The Influence of Governance on the Quality of Health Services Delivery in Bangladesh

A Comparative Study of Rural and Urban Health Service Organisations

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Acronyms and Abbreviations

ADB	Asian Development Bank
ADP	Annual Development Program
AIDS	Acquired Immune Deficiency Syndrome
AL	Awami League
AO	Accounts Officer
ACR	Annual Confidential Report
AHI	Assistant Health Inspector
BHFS	Bangladesh Health Facility Survey
BMA	Bangladesh Medical Association
BNP	Bangladesh Nationalist Party
BMMS	Bangladesh Maternal Mortality Survey
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
BBS	Bangladesh Bureau of Statistics
BIDS	Bangladesh Institute of Development Studies
BMDC	Bangladesh Medical and Dental Council
BCC	Behavioural Change Communication
CPD	Centre for Policy Dialogue
CBR	Crude Birth Rate
CBO	Community Based Organisation
CSO	Civil Society Organisation
CHW	Community Health Worker
CC	Community Clinic
CCC	Committee of Concerned Citizens
CS	Civil Surgeon
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
DSF	Demand Side Financing

DG	Director General
DC	District Commissioner
EPI	Expanded Program on Immunisation
EPZ	Export Processing Zone
ECG	Electrocardiogram
FWA	Family Welfare Assistant
FGD	Focus Group Discussion
FP	Family Planning
FPO	Family Planning Officer
FPI	Family Planning Inspector
FPV	Family Planning Visitor
FCPS	Fellowship of the College of Physicians and Surgeons
FIVDB	Friends In Village Development Bangladesh
FWA	Family Welfare Assistant
FYPs	Five Years Plans
GoB	Government of Bangladesh
GO	Government Organisation
GPO	General Post Office
GED	General Economic Division
GK	Gonoshastha Kendra
HW	Health Worker
HPSS	Health and Population Sector Strategy
HPSP	Health and Population Sector Program
HNPSP	Health, Nutrition and Population Sector Program
HRD	Human Resource Development
HSC	Health Service Committee
HA	Health Assistant
HI	Health Inspector
HC	Health in Charge
IMR	Infant Mortality Rate

ICDDR,B	Centre for Diarrhoeal Disease Research, Bangladesh
ICT	Information Communication and Technology
KLA	Karnataka Lokayuka
LG	Local Government
MDGs	Millennium Development Goals
MoHFW	Ministry of Health and Family Welfare
MoF	Ministry of Finance
MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Rate
MICS	Multiple Indicator Cluster Survey
MP	Member of Parliament
MO	Medical Officer
MR	Measles and Rubella
MR	Medical Representative
MT	Medical Technologist
MMR	Measles-Mumps Rubella
MIS	Management Information System
MLSS	Member of Lower Subordinate Staff
MBBS	Bachelor of Medicine, Bachelor of Surgery
NHP	National Health Policy
NCD	Non Communicable Disease
NGOs	Non-Governmental Organisations
OT	Operation Theatre
OCH	Officer in Charge of Health
PHC	Public Health Care
PPP	Public Private Partnership
PC	Planning Commission
PM	Program Manager
PNC	Post Natal Care

RMO	Residential Medical Officer
SFYP	Sixth Five Year Plan
SACMO	Sub Assistant Community Medical Officer
SBREC	Social and Behavioural Research Ethics Committee
SMA	Statistical Metropolitan Area
SC	Satellite Clinic
SS	Shastha Sebika
TFR	Total Fertility Rate
THC	Thana Health Complex
TB	Tuberculosis
TIB	Transparency International Bangladesh
TT	Tetanus Toxoid
UHC	Upazila Health Complex
UZP	Upazila Parishad
UHFPO	Upazila Health and Family Planning Officer
USC	Union Sub Centre
UP	Union Parishad
UPC	Upazila Parishad Chairman
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UFPO	Upazila Family Planning Office
U5MR	Under 5 Mortality Rate
UNO	Upazila Nirbhai Officer
UHFWC	Union Health and Family Welfare Centre
UPCC	Upazila Coordination Committee
UHSO	Upazila Health Service Organisation
VDP	Village Defence Party

VCG	Village Community Group
WB	World Bank
WHO	World Health Organisation

Abstract

Bangladesh has made satisfactory progress in maternal and child health as indicated by impressive reductions in quantitative indicators such as the maternal mortality ratio and the infant mortality rate. However, progress is slow in terms of qualitative indicators of affordability, accessibility, and the quality and efficiency of services. The reasons are inadequate responsibilities of health service actors and the various factors, which contribute to weak governance in health service organisations, particularly those issues that deal with accountability, transparency and participation. The main objective of the thesis is to examine the impact of governance on the quality of health service provision of rural and urban health service organisations and to analyse the health professional's responsibilities and duties for understanding governance, the role of community participation in promoting governance, and the various factors that affect governance and the quality of health service delivery in rural and urban health service organisations. The thesis uses empirical data to address the following research questions: (a) how do the responsibilities and duties of various health professionals contribute to improving/limiting governance and quality of health service delivery? (b)how does community participation contribute to governance and quality of health care in rural and urban areas? (c) how do various factors affect governance and health care delivery? (d) to what extent does governance work differently in rural and urban health service organisations? and (e) how is the governance of NGOs' health service delivery conducted - is service delivery of NGOs more efficient than that of public providers? This research investigates the above mentioned aspects of governance with the help of case studies in an urban and a rural sub-district health complex of the government of Bangladesh, namely Chhatak in Sunamganj district (rural) and Savar in Dhaka district (urban).For comparative purposes, two non-governmental health organisations, namely the Bangladesh Rural Advancement Committee (BRAC) and Gonosashtha Kendra (GK) have also been included in the study. In particular, the thesis examines the roles and responsibilities of health service managers and health service professionals in the sub-district health complexes and their associated health centres. Additionally, various factors related to political, managerial, and socio-demographic and women's empowerment features have been examined to understand the impact of governance on the quality of health service delivery.

The analysis is based on qualitative case studies (mixture of descriptive and hypothesis generating) comprising 68 in-depth interviews of national informants, healthcare managers, health service professionals, elected representatives and local informants, as well as five focus group discussions each consisting of seven to eight health service users. As a mainly qualitative study, the thesis analyses of respondents' views and experiences in order to gain an understanding of the influence of governance on the quality of health service delivery.

This study illuminates several ways in which governance affects quality of service delivery. Coordination among different units within each health service organisation and that between a government and non-governmental health organisation pose challenges for improving governance (that is, accountability, transparency and participation) and quality of health service delivery, in both rural and urban health service organisations. An important managerial factor–that of supervision- is carried out more efficiently in the urban area (Savar) than it is in the rural area (Chhatak). This may be attributed to better physical communications, proximity to the central administration, and the style of leadership in Savar. With respect to professionalism, the urban health care providers are found to work with greater enthusiasm to provide good quality health services. This may be attributed to their greater motivation to work (with less absenteeism), responsibility and accountability, facilitated by better facilities and greater exposure to national and

international healthcare professionals and organisations. On the other hand, inadequate facilities such as children's schooling or one's own career betterment mean there is less motivation and greater absenteeism in the rural area (Chhatak). There are better opportunities for the doctors in the urban area (Savar) to do after-hour private practice (allowed by the government), however the lack of such opportunity in the rural area ensures that doctors in Chhatak seek private practice in the nearest urban area, which leads to greater absenteeism. The doctors in the rural health centres are found to be less accountable to their duties. A weaker management in Chhatak also contributes to absenteeism among its doctors.

The findings show that the introduction of modern technology such as the Internet and electronic devices for record keeping contribute significantly to enhancing transparency in health service delivery in the urban health centre (Savar) which, in turn, leads to better quality of health services. For example, information and communication technology (ICT) provides an effective mechanism for sharing information with the ~~to~~ public and promotes transparency, potentially reducing corruption. However, resource constraints in the rural health centre (Chhatak) impact adversely on the improvement of technology, which leads to less transparent health service delivery. Moreover, greater community initiatives and frequent oversight by authorities have contributed to better transparency at the urban health complex.

Community participation is an aspect of good governance that might affect quality of service delivery.The findings of the study suggest that health service activities are potentially more participative at the sub-district health centres in rural areas. Compared to their urban counterparts, the local elected representatives and other members of the community in rural areas have greater awareness of local health problems and want to participate in the sub-district healthcare delivery to reduce corruption and absenteeism. However, they are not able to do so due to a lack of decentralisation, limited supervisory authority and poor political commitment. The bureaucrats at the centre are also unwilling to decentralise the health system and dilute their power. In fact, healthcare decision-making is politicised, elite-centred, bureaucratic and centralised. Nonetheless, the story is different when one looks at the lower level community health clinics (below the sub-district health centres). Here, the Savar community clinics are found to be more participative as a result of better supervision and good operating management, which is absent in Chhatak.

Civil society organisations (local informants) have a significant role to play in promoting governance. Evidence shows that the urban sub-district health centre has a greater involvement of civil society organisations, due to which accountability and health service delivery are better than those in the rural sub-district health complex. Women's empowerment has also been found to promote participation, which leads to better decision-making and improved quality health care delivery. However, women have a poor participation rate in the rural health centre due to their poor socio-economic conditions, lack of education and traditional values. Although women in Savar have improved education and economic conditions, their participation in health care services is not adequate as the majority of the women in Savar are migrants and are busy working in the garment industry. Moreover, local politics limit people's effective participation in both the rural and urban health service organisations.

