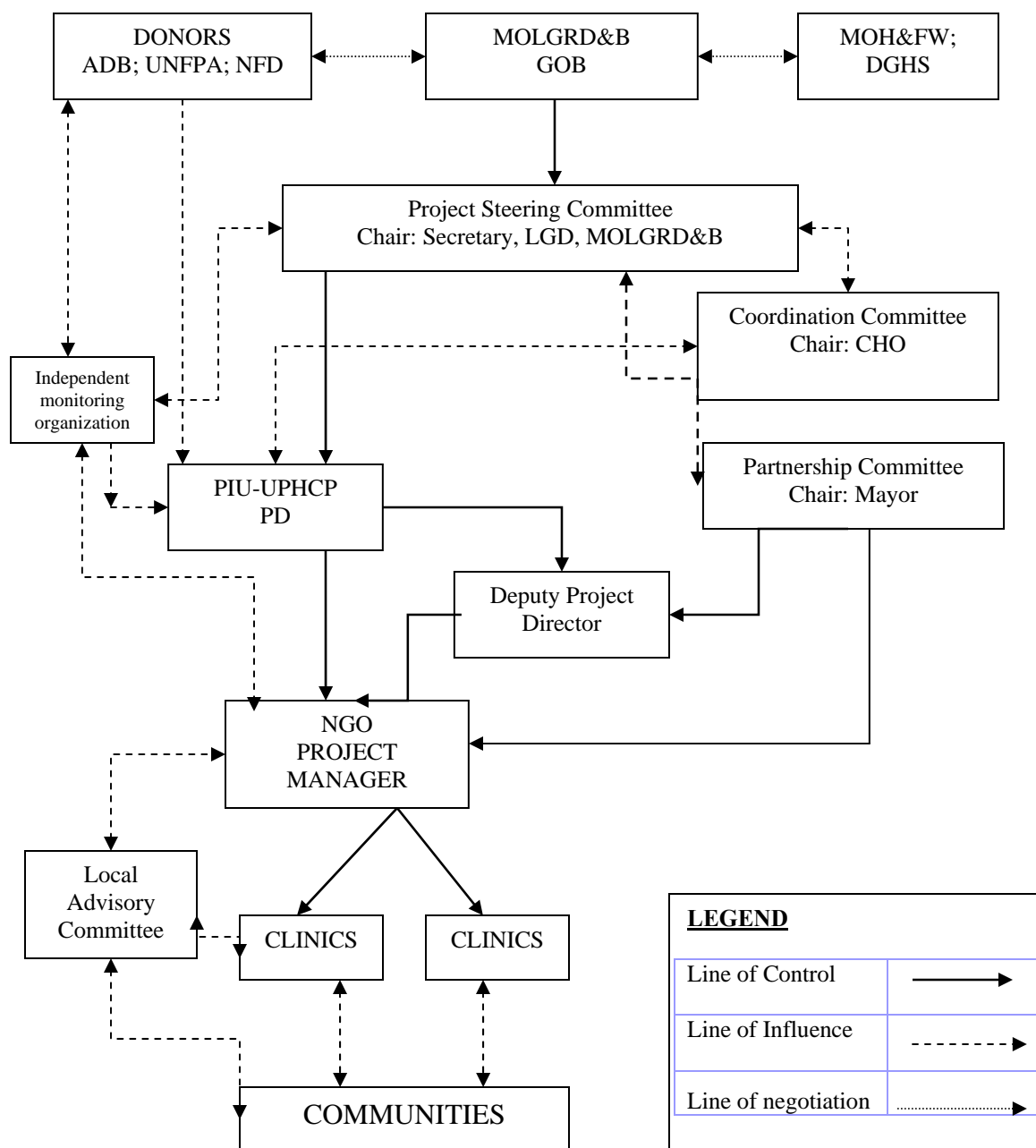


Figure 4.3: Actors in the UPHCP service delivery

government agencies, MOLGRD&C, other NGOs, different committees etc. Figure 4.2 depicts the whole range of relations among the various actors in the UPHCP that have formed the architecture of the service delivery mechanism in post-reform period. At the policy level, the donors, MOLGRD&C and MOHFW are three most powerful actors, who determine the project budget, set the criteria to evaluate the partner's eligibility and

define their role. These actors do not control each other but come to common understanding and definition through negotiation based on their institutional interest.

As the figure 4.3 shows, the Local Government Division on behalf of the MOLGRD&C forms and heads the highest level of policy body Project Steering Committee. Project Steering Committee employs the Project Implementation Unit (PIU) to manage the implementation of the project. The key personnel is recruited by the LGD and approved by the Project Steering Committee (henceforth PSC). The PIU is ultimately accountable to the PSC. There is another important body, namely Project Coordination Committee, mainly to coordinate all implementation activities. This Coordination Committee is headed by the Chief Health Officer of the DCC; CHOs from other city corporations, and PD are members. The Director, Primary Health Care of DGHS is also a member of the committee. However, this committee does not have any direct controlling authority over the activities of the PIU, but they can influence the decisions. The PD controls all project implementation units at the city level, which is headed by a DPD. The DPD is the member of the city level Partnership Committee. Partnership Committee regularly reviews the activities of the partner NGOs in respective city. The Mayor is the chief of this committee. This committee has to some extent controlling authority over the activities of the NGOs. At the same time partners are also supposed to follow directions and orders issued by the PD office from time to time. In between, there is another actor who is known as Monitoring and Evaluation firm. Usually it is a business firm, who has been awarded the contract to evaluate and monitor the activities of the Partners. This firm supposed to conduct Baseline Survey, Midterm Survey and End line Survey for the project. Therefore, they have to communicate with donors, the MOLGRD&c and partner NGOs. In either case, it does not have any controlling authority; however, it can influence decisions of others by feeding them information. The Project Office controls the clinics. The clinics influence the communities by their Behavior Change Communication (BCC) activities and the communities can influence the clinic activities by using 'exit' role. They also can influence the decisions of the clinics through the political leaders and local elites who are the members of the LAC. In general, the line of control flows downward from the top while the line of negotiation flows horizontally among the policy actors. The line of influence flows, in most cases, upward, downward

and horizontal directions. For service delivery, the partner NGOs is also dependent on a bunch of government and non-government organizations. For example, one of the core service components of the clinic is Child Immunization and vitamin A supplementation; but no NGO can procure these vaccines independently, they have to collect from the EPI directorate. For UPHCP in city corporation area, the distribution of vaccines is made through the city corporation health department. Therefore, all partners have to go the city corporation to collect vaccines. Again, the family planning products i.e. contraceptives have to be collected from the government's District Family Planning Directors office, medical equipments have to be collected from the PIU. Therefore, it is clear that a complex web of authority, influence and dependency has developed among various government and non-government actors surrounding the UPHCP.

#### 4.4. CONCLUSION

To conclude, several special characteristics that have developed in the health care system in Bangladesh in course of neoliberal reform design and implementation can be identified. First, throughout the history of health reform in Bangladesh, donors have been influential. Second, concepts and ideas are coming from the global discourse. Third, resource-shortage of the government and local actors gives the way to the donor. Fourth, the patron-client relationship is affecting the actor's behavior and position in the policy arena. Fifth, the reform policy formulation and implementation was done in a very technical manner as it did not involve any political forum such as parliament, city councils or political parties to debate over the content and course of reform. Sixth, and most importantly, after implementing the reform the previous hierarchical service delivery mechanism has been replaced by a network of actors. And, it is also clear that whole network is characterized with interdependency among actors and they are connected with different form of relation. Lastly, the state role in health care has changed. This qualitative change in the state role and its implication for the poor is discussed in Chapter 6. Nevertheless, what is important to see that the service structure has been disintegrated and an individual actor (partner) is given greater degree of independence (within the framework of term of reference of the contract). Thus the actual impact of this reform at the community level is mostly depends on this partners and how they are implementing. Thus, partner organizations deserved to be discussed in detail.

## **CHAPTER 5**

### **IMPLEMENTATION OF THE REFORM: TALE OF TWO IMPLEMENTING AGENCIES**

The health reform policy has been implemented on the ground by 11 different organizations. Each of these organizations operates in different communities; this means, they are operating in different context. An early midterm evaluation report shows that there are significant differences in health indicators between and within the cities, and within the same partnership areas (Mitra and Associates & Measure Evaluation 2003). Taking this variation into consideration I have planned to examine my propositions by analyzing two implementation cases under two different types of organizations. This chapter will give an account of the implementation process of the reform so that we can have comparison of independent variables in order to explain the variation in impact.

This chapter organizes in three parts: the first and second part is the account of the implementation process by two different organizations and the third part is a comparison of the two in terms of our variable set. I have chosen Marie Stopes Clinic Society to represent the main bunch of service providers (NGOs) and Chittagong City Corporation as the main variants among the providers.

#### **5.1. MARIE STOPES CLINIC SOCIETY IN UPHCP**

##### **5.1.1. Brief Overview of Marie Stopes**

Marie Stopes Clinic Society (henceforth MSCS), a franchised partner of the Marie Stopes International, was established in 1988 in Chittagong to provide sexual and reproductive health care and education (MSCS 2000). Since it began, MSCS has grown to include 30 comprehensive health clinics throughout the nation and an additional 36 “mini-clinics” in urban slums. MSCS services include family planning education and services; ante and post-natal care; female sterilization; vasectomy; primary health care; youth services; prevention, diagnosis, and treatment of sexually transmitted infections; and STI/HIV/AIDS awareness-raising initiatives. It provides services to a wide range of population groups, which includes urban poor, factory workers, men, brothel based sex workers, floating and homeless populations, transgender population.

During last five years Marie Stopes implemented many projects such as Better Health For

Urban Poor (2001-2004), Expanding Access of Low Income Women and Men to reproductive Health Services in Under Served Urban and Peri Urban area (1999-2002) (MSCS 2002). Currently there are four major projects are running. Marie Stopes has a wide fund-base, which includes DFID, UNFPA; EC; ADB and MSI (MSCS 2006).

The organization is registered under NGO Bureau, Social Service Department and Directorate of Family Planning. It is run by 7-members Board of Directors; however, the Managing Director heads the regular operation and management. Every project has own manager. According to official sources, around 80,000 clients per month come to MS clinics and mini-centers (MSCS 2002).

#### **5.1.2. The UPHCP under Marie Stopes**

Marie Stopes is one of the partner organizations of UPHCP. In fact, Marie Stopes formed a consortium with Radda MCH-FP Center, Bangladesh Women's Health Coalition and the Society for Urban Health and made the bid or the UPHCP. The consortium was awarded two partnership agreements (contract) for two areas. Marie Stopes as the lead organization was given the responsibility to provide services in the areas under PAA-6, which covers the greater Mohammadpur and Dhanmondi area of Dhaka city. The contract was awarded in 2000 and went in full operation in from 2001. MS provides services through 7 Primary Health Care Centers including 1 Comprehensive Reproductive Health Care Center (CRHCC)) in partnership area 6. This PAA 6 area includes 44, 45, 46, 47 numbers of Wards of Dhaka City Corporation.

#### **5.1.3. Reasons to get involve in the UPHCP**

For Marie Stopes, there were several important reasons for being interested to get the contract. Firstly, there was the goal compatibility between the UPHCP and Marie Stopes, as both of them have the aim to improve the reproductive health of the poor in Bangladesh. Secondly, as Dr. Yeasmin H. Ahmed- the Managing Director of the organization reports,

“We had a good relation with the Dhaka City Corporation since long. Yet, since our main target population lives in urban areas and particularly Dhaka is the largest working area, we need to cooperate city authorities all the time. We thought this project would give us the opportunity to make our relation closer with them. Moreover, it was a government project and



first of its kind, naturally we were interested to be a part of it. More importantly, we had the exactly right kind of expertise and experience to do the job and the project promised to give full autonomy to the partners to implement their innovative approaches”.

From the observation and interview with key personnel of both UPHCP and MSCS, we found that there were three most important reasons: *organizational drive for growth and survival; enhancing legitimacy; values-compatibility*. In the context of Bangladesh, middle-sized organizations like Marie Stopes survive on project funding. However, most of the project is of short term, on average a project run for 3.5 years. Projects are the main, if not only, sources of income and influence for the organization. Therefore, there is always a tendency to get as many as projects. MSCS is no exception. Legitimacy crisis is another important motivation for the MSCS to be involved in the UPHCP. As we know, Bangladesh society is predominantly patriarchic and conservative, where the issues whom the MSCS does work with, are ‘sensitive’. There is a strong opposition from the conservative political parties and social forces to this kind of organization. The organizations doesn’t expand its activities to the rural areas - where the majority of the population lives and needs are even higher, it is because of the fact that the opposition is much stronger in rural areas comparing to cities. So, for the MSCS to be involved in a project which is run by the government and city council seemed a good opportunity to enhance their legitimacy among their constituency, and political actors as well. The government and the city corporation provided an umbrella for the partners through UPHCP. In addition, while big players like ADB, UNFPA, and NDF funded the project, the UPHCP provides the partners with opportunity to build relation with donors. Last but not the least, compatibility of values has also a big role in building relation between two actors. In general, the core value of the MSCS is individual freedom in relation with one’s sexual reproductive rights. This value can be observed by improving the reproductive and sexual health of women and men. The UPHCP is also based on the same value premises as it provides services to women in order to improve their reproductive health. Therefore, value compatibility leads MSCS to be interested for the project.

#### **5.1.4. Organization and Management**

The UPHCP project under MSCS is headed by the Project Director. The Managing

Director of Marie Stopes holds the post of the Project Director, however, the Project Manager is the most important person who runs the whole the project. The organization and management of the project can be divided into two layers: project levels and clinic level. The project level is consists of small unit of 6 personnel including one Project officer, Accounts cum Administrative Assistant, MIS Assistant. This unit is responsible to coordinate activities of all clinics under the project (Figure 5.1).

The most important part in the whole UPHCP project chain is the clinic from where the services to the people are actually delivered. The clinic is run by a Clinic Manager, usually a medical graduate. The clinic manager runs a unit of 8-12 members, which includes 1 medical Officer, 1 Community Organizer, 1 Paramedic, 1 Health Educator, 1 Counselor, 1 volunteer, 1Caretaker and 1 Cleaner (Figure 5.2). The Clinic Manager is chief of administrative and technical aspects of service delivery. Dr. Asif Anwar, the Clinic Manager of Bashbari City Maternity Center reports, “we all colleagues make a monthly plan of activities in our monthly plan where we review activities of

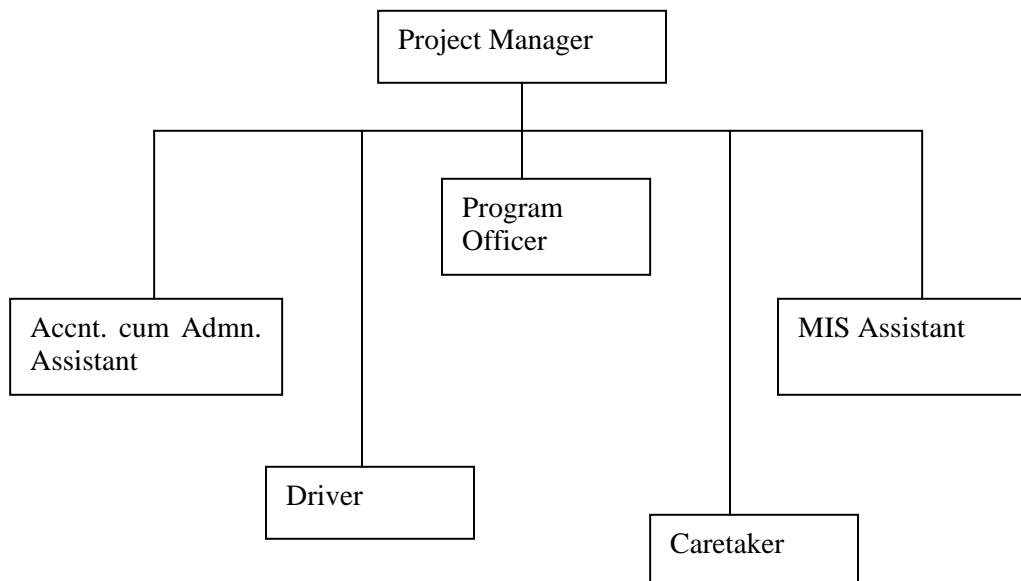


Figure 5.1: UPHCP Project Office in MSCS

the previous month and plan for the coming month. In this meeting, we set targets for each of us. We also meet weekly to review the progress of the monthly plan”. The Medical Officer is responsible for all clinical health and family planning services. The

Counselor and the Community Organizer are responsible for mobilizing the community and providing them with all information. The clinic also undertakes various outreach activities in the communities such as Satellite Clinic, observation of National Immunization Day, door-to-door visit in the poor neighborhood, yard-meeting and so on regularly. These community activities is mainly organized by community organizer and his/her colleagues in cooperation with local community leaders. The Clinic Manager is accountable to the project manager. The organization and management of Community Health Clinic (CHC) slightly differs from Community Maternity Clinic. The additional service that is provided by the Community Maternity Clinic is Emergency Obstetric Care for which the CMC (CMC) has some extra employees; however, in both cases Clinic Manager is the chief.

#### **5.1.5. Decision Making Process**

Based on the organizational level the decision making process is also can be divided in to two levels. In relation with the UPHCP under Marie Stopes, the project-level deals with policy issues and the clinic-level decisions deals with day-to-day operation of service delivery. At the project level, all policy decisions are made in a coordination committee where Project Manger, all clinic managers and Project Officer participate; the Project Director chairs the committee. This committee makes decisions regarding the annual operational plan, budget and other policy issues. This committee also resolves disputes among the Clinic Managers. Yet, this committee only decides about the issues related with the project operation, but key decisions like the recruitment or termination of any stuff is beyond their jurisdiction. These kinds of decisions are usually made by the Project Director and Project Manager. The Project Manager is not only a stuff of the project but also senior manager level stuff of the Marie Stopes. However, others like Medical Officers, Clinic Managers are employed only for the project. Table 5.2 shows the health center level decision making and authority channel.

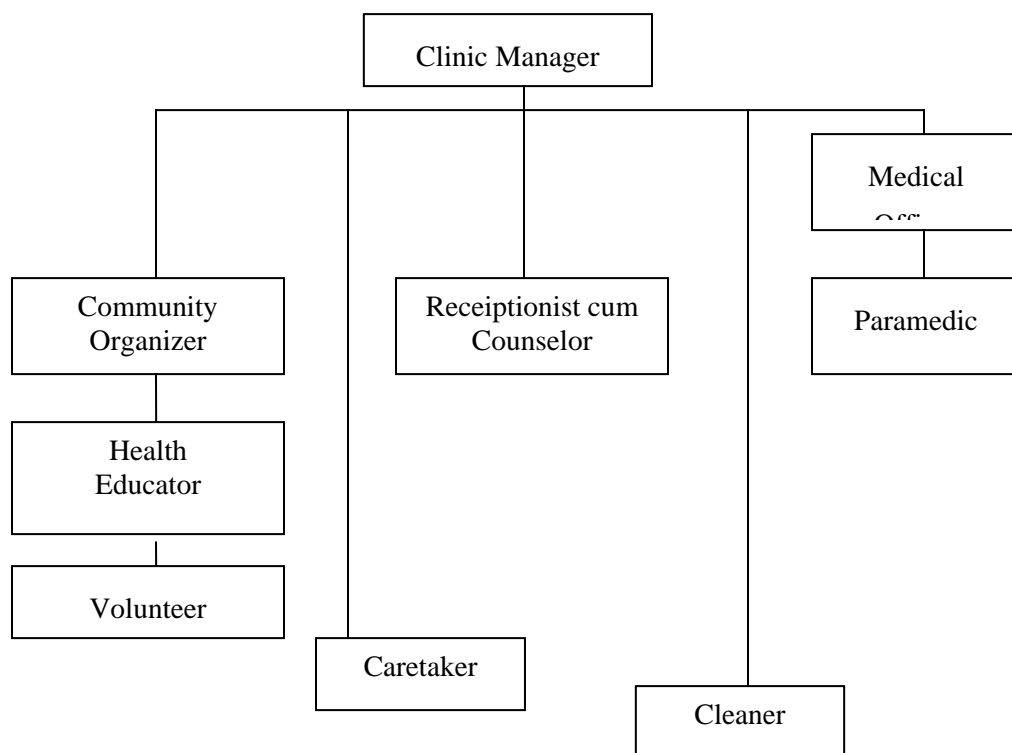


Figure 5.2: The organogram of a typical City Health Center under MSCS

The clinic-level decisions include number and location of outreach activities, distribution of subsidized health cards, petty-purchase, personnel administration of clinic stuffs, monthly target-setting etc. The Clinic Manager alone, generally, takes all decisions. Mr. Tanvir Hossain, the Community Organizer of Godighar Clinic reports, “The clinic manager makes all the decisions. Sometimes he discusses with us.” He takes all kind of emergency decisions as well. However, the medical officer enjoys some degree of independence in relation with technical decisions i.e. what kind of treatment, who or when to operate or send to referral hospital. The clinic manger prepares the operational plan and shares it with his/her subordinates and gives them target to achieve for a particular period. The Clinic Manager is directly accountable to the Project Manager. Therefore, it is clear that the decision making structure is vertically organized within the clinic and the project.

#### 5.1.6. Accountability

Marie Stopes, as a contract awarded organization, is obliged to follow the terms of

reference of the contract. The contract itself provides the institutional basis of the accountability of the service provider to the Project Implementation Unit. The service provider NGOs (other wise called partners) are members of Partnership Committee of UPHCP at the city corporation level, where they have to present their quarterly performance report and explanations if there is problems in attaining target (ADB 1998: 10).

Within the Marie Stopes, the Project Director is accountable to the Board of Directors of the organization. The Project Manager is accountable to the Project Director. However, since the Project Director is simultaneously the Managing Director of Marie Stopes and being stayed busy with many other things, has actually delegated all responsibilities of the project to the Project Manager. Therefore, the Project Manager became the *de facto* PD. Yet, the project manager is accountable to the organization in several ways. For example, Dr. Hashrat Ara Begum - the Project Manager, informs, “All of our managers have to report about our programs in monthly meeting chaired by the General Manager, here we get other colleagues criticism, suggestions and so on.” All Clinic Managers are accountable to the Project Manager and all clinic level stuffs are accountable to the Clinic Manger for their performance in terms of attainment of predetermined target. From the data and documents it is clear that vertical and upward accountability exist in UPHCP project of Marie Stopes. The service users or clients have no part in the system of accountability.

#### **5.1.7. Coverage of Service Provided**

It is already discussed that City Health Centers under UPHCP project does provide ESP services. I shall not discuss in this place the detail of the services, however, just to give an idea how a CHC works I will present some data of one health center run by Marie Stopes. In the Year 2004, all CHCs under Marie Stopes have served together a total number of 139,562 persons who received 233,538 service components (MSCS 2005). Data shows in 2004, on average, monthly 11,630 persons received 19,462 services from all 6 clinics of Marie Stopes. These services include ANC, PNC, Child health, Maternal health, general health, delivery, TB, family Planning, pathology tests, awareness meeting and so on. In another estimate it has been seen that, City Health Center-5 (Sultanganj, Rayer Bazar,

Dhaka), through its static and outreach activities, has served total 14,297 persons who received 28,954 service components in 2005 (MSCS 2006a).

Table 5.1: Performance of Marie Stopes's City Health Centers (static services),  
October - December 2004

	<b>CHC 1</b>	<b>CHC2</b>	<b>CHC3</b>	<b>CHC4</b>	<b>CHC5</b>
<b>Total Client</b>	<b>5142</b>	<b>3682</b>	<b>3998</b>	<b>4358</b>	<b>4731</b>
<i>Free Clients</i>	3251 (63%)	1353 (37%)	994 (25%)	1371 (31%)	2418 (51%)
<i>Partially Free</i>	621	304	179	265	242
<i>Paying Clients</i>	1270	2025	2825	2722	2071
<b>Total Services</b>	<b>9488</b>	<b>6740</b>	<b>7006</b>	<b>7193</b>	<b>7787</b>

Source: UPHCP 2005

Table 5.1 shows that monthly on average 1200-1500 persons, which means daily about 50 persons, come to health centers and receive services. Of course, the number varies with the location, marketing strategy and of the clinic mainly. It also shows that large number of the service users is very poor; they can render services without paying. On average, 41% of total patients in each of health centers are treated free. Yet, the centers used to have a target to recover a certain part of the total cost of the center. We shall discuss about the financial issues in the next section in brief.

#### 5.1.8. Financial Target and Achievement

In general, services are delivered at a very low price in the UPHCP. Every service provider organizations had submitted a cost recovery plan in their technical proposal. For Marie Stopes, it was 20%. However, "...our current cost recovery rate is above 30%" informed the Project Manager Dr. Hashrat Ara Begum. The income of the health centers can be divided in two categories: income from service charge and income from selling medicine. The major part of the income comes from the service charge category.

Table 5.2: Income and Expenditure of City Health Centers of MSCS, Oct-Dec 2004(Taka)

<b>Center Name</b>	<b>Income from Service</b>	<b>Income from Medicine</b>	<b>Total Income</b>	<b>Total Expenditure</b>
<b>CHC1</b>	77,340.00	17414.00	94,754.00	468,191.00
<b>CHC2</b>	55,313.00	12869.00	68,182.00	495,008.00

<b>CHC3</b>	90,139.00	33290.00	123,429.00	407,954.00
<b>CHC4</b>	41,674.00	23365.00	65,039.00	360,182.00
<b>CHC5</b>	36,009.00	8162.00	44,171.00	385,500.00
<b>Total</b>			<b>395,575.00</b>	<b>2116,835</b>

*Source: UPHCP 2005*

Table 5.2 shows, during the October - December 2004 the rate of cost recovery varies from 14% to 30% among different health centers. However, in this quarter the average cost has been recovered at about 19%.

### **5.1.9. Community Participation**

There was no explicit provision in the project document to make community participate in the project; rather the issues had been left to the respective contract awarded organization to manage (ADB 1998: 5). However, the UPHCP provided some guidelines through which community can participate in the system of service delivery. According to the PAM, the beneficiary's participation can be ensured through following ways (ADB 1998: 5):

1. through the partner NGOs
2. by forming Community Primary Health Care Committee
3. participation in monitoring and evaluation through community meeting and FGDs
4. participating in site selection through elected representatives
5. participation through providing land and facilities for health centers and outreach activities

In fact, for Marie Stopes and the project as whole, the participation of the community has been considered as a 'strategy to make the implementation smooth'. I shall take the issue participation at length in the next chapter, here I would like to present the rules and structure through which Maries Stopes ensured community participation in the UPHCP project.

The most visible and important forum of community participation that Marie Stopes installed in its UPHCP is Local Advisory Committee (LAC). For every health center there is one LAC. The local elected representative - Ward Commissioner- to the City Corporation, heads the LAC. LAC members include clinic manager and local elites such

as schoolteachers, media personality, businesspersons, social workers and DCC's health department official. On average, 9-15 persons form the committee. The main role of the committee is to provide suggestions to make the service better. In fact, it does not have supervisory or monitoring role, but kind of optional 'advisory' role. Mr. Abu Sayed Bapari, President of the Local Advisory Committee for Bashbari Clinic and Ward Commissioner for Ward no. 46 of DCC reports, "We meet very irregularly, whenever clinic manager feels, convenes the meeting. We discuss various issues of the health center and give them suggestions to improve the services of the clinic." Another member of the same committee, Mr. Habibur Rahman, who is an Administrator of a local school, commented, "our participation in the meeting is nothing more than ornamental, they simply inform us what they do, we do not have any specific roles and responsibilities regarding their management". Among total 31 members of all local advisory committees, only 8 are women including Marie Stopes's own official. Only 2, among those 8, represents the commoners. Moreover, the community people were not consulted during the planning phase and in site selection. However, the Ward Commissioner helped to find a place to build the clinic. From the field observation it has been seen that the Local Advisory Committee mainly play role in conflict resolution.

#### **5.1.10. Monitoring and Evaluation**

There are several rules, and mechanisms are in place for monitoring and evaluation of the project performance. First, the Project Manager monitors the health clinics through three ways: monthly meeting with the clinic managers, clinic meeting at each clinic and sudden visit and exit interview. In addition to the monthly review meeting held at the project office, the project manager also heads a monthly meeting in each clinic where s/he reviews all the activities of the respective clinic and listen opinions and suggestions from all levels of employees of the clinic. The Project Manager also makes sudden visit to clinics during the working hours and conduct exit interviews among the service users/clients. Besides, there is one more institutional procedure, which is called *Clinicscan*. *Clinicscan* is a form that is used to make rapid clinic assessment (MSCS 2005a). The form contains total 23 sections covering all aspects of service delivery and for every single aspect the supervisor is supposed to give a score within a range from 0 (very poor) to 4 (very good).



At the clinic level, the clinic manager also conduct weekly meeting with his colleagues and visits outreach activities. He also conducts exit interview among the clients. In addition, there is another instrument called *Satscan*, which usually clinic managers and project office officials used to monitor outreach or satellite clinic's activities in the field. This *Satscan* is also designed based on quantities scoring on various aspects of service delivery. There is also another similar kind of instrument to monitor activities of the field workers namely, community organizer and volunteer, which is called *Field Monitoring Form*. In general, it has been observed that within the organization the monitoring and evaluation system is strong and institutionalized. However, it is only limited among the project stuff, client's involvement is marginal, if not absent.

In the above discussion we see how service deliver is conducted by the Marie Stopes and what other actors how related to the service delivery mechanism. Now in the following section we shall discuss the case of Chittagong City Corporation (CCC). The CCC deserves to focus differently because of its special status as a local government body.

## 5.2. CHITTAGONG CITY CORPORATION IN UPHCP

### 5.2.1. Chittagong City Corporation: Brief Overview

The Chittagong City Council (*pourashava*) was established during the British colonial regime, in 1863. The main aims of the council were to provide health, sewerage and sanitation services to the city dwellers. The *Chittagong Pourashava* was upgraded to City Corporation by the Chittagong City Corporation Ordinance in 1982. Chittagong is the second largest city in Bangladesh and it is the prime port for the country which controls almost 80% of total external trade. The current population, as per the *Population Census 2001*, about 2096000, which is growing at annual rate of 3.11%.

Like other city corporations, the CCC has also a health department that manages the health care activities in the city. The CHO heads the health department. The health care activities in the CCC are much more vibrant comparing to other cities. The CCC has initiated quite several projects from its own. Particularly, since 1995 the city corporation's health activities grew to a large scale. Currently, in addition to the UPHCP clinics, health department is running 1 hundred-bed full-fledged maternity and general hospital (*Memon Hospital*), 5 fifty-bed maternity hospital, 19 dispensaries and 1000

center for EPI program. In addition, there are special TB clinics, HIV/AIDS awareness programs and public health activities (Chattogram Mancha 2005).

### **5.2.2. The UPHCP under CCC**

The CCC has been contracted two PA to run in the city; as we have mentioned earlier that this contract has been awarded to the CCC without bidding but with the same terms and conditions as applicable to others. Officially, the main purpose of this special provision was to ‘create an opportunity to compare the performance of NGOs with public organization’ (ADB 1998: 11), however, why this comparison is needed has not been explained anywhere in the official documents. The CCC is responsible to provide services through 25 health centers in PA 1 and PA3 of Chittagong, which is a huge geographic area consisting of total 37 wards. For PA1 the Chief Health Officer himself is the Project Coordinator and the Deputy Chief Health officer is the DPD for the PIU Chittagong. Senior Health Officers have been appointed the Project Manager for both PA. Both of the PA formally rolled on in April-May 2000, however, went in full functioning from April 2002.

### **5.2.3. Reasons to get involve in the UPHCP**

We have explained in earlier section that the political leadership of the city corporation has special interest to get the project. However, it was not in the early plan to give CCC any of the PA without competitive bidding. But it was changed for political and strategic reasons during the planning phase. Mr. Ashrafuddin, one of former LGD Deputy Secretaries, reports:

“Mayors, particularly of Dhaka and Chittagong, kept continuously lobbying to the Minister to have a big part of implementation under their direct control. Since these two Mayors were from the then ruling political parties, they manage to convey their demand to the top of the Ministry. At the same time, for the ministry and donors it was very important to secure the full support from the city corporations. Because, the most important but difficult part for the project was to procure land to build clinics and it was simply impossible to make it happen without support from the Mayors offices. Therefore, the Ministry incorporated the provision to leave some of PAs to DCC and CCC.”

However, finally, DCC lost their interest; but CCC went on. There was another important reason for the CCC to be involved in UPHCP. The Mayor (Mr. Mohiudddin

Chowdhury), during his election campaign in 1994, committed to his voters to establish one health center in each ward. He got elected, but the commitment was far from the realization. Meanwhile, he was approaching to another election in 1999. In order to protect his face, Mr. Mohiuddin was seriously interested to get the project (*Chattogram Mancha* 2005). There was 19 CCC dispensaries in 19 wards and then he got another 25 health centers to establish and run in another 25 wards. Of course, as we have already said that the CCC had been quite active in health care in various ways since 1995, during these years it had achieved lot of experiences and confidence to run a project like UPHCP which also gave them moral to be involved in the project.

#### **5.2.4. Working Area and Service Provided**

There are 20 City Health Centers and 1 Comprehensive Reproductive Health Care Centers in 20 wards under PA 1. PA 3 runs 5 City Health Centers and 1 Comprehensive Reproductive Health Care in five wards of the city. In general, the health centers are situated in wards where concentration of poor population is comparatively larger.

The UPHCP under CCC has treated 747,912 persons until December 2004 through its health centers (UPHCP 2005). Since service components are same for all partners, I shall not discuss them in order to avoid repetition.

#### **5.2.5. Organization and Management**

Organization and management of UPHCP under CCC is almost same as it is under Marie Stopes or other partners, it is because the terms of reference in the bidding document, yet, there are some little but significant differences.

The organizational structure of UPHCP under CCC is same as to the other partners. The PA 1 is headed by a Project Manager, he heads a small team of 5 persons. It is also same for PA 1, however, with difference at the clinic level. For CCC, UPHCP clinic or Primary Health Care Center is run by a Medical Officer. The other employees of the health center include 1 paramedic, 1 nurse, 1 field supervisor, 2 health workers, 1 caretaker, 1 Aya and 1peon. Figure 5.3 shows the organizational structure of the health center under UPHCP of CCC. The organizational structure is slightly different than that of other partners, however, not entirely new. But what is entirely new is its complex distribution of job

among the key project officials. To make it more clear, the Chief Health Officer of the CCC is an *ex officio* Project Coordinator for the UPHCP. At the same time, he is also the Project Manager for PA 1. Furthermore, he is also member of the central project Coordination Committee. In addition, he is also member of Partnership Committee at the city level. Similarly, one of senior Health Officer of the CCC is the Project Manager of PA3 under CCC while health officer of the CCC has a monitoring role for the health clinics. Therefore, we can see there is overlapping of conflicting roles played by the same persons. The Chief Health Officer is occupying two important positions, which has conflicting job description. Being the Chief Health Officer, he is supposed to control, monitor the partner's activities. However, at the same time, being the Project Manager he is supposed to report all of his activities to the Chief Health Officer. In other words, CHO is controlling his one's project.

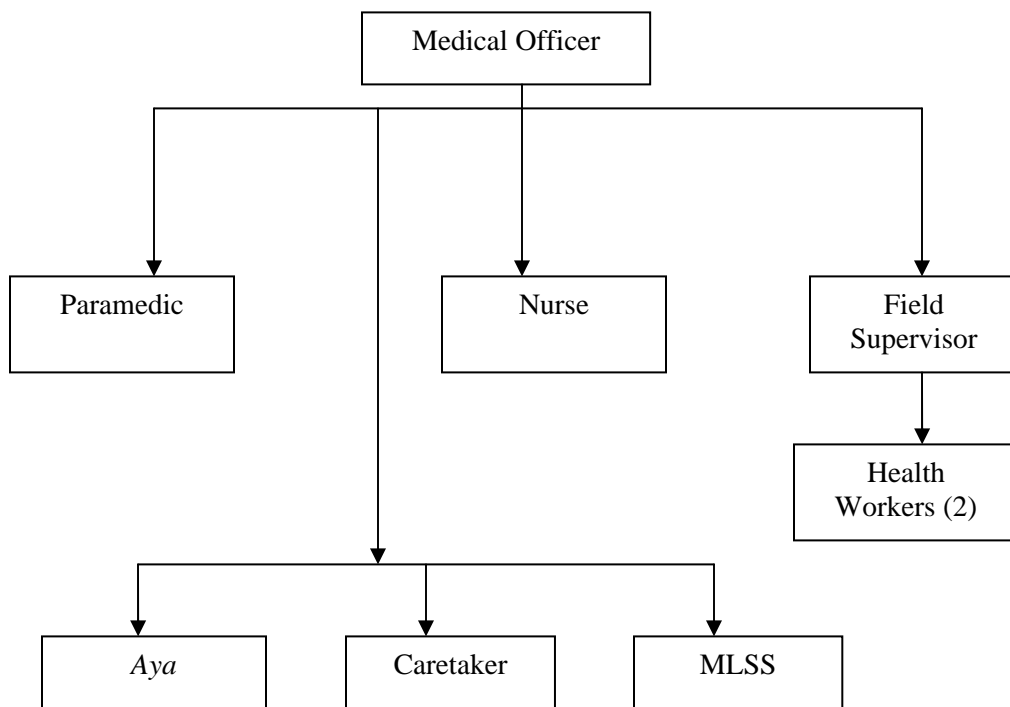


Figure 5.3: The organogram of a City Health Center under CCC

#### 5.2.6. Financial target and Achievement

Financial target and achievement of the Chittagong City Corporation as a partner of UPHCP is similar to other partner NGOs. However, CCC follows one principle: it does provides medicine and contraceptives for free to the service users. For this principle, the

health centers under CCC could not recover a large part of their expenditure. Mr. Nasim Bhuyan, the Project Manager of PA3, reports, “it is because, the Mayor made the commitment to the city dwellers that medicine will be provided for free from all of the city corporation health centers. We have negotiated with the UPHC regarding this issue”. Nevertheless, the health centers continued to take fees from the patients as service charge. The CCC for all of UPHCP and non-UPHCP health centers, introduced a system of family health card, in which each service user has to make a *Health Card* for 20 Taka (0.30 US\$) for once. After that, one can make as many visits to the health centers as s/he wants paying only 5 taka per visit (which is at least 10 times cheaper than the cost of same quality of services from private providers). One’s spouse, children, and dependent also can use the same card at the same rate of service charge.

Under PA1 during the period from October to December 2004, all 20-health centers and 1 maternity center earned in total Taka 371,225.00 (this includes income from Lab test and Satellite clinics) (UPHCP 2005). Estimates show that under CCC, during the same period, per health center, per quarter income on average was about 15000.00 Taka where as the expenditure was 2504000.00 Taka (UPHCP 2005). The gap between this income and expenditure is mainly caused by the provision of free medicine. It can be more clearly visible from another data of City Maternity Center (CMC) while during the same period the CMC earned from service charge and lab test 774,555.00 Taka and spent 761,256.00 Taka - this data shows a positive balance between income and expenditure, given that medicine cost is being excluded. During the same period, the CMC purchased medicine of 400000.00 Taka (UPHCP 2005). PA3 under CCC has also shown somewhat similar trend regarding income and expenditure. Health centers under PA3 has an income on average, during October-December 2004, of Taka 13800.00 and expenditure 183,642.00, which mean the cost recovery rate was that time around 8 percent (UPHCP 2005).

#### **5.2.7. Decision Making Process**

The decision making process in UPHCP under CCC is different from that of others. Since UPHCP project is given to the CCC as a partner, the CCC institutionally is involved in decision-making. Therefore, the whole city corporation, which is headed by the mayor is

also part of the decision making process. Thus, the decision making of the UPHCP can be divided into three separate realms: corporation level, project level and clinic level.

In the corporation level, ward commissioners are the members of the council and the Mayor is the Chair. It is a broad political forum where all policy decisions of the corporations are being taken. However, according to the Chittagong City Corporation Ordinance 1982, the corporation runs in a 'presidential' mode, thus the Mayor himself possesses most of the decision making power for the corporation; the power of the commissioners depends on the extent of delegation of responsibilities made by the Mayor to respective person. The Corporation is supposed to meet at least once a month. There are 21 Standing Committees in the corporation for dealing with various issues related with public utility services in the corporation; one among them is about health. The corporation in general and the Standing Committee on health in particular, determine the policy issues like, the location of health center, approval of budget. At the corporation-level, there is another institution: Health Advisor to the Mayor. The CCC has created this office specially to deal with health problems of the city in 1997. The Health Advisor is accountable to the Mayor and the Corporation, the office mainly provides policy inputs to the health department of the corporation and the Mayor. One retired professor of Chittagong Medical College Hospital has been appointed as the Health Advisor; she has been there since 1997 to date. The health Advisor is not directly linked with the UPHCP, however, informally can influence many decisions of the project.

The project level is headed by the concern project manager. The project managers supervise the operation of the Health centers in general. He makes all major decisions, such as monthly work plan, annual budget, recruitment, training plan, and procurement. The decision-making is centralized and non-participatory as the clinic managers do not have any role in the process. "We are asked to report our problems, necessities, plans, but the decision is taken by the project manager," said one Medical Officer (prefers to be reported anonymous).

At the clinic level, the Medical Officer is the main decision maker. However, s/he consults with other stuffs regarding the number and locations of satellite clinics, waving service charges of patients, monthly and weekly work plan of the center and personnel

issues of subordinate stuffs. In effect, the decision-making at the clinic level resembles the centralized mode of project and city level.

#### **5.2.8. Monitoring and Evaluation**

Monitoring is done mainly by the respective higher level of manager. For example, the Medical Officer monitors activities of clinic-level stuffs, the activities of the clinic as a whole is monitored by the Project Manager. For each case, there is weekly monitoring form in place. Besides, the clinic manager and project manager themselves do pay visits to the working site to monitor and supervise. In addition to this, the Project Implementation Unit at the city level has one specific responsible officer - *Senior Monitoring and Evaluation Officer*- who monitors the activities of the entire project regularly and reports simultaneously to the Deputy Project Director at the city level and the central PIU office. The Project Coordination Committee and Partnership Committee at the city level also do some monitoring job as Project Managers are supposed to report their activities to those two committees regularly. But the peculiar situation of the UPHCP under CCC where holding of two positions - the Chief Health Officer is the Project Manager of PA1 and the Project Coordinator for the entire UPHCP project in CCC area - at the same time makes the project monitoring job somewhat weak.

#### **5.2.9. Community Participation**

There is no specific program and rules to ensure community participation in project activities. In the project document, the community participation is perceived in terms of Behavior Change Communication, which includes awareness and mobilization meetings and rallies in the communities with various target groups such as women, men, community leaders. The aims of these activities are to create awareness and promote knowledge, create demand, promote health-seeking behavior, bring about changes in the attitudes and practice towards healthy life (UPHCP 2005: 29). Within the framework of ‘community participation’ of the project, there have been hundreds of events taken place in both PA1 and PA3. However, BCC activities involve community members as passive listeners or participants only. Observation shows that, this kind of activities eventually turned to “marketing activities” for the project. In addition to the BCC activities, there is one forum called Local Advisory Committee, which is headed by the Ward

Commissioner. Although Dr. Sarfarz Newaz Khan, the project manager of PA 1 claimed that the local advisory committee arrange meeting with the local citizens each month at each center, only five lists of such committee has been found. On the other hand, Dr. Nasim Bhuiayan reports that “the Mayor is the chief patronage of all advisory committee of all city health centers in Chittagong. The centers hold meeting once a year”. This comment makes it clear that the advisory committees actually act as an ornamental forum, which is not democratic as members of this committee are selected arbitrarily from the local elites. Moreover, no evidence of regular meeting was found during the field visit, interview and observation.

#### **5.2.10. Accountability**

The accountability of the service providers are maintained vertically in line with the respective organizational hierarchy. With respect to accountability, CCC plays a dual role. On the one hand, the CCC itself is an implementer and on the other, coordinator for the entire CCC area. The Chief Health Officer (CHO) is directly accountable to the Mayor in particular and to the corporation in general. In addition, the CHO as a project manager for PA1 is also responsible to the Partnership Committee where the Mayor is the Chairperson. All project managers are also accountable to the PIU at Dhaka. PA3 project manager is also accountable to the Mayor, City Corporation and the PIU. Accordingly, Medical Officers are accountable to the Project Managers and other subordinate stuffs are accountable to their respective medical officer. However, this is the formal chain of accountability, which does exist on paper only. The reality is different.

Observation shows that the Mayor of CCC himself has an interest in development of health status of city dwellers. As we have mentioned before that, besides UPHCP health centers, the CCC, under special initiative of the Mayor took many significant public health measures in city. Therefore, he himself is also very eager to continue the existing health projects. One Medical Officer of PA1 reports, “The Mayor supervises all health centers with his personal interests through informal channels. He even uses the health centers cleaners who used to visit the health center every morning. The Mayor asked them to report him personally if they saw absence of doctors in any centers”. Nonetheless, the use of informal communication channel for ensuring accountability is



not applicable for all key personnel of the project. The CHO and other project manager has personal tie with the Mayor, thus they stay above of this strong accountability measure. In fact, emphasis on informal and personalized channel of communication undermined the formal accountability arrangements. The project staff has been found reluctant to send financial and activities report to the PIU regularly.

#### **5.2.11. Relationship with other Actors**

The CCC maintains various horizontal and vertical upward and downward relations with many organizations in the city. The CSO has two important authorities, first it controls distribution of all vaccines for children and women; secondly, it is the sole authority to provide license for establishing clinics or clinical services i.e. diagnostic laboratory, operative services. Thus, city corporation has also built a good relation with them. Relation with other UPHCP NGOs and non-UPHCP health NGOs is also an important dimension in the service provision network in Chittagong. There are three more important health NGOs: *Nishkriti*, *Image* and *Mamota* who covers 35 wards of CCC together. *Mamota* is also running PA2 of UPHCP. Since these NGOs and the City Corporation providing the same service components, duplication of services and overlaps of working area commenced and as a result, the relation between CCC and those NGOs grew conflicting since 2001. In order to resolve the disputes and conflicts the City Corporation formed a coordination committee under the leadership of the Health Advisor of CCC in 2003 and finally the committee has been successful to establish better working relations among them.

### **5.3. COMPARISON BETWEEN TWO IMPLEMENTING AGENCIES**

I have analyzed two implementation programs under two actors of different nature. It is clear that they are different in many aspects: context, organizational mission, vision, structure, processes and the way they do the business for their constituencies. Now I will make a comparative analysis of them two in the following section:

Table 5.3: Comparison of implementation features of two organizations under UPHCP

Features	Marie Stopes	Chittagong City Corporation
<b>Context</b>		
Experience in the health care sector	2	2
Understanding of the communities working in	2	2
Competition with other service providers	2	0
Relation with related government agencies	1	1
Relation with political parties	0	2
Relation with local political elites	1	2
Relation with local social elites	2	0
Organizational dependence on the project	1	0
Autonomy from the PIU	1	2
Strength to bargain with the controlling government Ministry	0	1
Linkage with referral health care service centers	1	2
<b>Process</b>		
Commitment of the organizational leader to the cause of the health of the poor	1	2
Professionalism in organizational practices	2	0
Skill and experiences of key staffs	2	1
Commitment of the project manager to the goal of the project	2	1
Accountability of project staffs	2	1
Regular and systematic monitoring of the project	2	0
Information sharing among other units	1	0
Participation of project staffs in decision making	0	0
Participation of project staffs in making action plan	2	1
Financial transparency	2	0
Discretion of the clinic manager to make operational decision	1	0
<b>Ideology</b>		
Particular ideology bias	0	2
<b>Interests</b>		
Political interests	0	2
Financial Interests	1	1
Legitimacy, Recognition interests	2	2
Professional interests	2	0
<b>Key: High- 2; Medium - 1; Low - 0</b>		

The above comparison in key features related with organizational (Table 5.3) feature shows that the two actors are very different from each other. They are difference in contextual factors, organizational factors and ideological and interests factors. However,

it will be interesting to see if these differences explain the variations in their impact that they are producing through the implementation of the project in respective cities.

#### 5.4. CONCLUSION

In conclusion of this chapter, we can identify several important features of implementation of health sector reform in urban primary health care services. Firstly, it is clear that the implementation of reform largely depends on the lead actor, in this case the service provider organization. We have seen that an NGO and a local government body how differently they are implementing the same program. The service regimes i.e. the price, the target people, the behavior of health providers to the service users, rules-regulation at the center are different in Marie Stopes and CCC. It is mainly because of the difference of organization's aims and objectives and the nature of the organization.

This chapter also demonstrated that the political commitment of the leading actor is an important factor in the implementation. Marie Stopes is a professional-based private sector organization where as the CCC is a political organization; one is run based on professional commitment while the other is based on political commitment.

The implementation also differs because of the differences in organizational values. For Marie Stopes, target achievement, efficiency is important where as for the CCC, the citizens satisfaction is more important. The Marie Stopes's drive in health services is characterized by impersonalized professional values and on the contrary, the CCC's is characterized by its constitutional responsibility and personalized political goal. Due to these differences in values, aims and objectives led these two organizations having different organization and management structure of the UPHCP. As a result different organizational configuration they offer different set of institutions and asset to the service users and which resulted different degree of impact on state and community. I shall examine the impact on state and community in following chapters.

## **CHAPTER 6**

### **IMPACT ON THE ROLE OF STATE IN HEALTH SECTOR**

Ensuring health for its citizen is one of the constitutional duties of the state of Bangladesh. Particularly, the primary health care is heavily dependent on the state financing. However, there has been qualitative change in the role of state in health sector in recent years as a consequence of neoliberal reform in health sector in general, primary health care in particular. This chapter is an effort to analyze those changes.

This Chapter discusses the impact of health sector reform on state from a bottom-up macro perspective. It shows how state is moving away from its traditional role to a new role. The main argument of this chapter is that the impact of neoliberal reform on state is not one-dimensional. It is creating a paradoxical shift. On the one hand, there is a contraction in health care financing, withdraw from health care delivering and on the other hand, state is expanding its role over other forms of social organizations like NGOs (by binding them in terms of contract) and expanding its presence in the area where previously it was not (for example urban health care has come under the central government control from local government control). I argue that the role of state in changing situation has to be understood in more multidimensional way rather than formulating it in any dichotomous framework. e.g. centralization vs. decentralization. I shall elaborate my argument in the following section by reviewing government documents, literatures and field work data. And, finally, I shall discuss the implication of this change for the health entitlement of the poor.

In Bangladesh with respect to health care the state has been playing three types of roles: regulator, service provider and financier. I structure this chapter according to analyze changes in that three roles first, then I shall present three critical issues regarding the state and finally I discuss the implication for the poor.

#### **6.1. CHANGES IN THE REGULATION FUNCTION**

In the health sector state is the highest regulatory authority in Bangladesh. This authority is constitutionally endorsed, thus legitimate. State makes law, rules and policies which determine the boundary, scopes of for others actors to be engaged in the health sector.

This regulatory function of the state, particularly with respect to health policy is under challenge. Analyzing the health reform policy in Bangladesh, I argue this challenge is coming from mainly two sources: from the international funding agencies and from the NGOs. Although the state has been able to retain the power to say the last word, however, it is clearly under question. I will elaborate my argument in the following.

#### **6.1.1. Challenge from the Donors**

The health sector of Bangladesh is highly dependent on foreign assistance. On average, about 65% the health ADP finance comes from the external sources. It is not new. In fact, a donor consortium led by the World Bank has been providing financial and technical support to the GOB to implement the successive projects in health and population sector since 1970s, each five to six years in length (Perry 2000: 244). The first of this kind was named as First Population Project (1975-80). Similarly, there second, third and fourth Population and Health Project for each of five-year slots since then. In addition, there were quite many bilaterally funded and managed projects. However, the pressure from the donor community rose very high while the mid-term review of Fourth Population Project identified limited impact the project. There were concerns about the low utilization, cost effectiveness, financial sustainability and quality of government health services in the review report (MOHFW 1998a). The report identified the lack of government commitment to organizational and management reform and fragmented project-based approach are two key reasons that contributed to limited impact of the project. In this context, the need for systematic reforms in the government health system turned into a top priority for the donor. In 1996, the donor consortium informed government that it would not precede with further project planning until the government produces a strategy for substantive reforms in the health sector (Buse and Gwin, 1998). In response, the government developed its Health and Population Sector Strategy, which was thereafter made operational in a sector wide reform program - Health and Population Sector Program (Perry 2000: 245). Finally, of US\$ 3 billion of total HPSP budget, donors including the World Bank and other bilateral and multilateral agencies committed to provide approximately 1 billion US\$. But what happened is that the government had got its health care sector running but lost significant degree of autonomy, the power of setting health agenda for its own. In fact, in the UPHCP, the idea the contracting out to NGOS

and other private sector actors was devised in HPSS in 1996. Thus, I would argue that the government's power to make policy independently has been reduced in the course of neoliberal health policy reform.

In the chapter 4, I have discussed who are the key players and their sources of power and their position in the policy game and how the policy outcome is influenced by whose agenda. I show in that chapter that the health reform policies such as HPSS, UPHCP were not presented in the parliament, not discussed in the cabinet. Political parties were absent in the deliberation. But all of these policies were participated, guided by donors, government bureaucrats, international experts, local consultants and NGO leaders. All though these policies have passed through formal government channels, thus they are government decisions anyway; however, democratic quality of the decisions has decreased. In other words, the basis of the state regulatory power the -legitimacy- has been reduced. Jeremy Shiffman and Yonghong Wu (2003: 1549) analyzing health policy reform in Bangladesh commented:

“...the health agenda is set largely by the donor community and health decision-making power resides primarily, if not exclusively, in the hands of donors. The host government serves at best as a junior partner in a health reform coalition and at worst as an institution with no meaningful voice in the health affairs of the nation it is supposed to govern.”

They identified this situation as the “complete disempowerment” of the host government in the name of health reform.

### **6.1.2. Challenge from the Within**

State regulatory function has come under challenge from within as well (Reich 2002). This challenge came from the inefficiency in corruption in government health service. The government health care service is run under a bifurcated civil service cadre with separated organization and management; while one is to deliver health services, the other provides family planning. However, since the early nineties the Family Planning Directorate also had also started to provide maternal and child health services, thus created duplication as well as rivalry between the health and family planning cadres (DFID 2001). As a result, the health system became grossly inefficient and not well suited to deliver integrated health services. Corruption is another concern for which

government legitimacy has been reduced. Unofficial fees, informal payment, corruption in procurement are very common in the health sector in Bangladesh (Killingworth et al 1999; TI 2006; TI 2004). Reich argues that ‘corruption has multiple consequences for the state. It undermines the legitimacy of state agencies, as it reduces effectiveness, redirects official activities, and tears at the moral fibers of the state and society.’ (Reich 2002: 1671). All in all, it could be argued that the due to inefficiencies and corruption the state’s regulatory authority is questioned to its citizens and international communities.

### **6.1.3. Challenge from the NGOs**

I have discussed in Chapter 3 how NGOs are growing in number, capacity and power in Bangladesh. There are 4061 NGOs working in the broader health sector (Perry 2000). A WHO report suggests that the numbers of NGOs having activities in health sector numbers 913, of which 62 are national, 59 are international and 792 are local. At present, altogether NGOs covered some 24 million of people as beneficiaries (Begum 2003: 66-67; Blair 2000: 195). There might be some disputes over the exact number of NGOs and their beneficiaries, but does not matter. What matters is NGOs are becoming an influential political force. In Chapter 3, I have argued that the NGOs have become an important player in the national political space since nineties. Westergard argued NGOs influence politics through their federation by negotiation, influencing government policies through their international donors and by encouraging beneficiaries to take part in the local government election in the rural area (Westergaard 2000). Researchers observed that NGOs are growing influential mostly because of their foreign connection. In fact, donors have increasingly been interested to provide their aid through NGOs instead of the state agencies in recent years. One estimate shows that in 1972/73 the proportion of total foreign aid to Bangladesh disbursed through NGOs was about only 1% while in 1980s it was increased to about 16.39% (Aminuzzaman 1998). The number of NGOs receiving foreign funds is also increasing. The total number of foreign fund receiving NGOs increased from 494 in 1990 to 1245 in 1998 (Begum 2003). All this data indicates that NGOs are challenging government from the bellow in terms of their influence in the policy arena. Regarding the case of health reform it is more evident, I have already showed it in chapter 4. This argument can be further elaborated by showing one example. There are three laws in the US- The Helms Amendment 1973, Mexico City

Policy and Kemp-Kasten Amendment 2002, which prohibits use of US assistance for abortion service overseas. This has a great implication for the health sector in Bangladesh because, currently, 33 local NGOs, under USAID funded NGO Service Delivery Project (NSDP), are providing primary health care services in 91 of the total 290 municipalities and city corporations throughout the country. Under NSDP programs NGOs delivering an essential package of health services (ESP) that include child and maternal health care, reproductive health care (Rahman 2006). This means, in 91 municipalities where 33 NGOs are using US funds for providing primary health care they are not allowed to give any abortion service to their constituencies. While abortion is recognized as one method of family planning and woman's right, thousands of women are denied to have their service and right. But in Bangladesh, the government has no direct prohibition or discouragement regarding the issue. Bringing this issue I want to argue that the by following their donor's regulations, laws NGOs to a grater extent either by passing or neglecting local need and laws. Haque (2002) also argued that NGOs are making state weak by making public accountabilities difficult. This is how NGOs are challenging the state's regulatory function in Bangladesh.

## **6.2. CHANGES IN THE SERVICE DELIVERY FUNCTION**

State's role in service delivery, particularly in health care has changed lot due to the neoliberal reform in Bangladesh. In order to understand how it has changed we need to know first how it was.

### **6.2.1. Public sector Health Care Delivery System**

The government of Bangladesh has an extensive infrastructure of facilities as well as relatively extensive human resources base for the delivery of health and family planning services for its population. Health services can be divided into three types: primary health care, secondary health care and tertiary health care. The public health care service delivery system in Bangladesh is focused on the primary health care, which has various levels of service delivery. However, government does deliver not only primary health care services but also secondary and tertiary cares.

The public health care service delivery system is hierarchically organized within which the primary, secondary and tertiary health care facilities are interconnected with referral



system. Health care service delivery facilities from the bottom to the top hierarchically connected not in terms of the 'chain of command' but in respect to expertise, resources each of the level employs to tackle health problems of the population.

The highest level, national level, of the health care delivery system is consists with specialized hospitals like National Chest Hospital, National Eye Hospital, National Orthopedic Hospital and higher level research and training institute like Bangabandhu Sheikh Mujib Medical University, National Institute of Cardio-Vascular Disease (NICVD). These hospitals and institutes works as the referral hospital for the secondary level specialized health care. Currently there are nine specialized hospitals with 2464 bed-capacity (MOHFW 2005a). All of them, except one, are situated in the capital city.

At the regional level, there are 13 public medical college hospitals to provide specialized health care, medical education and to act as the referral for the hospital for the secondary level health care. Medical college hospitals have inpatient and outpatient service sections. The outpatient departments provide primary health care. At present the total bed-capacity of all pubic medical college hospitals is 8430 (MOHFW 2005a). There are 59 district hospitals at the district level in order to provide the secondary level heath care. These hospitals work as the referral hospital for the Upazila health complexes. The total number of beds in district hospitals in Bangladesh is 7400 (ibid). At this level there are some other hospitals like military hospital, police and jail hospitals an so on. The total number of beds in these kinds of hospitals is about 1600. At the bottom of the public health care service delivery structure there is the Upazila Health Complex. Upazila Health Complex is actually responsible for providing primary health care.

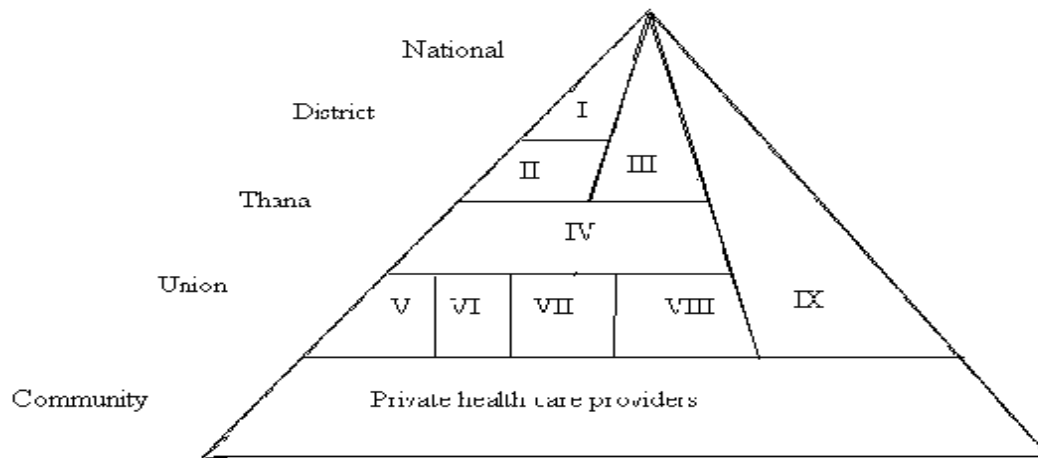
Table 6.1: Public Sector Health Care Delivery System

Level	Facilities	Number	Total Bed	Services
Tertiary Health Care (National level) (Regional level)	Research Institutes Specialized Hospitals	09	2464	i. Referral hospital for the secondary level of health care ii. Education, research and professional development in health science
	Medical College Hospitals	13	8430	iii. Highly specialized health care provision
Secondary Health Care (District level)	District Hospitals	59	7400	i. Specialized secondary level health care provision ii. Referral hospital for primary level of health care
	Other hospitals	26	1615	iii. Support service to primary health care facilities
Primary Health Care (Upazila level)	Upazila Health complex	395	12615	i. First referral level of the primary health care network ii. Limited ambulatory care iii. General long-term care iv. Support services for domiciliary and community level primary health care
Union Level	Union Health and Family Welfare Center	4200	0	i. Treatment of common and minor diseases ii. Prevention of contagious diseases iii. Maternal and child health care
Community level	Health posts		0	i. Motivational work ii. Prevent ional and curative care
Household level	Visiting Staff attached to UHC		0	i. Basic health education ii. Immunization iii. family planning and maternal and child health iii. Oral rehydration and control of contagious diseases

Source: Compiled from MOHFW 2005a; Osman 2004 and Perry 2000

Table 6.1 presents a general picture of the public sector health care delivery system. This delivery system is hierarchically organized (Figure 6.1).

Figure 6.1: Health Care Service Delivery Hierarchy in Bangladesh



<b>Notes:</b>	
<b>I</b> - Medical College Hospitals (300-500 beds)	<b>V</b> - Dispensary (Outpatient only)
<b>II</b> - District Hospitals (50-200 beds)	<b>VI</b> - Union Family Welfare Center (Outpatient only)
<b>III</b> - Specialized Hospitals	<b>VII</b> - Other health centers
<b>IV</b> - Upazila Health Complex (31 beds)	<b>VIII</b> - Maternal and Child Welfare Center (2-10 beds)
	<b>IX</b> - Other hospitals
Source: Adopted with modification from Osman 2004; and Khan 1984	

Figure 6.1 presents the hierarchic system of public sector health care delivery in Bangladesh. However, currently at every level private sector providers are also present. In the hierarchy Levels IV, V and VI are exclusively meant for primary care.

### 6.2.2. Primary Health Care Delivery System in Urban Areas

Primary health care is defined in the public health system in Bangladesh according to the Alma Ata 1978 declaration (WHO/UNICEF 1978). The government, however, has also prepared its own features of primary health care considering the context and pattern of health problems in Bangladesh.

There are nine elements of primary health care in Bangladesh (Khan 1988). They are:

1. Education concerning prevailing health problems and methods of preventing and controlling them
2. Promotion of food supply and proper nutrition
3. Adequate supply of safe water and sanitation
4. Maternal and child health including family planning services

5. Immunization against major infectious diseases
6. Appropriate treatment of common diseases and injuries
7. Prevent and control of endemic diseases
8. Provision of essential drugs
9. Promotion of mental health care

It is understandable that the components of primary health care, as it has been set, are very comprehensive in coverage. Some of its components such as promotion of food supply, supply of safe water and sanitation are not usually covered by functions of the Ministry of Health and Family Welfare of Bangladesh Government. Rather, primary health care services are made reduced to general preventive, child and reproductive health care services. Recently, with the reform program in 1998 government of Bangladesh redefined the scope of primary health care services. In fact, in the new program primary health care has been further reduced to a service package, namely Essential Service Package (ESP) and the government has given the full charge of implementing and supervision of ESP delivery to the Director, Primary Health Care, DGHS of the Ministry of Health and Family Welfare (MOHFW 2004).

In Bangladesh, there are 522 urban centers of which 290 have urban local governments (6 City Corporations and 284 *pourasavas*), rests have no municipal authorities, where government agencies run the operation of urban utilities services. There are six relatively large urban centers: Dhaka, Chittagong, Khulna, Rajshahi, Barisal and Sylhet which are called metropolitan cities. Besides, there are 18 cities with population of over 100,000 each. The present urban growth rate is six percent (MOHFW 2004:6). Migration from rural and small town is the main cause of this rapid urbanization. Most of these migrants are poor. According to Islam (2002) 44% out of 30 million urban population is poor.

City councils are the responsible authorities to deliver and manage primary health care for the urban areas. However, the delivery infrastructure in practice is rather complex, mixed in nature and consists of government, private and NGO facilities. We have already reported in previous chapter that the health care system, in general, is urban biased. However, the primary health care services, particularly for the poor, have been left neglected all along. For primary health care, in rural areas, the government health care

delivery infrastructure is reasonably strong, where as in the urban areas it is almost nonexistent (Perry 2000: 60). On the contrary, the specialized health care delivery infrastructure is very strong in the urban areas.

In bigger cities and district towns, the government health care is provided through two channels: the government-run general and specialized hospitals (usually attached to various medical college and institutions) and municipal authority run hospitals and dispensaries. The government run general and specialized hospitals have both inpatient and outpatient departments. Usually the outpatient departments provide the primary health care, with a very low (official) user fee. The Ministry of Health and Family Welfare is the central, apex government agency for managing and regulation of these hospitals. In smaller urban centers like the district towns, the district general hospital and in some relatively more urbanized upazila headquarters the Upazila Health Complexes deliver primary health care services. Currently, there are 13 government medical colleges in 12 district towns. In addition, there is one dental college in Dhaka and two Dental units attached with Rajshahi and Chittagong medical colleges. 8 specialized national level hospitals out of 9 are located in the capital city.

The other channel of the health care services consists of hospitals and dispensaries run by the city councils. There are 290 city councils among 522 urban centers in Bangladesh. In 6 larger metropolitan cities, city councils - urban local government bodies are called City Corporation and in other cities they are called *Pourasavas* (city council). There are 284 Pourashavas all over the country. Although city councils are mandated to provide the health care services to its citizenry, however, no appropriate infrastructure has been developed under them until very recently. For example, in Dhaka, for more than 10 million people, there is only one general 50-bed hospital, named Dhaka Mohanagar General Hospital, run by Dhaka City Corporation (DCC). The treatment is provided at very lower cost. The DCC also runs one 100-bed child hospital. In addition to these hospitals, there are 3 maternity centers, 17 dispensaries and 3 homeopath dispensaries run by City Corporation in Dhaka. The city corporation has Health Department headed by the Chief Medical Officer, which is responsible for monitoring and regulating hospitals and dispensaries of the corporation. In Chittagong, a city of 4 million, the situation is relatively better comparing to Dhaka. There are city council run 19 dispensaries from

where primary health care services are provided for the citizens in Chittagong. Besides, there is one 100-bed full-fledged hospital (Memon Maternity Hospital) and five 50-bed maternity hospitals run by the Chittagong City Corporation. Moreover, Chittagong City Corporation has its own special health program on health care for orphans, child and mother immunization programs and disease surveillance activities since 1994 (CCC 2005). However, in spite of having government and city council's health facilities, particularly facilities for primary health care delivery, the health status of the urban poor are often worse than the conditions of the rural poor. Research shows that the morbidity is higher among the urban poor and the cost of illness is also higher among them comparing to rural poor (Desmet et al. 1998). Islam et al. reports:

“Theoretically, the poor have equal access to all the Government health facilities in the urban areas. In reality, however, very little access is available to them. Many patients are discouraged by overcrowding and suffer neglect. The time and expenditure involved in reaching the facilities, the waiting period (often whole day or several working hours), the quality of attention received and lastly the expenses involved in allopathic medicine, all discourages the poor. They are often found to seek services from homeopaths, traditional healers and even quacks” (Islam et al. 1997: 88).

Having reviewed the entire public health care service delivery system, particularly the primary health care delivery system, it could be said that the state - the central government and local government, was the key actor. Primary health care service delivery mechanism was hierarchically organized. But after implementing the reform under UPHCP this role of the state in primary health care delivery mechanism has changed qualitatively.

### **6.2.3. Changes in the State's Role in the Primary Health Care Delivery in Urban Areas: *Moving Towards Multi-level Governance***

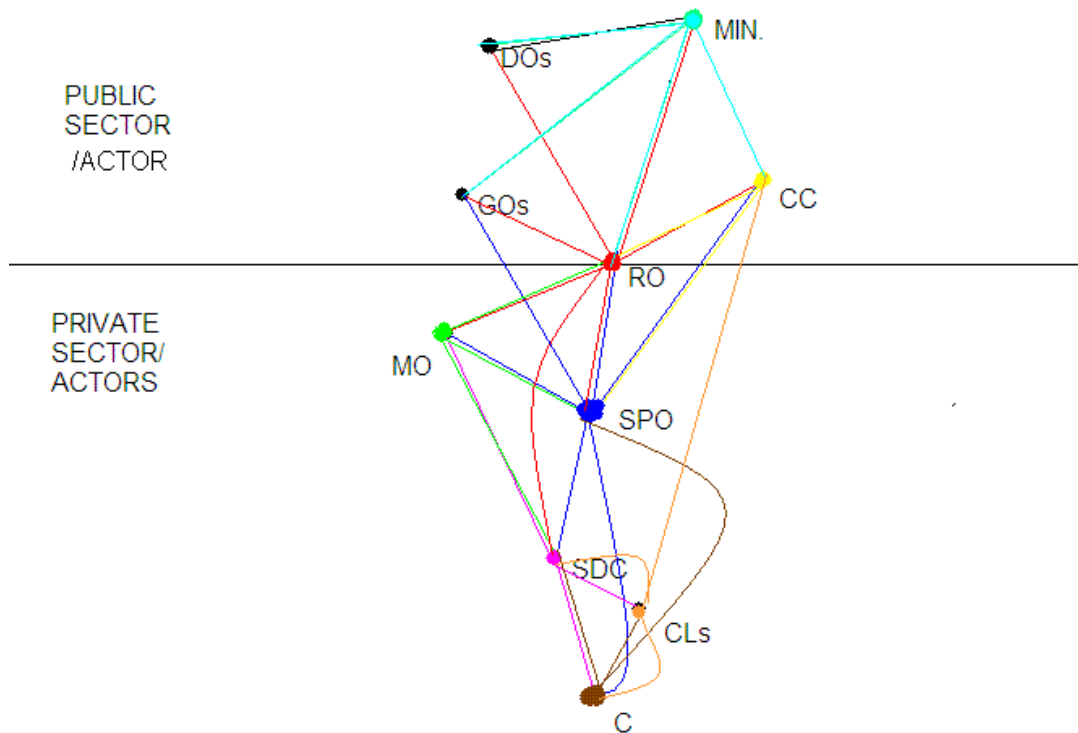


Figure 6.2: Emergence of Network of multilevel governance

<b>Legends:</b>	
<b>DO</b> - Donor Organizations;	<b>MIN</b> - Government ministry;
<b>GO</b> - Government organization;	<b>CC</b> - City Council;
<b>RO</b> - Regulatory Organization;	<b>MO</b> - Monitoring Organization;
<b>SPO</b> - Service Providing Organization;	<b>SDC</b> - Service Delivery Center;
<b>CL</b> - Community Leaders;	<b>C</b> - Community

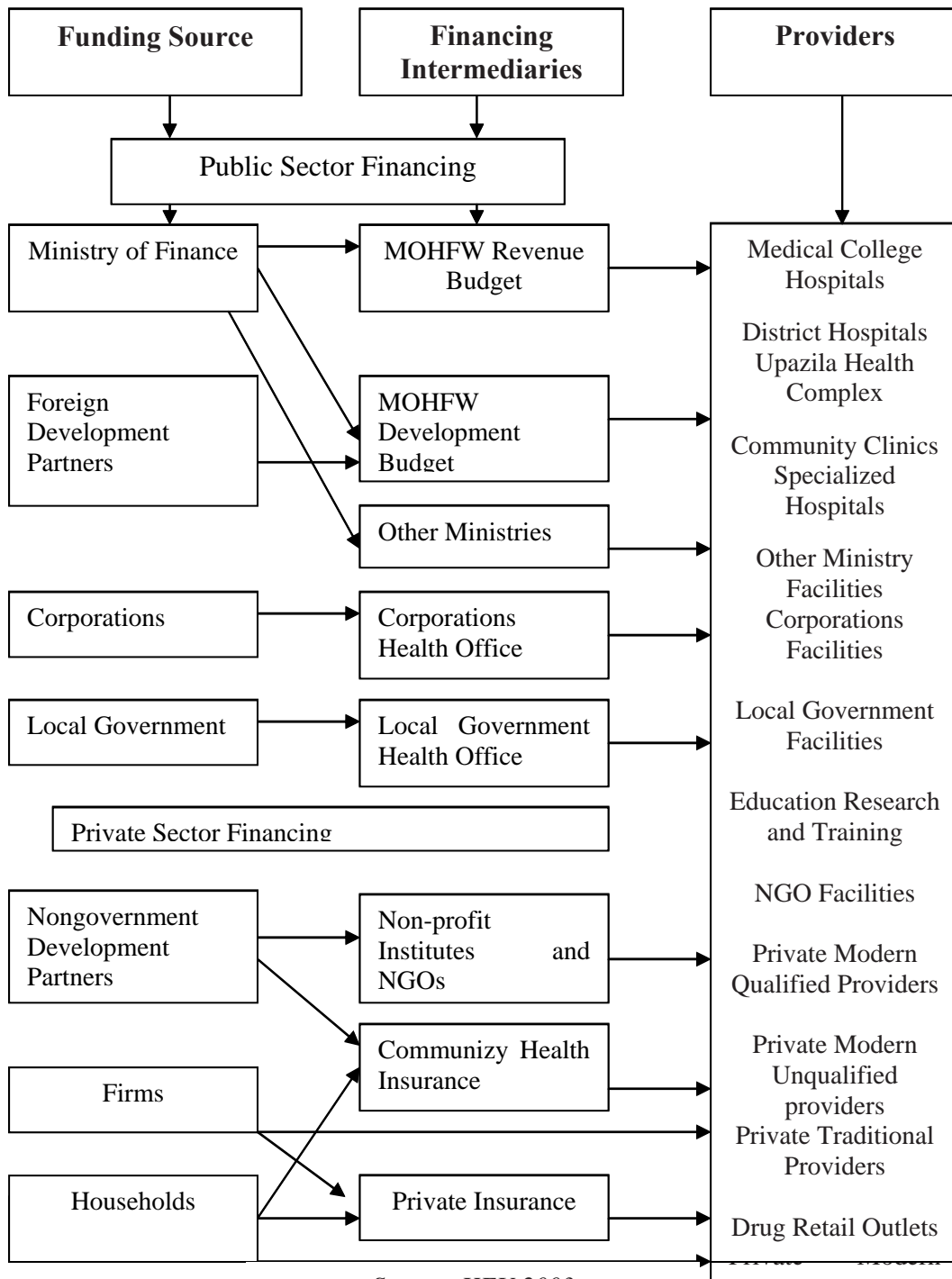
With respect to the primary health care service delivery in urban areas, as a result of the new rules and regulations of the UPHCP, somewhat a model of multi-level governance has emerged. *Multi-level governance* refers to the changing relationships between actors situated at different territorial levels and from public, private and voluntary sectors. Hooghe and Marks (2003; 2004) argue that multi-level governance reflects relationship among the actors that is more complex, fluid and consisting of several jurisdictions. According to them, these jurisdictions often overlap each other. In the case of primary health care service delivery in Bangladesh, the structure was previously hierarchically organized under the political-leadership. For example, the city corporation's health

department organizes its all clinics and dispensaries hierarchically being stayed the Chief Health Officer and the Mayor at the top. However, in the UPHCP, we have seen that, there are several influential actors like the ADB, the LGD, City Corporations and NGOs are nested together through various decision-making bodies. For example, the recruitment decision of a Project Manager for a service-provider NGO has to be made and approved through Partnership Committee, Steering Committee and so on. ADB is a multilateral donor organization whose jurisdiction covers the whole region, whereas the LGD is a national actor. Similarly, the city corporation is a local actor and a particular service-provider NGO is community level actor. These actors, from various territorial and functional jurisdictions, came together and formed a complex interdependent relation-structure among them in order to deliver services.

Figure 6.2 depicts the network of multi-level governance that has been emerged as a consequence of the reform under UPHCP. Figure shows, the PIU is working as the hub between state and non-state actors, between providers and planners. The PIU is identified as the RO (regulatory organization) in the figure. This RO maintains contacts with ministry, donor organizations (like ADB, UNFPA). It has to inform them formally and informally. At the same time RO also informs, negotiates with government agencies such as DGHS. Service providing organization is the partner organizations who are actually delivering services. Service providing organization is also providing services through the clinics (SDC - service delivery center) who are connected with community leaders and so on.



Figure 6.3: Flow of Funds in Bangladesh Healthcare



Source: HEU 2003

What is clear from the network, that the state is no more ‘the most powerful’ actor in the network. All actors are connected to each other for their interdependencies. For instance, partners are dependent on city corporations for their supply and fund release approval. Even, LGD is also dependent on the NGOs for the success of the project. This is to argue,

the states dominating, monopolistic role in service delivery mechanism has changed.

### 6.3. CHANGES IN THE FINANCING FUNCTION

Financing in the health care one is one the most important traditional function of the state of Bangladesh. Broadly, the definition of health care financing includes three major components: mobilization of funds for health care; allocation of funds to the regions and population groups and for specific types of health care and mechanisms for paying health care (Hsaio and Liu 2001).

There are three sources of health care financing in Bangladesh: Public expenditure, private expenditure and external aid. Public expenditure encompasses all expenditures on health services by the Government of Bangladesh. I shall focus on the changes in the public expenditure.

Table 6.2: Total Health Expenditures, 1996-97 to 2001-02

<b>Indicators</b>	<b>1996-97</b>	<b>1997-98</b>	<b>1998-99</b>	<b>1999-00</b>	<b>2000-01</b>	<b>2001-02</b>
Total Health Expenditure <sup>30</sup> (THE) in million Taka	55,763	62,022	68,281	74,785	80,966	88,313
THE in million US\$	1,358	1,369	1,420	1,487	1,499	1,549
Real growth rate of THE	-	5.6	5.2	7.5	6.6	5.7
<b>MOHFW as % of THE</b>	27.6	28.3	27.2	25.7	24.0	24.3
NGO as % of THE	2.9	3	4.1	6.8	8.8	9.2
Household as % of THE	64.1	65.1	65.7	64.6	64.4	63.8
Development partners as % of THE	10.5	-	-	12.2	12.9	13.3
ESP as % of THE	-	-	-	19.7	19.1	19.9

Source: NHA-2 in HEU 2003

Table 6.2 presents the detail scenario of the health care financing in Bangladesh, from 1996-97 to 2001-02. It shows that Total Health Expenditure has dropped in the year 2001-02 from 1999-00. At the same, the table also indicates the changes in the pattern of

<sup>30</sup> According to the conceptual framework of Bangladesh National Health Accounts, National Health Expenditure (NHE) encompasses health expenditures of a country during the accounting years comprising expenditures on all healthcare functions. On the other, Total Health Expenditure (THE) which includes NHE plus capital formations, education and research expenditures of all healthcare providers during the accounting period (HEU 2003).

health care financing in Bangladesh as it reflects the contribution of MOHFW or government direct health expenditure to the THE is on a decreasing trend. It shows, the government expenditure has dropped from 28.3% percent in 1997-98 to 24.3% in the year 2001-2002. On the other, household out of pocket expenditure and development-partner's contribution both have been increasing. The share of NGO expenditures increased from 3% in 1997-98 to 9% in 2001-02. Along with the overall increase, the share of donor support to MOHFW and NGO expenditures also increased significantly in the same period both in relative and absolute terms.