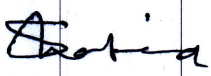
Staff members of NGOs ensure their accountability to their higher officials and their funding agencies and perform their job responsibility. They are not as much accountable to the government and local elected representatives because of poor coordination, lack of policy, and an inadequate legal framework. In addition, community participation in the activities of the NGO is also very low, which limits the community's ability to promote accountability in these organisations. The mechanism of supervision in the NGOs is cooperative and supportive which closely guides the staff to contribute to improved quality of health care. NGOs have limited resources for promoting health care although

they use their available resources efficiently, with strong monitoring and supervision to provide satisfactory health service delivery. In addition, the positive behaviour of NGO health care providers, the minimal amount of time needed in getting services, friendly insurance schemes, freedom from politics and greater fairness all contribute to improved accessibility and affordability of health care. This study has however found that women who have a poor decision-making role in family and society have less empowerment that consequently affects their participation in the NGO health programs.

This study recommends the oversight of management and coordination, strengthening of the community and civil society organisations, government-non-government/public-private collaboration, and decentralisation of health care services to improve and enhance the quality of governance and health service delivery.

Declaration

I certify that this thesis does not incorporate without acknowledgement any materia previously submitted for a degree in any university and that to the best of m knowledge and belief it does not contain any material previously published or writte by another person except where due reference I made in the text.



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Chapter 1

Introductory Discussion

1.1 Introduction

Bangladesh has achieved considerable improvements in health in recent times. For example, there have been large reductions in the rates of maternal and child mortality over the last decade (Directorate General of Health Services (DGHS) 2009; Planning Commission 2009; Osman 2008, p. 277; World Bank 2013). Between 1990 and 2013, Bangladesh's Infant Mortality Rate (IMR) declined from 94 to 33 per 1,000 live births, while between 1980 and 2007, the Total Fertility Rate (TFR) declined from 5.04 to 2.7 children per woman during her reproductive years. At the same time, life expectancy at birth increased from 47 to 68.9 years, and full immunisation coverage for children aged between 12 and 23 months increased from 2 per cent to 82 per cent (Osman 2008, p. 267; Directorate General of Health Services 2009, p. 1; World Bank 2013). Similarly, the maternal mortality ratio declined from 322 per 100,000 live births in 2001 to 194 in 2010 (Bangladesh Health Facility Survey 2012, p. 15). However, these impressive improvements in the quantitative indicators of health are not accompanied by similar progress in bettering the quality of health care[1]. The quality of health services has been very limited, negligible or unsatisfactory (Bangladesh Health Facility Survey 2012). A report by the World Health Organisation (2010a) shows that one of the main causes of the poor quality of health care in Bangladesh is weak governance and inadequate planning. Thus, governance[2] is one of the main concerns that are significantly

[1] Quality of health care is the degrees to which health services for individuals and populations increase the likelihood of desired and improved health outcomes and are consistent with current professional and managerial knowledge (Chassin & Galvin 1998, p. 1001). Studies show that a number of components: affordability, accessibility, efficiency, effectiveness and utilisation comprise quality of health service delivery, which enables people to achieve desired health outcomes (World Bank 2010a; Al-Qutob et al. 1998).

[2] Governance is used as a system, a process of management, and an interaction of various actors, which works to provide quality of service delivery. Good governance introduces a normative dimension to addressing the quality of governance which is opposite of poor/inadequate governance. Good governance is defined a number of positive quality of governance which has been used by the development agencies and the scholars in order to understand development discourse. This thesis will be used accountability, transparency and

related to the quality of health care that will be addressed throughout this study. As explained in Section 2.3 of this thesis, governance can be defined as a system of values, policies and institutions by which a society manages its economic, political and social affairs through interactions within and among the state, civil society and private sector (United Nations Development Program 2000, p. 1), or as an interaction of various actors (public or private), aimed at achieving organisational goals to enable the organisation to provide efficient and effective services for meeting people's expectations (Alcantara,1998, p. 105 ; Khan, 2009, pp. 41-42). Thus, governance is an interactive process involving adequate management by multiple actors for the purpose of achieving organisational goals to meet public aspirations.

1.2 Background of the Study

Health services in Bangladesh are provided by a combination of public-private institutions and non-government organisations (NGOs) for the achievement of the National Health Policy (NHP) objectives and the Millennium Development Goals (MDGs). To enable this, the public sector provides both curative[3] and preventive[4] services. Generally, the private sector provides curative care whereas the NGOs offer mainly preventive and basic care. The overall services are organised under the supervision of the Ministry of Health and Family Welfare (MoHFW), a centralised and bureaucratic organisation, headed by a cabinet minister (see Appendix 1). This organisation is responsible for implementing, managing, coordinating and regulating health service delivery which is divided into two branches: health services and family planning, administered by separate directorates (Ara n.d, p. 5). Primary Health Care (PHC) is not free, but requires only a very small fee for service as defined under government provisions. This health care is provided through a four-tiered system of

participation among other components, which should be critical to understanding governance for this study (United Nations Development Program (UNDP) 2000; Asian Development Bank (ADB) 2004; Khan 2009).

[3] Curative means servicing or tending to cure particular diseases. However, curative care refers to treatment and therapies provided to a patient with intent to improve symptoms and cure the patient's medical problems. The examples of curative care are providing medicine or therapy that cure disease or relieve pain.

[4] Preventive service refers to a pattern of nursing and medical care that focuses on disease prevention and health maintenance. It includes early diagnosis of disease, discover and identification of people at risk of development of specific problems, counseling and other necessary intervention to avert a health problem. Screening tests, health education, and immunization programs are common examples of preventive care.

government-owned and staffed facilities at the *union*[5] (lowest administrative unit) level all the way up to the central/regional level (Mridha et al. 2009, pp. 133-34), which is based on an administrative hierarchy (see Appendix 2).

In fact, the health system in Bangladesh and the delivery of health services are based on a hierarchy of organisations (see Appendices 3, 4). The health service organisations both in rural and urban areas provide services by using the availability of medical equipment and human resources, and through maintaining close supervision and monitoring health activities. Good governance contributes to effective managerial activities in the health sector to provide adequate quality services. Nevertheless, corruption[6] affects the quality of health care and the poorest citizens are highly penalised by corruption in Bangladesh (Knox 2009. p. 117). Knox's (2009) study further shows that 41.8 per cent of respondents have experienced corruption in receiving health services and the major forms of it include: bribery, health professionals' negligence of duties, nepotism, embezzlement or deception. Informal payments (locally known as bribery) and negligence, experienced by 52% and 43% of service users respectively are the most frequently experienced forms of corruption as reported by the health service users. The lack of governance in health service organisations might be one of the causes of corruption as well as poor quality of care both of which will be investigated in the thesis. Nevertheless, the quality of health service delivery depends on allocation, utilisation and implementation of health care finance, which are influenced by the governance of the organisations.

1.2.1 Health care financing

Osman (2008, p. 272) states that sources of finance for the health sectors in Bangladesh consist of a combination of different ones, which include households, government revenue, donors and the community through Non-Governmental Organisations (NGOs). Osman (2008) states that the majority of health expenditure comes from households, accounting for 45.6 per cent of the total health expenditure in Bangladesh in 2006. Of the remaining expenditure, 26.6 per cent comes from

[5] Union Councils (or Union Parishads or Town Unions or Unions) are the smallest rural administrative and local government units in Bangladesh. (*Khan, Dr. Mohammad Ibrahim. "Functioning of Local Government (Union Parishad): Legal and Practical Constraints" Democracywatch.*

[6] According to Transparency International: "Corruption is the abuse of entrusted power for private gain. It can be classified as grand, petty and political, depending on the amounts of money lost and the sector where it occurs".

government revenue, 25.8 per cent from external donors, and 2 per cent from community sources through NGOs. Osman (2008) further states that a donor consortium,[7] led by the World Bank (WB), provides financial and technical assistance on a continuous basis to the health sector of Bangladesh that could contribute to enhancing governance of health service organisations. One of the criteria of improved service delivery of health service organisations is the amount of money allocated by the government. The government Annual Development Program (ADP) report shows that the government allocation to the health sector is relatively poor in Bangladesh (Annual Development Program 2010). The effective delivery of services consists of efficiency of health professionals, sufficient allocation of budget, and the managerial efficiency of the organisation (details in section 2.2). With regard to allocation, the ADP report in Bangladesh states that US$560 03 million has been allocated to the Annual Development Program (ADP) which is 37.3 % of the total health budget (similar to 26.6% in 2006) and 5.68% of the total budget of the country for the 2010-2011 financial year to improve health, nutrition, population and family planning and to assist in achieving the goals of health for all including the targets of the MDGs (Annual Development Program 2010, p. 319). This percentage of the development budget in the health sector has slightly increased from 37.3% to 41% in 2012-13 (Ministry of Finance 2013). However, this amount is relatively small and inadequate to meet the necessary health goal of providing sufficient delivery of services. Data show that in 2006, the total health expenditure in Bangladesh was $14 per capita, compared to $29 per capita in India, and $57 per capita in Sri Lanka during the same period (Planning Commission 2011b, p. 349).