As it is depicted in the Table 6.3, the largest contribution comes from the household which is followed by government and donors<sup>31</sup> The Table 6.4 also shows that the government financing has increased in absolute terms, however, it has declined as a percentage of Total health Expenditure. From around Taka 13.4 billion in 1996-97, in 2001-02, government expenditure increased to Taka 18.6 billion. However, as a percentage share of Total Health Expenditure, government expenditure has declined from 24% in 1996-97 to 21% in 2001-02. During the same period, the donor's contribution has increased from around Taka 5.8 billion in 1996-97 to Taka 11.7 billion in 2001-02. In relative terms, it also increased from 10.5% in 1996-97 to 13.3% in 2001-02. Household contribution, over these years, remains almost steady, on average 64%.

Table 6.3: Total Health Expenditure by Sources of financing, 1996/97-2001/02 (in million Taka)

Source	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
GOB	13,450	13,998	14,550	15,818	16,590	18,597
Development Partners	5,842	7,295	8,391	9,158	10,453	11,745
NGOs	194	224	259	271	512	301
Household OOP	35,293	39,579	44,021	48,344	52,153	56,341
Private enterprises	979	917	1048	1178	1231	1297
Private Insurance	2	2	3	3	10	11
Community Insurance	3	7	9	13	17	21
<b>T H Expenditure (THE)</b>	<b>55,763</b>	<b>62,022</b>	<b>68,281</b>	<b>74,785</b>	<b>80,966</b>	<b>88,313</b>

Source: HEU 2003

According to the National Health Accounts principles, the public sector expenditure consists of expenditures undertaken by: **a.** Ministry of Health and Family Welfare (MOHFW) **b.** Other Ministries **c.** GOB owned Corporations **d.** GOB Non Profit

<sup>31</sup> In official documents of the Government of Bangladesh, bilateral and multilateral donors are called as 'Development Partner', therefore, one may find use of both of the terms in this text, however, they mean the same entity.

Institutions (NPIs indicating Public Universities) e. Local government bodies (HEU 2003: 41). Since the Ministry of Health and Family Welfare (MOHFW) is the largest institutional healthcare provider in Bangladesh with an extensive network of facilities across the country that provides varied services ranging from primary healthcare typified by Essential Services Package (ESP) to complex treatment care, our discussion in this part will focus on the expenditure undertaken by the MOHFW only.

Table 6. 4: Revenue and Development budget allocation in Health, 1993/94- 1997/98; US\$ million, 1997/98 constant price

	1993/94	1994/93	1995/96	1996/97	1997/98
Revenue-Health	117.14	136.64	147.17	162.38	163.22
ADP-Health	66.47	79.81	103.78	138.82	134.12
Revenue-Health as % of Total revenue budget	3.20%	3.24%	2.91%	3.30%	2.96%
ADP-Health as % of Total ADP	3.52%	3.49%	3.64%	5.00%	4.59%

Source: HEU 1998

The data of Table 6.4 reveals that both revenue and ADP allocations in health have increased over years, particularly from 1993 to 1998. While in total ADP allocation, the share of health continues to increase slowly from 3.52% in 1993/94 to around 5 in 1997/98, the share of health in the revenue budget has declined from 3.20% to 2.9% (HEU 1998:10). In other words, it is evident that the revenue budget allocation to health increased in absolute terms, but on the other, in relative terms it, in fact, has decreased. This trend continues until recently. National Health Accounts data reports a modest increase in both revenue and development budget in health in recent years.

Table 6.5: MOHFW Expenditure by Providers, 1996/97, from 1999/00 to 2001/02 (Million Taka)

Providers	1996-97	1999-00	2000-01	2001-02
Health Administration	2,205	2,518	2,644	4,247
University Medical Colleges Hospital	--	255	205	225
Medical College Hospitals	1,935	1,400	1,323	1,316
District Hospitals	1,765	1,181	1,153	1,454
Upazila and Bellow level Health Facilities	6,553	12,527	13,532	14,393
Specialized Hospitals	2,663	1,023	621	812
Other Health Facilities	130	500	142	166
Education, Research and Training Institutes	1,920	625	1,007	1,197
Total Expenditure	17,171	20,029	20,627	23,810

Source: HEU 2003

Table 6.5 indicates that the upazila and bellow-level health facilities take the higher share of the MOHFW annual budget allocation. In the year 2001-02 out of 23810 million Taka, about 60% of the budget (14,393 million Taka) was channeled through the lower level health facilities. We know that the upazila and bellow-level health facilities mainly provide the basic primary health care. On the other, in the same financial year secondary and tertiary health care facilities take 1454 and 2128 (Medical college hospitals and specialized hospitals together) million Taka respectively.

Due to the implementation of new health sector program HPSP in 1998, a major shift took place in the structure and focus of the government expenditure in health. Since then primary health care services have been integrated into the ESP and the government of made successful implementation of ESP. Thus, a bulk of finance was dedicated to ESP implementation. National Health Accounts reports that 54%, 49% and 48% of total MOHFW budget allocation was made on ESP in 1999-2000, 2000-01 and 2001-02 years respectively (HEU 2003). The same source also suggests that during the 1999-2000 to 2001-02 periods, ESP as percentage of NHE has formed around 21%.

Least but not last, one more important feature of public sector expenditure deserves to be discussed in this section i.e. per capita MOHFW expenditure. Table 6.6 indicates that the Public Expenditure Review 1999-2000 shows that in spite of an increase in the health allocation in absolute terms, the per capita spending has not increased in recent years. The per capita public sector expenditure rose between 1998-99 and in 1999-2000 it has slightly from 135 Taka to 143 Taka per person. This is a small real terms increase but still remains bellow the levels of 1996-97 levels.

Table 6.6: Per Capita Expenditure by MOHFW, 1993-94 - 1999-00

Period	Per Capita expenditure on health and family welfare		Share in GDP
	At current price in Taka	At constant price (1993-94= 100 Taka)	
1993-94	92.71	92.71	1.12
1994-95	116.58	107.09	1.27
1995-96	121.63	104.75	1.21
1996-97	143.95	120.93	1.36
1997-98	153.82	119.99	1.34
1998-99	135.30	103.80	1.15
1999-00	153.5	115.18	1.10

Source: HEU 2001

From the above data and discussion, it is very clear that there has been a change taking place since 1997-98 in the role of state in health care financing - in amount and pattern. We already know that the major reforms in health sector started to be implemented since 1997-198. Ministry of Health and Family Welfare is the states representative in the health sector. The above discussion points several features of state financing:

1. MOHFW is the single largest institutional financier in the health sector.
2. Since 1997-98 the contribution of the state in health sector is decreasing
3. Since 1996-97 per capita state's health expenditure is decreasing
4. The large part of the state's expenditure is dedicated to primary health care, particularly for rural population
5. During the same period the household out of pocket expenditure has not changed, more or less same, however, percentage of NGOs share has increase from (3% to 9%) and share of donors also increasing
6. Contribution of private firm/insurance in health expenditure has no significant presence in the health care.

What it all implies that the state of Bangladesh is gradually shrinking its presence in the health care sector. But private business sector has not showed any sign to take over; instead, NGOs are growing at relatively faster rate in the health sector.

#### 6.4. CHANGES IN THE ROLE OF STATE: IMPLICATIONS FOR THE POOR

The implications of changes in role of the role of state for the poor are multifaceted which can be captured in following:

##### **6.4.1. Marginalization of Local Government**

It is argued that the local government is relatively closer political institution to the poor. Devas et al. analyzing experiences of ten southern cities has showed that municipal government can positively affect the urban poverty (Devas et al. 2001). But in Bangladesh the role of local government in health service delivery has been marginalized due to the implementation of neoliberal reform. I discussed that the city corporation - the

local government bodies are constitutionally mandated to provide public services to its citizens. However, when we look into the overall UPHCP decision-making structure, we would find the city corporation is left with a very small part to play. Under UPHCP, the services are provided by the NGOs; the finance is given by the central government; regulation and day-to-day management is run by the PIU (as a direct administrative part of the LGD), monitoring and evaluation is carried out by the private sector then what else has been left for the local government? In fact, in practice there is almost nothing. But, irony is that the second objective of the UPHCP was to building capacity of the city corporation in delivering health care services. The city corporations are only given a coordinating role in the UPHCP without having any control over distribution of material and non-material resources. In this backdrop I argue that this marginalization of local government's role will affect urban poor negatively.

#### **6.4.2. Transformation of Citizens into Customer**

Another significant implication poor is changes in the health entitlement. Under UPHCP, the citizens have been turned from service recipient to clients. Traditionally, the city corporation has been providing primary health care services for free or with a very minimum price. People were entitled to get the services. It has been seen that the poor uses the public facilities. However, under the UPHCP, the citizens are considered as clients/customers. All NGOs are asked to recover the costs they make in delivering health services. Thus, the service providers are allowed to charge fees up to a certain amount determined by the partnership committee in order to recover their operation cost. This means, the poor clients have to pay for the services they want. No service is free now, prices may vary though. Therefore, the relationship between the provider and receiver has changed into buyer and seller. And, this transformation very likely would reduce the access of the poor.

#### **6.4.3. Expansion of Central Government's Control over Local government**

It is argued that transfer of power and authority to the local government agencies likely to produce positive impact on the poor. Crook and Sverrisson (2001) argued decentralization in developing countries brings government closer to the people which will make it more responsive and hence develop policies to meet needs of the poor. Since

contract out is regarded as one form of decentralization (Rondinelli 1981), it supposed to have positive impact on the poor. But I argue that through this contracting out no significant transfer of power and authority is taking place, rather an expansion of government control over NGOs and on the other hand, intrusion of central government in the functional jurisdiction of local government is occurring. And through this process disempowerment of local government is made and NGOs are somewhat integrated into government structure. I discussed that providing health services to the city dwellers is the function of City Corporation. But, through the reform program the ministry of LGRD&C is taking over this function into its own hand. The PIU is, in effect, as working as a subordinate office of the ministry. The PIU is not accountable to the city corporation. On the other the NGOs are also not accountable to the city corporations. This means, City Corporation has no control over the service providing organizations. On other side, being awarded with the contract, NGOs have become part indirect part of MOLGRD&C through PIU. Ideally, they are to be allowed to have their autonomy in designing service provisions. But in practice it is not happening. Many day to day decisions are also informally controlled from the PIU. Since the 'control' culture is predominant among the officials of PIU (who think themselves as part of the MLGRD&C bureaucracy), they interfere very often in the management and operation of partner NGOs in the name of 'monitoring'. So what happened as a consequence of that is a bureaucratic behavior pattern is also developing in the partner NGO. Thus, I argue that having been part of the UPHCP, NGOs are somewhat integrated in with the government structurally and behaviorally. Thus, as a result of these two processes the contract out is acting as counter-decentralization process.

## 6.5. CONCLUSION

This chapter presents the impact of the neoliberal reform on the role of state in health care in Bangladesh and it demonstrated that state's traditional roles are challenged from the donors, from within and from the NGOs. Evidences also showed state is gradually withdrawing from the service delivery and a new form of service structure is gradually taking over the previous hierarchical delivery mechanism. Somewhat a model of multi-level governance is emerging in the health care arena. It is also seen that state is reducing its financing in the health sector. All this changes in the role of state in health sector,



from macro perspective, is assumed to have negative impact for the health entitlement of the poor.

However, there is one more interesting observation, usually contract out is considered as 'rolling back' of state from the service delivery, but this study found that it is actually other way round. In effect, in case of Bangladesh, state is actually expanding its role in a different form through contracting out. It can be explained as a strategy of state for repositioning its power over the society. Thus, with respect to the impact of neoliberal reform, conclusion can be drawn that it should not be taken for granted that the neoliberal reform will be resulted in state withdrawal from the society, rather, one should be cautious about the very specific dynamics in ground.

## **CHAPTER 7**

### **IMPACT OF HEALTH REFORM ON SOCIETY**

The central research question of this study is if health sector reform does benefit the poor. I have already discussed that the term benefit is conceived in its extended notion which incorporates health (medical and economic) and political (social and political) benefits. In order to answer the question the study aims to analyze and understand the impact of health reform on state and society. This chapter presents the impact on society. However, one should keep in mind that the aim of this study is to understand the impact rather than ‘measuring’ impact. In other words, the research focuses on understanding the multidimensional gravity of the impact on society; not merely focusing on to identifying quantitative association between health sector reform and its impact. In following sections I shall present the impact on the individual and community levels.

In order to build a holistic picture of the health and political impact of the health reform, this chapter is divided into seven sections. The **first** section presents the socio-economic and demographic characteristics of the service users or potential service users. The **second** section deals with health service usage and the **third** with health knowledge and awareness. The **fourth** section presents impact on access to services while the **fifth** presents the impact on of health system which is followed by section **six** that presents impact on participation and accountability. The **final** section discusses impact on collective political action. At the end, conclusion summarizes the entire chapter. The impact will be presented on:

#### **7.1. SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERSTICS OF PEOPLE AND COMMUNITY**

In order to understand the impact on the individual and community we need to have an idea about the socio-economic, demographic characteristics of the individual service users or potential services users and the community they live in.

The unit of analysis, in relation to understand the impact at the community level, is the individual, more precisely mother/care giver of child of 0-12 months age. Since

individuals form a household and households form a community, individuals are regarded as representatives of both her household and the community she lives in. Therefore, I would primarily depict the characteristics of the respondent and her household. In addition, I would also present some extra-household feature of the community in order to construct a complete picture of the context urban poor live in.

Table 7.1.1 presents the distribution of respondents in surveyed communities in Dhaka and Chittagong. Dhaka represents the NGO-run health care service provision and the Chittagong represents CCC-run service provision. Table 7.1.1 shows more or less equal distribution of respondents among cities and communities.

Table 7.1.1: Distribution of respondents according to communities and city

City	Community	Frequency	Percent
Dhaka	Sultanganj	50	22.9
	Godighar	56	25.7
Chittagong	Ashkar Dighi	55	25.2
	Amanat Shah Majar	57	26.1
	Total	218	100.0

#### 7.1.1. Age, Education and Profession

Since our respondents are mother of 0-12 years of child, therefore, the respondent must fall within the reproductive age group which is 15-49 in the context of Bangladesh. The field survey confirms the fertility age of women in Bangladesh. The mean age of the respondent is 24 years. Table 7.1.2 shows the largest proportion, 37%, of the respondent falls under the age group 20-24 which is followed by next age group with 31% of respondents.

Table 7.1.2: Distribution of age of respondents

Age	Frequency	Valid Percent
15-19	36	16.6
20-24	81	37.3
25-29	67	30.9
30-34	27	12.4
35-39	3	1.4
40-44	2	.9
45-49	1	.5
Total	217	100.0
Missing	1	
Total	218	

Table 7.1.3 presents the education status of the respondent which reflects the low educational attainment of women in urban poor neighborhood. Around 58% of women are illiterate while 26% had attended primary school. Only one percent of women attained more than 10 years of schooling.

Table 7.1.3: Respondent's level of education

<b>Education level</b>	<b>Frequency</b>	<b>Valid Percent</b>
Illiterate	126	57.8
1 to 5 years of schooling	58	26.6
6 to 10 years of schooling	32	14.7
10+ years of schooling	2	.9
Total	218	100.0

According to the Census 2001 sources, the adult (15+) literacy rate in Bangladesh is for both sex 47.5, male-53.9, female-40.8 (BANBEIS 2006). The field survey data shows, more or less, compliance with national level data. However, the gender difference in educational attainment is visible in data about husband's educational status (Table 7.1.4). It is seen that the literacy rate is higher among adult male, which is about 58%. However, Table 7.1.4 also showed, about 55% of respondent's husband ended their academic training within 10 years of schooling.

Table 7.1.4: Educational attainment of respondent's husband

<b>Education level</b>	<b>Frequency</b>	<b>Valid Percent</b>
Illiterate	92	42.2
1 to 5 years of schooling	74	33.9
6 to 10 years of schooling	47	21.6
10+ years of schooling	5	2.3
Total	218	100.0

The field survey shows the husband's mean age is 32, which indicates a mean age gap of 8 years between husband and wife. The main criterion for respondents to be selected was: mother having child 0-12 months of age; thus, we need to look into the age structure of the children. It has been seen that the mean age of child is 5.68 months. Respondent's mean age of first marriage is 16 years while the mean age for first pregnancy is 18 years. In Bangladesh according to the law, nobody is allowed to marry before 18 years of age. It is regarded as a criminal offense if somebody gets married before 18. In addition, government and non-government agencies has been campaigning for about two decades or so to push the age of first marriage for women up to 20, but it seems the campaign

didn't work much. The survey results shows 67% of respondents got married before their age reach up to the legal limit of 18 (Table 7.1.5). Further estimate indicates 89% of respondent got married before 20 years of age.

Table 7.1.5: Respondent's age of first marriage

		Percent			Percent
Married at under 18 years of age		67.4	Married at under 20 years of age		89.0
Married at 18 or above age		32.6	Married at 20 or above age		11.0
Total	%	100.0	Total	%	100
	N	218		N	218

The lower mean age of marriage leads to have early pregnancy which is also evident among our respondents. The data shows that among the respondents a large part has got their first pregnancy at their adolescent age. It is found, around 73% respondents have had their first pregnancy within 19 years of age.

Table 7.1.6: Profession of the respondent

	Frequency	Valid Percent
Household work	202	92.7
Office worker	4	1.8
Domestic worker	6	2.8
Small business	1	.5
Garments worker	5	2.3
Total	218	100.0

Participation in labor market among the respondent is very low (Table 7.1.6), it shows only 7.3% of respondents are employed in paid work. While the baseline survey of UPHCP found that around 26% of poor women of reproductive age is involved in earning in addition to their daily routine (Seraji et al. 2000), our respondent shows only 7.3%. The main reason of this very low involvement lies in the process of respondent selection for this study. The respondents are mother of 0-12 years of age and the mean age of child is 5 .6 months, which is the age when children are mostly dependent on the breast milk. The data also shows that 97% of respondent feed breast milk to their babies and on average a respondent gives breast milk to her child 13 times in 24 hours. In this situation, it is very difficult for a mother to work outside of the household. As a result, in the post-delivery period most of the women do not have income-involvements.

On the other hand, the complete opposite scenario comes up regarding the income

involvement of the husbands of respondents. The Table 7.1.7 shows, all of the respondent's husbands are involvement in various kinds of income activities. In fact, otherwise they can not survive. According to our data (Table 7.1.7), the majority of the respondent's husbands, 27%, make their living by pulling rickshaw/van (try-wheeler human hauler, manually driven) which is followed by working in garments and small business with 20.6% and 16% respectively.

Table 7.1.7: Income-involvement of the husband

	Frequency	Percent
Rickshaw/van puller	59	27.1
Garments worker	45	20.6
Shop keeper	12	5.5
Domestic worker	3	1.4
Small business	35	16.1
Day laborer	24	11.0
Office worker	7	3.2
Driver	10	4.6
Others	23	10.6
Total	218	100.0

### 7.1.2. Household Features

It has been seen that in four study communities in Dhaka and Chittagong more than 89% households are headed by male, which is close to the Baseline survey that reported to have 90% male headed households in all four cities (Seraji 2000).

The mean size of the household in our surveyed communities is 4.88, it is also pretty similar to the Baseline survey which reported to have a mean 5.3 for household size for all four cities (Seraji 200). The national level survey also confirms the result that reported mean size of the household for national urban population is 5.03 (MOHFW 2001).

Table 7.1.8: Source of drinking water for the household

Sources of drinking water	Frequency	Percent
Pond/River	1	.5
Paved Tube well	27	12.4
Non-paved Tube well	3	1.4
Tap/Supply	185	84.9
Boiled	2	.9
Total	218	100.0

Table 7.1.8 indicates that 85% of the household collects drinking water from the city

corporation supply and 12% from paved tube-well; this means, almost all have a access to safe drinking water.

Place of defecation is an important aspect of one's health and sanitation which is reflects economic and social condition of living. Table 7.1.9 indicates more than half of the respondents do not have access to hygienic place of defecation, they use traditional latrine or open spaces like canal or drain flows nearby.

Table 7.1.9: Place of Defecation for the household

Place of defecation	Frequency	Percent
Sanitary latrine	106	48.6
Canal/Drain nearby	68	31.2
Pit latrine in closed place	31	14.2
Pit latrine in open space	13	6.0
Total	218	100.0

Data were collected regarding the ownership of houses and types of dwelling. It is found that there are three types of housing ownerships: own house, rented house and own house on others land (government, company, absentee owner etc.). The survey shows only 6% of the respondents live in their own house and 83% live in rented house and 11% live in own house built on others land.

Table 7.1.10: Types of dwelling

Types of dwelling	Frequency	Percent
Tin roof and earth floor	58	26.6
Tin roof and brick floor	31	14.2
Straw-leafs roof and earth floor	62	28.4
Brick roof and brick floor	27	12.4
Semi bricked	1	.5
Others	39	17.9
Total	218	100.0

Table 7.1.10 shows the types of dwelling based on the materials of the roof and floor. Wall material is not considered because usually it is the same with the floor material. Data reflects the poor condition of dwelling where 55% live in *katcha* house; and 15% live in *semi-pucca* house and 12% live in *pucca* houses.

### 7.1.3. Income and Expenditure

The mean income of the household is 4494.72 Taka (81.72 US\$;1USD@55BDT). It has

been seen that 67% of respondent lives under poverty line<sup>32</sup> and 40% of the households live below the hardcore poverty line (Table 7.1.11).

Table 7.1.11: Distribution of household Income and Expenditure

Percentage distribution of respondent by income and expenditure category	Income Percent	Expenditure Percent
1500 - 2500 Taka	11.0	12.4
2501 - 3500 Taka	39.0	40.8
3501 - 4500 Taka	16.5	17.9
4501 - 5500 Taka	13.3	14.2
5501 - 7500 Taka	10.6	8.3
7501 -above	9.6	6.4
Total	100.0	100.0

On the other hand, the expenditure data shows that the mean expenditure of a household is Taka 4170.18. A large part of the household expenditure goes for food. The mean food expenditure per household per month is Taka 2692.43. The survey result indicates about 87% of household have more than 50% of total expenditure only for food. Among the respondents 86% are landless. The mean land ownership is only 24.63 decimal<sup>33</sup>.

#### 7.1.4. Comparability of Communities

I have already built a general picture of the respondent, their household and the setting they live in. In addition to that, I would like to show to what extent these different communities in Dhaka and Chittagong are comparable to each other. Table 7.1.12 presents the comparability of communities on the basis of some basic indicators such as age of the child, age of the respondent, age of respondent's husband, household income, household expenditure, age of first marriage, age first pregnancy and so on. The table 7.1.12 shows, the communities are reasonably comparable to each other in terms of their population's demographic and socio-economic characteristics.

<sup>32</sup> Poverty line has been estimated on the basis of the Urban Poverty Survey 1995. The first major and widely accepted survey on urban poverty in Bangladesh was conducted by the Center for Urban Studies with funding from Asian Development Bank in 1995. The survey determined poverty line at Taka 3500 (US\$87.5 @ 40BDT) per household per month and Taka 2500 (US\$62.5) as the poverty line for the hardcore poor household (Islam et al. 1997). Adjusting with the current US dollar price (1USD= 55BDT) and inflation we determined the poverty line at 5000 Taka per household per month and poverty line for hardcore poor at 3500 Taka per month per household.

<sup>33</sup> 1Decimal=50 sq. Yards and 100 Decimal= 1 Acre



Table 7.1.12: Comparability of the communities

		Mean Age of the Child	Mean Age of respondent's husband	Mean Age of the respondent	Mean Age of Marriage	Mean Age of first pregnancy	Mean size of the household	Mean Monthly income of the household	Mean Monthly expenditure of the household	Mean monthly food expenditure of the household
Sultanganj		5.65	32.48	24.06	16.28	18.24	4.40	4018.00	3668.00	2245.00
Godighar		5.64	30.86	23.64	16.05	17.32	4.54	3446.42	3392.85	2380.35
Ashkardighi		5.26	32.15	24.42	16.60	18.07	5.55	5213.63	4767.27	2965.45
Amanat Shah Majar		6.20	32.67	24.19	16.58	18.46	5.00	5249.12	4798.24	3128.07
Total	Mean	<b>5.69</b>	<b>32.03</b>	<b>16.38</b>	<b>18.02</b>	<b>24.08</b>	<b>4.88</b>	<b>4494.72</b>	<b>4170.18</b>	<b>2692.43</b>
	N	215	218	218	218	218	218	218	218	218

### 7.1.5. An Important note on Understanding the Impact

The impact on individual and community is analyzed on three levels of comparisons: (a) pre-reform vs. post-reform; (b) NGO vs. Local government and (c) Among selected communities. For the comparison between pre-reform and post-reform I used data from two official sources: Baseline Survey 1999 and Endline Survey 2004. For the comparison between two cases, I used both official data and data collected from my own field survey. And for the comparison between communities under the selected two cases, I used my fieldwork survey data.

In addition, to understand the impact in the context of national trend I would also use *Bangladesh Health and Demographic Survey 2000* (Conducted by the Bangladesh Bureau of Statistics) and *Bangladesh Demographic and Health Survey 2004* (conducted by National Institutes of Population Research and Training). These two surveys drew on a national level representative sample.

In summary, it is seen that there has been homogeneity among the respondents in terms of their socio-economic and demographic characteristics. It is also seen that the communities are of similar nature in terms of their physical and environmental characteristics. The homogeneity among respondents and their communities laid the foundation of the validity for comparative analysis of the impact. Having fulfilled the condition of comparability, we can move for more detail analysis of the impact.

## **7.2 IMPACT ON HEALTH SERVICE USAGE**

In order to understand the impact of the reform, primarily, one needs to consider them in relation with the objectives of the project. According to the Project Administration Memorandum (ADB 1998), project's primary objective was to improve the health of the urban poor and reduce preventable mortality and morbidity, especially among women and children, by increasing access to PHC services. Therefore, at the first place I shall examine to what extent the project has contributed improving the maternal, and child health status among the urban poor.

There are quite many indicators of maternal and child health care, however, it is not feasible to use all of them in this place. Therefore, I made a selection of indicators considering three main features: a) the ability to capture the impact of the phenomena b) measurability and c) comparability with other national and international surveys.

### **7.2.1. MATERNAL HEALTH CARE**

Since the reform program has introduced new service provision specially aims to improve the status maternal health in the urban areas, I took most important indicators of maternal health care such as antenatal care (coverage, number and timing, provider, consultation), delivery care and post-natal care. These indicators are important because they are able to capture the large part of causes of maternal death. It has been seen that, about 36% of maternal deaths are from pre and post pregnancy complications (MOHFW 2001: 46). The present status of the maternal health in comparison with the bench mark year 1999-2000 (for both project and national level) can provide understanding of the effectiveness of the program in terms of its goal attainments.

#### **7.2.1.1. Antenatal Care (ANC)**

Antenatal care is an effective maternal health care intervention in identifying the pregnant women who are at risk of developing adverse pregnancy outcomes and treating them appropriately at early contacts (Seraji et al. 2000). The antenatal care also includes preventive health care services such as Tetanus Toxied immunization and supplementation of iron and folic acid, essential for pregnant women and child to be born. A woman of 15-49 years said to have antenatal care if she visited a health facility or consulted someone for advice or service related to her latest pregnancy.

#### 7.2.1.1.1. Coverage of Antenatal Care

The End-line survey (Islam et al. 2004) of the project reports a significant level of coverage of at least one visit to any health care provider for ANC in four project cities. For births that took place in one year before the survey, at least 80 percent of mothers in four project cities received ANC during pregnancy. The coverage is highest (87%) in Dhaka and lowest (80%) in Chittagong among the four cities (Table 7.2.1).

Table 7.2.1: Antenatal care coverage

Percent distribution of live births in the year preceding the survey by coverage of antenatal care according to cities and timeline					
Characteristics		Dhaka	Chittagong	Khulna	Rajshahi
Had any ANC	Endline	87.4	80.3	84.4	83.1
	Baseline	60.3	48.1	61.5	56.3
Had no ANC	Endline	12.6	19.7	15.6	16.9
	Baseline	39.5	51.9	38.2	43.0

Source: Islam et al. 2004 and Seraji et al. 2000

Table 7.2.1 also indicates the relative increase in the ANC coverage in four cities. In comparison with the data of baseline survey (conducted at the beginning of the project), It is evident that though the coverage of ANC in Chittagong is lower than other three cities, the rate of change is the highest. The mean change rate between pre and post project period is 27% where as for Chittagong it is more than 32%. The scenario is different among the poor population. The increase rate is also higher among the poor in Chittagong comparing to other cities (Table 7.2.2).

Table 7.2.2: ANC coverage among the poor

Percent distribution of live births in the year preceding the survey by coverage of antenatal care according to cities and timeline				
	Dhaka	Chittagong	Khulna	Rajshahi
Endline	61.8	65.5	66.0	64.9
Baseline	60.3	48.1	61.5	56.3

Source: Islam et al. 2004 and Seraji et al. 2000

Tetanus Toxoid (henceforth TT) is a vaccine which should be taken during pregnancy to protect both mother and child from tetanus infection. TT awareness has been very high among women all over the country due to a huge range of mass-campaign since mid eighties. TT vaccine is regarded as one of the important antenatal care. Evidence shows

that among the ANC receivers TT is the highest (MOHFW 2001). If we take this as an indicator of ANC then, the project (city) level data can be compared with national level data. The national data shows that 70% of women have received TT during their latest pregnancy, which is 67.7% and 74.1% among the rural and urban population respectively (MOHFW 2001: 33). Thus, this 74% can provide us the benchmark for the overall urban areas including city corporations for the year 2000. This means, the average coverage of ANC in the city corporation areas, 56.6%, which was reported in the base line survey, was considerably lower than the national urban level of 74.1% (Islam et al. 2000 and MOHFW 2001) before the reform took place.

#### *7.2.1.1.2. Number and Timing of Antenatal Care*

The number and timing of visits is considered as the most important aspects of antenatal care, aim at preventing adverse pregnancy outcome and treating problems early to avoid further complications. Care is most effective if the contacts are started early during pregnancy.

According to the existing standard procedure of antenatal care, contacts be made monthly for the first seven months, fortnightly in eight months and then weekly until birth (Mitra et al. 1997: 112 cited in Seraji et al. 2000). However, it is very difficult to maintain this schedule for poor, illiterate and working women in the context of Bangladesh. Therefore, Park and Park has suggested a simpler version of this schedule: minimum five visits during 4<sup>th</sup>, 6<sup>th</sup>, 8<sup>th</sup> and 9<sup>th</sup> month of pregnancy (Park and Park 1989).

The Endline survey reports that the median number of contacts is 3.6-5.5 among four cities (Islam et al. 2004) which were 3-4 during the Baseline survey. The Baseline survey indicates that more than 40% of women in Dhaka city reported to have at least four ANC contacts during their last pregnancy where as only 24% of women in Chittagong reported to have four or more ANC contacts. The median contact was 3 for all four cities, however, among the poor sample group reported to have a lower median, 2, in Chittagong (Seraji et al. 2000). Nevertheless, the information about the number of ANC contacts shows that though more than 80% of women are seeking ANC they have fallen below the recommended visits during pregnancy except Dhaka. While the number of women having at least four ANC visits increased in Dhaka from 42.7% to 59.3% during

the project period, the number of ANC contacts, for Chittagong, has increased from 24.6% to 39.2% at a relatively lower rate (Seraji et al. 2000 and Islam et al. 2004) during the project period. It is seen that the number of women having at least one ANC visit is increasing at a higher rate in Chittagong comparing to Dhaka, but the number of women having at least four visits is increasing relatively lower rate in Chittagong. It means the number of women seeking ANC care is increasing but for some reasons they are not maintaining regularities.

The timing of first and last ANC contact is also regarded as one of important indicator of maternal health as it captures the health awareness among the mothers or potential mothers. Survey reports that 39-55% of first visit were made within the first three months of pregnancy (Islam et al. 2004: 44). In comparison between Dhaka and Chittagong on the one hand, between Baseline and Endline data, it is seen that the number of women who received at least one ANC care within the first three months of their pregnancy rose from 49% to 55% in course of the project period in Dhaka; on the other hand, these respective figures have shown a very insignificant increase from 46.7% to 47% in Chittagong (Seraji et al. 2000, and Islam et al. 2004). These data show the project has very limited impact on increasing the awareness of timing of ANC among the women in Chittagong.

#### 7.2.1.1.3. Provider of Antenatal Care

The quality of ANC depends very much on its provider given the presence of a wide range of providers from Traditional Birth Assistant to specialized gynecologist. It is assumed that better quality is ensured if the ANC is provided by trained health personnel including doctors, midwives, government health workers and trained birth attendants.

Table 7.2.3: ANC from trained personnel

Percentage of live births in the one year preceding the survey by having ANC from trained health personnel, according to cities, Baseline and Endline Household Survey of UPHCP				
	Dhaka	Chittagong	Khulna	Rajshahi
Endline	86.1	79.6	84.4	83.1
Baseline	72.7	55.8	72.5	64.9

Source: Seraji et al 2000 and Islam et al. 2004

Table 7.2.3 presents the information about the women who had at least one ANC contact

with trained health personnel at two point of time. The table shows that there was high variation among the cities in this regard at the beginning of the reform project ranged from 56 in Chittagong to 73 in Dhaka. However, in course of UPHCP implementation all four cities reached the 80-85% level. It is important to note that the Chittagong has shown very significant attainment in this regard. Comparing with national trend, according to the government survey in 2000, nearly 75% of women reported consulting some trained health personnel (MOHFW 2001). Another important survey with a different sampling method, estimated that, for the national level, ANC provided by trained health personnel has increased dramatically, from 33% in 1999-2000 to 48% in 2004 (NIPORT et al. 2004). It is noteworthy, referring the same source, that the urban-rural differential in ANC coverage is large; 71 percent of urban births had ANC from trained health personnel, compared with only 43 percent of rural births. Higher rates of consultation with trained health personnel in cities, especially in City Corporation areas, might be a result of the concentration of health facilities and higher number of trained health personnel in urban areas. Thus, it could be argued that the presence and activism of trained health personnel are higher in Chittagong comparing to other cities so that a sharp increase in ANC coverage has achieved.

Indeed, the quality of ANC varies among different PAs within cities. For example, the Baseline survey reports that during 1999-2000 in PA - 6 (This PAA is run by Marie Stopes through its 7 clinics) 80.9 percentages of women had at least one ANC contact with trained health personnel during their last pregnancy. For Chittagong PA-1, the same percentages were 47.7 (Seraji et al. 2000). The Endline survey also reflected on the variation between PAs. However, our field survey reported from one step bellow, which collected data from the communities within a particular PA. The data from the community level presents the variation within the PA and also can be used to comparison between different communities of different cities.

Table 7.2.4: Comparison of between Marie Stopes and CCC on receiving ANC from trained health personnel

Percentage distribution of mothers who received ANC from trained health personnel	Dhaka Marie Stopes		Chittagong City Corporation	
	Sultanganj PA-6	Godighar PA-6	Ashkardighi PA-1	Amanath Shah Majar, PA-3
Baseline 2000	80.9 %		47.7 %	
Endline 2004	95.2 %		85.4 %	73.4 %
Field survey 2005	92.0 %	78.6 %	83.6 %	87.7 %

Source: Field Survey; Seraji et al. 2000; and Islam et al. 2004

Table 7.2.4 presents the very diverse nature of impact of service provision under the reform project. At the first place, the Baseline and Endline data established that the impact could be different in different part of the same city. Secondly it also showed that the impact also may vary among different communities within the same PAA. For example, in Dhaka, in Sultanganj and Godighar this two areas, the rates ANC from trained health personnel have been found different one of which is closer to the PA level data of Endline survey while the other one is far lower than its neighbor community and other communities within the same zone. For Chittagong, it is interesting to see while the PA level data indicates, according to the Endline survey, relatively a lower rate, the community level shows higher rate. There could be many factors that cause these variations in the impact.

#### 7.2.1.1.4. Source of Antenatal care

According to the Endline survey of the UPHCP, about 30% of the mothers who received ANC were reported to receive it from the clinics run by NGOs under UPHCP in all cities except Khulna. Since the study is aimed to understand the variations in impact at the community level of service provision run by two different actors: NGO and city corporation, the Baseline and Endline survey can not provide such details. Therefore, a look into the field survey data can provide us the deeper insights. It is seen that, in general, the new health centers that were built under the reform project have been the main source of ANC services for most of the poor women living in urban poor neighborhood. Table 7.2.5 presents the state of utilization of different health care facilities in four communities in Dhaka and Chittagong. In Dhaka, there are two health centers run by Marie Stopes in Sultanganj and Godighar area while CCC runs two health

centers in Askardighi and Amanatshah major areas.

Table 7.2.5: Sources of ANC received

Sources of ANC received	Sultanganj (Dhaka)	Godighar (Dhaka)	Askerdighi (Chittagong)	Amanatshah Major (Chittagong)
Government facilities	14.3%	2.2%	7.9%	8.2%
UPHCP partner's facilities	64.3%	84.4%	28.9%	63.3%
NGO facilities	19.0%	8.9%	47.4%	16.3%
Private facilities	2.4%	4.4%	15.8%	12.2%
Total	100.0%	100.0%	100.0%	100.0%

*Source: Field survey*

It is very clear from the Table 7.2.5 that the UPHCP health centers have become the main ANC provider for all poor communities except Askerdighi. The highest utilization is in Godighar. People in Askerdighi community live in four sides of a large water-body which is located in central part of Chittagong city. The main reason of low utilization of UPHCP health center is the presence of another NGO (Nishkriti) health facility close to the locality. Besides, the local Bazar is located at the nearest distance of the community; therefore a significant number of mothers went to take the services from the private sources. On the other, the highest rate of utilization can be resulted from multiple factors. However, one of the main reasons is the physical location of the community itself. Godighar community situated at the outskirts of the city, from where all other health facilities are far away and costs time and money. In addition, the health center is located within the community; mothers can go there by walk in minutes. Indeed, there might be some other reasons which I shall try to examine in following sections.

#### **7.2.1.2. Delivery Care**

Pregnancy and delivery related complications account for high proportion of mortality and morbidity of mothers and infants (Islam et al. 2004). It has been seen that the complicated child birth (i.e. prolonged labour, retained placenta, prolapsed cord) caused about 14 percent of all maternal deaths and over one-third of maternal deaths were from complicated pregnancy in 2000 (MOHFW 2001). Therefore, the status of pregnancy complication and delivery care forms an important indicator for overall health.



### 7.2.1.2.1. Prevalence of Pregnancy and delivery complications

Table 7.2.6: Prevalence of pregnancy and delivery complications

Percent of live births, preceding one year of the survey, for which mother had signs or symptoms of complications during pregnancy and delivery according to city and Baseline and Endline Survey of UPHCP				
Cities	Had Pregnancy Complications		Had Delivery Complications	
	Baseline	Endline	Baseline	Endline
Dhaka	26.7	22.4	25.4	26.5
Chittagong	19.5	21	19.4	17.9
Khulna	26.7	26.2	22.1	16.3
Rajshahi	31.3	25.5	25.5	26.5

Source: Seraji et al. 2000 and Islam et al. 2004

Table 7.2.6 presents two sets of information related with pregnancy and delivery of two different points of time. Information on the pregnancy complications reports prevalence of any signs and symptoms of complications i.e. vaginal bleeding, swollen leg, severe abdominal pain, high blood pressure, no movements of fetus, early flow of water through vagina, convulsion. On the other, information on the delivery complications captures prevalence of any signs and symptoms of complications such as prolonged labor, no progress after show, abnormal positions of the baby, abnormal presentation of the baby, cord around the neck of the baby, convulsion, retained placenta, tear in perineum, vaginal bleeding, and severe abdominal pain. Table 7.2.6 shows that, currently, 21 to 26 percent of women in four cities reported to had a complication during pregnancy and 16 to 27 percent of women reported to have had a complication during delivery. Pregnancy and delivery complications both show declining trend in all cities comparing to the Baseline surveys. However, there are two exceptions: at first, in Chittagong the reported pregnancy complications somewhat increased and in Dhaka, reported delivery complications have slightly increased. Nevertheless, overall impact of the reform project seems to have been positive by reducing pregnancy and delivery related complications in four cities, given the variations within cities and within communities. Field survey reports that Sultanganj and Godighar communities in Dhaka under PA 6, 23% and 27.3% women reported to have had sign and symptoms of pregnancy complications respectively. Similarly, in Chittagong, in Askerdighi and Amanatshahmajar communities where services are provided by the city corporation, the respective rates are 20.2% and 18.7%.

A further closer look into the pregnancy and delivery related care can help us to understand more detail of the health service and its impact. For example, information about the place of consultation for pregnancy complications can be taken as a way to look deep into the community level dynamics. The Endline survey of UPHCP shows that the percentage of women who had first level obstetric care<sup>34</sup> for their pregnancy complications in Dhaka PA-6 area, 44.4% is quite lower than that of PA-1 and PA-3 which are 63.9% and 51.5% respectively (Islam et al. 2004: 56). This data indicates the differences between NGO-run and local government-run service provisions and their differentiated impacts on the community.

#### *7.2.1.2.2. Place of delivery and Assistance during delivery*

Place of delivery and assistance during delivery are two important indicators of maternal health because it reflects the conditions in which a birth occurred. Births that occur under medical supervision reduce the risk for both mothers and children. Reducing the risk of infections and facilitating management of complications can be achieved by hygienic delivery practices and medical attention by trained personnel.

The Endline survey (Islam et al. 2004) reveals that there has little change been achieved in relation to the place of birth from the Baseline survey year, still the majority of birth takes place at home. According to the Endline survey of UPHCP, Dhaka and Rajshahi have a higher proportion of births (46 percent in Dhaka and 51 percent in Rajshahi respectively) taking place in health facility comparing to other cities. Health facility includes all kinds of government, NGO and private facilities which is able to provide modern health services by trained health personnel. On the other, Chittagong has the lowest proportion of births, 23%, taking place in health facilities. A comparison of the Endline survey results with Baseline survey indicates, the percentage of women gave birth at home in Dhaka has decreased from 65.3% to 52.2% where as for Chittagong the respective number has decreased from 80.7% to 70.2% (Islam et al. 2004; Seraji 2000). Field survey results showed quite contrasting result comparing to the Endline survey results.

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<sup>34</sup> Community level health centers, family welfare centers and satellite centers - that is served by trained health personnel are defined as the first level obstetric care.

Table 7.2.7: Place of delivery in selected communities in Dhaka and Chittagong

Percent distribution of live births in the preceding one year of the survey by the place of birth, according to communities					
Place of birth		Dhaka		Chittagong	
		Sultanganj	Godighar	Askerdighi	Amanatshah
Birth at health facility		4.0	8.9	14.8	21.1
Birth at home		96.0	91.1	85.2	78.9
Total	Percent	100.0	100.0	100.0	100.0
	Number (N)	50	56	54	57

Source: Field Survey

The field survey results presented a totally different story from the community level. The survey shows that in two communities in Dhaka, the rate of delivery at health center is very low only 4-9 percent of mother who had a child of 0-12 months in the year of survey reported to have had delivery in some kind of health facility. On the other, the respective rates are more impressive in two communities in Chittagong, comparing to Dhaka. In Chittagong, only 15-21% of mother who had a child of 0-12 months in the year of survey reported to have had delivery in some kind of health facility. This contrasting result with the Baseline and Endline survey results can be explained, at first, by acknowledging the fact that there are wide variations among various part of the same city and various communities within the same PAA. Secondly, for the field survey the population was very poor, slum dwellers only; on the other hand, the project's Baseline and Endline survey's population were the entire urban population. Moreover, the difference between sample-size of these two surveys may cause difference in the result. Nevertheless, most important thing that has been clear from the Baseline, Endline survey results and my own field survey result is that the UPHCP project has limited success in changing a long established practice like giving birth at home. In other words, the project has been successful to deliver some routine services but failed to bring changes in the values and attitude level. The project had brought the health facilities closer to the communities; it has been seen in the field survey result that the mean distance to health centers from respondent's home is only 422 meter. Which means, it is not mere the physical access that can alone bring the break through in long-established beliefs and practices of the people, rather some additional measures are required. I would argue that the increase of physical access is one of the *preconditions* to achieve health, and thus empowerment

outcomes but itself alone can not ensure the achievement of health goals.

Like place of delivery, the assistance during the delivery is also important. It tells us who attended the birth. In other words, it tells us the person(s) who supervised the delivery process being present at the spot. The Endline survey reports that there is improvement in the delivery assistances by trained health personnel in all cities than observed in the 1999 Baseline survey. There are various category of service provider during the delivery. For Dhaka, 65 % births are attended by trained health personnel while it is substantially low in Chittagong - only 44%. However, at the PA level, it is seen that within Dhaka, in PA 2, 85% births are attended by trained health personnel where as in PA 8 it is only 48%. For PA 6 the respective rate is 74.4% on the other for PA 1 and PA 3 in Chittagong they are 48.1% and 43.3% respectively (Islam et al. 2004: 58). However, the field survey result is quite different than that of official project survey results.

Table 7.2.8: Types of delivery care provider in selected communities under Marie Stopes and Chittagong City Corporation

Percent distribution of live births in the preceding one year of the survey by types of delivery care providers and communities in Dhaka and Chittagong					
Place of birth		Marie Stopes		Chittagong City Corporation	
		Sultanganj	Godighar	Askerdighi	Amanatshah
Delivery attended by trained health personnel		2.0	8.9	20.4	21.1
Delivery attended by untrained personnel		98.0	91.1	79.6	78.9
Total	Percent	100.0	100.0	100.0	100.0
	Number (N)	49	56	54	57

Source: Field Survey

Table 7.2.8 presents a community wise comparison between two different PA in two different cities. The result is quite opposite to the city level trend. One of the main reasons of this huge difference between city level trend and community level trend is the very mobile nature of the urban slum population. They do move very often from one slum to another. Secondly and most importantly, there is a social custom in Bangladesh which can provide strong explanations to this variation. In general, women are expected to give birth at their mother's house. So, in most of the cases, doesn't mater poor or rich, the pregnant women travel to their mother's house. Since the slum dwellers migrated

from rural areas, women's mother's house in some where out of Dhaka city to where they travel during their late stage of pregnancy and comeback own home after giving birth. Therefore, when I interviewed the mothers of 0-12 months baby, in most case they were found gave birth in villages. And in villages, it is very likely that traditional birth attendants, relatives will be the main care giver during delivery. In fact, relatives formed 36% of total delivery care givers for all cities. Nonetheless, organizational and structural factors also should be examined if they have some impact on availability of trained health personnel during pregnancy. I will discuss it later separately.

#### 7.2.2. CHILD HEALTH CARE

One of the major objectives of the UPHCP is reduction of child morbidity and mortality. Thus a large part of the service component is especially targeted for children. There are several service components in Essential Service Package for children such as vaccination, vitamin A supplementation, and management of ARI and diarrhea.

##### 7.2.2.1. Coverage of Vaccination

Child vaccination is provided in Bangladesh under the Expanded Program on Immunization under the guidance and supervision of WHO. According to the guidelines of WTO, all children should receive a BCG vaccination against tuberculosis, three doses of DPT vaccine for the prevention of Diptheria, Pertusis (whooping cough), and tetanus, three doses of polio vaccine and a vaccine against measles. WHO recommends that children receive all of these vaccines before their first birthday.

The EPI has been started since mid eighties in Bangladesh and almost every public and private health facilities have vaccination program and it is almost free of charge (some private firms take minimum charges for the syringes). It has been an inseparable part of UPHCP as well.

According to the Endline survey of UPHCP, at least 79% of children of age 12-23 months in the four cities can be considered as fully immunized. The rate was 65 percent or more in the Baseline period, which shows an improvement of 21 percent in UPHCP cities. Since child vaccination is not an exclusive service of the UPHCP we will not go into detail of child vaccination data. However, the main findings are that the official

surveys shows that there is a significant improvement in child immunization in UPHCP cities in the period of project implementation (Islam et al. 2000: 62). The Endline survey further reports that in PA-6 of Dhaka, the percentage of children of 12-23 months, who have received all recommended vaccines is 85.5 percent while in PA-1 and PA-3 of Chittagong they are 78.7 percent and 78.8 percent respectively. During the same period the national level survey shows a similar trend. According to the *Bangladesh Demographic and Health Survey 2004*, in Bangladesh currently, percentage of children age 12-23 months who received all vaccines is 73.1%, however, the vaccination rate for urban area is 81%. It means the improvement in the UPHCP-cities is no extraordinary; in fact, to some degree lower than the national urban level (NIPORT, Mitra and Associates and ORC Macro 2004). If we look into the national improvement rate which is about 23% from 1999-2000 to 2003-2004, we would see for the same period of time, the improvement in the UPHCP-cities is 21 percent (NIPORT, Mitra and Associates and ORC Macro 2001). Putting differently, we can say though the reform project has contributed to achieve child vaccination goal to a large but, UPHCP has not been able to produce any exclusive contribution.

#### **7.2.2.2. Vitamin A Supplementation**

Vitamin A supplementation is a very important intervention for the child health. Researches showed that one of the leading cause of preventable childhood blindness as well as a major contributing factor to the severity of several other causes of childhood morbidity and mortality is vitamin A deficiency (Islam et al. 2004: 65). Vitamin A has an important role in proper functioning of immune system. In order to avoid the problem developed due to the deficiency of this crucial micronutrient, children are recommended to have supplements of vitamin A by capsule, usually for every six months (NIPORT, Mitra and Associates and ORC Macro 2004). Vitamin A supplementation can reduce mortality from measles and diarrheal diseases by about 30% percent (World Bank 1993: 81).

Bangladesh has introduced vitamin A supplementation program through its health care system. The present policy is to start vitamin A supplementation after a child completes the first nine months of life. Children 9-11 months of age are provided vitamin A capsule

at the time of measles vaccination and those who are 12-59 months old receive the supplementation once in six months during National Immunization Days and Vitamin A campaigns. In accordance with the national health policy, the UPHCP identified achievement of 85% of children of 6 months to 6 years within the project area being given vitamin A supplementation in last six months as one of its objectively verifiable indicator (ADB 1998). It has been seen in the Endline survey of UPHCP, around 75% of the under-five children in Dhaka received vitamin A capsules in the six months period preceding the survey. For other three UPHCP-cities, the rate is higher than that of Dhaka which ranges from 81 to 85%. However, If we look into the Baseline survey results given that sampling method is similar, we would see during the Baseline-period, the coverage of Vitamin A capsules in all of four cities except Chittagong were higher than that of Endline survey results! In a straight look, no positive impact of the project is seen in any of UPHCP-cities but Chittagong. In Dhaka, the Vitamin A coverage has dropped by 5%, on the other hand, in Chittagong the coverage has increased by 10% (Table 7.2.9). However, the city level decreasing or increasing trend does not hold true for all of the PA or zonal levels. There is a wide variation. For example, while PA 7 in Dhaka registered 65.6% only, PA 6 attained 80% the vitamin A coverage. Similarly, for Chittagong the rate varies from 74% to 85%.

Table 7.2.9: Comparison of Vitamin A supplementation coverage

Percentage of children 06-60 months, who had received Vitamin A in the six months period prior to the survey, according to cities and surveys				
Cities	Percent		Number of children	
	Baseline	Endline	Baseline	Endline
Dhaka	80.3	74.8	5648	5609
Chittagong	70.7	81.2	1547	2167
Khulna	87.1	83.8	1249	1060
Rajshahi	85.4	84.7	628	802

*Source: Islam et al. 2004: 65 and Seraji et al. 2000: 81*

The opposite trend between Dhaka and Chittagong in terms of vitamin coverage primarily can be explained by the very mobile nature of the slum population who formed a large part of the sample. We have already seen that Dhaka is growing at a very high rate; during 1974-2000 it was 6.9% (UN, 1998). For the period 2000-2015 Dhaka is

expected to grow at a 3.6% annual growth rate and reach a total population of 21.1 million in 2015. Official sources claim that the main cause of the high growth rate is rural-urban migration. According to 1991 census estimates rural-urban migration contributed nearly two-thirds to urban growth between 1981 and 1991(BBS 1992). About one-third of this population is living in slums faces extreme poverty due to its low level of earnings and the majority is living below the poverty line (Hossain 2006). This extremely poor population not only moving from villages to Dhaka city but also keeps moving from one slum to another in response to their livelihood and external factor like eviction. Because of the movement and addition of new population in the total, dropout rate rises high in the vaccination schedule and thus in the vitamin A supplementation. On the other hand, the rural-urban migration and in-city movement is relatively lower in Chittagong, thus it became easier for the service users and the providers to continue with a specific vaccination scheme. Another important reason that came up in the process of qualitative data is community feelings. Community feelings refer to individual's sense of belongingness to a particular group of people, place and identity. This 'community feelings' is found at higher degree in their frequent use of '*amader elaka/moholla*' (our neighborhood) among the respondents in Chittagong. It has been observed that where the inter-household relationship is stronger, a social pressure grew among the members in a particular community as demonstration effect. When a mother observes others following health care providers suggestions regarding their children health, she also try to follow the same. In this way, many women continued to follow the vaccination schedule in Chittagong. What is more, in Chittagong the political leadership of the city corporation is more committed to the health issues than Dhaka, which also kept the city corporation focusing on child vaccination.

#### **7.2.2.3. Treatment and Management of Diarrhea**

Dehydration caused by diarrhea, is an important reason for death in young children. It has been seen that the proper treatment and management of diarrhea reduces the duration of diarrhea episodes and mortality by substantial proportion. The use of Oral Rehydration Therapy (ORT) is a simple but affordable means to reduce the severe effects of dehydration. ORT entails giving the child a solution prepared by mixing water with commercially prepared packets of rehydration salts or a home-made solution made from



sugar, salt and water (Islam et al. 2004) . The government and nongovernmental organizations have been campaigning to use the home-made solution since early eighties; by now it has been a widely known treatment practice for diarrhea in Bangladesh. The commercially prepared and marketed ORS (*khabar saline*) is also available for over-the-counter sell. The care givers are highly recommended to give fluids and foods more than normal to the children during diarrhea episodes. The practices of treatment and management of diarrhea reflects on the one hand, the prevalence of the disease and on the other, shows the state of awareness and mother's ability to make decisions and act upon their decision in crisis.

Table 7.2.10: Treatment and management pattern of diarrhea

Percentage of under five children who had had diarrhea in 2 weeks prior to the survey, who were given ORS, other fluids and foods according to cities and surveys								
Cities	% given ORS		% given more fluids		% given more foods		% had consultations with health professional	
	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
Dhaka	83.6	84.3	44.0	58.5	28.8	40.5	54.8	52.2
Chittagong	80.9	87.7	42.5	44.2	11.4	26.6	60.6	54.2
Khulna	77.7	81.4	44.3	45.5	26.8	59.1	49.6	39.4
Rajshahi	79.2	75.8	41.7	65.9	23.8	41.9	54.5	47.3

Source: Seraji et al. 2000 and Islam 2004 et al. 2004

The Endline survey of UPHCP reports that about 76-88 percent of the children of four cities who had had diarrhea episodes in the previous 2 weeks received ORT either in the form of commercially available ORS packets or recommended home fluid (Islam et al. 2004). Comparing to the Baseline survey results, it shows change in the pattern of Diarrhea management (Table 7.2.10). Again, the survey data suggest that the rate change is higher in Chittagong comparing to other cities, where percent of diarrhea affected children who were treated with ORS has increased from 81 to 88 in project implementation period. It means, the rate of increase is 8% - which is the highest among the four cities, while during the same period the increase rate for Dhaka is only 1%. The Table 7.2.10 not only indicates the increase in the ORS use, but also traces the management pattern of diarrhea episodes. In the context of Bangladesh, the main care giver to all family members, particularly to the children in the household is the mother of the child. Therefore, while survey reports that more children are given more fluids and

foods than normal, indicate that mother is more aware of following recommended diarrhea-management procedures. In other words, the health awareness of mothers has increased as a result of reform implementation. However, a closer look on the PA level reveals that in PA-6 Dhaka, where the ORS coverage was found 90% in overall sample and 84% in poor sample (Seraji et al. 2000) in the Baseline survey, but in the Endline survey reports a decrease in the ORS coverage, which came down from 90% to 81% (Islam et al. 2004). On the other, in Chittagong for PA-1, the ORS coverage has increased from 78% to 87%.

To conclude, the reform program has achieved most of his health target. The usage of maternal health, child health services has increased in all important indicators in all reform-cities. In general, thus it can be said that the reform program has attained high level of effectiveness in terms of gain in health indicators. There is not much variation between Dhaka and Chittagong. In other words it could be said that there is no significant difference between NGO-run health service provision and Local government run health service provision with respect to their contribution in rendering health benefit to the urban poor. However, there are several important things to note. Firstly, ANC coverage has increased in both Chittagong (Local Government) and Dhaka (NGO) service areas, however the rate increase is much higher in Chittagong than that of Dhaka. Similarly, it can be said about number of women received ANC from trained health professional.

### **7.3. IMPACT ON HEALTH KNOWLEDGE AND AWARENESS**

Knowledge and information are considered as the crucial resources which can be treated as both health and non health benefit for the poor. It is both health and political dimension. Knowledge and information are important because it helps an actor to make meaningful, choices; that is, the actor is able to envisage options and make a choice. Knowledge and information provide actors with the ability to envisage evaluate and predict options, thus inform her/his decision. Therefore, it could be argued that, increase or decrease in the knowledge and information can be regarded as indicator of one's political benefit. Health knowledge and information is inseparable form other part of one's knowledge-base. Health knowledge and information determines not only health related decision and behavior but also other livelihood-decisions. In the following I shall

examine some of the areas of health knowledge and information to see if it has been affected as a result of the health sector reform program under UPHCP.

#### 7.3.1. KNOWLEDGE ABOUT TREATMENT OF DIARRHEA

Comparison between Endline and Baseline survey data reveals that the knowledge about diarrhea treatment became widespread before the project came into existence. It is found in both Baseline and Endline surveys, the knowledge of use of ORS either in form in commercially packed or home-made was and is universal across the cities. However, the knowledge of giving more foods and liquid has changed during the project period. It is seen, during Baseline, more than 60% of women had the knowledge of giving more fluids during diarrhea episodes which increased to more than 75% in the Endline survey. Similar trend is also found regarding the knowledge of giving more food during and immediate after diarrhea episodes. Giving more foods during and immediate after diarrhea is very important to recover the nutritional losses that is caused by the dehydration. Survey shows that, knowledge of use of extra food during diarrhea was very low in all of four cities; Chittagong had the lowest, only 26% (Seraji 2000:99). However, the percent of women who had the knowledge of use of extra food during diarrhea episodes has increased in all four cities; it is now more than 55%. Chittagong still registered the lowest; however, the increase rate is the highest among all other cities. In Chittagong, the percent of women who had the knowledge of use of extra food during diarrhea has been doubled from 26 to 58% where as for Dhaka, it has just increased from 53% to 66.2% (Islam et al. 2004).

The higher growth of knowledge about diarrhea management among the women in communities in Chittagong can be explained by qualitative data. Focus group discussion with one mother group in Askerdighi community reveals that their main source of health information is the field level health worker - who used to visit household at a regular interval. Beside the doctors, radio, television and neighbors are other sources of health information. Ms. Salima, 24, mother of two children, reported:

“last month my youngest child (11 months) had diarrhea, I went to the drugs shop round the corner and bought few packets of ORS. I knew it is important to feed child saline during diarrhea, however, I was scared of giving him normal food considering that it might not help stop loose motion. But my neighbor, Ruby apa, she is senior to me and has 3 children, suggested

to give my child more food during and after diarrhea. My daughter became weak for diarrhea, thus, her suggestion made sense to me, I followed.”

This response showed that the community itself has an impact on the health outcome in the first place, in one hand, and on the other, health knowledge helps to make interpersonal relations stronger within the community. It is evident that while health information passes from one woman to another the action of individual changes. At the same time the positive outcome of the action makes both of them more confident than before in general and particularly in dealing health problems. We can recall what Latour has suggested in his ‘translation model of power’. According to him, knowledge (token of power) is transformed and translated as it is passed on, appropriated, modified, added to or dropped by each of the people in touch with it (Latour 1986). For him, power is not possessed; it is exercised. Therefore, it could be argued that since health information is passing from one person to another, it is exercised and the more it is exercised the higher the political benefit is.

#### 7.3.2. KNOWLEDGE ABOUT BREAST FEEDING

Breastfeeding has huge benefit in terms of nutritional status, morbidity and mortality of young infants (Islam et al. 2004). An estimate showed 1.5 million infants lives can be saved each year by exclusive breastfeeding for six months (UNICEF 1997). Researches reported incidence and severity of diarrhoeal diseases is reduced by exclusive breastfeeding (de Zoysa 1991; Dewy et al. 1995). What more is, early initiation helps to establish lactation and it also contributes to reduction in maternal morbidity and mortality by minimizing postpartum hemorrhage. Despite of widespread breastfeeding practices in Bangladesh the continuous sub-optimal practices such as giving prelacteal feeds and failure in exclusive breast feeding is a major concern in Bangladesh. It is worthy to notice that the sub-optimal breast feeding is mainly caused by lack of proper knowledge, information and cultural practices. Thus the role of health knowledge and information is much more important in this regard comparing to other aspects.

Both Endline and Baseline surveys reported almost all children regardless of their economic status and cities of residence are breast fed for some period. Therefore, it does matter less if the children are ever breast fed, rather, the timing of initiation and length of

breastfeeding period what matter more. Early initiation is important for both child and mother. For children, the first milk (colostrums) which is rich in antibody helps them to form protection against diseases. For the mother, it helps in contraction of the uterus (Seraji et al. 2000).

Table 7.3.1: Practice of First feeding of the child after birth in selected communities in under Marie Stopes and Chittagong City Corporation

		Sultanganj	Godighar	Ashkar Dighi	Amanat Shah Majar	Total
Breast milk		22.0%	19.6%	36.4%	36.8%	28.9%
Misri Water		20.0%	17.9%	10.9%	5.3%	13.3%
Water		.0%	5.4%	.0%	.0%	1.4%
Sugar-water		10.0%	14.3%	.0%	.0%	6.0%
Cow-milk		2.0%	.0%	.0%	.0%	.5%
Honey		46.0%	42.9%	52.7%	56.1%	49.5%
Others		.0%	.0%	.0%	1.8%	.5%
Total	%	100.0%	100.0%	100.0%	100.0%	100.0%
	N	50	56	55	57	218

Source: Field survey

The Endline survey result shows that the 41%-59% percent of children were breast fed within one hour of birth in four cities, however, the percentage of the children who were fed breast milk within one day of birth varies from 80 to 89 percent (Islam et al. 2004). Looking back into Baseline survey results indicate that there is an increase of 16% - 20% for both cases in all cities. However, if we look one level down to the community level, in order to see how and what actually is fed as the first food to the children, we would reveal a different story. Table 7.3.1 shows that there are a wide range of liquids are given to the children immediate after birth while colostrums is the only recommended food to the new born. In four communities in Dhaka and Chittagong it is evident that only 29% children are given breast milk as the first food where as 50% of children fed honey which is followed by *misri-water* (solid sugar water), and other sweet liquids. This data of Table 7.3.1 is important because it opens the belief-system of the poor living in the urban slums in cities. The predominance of sweet (honey, sugar, *misri* etc.) liquid reflects people's belief what says that if newborn are fed with something sweet, the child will be well-behaved, soft-spoken and modest in future. However, Table 7.3.1 also shows that among 63 children of four communities, the percentages of children who were given colostrums

are higher in communities in Chittagong comparing to Dhaka. This means, the process of information sharing is more effective in Chittagong than Dhaka which also supports the Endline survey results.

### 7.3.3. KNOWLEDGE AND USE OF IODIZED SALT

Iodine is one of the core micronutrient for mental and physical development of children. Many studies reported that iodine deficiency causes mental retardation, delayed motor muscular function and stunting as well as neuromuscular, speech and hearing disorder (Islam et al. 2004: 79). It is one of the main preventable causes of intellectual impairment. Thus, iodine is not a mere medical intervention, rather, bears greater social implications. On the one hand intervention to reduce iodine deficiency is directly contributing in reduction of disability, on the other, contributing in a way so that individual's agency grows, so that individuals can live healthy life being able to make informed decisions.

In Bangladesh, there are several strategies are in place; in fact, they have been there for about two decades. Iodination of salt is one the most important strategies that government are and non-government organizations have been working with. Creating awareness regarding benefit of using iodized salt has been placed in national health policy and programs for quite long. So, understandably the UPHCP also took it as an important intervention in their ESP.

In Endline and Baseline surveys, respondent were asked, at the first place, if they knew about iodized salt, then they were also asked if they knew the reasons for using it and if so, what the reasons are. It has been found in those surveys, almost all, 96% or more, in four cities reported that they knew about iodized salt and about 95% of them also use iodized salt, the situation in the Endline survey is as good as it was in the baseline survey (Islam et al. 2004: 79). This means the information about use of iodized salt has reached to almost the universal level before the project is being implemented. In other words, the reform has no impact on spreading information on use of iodized salt. As we know, empowerment involves use of human agency, which means, an empowered person's action is an outcome of informed cognitive process. If it is so, one needs to examine the relation between action and the reasons in order to understand the cognitive part of the

health awareness. Using the survey data, I find, although the coverage of iodized salt use is about 95% across the cities, but only about 75% of them mentioned at least one specific reason for using iodized salt (Islam et al. 2004). Comparing with Baseline data, it is seen that during Baseline for all four cities this percentage of respondent who knew at least one benefit of using iodized salt was about 70% given the variation between and within cities (Seraji et al.2000). In other words, the UPHCP project has been able to make people understand the link between action and reason. This suggests, a relatively permanent change occurred in the course of the project implementation.

#### 7.3.4. HEALTH RIGHTS AWARENESS

Health awareness refers to a cognitive state of being informed and knowledgeable about various health related issues and aspects, more precisely physical health related issues. It includes information on causes and consequences of various diseases, healthy life style, hygienic food and living conditions etc. Indeed, increase in health information itself indicates one's power gain as I do consider information and knowledge is power. Health rights awareness, however, is clearly distinct from health awareness. Health rights awareness refers to one's cognitive state in which s/he considers health as a fundamental human right. The idea of health right captures the political dimension of health; it does establish one's entitlement to quality health services. Health rights are viewed from two perspectives: political and economic. The political perspective considers health as one of fundamental human rights. The economic perspectives, considers health right as part of consumers rights. At this point, I would not discuss the details of these two perspectives; neither will do differentiate them in our study. I would rather consider these two perspectives complementary to each other. It is so because, the political dimension of health rights provides the citizens with legitimacy to their demand on the state. On the other, the consumer rights dimension enables citizens to be protected of mal-treatment from a specific service provider. I would argue health rights awareness is the prerequisite of health rights to be observed. If citizens are aware of their rights only then can demand and put pressure on the state for the rights to be observed. If people are not aware of their entitlement, they will not be able to take action to make their entitlement respected and met. If we consider, health rights as a part of consumer rights, the argument remains equally relevant. In that perspective, a consumer or citizen can put her demand of quality

health service on board only when s/he is aware that s/he has the legal right to do so, her entitlement is legitimate. Therefore, it could be said that health rights awareness is the precondition to make rights fully observed. In other words, awareness of rights is the first step to be empowered. However, in a context like Bangladesh where many other constitutionally endorsed fundamental human rights are very often threatened and economic priority takes over others, it is not easy to make citizens aware of their health rights. The main difficulty lies in the way people perceives health. The dominant perception views health in relation with physical illness. And while health is reduced to physical illness, it is very likely that individual does personalize the reasons of the illness i.e. linking a disease to one's own 'fate', 'deeds', 'curse' and life style and very often excludes the contextual factors quickly. And once the reasons of health problems are personalized it is likely that s/he will not demand others to take care of the situation that arises for her 'own' 'fault'. Due to this underlying reasoning, health rights took long to be established as a right while other rights like freedom of expression, universal suffrage etc. had been established relatively earlier. Nevertheless, health rights awareness will not be achieved unless it comes at the discourse level which is connected with institutional development in the greater society and health sector. A quick review of institutional landscape reveals that there is no formal institutional infrastructure to ensure health rights in Bangladesh.

The constitution of Bangladesh, in the Article 15(a), has recognized health as one of basic necessities; but did not consider as fundamental human rights. Nonetheless, the Constitution of the Peoples Republic of Bangladesh, in Article 15(a) and 18(1) clearly expressed its commitment to the provision of health care for the citizenry and entrusted the responsibility to ensure people's health to the state (GOB 2004). Therefore, according to the constitution, health care is the state's one of the core constitutional responsibilities. Although the health right has not been enshrined in the constitution of Bangladesh as one of the fundamental human rights directly, but the Bangladesh state acknowledged and endorsed it indirectly, through its endorsement of international conventions and treaties like Alma Ata Declaration 1978, Ottawa Charter for Health Promotion 1986, Universal Declaration of Human Rights 1948 and the International Covenant on Economic, Social and Cultural Rights 1966 (Rahman 2006). Moreover, as a member of WHO, Bangladesh



is also committed to uphold the constitutional mandate of the WHO which stated “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, social and economic condition” (WHO 1986). In addition, the Government of Bangladesh has formally endorsed the health right as one of fundamental human rights in its new health policy and called for increasing the awareness of the citizens regarding their legal rights to health services (GOB 1998). Therefore, although there is no specific legislation to ensure health rights but it could be said that health rights have gained somewhat prominence in the political domain in recent years. Looking at the other side, the legal infrastructure to protect consumer rights in general is very poor (Rahman 1994). Regarding health rights, currently there has no Bill of Rights for consumers of health care in Bangladesh. In addition, there is lack of effective mechanism for lodging complaints or obtaining compensation for damages resulting from the negligence of health care providers (Perry 2001; *New Age* 2006). The government, however, in accordance with the Health and Population Sector Program 1998-2003 (GOB 1998a), adopted a Patient’s Charter of Rights in 2000 and took several initiatives to create awareness about the client’s rights in relation to health care services. The current Health, Nutrition, and Population Sector Program (HNPS) of 2003 also expressed commitment to continue promote actions for ensuring health care as basic rights of every citizen (GOB 2003).

According to the arguments of this dissertation, health rights awareness is profoundly a political benefit, component of citizenship. Thus, I argue that in order to examine the impact of health care reform on society one needs to look at the level of awareness members of communities do have. In order to do understand citizen’s health rights awareness 8 FGDs and 10 in-depth interviews were conducted. FGDs were mainly participated by the mothers of 0-12 month children and male members of the poor slum residents. However, local elites were also interviewed in order to get the overall picture health right awareness in the society.

Overall findings of the FGDs and interviews came out as follows:

1. Most of the participants referred ‘adhikar’ (Rights) to the political rights such as right to vote in national and local polls, right to be member of political parties,

- right to go to court, right to do any organization, right to buy or sell properties, right to have children, right to do religious services.
2. Only 7 out of 61 female participants of FGDs mentioned education as one of their rights, however, none of them but one mentioned health care as their rights.
  3. The main difference between rights and ‘non-rights’ is the role of government. Participants believed that the government is responsible to ensure their rights. According to the responses, for rights, government has a mandatory role where as for ‘non-rights’ government’s role is not mandatory but optional.
  4. Poor do not have access to the private (clinics) and government hospitals (medical college hospitals) as they are expensive.
  5. Government should run hospital where poor can have doctors and medicine for free.
  6. The service quality of UPHCP health centers is satisfactory in terms of quality and cost; however, their services are inadequate as they do not have in-patient and emergency services.
  7. Not all doctors do behave well to them, but some of them do. Most of the nurses behave rude to the children. Doctors do not listen carefully to their problems; give very little time to listen case history and physical examination.
  8. About 30% participants took part at least one yard-meeting organized community organizers came from the health centers. Most of the yard-meetings are about what they should do during pregnancy, family planning methods, child health care, benefits of breast feeding etc. However, no information has been given to them about their rights as client. Respondents expect doctors and nurses do behave respectfully to them, however, they do not know what they should do if they do not. They do not know to whom they should make complaints if necessary. Only 6 participants reported that they were told about the complaints mechanism, however, never made any complaints against anybody.
  9. Doctors never discussed to them about the diagnosis, neither have they told about side effects of a particular treatment. They only tell how and when medication has

to be taken. All service users need to make health card in order to obtain services from the health centers. Doctors keep records with health card while they visit health centers.

10. The environment of health centers is good; all of them have waiting room with television. But there is no enough room where children can play during their waiting to render services. The main problem regarding health centers is unavailability of necessary medicines; they do buy most of the prescribed medicines from market.
11. The most important feature of the health centers is absence of ‘unofficial fees’<sup>35</sup>. The price of the services well placed in the notice-boards.
12. Political parties can influence government decision if government does not take actions in order to ensure peoples rights

#### Box 1: Patients Bill of Charter

##### **Patient’s Charter of Rights**

- Right to know about the services
- Right to access regular and safe service
- Right to choose treatment and family planning
- Right to access quick services in emergency
- Right to get quality service at cheaper rate
- Right of being secured
- Right of getting impartial and equal services
- Right of giving opinions, respect and a humble environment.
- Right to get services according to necessity and emergency
- Right to have a copy of records of the services taken
- Right to inform the clinic authorities if any of the rights is not pursued.

Source: MOHFW, 2000

13. But all political parties are more attentive to the rich than the poor. Rich are the

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<sup>35</sup> Unofficial fees is defined as unauthorized fee payments that coexist with ‘free care’ and formally approved official health services charges collected at the health centers under the publicly stated policies (Killingsworth et al. 1999). Usually, it happens to public health facilities. These fees may not be visible to the service user; in some cases they may be well known. It is reported that in most of the public hospitals In Bangladesh, used to have system of unofficial fees of one kind or another.

leaders of political parties. It is not possible for the poor to be leader of any political party. For them, it is difficult to see Ward Commissioners or other public office bearer. There are some intermediaries in between communities and local political leaders specially the office holders. Intermediaries include *sarder* (leaders), businessman and school teachers living around the community.

14. Political leaders and officials in government hospitals are corrupt, if somebody can pay bribe or make a personal connection to the hospital officials only then s/he can be given a room in the hospital or doctor will pay enough attention to her problem.

The responses that came out in the FGDs are not surprising; rather, they reinforced the typical perceptions of the society in general. It is understandable that rights are limited to political rights only. Although none of the participants were formal members of any political parties, however, they could name at least three main political parties including the two major players: Bangladesh Awami League and Bangladesh Nationalist Party, they also know the names of the top leaders of those major political parties. In Chittagong, participants also know the name of the Mayor of the city corporation. In general, it is clear that the political awareness has been reached to a fairly reasonable level. In fact, the political history of the country, particularly, the struggle for democracy in recent years and regularly held national parliamentary elections made people aware of their political rights. '*voter adhikar*' (right to vote) and '*bhater adhikar*' (right to food) has been two common slogans in the political rhetoric for last two decades or so. The parties in opposition very often used these slogans. It has also been seen that the awareness has not been achieved through political activism but by confronting political activities like rally, public meetings, *hartal* (general strike), *dharmoghot* (strike), *gherao*, *aborodh* (sit in) etc. in course of their everyday making of living. Indeed, media, particularly television has a big part as most of the participants reported to have somehow managed to watch television for some times in a day.

The result shows that the health centers have no initiatives to make clients aware of their rights. The UPHCP project has a BCC (Behavior Change Communication) components in their service package under which includes household visits, conducting group

meetings and meetings with community leaders, outreach clinics etc. Every service provider organization has at least one community organizer/BCC worker/Field Worker to conduct BCC session in the community. Ms. Alpona Das, BCC worker of Bashbari health center run by Marie Stopes said, “We discuss about ANC, family planning, personal hygiene, TB, diarrhea, pneumonia iodized salt etc in our BCC.” On average a health center conducts 20 BCC meetings in various communities per month within the catchment area, however, no evidence is found that these sessions included client’s rights in their BCC contents. The sessions are mainly to disseminate information on health awareness but rights issues are not addressed. Mr. Tanvir Hossain, Community Organizer, worked for the Marie Stopes Clinic Gadighor, Dhaka reported that “the patient flow to the health center depends on the frequency of outreach activities”. In other words, the BCC activities serve the marketing purpose for the health centers.

Participants who mentioned education and health as their fundamental rights, they were found somehow connected to other organizations. For example, Ms. Shilpee Begum, 29, mother of three children, from Askerdighi Uttorpar reported:

“my husband does sell fish in local market for our living. We had two more children who died within one month of their birth. I visited 5 times to city corporation run health center. I used to work in a garment factory before I gave birth of my youngest child. I had have several meetings with some NGO *apa* during my work in the garment factory from where I came to learn about rights of workers and other rights like education, health and housing. I know that our child has right to go to school and to have necessary health care. But you see, there is nobody to establish our rights.”

The interviews of local community leaders and elites also showed similar level of awareness of health rights and patient’s charter. The political leaders were found known about the fundamental needs, however, not confirmed if health is a right of every human being. For example, Ms. Nargis Chowdhury, an influential local elite who had contested in 2005 city corporation election for the post of Ward Commissioner from Ward No. 28 (Jamalkhan) of Chittagong City Corporation. She is 32, completed 14 years of education, mother of two children, and lived very close to the Askerdighi squatters. Ms. Chowdhury, told “I do not have any idea of patients charter of rights”. On the other Mr. Jashimuddin Mahmud, Ward Commissioner for the Ward 47 of DCC and Chairman of the Local

Advisory Committee, of Sulatnganj UPHCP health centers run by Marie Stopes, acknowledged:

“patient’s charter of rights is a new issue to me as well. However, I know that there are several mechanisms to lodge complaints against health center staffs including doctors. People can also come to me if they have any particular complaints regarding the health centers. But, I can not remember if any person came to me ever.”

Analyzing the data and responses of this section two points have been clear that due to the reform program health information and knowledge has increased among the poor, however, no awareness about health rights or consumer rights have not been created among the poor; nor the issues been able to be placed in the community or city level elite discourse. Therefore, the health as a fundamental human rights is has not been taken nor by the service providers nor the political elites. It is important to note that the “Patients Bill of Rights”, prepared by the MOHFW, was in place before the full implementation of the reform project. However, no initiative was taken to incorporate it in the service package by any of the actors. The new health care regime under UPHCP was just ignorant to the rights dimension of health. At the same time the UPHCP failed to produce a balanced relation between service provider and receiver as it did not include and offered any awareness program to make service users aware of their rights in its service package. Therefore it could be said that, the health reform program under UPHCP has little or no contribution to the increase of poor citizen’s health rights awareness, in other words the political benefit from the health reform for the marginalized groups is extremely low.

#### **7.4. IMPACT ON ACCESS TO HEALTH SERVICES**

In this section I deal with the most important aspects of the health care system: access. I argued access is directly related with one’s physical, social and economic wellbeing. Thus, this variable can capture if a person is getting political benefit out of the health system. Since there is no systematically collected data regarding access to health care, on the studied population for the period before the reform took place, no direct comparison between pre and post reform phase will be possible to indicate the trend or direction of changes. Nevertheless, I shall analyze the recent situation on the basis of qualitative and quantitative data that have collected during the field work. At the end, I shall make inference by comparing with some macro data.

Before moving into analyze the impact of UPHCP on the access to health care of the urban poor, it is important to make it clear at the onset that what we meant by the term access to health care.