Lewis (2006, p.14) conducts a corruption survey in twenty-three developing countries including Bangladesh and shows that health ranked as the second most corrupt sector in Bangladesh. This study demonstrates that lack of accountability and transparency in health sector operations are the main reason for corruption. Besides this, the study reveals mismanagement in health service delivery. The study has also identified the factors related to this mismanagement: poor understanding of

[7] The Donor Consortium consists of international development organisations who work towards improving governance and health service delivery for developing nations such as Bangladesh. These organisations work in different health sectors in Bangladesh. For example, the United Nations Children's Fund (UNICEF) supports child health, immunisation and nutrition programs; the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) support family planning service delivery and population education; the World Health Organisation (WHO) is the main international source of technical assistance in the field of health supporting primary healthcare and maternal and health services; and the Asian Development Bank (ADB) provides support for health planning capacities(Osman 2008, p. 272).

health policy, irregular record keeping, and inadequate information systems. This research also suggests that the availability of funding, adequate health staff, maintaining basic record systems and improvement of facility performance are crucial ingredients for reducing mismanagement and enhancing quality of health service delivery (Lewis 2006, pp. 34-35). The organisational procedures that have been applied to improve management in the study can be useful for examining governance and quality of health care in Bangladesh.

The above evidence shows that both the allocation to and the expenditure on the health sector have improved slowly but the amounts allocated are still too small in comparison to some of the developing countries such as Sri Lanka. The small budgetary allocation is one of the obstacles in the path towards improvement and enhancement of the quality of health service delivery in Bangladesh. Inadequate funding affects governance and, in turn, inadequate governance affects the management of health financing due to corruption, lack of efficiency, inadequate information and limited participation, all of which may lead to insufficient and poor quality of delivery of services. Nevertheless, service delivery and governance in health organisations have improved since the independence of Bangladesh through the promotion of various policies, programs and planning initiatives (Mridha et al. 2009; Ahmed et al. 2013). This thesis will examine how the quality of governance impacts on health service delivery in implementing health programs and, conversely, what the negative outcomes of poor governance in this regard are. In addition, governments have also undertaken several health programs through five year plans to promote quality of care, which is the focus of the next section.

1.2.2 Health care delivery through Five Year Plans (FYPs)

The promotion of the health sector in Bangladesh started with an underlying emphasis on the growth of the population and the provision of minimum healthcare to the entire population, particularly to the poor and the disadvantaged. With this objective, the first two consecutive five year plans[8] and the population policy[9] of

[8] The government of Bangladesh implemented the First Five Year Plan (1973-78) and the Second Five Year Plan (1980-85) to ensure minimum healthcare to all citizens. For this, necessary initiatives have been undertaken on behalf of the government to develop health infrastructure and to improve training facilities so that minimum primary health care can be ensured to general people at sub district level (Mridha et al.2009, p. 128).

[9] The first population policy was adopted in 1976 to control population growth through promoting health and family planning services. The policy mainly outlined family planning and social reformation programs to ensure improved living standards, improved health status for women and children through making family size smaller. In addition, the first population

Bangladesh were implemented by the government to promote health infrastructure, particularly at the sub-district and union levels, enhancing health service capacity with the help of NGOs and private facilities including family planning services in order to ensure minimum health care to all (Osman 2008, p. 265).The Third Five Year Plan (1985-90) added a new dimension in health services by focusing on Maternal and Child Health (MCH) as an effective means of controlling population growth. Accordingly, some MCH programs such as the Expanded Program on Immunisation (EPI), Vitamin 'A' distribution and control of diarrhoea were intensified towards enhancing service delivery for women and children. The Fourth Five Year Plan (1990-95) also emphasised MCH services along with primary healthcare and the improvement of inter-sectoral collaboration (Mridha et al.2009, p. 128). In fact, several plans and programs have been undertaken by the government to fulfil the expectations of the service receivers through promoting quality health care, however, the process of implementation has been too weak, and poor governance may be one of reasons for this slow progress in implementing health programs.

The Fifth Five Year Plan (1997-2002) added certain new strategic issues under the influence of the Health and Population Sector Strategy (HPSS). It was adopted in 1997 to give a new direction to the health sector to improve accountability, efficiency and cost-effectiveness by advocating certain institutional and governance reforms to accelerate effective service delivery. In addition, the HPSS promoted into the Fifth Five Year Plan (1997-2002) and the National Health Policy (NHP), which was approved on 14 August 2000 to promote health service delivery (a brief review on health policy in found in section 1.3). As a result, these three documents, FYP, HPSS and NHP, have been viewed as very similar in terms of their goals and strategies and these papers are interconnected for promoting health governance and quality of service delivery. In order to put the health policy into practice, the government in Bangladesh has commenced some of crucial health programs to strengthen health care delivery, which is discussed in the following section.

1.2.3 The major health programs in Bangladesh

Necessary initiatives were taken by the HPSS to unify health and family planning wings of the Ministry of Health and Family Welfare (MoHFW). This was done to provide health and family planning services in a package to ensure efficiency gains.

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policy emphasised strengthening structure of population and family planning programs along with strengthening monitoring management and decentralization of administrative and financial powers (Ministry of Health and Family Welfare 2004, p. 4).

The objective of introducing the unification was to make it easier for clients to access multiple health services through a strengthened health service delivery. In addition, the objective of the unified health and family planning services was to construct community clinics for every 6,000 persons to take the healthcare service structure closer to the people at the grassroots level through improvement of governance.

The Health and Population Sector Program (HPSP) (operational plan of HPSS) expired in 2003, and since then, the Government of Bangladesh (GoB) has undertaken another program, the Health, Nutrition and Population Sector Program (HNPSP) (2003-2010), to improve primary health care including nutritional status through enhancing governance. The major initiatives of the HNPSP are to strengthen the public health sector management, enhance Public Private Partnerships (PPP), and introduce Demand Side Financing (DSF) particularly for poor household through subsidising the cost of drugs, tests and transport which enhance the availability of health facilities. Further, domiciliary services are reintroduced by the family planning wings of the Ministry to strengthen population control and nutrition programs at the grassroots level. All of these initiatives have made significant improvements in health indicators particularly in total fertility, infant mortality, nutrition, and children's vaccination, however, inequity in access is still great and the quality of maternal and child health also remains low (Osman 2008, p. 268). Besides this, the implementation of the program is not completely successful and the process of implementation is too weak. Addressing governance issues may assist in understanding the causes of poor health program implementation and the lack of quality of health care (Osman 2008, p. 268; Planning Commission 2011b; Mridha et al.2009).

1.2.4 Health plans-the latest initiatives

Recently, the GoB has formulated the Sixth Five Year Plan (2011-2015) and the Perspective Plan of Bangladesh (2010-2021)[10] to improve the nutritional status of women and children, to promote healthy life styles, and to reduce maternal and child

[10] Planning Commission (2011b, pp. 348-52) stated that life expectancy has progressed from 45 years to 70 years from 1970 to 2021.Besides; the population growth rate will be 1.3, MMR 143, IMR 31, TFR 2.2 and fully immunized children 90% among other health indicators by the year 2014 to 2015. The Perspective Plan of Bangladesh (2010-2021) outline that the maternal mortality will be 1.5 per cent, raised the use of birth control methods 80 per cent, and brought down infant mortality 15 per thousand live births by 2021 (General Economic Division 2010 p.2). This plan targets poverty line 15 per cent and standard nutritional food to at least 85 per cent of the population by 2021.

mortality towards the achievement of Millennium Development Goals (MDGs) and the Vision Bangladesh-2021[11] (see Appendix 5: summary of health plans, policies and programs, 1973 to present). Additionally, these plans highlight the quality of maternal and child health care including improved governance of health service organisations, which is still a challenge for the health sector in Bangladesh.

The above discussion has presented an overview of the health system including budget, quality of service delivery and health governance in Bangladesh. The discussion has also shown that health administration is hierarchical[12] and the management of program implementation is inefficient which limits not only participation but also increases corruption. Additionally, the health sector suffers not only from financial deficiencies, but is also influenced by mismanagement (Knox 2009, pp.121-22). Consequently, inadequate and poor quality of service delivery is a common feature of public health care providers. However, a significant improvement has already been achieved particularly in women's and children's health care due to promoting participation of NGOs and private sectors, necessary policy initiatives and political commitment over time (Das 2013). However this achievement is relatively poor, inadequate and the qualitative improvement is significantly low due to inadequate governance, which has been hardly addressed in this study (Bangladesh Health Facility Survey 2012).

1.3 Health policy in Bangladesh: a brief critical review

The National Health Policy (NHP) has been formulated to ensure essential health services for the entire population of the country. The aim of the policy is to achieve the availability of health services for the both rural and urban communities, and to improve the nutritional status especially for children and mothers in accordance with the guidelines of constitutional provisions in Bangladesh.[13] Additionally, the NHP

[11] Vision Bangladesh-2021 is a framework of goals for improving human and socio-economic development at the 50th anniversary of the independence of Bangladesh. The vision is also composed of eight inter-related goals set by the UN Millennium Summit in 2000.The aim of this goal is to implement short term and long term strategies needed to transform Bangladesh by 2021 into a middle income country, free from extreme forms of poverty, constructed upon democratic foundations and well-governed institutions (Centre for Policy Dialogue 2007, p. xi).

[12] See Appendix 3

[13] "The state shall be fundamental responsibility to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens the provision of the basic necessities of life including food, clothing, shelter, education and medical care. In addition, the state shall regard the raising of the level of nutrition and the improvement of

especially highlights improvements in healthcare for women and children in order to achieve the target of MDGs. For this, the NHP suggested a number of mechanisms and principles to promote maternal and child health care. For instance, one of the mechanisms is to strengthen family planning programs through ensuring more accountable, transparent, participative and cost effective health management.

The health policy also focuses on restructuring the administrative arrangements to promote good governance and effective service delivery. For this, special attention has been paid to needs-based human resource development (HRD) for the fulfilment of organisational demands, providing regular training to enhance organisational capacity, installing technological devices to promote management information systems (MIS) in order to facilitate implementation and monitoring health service delivery. In addition, the policy suggests strengthening community and local government (LG) organisations to promote accountability and participation quality so that primary health service delivery for women and children is ensured. Furthermore, the policy suggests the improvement of health infrastructure and transportation systems to minimise the disparity between the rural and urban areas in order to enhance service accessibility (National Health Policy 2000). Despite a wide range of initiatives taken by the health policy over the last decade to promote quality of health care, the improvement has not been achieved as required due to poor governance and its associated actors and factors, which will be investigated in this thesis.

For more than a decade, various scholars have conducted studies on public health issues concerning health policy in Bangladesh from different contexts. A number of these studies have shown that politics and bureaucratic management have significantly influenced the formulation of health policies in the country (Osman 2008; Jahan 2003; Gwin & Buse 1998; World Health Organisation 2010a). However, these studies also showed that the formulation of national health policy, including various plans and programs, has been dominated by health professionals, particularly the Bangladesh Medical Association (BMA) through enhancing self-community interest[14] rather than keeping the benefit of the common people in mind (Rabbani 2010, p. 55: Hossain & Osman 2007, pp. 32-33). Additionally, Jahan's (2003 p. 184) study shows that several factors such as poor resource capacity, a

public health as among its primary duties" (Constitution of Bangladesh 2008 Articles-15(a), 18(1))

[14] For instance, due to resistance and opposition of the BMA, the government has been unable to decentralise the health administration to promote people's participation through transferring power to local bodies as well as to implement rules on banning private practice.

bias towards the elite such as higher level health professionals, lack of political will of the government, and the silence of donors all contribute to inadequate participation of citizens and poor empowerment of the community including the civil society which, in turn, lead to weak health policies and programs. In addition, a number of studies have shown the influence of external resources on the formulation of health policy (Gwin & Buse 1998, p. 667; International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B) 2006 p. 8; Jahan 2003, p. 184). All of these studies have looked at the various weaknesses in the formulation of health policies only in the form of the influence of politics, bureaucracy and resources; however the important issues of governance have been neglected (the issues of governance discuss in Section 2.4 of Chapter 2).

Some studies have examined the implementation of health policy from different contexts by analysing the role and responsibility of various actors and factors. The World Health Organisation (WHO) (2010a, pp. 32-33) shows that resource constraints such as lack of skilled personnel and financial deficiency, in addition to inefficiency and inequitable use of resources, affect implementation of health policy. The Planning Commission (PC) states a completely different view and argues that lack of routine supportive supervision and monitoring are one of the major causes of limited implementation of health policies and programs (Planning Commission 2009, p. 84). However, the ICDDR,B (2006) report identified some key causes concerning organisational, financial and technological aspects in order to examine the lack of implementation of health policy. Besides this, studies show that lack of human resources, inadequate facilities, socio-economic disparities, dynamics of power and politics e.g., ruling party supporter influence in decision making, and lack of knowledge and education of common people affect participation which lead to poor implementation of health policy (Siddiquee 1997, p. 153; Mahmud 2004, p. 17, Islam & Ullah 2009, p. iii).

In fact, most studies have found the causes of poor implementation to be resource constraints, managerial inefficiency, an overcentralised health system, poor technology, and socio-economic and political barrier among others. In addition, corruption, poor coordination in management and the lack of integrity of doctors are the most significant factors that contribute to poor quality services at the government-run hospitals (Schurmann & Mahmud 2009, p. 538). These studies highlighted only various challenging factors to understand the nature of service delivery, but hardly examined the effects of governance in health service

organisations. Moreover, governance issues in health policy implementation have been hardly addressed in the studies mentioned above. Additionally, quality of health service delivery, which is more significant for Bangladesh, has not been addressed in any study so far.

The above studies show that the public health sector has incurred multiple problems. Insufficient equipment and essential supplies, inadequate facilities, lack of cleanliness, long waiting times, absence or lack of doctors and nurses, inappropriate behaviour by doctors, and a lack of confidence in public facilities and staff all affect effective service delivery (Rahman 2006, p. 10).

The above literature indicates that a number of studies particularly concerning the various factors that affect formulation and implementation of effective health policies and programs have been conducted. In this regard, studies show that formulation of health policy is affected by several factors such as poor resources, corruption, and limited participation, lack of political commitment, poor coordination and elite bias.

Critically, understanding governance and its impact on the quality of health service delivery promises to be a significant study with great potential to contribute to the improvement of the health sector in Bangladesh. However, no study has yet addressed the impact of governance on quality of health service delivery with reference to rural and urban health service organisations in Bangladesh. In addition, there is no direct research on how governance affects the formulation and implementation of health policies and programs and to what extent governance contributes to policy reforms to improve the quality of health care. Besides this, there are no studies, which have addressed the governance of community organisations including the general community, to promote or hamper the quality of health service delivery. Moreover, the existing studies have hardly examined how the socio-economic conditions affect governance with reference to quality of health care. Finally, there are no major studies relating to the governance of non-governmental organisations (NGOs) in delivering health services in Bangladesh.

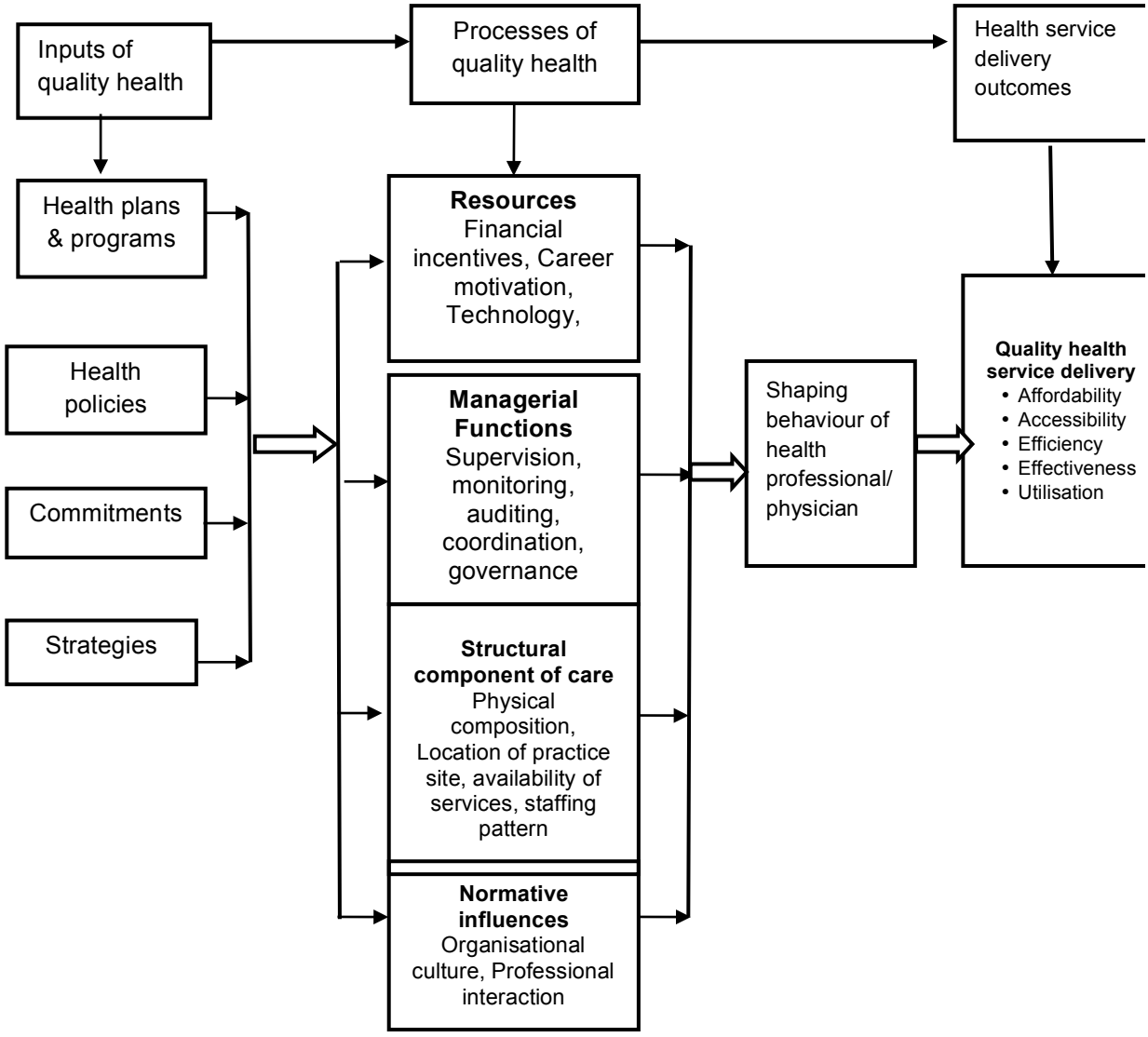
1.4 Research problem

Over the last few decades, quantitative health indicators have shown improvements in various aspects of health in Bangladesh as mentioned in Section 1.1. However, quality of health care including good governance is a great challenge to health service organisations (Bangladesh Demographic and Health Survey 2012, p. 24;

Bangladesh Maternal Mortality Survey 2010, p. 3; World Health Organisation 2010c; World Bank 2010, p. 27; Andaleeb 2007b, p. 261). In addition, most public health service organisations and health service providers do not pay full attention to public demands, neglect public opinion, and do not appear to encourage their participation in health service delivery (Islam & Ullah 2009; Mahmud 2004). These studies show that the quality of health inputs in terms of policies, commitments and strategies influence the quality of health service delivery. In addition, the proper utilisation and mobilisation of resources and the coordination and maintenance of efficient management within the health service organisations contribute to improvements in the positive behaviour of health service professionals which, in turn, lead to improved quality of health service delivery (see Figure 1).