A quick review of the public health literature revealed diverse use of the term access. The term ‘access’ had its origin in Latin, which means approach or entrance (Barnhart 1995). A public health dictionary defined access as the capability to attain health care that includes available health care providers, services, transportation, and admittance by facility, ability to meet financial obligation, and insurance benefits (Slee, Slee, and Schmidt, 1996). According to a WHO working paper, access to health care is the ‘possibility of obtaining health care when it is needed’ (WHO 2000). Although appealing, this definition is overly simplified. Penchansky and Thomas (1981) suggested that access is very often defined as people’s ability or willingness to use the health care service (cited in Norris and Aiken 2006). Norris and Aiken, however, commented that this definition ‘lacks precision but captures the spirit of the general understanding of the concept’ (Norris and Aiken 2006: 60). Penchansky and Thomas (1981), in addition, identified five distinct dimensions of access: availability, accessibility, accommodation, affordability, and acceptability. Since their definition is able to captures the main idea of the concept, we would like to consider this dimensions as defining components of the concept ‘access’. The first component of the concept is *availability* refers availability of health care services in adequate amount and in standardized quality, while *accessibility* refers the physical proximity of a service point to its target recipients. *Accommodation* refers if the service center can provide enough spaces for all who needs the service and *affordability* refers the ability of the potential users to pay for the services. And finally, *acceptability* denotes the compatibility between potential user’s cultural norms and the service norms. Putting it differently, acceptability refers potential users perception of the service is provided in a manner which is not conflicting to their culture. For example, in a context like Bangladesh separate waiting room for man and women is more acceptable than a common room for all gender; or a female care giver is more acceptable to the female patients than a male care giver.

Based on this definition, in order to understand the impact of the services provided by the UPHCP health centers on access, we shall examine following issues, from users

perspectives:

- b) if all necessary services are available at the health center
- c) if enough numbers of care givers included doctors nurses are available regularly
- d) how far the health centers from poor communities
- e) how must it cost (in terms of money and time) to go to the health center
- f) how long one needs to wait to obtain the require service
- g) if the service charge is affordable to the poor
- h) if the physical and social environment is compatible to the culture and beliefs of the poor

In approaching all of the above issues I shall use both quantitative and qualitative data collected from the fieldwork.

#### **7.4.1. Availability of Services**

I already discussed that the ESP was the main service package which was introduced by the said reform program. ESP enjoys support from the World Bank and WHO and endorsement by the National Health Policy 2000. ESP consists of basic components of primary health care including reproductive health care (ANC, PNC and family planning); child care (immunization, diarrhea management, ARI management, micronutrient supplementation); communicable disease control; limited curative care; behavior change communication and counseling and medical treatment for women victim of domestic and other violence.

From the survey and FGDs, it is evident that the women are, in general, satisfied about the services which are available to UPHCP health centers. However, quite few did complain about lack of ultrasound machine which is a very important service for antenatal care. X-Ray machine is also not available at every health centers. Among 32 health centers under Marie Stopes and Chittagong City Corporation, only 7 have ultrasound machines. But men are unaware of the services. Mr. Mintu Sheikh, 40, rickshaw puller, lived in Askerdighi reported that, “I don’t know if the health center does provide services to the male. My wife went there twice with our children, but nobody told



me that they also provide treatment for us”. Mr. Jashim, 22, a day laborer from Sultanganj, Rayerbazar also reported the same. The FGD-reports, from male groups of both NGO and CCC catchments, present sufficient evidence that there is lack of information among the male members of the community about the availability of the services. In the first place, they do not know if the services are available for man; secondly, what are the services man can obtain from the health centers. This situation developed because of over-emphasis put by health centers on maternal and child health; theoretically, the services are available for both man and women though. Another important cause of this left out of man is the timing of community meetings. Health center staffs and participating women both confirmed that most of the meeting held at a time when most of male members of the communities go out to work, therefore, they could not take part in those meetings.

#### **7.4.2. Regular Availability of Doctors and Staffs**

Survey results show that medical and non-medical staffs are available regularly. The mother who received services from UPHCP health centers were asked if they found doctors and nurses are available during their visits, 97% of respondents answered positive. Disaggregated data between NGO-run and CCC-run health centers also showed no significant difference, in both cases above 95% respondent have found doctors and others available at health centers. This data is also supported by the health center visit during the exit interview.

However, this high rate of presence of health centers staff is a very significant improvement in comparison with the national scenario. A very influential study reported that the average absentee rate for all job categories and types of facilities was 35% in public health facilities. The absentee rate for doctors was 40% at the larger facilities and 74% at the smaller sub-centers with a single physician (Chowdhury and Hammer 2004), given that the study reported the rural context only. This very opposite trend of UPHCP health centers in contrast of the (rural) government health facilities can be explained, primarily, by the presence of the extensive monitoring system and the location of the health centers. All health centers under UPHCP have multi-party monitoring system which includes monitoring from the project office, PIU, donors, City Corporation and the

responsible independent organization. Having the centers located within the main part of the city made them exposed to unexpected visits of various authorities and thus made it difficult for staffs being absent without reason.

### 7.4.3. Physical Proximity of the Health Centers

Physical proximity of the health centers is a very important indicator for the access. In simple relation, the more it is closer to the community the higher their access. It is evident that the, the health care reform under UPHCP has been very successful in bringing the service center close to the poor communities.

It is seen that most of the health facilities are located within or very close to the poor communities. The mean distance of health facilities from users home is only about a half a kilometer (Table 7.4.1). It is seen that the Sultanganj health center is at the shortest distance from the surveyed community, while the Amanat Shah Majar health center is at longest distance from the surveyed communities. However the difference between shortest and longest distances is very insignificant.

Table 7.4.1: Mean distances of health facilities from home of the user

Communities	Mean Distance of the health center from user's home (KM)
Sultanganj	.2574
Godighar	.4066
Ashkar Dighi	.4493
Amanat Shah Majar	.5586
Total	.4246

*Source: Field Survey*

The data analysis also revealed that all mothers, who received health services from UPHCP health facilities, reported to have their health centers within a kilometer distance from their home, while 86% of them reported that the health centers are within a half of a kilometer (Table 7.4.1). It is revealed that the private and government health facilities are relatively at longer distance than the UPHCP facilities. However, an important part, 70% of non-UPHCP facilities users, also reported to have their service centers very close to their house. It is because, in most cases the private practitioners chambers, retail drug-shops and homeopath facilities are mushroomed around the poor communities to tap the demand of a huge number of consumers.

One of the main objectives of reform under UPHCP was to make services physically available to the poor, in that sense it could be said that that primary objectives have been achieved.

Since, health centers are located at shorter distances, the time and cost to go to the health center will be low. Field survey presents that in selected communities of Dhaka and Chittagong, the mean time to go to the health center for the UPHCP service users is 10 minutes and for non-UPHCP users it is 13 minutes. While 93% of the UPHCP- service user respondents go by walk to the health centers, and 6% of mothers use rickshaw or van. Almost none have reported to have used any motor vehicle like bus, or taxi. On the other, among the non-UPHCP service users 76% used to walking to the health center which is followed by 24% of women who use to take rickshaw/van. Given relation between distance, time and mode of transport, the cost is also likely to be very low.

Table 7.4.2: Comparison of mean time and transport-cost among communities

<b>Communities</b>	<b>Mean time to go to the health center (minutes)</b>	<b>Transport-cost to the health center (Taka)</b>
Sultanganj	10.77	5.72
Godighar	10.80	4.44
Ashkar Dighi	11.85	6.86
Amanat Shah Majar	12.32	8.72
Total	11.46	7.06

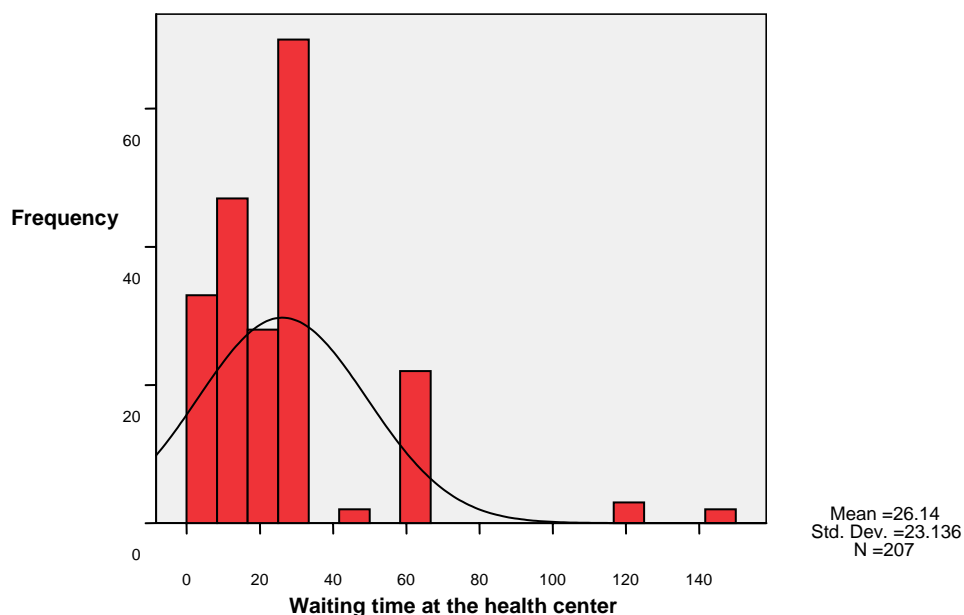
*Source: Field survey*

Table 7.4.2 indicates, the mean transport cost to go the health centers is only 7 Taka (55 Taka=1USD). At the present level of living cost 7 Taka is well affordable to all members of the selected poor communities.

#### **7.4.4. Waiting Time at the Health Center**

The waiting time is another important aspect of access to health care. Long waiting time, primarily, implies either there is along queue of service users or the system of service user management is not effective. Whatever the reason, results hardly changes. Long waiting time likely to increase dissatisfaction among the service users and may cause dropout from the treatment schedule, in effect, may reduce the access. It has been seen that the mean waiting time at health centers is 26 minutes (Figure 7.4.1). However, there is a small difference between the UPHCP service users and non-UPHCP service users.

Figure 7.4.1: Distribution of waiting time at the Health center



For the UPHCP-center-users the mean waiting time is 31 minutes where as for the non-UPHCP-center-users it is 22 minutes. Furthermore, data also shows that the waiting time is less (20 min.) in City Corporation run centers than that of NGO-run health center (33 min.). Indeed, the waiting time is closely associated with the numbers service user in-flow given the health centers resources are fixed. It is seen that on average, per day the number of service user in NGO-run health centers in Dhaka is about 50 while it is 37 for local government-run centers in Chittagong. Nevertheless, the exit interview reports that the service user in both NGO-run and local government-run centers are satisfied with the waiting time. Ms. Halima (24) reports, “If I go to medical college it would have taken more than two hours standing in the queue and another three to fours in the way, but I can not afford to a full day off from my work very often”. This less waiting time in comparison with pre reform period or extra-reform service provision indicates a positive impact on the individual’s asset endowment, thus empowerment; it so because the new service provision provided the individual with more time for work on the one hand, on the other, reduced their possibility for being dropped out of the health care system.

#### 7.4.5. Service Charge

I have mentioned in the previous section that all service providers are asked to recover a certain part of their cost from the service charges and medicine sell. There are, however, no uniformed service-charge rules; every service provider does it in their own way that they mentioned in their respective contracts.

Since there are varieties of services, the charge varies. However, service-prices vary from 20.00 Taka for consultation fees to 6000.00 Taka for Cesarean delivery. Of course, there are some services are given for free, for example birth control consultation and contraceptives. Marie Stopes and Chittagong City Corporation take service charges differently. However, there is one thing common between them: all clients have to make a health card at the very first visit. Health card serves three purposes: works as an identity card, a registration card and a record card. Marie Stopes has introduced four types of cards in their health centers. The clinic manager of Bashbari (Sultanganj) maternity center Dr. Asif Anwar told, “The Red card for the ultra poor<sup>36</sup>; blue card for the very poor, green card for the poor and white cards for rest of others. Those who have red cards they do not have to pay for any services except the five Taka fee for the health card. They are also given free medicine, if advised. The blue card is also for very poor, however they have to pay a very small part of the services, and green card-holders have to pay 25% of the service charges they received and white-card holders have to pay the full charge.” However, service charges are not high. For example, at Marie Stopes clinic, doctors consultation fee is only 20 Taka, which is in comparison with other private health care sources, is just one fourth. In addition, the health cards are applicable for the whole household.

Chittagong City Corporation has a different system. No client is entirely free in CCC centers; however, service charges are very low. In general, making a family health card is mandatory to obtain the service and getting a health card is free of charge. For every visit, any member of the family can have doctor’s consultations by paying 15 Taka only. There is no differentiation between poor and non-poor. More importantly, the medicine is

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<sup>36</sup> Marie Stopes has developed a poverty grading system in their catchment with participatory approaches by which they identified three grades of poor: ultra poor, very poor and poor. The grading system is based on bunch of qualitative and quantitative situational indicators (Kahan 2004).

totally free in CCC health centers. Child vaccination, family planning methods are also free of charge. However, laboratory tests, radiology, sonology services are not free anywhere. Clients have to pay for that. The clinic managers have discretionary power to wave fees of any clients from any kind of services s/he obtains.

According to the field survey data, out of pocket expense at the health center is not that much. Per visit mean expense at the health center, which includes service and medicine charges, is only 21.28 taka. However, there is differentiation within cities and among health centers. It is seen that, a mother, who received services from UPHCP-centers, used to pay for every visit, on average, 18 taka. While for non-UPHCP facility users paid 23.24 taka. Among the centers the difference in mean expenses is negligible. Table 7.4.3 presents a more detail view of the out of pocket payments at health centers. It clearly indicates that the almost all UPHCP facility users can manage to obtain their required health care services paying maximum 25 taka only. While those who remained somehow out of UPHCP facilities, only of half of them manage to get the same level of care with paying equal amount of money.

Table 7.4.3: Per visit out of pocket payment at health center

Percentage of mothers who received health care services from during their latest pregnancy or youngest child rearing according to their per visit average out of pocket payment at health center		Sources of Services	
Payment at health center		UPHCP facilities	Non-UPHCP facilities
Taka 1 to 25		96.9%	49.5%
Taka 25+ to 50		2.0%	35.2%
Taka 50+ to 100		1.0%	7.6%
Taka 100+		.0%	7.6%
Total	N	98	105
		100.0%	100.0%

Source: Field Survey

The Table 7.4.3 presents almost 8% of non-UPHCP facility users have to pay on average more than 100 taka per visit, which is very high. It is also seen that the mean monthly household income is about 4500 taka and household expenditure is 4125 taka. If we consider per visit health care expense in comparison with monthly household income and expenditure, we would see health care costs form only less than a half percent of

household income and expenditure. In other words, it can be said that the cost of the health care under UPHCP facilities is very much within the reach of the poor.

#### **7.4.6. The Physical and Social Environment of Health Centers**

I have argued before that physical and social environment is an important factor by which access to health care could be greatly affected. In this area, I mainly wanted to understand if the new service regime, which has been offered through the reform program, is acceptable to the service users or potential users. So, in simple sense, I tried to capture service user's views on the rules-regulation and physical setting of the health center.

Ms. Shahinoor, 26, is a housewife lives in the factory colony in Rayerbazar. She rendered three visits in last six months for pregnancy and her newborn's health care. She said:

“to me the system of the urban health center is fine. I didn't see any problem. At the first visit, my husband went with me, but since then I used to go alone there and I don't feel any problem. They have lady doctor and nurses, I talked to them, they behaved well.”

In fact, Ms. Shahinoor's comment reflects the overall responses from others as well. Everybody - those who have been in any of UPHCP health facilities at least for once - expressed positive attitude regarding the service delivery system.

The above discussion on impact of the health reform on access to primary health services of poor people under the UPHCP reform clearly demonstrates that access has increased in all the indicators. The services are now close to their home, costs are affordable, services are available, they do not need to wait for long time and no visible barriers or discriminations are reported. Thus, at the end it can be said that in general the access of poor to health care has been increased as result of the health care reform under UPHCP.

### **7.5. IMPACT ON RESPONSIVENESS OF THE HEALTH SYSTEM**

Responsiveness is comparatively a new concept in the context of health care system. It is first introduced in a major scale by WHO through its ground breaking publication *The World Health Report 2000 Health Systems: Improving Performance* (WHO 2000). WHO suggests that any health system has three intrinsic goals: improvement of health, delivery of health services in responsive way and ensure fair distribution of health resources.

WHO reports:

“....while improving health is clearly the main objective of a health system, it is not the only one. The objective of good health itself is really twofold: the best attainable average level – *goodness* – and the smallest feasible differences among individuals and groups – *fairness*. Goodness means a health system responding well to what people expect of it; fairness means it responds equally well to everyone, without discrimination.” (WHO 2000: xi)

Responsiveness is defined as an “outcome that is achieved when institutions and institutional relationships are designed in such a way that they are cognizant of and respond appropriately to universally legitimate expectations of individuals” (de Silva 1999). In other words, the concept of responsiveness refers the ability of a health system to meet the ‘legitimate expectations of the population for the non-health enhancing aspects of the health system’ (Darby et al. 2000). In fact, the concept of responsiveness incorporates and signifies the non-medical aspects of the health, which includes seven elements: dignity, confidentiality, autonomy, prompt attention, social support, basic amenities and choice of providers (WHO 2000a). WHO used the concept to measure the performance of a health system and in doing so; this is a breakthrough in the conventional wisdom. The responsiveness bring the opportunities in the analysis of the performance of health system (or subsystem) to place the qualitative and social aspects of individual well being into the epidemiology dominated and quantitative measurements focused framework.

The concept of responsiveness is important to us because of its social and political dimension. I argued that gain in responsiveness implies increase in political benefit.

The concept of responsiveness is inherently political as it is grounded on the notion of fundamental human rights. Physical integrity and dignity of the individual are recognized as fundamental human rights. However, there have been many examples of the perversion of medical practices, such as involuntary or uninformed participation in experiments or forced sterilization. Health systems therefore have an additional responsibility to ensure that people are treated with respect, in accordance with human rights (WHO 2000a). Respecting one’s rights is *de facto* acknowledgment of ones ability to make choices. Ability to make choice and act upon that is expression of one’s power over his/her course of action. Those who are denied to have choices, they do not have



power or *vis-à-vis*. Therefore, it could be said that responsiveness is one indicator of political benefit of the health care user. Moreover, responsiveness indicates a special type of relationship, in which one's choice, dignity and opinions are being valued, that can be treated as one form of intangible resources for the service users (Kabeer 1999a).

Treating individuals with respect, dignity and confidentiality is a good thing in itself, yet, can help to empower people in two ways. Firstly, higher responsiveness promotes higher utilization of health care, thus better health. It is so because potential patients are more likely to utilize if they anticipate of being treated with dignity and confidentiality (de Silva 1999). Better health is itself an empowerment indicator in its own intrinsic value. Secondly, perhaps more importantly, responsiveness helps to improve one's agency - the ability to define one's goals and act upon them. Agency is also considered as power within (Kabeer 1999: 3). When an individual is treated with dignity and confidentiality s/he feels herself important, worthy. This sense of worthiness helps to open his creative faculties, enhance her ability of reflection and analysis. Since responsiveness also involves better communication between the service provider and receiver, it creates opportunity to apply one's bargaining and negotiation capacity and in that process one's power from within increases.

Responsiveness is to take into account what an individual expects from a system, how and in which amount s/he wants to consume a particular service. In other words, responsiveness is actually about to considering and acting on the basis of citizen's views and voices. Therefore, the concept is concerned to incorporate participation of the service user in the health system. Participation makes individual empowered. While we consider a health system is responsive, it implies the system offers an opportunity structure in which citizen's voices, demands are considered and met. Therefore, the concept of responsiveness can be used as an indicator to assess a health system or subsystem, in our case urban primary health care, if it does offer an opportunity structure within which citizen's expectations and demands are met.

To conclude the above discussion it is valid to say that the conceptual connection between responsiveness and empowerment made it as a valid indicator of political benefit related with health system. And it could therefore be argued that a system that is more

responsive is said to be more benefiting to the poor.

There are seven elements of responsiveness: dignity, confidentiality, autonomy, prompt attention, social support, basic amenities and choice of providers. While examining responsiveness of the new service provision that is introduced by the UPHCP, one needs to see people's views on whether their dignity, privacy, participation is observed in the health centers under UPHCP in Dhaka and Chittagong. Although WHO considers responsiveness is about the meeting the 'universally' legitimate expectations of the population for the non-health enhancing aspects of the health system (Derby et al. 2000), I argue that these 'expectations' can not be universal, the assumption behind this argument is that expectations are the outcome of the interplay between contextual and institutional factors of the population within which they live. Therefore, I explored what are the legitimate expectations of the urban poor in Bangladesh in the first place. FGDs from my fieldwork (potential service user mothers and male) have found the following expectations of the poor about non-health aspects of the health system:

- (a) Service provider will respect the patient
- (b) Doctors and nurses will behave well to the patients
- (c) Doctors and nurses will pay attention during the physical examination with sufficient time
- (d) Doctors will listen their problem attentively
- (e) Doctors will maintain serial of the patient
- (f) Female doctor/nurses should deal with female clients
- (g) All of their information should kept secret
- (h) No priority will be given to the rich client
- (i) Doctor and nurses will help them to understand how medication should be taken and what kind of diet they should take during the illness
- (j) Waiting room and toilets should remain clean
- (k) There should be some system of complaining about any staff of the health center

The analysis of the FGD reports shows that the expectations of the urban poor in Bangladesh has largely complied with what has been determined by the WHO (WHO 2000a; Derby 2000) but with a small difference. The most important difference is absence of the expectation to question doctors about their suggestions. None of the participants expected to engage in argument or questioning the doctor why s/he has suggested a particular medication. Ms. Rokeya (39), mother three children, told that “doctors know the best about the health problems of my child, why should I question him?” In another response, Mr. Subol Chandro (44) said, “they are highly educated, big doctor, should an uneducated person like me question him?” These two responses represent the most of the participant’s as well as the common people’s attitude towards doctors in Bangladesh. This attitude can be explained by the institutional features of Bangladesh community. In general, doctors are highly respected and, to a greater extent, obeyed for their authority that comes from their professional expertise. The unquestionable position of the doctors is rooted in the society; it is not the case that doctors are positioned in the higher rung of the bureaucracy. Therefore, doctors authority should not be regarded as legal-rational authority (Weber 1968); rather, it does resemble the concept of professional authority which argues professionals gain considerable authority because of their technical skills and higher standard of training; not at all for holding particular office (Hirst 1982).

Considering the context of Bangladesh and the primary health care setting, the responsiveness of UPHCP centers is examined under following subtitles based on the field survey data.

#### 7.5.1. DIGNITY OF SERVICE USERS

The question of dignity is one of the most important elements of responsiveness. It is not easy to examine the issue of dignity through quantitative survey. I have tried to capture it through several questions. The first was to know if the health center staffs do address the service users with respect (*apni* or *tumi*<sup>37</sup>) and how often. Field survey results show that

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<sup>37</sup> In Bengali language, ‘*apni*’ and ‘*tumi*’ both are used as the synonym for the English word ‘you’. However, in the formal setting the first expression ‘*apni*’ is used to address someone who is respectful, important while ‘*tumi*’ is used to address the younger, not-respectful and unimportant persons. It is important to know that in Bangladesh there is a common cultural feature that, the powerful persons very

about 95% of mothers from all communities reported to be addressed respectfully from the UPHCP health center staffs (Table 7.5.1). None of them answered that they never received respectful address. However, relatively low number of mothers from Askerdighi community answered that they always received respectful address. Our FGDs on mother group in Askerdighi gives a hint of this answer. Ms. Nadira Begum (26), mother of one child told, that “there is a nurse in urban health center who is pretty old and address all women ‘tumi’, she doesn’t like children, she shouts at them”.

Table 7.5.1: Attitude of health center staffs towards service users

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Health center Staffs address clients with respect	Communities				Total
	Sultanganj	Godighar	Ashkar Dighi	Amanatshah Majar	
Always	95.5%	94.1%	87.5%	96.6%	94.1%
Sometimes	4.5%	5.9%	12.5%	3.4%	5.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

#### 7.5.2. BEHAVIOR OF THE MEDICAL STAFFS

Behavior of the health center-stuff is very important. It reflects doctor’s attitude to the poor service users which forms a part of dignity aspect of responsiveness. Table 7.5.2

Table 7.5.2: Behavior of doctors of UPHCP health centers to the service users

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Behavior of the doctors of the health center with service users	Communities				Total
	Sultanganj	Godighar	Ashkar Dighi	Amanatshah Majar	
Excellent	36.4%	26.5%	62.5%	51.7%	41.6%
Good	59.1%	73.5%	37.5%	44.8%	56.4%
Moderate	4.5%	.0%	.0%	3.4%	2.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

shows that more service users in communities in Chittagong reported to have found

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often use ‘tumi’ to address the less-powerful particularly, the poor. For example, there is common trend to address rickshaw-puller by ‘tumi’.

doctors behavior excellent than that of communities in Dhaka. Overall opinion regarding doctor's behavior is good.

Nurses and paramedics are also very important part of the service provision in the context of small health center like UPHCP. Therefore, their behavior towards service users is should be regarded part of responsiveness. Table 7.5.3 indicates that most of service users opine to have good behavior from nurses as they did from doctors.

Table 7.5.3: Behavior of nurses of UPHCP health centers to the service users

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Behavior of the nurse and other stuff with you	Communities				Total
	Sultanganj	Godighar	Ashkar Dighi	Amanat Shah Majar	
Excellent	36.4%	20.6%	62.5%	37.9%	35.6%
Good	59.1%	76.5%	31.3%	48.3%	57.4%
Moderate	4.5%	2.9%	6.3%	13.8%	6.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

### 7.5.3. DOCTOR'S ATTENTION TO THE SERVICE USERS

Field survey reports that in general, all service users are happy with the time a doctor spent on average for a patient during their visit to the UPHCP health care centers. Almost all mothers (97%) from all communities, who have received health care during their latest pregnancy or rearing of their youngest child, said that doctors spent, on average per patient, sufficient time. A small difference is found in UPHCP (97%) and non-UPHCP (91%) service users. Therefore, in general, it could be said that doctors in UPHCP health centers spend, on average, more time than that of non-UPHCP centers. In other words, reform has offered increased attention of doctors to the service users comparing to other sources of health care services.

Table 7.5.4: Doctors attention to listen service user's problems

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Doctors listen attentively service user's problems	Communities				Total
	Sultanganj	Godighar	Ashkar Dighi	Amanat Shah Majar	
Always	95.5%	97.1%	75.0%	96.6%	93.1%
Sometimes	4.5%	2.9%	25.0%	3.4%	6.9%

Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

Doctor's attention to the service users can further be confirmed from the Table 7.5.4 which indicates that 93% of service users found doctors listen their problem attentively.

#### 7.5.4. PRIVACY OF THE SERVICE USERS

The question of privacy is a very important part of the concept of responsiveness. The main assumption every human being has the right to maintain her privacy. The privacy in relation with health care service has two dimensions: first, the privacy of patient's body and privacy of patient's information. Both are equally important.

Table 7.5.5: Patient's physical privacy in health centers during their treatment

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Presence of third person in the physical examination room	Communities				Total
	Sultanganj	Godighar	Ashkar Dighi	Amanat Shah Majar	
Yes	14.3%	5.9%	31.3%	10.3%	13.0%
No	76.2%	76.5%	62.5%	89.7%	78.0%
Can not remember	9.5%	17.6%	6.3%	.0%	9.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

Table 7.5.5 presents, mothers, who have received service UPHCP centers during their latest pregnancy or rearing of their youngest child, 78% of them reported to have found no third person<sup>38</sup> in the physical examination room during their or their child's examination. However, 13% of service users reported the presence of third person during their physical examination which is a gross violation of human rights and medical ethics. The similar kind of trend is also visible for the service users who took services from non-UPHCP health centers.

Table 7.5.6: Perception of reliability of doctors to the service users

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Do you consider doctors reliable to tell private exclusive problems	Communities				Total
	Sultanganj	Godighar	Ashkar Dighi	Amanat Shah Majar	

<sup>38</sup> *Third person* refers any person who is not a doctor or nurse or any of the patient's approved attendants like husband, mother.

Yes	100.0%	88.2%	93.8%	93.1%	93.1%
No	.0%	11.8%	6.3%	6.9%	6.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

Regarding the secrecy of information, the general impression is that doctors are reliable to hold private information secret. Most of the respondents, 93%, reported that they found doctors of UPHCP health centers are reliable to tell their exclusive private information (Table 7.5.6). However, it is worth mentioning here that, the FGD reports suggest secrecy of their private information is not a big concern for them, particularly for the women. On the contrary, male members of FGDs reported that secrecy of their information is very important and they expect doctors maintain that privacy.

#### 7.5.5. COMMUNICATION BETWEEN DOCTORS AND SERVICE USERS

Better communication between service providers and receivers refer to have information sharing between doctors and patients about disease, alternative treatments, suggested treatment, the reason for suggesting treatment, the side effects of a prescribed medicine. This is a very important aspect of responsiveness. In the western health care system, where the power gap between doctor and patient is relatively low, the question of better communication may not appear as important as it does in the context of Bangladesh. We argue better communication between doctors and patients suggest empowerment of patient. It is so because, on the one hand it is the observance of client's charter of rights; on the other hand, it inform the patient and stimulate her agency to think herself and provoke her to question the doctor for choosing a particular way of treatment. And once a poor mother is able to question a doctor with whom a high power gap does exist, it is very likely that she would be able to translate this questioning ability to other areas of her life.

Table 7.5.7: Pattern of better communication between doctors and patients

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Does the doctor discuss about the causes, side effects and alternative ways of treatment with you	NGO		Local government		Total
	Sultanganj	Godighar	Ashkar Dighi	Amanat Shah Majar	
Yes	90.9%	76.5%	75.0%	48.3%	71.3%
No	9.1%	23.5%	25.0%	51.7%	28.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

Survey data shows that (Table 7.5.7) 71% of mothers, who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child, found the doctors of health centers discussed causes of their health problems, side effects of prescribed medicine and alternatives of treatments with them. At the same time, 29% of mothers answered negative to the same question. However, a further closer enquiry through FGDs reports that the meaning of ‘better communication’ to most of the participants appeared as sharing information about ‘side effect of the prescribed medicine’ and ‘way of taking medicine’. And in fact, the communication is one sided as the patient hardly raised any question; rather they received information passively. While the qualitative data contradicts the quantitative results, it is not easy, further support is needed to reach in any firm conclusion. However, one important data can be presented here: survey results show that, there is a big difference between UPHCP and non-UPHCP service users regarding communication between doctors and patients. It is seen, while 71% of UPHCP users answered affirmative to the question if the doctors discuss about the causes, side effects and alternative ways of treatment with them, only 51%% non-UPHCP users answered affirmative. This means, the doctors in other health facilities are less-communicative comparing to UPHCP doctors.

The question of power relation has further been tackled in the following two questions as well.

#### 7.5.6. ARGUMENT WITH DOCTOR

Arguing with doctor reflects the very relation between doctors and patients. It’s not likely that patient will argue with doctors regarding any aspect of health care services. We



know that the main reason is doctor's professional authority and the information asymmetry. However, if the health care system trains its service providers to encourage the patients to question his decision, then things could have been changed. Nevertheless, we tried to have a first hand impression from the service users whatsoever.

Table 7.5.8: Questioning the doctors decision

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Have you ever questioned/argued with doctors about the way of treatment	Communities				Total
	Sultanganj	Godighar	Ashkar Dighi	Amanat Shah Majar	
Yes	9.1%	2.9%	6.3%	13.8%	7.9%
No	90.9%	97.1%	93.8%	86.2%	92.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

Table 7.5.8 reflects the existing power gap between service users and receivers. Only 8% of mothers who have received services from UPHCP centers questioned or argued with doctors regarding their decision. The number is not big, however, important. There is a small difference among communities which is also significant. It is seen that about 13% respondent of Amanatshahmajar community questioned doctor which is the highest among other communities. It has been seen that, many of the respondent's husband in the Amanatshahmajar community, works for the conservancy department of the City Corporation; therefore, they have a more acquainted relation with the health center staffs. This means, personal or professional relation may offer a more congenial atmosphere to question the provider. In addition, while we compare between UPHCP and non-UPHCP service users, we see a small but significant difference between them. More than 96% of non-UPHCP respondent never questioned or argued with the doctors where as the respective number for UPHCP users is 92%. This also supports our previous findings that the doctors in UPHCP centers are relatively less authoritative than their colleagues working in other health facilities.

#### 7.5.7. COMPLAINING AGAINST SERVICE PROVIDERS

The existence and use of the system complaining is a direct acknowledgement of client's charter of rights and a structure that can offer opportunity to exercise client's power. This means, in a simple statement, the more the number of complain the higher the degree of

empowerment. Thus, the practice of complaining in the context of Bangladesh is a very important element of overall responsiveness of the health care system.

Table 7.5.9: Knowledge about complaining system

Percentage distribution of mothers who have received services from UPHCP health centers during their latest pregnancy and rearing period of their youngest child by communities					
Do you know any system to make complaints about anything of health center	Communities				Total
	Sultanganj	Godighar	Ashkar Dighi	Amanat Shah Majar	
Yes	9.1%	14.7%	.0%	.0%	6.9%
No	90.9%	85.3%	100.0%	100.0%	93.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
N	22	34	16	29	101

Table 7.5.9 shows that the knowledge of service users regarding the existence of any complaining system in the health center. It is seen that, 93% of respondent do not know the existence of any complaining system in the health center. More importantly, the difference between communities is also very significant. Since the 9-15% of respondents in Sultanganj and Godighar communities, where services are provided by NGO, do know about system of lodging complains in their respective centers is very high comparing to other two communities, where nobody has reported known of complaining system. It is important to take into account that formally all health centers supposed to have a complaining mechanism, and it does exist on papers. This survey result is also supported by our FGD results which showed that nobody is informed about the complaining mechanism in the first place, even many of them participated in more than one community meeting. Secondly, the respondents are not much interested to know about the complaining system as they do not believe that anybody will pay attention at all to their complains. However, Marie Stopes as the representative NGO showed higher degree of commitment to respect the patient's charter of rights than the local government. Although, while asked further follow up question: if service user made any complains ever, it is found only 3% of respondents made complains. No wonder that the similar trend is also evident for the non-UPHCP service users. This means, in general, no complaining system in any kind of primary health care center in Bangladesh is in place or in function.

#### **7.5.8. CLEANLINESS OF THE HEALTH CENTER**

I also examined the physical environment, which includes: cleanliness of the health centers, adequate furniture, clean toilets, and sufficient ventilation of health centers because they also form a part of responsiveness (Derby et al. 2000). We employed several data collection methods for that, for example, center visit, exit interview, FGD and survey. However, the survey showed, all respondents (99%) reported that health centers are clean. Center visits supported the survey data. In addition, we also found that the centers are well designed so ventilation, sitting space is well organized. The toilets are found reasonably clean.

To sum up, of the responsive aspect of UPHCP, it could be said that there have been improvements in some area such as behavior of health center staffs, attitude towards and attention to the poor service users, but the area which is based on unequal power relation between service users and receivers, no change has been achieved. In other words, the reform has not been able to change the power relation between the poor and the elite yet in terms of responsiveness.

### **7.6. IMPACT ON PARTICIPATION AND ACCOUNTABILITY**

This section is to present the two core elements of political benefits: participation and accountability aspects of the UPHCP. Participation is dealt first, followed by accountability.

Participation is considered to us, in this study, as a means to gain political resources and at the same time a political resource by its own intrinsic value. Narayan (2005) argued participation is one of the basic elements of empowerment. In order to understand the impact of reform in primary health care sector on participation of the poor in health system we adapted the framework developed by Murthy and Klugman (2004), which is build upon on the theoretical assumptions forwarded by Arnstein (1968).

Figure 7.6.1: Types of participation

	<i>Lower order participation</i>	<i>Middle order participation</i>	<i>Higher order participation</i>
<b>Participants</b>	Powerful/rich Clients or users	Relatively easy to reach people in an area; Powerful groups in population; NGOs who represent community	Marginalized groups CSOs who represent their interest
<b>Rational</b>	Participation as a means to expand outreach, raise resources, maintain service infrastructure	Participation as means to improve management of services	Participation as a means to strengthen knowledge base; improve accountability and participation as a right by itself
<b>Intensity</b>	Manipulation Informing	Advice/Consultation	Collective or community decision making
<b>Scope</b>	Health service delivery	Health service delivery and management at periphery	Health policy, resource distribution, core management and service delivery at all levels
<b>Mode</b>	As individuals	As members of small collectives/committees	As members of mass-based organization and small collectives,
<b>Frequency</b>	Occasional, through invitation	Often, through invitation	Regularly, through invitation and demands from below being recognized as right and constitutionally guarded

Putting the above framework in the context of the UPHCP project at first, I will see what kind of opportunity structure for participation of the poor in UPHCP is on offer in formal documents and what kind of practices are being followed. Secondly, I also look at service provider level and examine if there is any difference between NGO-led and Local government-led service provision. In doing this part of analysis I shall mainly use qualitative data that has been collected through project document review, key informants interview and FGDs.

### 7.6.1. Impact on Participation

I would proceed in analyzing the impact on participation by asking following questions: Who participate in UPHCP policy formulation and management? Through what mechanisms, to what extent and how frequent do poor women and men participate in policy formulation and management within the UPHCP?

#### 7.6.1.1. Who Participates?

Community participation has given a little attention in the project document of UPHCP. As I mentioned in the earlier chapter, the UPHCP came into being as a top-down

initiative. The project was planned by the Local government Division of the Ministry of Local Government, Rural Development and Cooperatives and was being approved through the government project approval channel. Therefore, the bureaucrats (generalists in the Project Planning Unit of the LGRD&C ministry) took the lead in the planning phase. Actors such as donors, NGOs, professional organizations also took part in various formal and informal ways. Yet, unlike the HPSP where various stakeholders took part in project formulation in several phases formally (Jahan 2003; Murthy and Kulgmann 2004), no significant initiative was taken to incorporate stakeholders voice into the project planning. Dr. Jahangir, former DPD of UPHCP informed, “stakeholders voice were taken in the form of need assessment study which was conducted by the ADB. In a later stage of the project formulation Mayors and CHOs of city corporations were consulted.” Mr. Serajul Islam, former Deputy Secretary of the LGD, told:

“The UPHCP was designed within the framework of national policies, mainly HPSS. Since we knew stakeholders were involved in the formulation of HPSS, no further consultation with stakeholders was arranged. However, the ministry held meetings with implementing agencies, health ministry, DGHS, international organizations and two national leading NGOs. We did not have any direct consultation with the community.” (Interview)

Thus, from the above information, it is clear that participation of stakeholders in the formulation phase was very limited. It included only the powerful stakeholders. According to our framework, participation of few powerful stakeholders in the formulation phase indicates a lower order participation in the UPHCP.

For implementation phase, the situation is slightly different. The key document of the project the Project Administration Manual (ADB 1988) delineated the main guidelines for participation of the community in the project implementation. The community is perceived as the ‘beneficiaries’ of the project. According to the PAM, ‘beneficiaries’ will be involved as the partners sanction for the target population in their respective working areas. In addition, beneficiaries are also envisaged to participate in project evaluation through community meetings and focus group discussion. Moreover, the beneficiaries are also expected to take part in the site (for health center) selection process through their elected representatives (ADB 1988: 5).

The analysis of the PAM suggests that there is very little scope of direct participation of

the poor or marginalized groups in the project implementation. The term “beneficiaries” is just another undefined term in the project document. Since the project services are offered for all citizens in a particular catchment area of a city with a focus to the poor, beneficiary could be any one who gets benefit of one kind or other. In fact, the loose definition of the term ‘beneficiary’ provided the key actors with the opportunity to include or exclude the group(s) they want. In other words, it could be argued that the reform project did not offer any explicit opportunity structure for poor to participate in the project implementation directly. They only can participate as “beneficiary” through their elected local government representatives and NGOs. Then the question would be if the poor does not participate, who does? In order to answer this question one needs to recall the project implementation process what is discussed in Chapter 4.