Figure 1.1

Model of quality of health service delivery



Adapted from Donabedian (1978); Al-Qutob et al. (1998); Landon et al. (1998); Osman (2008); World Bank (2010a)

Health seeking behaviour is influenced by the socio-economic situation of service receivers. Anwar (2009, p. 399) shows that the poorest people in Bangladesh use public health facilities more than do the richest people, who use organised private health facility more than the poorest, as this is a common perception that private health facilities offer better quality health care than do the public facilities. Similarly, the study shows that the majority of rural women live in poverty, which limits access

to emergency obstetric, care and consequently increases maternal morbidity (Afsana 2004, p. 171; Hoque et al. 2012, p. 205). With regard to women's decision making, Parkhurst et al. (2006, p. 441) argue that not only poverty but also the lack of education restrict the decision-making of rural women regarding accessing health services. Ahmed et al.'s (2010) study addresses the influence of three basic socio-economic situations -women's economic, educational and empowerment status - in understanding maternal health care in developing countries. One of the findings of the study is that educated women have more accessibility to skilled birth attendants than illiterate or lower educated women. Based on overall findings, this study concludes that considerable increase in the use of maternal health services can be achieved through improving the socio-economic situation of women. In addition, improvement of women's socio-economic conditions assists in promoting their participation in decision-making, leading to better governance. Thus, the understanding of the socio-economic situation of women can have an impact on the governance and quality of health care in Bangladesh.

Some studies have also highlighted the role of NGOs in health development in Bangladesh. Rabbini (2010) finds that NGOs work mainly on curative health care for poor people as partners in order to enhance the government's capacity for the fulfilment of health policies and the MDGs. Rabbini (2010) also shows that NGOs have limited control over health policies and programs due to lack of resources. Nevertheless, Rabbini's (2010) study indicates that NGOs play an important role in health care activities as spokespeople for international health organisations, which are the donors of the NGOs. As such, it could be said that the NGOs are accountable to the donors rather than the common people they claim to serve. However, the NGOs are highly controlled by the Government of Bangladesh and they contracted by the government through the NGO Affairs Bureau, a government regulating agency (Shandra et al.2010, p. 138; Rabbani 2010, p. 53; Zafar Ullah et al,2006, p. 143).This thesis will also provide an understanding of how governance of NGOs contribute to quality of health care through the existing monitoring management by the government.

Various factors affect the delivery of health services in rural and urban health services. Health performance in rural areas is relatively poor compared with that of urban areas due to inadequate organisational supervision, lack of close monitoring, and the non-availability of resources in rural areas (Osman 2008, p. 278). The Bangladesh Bureau of Statistics (BBS 2012a) states that in 2011, the literacy rate

for population aged 7 years and over was 52.82% in rural areas and 69.58% in urban areas; infant mortality rate (IMR) was 37.9 per 1,000 live births in rural areas and 35 per 1,000 live births in urban areas, while the crude birth rate (CBR) was 17.91 per 1,000 population in rural areas and 17.74 per 1,000 population in urban areas. Osman's (2008, p. 279) study further shows that only 16 per cent of qualified doctors practised in rural areas, 41 per cent of doctors' positions in rural areas were left vacant, and a significant number of physicians were absent from working at rural hospitals. However, nearly 80 per cent of the population of the country lives in rural areas where doctors are not as ubiquitous as they are in urban areas due to managerial inefficiency, poor accountability and lack of motivation to work in rural areas. Weak governance may lead to high absenteeism of doctors in the rural health context. Likewise, poor governance may contribute to inequalities in health services between rural and urban areas. Therefore, examination of these issues in the thesis will provide valuable insight.

The General Economic Division (2010, p. 20) shows an oversupply of medical personnel in urban areas and a shortage in rural areas as a result of inadequate planning and poor management. Further, allocation of the Ministry of Health expenditure to the *upazila* (sub-district) level and below, where the health services are mostly used by the poor, declined from 51 per cent in 2003-04 to 42 per cent in 2005-06, while money for tertiary hospitals, which is located to urban areas, and the administrative expenditure of the health ministry have increased significantly (Osman 2008, p. 279). This evidence shows that the allocation of resources for healthcare in urban areas has improved over the last few years whereas in rural areas it has declined. Rahman (2006) argues that differential improvements in health care for women and children between the rural and the urban areas are significantly affected by poor governance, mismanagement, and inefficiency of managerial activities to provide health care services.

Additionally, poor governance also contributes to regional inequality in health service provision due to inadequate socio-economic and political conditions, which lead to poor health care for women and children.[15] For example, Sylhet is one of the

[15] Public health organisations provide a wide variety of services such as preventive and curative health care. However this study has examined governance of health care concerning primary health care for women and children in two selected health service organisations in Bangladesh. The selection of the particular area, women and children's health care is due to time and resource constraints, however, these selected areas of health have special importance to the national health policy (2000) as well as the millennium development goals (MDGs). In addition, understanding the governance of health service

poor socio-economic regions in Bangladesh. Table 1.1 depicts the various health indicators of six divisions in Bangladesh (%) for understanding governance and quality of health care of the highest and the lowest of health performing regions.

Table 1.1

Health indicators of six divisions in Bangladesh (in %)

Health indicators	Dhaka	Rajshahi	Khulna	Sylhet	Chittagong	Barisal
Maternal Mortality	3.3	3.4	3.3	3.8	4.0	4.4
U5 mortality	6.7	6.7	5.7	7.4	5.7	6.0
Infant mortality	7.5	7.0	6.6	10	6.8	6.1
Vaccination coverage(12 month)	78.3	82.2	81.3	73.3	76.2	81
Medically trained personnel	19.8	15.4	26.6	10	18.5	13.4

Source: Planning Commission 2011a p. 174; Directorate General of Health Services 2011 p. 41; General Economic Division (GED) n.d, p .18

The table shows that the maternal mortality of the Sylhet division is 3.8% and under-5 mortality is 7.4% which are relatively higher than those rates of the Dhaka division, (3.3%) and (6.7%) respectively. Similarly, the rate of vaccination coverage (12 months) of the Rajshahi division is the highest (82.5%), the Dhaka division is medium (78.3%), and the Sylhet division is at the lowest level (74.3%). The data also show that the infant mortality of the Sylhet division is the highest (10%), the Dhaka division is medium (7.5%) and the Barisal division is the lowest (6.1%). The percentage of deliveries assisted by medically trained personnel in the Khulna division is the highest (26.6%), the Dhaka division is medium (19.8%), and the Sylhet division is at the lowest level (10.9%).

In fact, the women's and children's health indicators of the Sylhet division is at the lowest level, however maternal mortality is better in the Dhaka division, vaccination cover rate is better in the Rajshahi division and the infant mortality rate is better in the Barisal division. The level of improvement of other health indicators such as vaccination coverage, infant mortality and delivery of medically trained personnel of Dhaka division is moderate. The gross/overall improvements in women and children's health indicators are the best in the Dhaka division. Therefore, two

organicstations can be best done through examining the social phenomena of quality of health service delivery for women and children, which is also a neglected area of study in the existing literatures.

divisions (Dhaka and Sylhet) based on level of health indicators (in average high and low performance) have been selected for understanding governance and service delivery. Additionally, two districts (Dhaka and Sunamganj) from these divisions have been selected for exploring governance of health service organisations based on human poverty index.[16]

A study of Centre for Policy Dialogue (CPD) (2008, p. 13) argues that the performance of health in different areas are quite distinct due to inequalities of socio-economic development in those regions. However, the study of the Planning Commission (2009, p. 84) argues that inadequate geographical accessibility, poverty, poor leadership capacity, lack of coordination, illiteracy and poor social and cultural norms are the causes of unequal health improvement among the various regions of Bangladesh. The socio-economic indicators including managerial and geographical factors have been used in this thesis as significant factors for understanding governance of rural and urban health service organisations.

Studies suggest factors that are challenges to good governance are: the lack of managerial efficiency, inadequate resources, poor planning, lack of coordination, and poor political commitment. Moreover, evidence demonstrates that the inequalities in health care between the rural and urban areas, as well as among the different regions, are due to inadequate policy initiatives, lack of policy implementation, weak supervision and poor community participation, lack of awareness and education among others. Besides this, NGOs are unable to provide quality of health care due to poor resource capacity and excessive control of government. The studies reviewed above show that poor governance contributes to insufficient quality of health care. Therefore, the impact of governance on quality of health service delivery is crucial and provides a valuable research agenda for a country such as Bangladesh. Additionally, earlier evidence (Section 1.3) shows that no study has addressed this research agenda. Consequently, addressing and analysing the identified gaps will generate new knowledge that will contribute to the enhancement of health service delivery in Bangladesh.

[16] The Dhaka district has the lowest human poverty index (26.51%). Conversely, the Sunamganj district of Sylhet division has the highest human poverty index (39.44%) (Sen & Ali 2005, pp.15-16). The study by Sen and Ali (2005, p. 6) shows that the districts which have lower income poverty levels, also tend to have a lower human poverty index, reduced child mortality and low fertility rates.

1.5 Research questions

This thesis requires empirical data to understand the impact of governance on quality of health service delivery of rural and urban health organisations. For this purpose, the following questions will be posed in this thesis:

a. How do responsibilities and duties of various health professionals contribute to improving/limiting governance and quality of health service delivery?
b. How does community participation contribute to governance and quality of health care in rural and urban areas?
c. How do various factors affect governance and health care delivery?
d. To what extent does governance work differently in rural and urban health service organisations?
e. How is the governance of NGOs' health service delivery conducted? Is service delivery of NGOs more efficient than that of public providers?

1.6 The proposed research

This thesis proposes to examine the critical understanding through addressing the following aspects:

Firstly, this study will assess the impact of governance on the implementation of primary health care programs for women and children through evaluating the roles and responsibilities of various health care providers. Also, the impact of supervision, monitoring, auditing and coordination contributing to enhancing/ limiting governance will be examined with reference to quality of health service delivery. In addition, the influence of corruption on governance, how it contributes to poor quality of service delivery and why it occurs, will also be examined. Moreover, the effects of politics on governance will be examined with reference to quality of health care. Further, this thesis will explore to what extent various factors contribute differently to governance and quality of health care of health service organisations at rural and urban areas.

Secondly, this research will examine participation of various communities (local elected representatives, local politicians, Community Based Organisation

(CBO)/Civil Society Organisation (CSO) representatives, local elites, general community) in enhancing/restraining governance and quality of health care or, alternatively, why does a community have a poorer capacity to influence the responsibilities of service providers? Additionally, the study will examine how governance contributes to the enhancement of quality of health care for the community and what the policy initiatives required are in this regard. Besides this, public opinion, especially the ideas of service users, will be assessed in order to know their demands, expectations, motivations, and suggestions concerning women's and children's health care for understanding the impact of governance on the quality of that health care.

Thirdly, this thesis will address socio-economic conditions including their associate factors of the selected rural–urban areas to understand the impacts of governance on quality of health care. For this purpose, this study will assess the impact of women's decision-making power on health service activities. Besides this, the research will examine how the factors (for example, education, income, employment) contribute to governance and quality of health service delivery.

Finally, the research will explore the impact of governance on quality of health care with reference to NGOs' health care. Therefore, this thesis will examine how accountability and transparency work in the activities of management of NGOs' health care and to what extent they contribute to the enhancement of maternal and child health programs. In addition, this thesis will examine how better coordination contributes to quality of governance and quality of health services, or conversely, what is the consequence of poor governance in this regards and how does it work in terms of primary health care for women and children? Moreover, the research will address the question of how the participation of NGOs ensures effective implementation of health policy for enhancing quality of health care and how NGOs health care is more efficient than solely that of public providers.

1.7 Research objectives

The main objective of this thesis is to examine the impact of governance on the quality of service provision of health service organisations and analyse how governance differently affects the rural and urban health services in Bangladesh. The following objectives have been chosen specifically for this purpose:

a. To identify the major health care providers in health service organisations and examine how governance works to promote or limit health, its roles and responsibilities in delivering quality of health care.
b. To examine the impact of governance on quality of health service delivery from community perceptions.
c. To analyse how governance contributes differently to rural and urban health service organisations and non-governmental organisations providing healthcare.
d. To draw lessons and to suggest policy implications for government in Bangladesh and for developing countries with similar socio-economic environments.

1.8 Significance of the study

The significance of the study lies in its approach to examining health service delivery in Bangladesh through the aspect of governance. As the brief review of the current literature suggests, no specific study of the impact of accountability, transparency and participation on health service delivery has been undertaken in Bangladesh. As such, this thesis will contribute towards a deeper understanding of governance and quality of service delivery in Bangladesh, especially in primary health care for women and children in Bangladesh through examining the role and responsibility of health care professionals as well as community participation. Understanding governance through examining the views of health professionals' roles will make a significant improvement of quality of service delivery, which will benefit the major communities/health care receivers. Besides this, understanding governance through community perceptions enables one to understand the public participation to health service organisations. This knowledge will contribute to the enhancement of quality of service delivery for not only the disadvantaged population, but also for Bangladesh's underdeveloped localities. In addition, this knowledge will assist policy makers to improve health policy in the country. Moreover, a deeper understanding of governance and quality of health care will contribute significantly to enhancing socio-economic and human development in the nation.

Additionally, a thesis concerning the impact of governance with regard to NGOs' health care enables an understanding of the efficiency and effectiveness of health care delivery, which will also offer innovative knowledge for the health sector. This significant new awareness, especially for the health sector in Bangladesh including

developing nations, has the capacity to contribute to policy implications. Also, this thesis will contribute to national and international health organisations and service providers as well as community organisations involved in policy implementation.

1.9 Organisation of the thesis

This thesis is organised into ten chapters. **Chapter One** (the present chapter) has provided the introduction, background, the research problem and research questions, the objectives of the study and its significance. **Chapter Two** presents the literature review for this study. **Chapter Three** outlines the methodology, details of the data collection and the method analysing the qualitative data collected for this study. **Chapter Four** offers a background of health service organisations and study sites. The data analysis is organised into five chapters. **Chapter Five** explores the impact of managerial responsibility on accountability and health service delivery. **Chapter Six** investigates the impact of professional responsibility on accountability and health service delivery. **Chapter Seven** examines the impact of transparency on health service delivery. **Chapter Eight** addresses the influence of community participation on health service delivery. **Chapter Nine** analyses governance in NGOs' health service delivery. Finally, **Chapter Ten** presents the conclusion of this study.

Chapter 2

Governance and Health Service Delivery in Bangladesh: A Review of Available Literature

2.1 Introduction

This thesis examines the role of governance in the delivery of health services in Bangladesh; by comparing two contrasting areas- one with a comparatively good and the other with a relatively poor health service delivery. In order to adequately contextualise the study, it is necessary to review the available literature on governance and health service delivery. This literature review is divided into two parts. Part I deals with governance and health service delivery in general, providing a theoretical context to the study, and is organised into two sections. The concepts 'service delivery' and 'quality of service delivery' are defined in the first section from the perspective of management of health service organisations. The second section deals with the concepts 'government' and 'governance' for a theoretical analysis for the study.

Part II deals with available literature of health services in Bangladesh. For this, various studies on health system and health service delivery are reviewed. This part is organised into four sections. The first section examines the literature on health policy, health service reforms, human resources and partnerships of health care in Bangladesh. The second section contains a review of the available literature with regard to accountability, participation and corruption in health care in developing countries including Bangladesh. The third section of the literature review deals with factors that affect quality of health service delivery. The final section summarises the overall literature review and based on the literature review, a framework for analysing field data is presented to assess the impact of governance on the quality of health care in Bangladesh.

Part I: Governance and Health Service Delivery

2.2 Service delivery

In general, 'service delivery' means managing services for particular people and places according to the goals of an organisation. The main purposes of an organisation are to meet the needs and expectations of the population, which depends on the quality of services provided. Chen et al. (2009, p. 39) argue that service delivery is the process of applying specialised competencies (knowledge and skill) to provide customer services. Therefore, meeting public expectations at optimum level are significant issues in the delivery of services, which have been addressed in the thesis as one of the aspects of quality of health care.

2.2.1 Quality of service delivery

Quality of health care depends upon the distance and accessibility of the facility, cost involved, clients' satisfaction. There are several definitions of quality of service delivery, which may be context specific. It depends on the behaviour and attitude of service providers and the availability of supply of medical equipment provided by the health care organisations (Anwar 2009, pp. 396-97). Quality of service delivery enhances services through some qualitative aspects of the organisation such as efficiency of management, availability of funds, and effective public participation that leads to significant changes in service delivery to promote customer satisfaction. One of the factors that promote quality of health care is affordability and accessibility in delivering services to people.

Mazta and Thakur (2012), explaining the accessibility and affordability of maternal and child health care in the Indian state of Himachal Pradesh, argue that health centres should be built within the inhabited area of the village rather than at its periphery so that services are easily accessible to the people. In addition, the study shows that even though immunisation and other services are offered free of charge, most mothers have to spend hours waiting for services due to geographical distance and pay transport costs to avail themselves of these services. They also argue that several other factors such as adequacy of resources, supervision and effectiveness of coordination promote accessibility to health care.

Efficiency is an important aspect of quality of health care. An efficient healthcare system makes the best use of resources to achieve the maximum outcome. In

measurable terms, efficiency means the ratio between input and output. Tang (1997, p. 462) argues that the most efficient arrangement in any system is one that produces the greatest output per unit of input, for example, the lowest cost for a given level and quality of service. Rutger et al. (2010, p. 774) state that efficiency, as a core value in an organisation, encompasses a broad value spectrum, that is, the ability to act and act in a timely manner, to be knowledgeable, to have integrity, and so on.