I showed there are three main bodies are involved in making key decisions related with the project implementation: The project Steering Committee, the Coordination Committee and the Partnership Committee. I have discussed the formation and functions of these committees in the previous chapter; however, the particular interest in this section is to examine the nature of participation in these committees. I find that in the most powerful committee - *the Project Steering Committee*- only the senior bureaucrats from the relevant government agencies and donor representative take part. For the *Coordination Committee*, the scenario is more or less same. The committee extends its membership beyond government bureaucrats to include city corporation officials. The next important committee is the *Partnership Committee*, which is formed by the representatives from UPHCP contract awardees, project stuffs and city corporation representatives. The Mayor of respective city corporation chairs the committee. The committee serves several important functions including determination of user fees which is directly related with ‘beneficiary’s willingness and ability to pay, yet the beneficiaries are not represented in the committee.

Overall analysis of the core decision making forums shows that mostly the bureaucrats, city corporation officials and to some extent contract awardees participate in the decision making process, but no poor or marginalized groups participate in those forums, neither the ‘beneficiaries’. Further analysis of the actors who take part in those groups indicates the very ‘bureaucratic dominance’ in the decision making forum; no elected officials like

ministers, parliament members, or ward commissioners participate. Mayors as the only elected urban authority have some power in partnership committees.

#### *7.6.1.2. Rational of Participation*

The project document laid down the rational of beneficiary's participation in the implementation phase (ADB 1998: 5). According to the PAM, the beneficiaries are required to participate in order to share some cost with the community. The PAM mentions "communities will donate land for the health centers" and will "provide temporary facilities to be for outreach activities" (ibid). This means, community participation has been perceived as a means to expand outreach, raise resources for the project. Putting it differently, the project document allows only lower order participation. However, we know, reality very often differs with the document. Therefore, in order to know the actual rational of participation one needs to go beyond the project document and ought to take into consideration how these directions of the document are translated into day to day life of the project by the street bureaucrats<sup>39</sup>.

Participation of poor or beneficiaries is conceived in terms of their involvement in community meeting arranged by the health service providers. I have already mentioned in previous chapter that in every partner organization has an extensive outreach program; BCC is one of the main components of that outreach activities. Usually, community level staffs of service providing organization mobilize community members and meet together in a place within the community where service providers discuss on various issues related to health. The organizers provide whole range of information from nutrition to sanitation and everything in between related to health. These meetings are no way to listen community's voice about the implementation of the project; at best, they could be seen as awareness meetings. But UPHCP partners claim to have achieved community participation through these meetings. They may be right on their claim but wrong on the conception of participation. The project managers, clinic managers perceive that their BCC activities are their effort to make the community participate in the UPHCP. But the examination of the content of the BCC meetings clearly demonstrates that BCC meeting is

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<sup>39</sup> The term street bureaucrats refers to the people who are directly involved with providing services to the clients. In this study, it refers the doctors, nurses and other staffs of health centers who are directly involved in service provision and in direct contacts of service users.

only a way to disseminate health information to the potential clients. In fact, to a greater extent the BCC sessions worked as the marketing activities for the respective clinics. Dr. Mizan, Clinic Manager, Sultanganj Rayerbazar said:

“We know the value of participation of the community people in our project activities. Without community support we wouldn’t have been able to continue our activities in the neighborhood. Community gives us places to conduct meeting, to arrange satellite clinics and so on. Through BCC sessions we organize peoples and give them health information.”

The above statement shows the instrumental nature of community support in the project, but has been seen as a means to raise resources and expand outreach activities. Therefore, it could be said, in general, lower order participation does exist in UPHCP.

#### *7.6.1.3. Intensity and Scope of Participation*

The UPHCP envisaged community participation in terms of participation of beneficiary, however, the scope and intensity for that beneficiary participation is even lower. Analysis of directions, rules and practices revealed that the beneficiary’s participation is mainly aimed to manipulate community resources such as their support in organizing meetings, places for meeting and so on. At the same time, the other form of participation - BCC - is specifically targeted to change the health seeking behavior of the catchment population. The BCC is specifically designed to inform the target population.

Further analysis also reveals, beneficiaries are allowed to participate only to the service delivery issues. Policy decisions are made off limit for the beneficiaries - poor or rich doesn’t matter. In other words, taking stock of intensity and scope of participation of the community in UPHCP establishes the fact that community participation is very low.

Indeed, the above picture reflects the common situation of the overall UPHCP. It is worth mentioning at this point that this discussion is mainly concentrated on what was prescribed in the Project Manual Administration. However, given the narrow conception of participation, the PAM had left a major part to the partners for designing strategies to involve community in their respective project. In response to this responsibility, partners devised their own way to bring community’s participation in the project activity, but no common system or approach has been developed among the partners. Rather, there are some variations in the way particular partner organization approaches the issue of



participation in their part of implementation of UPHCP. For Example, Marie Stopes has taken participation as a strategy to identify potential users and to determine their economic status in a participatory way in their partnership area. Although all partners under the UPHCP are recommended to recover a part of their operation cost, but at the same time they are also recommended to put special provision in place to provide services to the poor. In order to follow this guideline, Marie Stopes introduced differentiated pricing system for the poor according to their economic status in its catchment area. Determining socio-economic status of the poor, however, is no easy job. The MD of Marie Stopes, Dr. Yeasmin Ahmed reports, “When it comes to extreme poverty in slums, it varies so much and there is no one criterion which you can use to measure. So we went back to the community and ask them to grade their own poverty.” She further explains:

“We took volunteers who were actually members from the same slum and asked them to grade households according to whatever they think would be the criteria. ...They categorized them into four groups. We found those community volunteers used some of the things as their criteria, which hadn’t been used before in research. Like the type of fuel they used: whether they used rubbish for cooking or would go and buy fuel from the market. They came up with quite a few fifty criteria which we thought really worked well. On the basis of these criteria the community members determined the different indicators of poverty and levels of these indicators for rich, middle, poor, and very poor households in their community” (Kahan 2004).

In pricing, Marie Stopes used this poverty grading to determine to whom they should offer services for free. In a way, this participation of the community members in identifying their own socio-economic status has created an opportunity to utilize their own agency; the scope of their participation was somewhat limited though. Because, the community volunteers were only asked to identify the criteria on the basis of which their poverty situation could be evaluated, but the decision regarding the pricing or which poor group are willing to pay which amount was not examined; it was solely determined by the NGO officials. Nonetheless, the intensity of the community participation had somewhat increased; but the scope was limited. In the end, it should be mentioned that this kind of participatory approach in identifying service user’s economic condition was not used by any other partners in UPHCP. So, what ever impact it could have made, was not exhausted in full.

#### *7.6.1.4. Local Advisory Committee: for community participation?*

In spite of having a narrow scope of community participation, the reform project, at a later stage, adopted a new mode to involve more community members in project implementation, which is called Local Advisory Committee. In brief, Local Advisory Committee is a forum consists of members recruited from the adjacent communities. The committee is responsible to give suggestions regarding all health and non-health issues concerning a particular health center. The size of the committee ranges from 5 to 11, the elected Ward Commissioner of the respective ward chairs the committee and members could be recruited from catchment population (50,000) of a health center. In fact, the establishment of LAC was not suggested in the PAM; however, the idea had developed mainly from the experiences faced in procurement of land for building health centers. Dr. Jahangir, the former DPD of UPHCP informs:

“Land procurement came up as a big problem in the early phase of the project. It was very difficult to find appropriate land to build health centers close to the slum areas. In many cases there was no city corporation-own land and in some cases city corporation land were illegally grabbed by local powerful political elites. These local elites were not interested to give up their control over land; even some of the ward commissioners in both Dhaka and Chittagong resisted the land procurement.”

This land crisis emerged mainly not because of the scarcity of land but the illegal land grabbing of the local elites. In most cases, the local elites built slums and small shops and rented them out to the poor in-migrants to the city. These in-migrants, on the one hand, are source of income and on the other hand, once they become voter, acted as their political supporter. So, naturally, building health centers in the slums brought no good reason for those who grabbed this public land illegally. In fact, introduction of the Local Advisory Committee was a response to accommodate these local elites. Not only land problem, “there were some other problems such as rent seeking by the local hooligans from the contractor of building-construction, pressure for issuing illegal medical certificates from the health centers and so on” reported Dr. Asaduzzaman, former Project Implementation Specialist of UPHCP. Local Advisory Committee has no detailed job description, however, is broadly responsible to provide suggestions to the clinic authority in order to make services better. It does not have any decision making authority, the recruitment of

LAC members are arbitrary. It has been seen, among the 31 LAC members of 6 health centers under Marie Stopes, none of them lives in slum. 3 out of them are school teachers and 5 are businessmen. Out of 31 only 8 including Marie Stopes officials are women. For each committee at least two persons from the respective NGO or clinic have been included as members. None of the committee member represents the poor in terms of their income and other social status.

On papers, the LAC is a forum to ensure community's voice in clinic management; however, the forum lost its functionality because of lack of its authority over clinic staffs. No resources were invested to make this forum effective. There is no regular schedule for meeting; it fully depends on the will of clinic manager. Nevertheless, the ward commissioners, being the chair of the committee, established a very weak political connection between the health center and the community. All in all, the LAC as an institution offered nothing more than lower order participation.

#### *7.6.1.5. Participation: Views of the poor*

I have discussed up to now the supply side of community participation. However, one also needs to look into the demand side: what do the poor think about community participation, in which way they want to participate in health system? In order to get these answers I used my qualitative data.

While asked if they knew who run the health centers, the participants in Dhaka gave different answers. Some of them answered 'government' while others answered 'NGO'. Some also mentioned 'City Corporation' and only few named 'Marie Stopes'. However, in Chittagong most of the participants answered that it is the city corporation running these clinics. These simple answers can give us some important insights regarding the willingness of the community to participate. For Dhaka, unspecific answers from the participants indicate their lack of interest to know more about the health centers. Ms. Zaheda, mother of three children, 30, from Shikdar bastee told,

"I don't need to know who runs the hospital, rather it's important for me to know if they do offer services I need for my children. For poor like us, it makes no sense to know who runs, how it runs".

Indeed, this is an extreme example; however, many shared this view. In general, the

struggle for life is harsher in Dhaka, so they are more engaged in making their living. In contrast, in Chittagong, almost everyone knew that the health centers are run by the City Corporation. It is because; the city corporation has a strong presence in health care sector before the UPHCP came in. In addition, the city corporation constructed the buildings in similar fashion so that it can appear as easily recognizable brand to everyone. At the same time, the responses in Chittagong showed the participant's higher level awareness of the health system.

When participants were asked if they knew any system of participation in health center management, almost all of them answered negative. They did not know the existence of LAC, however, many knew the ward commissioner but did not have idea if s/he chaired any such committee.

The participants were asked to identify areas of health system where they can contribute by participating. There were several creative and useful answers from the participants. "We can form a committee to over see if doctors come regularly to the health centers, if they behave well to the patients" said Ms. Sanowara Begum of Beribadh bastee. While Ms. Kulsum tells "we can tell clinic staffs where they should arrange satellite clinic", Mr. Ranjan from Ashkerdighi opined, "We can form a committee to see if medicines are purchased and distributed properly". Summary of different responses from different Focus Group Discussion suggests two things: first, a committee which would allow the poor, particularly the women to make decisions regarding monthly activities of the health center is expected to be formed; secondly, a more general type of committee including local elites, clinic staffs, poor and women is to be formed which will deal not only issues related to diseases and patients but also issues related with sanitation, food habit, children health, health awareness, drinking water and so on. The health center is expected to be the center of coordination for this committee.

Several important observations could be made out of the responses of the participants. First, the poor and particularly the women did not demand much in terms of participation. They did not expect to participate in policy making; rather they put themselves in a realistic position. They wanted to make it sure that their suggestions regarding activities of the health centers i.e. outreach activities, immunization program, pricing will be heard.

The poor did not challenge the omnipresent professional authority of the doctors on health issues. Secondly, the poor accepted the health centers activities but wanted to make it more inclusive in terms of its activities and management. They wanted to make a more inclusive committee but did not exclude local elites and political leaders. And at the same time they wanted to make the health center core of the all social activities in the community including sanitation, nutrition, child-care and so on.

These responses deserved to be dealt more carefully. In a plain eye, it is clear that the participants did not want significant changes in the present space for participation. However, one needs to take into consideration the context from where the poor, mostly illiterate women and men are expressing their views. The belief about “health is to be dealt by the expert” is so strongly rooted into the society, even among the educated, well-informed men, that it is very unlikely to find someone challenging that institution. This institution shaped individuals sense of ‘good’ or ‘bad’, therefore, the participants let the experts to make the policy decisions for them. They are happy if they can contribute in service delivery level. Moreover, the lack of experience in community organization restricted their expectation; many of them showed ambivalence to their ability of making difference by participating in health center activities. It does make sense; because there are no many opportunities in the communities where the poor, the women can participate in public spaces. This situation suggests to increase the ‘supply of participation’ to create more ‘demand of participation’. The classical demand-supply rule of economics is not applicable in this case. We know participation creates more participation. Therefore, enhanced opportunity structure could offer more spaces for exercising people’s agency and thus create more assets and finally create demand for more opportunity.

#### **7.6.2. Impact on Accountability**

Accountability is another important element of community empowerment (Narayan 2005), thus regarded as important political benefit. Accountability refers to the ability to call public officials, private employers or service providers to account, requiring that they be answerable for their policies, actions and use of funds. There are three main types of accountability: political, administrative and public. Political accountability of political parties and representatives is increasingly through elections. Administrative

accountability of government agencies is through internal mechanism. Public or social accountability hold government agencies accountable to citizens. Social or citizen accountability can reinforce political and administrative accountability mechanisms. To contextualize this definition in our study, it could be said that it is the way of holding service providers (from the community level provider to the higher level executives) for their performance and the results of their decisions. The concept of accountability would be more meaningful considering what kind of accountability exists: to whom, by whom and for what (Cornwall, Lucas and Pasteur 2000).

Measurement of accountability is always a big challenge. In our case, I would like to use the following matrix (Figure 7.6.2) on which at horizontal row accountability will be classified from lower order, middle order to higher order; and at vertical column 6 aspects of accountability i.e. accountability to whom, accountability of whom, accountability with respect to what, when accountable, purpose of accountability and mode accountability.

Figure 7.6.2: Accountability Measurement Matrix

	<b>Lower order accountability</b>	<b>Middle order accountability</b>	<b>Higher order accountability</b>
<b>Of whom</b>	Service worker	Midlevel managers, doctors	Personnel of all levels including policy makers
<b>To whom</b>	Higher ups	Higher ups and colleagues	Community members and marginalized groups
<b>For what</b>	Input, Managerial	Input, Output, Expense, managerial	Impact, social relevance and other variables
<b>Which level</b>	Post implementation	Post implementation	Design and post implementation and non-implementation
<b>Purpose</b>	To detect any error	To detect any error	To prevent any error and to detect any error
<b>Mode</b>	Bureaucratic rules	Self regulation	Pressure from the bellow

*Source: Adopted from Murthy and Klugman 2004*

Applying the above matrix I shall examine the degree of accountability that has been provisioned in the reform project under UPHCP. At first, I shall examine the official rules and procedure and then opinion of the community members on the issue of accountability.

I have discussed how a particular service providing organization itself is accountable to whom and I also discussed what kind of mechanism are in place in service providing organizations for their different category of workers. However, in this section I will review and those discussion and link them together in order to understand its impact on

empowerment. Since my main focus is to understand if the reform project has offered any opportunity structure through which poor community can make the service providers (from the bottom to the highest policy makers) accountable, my analysis will embark on the bottom-up evaluation of the formal rules regulations and practices. Given the UPHCP framework, my analysis shall proceed with following questions:

- (a) can the poor community hold policy makers accountable?
- (b) can the poor community hold the service provider organization accountable?
- (c) can the poor community hold accountable the health center staffs?
- (d) is there any difference in terms of accountability gain between Marie Stopes and City corporation service provision

Answering the first question, I need to identify the key policy makers in relation with the reform project I am dealing with. It should be mentioned that the common notion of ‘policy maker’ has been delimited from the political leaders to the key actors related with the UPHCP. In other words, I will exclude the political leaders such as the ministers, legislators and so on from our analysis in consideration that the relation between those political apex and community is very indirect and naive and has got little to do with the policies of the UPHCP.

I have identified the key actors in relation with the UPHCP in the Chapter 4. According to that earlier investigation, we saw the LGD, Ministry of Health and Family Welfare, Dhaka City Corporation Health Department of Dhaka City Corporation, Donors (ADB, NDF and UNFPA), City Corporations, and The NGOs and Bangladesh Medical Association (BMA) were the key actors who had played crucial role in the reform policy formulation phase in different ways. In the implementation phase, few more actors have been added to the previous list, for instance, the Project Implementation Unit and Consultants (individual and organizational). These actors, in various combinations, used to make key policy decisions for the UPHCP through Project Steering Committee, Project Coordination Committee and Partnership Committee. These committees are the space where decisions are made and where actors have to justify their actions and inactions. Therefore, it could be said that this committees are simultaneously acting as a mechanism for maintaining

accountability of the actors to some extent. If we look into the formation of these committees, we would see community is not represented in any form there. The committees are mostly populated by various government officials. Even the elected political leaders are also absent in those bodies. Thus it could be argued that it is not possible for community to hold accountable the key actors directly. According to the project design the supreme power of the reform project lies in the hand of the Steering Committee which is headed by the Secretary of Local Government Division of MOLGRD&C. This means, a government bureaucrat holds the highest authority regarding the UPHCP. Of course, the secretary works under the authority of the minister while the minister is an elected political leader. And the political leader is accountable to his constituencies through elections. But this indirect relation of political accountability hardly functions in the context of Bangladesh. Therefore, finally, I can say that there is an upward accountability mechanism for the key actors but there is no way by which the community or beneficiaries can directly make them accountable. This means, according to our matrix, the degree of accountability in the UPHCP framework is low.

In reference to the second question, accountability of the service providing organization is very important as it directly affects the community life. We know there are two different kinds of service provider organizations: NGO and City Corporation. Although both of them are providing services under the same project, however, may have different mechanism for ensuring accountability. I have discussed in detail in Chapter 5 that how accountability is maintained in service providing NGO and City Corporation.

According to the program design, any service providing organization is bound to follow the terms of references of the contract it is awarded with. The contract includes the technical and financial proposal they submitted in the bidding. The contract itself provides the institutional basis of the accountability for the service provider to the Project Implementation Unit. The service providing NGOs are members of Partnership Committee of UPHCP at the city corporation level, where they have to present their quarterly performance report and explanations if there is problems in attaining target (ADB 1998: 10). The Partnership Committee is headed by the Mayor of the respective city corporation. Broadly, the accountability of the service providing organization is maintained in terms of their target attainment to the Partnership Committee and to PIU.



But there is no representation of community. NGOs are member of the partnership committee, but not as a representative of the community rather, as an implementing agency. From the community's point of view, implementing agency is regarded as a formal part of the project, does not matter if it is an NGO or city corporation. The only representative from the community is the Mayor who is an elected public official and accountable to his constituencies. However, the partnership committee is mainly for review the performance and to resolve conflicts between the partners. The executive power to impose sanction or cancellation of the contract rests on the PIU and through them to the Steering Committee. Therefore, it could be argued that ensuring accountability to the community is not possible through the Partnership Committee.

Concerning the accountability of UPHCP project to respective organizations are maintained through various institutions within the organization. Since these organizations are run according to their own constitution and organogram, there is no opportunity for the community to interfere in that organizational structure. In that case, the project's upward administrative accountability is maintained only through the organizational hierarchy. Therefore, we can argue that the community can not hold accountable the service provider organization to them within the UPHCP framework.

The third question is related with the accountability of the staffs of the health centers who are directly engaged in providing services to the people. According to the matrix, accountability of service provider for their services itself is regarded as lower order accountability. However, it is worthy to see if that lower order accountability is maintained at all and what role the community can play in that regard.

In Chapter 5, I reviewed the detail accountability mechanism for the clinic level staffs under UPHCP. Given some small variation between NGO and City Corporation, the clinic level staffs are accountable for their action and attainment of target to their respective bosses according to the organizational hierarchy. This means, the UPHCP offered institutions for lower order accountability at the health center level.

In addition to this administrative accountability, a separate process of accountability, in which service users can play a direct role, is in place in all health centers under UPHCP. In fact, it was a condition from the UPHCP for the partners to put a system of making

complain in health center; not all organizations put a similar system of complain though. For example Marie Stopes has introduces a system which comprises a permanent complain registrar in each health center and a direct hotline for the service users. “any client or anybody can write their complaints against any staff of the health centers in the registrar or any client can call directly to the head office on a special number to registrar her/his complaints” informed Ms. Hasrat Ara Begum, the Project Manager of UPHCP in Marie Stopes. She also explains, “Complaints registrar is weekly reviewed by the head office service improvement team, no clinic staff can influence it”. She also mentioned that the Marie Stopes informs back the person who made the complaints about what kind of steps were taken against her/his complaints. For CCC, there are also complain registrar in their health centers, no hotline system does exist there. While introduction of call-registrar or hotline is a big step forward in a context like Bangladesh towards empowering the service users, however, our household survey and FGD both confirms for both Marie Stopes and CCC, the complain mechanism is hardly known by the service users. According to our household survey it has been found that only a very small proportion, 7% of the total users are informed of the existence of any kind of complain-mechanism. This quantitative data has also confirmed by the exit interview where it has been found that none of the service seeker were told by the health center staffs about the way of making complaints. But only a few reported that they knew it by themselves because they can read and saw there was a complain register in the center. Therefore, finally I argue that a system of making complaints have been introduced in service points for the service users in order to detect the error (behavior or process) of the service delivery system that can somewhat ensure lower order accountability. However, due to the negligence of the health center staffs to inform the complaints-mechanism to the users the system has not achieved its benefit.

The last but not the least, Local Advisory Committee has also an indirect role in ensuring accountability of the service providers at the clinic level. Since the committee is headed by the local ward commissioner who posses to some degree of political and administrative power, can influence the service delivery decisions of a health center. Thus, the community, to some extent, can hold a particular health center accountable to them through the old political channel.

Concerning accountability, no significant difference between NGO-run service provision and city Corporation-run service has been found except one. It has been seen that the Marie Stopes depend on the organizational rules and regulations to ensure accountability of its health mainly by the attainment of target and standard of the services. And in doing so, Marie Stopes uses formal rules and norms. On the other hand, for the CCC, accountability is mainly regarded as a part of the bureaucratic rules; target attainment is not related with accountability. Another important observation about the CCC is: there some informal rules and channels of accountability in place. However, due to the overlapping of some core responsibilities at the top of the UPHCP management in CCC administrative upward accountability has been eroded to a greater extent.

Having analyzed all three questions regarding the state of accountability in the reform project under UPHCP, I can finally say that the reform did not initiated or introduced any ground breaking institution by which health policymakers or key actors and service providers can be hold accountable to the citizens, particularly the poor. Thus, the impact of the reform project, in terms of social accountability, on political benefit is felt very insignificant.

The reason for poor impact of reform project, in terms of accountability, could be explained by using new institutional theory (March and Olsen 19984). The analysis shows that the key actors in reform-design were not interested to bring any new changes in the area that can affect the existing power relation; rather their action was very much path dependent. We see, the bureaucracy dominated formulation-team emphasized on the administrative and upward accountability with whom they are used to. In other words the key actors used existing institutional templates to design the accountability aspects of the new service provision (Hall and Taylor 1996). The other actors, the professional and NGOs all have supported the idea as it did not pose any threat to their traditional power base.

To conclude this section, the reform program did not introduced any rules or provision so that the community can participate in the health system in a meaningful way. The narrow conception of participation in the project framework allowed only low degree of participation of the beneficiaries. Same can be said about accountability. For

accountability, only upward bureaucratic accountability mechanism is there. In other words the degree of social accountability is low.

For both issues, I argue the reason for absence of institutions for higher degree of participation and accountability is laid in the structure of policy formulation process and within the institutions through which the policy was produced. This means, since the policy formulation process was participated only by a few, mainly bureaucrats and donors - their views, perception and interests have been reflected in the policy content, so that they did not introduced any wider options for peoples participation and social accountability.

### **7.7. IMPACT ON COLLECTIVE POLITICAL ACTION**

This section examines the impact of the health reform on collective political action. I argue that any reform policy does offer not only a ‘service package’, but also a process through which the services come to the individuals. The process entails interactions among individuals and regulations. This encounter with people and processes makes individuals exposed to new people, new contacts, new beliefs, and new expectations; thus, provides a motive and opportunity for collective action. Within the framework of UPHCP, there are some provision and services which entails collective actions. In order to understand the impact of that collective actions specifically and overall impact of the project on collective political life of the individual in catchment communities this section is organized in two parts, at first part the genesis of collective action: self and political efficacies are examined and then collective political actions.

#### **7.7.1. Impact on Self and Political Efficacy**

Self and political efficacies are the two important psychological assets of human being which form the foundation of human behavior in the public domain. Putting it differently, these are the two important aspects of individual as well as community empowerment. These two concepts capture one’s believe on oneself that his action can influence the direction of events. For example one service user will make complaints when s/he knows that his complaints may change the situation. It is assumed that if somebody is treated with dignity, given information and opportunity his/her self and political efficacy will increase and likely to act accordingly. Therefore, in this study I was interested to

understand the state of the self and political efficacy of the poor who have come in direct or indirect contact of the health reform program, UPHCP. Naturally, I depended on the qualitative data.

The participants in FGD were asked what they can do to change the health inequity in their community and some follow-up questions were also put on board. It has been seen that the participants from the communities in Dhaka, who are served by Marie Stopes, suggested bringing health service provision under honest political leadership. And in that case they defined their role as passive supporter of that change. “we can not do anything, nobody listens poor” said Mr. Shamsu (42), from Rayerbazar. He believed that they themselves can not make any difference. Another participant, Ms. Jobaida, 35, reported:

In our *bastee* (slum) people from clinic come to give *tika* (vaccines) and pills only once in two months, but it does not help us much as we need pills (contraceptive pill) every month. Once I thought to request them to come more often, but I didn't. I didn't because I knew they will not care request of a poor woman like me”

However, the situation in Chittagong is different. A good number of participant reported that if they move together with some demand or complaints to the local ward commissioner or to the city corporation they can influence the decisions. It has been seen that the relation between the local political elite and the communities in Chittagong are relatively closer than that of Dhaka. This relatively closer relation gave many people the confidence that they might influence some of the decisions. For example, Mr. Hashmot, 45, a construction worker from Ashkerdighi reported:

“We live very close to the local Bazaar, where many small petty sellers particularly, vegetables and fish sellers come every morning. And every day they used to leave behind a huge amount of waste in the narrow drain of the Market which flows by our houses. Since our house is very close to the market, we suffered from the bad smell every day. One day I went to the President of the Bazaar committee and requested him to ask the petty sellers not to throw their waste in the drain. He was convinced and eventually it stopped and a new garbage-place was built in the market within few months”

It is also seen people's efficacy increases once s/he is rewarded for being prompt. In other words, psychological asset will increase if enabling environment is there. All in all, it could be said that the reform program has no direct impact on the self and political efficacy of the poor, however, the women who visited more the health center and

participated higher number of BCC sessions are felt more confident than others who did not. They are also found active in organizing community meetings and collective actions.

### **7.7.2. Impact on Collective Actions**

The collective action is the expression of the use of political resources. The involvement in collective action reflects individual's political efficacy and believe in group action on the one hand, and community's eagerness to influence the public policies that affect their life.

In relation with health reform, there is some potential to have some impact on the collective action in catchment communities. I have already discussed that BCC is an important component of the ESP that is provided by all partners in all catchment areas. The main idea of BCC was to make aware of the health and health services in the catchment areas so that the coverage of the service use grows. And, in the process of attending BCC-sessions community members are likely to have engaged more in collective actions. Secondly, health centers used to arrange various awareness rallies, procession in connection with observation of several national and international days like World Women Day, World Aids Day, National Immunization Day, World Child Rights Day and etc. People from catchment communities are likely to participate in those programs. This means, in connection with UPHCP there are several direct opportunities which enhances the possibility of collective action in the communities. However, its not easy to identify the factors which led what kind of collective actions in the community. In this section, I want to see the overall associational life of the poor and their participation in public domain in the following subsections:

#### *7.7.2.1. Organizational Membership*

Organization includes a wide range of civic organizations vary from various *samity* (cooperative) to sports organizations except political parties and illegal organizations. It has been seen that about one fourth of respondents have membership of at least one organization (Table 7.7.1).

Table 7.7.1: Pattern of Organizational membership

Percentage distribution of mothers of 0-12 months child by cathchment areas and organizational membership			
	NGO-run communities	Local government-run communities	Total
Member of organization	30.2%	21.4%	25.7%
Not member of organization	69.8%	78.6%	74.3%
Total	100.0%	100.0%	100.0%
N	106	112	218

Source: Field survey

It is also important to note that the multiple-membership is very common. While among the members 61% women are members of one organization, 25% are member of two organizations and 9% are having three memberships and 5% respondents have more than three memberships. Concentration of NGOs in urban slum is a well known phenomena in Bangladesh, our data supports this assumption. However, coverage is not that high. Organizational membership is not a simple thing. From the organization theory we know, there are many factors like organizational power, identity, resources, ideology etc. which moves people to get membership of any kind of organization. But a common feature is any individual primarily shows ambivalence to enter into organization. However, once a person becomes member of one organization then s/he starts getting free from early dilemma and it is very likely for him to be member of more organizations. Researches show that one of the main reasons for being member of NGOs/civic organization/samity is to get access to micro-credit. Our field survey reports (Table 7.7.2) 57% of total member respondents are member of credit giving organization. Since the NGO-concentration is higher in Dhaka than that of Chittagong, versatility in organization's work is also higher in Dhaka. Therefore, the data reports that credit and non-credit organization coverage in Dhaka is equal where as in Chittagong credit giving organizations are the main.

Table 7.7.2: Types of Organizational membership

Percentage distribution of mothers of 0-12 months child by cathchment areas and organizational membership types			
	NGO-run	Local government-run	Total
Member of credit organization	50.0%	66.7%	57.1%
Member of non-credit organization	50.0%	33.3%	42.9%
Total	100.0%	100.0%	100.0%
N	32	24	56

Source: Field survey

#### 7.7.2.2. Attending Yard Meeting

While yard meeting is a common forum to participate in the public domain, survey result reports a very low attendance in yard meeting among the respondents from all four communities under survey. While respondents were asked if they ever attended any group meeting on health issues, only 13% of them answered affirmative. And among the respondent who took services from UPHCP facilities, in other words, who are registered service users, among them only 11% have ever attended meetings arranged in community. There is, however, a difference between NGO-run and CCC-run communities. 71% of total respondent who took part in health related group meetings lived in the NGO-run communities. All in all, the low attendance in group meetings indicates lower participation tendency in collective actions.

#### 7.7.2.3. Participation in Public Rally/Demonstration and Election

Participation in public rally, procession, demonstration and election activities are well established indicators of collective actions. This activities does not have direct link with health reform, however, indirect relation is significant.

The field survey results present participation in direct political activities which requires being visible in the public domain is very low among the women who had 0-12 months of child during the survey (Table 7.7.3). However, the important aspect of women's involvement in public direct political activities is that 41% of them are voter of their respective home area. Table 7.7.3 also presents that about 38% of women cast vote in national or local elections.

Table 7.7.3: Pattern of participation in political activities

Percentage distribution of mothers who had 0-12 months of child during the survey			
	Yes	No	Total
Participation in public procession/rally/demonstration	4.1%	95.4%	100%
Voter of this area	40.8%	59.2%	100%
Casting vote in national/local elections	37.6%	62.4%	100%
Contesting in local/national elections	.5%	99.5%	100%
N			218

Since the respondents are women, the data presented in the Table 7.7.3 makes sense. It is clear that the activities which requires higher level of visibility and mobility in public spaces, respondents participation in those activities such rallying or demonstrating is very



low comparing to those which does not, for example casting vote. This means, the traditional role of women still very much in action, for which poor women are participating less in collective actions in public spaces. A further analysis, however, shows a modest sign of change. It shows, those who are voter in their respective areas (Dhaka and Chittagong), 82% of them cast vote in national and/or local elections. It implies, these slum dwellers took part in immediate past (national/local) elections. Being voter of the in the locality where one lives is considered to be an advantage for the voter in the context of Bangladesh. It is because of the fact that the very unstable nature of the slum-residence, which always obstructed the slum dwellers to be voter. But once they have voting right and have been exposed to at least on election, it is very likely they will have more power to negotiate with local political elites comparing to those who doesn't have. It is also seen that the number of voter and number of respondent who had at least one voting experience are higher in Chittagong than Dhaka. This data confirmed again the higher level of collective action in communities served by local government (Chittagong) comparing to communities served by NGOs (Dhaka).

To wrap up this section, it is seen in general, the political and self efficacy among the poor is low. However, women and men in communities in the catchments of CCC both are found more confident than their fellows in communities in the NGOs catchment in Dhaka to exert influence on political leaders. On the other side, the level of collective actions among the women have found very low. However organizational membership is reasonably good. Lastly, it is seen that if one has the voting right s/he is slightly more empowered than those who does not have it.

## **CHAPTER 8**

### **CONCLUSION: TOWARDS A MODEL OF POLITICAL ANALYSIS OF HEALTH REFORM**

This study focuses on the political dynamics of policy reform process that shape the design and implementation of public policies in Bangladesh. It analyses the role of key actors, institutional mechanism and contextual factors. By building the account of a particular reform program - Urban Primary Health Care Project, the study reveals the political dynamics within the public policy process in one hand, and the differentiated impact of the reform on various groups and institutions in state and society in the context of developing nations.

The study reveals that the nature of the process of health reform policy making is mainly determined by the nature of the state and politics in Bangladesh. It is seen that historically, military and civil bureaucracy are the two most powerful actors occupying central position in the state policy making. Political parties, who are developed from the background of land-owning class and backed by urban middle class, act as the third important actor in policy making. However, after 1991 the situation changed because of the liberalization of economy and installation of electoral democracy in the country. Indeed, the multilateral and bilateral donors have gradually become very powerful over years since independence due to the chronic dependency on foreign aid. As a result, few new actors like donors, business elites, NGOs and media have increasingly been important. This new actors along with the older actors formed the key actor's group in the area of health reform policy, albeit not all the members of this group have played equal role in shaping and implementing the Urban Primary Health Care Project. Nevertheless, the study shows that reform policy making and implementation is a complex, dynamic political process in Bangladesh which involves donor organizations, government bureaucracy, professionals, NGOs and political leaders - national and local. More importantly, the study also shows that common people in general, particularly the poor and the women have no participation in any phase of the reform design and implementation. Since the study begins with the aim to understand if an elite-driven reform policy does benefit the poor, results and analysis suggests that a more

participatory model of reform is needed to empower the poor and thus establish social justice in Bangladesh. I shall elaborate the participatory model in the policy recommendation.

The study reveals that the impact of reform in urban primary health care sector on state and society is multifaceted and multifold, some of which directly linked and visible; and some are not; some are long term, some are short term. Some of the impact is directly related with gains in health, some are connected with awareness and some are related with structural changes in power-nodes within and outside of the health system. The study tried to grasp all of these diverse dimensions in this chapter and at the same time opens a discussion towards building a model for political analysis of policy reform. This chapter is organized in five sections: summary of the all findings, comparison of findings between two implementing agencies, model for political analysis of policy reform, policy recommendations and future research agenda.

## 8.1. SUMMARY OF THE FINDINGS

### 8.1.1. Health Sector Reform: Impact On the State

It has been seen that health care reform has multidimensional and complex impact on the role of state in health care in Bangladesh. First, it is evident that the state's traditional roles are challenged from the three sources donors, from within and from the NGOs. These two actors- donors and NGOs- have used the health reform policy as a site for exerting influence on the state so that it reduces its presence and control and let open it for others to come in.

Second, evidences also showed state is gradually withdrawing from the service delivery and a new form of service structure is taking over the previous hierarchical delivery mechanism. Somewhat a model of multi-level governance is emerging in the health care arena.

Third, the state through the reform policy extending its power over the local government agencies and social actors like NGOs.

Fourth, the evidence clearly show that the state is reducing its financing in the health sector through the implementation of the reform

Fifth, as a result of the reform, the local government agencies are losing its traditional functional authority to two sources: the central government and the NGOs

I conclude that, paradoxical impact has been produced on the state with respect to its role in health care sector. On the one hand, it is rolling back from the health sector with pressure from the external, social and internal forces. On the other, it becomes resilient by extending its control over social organizations through the reform. However, how this change will affect the wellbeing of the poor that is not clearly visible. Nevertheless, if the government can regulate the non-state service providers to maintain pro-poor service provision, poor will not feel any immediate negative impact, but for how it will affect in the long run that needs to be further researched.

In order to explain the paradoxical changes in the role of state in health sector, we should look into the fact that how policies are made in Bangladesh, what is the nature of the state, who are the dominant coalition and what is the ideology of the hegemony. In the respective chapter I have analyzed them in detail; however, I can bring the main points in again. My analysis of the historical development of the state Bangladesh, policy process, policy actors and their power clearly showed that, except a very short period immediate after the liberation, rest 30 years all the regimes had suffered for legitimacy crisis. Even after the democratic reinstallation the state could not institutionalize the democratic practices in its policy making. Major democratic institutions like parliament, political parties and local government have not been institutionalized. Political scientist analyzed this situation and marked as illiberal democracy (Croissant 2004: 157-178). Therefore, the democratic deficit of the state has never been well filled. The relation between the state and society has never been made easy, transparent and accessible. Using this opportunity, the early military-bureaucracy oligarchy with some new partners like business and NGOs who represents the urban middle class grew as a result of economic liberalization and extensive flow of the foreign funds, they created the hegemony; hegemony of consumption, hegemony of market. During this time most of the alternative political voices went down as bi-party electoral politics grasped them all by distributing patronages. Therefore, this hegemony influenced the government to pursue for their interests so that the state opens its health sector for NGOs and businesses.

### **8.1.2. Health Sector Reform: Impact On the Society**

In this section I shall present the summary of the impacts on the community level, what I have analyzed from the perspective of the marginalized deprived group of population.

#### *8.1.2.1. Maternal Health*

In general, maternal health care for poor has improved in all four cities after the reform. ANC coverage has increased in four cities comparing to the pre-reform period. The increase rate among poor in Chittagong is highest in four cities. The status of number of and timing of ANC visits have also improved

The quality of ANC has increased as the number of women received ANC from trained health personnel has increased to, on average, above 80% from 66% in reform period. However, there is wide variation among various communities. The newly built health centers under the reform have been established as the main sources of ANC for poor women in all four cities. Pregnancy and delivery related complications have declined in all four cities with a little a variation among the cities. However, no significant increase has been achieved in the rate of institutional delivery, still more than half of the women in Dhaka and short of three fourth women in Chittagong are giving birth at home. There is a wide variations among communities which is reflected in our field survey results that shows in four communities the rate of giving birth at home is even higher than official data. Moreover, delivery attended by the trained health personnel has also remained very low during the reform period.

#### *8.1.2.2. Child Health*

Child vaccination coverage has increased by more than 20% and made 79% of all children of age 12-23 months fully immunized in all four cities after the reform. However, the rate of increase in the vaccination coverage in reform-cities is lower than the national urban level increase rate. Coverage of vitamin A supplementation has increased but not at a expected rate. In fact, in all cities but Chittagong the Endline survey reported to have lower rate of vitamin A supplementation. While the rate has dropped by 5 percent in three cities, in Chittagong it has increased by 10 percent in the period from Baseline to Endline. There has been an increase in the use of ORT for treating diarrhea, it

has been seen that about 76-88% of the children in four cities who had diarrhea episodes received ORT either form of commercially available ORS packets or recommended home fluid. The rate of increase is higher in Chittagong comparing to other three cities.