The service providers' role and their organisational attributes such as professionalism, commitment, ethical values and leadership qualities have an impact on the efficiency of service delivery (Kemoni et al. 2008, p. 300). Similarly, Routh et al. (2004, p. 20) argue that the quality of leadership and management promotes the efficiency of personnel, which, in turn, contributes to low wastage and appropriate decision-making in the organisation. This, ultimately, leads to improved and adequate services. A World Bank (2005, pp. 76-77) study shows that many factors such as the responsibility of local residents, through their contribution to the cost of the project, and the participation of the community and civil society through raising their voices, and creating collaboration in implementing the project, all contribute to enhanced efficiency to deliver services. Moreover, sufficient resources and their efficient use improve the efficiency of an organisation by providing it with the necessary services (Shetty & Pakkala 2010, p. 516). Besides this, adequate knowledge and skills, good management practices, and the use of technology have positive effects on service efficiency (Swierczek 1982, p. 285). How these factors contribute to enhancing governance can be useful understanding for this thesis.

However, the negative attributes of service providers such as poor leadership, lack of understanding, corruption, lack of accountability, and poor motivation contribute to inefficiency in delivering services to organisations. Moreover, there are a number of other negative attributes, particularly power politics, bureaucratic mismanagement, and inadequate resource capacity, high compliance costs, local elite influence, and lack of technology which have adverse effects on health service efficiency (Tang 1997, p. 463; Devas 2008, p. 45). Addressing and exploring these issues in assessing health service delivery will provide an understanding of why health service organisations have poor governance.

As mentioned above, one aspect of service delivery quality is effectiveness, which implies achieving valued outcomes whatever the resource implications (Rutger

2010, p. 759). Effectiveness is an indicator of how far the objectives of an organisation have been met, and how the quality of services has been provided by health service organisations according to the needs and priorities of the local citizens. Burke (2006) argues that effectiveness refers to the extent to which a service achieves its intended results through the proper use of management to achieve the goals and objectives of the organisation. However, there are various factors that can threaten the effectiveness of service delivery in health service organisations. These factors include the lack of coordination among the different departments and stakeholders,[17] corruption, inappropriate procedures, and the responsibility of officials. The hierarchical nature of an organisation, the non-cooperative attitudes of officials, mismanagement, misuse and illegal use of resources as well as the neglect of duties and responsibilities are factors that affect the achievement of goals in an organisation.

Utilisation is one of the indicators of quality of health service delivery, which is based on the organisation's capacity and population health characteristics. Utilisation depends on how efficiently the service providers use time and resources through organising and managing health service organisations (Bradley et al. 2010, p. 4). Conversely, any mismanagement in the organisation affects utilisation, which contributes to poor health performance. According to Chassin et al. (1998, p. 1002), problems of utilisation of health service delivery can be categorised as underuse, overuse and misuse, and any of these problems affect the quality of health care however, poor accountability can contribute to inefficient utilisation of health care.

The impact of the specific components of governance, which are used in this thesis to assess the quality of health care, is described in Section 2.8 as a framework for understanding how the various actors and factors play their role in health service organisations. This thesis has defined 'governance' to understand the main key word used in the study which is the focus of the following sections.

2.3 The conceptualisation of governance

As mentioned earlier, governance is a broader term than government, which is used not only in development discourse but also in the development strategies of

[17] Women and children's health care at the field level is directed through the two major departments of the Ministry of Health and Family Welfare, the Health Service Department and the Family Planning Department. In addition, NGOs and donor organisations work together with government organisations for efficient delivery of services concerning women and children's health care.

unindustrialised countries in order to meet public demands (Alcantara 1998, p. 111; Senarclens1998, p. 92; Asaduzzaman 2008, p. 17). However, Rahman and Rabinson (2006, p. 131) argue that governance is not only a matter of the structural attributes of states but also about values, processes, and outcomes. For example, it is easier to establish an anti-corruption commission; however, transforming this into an effective deterrent against corruption based on a broader social consensus requires efficient management, political commitment and effective public participation.

The United Nations Development Program (UNDP) defines governance as a system of values, policies and institutions by which a society manages its economic, political and social affairs through interactions within and among the state, civil society and private sector (United Nations Development Program 2000, p. 1). Similarly, Alcantara (1998, p. 105) and Khan (2009, pp. 41-42) state that governance is defined as the interaction of various actors, whether public or private, which is aimed at achieving organisational goals so that the organisation is able to provide efficient and effective services in order to meet people's expectations. These definitions show that governance is an interactive process involving multiple actors and adequate management for the purpose of achieving organisational goals to meet public aspirations.

Santiso (2001) study defines governance from a managerial point of view. This study states that governance is a form of political regime, during which authority is exercised in the management of a country's economic and social resources for the purposes of development. In addition, governance enhances the capacity of governments through involving a multitude of partners to design, formulate and implement policies and programs to meet public demands (Santiso 2001, p. 5). On the other hand, the Commission on Global Governance (2005) focuses on the issues of compromise and conflict to understand governance, and states that governance is the action of managing common affairs by involving individuals and institutions, both public and private, to accommodate conflicting and diverse interests with cooperative action. It also includes formal institutions and regimes empowered to enforce compliance as well as informal arrangements that people and institutions have, either agreed to or perceived to be in their interests (Weiss 2000, p. 797). Thus, governance is used as a system and a process of management, which works to provide efficient delivery of services to enhance socio-economic development. Stoker (1998) defines governance from a broader

perspective. He shows that governance provides the methods of reducing central responsibilities, blurring of boundaries of public and private organisations, and requires interactive processes, self-governing actors, and innovation to achieve organisational goals. Overall, governance is a process of management and the interaction of multiple actors who work in the organisation in order to promote improved delivery of services.

Governance can be addressed through normative dimensions, namely transparency, accountability, efficiency, effectiveness, fairness, participation, predictability and ownership (Woods 2000, p. 824; Asian Development Bank 2004, p. 4) which enables an organisation to meet people's expectations. These normative dimensions are regarded as representing the quality of governance/good governance by the donor organisations and scholars. It may also be defined in terms of a number of components by development agencies and scholars; however the present study uses three main components of governance, namely accountability, transparency, and participation that are deemed critical for understanding the impact of governance on the quality of health service delivery

2.3.1 The meaning of accountability

Accountability is a system or set of mechanisms to improve governance where service providers have an obligation to perform their duties and responsibilities in accordance with organisational regulations and to work efficiently to provide services for people (Devas 2008, p. 111). Additionally, answerability is the prime concern of accountability. *The Oxford English dictionary* (2008, p. 325) defines accountability with reference to answerability as: 'answerability for performing functions to some person or body'. Answerability helps to assess how the actors respond to people's enquiries in an organisation. However, Romzek and Dubnick (1998, p. 6) conceptualise accountability in a slightly wider way as they argue that it is not only answerability to persons but also to organisations.

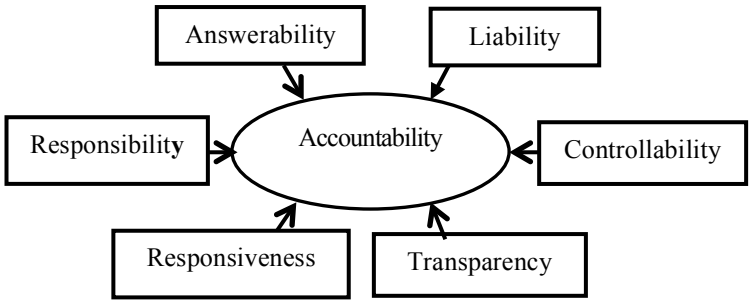
Wang (2002, p. 350) defines accountability through addressing public participation in an organisation and argues that responsiveness, public consensus, and stakeholder trust are significant tools to strengthen accountability. Public participation in an organisation, and the strengthening of supervision and monitoring of organisational activities ensure answerability to promote accountability of service delivery. However, Bovens (2007, p. 453) argues that transparency is an element to encourage accountability as transparency is the way of getting adequate information

for service delivery, which leads to enhancing accountability. Koppell (2005) has provided a broader framework concerning accountability through presenting five dimensions: transparency, liability, controllability, responsibility, and responsiveness in order to understand organisational effectiveness.

To summarise, accountability is the way of ensuring answerability on how the actors perform their responsibilities in order to improve organisational goals. Participation, responsiveness, organisational rules and procedures, and transparency also promote accountability (see Figure 2.1). Accountability ensures not only individual responsibility but also promotes organisational efficiency and effectiveness through ensuring responsibilities of all employees. The delivery of services at a satisfactory level and promotion of good governance is the first rate concern of accountability in the organisation.