#### *8.1.2.3. Impact Knowledge and Awareness*

Knowledge and information are considered as the crucial resources for human agency and reducing the power gap. The knowledge of giving more foods and liquid has changed during the project period. The number of women who has knowledge of giving more fluids during diarrhea episodes increased 60% to more than 75%. Similar trend is also found regarding the knowledge of giving more food during and immediate after diarrhea episodes. The increase rate is the highest in Chittagong among all other cities, currently, the percent of women who had the knowledge of use of extra food during diarrhea has been doubled from 26 to 58% where as for Dhaka, it has just increased from 53% to 66.2%.

There is important knowledge gain regarding the importance of breast feeding among the mothers in all four cities. Currently, 41-59 percent children are breast fed within one hour of birth and 80-89 percent is breast fed within 24 hours of birth in all four cities which suggests on average 16 -20 % of increase from pre reform to post reform period. It suggests that mothers have gained knowledge about the importance of breast feeding. However, still the traditional practices are dominant among the poor households. Knowledge about importance and usage of iodized salt has been wide spread during the project period, currently, 96% of women know and use iodized salt.

No initiative was taken under UPHCP to make the service users/citizens aware of their health rights, neither of their rights as a client of health care. The overall level of health right awareness among poor and non poor is very low. However, it has been seen that the citizens are becoming aware of their health rights by participating, directly and indirectly, in various form of political spaces. Elites are reluctant to establish effective mechanism to ensure Patient's Bill of Rights.

#### *8.1.2.4. Impact on Access to Health Care*

The UPHCP has made most of the essential primary health services available to the

community by its amount and cost. However, potential male users are not informed about the service availability. Unlike the government health facilities, doctors and other health personnel are found attending their job regularly in UPHCP health centers. The UPHCP has increased access of the poor to the health care service by establishing the health centers closer to the poor communities. Most of the health centers are found within a half kilometer, on average, from most of the poor communities in the respective ward. The UPHCP has saved time and cost to go to the health centers for the poor. 93% of poor can go there by walk which takes only 10-15 minutes from home and costs less than 10 taka on average. Waiting time at health centers has also been reduced to a reasonable level, less than thirty minutes, to the service users. Service cost has been made affordable under UPHCP, and differentiated approach for various categories of service users made the care accessible to the poor. It has been seen that out of pocket expense per visit is only 18 taka. About 96% of service users are able to get their required health care services paying maximum 25 Taka. Physical and social environment is also congenial to the poor service user women.

#### *8.1.2.5. Impact on Responsiveness of the Local Health System*

Under the system of UPHCP, the service users are addressed respectfully by the health center staffs. Poor service users reported to have found doctors and nurses behave well with them. Poor women service users are satisfied as doctors pay attention to their problems. Concerning privacy, doctors in UPHCP health centers do care of the patient's privacy and almost all service users also regard doctors reliable to tell them their private information. However, no significant information sharing about medical and behavioral aspects of diseases and medication takes place between the service users and providers; the patients are passive receiver of the information and they never question any decision taken by the doctor about her/his health and medication. Nevertheless, a significant difference between UPHCP-users and non-UPHCP users have been noticed; while 71% of UPHCP service user mothers reported have better communication with doctor, only 51% non-UPHCP users found their doctors shared information about disease and medication with them. No effective measures are promoted to establish better communication and encourage doctors to provide information to the patients. Service Users are happy with the cleanliness of the health centers under UPHCP.

#### *8.1.2.6. Impact on Participation of Poor*

Powerful stakeholders took part in reform formulation phase, no opportunity was offered for the poor or marginalized groups to participate in any form. Even participation of elected public office holders also is very limited.

In the implementation phase, there were some provisions for beneficiaries. All types of service users including the poor, women have been put under one category 'beneficiaries'. The reform project offered no special opportunity for the poor but several opportunities for the beneficiaries in general. Key decision making powers are held by the senior government bureaucrats and professionals only. Among the elected public officials only the Mayor heads one forum of decision making at city level.

Considering all dimensions i.e. who are participating, rational of participation, level, scope and intensity of participation it is clear that the reform project failed to offer opportunities nothing but lower degree of participation; which is, in fact aimed not to empower the marginalized groups, rather, to legitimate the power-holders decisions.

#### *8.1.2.7. Impact on Social Accountability*

Key actors are accountable to their respective superiors in the administrative hierarchy. While service providers are also accountable with concern service providing organizations, the health centers staffs are accountable to their bosses (clinic manager) for their performances. Having analyzed all aspects of accountability in the reform project under UPHCP, we can say that the reform did not initiated or introduced any ground breaking institution by which health policymakers or key actors and service providers can be hold accountable to the citizens, particularly the poor. Thus, the impact of the reform project in establishing accountability, and thus empowering the poor, is felt very insignificant.

#### *8.1.2.8. Impact on Collective Political Action*

The reform program has no direct impact on the self and political efficacy of the poor, however, the women who visited more the health center and participated higher number of BCC sessions is felt more confident than others who did not. They are also found active in organizing community meetings and collective actions.



The reform program has not created any opportunity to increase collective action among the service users or actors including the community. All the established approach like BCC has been posited as a form of collective action which creates a little effect. However, it is been seen that people in NGO-run communities are relatively more involved in various collective activities than the people in CCC-run communities. There are many people who are member of more than one organization at the same time. Half of the people, who are member, are member of micro-credit-giving organization.

Very few people participate in public rallies, demonstration and other form of collective political actions. Around 40% of the people in the catchment areas are voter and more than 80% of the voter cast vote in national or local elections in their respective area. Women participate less in collective actions which made them visible in public spaces comparing to them which does not.

From the above summary it is clear that, in general, the health reform has produced positive impact in the area of maternal and child health, health knowledge, access and responsiveness. In other words, it has brought improvements only in the area of health of the poor which is allowed by the dominant health professional hegemony. Following the views of the economic and professional actors the whole health agenda has been reduced to reproductive health. On the other, the areas of health which are pertinent for the development as a complete citizen, a political being capable of making informed choice has largely been ignored. No impact has been felt on the collective dimension of human involvement. Rights, consumer rights, participation and accountability have not also been addressed through the reform program. The service users were considered as passive receiver of advices and drugs; their human agencies were not taken into account. Interesting to see that there is no major difference between NGO and local government (given some small differences are there; I shall explain them later) in most of the aspects with respect to their impact. This implies, the NGOs and local government agency does not have any qualitative difference in their approach to the health of the poor. Since none of them took any initiative to address the social and political aspect of health, they showed their institutional loyalty to the hegemonic perception of health. However, we should not forget there are some differences which need to be explained.

Table 8.1: Comparison of impacts of the health reform between Dhaka (NGO-run) and Chittagong (Local government-run) on selected indicators from macro level

Indicators	Dhaka	Chittagong
<b>Maternal Health</b>		
ANC coverage	▲	▲ ▲
ANC number of contacts	▲	▲
ANC timing	▲	—
ANC from trained personnel	▲	▲ ▲
Had delivery complications	▼	▲
Had pregnancy complication	▲	▼
Place of delivery is health facility	▲	▲
Delivery attended by trained health personnel	▲	▲
<b>Child Health</b>		
Coverage of vaccination	▲	▲
Vitamin A supplementation	▼	▲
Treatment of diarrhea	—	▲
Management of diarrhea	▲	▲
<b>Health Knowledge</b>		
Knowledge about diarrhea treatment and management	▲	▲ ▲
Practice of early breast milk initiation one hour	▲	▲
Knowledge of iodized salt use	▲	▲

**Key: Increase - ▲; Decrease - ▼; No change - —; Change at very high rate - ▲ ▲**

Table 8.1 shows the changes in maternal and child health aspects that happened after implementation of UPHCP on the basis of macro level data at a glance.

## 8.2. FINDINGS IN COMPARISON

I have already explained what kind of changes in the health of the poor has been made as the impact of the health reform program. The characteristics of the communities were controlled to see if there is any effect of the leading actor (implementing agency), as it was one of our propositions that the changes in the actor can make difference in the impact. As we have already noticed in our data analysis, which is much more visible in the table 8.2, that there is little differences between communities in terms of the impact. Even in most indicators, there is no significant difference have been found among cities.

Table 8.2: Comparison between communities in all indicators

Indicators	NGO-run		Local government	
	Sultanganj	Godighar	Askerdigi	Amanatshah
Use of UPHCP centers for ANC	▲	▲▲	▼	▲
Birth at health facility	▼▼	▼▼	▼	▲
Delivery attended by trained health personnel	▼▼	▼▼	▲	▲
First food is breast milk	▼	▼	▲	▲
Health right awareness	▼▼▼	▼▼▼	▼▼▼	▼▼▼
Availability of services	▲▲	▲▲▲	▲▲	▲▲
Regular availability of doctors	▲▲▲	▲▲▲	▲▲▲	▲▲▲
Physical proximity of health centers	▲▲▲	▲▲▲	▲▲▲	▲▲▲
Mean time and transport cost	▲▲▲	▲▲▲	▲▲▲	▲▲▲
Waiting time at the health center	▲▲▲	▲▲	▲▲▲	▲▲▲
Service charge	▲▲	▲▲	▲▲▲	▲▲▲
Physical and social environment of the health center	▲▲▲	▲▲▲	▲▲▲	▲▲▲
Addressed respectfully always	▲▲▲	▲▲▲	▲▲	▲▲▲
Behavior of doctors	▲▲▲	▲▲	▲▲▲	▲▲▲
Behavior of nurses	▲▲▲	▲▲	▲▲▲	▲▲
Doctors pay attention to listen	▲▲▲	▲▲▲	▲▲	▲▲▲
Privacy during physical examination	▲▲▲	▲▲	▲	▲▲
Privacy of information	▲▲▲	▲▲▲	▲▲▲	▲▲▲
Doctors discusses details of problem and treatment	▲▲	▲▲	▲▲	▲
Knowledge about complaining system	▼▼▼	▼▼	▼▼▼	▼▼▼
Cleanliness of the center	▲▲▲	▲▲▲	▲▲▲	▲▲▲
Participation	▼	▼	▼	▼
Accountability	▼	▼	▼	▼
Self and political efficacy	▼▼▼	▼▼▼	▲	▲
Member of organization	▲	▲	▼	▲
Participation in yard meeting	▲	▲	▼	▼
Participation in Public rally and meeting	▼▼▼	▼▼▼	▲	▲
Voting in national election	▲	▲	▲	▲
<b>Key: High/Good- ▲; Very high/good - ▲▲; Very very high/good - ▲▲▲</b> <b>Low/Bad- ▼ Very low/bad - ▼▼; Very very low/bad - ▼▼▼</b>				

It is not a surprise, mainly because, the indicators which are showing that there is no difference they represents the feature of the health care system which is not a threat to the

dominance of the medical professional, which is compatible to the existing conception and practices of health care like access of the health care. Indeed, due to the reform there have some tremendous improvement, particularly in the area of access and responsiveness these two variables are very significant. And, fortunately in all communities people are enjoying these health services with dignity and privacy in time and with very minimum price.

Table 8.3: Comparison of implementation features of two organizations under UPHCP

Features	Marie Stopes	Chittagong City Corporation
<b>Context</b>		
Experience in the health care sector	2	2
Understanding of the communities working in	2	2
Competition with other service providers	2	0
Relation with related government agencies	1	1
Relation with political parties	0	2
Relation with local political elites	1	2
Relation with local social elites	2	2
Organizational dependence on the project	1	0
Autonomy from the PIU	1	2
Strength to bargain with the controlling government Ministry	0	1
Linkage with referral health care service centers	1	2
<b>Process</b>		
Commitment of the organizational leader to the cause of the health of the poor	1	2
Professionalism in organizational practices	2	0
Skill and experiences of key staffs	2	1
Commitment of the project manager to the goal of the project	2	1
Accountability of project staffs	2	1
Regular and systematic monitoring of the project	2	1
Information sharing among other units	1	0
Participation of project staffs in decision making	0	0
Participation of project staffs in making action plan	2	1
Financial transparency	2	0
Discretion of the clinic manager to make operational decision	1	0
<b>Ideology</b>		
Particular ideology bias	0	2
<b>Interests</b>		
Political interests	0	2
Financial Interests	1	1
Legitimacy, Recognition interests	2	2
Professional interests	2	0
Key: High- 2; Medium - 1; Low - 0		

Therefore, this improvement will affect positively in the health of the poor, thus they will

be benefited. However, there are some little differences in some area which I will explain by using the table 8.2 and 8.3. If we look down to the table 8.2 we see there are few but significant differences between communities under NGOs and communities under CCC. From 8.2 it is seen that birth at health facility is very low in both of the communities under NGO-run service provision where as in communities under CCC it is relatively higher. Again, the practice of giving breast milk as the newborn's first food is also higher in communities under CCC than that of NGO. These differences are small but significant. It shows that CCC is performing better in the area of health seeking behavior which requires continuous and intimate communication to be changed. The relation between the community and service providing organization plays crucial role in this respect. Being a political institution the CCC has relatively closer relation with the community. In other words, political linkages make people feel closer to the service providing organization which in turn being translated into higher health benefit. It confirms that the political benefit and health benefits are complimentary to each other and can reinforce each other. Table 8.2 also shows, self and political efficacy is higher among the people live in communities served by CCC than that of NGO. It does mean, the people live in slums in CCC catchments are more confident, than that of Dhaka. They do believe that their action can change the structure. They know how to approach the power structure; why they know it, why their efficacy is higher than that of Dhaka can be explained by the table 8.3. From the table 8.3 it is also seen lot of convergence between these two different types of organization, however, there are also some little but significant differences. We can see that CCC is maintaining very high relation with local political and social elites for their political interest and also maintaining good relation with political parties. These local political elites, party cadres are some opening for the local poor people; they are the interfaces between local state and community (Mitra 1992). It seems community members know it and there is some evidence that they use it. Similarly it is also visible that they do take part in public demonstration related with health activities. They are exposed to the public domain through the health activities. From this point I would like to build my argument that, if the actors are democratic in nature, if they come from some representative institutions it is very likely that they will produce more egalitarian output. So, finally, look back to the propositions, I can say that no direct affect of context has

been found, since content is same for all it is automatically controlled, but what appears more significant that the nature of the actor and its ideology is very important factor to produce more permanent kind of impact which can reduce the power gap and thus sustains the health impact more fruitfully.

### 8.3. TOWARDS A MODEL FOR POLITICAL ANALYSIS OF HEALTH REFORM

The analytical framework of this study suggests, for understanding a particular reform policy and its impact, analysis should focus on five major elements of a reform policy: process, context, actor, content and ideology. These five elements can be analyzed separately in order to understand both why a reform measure is taken and what impact it does produce. Since the policy content reflects actor's ideological position and preferences, for some it may not feel necessary to put separate emphasize on analyzing policy content as an independent variable. Of course, in comparative policy analysis policy content may appear as very important factor. This study is dealing with one particular policy which is equally applicable for all implementing agencies, thus content does not have the ability to explain variation in the impact of the policy implemented by different actors. However, I analyzed content for the purpose of understanding ideological orientation of the actors.

The analytical framework of this study has been built with the help from two different kind of models: Easton's general system model (1965) and Walt and Gilson's (1994) critical analysis model. The analytical framework suggests building arguments on the basis of five variables: decision making process, actor's constellation, political and socio-economic context in which policy is made, ideology of dominant actors and content of the policy. Having taken this framework into account, six key propositions are postulated. I will bring them here again to review and draw generalization out of this case study.

The first two propositions, '*the more public, political the actors are the higher the political benefits are*' and '*the more private, economic and professional actors are the higher health the benefits are*', are derived from the actor's constellation variable. The argument is policy outcome and its impact depends on the combination of actors who are involved in decision making and implementation. The analysis of the health reform initiatives that were taken of before and after 1990 shows that bilateral and multilateral

donors including World Bank, WHO, UNFPA, ADB, USAID, DFID have been playing most important role in deciding policy measures and implementation strategies in the health sector in general. These actors have material power, decision making power and discursive power. With particular reference to our case of UPHCP, ADB has been the most powerful actor as it provides 67% of total budget. At the same time, ADB is included in key decision making bodies like project steering committee. It also has discursive power to set the standard of operation during implementation. At the decision making level, for the overall health sector MOHFW is the most powerful actor as it represents the central government. In case of UPHCP, however, instead of MOHFW, the Local Government Division of MOLGRD&C represents the central government and civil bureaucracy with its decision making power. Along with these two leading actors, there were NGOs like ADAB, BRAC, Dhaka City Corporation, City Corporation leaders who played supporting role. On the other, professionals (BMA), DGHS and few NGOs tried to resist at the initial stage. But due to the lack of material and decision making power their resistance failed to influence the policy decisions. The reform was supported by the cabinet too. All in all, it is seen that nature of the two most powerful actors ADB and MOLGRD&C is economic and professional. And the analysis of policy content and impact clearly shows that chosen policy measures, such as contract out, motivated by economic interests in one hand, and on the other, health benefit is found higher than political benefit after implementation. In other words, our case study validates the second proposition. Looking back to the implementation cases, the study shows that the political benefit is relatively higher CCC-run areas than that of NGOs. Marie Stopes is a professional health NGO and CCC is a political organization. Therefore, it can be said that because of involvement of political actors in implementation creates more political benefit to poor, albeit not very significant level. This means the first proposition is also proved valid, however, a comparative policy analysis can provide more strong evidences.

The third proposition '*the more transparent and accessible the decision making process is the higher the benefit*' is derived from the variable process. I argue, the nature and quality of benefit is highly related with the nature of the decision making process. This means, decentralized, open and participatory policy process creates more chances for mobilizing more views, ideas and resources and policy ownership for the policy

implementation (Naryan 2005). Therefore, overall benefit will be higher if have many actors particularly public, political and social actors participated in the decision making and implementation phase. Moreover, many scholars, for example, Gaventa and Valderrama (1999), Lund (1990) and Arnstein (1969), argue that citizen participation in all phases of public policy is a way to acquiring power for the poor. Therefore, it can be argued that an open, transparent and inclusive policy process bring more political benefit for the poor. Similarly, if the decision making process is highly centralized, less deliberative and less transparent it is very likely that the impact will be very limited in terms of its low impact on all aspects human agency and unequal power relation.

The analysis of the policy process shows that, regarding UPHCP, the decision making process is extremely exclusive, only few actors took part. Involvement of legislature in designing the reform policy did not occur. The UPHCP was discussed neither in house nor in the parliamentary working committee on health (Nizam 2002: 148). Health has never been in the discourse of political parties. The review of election manifesto of four major political parties reveals that parties have no specific program for the health sector. It means, no deliberation took place among the political parties outside the parliament. In the cabinet the project was approved without much meaningful deliberation. Analysis of various decision making committees regarding UPHCP is dominated by bureaucrats from LGD, donor organizations, and city corporation mayors and CHOs and service provider organizations. In other words, the policy process is not open and inclusive. With reference to impact of UPHCP, we see there is increase in health benefit but political benefit is very low. Thus it can be said that the overall benefit of the project remained low, particularly the political benefit remained very low. Thus, the proposition proves valid.

The fourth proposition, '*benefit changes as context changes*', suggests that the same reform program can produce different outcome in different context. Since the study is, primarily, a single case design, it was not possible to test the proposition at policy formulation level. However, analysis of socio, political and economic policy-context in Bangladesh shows why some actors became more important than others. For example, chronic dependency on donors fund for development budget in the health sector paved the way for the donors to be influential. Similarly, NGOs become important because of



the overall social political context. Therefore, it can arguably be established that changes in context may affect actor's preferences and importance in the policy game in one hand, and on the other hand, the implementation of the reform. In this study, the context factor has been tested at implementation level. Analysis of variation in health and political benefit data between two different communities under the same implementing agencies proves that the context matters.

The fifth proposition '*benefit changes as the content of the policy changes*' derived from the argument that suggests the policy content reflects the objectives, goals and the strategy for implementation, thus any change in the content will obviously affect the impact of the reform. The main objective of formulation of this argument was to understand how different interpretation of the same policy content makes differences in the policy implementation process, thus in the impact. Indeed, it is very difficult to differentiate analytically policy content from the actor because the content reflects the values, ideologies of the actors which symbolized in the policy document. In this study there was no much scope for examining this propositions, however, the analysis reports some evidences from implementation level.

We know that all implementing agencies were awarded a contract for providing a particular set of services to the citizen of a particular catchment area. Putting it differently all implementing agencies have been working under the same policy directions. However, the study reveals that the interpretation of policy content was done differently by implementing agencies. For example, UPHCP implementing partners were recommended to have special strategy for the poor client. It is seen that Marie Stopes, the NGO, interpreted this measure differently than that of CCC. Marie Stopes identified the client in various groups according to their self-defined degree of poverty and assigned different health-cards for different groups to identify their economic condition and serve accordingly. In UPHCP under Marie Stopes, all service users have a card of particular color which shows their economic category and ability to pay for services accordingly. Marie Stopes thought it is the best way to serve the poor client. On the other, the CCC does not have any differentiated card system for identifying poor client; instead, it has universal card system and universal payment system which is affordable to poor as well. And they do provide basic drugs for the client without any cost. They though it is the best

way to serve the poor. For Marie Stopes, the argument is accurate identification of the people who needs most the support; however, the counter argument is that a card of particular color means a particular identity, which may create disrespect and ignorance for the patient. On the contrary, CCC wants to provide the service more universally, not particularly targeting the poor. Their argument is- before the health care providers there is difference between poor and rich, however, CCC policy makers strongly believed that differentiated card system may lead further exclusion of the poor. This example shows that different interpretation of the same policy content may produce different impact.

The final proposition is about ideology, which argues the ideology affects the perception of key actors of the definition of the problem and the standard of the performance to be evaluated. Therefore, benefit of the reform change as the hegemonic ideology changes. The essence of this proposition is to take the influence of the hegemonic ideology into account while evaluating the impact of the reform. The case study reports some strong evidences.

Hegemony is perceived in this study from Gramscian perspective in which the concept denotes a congruence of material and ideological forces that enables a coalition of interests to maintain a dominant position in society. This coalition develops over a long period of the historical development that transcends any one class (Gramsci 1988). Hegemony is maintained through material control over economic resources as well as ideological control over symbols, imagery, and modes of thought. The analysis what I presented in previous chapters clearly demonstrates that in Bangladesh a coalition among members of government bureaucracy, medical doctors, military high officials, NGO leaders, business leaders, academicians and media have grown over years. Political parties, particularly the two main parties (Bangladesh Awami League and Bangladesh Nationalist Party) are also included in the coalition. These groups, mainly, represent the urban middle class. Some of them are from the state and some are from civil society. They do control most of the state and non-state resources both material and ideological within the country. Actions and discourses show that the neoliberalism holds tied them together as the ideology. These groups support each other in relation to policy decisions. For that reason, denationalization and liberalization of economy has been going for last three decades without any opposition among any of them. The civil society for example,

academia and media helped legitimizing these policies. Regarding health reform policy, a sectoral edition of this grand coalition is visible. The health policy arena is dominated by the bureaucrats working in the MOHFW, doctors working in the DGHS, BMA, NGOs including ICDDR,B. Donors like ADB, WHO and WB are their external partners. It is clearly visible that health professionals and bureaucrats are the two core groups of actors are dispersed under these various institutional identities. For economic management these actors depend on market and for health management they emphasizes on medical aspects. In fact, marketization and medicalization are congruent to each other. The case study reports that opting for contract out of health care services to NGOs is a way towards complete privatization. And, other elements of NPM like cost recovery, are very much visible in the reform design. Likewise, content analysis of the policy document reveals, health is primarily perceived as physical health to the decision makers. That is why reform designers did not consider participation of citizens in implementation is necessary. It is also reported that these ideas of the hegemony successfully persuaded the implementing agencies. Therefore, the activities and decisions taken by the community level service providers also reflect the same perception of health and health management. Therefore, no health center took the participation issue seriously; no effort was found in place to promote patient's rights; no institutions were found there to make the service providers accountable to the community. They feel successful if they can achieve target number of patient and money. However, it is also evident that within the hegemony, particularly at local level, conflict between actors develops.

In summary of this review of the propositions in relation with the case study, I can say that the case study clearly establishes the validity of the key propositions. However, this study has paved the way for drawing broader generalization in studying reform policy out of the case study. Before drawing generalization, I shall give a short account of the political features of state and society in Bangladesh that emerged throughout the analysis of the case study.

1. The analysis shows, at the community level, poor people do not own the health service centers. They are not informed of who runs the centers, how it is run. It means, the sense of ownership regarding the health care service provision has not been developed among the community members.

2. Local political and social leaders are also found reluctant about the health service provision in their localities. The study reveals very weak linkage between local elites and the program management. However, the linkage is relatively stronger in Chittagong than that of Dhaka.

3. Since local social and political elites are not involved in decision making and managing health centers in their locality, the views, opinions, complains of community members regarding health services are reaching neither to the city level policy makers nor to the health center authorities.

4. In the new service structure traditional political channel of accountability has lost, instead a system of vertical accountability has been established along the line of organizational hierarchy at every level of reform implementation.

5. NGO professionals and activists are gaining more power and legitimacy by being involved in the service provision.

6. This study also exposed the very paradoxical nature of the neoliberal reform. Through the reform process, on the one hand state is getting smaller; on the other hand it is extending control over social organizations. Although state's role is changing, but it is also found that the state becomes resilient and regains its role as the most important player in the policy formulation phase while that may be reduced in the implementation phase. The reform disintegrated the previous hierarchical service structure and instead, in the process of reform implementation, an interdependent service network of actors emerges. The neoliberal health reform increases the power of the non-state actors in the health sector, and as a whole in Bangladesh. What this paragraph tells us is that, this reform is very likely to produce its opponents among the local level government bureaucracy because reform program reduces states', thus bureaucracy's role. However, reform program finds its alliance among the senior bureaucrats, thus it is very likely to survive regime changes.

Similarly, since the reform reduces the power of the conventional political institutions like political parties, local government bodies, and local political leaders and gives more power to the non-state and non-political actors, it is very likely to create opponents among the lower strata of political authorities like parties. However, since the democratic

institutions are not strong and representativeness of political elites are poor, thus one can expect that their opposition would very likely to create enough support within the party or in the government. As a result, the poor suffers more because, the traditional political leaders were closer to people inefficient though; on the other new non-state actors are efficient but do not have the capacity to bridge gap between the people and service providers.

7. The study reports that a model of multi-level governance is emerging in developing countries too, particularly in health sector, which need to be researched further.

8. Finally, this study reveals that the reform policy is actually becoming a site for contesting interests among the key actors. For the political actors like the minister and city corporation leaders the reform is an opportunity and mechanism to distribute material resources among its supporters. It is seen that the contract of building new health centers were given to the contractors who were supporter of the party in power of that time. Moreover, in case of UPHCP, it involved new employment, scholarships and training opportunities. The city corporation mayors and senior bureaucrats of the ministry took the opportunity to distribute patronage among their clients. Similarly the reform also helped the state actors, particularly the party in power and bureaucrats to gain legitimacy among the constituency. The reform helped the state actor to reduce their deficit in democratic legitimacy. The other members of the dominant coalition, like NGOs, they also gained legitimacy being involved in the program with the government and city corporation. For NGOs it was not only for legitimacy gain, it also gave them material and immaterial power. For example, the partner NGOs get the opportunity to build network with donors like UNFPA, NDF and so on.

Drawing on the above discussion and analysis it is clear that this study leaves opportunity for formulating some broader generalization beyond this case study. We can take our central research question again to draw generalization. The research question is does health reform policy benefit the poor? At this point, it can be said that there is no straight 'yes' or 'no' answer to this question because, this study reveals that the reform policy, in the given context, brings reasonably high health benefit but very low political benefit to the poor. But these two kinds of benefits are complementary to each other. The study also

shows that higher political benefit helps to bring higher health benefits. However, without political benefit, it is less likely that the health benefit would last long. This finding, in fact, relates the study with broader question of the social science. The broad and general question of this study was to know if elite-driven reform development initiatives bring social justice in the context of developing countries. The study considered, following Mitra's (2005) argument, the reform as an elite driven project. And insights from pluralism also supported the view that public policies are a result of negotiation among contesting interest group, although neo-institutional scholars kept informed the study that the elite or actor's behavior is determined by the embedded institution. In other words, the reform policy is a result of strategic choice of elites within a given institutional context. Now the question is does this policy help to establish social justice in the context of developing country? Social justice denotes a condition in which all members of a society have the same basic rights, security, opportunities, obligations and social benefits; in other words social justice can prevail in an egalitarian society. Citizen's rights, participation in decision making process, social accountability are the fundamental elements for promoting social justice. The analysis of the case study shows the reform program extended access to public services but without involving them in distribution decision. Thus, citizen's right to take decisions over issues by which they are affected is ignored. This is to say that the ground rules for promoting social justice have been ignored. While looking into the reasons for which this situation develops, it does lead one to remember the core arguments of this study. The essence of the argument is under a defective democratic system through an exclusionary policy process it is very unlikely, if not impossible, to have a public policy which is helpful for establishing social justice. This conclusion confirms once again the Sen's thesis which suggests that democratic management of social and economic sectors can produce higher growth and social justice (Sen 1981, 1999). Democracy may not necessarily ensure the social justice but without democracy social justice can not be achieved.

#### 8.4. POLICY RECOMMENDATIONS

One of the objectives of the thesis is to provide some policy suggestions which can be used in ground by the practitioners and policy makers. Without going for some radical solutions, I would propose some suggestions from pragmatic point of view, very much

program-related. In fact, the suggestions what I am going to offer now has originated from the discussions of my respondents during the field work. Indeed, these suggestions are primarily applicable for the Bangladesh context; however, one may think to apply in another context as well, given that the contextual adjustments will be made.

1. The health center has to be put in the center of all development activities in the community. This is to say that, there are many government and non-government interventions going on in the community such as drinking water supply, sanitation, child development and so on. In fact, these activities are closely linked with health. Therefore, I suggest putting a community coordination committee centering the health center in order to coordinate and facilitate important interventions activities.
2. With respect to urban health care in Bangladesh, I would suggest to elaborate the existing Local Advisor Committee to include more members from the community particularly the women. And this committee should be allowed to have certain degree of authority so that it can make decisions and make the clinic staffs follow the suggestions.
3. A federation of LAC should be formed and they should meet regularly to share the experiences of other health centers.
4. A separate committee to protect the rights of the service users and to protect them from any kind of abuse a service user's users committee could be formed
5. The provision of the yard meeting can be utilized more by adding some innovation and resources. At first its content should include rights aspects of the health. Patient's bill of charter and health as a social right should be incorporated in the module of yard meeting.
6. In order to ensure social accountability, the project manager and the leader of the organization should present accounts of the project to the LACs and service users committee regularly.
7. I would suggest involving the city corporation at every stage of the project. Along side NGOs city corporations should be given chances to run health

centers as others NGOs are doing. The management unit of the project (PIU) should be reorganized under formal control of the city corporation.

8. Finally, I would suggest decentralizing the entire health care management to the local government organizations and let have them the freedom to decide how they want to run their health care system in respective cities.

#### 8.5. FURTHER RESERCH AGENDA

This study opens quite many new areas for further research in the context of developing countries:

1. Since, there is a emergence of multi-level governance is taking place, thus how global actors are related with national, local actors; how it functions, relationship among various actors of the network can be a very good research issue.
2. The role of political parties, what found in case of Bangladesh, in health policy and reform is ambiguous, some have some agenda, some does not. I think a study on how political parties are perceiving health problems, health care system can be a very good study.
3. My study was focused only on the urban areas, however there is program also running in rural areas. Thus a comparative study on rural and urban health could be a very interesting study.



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## **ANNEX 1**

### **RESEARCH DESIGN AND IMPLEMENTATION**

This study is designed to understand and achieve new insights about the way neoliberal health reform policy works for the poor in a developing country like Bangladesh. And in order to build understanding and insight I decided to focus on analyzing health reform policy and its impact on poor communities in urban areas in Bangladesh. The research design is pronouncedly determined by the research question (Vaus 2001, Scarborough and Tannenbaum 1998), therefore, before elaborating the research design, let me get back to the core research question of this study once again.

The central research question of the study is: does health reform benefit the poor? In order to answer the question the study aims to analyze and understand the impact of the health reform policy implementation on state and society. It is very clear that the aim of the study has macro and micro dimensions which capture the state and society levels respectively. In pursuing the aim, I am studying the implementation of a particular health reform policy process in Bangladesh. The UPHCP is the case in point.

The aim of the study clearly demonstrates inductive, heuristic and interpretative nature of the study. Having considered the core question and the aim of this study, I designed the research on the basis of Case Study method.

#### **RESEARCH DESIGN: CASE STUDY**

The case study has an important position in the discipline of political science (Gerring 2004: 341). The reason for selection of case study method lies in the objective of the study which is mentioned earlier that the objective of the research is not to test any theory or hypotheses derived from theories; rather, it is dedicated towards building a new theory of health politics. Methodologists argue that the 'case studies have powerful advantages in the heuristic identification of new variables and hypotheses through the study of a particular case(s) in the course of field work' (George and Bennet 2005: 20). Similarly, Vaus (2001: 223) also suggests that case study helps to develop and refine propositions. Moreover, another important objective from methodological point of view is, this study intends to contribute in strengthening the dialogue between qualitative and quantitative

methodological divide. Although, case study is popularly known as a qualitative method, however, I tried to minimize the gap with quantitative approach by accommodating quantitative data collection techniques within the case study framework.

Case study is defined, from methodological point of view, ‘as an in-depth study of a single unit’ (Gerring 2004: 341). The case study is mainly used in the situation where the researcher wants to build understanding of a particular phenomenon aiming to elucidate various characteristics and dimensions of a larger set of similar phenomena. A case study can be structured in many ways; however, Vaus (2001: 228) identified six elements of a case study design, these are:

- descriptive or explanatory
- theory building or theory testing
- single case or multiple case
- holistic or embedded units of analysis
- parallel or sequential case studies
- retrospective or prospective

A cross classification of these elements can logically produce 64 different types of case study design. Although Yin (1994) simplified these wide variations in four major types: explorative, explanatory, analytical and descriptive case studies.

Focusing on the research question of this study, it is reasonably arguable that the health policy process, to be more precise, UPHCP is the issue in hand deserves an in-depth study in order to understand its impact on state and society. It is because; the policy process is a political phenomenon which entails various categories of actors, structures and institutions. The very complex nature of the policy process calls for employing the case study design for this study. It is worth noting at this stage that I conceive public policy process as an interactive process. Subscribing the argument of Thomas and Grindle (1990), I consider that different phases of a policy process i.e. agenda setting, decision making, implementation and evaluation are interrelated to each other, and each stage can influence at any point of time outcome of the other. This assumption leaves a

strong implication for the identification of unit of analysis of this study.

According to Yin (1994), a unit of analysis, depending on its nature, may be distinguished between holistic and embedded. A holistic case is studied in its whole. On other hand, there are some cases which consist of multiple levels or components these cases called embedded unit of analysis (Vaus 2001: 220). Since the case of this study is UPHCP which has different level i.e. decision making, implementation and impact, and more importantly it includes actors from various strata, various processes and organizations, and these components are embedded with each other, thus, it can be regarded as an embedded case. The main feature of the embedded case design is that it does recognize different levels and components within the same case. In other words, the unit of analysis of this study can be further differentiated at its embedded component's levels. For this study of UPHCP, in a very straight forward way, in order to answer the central research question, this study is focusing on three main sub questions: how decisions are made, how decisions are implemented and what is the impact. These three questions reflect three autonomous but embedded and interrelated three sub-processes within the same policy. These three sub-processes lead to identify three different units of analysis from three different levels and corresponding different designs:

(a) Studying the Reform Policy Making Process: Single Case Study

While the study undertakes the analysis of how policy decisions are made, who are the actors, what are the factors and what is impact of the health reform on the role of state in health, it considers the entire reform policy as a whole. The unit of analysis for this part is the whole UPHCP.

(b) Studying the Implementation of UPHCP: Comparative Case Study

The reform under UPHCP is being implemented in four cities by 12 different implementing agencies. These implementing agencies are in fact the service providing organizations. In this part I am interested to understand, what is the nature of reform implementing actors, in which approach these organizations are implementing the reform, what are their own agenda, how they view the poor service recipients and so on. Clearly, the focus of the analysis for this part is the organizations that are providing the services on the ground. Therefore, concerning implementation of the reform, the unit of analysis is

the implementing agency.

There are two broad genres of organization among the providers: NGO and Local Government. Following Charles Ragin (1987:1), who suggests that most of the knowledge of the social science comes from some kind of comparison, in order to construct a complete picture, I adopted comparative case study method for this part of the research; and naturally, the comparison is made between NGO service provider and Local government service provider. I shall discuss the selection of implementing agencies in the following section.

#### (c) Studying the Impact of UPHCP on Community: Household Survey

The most important part of the entire study is the impact of the reform on poor community. Community is the combination of individuals and individuals live in households<sup>40</sup>. However, as far as the impact of health reform is concerned, primarily the impact is felt by the individual because, this is the individual who receives the health service.

In summary, it is argued that the three different research methods can be applied for three different embedded components of a single phenomenon. Although, I have selected three different method, but they are complementary to each other and are linked methodologically. The interrelationship among these three levels has been maintained in the process of data collection. For example, selection of cases of implementing agencies has been done on the basis of sampling frame that was used for household survey. On the other, while the quantitative data that has been collected through household survey, were organized and analyzed in relation with selected implementing agencies. I argue that, in this way I have bridged the gap between case study and household survey.

Now I will discuss various data collection strategies that were used in this study.

#### 1. DATA COLLECTION STRATEGIES

The study employs various data collection strategy to feed the analysis which includes qualitative and quantitative techniques. Among the quantitative Household Survey is the main. For qualitative methods, Focus Group Discussion, In-depth Interview,

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<sup>40</sup> The defining characteristic of a household is members share the same food and live under the same roof.



Observation, Facility Inspection Exit Interview were conducted: Besides, a great deal of reports, documents, monographs are analyzed. Data collection techniques are discussed in the following:

#### **a. Household Survey**

This study is built on two-level analyses: macro and micro. The micro level analysis is concerned about studying the impact on the household level. For this part I conducted a household survey.

##### *The Unit of Analysis*

The unit of analysis is the mother of the child of age 0-12 months. Mothers are considered representatives of the household and community they live in. Before discussing the sampling strategy I must explain the reasons for why I chose mother of 0-12 months of child as my respondent. The reasons are as follows:

- (1) In the context of poor household in Bangladesh, mother is the key member in the family, in one hand, they maintain the household work, child rearing and on the other, they do contribute to the family income. Mothers used to take care of their children, particularly the health problems of the infants or young children are almost solely handled by the mother.
- (2) Mother is the member of the household who knows all about the household. In one hand, she knows their family history, and on the other, usually, she has the knowledge of livelihood strategies her husband is adopting. She is the center of the household.
- (3) The health reform program what we are concern about is aimed to improve the maternal and child morbidity and mortality rate. In other words, women and children are the main target of the program. Therefore mother's views about the entire reform program are very important.
- (4) From the gender relation point of view, the women are the most vulnerable member of the household. They are the poorer within the poor household. Therefore, the selection of mother keeps open an additional opportunity to analyze the impact of the health reform from gender perspective.

- (5) Last but not the least, there is a practical reason for selecting mother to represent the household. Women, especially, the mothers of young children, used stay home most part of the day. Therefore, selecting mothers is very likely to reduce the chances of missing respondent.
- (6) Finally, the question of why 0-12 months of children. There are two main reasons for selecting children of age between 0-12 months. Primarily, as I mentioned earlier, children particularly the infants are one of the major targets of new service packages that are offered under the Urban Primary Health Care Project on which the study is focusing. Secondly, the study requires data regarding antenatal, delivery and postnatal health care services. For this reason, who have the child of age between 0-12 months their memories during their pregnancy and after pregnancy period is expected to be remain fresh. In stead, if I would have selected mothers of children of 0-5 years of age then those memories could have been lost.

### *The Sampling Strategy*

The study undertakes Multi-Stage Cluster Sampling strategy for conducting household survey in order to collect data regarding the impact of health reform on community level.

Multi-stage cluster sampling is a procedure in which samples are selected in a series of stages with the sample at each stage being selected from the larger or greater number of portions of the previous stage (Cochran 1977, Balnaves and Caputi 2001). The first set of sample units selected from the available population for sampling is the primary sample; similarly, the subsequent samples, which are selected preceding stages, are called secondary, tertiary sets of samples. This sampling is especially applicable in a situation where population is scattered all over the country; in order to save time and cost this is widely used sampling techniques in social sciences.

#### *(a) Stage 1: Selection of Cities*

Since the UPHCP project has been implemented in four metropolitan cities: Dhaka, Chittagong, Khulna and Rajshahi. Therefore the population for the reform program was 4 cities. I have selected two cities: Dhaka and Chittagong purposively. There are several

reasons for selecting these two cities. First, Dhaka is the largest city of Bangladesh which is habited by about 12 million populations. It is the capital city and being the capital city all reform programs gets special attention from all stakeholders in implementation. Besides, the highest number of contracts has been awarded in Dhaka among NGOs. Likewise, Chittagong is the second largest city and home of about 4 million people. Most importantly, in Chittagong the most part of the reform program is implemented by Chittagong City Corporation which is unique in the entire UPHCP. Out of three PAAs, the CCC is running two. All in all in terms of the size of population, the comparable nature of social and economic condition, level of urbanization Dhaka and Chittagong have been selected purposively.

(b) Stage 2: Selection of Implementing Agencies

One of the proposition of this study is the impact of the reform may vary due to changes in the actors constellation. Implementing agencies, which are called *partners*, are the key actors to carry out the reform on the ground. There are total 12 organizations are given the contract to run 16 Partnership Agreement Areas (PAAs) for all four cities. However, in Dhaka there are 8 NGOs are implementing the reform in 10 PAAs while in Chittagong CCC and one NGO are implementing reform in three PAAs.

Table A-1: Selection of implementing agencies

Cities	Number of implementing agencies	Number of selected sample	Sampling Strategy
Dhaka	08	01	Random
Chittagong	02	01	Purposive
Khulna	02		
Rajshahi	01		
<b>Total</b>	<b>12</b>	<b>02</b>	

For Dhaka, the implementing agencies are homogenous in terms of their organizational identity; they all are NGOs, they all have experience of working in the health sector. They are also quite comparable in terms of their size as well. This homogeneity led to make random sampling. From the set of 8 NGOs I selected one randomly. I argue that since all NGOs are operating under the same terms of conditions of the project, studying one implementing agency as representative of a set of 8 is sufficient. Moreover, I could not ignore the time and cost factors as well. All in all, in order to make the selection of implementing agencies scientific and efficient, 1 organization seemed sufficient. This

organization is Marie Stopes Clinic Society, Bangladesh.

For Chittagong, selection of implementing agency was rather simple. As I mentioned earlier that, Chittagong City Corporation is the main implementing agency as it is implementing the reform in two PAAs out of three covering twenty five city corporation words out of 41 where as the only NGO, Mamota, is covering only 5 words . CCC is the only one non-NGO among the entire set of implementing organizations. Being a local government organization, CCC provides the chances to make a comparison between state and private actors. Therefore, I purposively selected, without hesitation, CCC from Chittagong.

(c) Stage 3: Selection of Health Centers

Health Centers are the main service point for the community; therefore, the quality of the services is largely dependant on these centers. Moreover, every center is run by a group of health personnel who enjoys significant level of discretion in running the health centers. This means, variation in the leadership at the health center level also may have some association with the level of impact. Thus, at this level I made the selection of health centers. For selecting health centers NGO and Local government was considered as two clusters. This means, In NGO cluster the number of population unit was only 6 and under the Local Government clusters the number of units were 25.

Table A-2: Selection of Implementing Agencies

City	Implementing agencies	Number of Health Center	Number Selected	Sampling Strategy
Dhaka	Marie Stopes	6	2	Purposive
Chittagong	CCC	25	2	Purposive
<b>Total</b>	<b>02</b>	<b>31</b>	<b>04</b>	<b>Purposive</b>

In a situation where population unit is not that large, in order to avoid selection bias, intentional sampling makes more sense (King, Keohane and Verba 1994: 136, 196-99). Therefore, the selection of Health Centers was done purposively. However, I took some criteria in consideration in selection of health centers. Since my research question is to know if poor are benefited from health reform, the first and foremost criterion for a health center to be selected was its location. The health centers were distributed in different parts of a partnership area (in general a partnership area was constructed according to the geographical boundary of wards of city corporation) and not all locations within a

partnership area are habited by poor people. Usually urban poor lives in slums and squatters which used to placed out of the main residential area of the ward. Therefore, I selected two health centers from each cluster which are built close to the slum areas.

(d) Stage 4: Selection of Household

The most important part of the entire data collection strategy is the selection of households. I mentioned earlier, according to the project plan, that a health center is build for a 50,000 population in an area. It means the catchment population for a health center is 50000. However, one should keep in mind that the health center is made for every citizen of the area, not for poor or rich only. What it says is within the 50000 population people from any income group can go and get the service. But this study is concerned only about the poor. Therefore, while selecting the household, I need to consider the incidence of poverty of the area. According to the *Poverty Monitoring Survey 2004* of Bangladesh Bureau of Statistics, the urban poverty incidence was 43.6% (estimated as per Direct Calorie Intake method) (BBS 2004). Having considered the urban poverty incidence, I took following steps for estimating the exact size of the sample for household survey.

1. Calculating the size of the population in each cluster: I have two clusters: NGO cluster (in Dhaka) and Local government cluster (in Chittagong). Each cluster is made up of two health centers. And each health center has 50000 catchment population. Since the poverty incidence rate in urban areas is 43.6%, we can assume, 43.6% of 50000 people are poor. Therefore, for each cluster the number of poor population is: 43600.
2. Determining the size of the sample in each cluster: For determining the sample size for each cluster I used a formula forwarded by Mian (1999) which is suitable for identifying sample size in a group of people which is characterized by a particular socio-economic feature. According to the formula:

$$n = \frac{N}{1 + N(e)^2}$$

Where, n= desired sample size, N= number of population, e = some margin of error in N

(sampling error) = 0.1. So, the estimated sample size for each cluster was 99.77; thus, I took the sample size as 100 for each cluster. All together, for the entire survey, the estimated sample was 200. However, taking into account the fact that the respondents are mother of children of 0-12 months, who has to remain very busy all the day for taking care of young infant along with her household works, which may lead some incomplete questionnaire, I added additional 10 units for each cluster sample size. Finally, the sample size came to 220. These 220 households were distributed among four poor neighborhoods under NGO and Local government clusters.

### 3. Identifying the Households:

In order to identify poor neighborhood in the catchment area of respective health centers, I used slum listing provided by the city corporation offices which was also used in the *Urban Poverty Survey 1995* (Conducted by Center for Urban Studies, Dhaka and Asian Development Bank). The number of slums in the catchment areas varied. Nevertheless, I purposefully (mainly by observing the housing and sanitation condition of the community) selected one neighborhood in each catchment area. The number of households in a neighborhood varies from 270- 410. I distributed 220 households in four neighborhoods in four catchment areas of four health center under two NGO and Local government clusters.

From each neighborhood I randomly picked up households having child 0-12 month of age. I started from one corner of the neighborhood and picked those household with 0-12 months of child dropping those without. I kept an interval of 5 household to pick the sample. 220 households were distributed among the neighborhoods in proportion to the number of household in respective neighborhoods. The distribution of household was as follows:

Table A-3: Distribution of Sample Households

City	Implementing Agency	Neighborhood	Sample Households	Sampling Strategy
Dhaka	NGO (Marie Stopes)	Sultanganj	52 (50) <sup>41</sup>	Random
		Godighar	56	
Chittagong	Local Government (CCC)	Ashkardighi	55	Random
		Amantshah	57	Random

<sup>41</sup> During the data collection process two questionnaire were incomplete and thus rejected

		Majar		
<b>Total</b>			<b>220 (218)<sup>42</sup></b>	<b>Random</b>

### **b. Focus Group Discussion**

Focus Group Discussion is a popular participatory method for qualitative data collection. It is a group discussion of small number of participants. Usually in the discussion a group of 6-12 persons take part and talk, express freely and spontaneously about a particular issue. In general, the researcher facilitates the discussion. The main purpose of conducting FGD is to obtain in-depth information on concepts, perceptions and ideas of a group. A FGD aims to be more than a question-answer interaction. The idea is that group members discuss the topic among themselves, with guidance from the facilitator (Khan et al 1991).

I have conducted total 12 FGDs in four communities. From each community I conducted 1 FGD among UPHCP service user women (age 15-49), 1 FGD among UPHCP non-user (age 15-49) and 1 FGD among the male (20 - 55 age) were conducted. Total 97 persons took part in FGDs, among which 59 were female and 38 were male. The participants were selected from the same community where the survey were undertaken but were excluded from the survey. I used FGD guide to facilitate the sessions. Mainly, service quality of health centers, behavior of health center staff, views on participation and accountability were discussed in the sessions. Primarily all discussions were recorded on tape along with note-taking. Finally the recorded discussions were converted into transcripts and reports. Reports were coded later and analyzed.

### **c. In-depth Interview**

In-depth interview is one of the most commonly used data collection techniques for qualitative research. This method is used in many disciplines, particularly in policy related research it is widely used

An in-depth interview allows the researcher dig deep into a topic through person to person discussion. The goal of the interview is to deeply explore the respondent's point of

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<sup>42</sup> Since two respondents were dropped because of their incomplete response which was sorted identified during the data collection process, thus finally the total number of household came to 218.

view, feelings and perspectives on important issue. Very often unstructured or semi-structured interview guides are used and therefore allow the interviewer to encourage an informant to talk in detail about the topic of interest. The in-depth interview uses a flexible interview approach. It aims to ask questions to explain the reasons underlying a problem or practice in a system or process or in target group (Paton 1990).

The effectiveness of in-depth interviews depends on the selection of key informants. Therefore identifying the right person who has knowledge about the issue is very important. Since this study deals with the reform policy process, I needed to identify the key actors and their views. For identifying key informants I used snowball sampling procedure<sup>43</sup>. However, not always I used Snowball sampling. While the key-informants are known then snowball sampling is not required. For example, I interviewed project managers, clinic managers, field workers, community leaders those people are well known for their position in the organization or in the society, thus, I did not use any special sampling procedure. Table A-4 shows various categories of key-informants from whom I have collected data through in-depth interview.

Table A-4: List of Key-informants who were interviewed

Category of key-informants	Numbers	Data collection instrument
<b><i>Reform Policy Making</i></b>		
Senior Bureaucrats	02	Open ended interview guide
Midlevel bureaucrats	06	Open ended interview guide
Senior level political leaders	04	Open ended interview guide
Officials of donor agencies	03	Open ended interview guide
Chief Health Officers of CCs	03	Open ended interview guide
Health Professional working in Government and CC	06	Semi structured questionnaire
BMA leaders	02	Open ended interview guide
NGO leaders (Chief executive)	02	Semi-structured questionnaire
Health activists	02	Open ended interview guide
Journalist	01	Open ended interview guide
<b><i>Reform Implementation</i></b>		
PD, PIU	01	Open ended interview guide
DPD	02	Open ended interview guide
Monitoring and Evaluation Officer	02	Semi structured questionnaire
Project Manager	02	Open ended interview guide
Clinic Manager	03	Semi structured questionnaire

<sup>43</sup> Snowball Sampling is procedure which starts with purposively selected one or two informants assuming that the person knows lot about the research topic. And then find the next respondents by asking the first person (s) (Paton 1990: 179-189).



Medical Officer	03	Semi structured questionnaire
Field-level workers	09	Semi structured questionnaire
Civil Surgeon office worker	02	Open ended interview guide
Local Advisory Committee Members	05	Open ended interview guide
<b><i>Reform Impact</i></b>		
Local Community leaders	05	Open ended interview guide
Local Political leaders	04	Open ended interview guide
Women organization activist	02	Open ended interview guide
Religious leaders	02	Open ended interview guide
<b>Total</b>	<b>69</b>	

#### **d. Observation**

Observation is one of the oldest data collection techniques in social sciences. In this study observation has been used in two areas: to understand the living condition, health seeking behavior of the poor women within their own setting and how health workers, particularly doctors and nurses interact with the service recipients. I undertook systematic observation in four communities and in two health centers: one in Dhaka and one in Chittagong.

#### **e. Facility Inspection**

Facility Inspection is also common in health system research. It is to collect data regarding physical infrastructure of the health centers. I inspected all of four health centers which were selected through sampling frame. In addition I visited two more centers in Dhaka and Chittagong

#### **f. Exit Interview:**

Exit Interview is a popular method, usually used in health system research and market research. In this interview clients or customers are interviewed on spot after receiving the service. It provides the quick assessment of user's attitude towards the service providers. For this study I took, 5 exit interviews from each health centers in randomly selected days. This exit interviews provided some additional insights which were not captured by our structured survey questionnaire.

#### **g. Literature Review:**

A very important part of data for the entire study came from literature review. I reviewed government documents e.g. project proposals of UPHCP, Concept paper for HPSP,

project proposal for HNPSP, health policy., population policy and so on. At the same time I also took lot of data from Baseline survey of UPFCP, midterm, and endline evaluation reports of UPHCP. Besides, government surveys, reports, monographs were extensively used. I used not only documents of Bangladesh Government, but also from other sources, for example the World Bank, Asian Development Bank and WHO. Related research reports, monographs (mostly unpublished) were reviewed. Daily news papers, weeklies and some other periodicals were also reviewed.

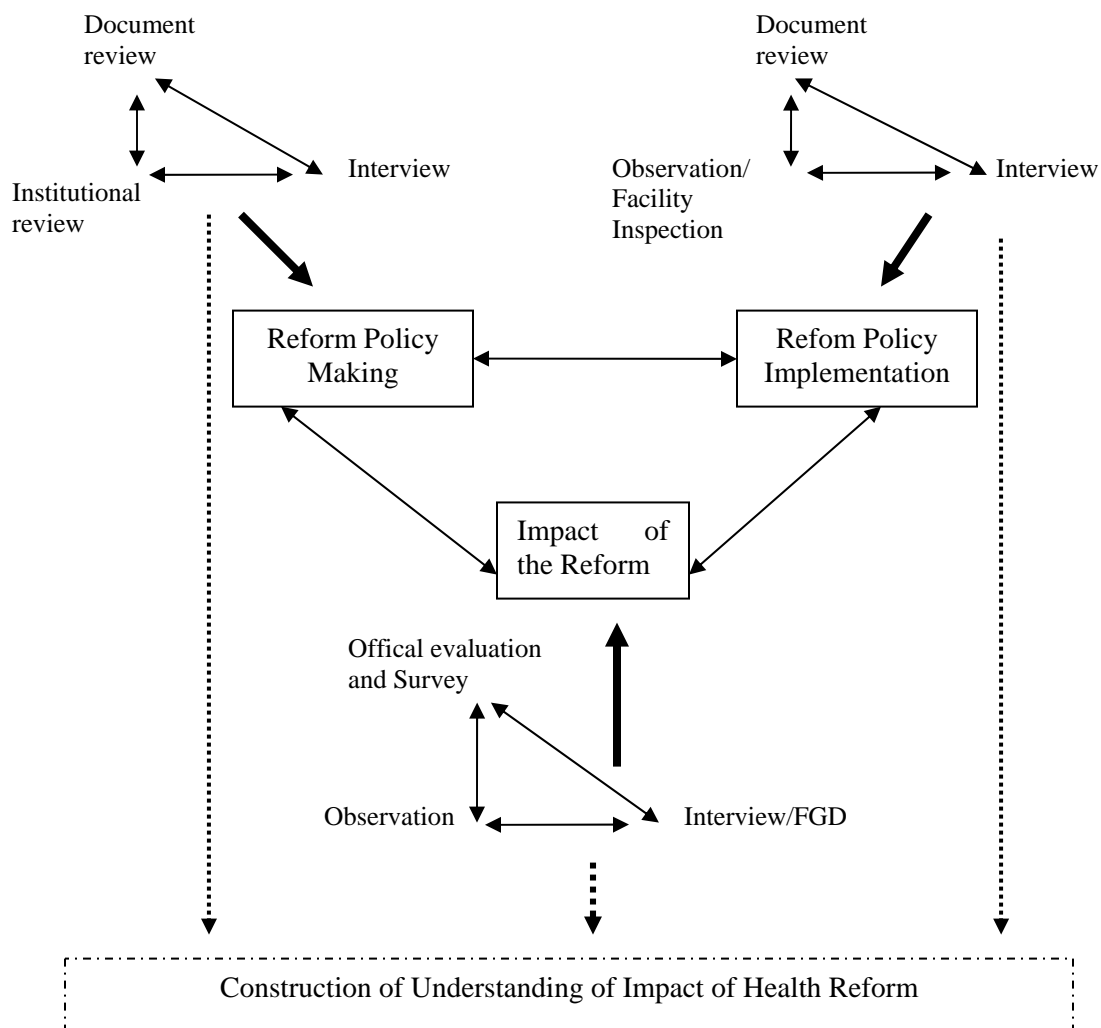


Figure A-1: Triangulation of various data collection techniques for three embedded levels of components of UPHCP

## **2. DATA ANALYSIS**

### **2.1 Qualitative Data**

This study deals with a bulk of qualitative data. In total 12 FGDs, 69 in-depth interviews, 17 exit-interviews were conducted. In addition, there were large amount of field notes and observation-notes, inspection- notes. Therefore, organizing all these qualitative data was a big task. I undertook, however, following steps for organizing qualitative data for analysis:

1. All interviews and FGD discussions were recorded on audio tape on spot
2. During interviews notes were also taken
3. All audio tapes were converted into transcript first and then translated
4. The translated scripts were coded

For every steps systematic quality control were made.

I used partly Reference Manger Version 9 for analyzing qualitative data. However, textual analysis of interviews was done manually too.

### **2.2 Quantitative Data**

For analyzing quantitative data I used SPSS 14 for windows.

### **2.3 Triangulation of Data**

Triangulation refers to the process of combining different methods - qualitative and quantitative for studying the same phenomena (Balnaves and Caputi 2001). Denzin (1970) suggests that there are four types of triangulation: data triangulation, investigator triangulation, theory triangulation. Triangulation enhances the internal validity of the research.

Figure A-1 shows that in this study triangulation of data were done for every level of analysis. While in analyzing the policy making process triangulation were done between what people were saying what is placed as organizational process and structure and what is written in concerned documents. This triangulation helped us to filter many noises from interviews and construct a solid picture of reform policy making in Bangladesh.

Likewise, regarding implementation, triangulation was done between organizational documents, managers and other service provider's interviews and what the investigators observed directly.

For analyzing impact, triangulation was done between observed data, structured questionnaire survey and in-depth interviews. All these triangulations finally constructed our understanding of the reform policy process as a whole what kind of impact it does produces for the poor in cities in Bangladesh.

#### **2.4. Internal and External validity**

The issues of internal and external validity of this study have given appropriate attention in its design. We know there is difference between the ways of establishing internal validity for experimental and case study design. However, for case study or any kind of research design the internal validity will be achieved if the case(s) can screen out influence of other factors than the key variable.

For this study, reform under UPHCP has been considered as a case. In this case, the internal validity is established in ideographic way, by developing the whole case in its full. Since the case has embedded components within it which are treated differently, to some extent autonomously, their internal validity also should be attained. I argue, by developing two cases of comparison with clear distinct features the key causal variables are made well-grounded. Thus, the internal validity for partial embedded regimes of UPHCP cases is also established.

External validity is related with its capacity for theoretical and statistical generalization. I argue, the UPHCP case can be generalized for any other of neoliberal policy reform phenomenon in the social sector in Bangladesh. And the implementation cases, the way they are selected, it clearly established their credible representation of other NGOs who are implementing health reform programs in Bangladesh. For impact, I again refer to the sampling frame for selection of households, which is statically supported, represents the poor living in urban areas. All in all, I argue that the external validity of UPHCP case is also been attained.

## **2.5. Difficulties and Obstacles in Conducting the Study**

I faced several difficulties and obstacles in the process of conducting my field work in Bangladesh during 2004 -2005. The most serious problem I encountered in conducting field research is to get the permission from concern government ministry for collecting and using data. My research topic is about an ongoing project, the concerned officers were didn't wanted to provide the policy documents. Most of the bureaucrats show the official secrecy act by which they are not allowed to pass any information to outsiders. However, I applied for formal permission through proper channel. But the formal permission never appeared; however, eventually I had been able to convince them to provide me with necessary information.

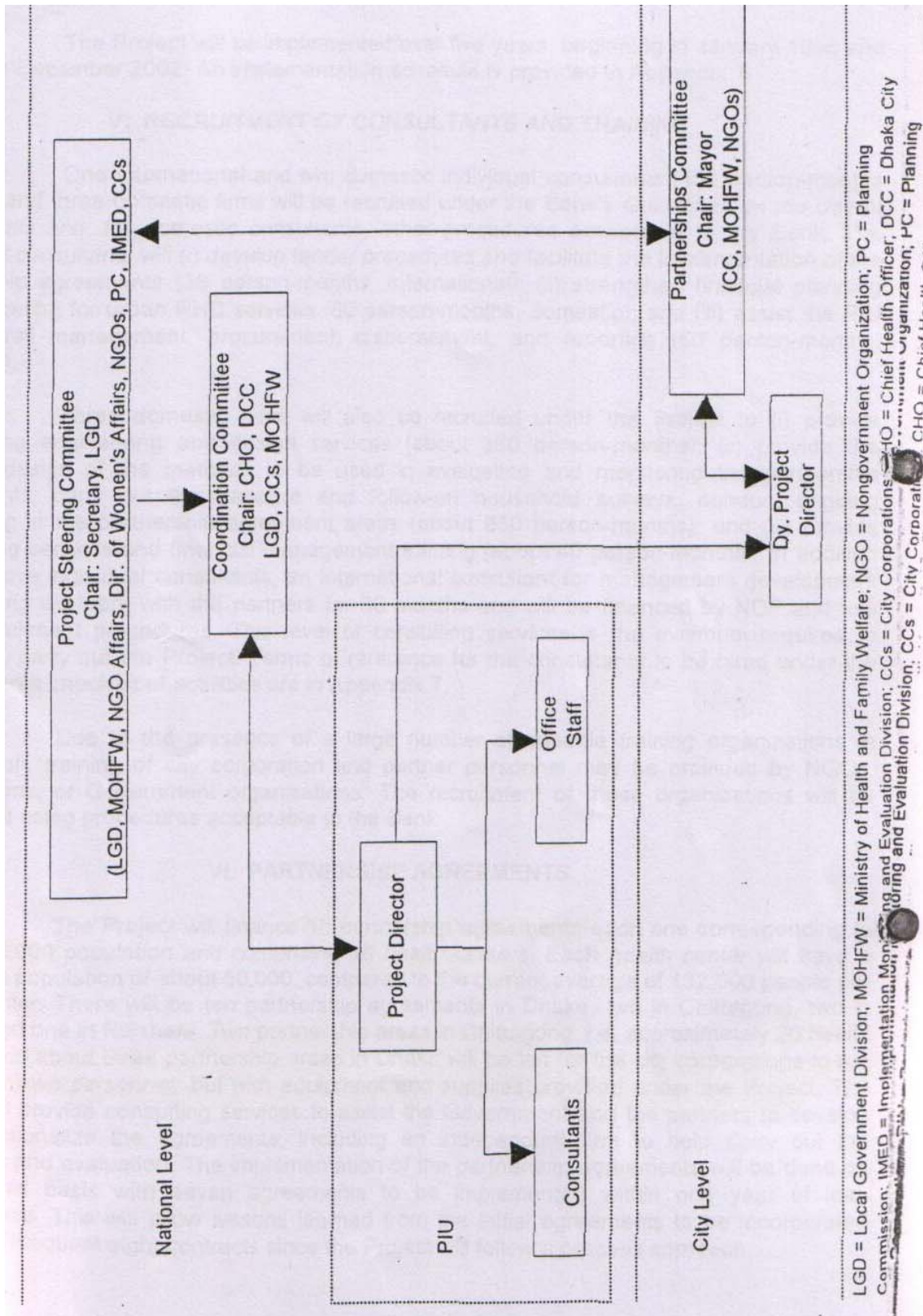
Similar problem I faced to take the interviews. Many key informants, mostly civil bureaucrats, were not interested to give the interview on the record. Since it was in-depth interview where even a small piece of information was very important for me, thus, without recording it would not have helped me much. It took long time for me to make them understand the importance of their interview and finally they allow me to take interviews on tape.

Another problem I faced in Chittagong in one of my research city. The city corporation was preparing for new city council election at that time. Thus it was very difficult to get the hold of many key informants in Chittagong. However, I managed by rescheduling the appointments several times.

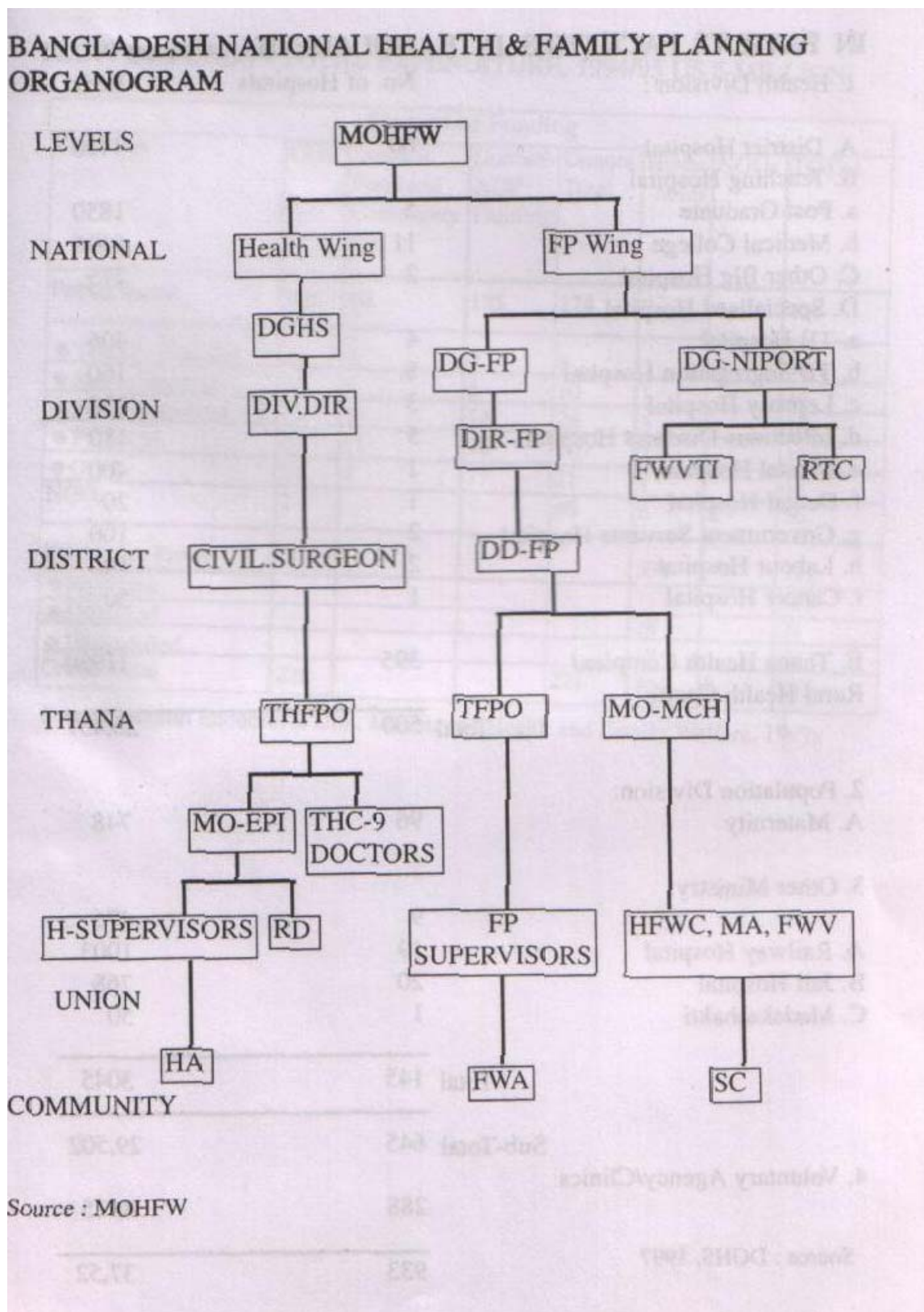
While I was conducting FGDs, I faced some problems in two communities in Dhaka from local political leaders. The slum where I was conducting interviews it was illegally owned by that political leaders, that is why does not allow outsiders to come into the community and talk with people. However, I had to manage the situation by using personal network.

Finally, I must acknowledge that managing a great deal of qualitative data was a big challenge. Taking interviews, Transcription, translation, quality control and so on took lot of time. However, with the help of an efficient research assistant team I managed properly.

## ANNEX 2: Organogram of UPHCP

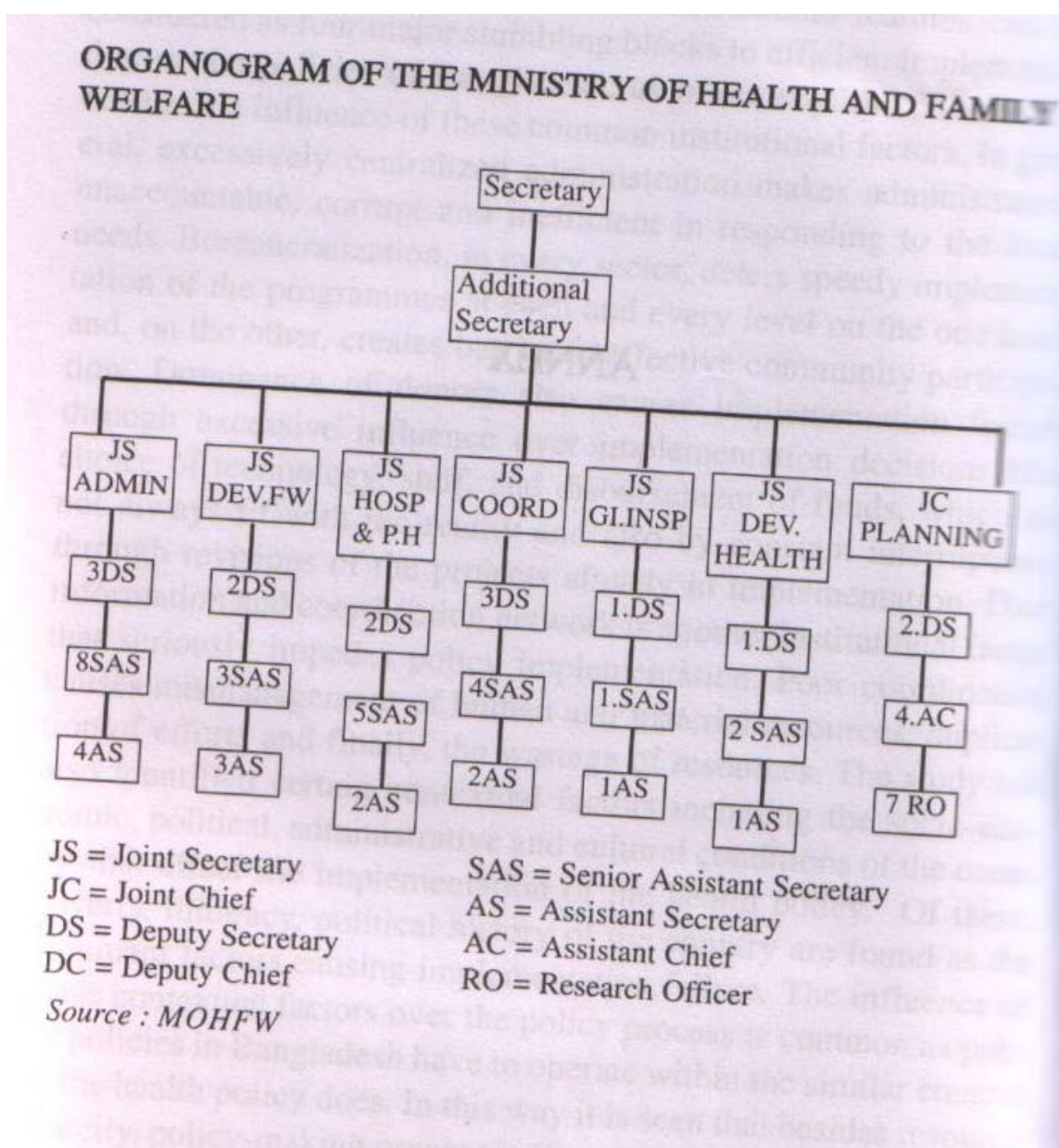


### ANNEX 3: Organogram of Bangladesh National Health and Family Planning Structure



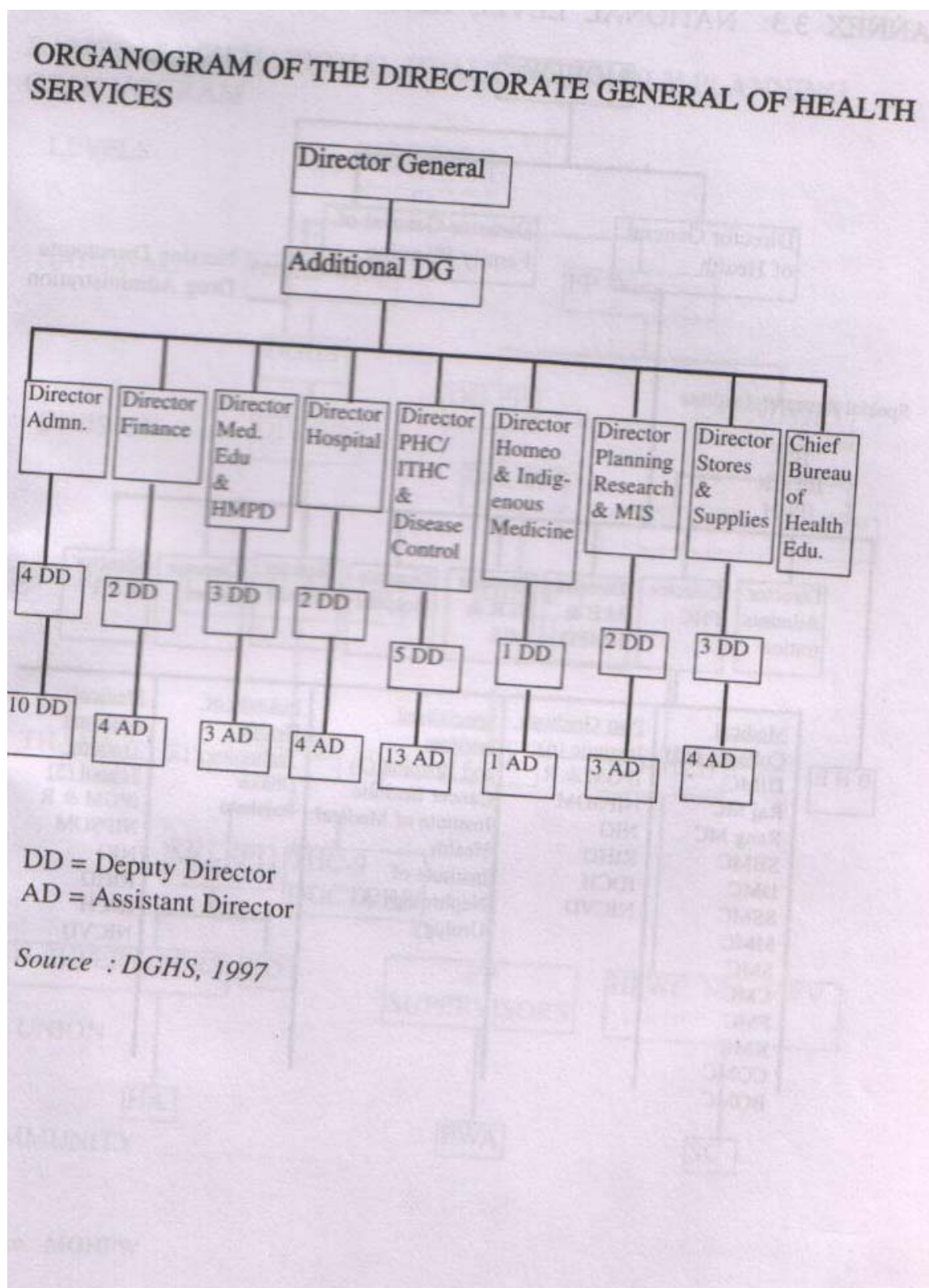


#### ANNEX 4: Orgnaogram of the Ministry of Health and Family Welfare





## ANNEX 5: Organogram of the Directorate General of Health Services



## **ANNEX 6: FGD Guidelines**

### **A study on**

### **Impact of health reform on state and society in Bangladesh**

Center for Development Research, University of Bonn, Germany  
Dept of Political Science, South Asian Institute, University of Heidelberg

#### **Focus Group Discussion Guideline For Male members of the catchment community**

#### Ethical Proclamation:

You are selected to take part in a group discussion organized to know your views on primary health care system in your areas. Your views and opinions will be used in academic research which is intended to contribute in the improvement of primary health care system in Bangladesh. Your identity will not be disclosed to any other authority except academic purposes. However, you can remain silent or refrain from making any comment.

#### General Principles for Conducting FGD

- Members of FGD facilitation group
  1. Facilitator 01 Person
  2. Recorder and Reporter 01 Person
  3. Gate Keeper 01 Person
- Maximum time for every session is 90 minutes.
- Maximum participation in discussion of the group members has to be ensured.
- Participants: The number of participants has to be limited within the range from 6 to 10. The representation of different age groups within adult population within the group has to be taken care of.

#### **Main Issues of Discussion:**

1. Knowledge, Attitude and Practice
  - Knowledge about ANC
  - Knowledge about service centers
  - Perception of institutional delivery
  - Perception and practices of conducting delivery
  - Perception of the first food for the newborn
  - Knowledge of child immunization
2. Access and usage of health care services
3. Behavior of the service providers
4. Participation in health center management
5. Complaining mechanism
6. Health rights
7. Client's rights
8. Role of political parties
9. Relation with local social and political elites
10. Organizational membership and activism

## **ANNEX 7: Interview Checklist for Community Level Service Providers**

### **A study on**

### **Impact of health reform on state and society in Bangladesh**

Center for Development Research, University of Bonn, Germany

**Dept of Political Science, South Asian Institute, University of Heidelberg**

Interview checklist for Community Organizer/Service Promoter/Field staff

- Introductory

1. Duration of job
2. Previous experience
3. Reason for working in this organization
4. Income and facilities

- How to deliver services

1. Main job responsibilities
2. Who are the target
3. How to reach target
4. How to identify poor
5. What are the especial services for the poor
6. How to organize poor
7. How to organize BCC
8. Who take part in BCC
9. Relation with local elites
10. Relation with local ward commissioner
11. Relation with government agencies

- Participation in health center management

1. Monthly meeting
2. Monthly work-plan
3. Budget
4. Reporting and monitoring
5. Accountability
6. Who decides about budget

- Service user's rights and Participation

1. Complain mechanism
2. Knowledge about client's charter
3. Knowledge about health rights

- Local Advisory Committee

- Who are the members
- What they do, when they meet, Who presides, What are the agenda

## **ANNEX 8: Interview Checklist for Local Elites**

A study on

### **Impact of health reform on state and society in Bangladesh**

Center for Development Research, University of Bonn, Germany

Dept of Political Science, South Asian Institute, University of Heidelberg

Interview Schedule for ward commissioners/political leaders/community leaders

- Introductory

5. Profession, Education, Income, Organizational membership
6. Participation in Election
7. Motivation for involvement in political or social activities

- Functions and Responsibility

12. What do you do for the community
13. Knowledge of the community situation
14. Knowledge about health problems of the poor in the community
15. Knowledge about child and maternal health
16. What is your program to solve these problems

- Participation in Health Center Management

2. Membership in LAC
3. Relation with the Health Center
4. Relation with other service provider
5. Knowledge about the operation of health center

- Knowledge about the health rights and Client's rights

4. Views about the participation of service users in health center management
5. Knowledge about the health rights
6. Knowledge about client's rights
7. What are the main problems of health centers
8. How to run the center better