Figure 2.1

Conceptual model of accountability



Source: Adapted from Devas (2008), Romzek and Dubnic (1998), Koppell (2005) and Bovens (2007)

2.3.2 Understanding transparency

Transparency is defined as openness that allows people to be informed of the organisation and its activities. Fairbanks et al. (2007) argue that transparency is the availability of information of matters of public concern, the ability of citizens to participate in political decisions, and the accountability of governments to public opinion or legal processes. Fairbanks et al. (2007) also examine the understanding of transparency through a broader context and argue that transparency could be regarded as a legal, political and institutional structure that facilitates the availability of information regarding the internal characteristics of a government and society to

service providers and clients, both within and without the domestic political system. However, understanding the supply and demand of information within an organisation can be the way of assessing transparency. Gambril (2007) argues that transparency requires a clear description of the gap between what the organisation claims to do and achieve and what is actually done, thus, identifying the exact discrepancy between the supply of information to people, and the people's demand for the same. Web-based health care information may be one of the ways to meet public demands in order to promote transparency and quality of health care.

Lebovic (2006, p. 545) states that transparency permits control over information that allows inside information such as documents to flow to outsiders. This information flow clarifies the actions taken by a government to benefit its people. Transparency can be ensured by supporting a free media and in publishing the public budget so that people are well informed of the budgetary process (Kjaer 2004, p. 173). Moser (2001) also demonstrates that transparency is the ability to look clearly through the windows of an institution and open up the working procedures so that organisations are able to enhance good governance and quality of service delivery. This is generally linked to individual rights such as freedom of speech, freedom of the press or the right to vote.

Additionally, Richard (2007, p. 168) argues that a number of organisational procedures, signing of codes of conduct egg, responsible employees are required to sign an agreement at the time of taking the oaths of office that they will not hide information from the public. In other words, officials must be committed to providing adequate information, to enable checks and balances in management, and they must be committed to facilitating increased citizen's participation and the involvement of civil society, all of which have impacts on improving transparency. However, studies show that the advent of modern technology and access to information are crucial for enhancing transparency and accountability to provide efficient services (Meijer 2009; Information Act 2009).

In summary, government can make health services transparent through providing information available to customers. But the health service organisations do not really provide the required information without being requested. There are many mechanisms for transparency including access to information, freedom of the press, participation of the general community, and modern technology to provide essential services to customers or citizens. In addition, formal organisational procedure

promotes commitment of officials to their organisations, which also leads to transparency. A transparent organisation is able to provide adequate services to the people.

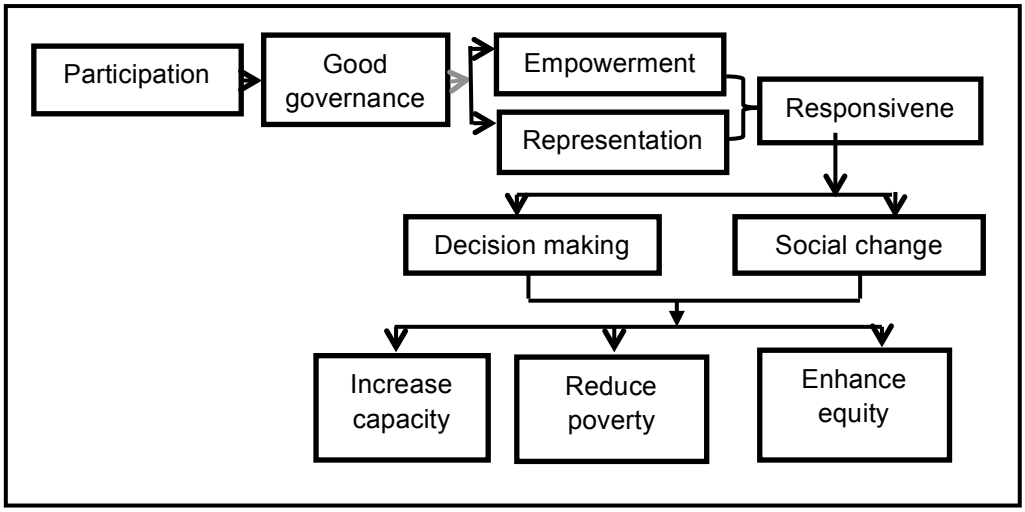
2.3.3 Conceptualisation of participation

Public participation in an organisation is a way of empowering the general public through ensuring that their voices are heard in the improvement of service delivery. The effectiveness of public participation may be context specific, but it is generally perceived that local government organisations may have effective community participation and bureaucratic organisations may have limited public participation for meeting public demands. Asaduzzaman (2008, p. 62) argues that participation is considered as a parameter of empowerment, which increases the capacity of individuals to improve their own lives, and it facilities social change for disadvantaged or marginalised groups. In other words, participation of local people helps to exercise their voice for their own interests as well as for the development of the organisation. Rowe and Frewer (2005) study uses a typology with three broad categories of public engagement: communication, consultation, and participation, Among these typologies communication and consultation might be significant for understanding governance decisions of satellite clinics, school visits and health education which discussed in section 8.4 of chapter 8.

Blair (2000, p. 21) has stated that increased responsiveness to, and empowerment of, citizenry and effective service delivery can be sustained through popular participation and accountability at the local level. For this purpose, he has identified a series of sequential steps from participation to everyone reaping benefits: participation leads to representation and public opinion, representation ensures empowerment, and empowerment gives benefits to all. Finally, empowerments reduce poverty and enhance equity among all socio-economic groups, which is the result of good governance (Blair 2000, p. 23). Similarly, Kakumba (2010, p. 173) argues that effective participation leads to representation, which in turn leads to empowerment in contributing to decision-making in an organisation, as illustrated in Figure 2.2 below.

Figure 2.2

Sequential steps of participation and good governance



Source: adapted from Asaduzzaman (2008), Blair (2000), Kakumba (2010)

In short, participation ensures representation and empowerment of people within the organisation, which promotes responsiveness through good governance. This responsiveness assists in decision-making for social change in order to achieve poverty reduction and enhancement of equity. Thus, good governance is an effective mechanism for achieving desired outcomes, and addressing this issue may provide a useful insight in understanding the quality of health service delivery.

The studies referred to above have analysed the conceptualisation of governance and service delivery from the literature of developed and developing countries. These identified conceptual issues enable a clear understanding of the theories presented in the current thesis.

A literature review of the health system in Bangladesh with examples and evidence from developing countries is presented in the following sections in order to understand previous research with regard to health service delivery. From reviewing the available literature, a conceptual framework is presented at the end of this chapter (Section 2.8) to understand the impact of governance on quality of health service delivery in Bangladesh.

Part II: Review of Available Literature on Health Service Delivery in Bangladesh

In the light of discussions of some crucial aspects of service delivery, this section presents reviews the available literature particularly empirical studies on the health system and health service delivery in Bangladesh and in other developing countries. The review of the literature is categorised into various sections as shown below. A conceptual framework for the study is presented in Section 2.8, which outlines the research questions, and the ways to interpret the field data collected to address the objectives of this study.

2.4 Policies, reforms, human resources and partnerships of health services

2.4.1 Challenges of health policy and planning

One of the challenges of the health system in Bangladesh is weak formulation and implementation of the health policy process. In this regard, Osman (2004) conducted a study on how actors and factors of the health administration impede the formulation and implementation of health policies in Bangladesh. Osman's (2004) study shows that amongst the actors, donors, bureaucrats, politicians and health professionals influence formulation and implementation of health policy for getting benefits. Osman (2004) also demonstrates that donors have an over dominate role that creates gaps between policy decisions and reality and has made the policy more the result of supply-push than the demand-pull. Bureaucrats affect popular participation in policy-making and centralise the decision-making process, which, in turn, creates a gap between policy decisions and local needs. Osman (2004) further shows that elected politicians have inadequate competence to create popular policy in accordance with public expectations. In addition, health professionals have more dominance over health policy for the affiliation of party politics. Most doctors are involved in politics through doctors' associations. Besides this, various contextual factors such as politics, poverty and illiteracy as well as institutional factors such as centralisation, poor coordination and information, and donor driven decisions affect the implementation of health policy and programs (Osman 2004).

A proper implementation of local health plans requires sufficient funds, efficient management and effective community participation. Gazi et al. (2005) have shown that the major challenges of implementing local health plans lie in the late release of

funds, lack of interest among sub-district managers, political pressure, lack of commitment of health care providers, and the tussles between staff of health and family planning directorates. Gazi et al.'s study (2005, pp. 144-148) also shows that community representatives have limited participation in health programs due to a lack of adequate training and motivation, lack of decision-making power, and their reluctance to take part in decision-making. Gazi et al.'s (2005) study has identified various challenges for the implementation of health plans: however, governance which was not addressed in their research, and understanding how governance affects health program implementation should be very useful for this thesis.

In summary, politics and bureaucracy are the major factors affecting health policy. The other factors that contribute to health planning and policy are: lack of participation, poor coordination, insufficient training and inadequate motivatio. The challenges of policy implementation could also be the causes of poor governance in the organisation; therefore examining the governance of current health care activities may be useful. Nevertheless, the implementation of health policy requires adequate reform initiatives in order to ensure quality of health care, which is the focus of the next section.

2.4.2 Some selected reforms in health care delivery systems

This section reviews some selected reforms in health care delivery systems in Bangladesh and selected other countries. One of the challenges of promoting the quality of health services is the implementation of reform initiated by the government in Bangladesh, such as decentralisation and user fees. Mahdy (2009, p. 411) shows that, in spite of various committees being set up by successive governments in Bangladesh since independence, with the objective of improving the quality of healthcare delivery to its population, various challenges still remain in fulfilling this objective. These challenges comprise lack of political commitment, inadequate funding, the crisis of confidence among the citizens and health service providers contributing to inadequate reforms, and the poor quality of health care (Mahdy 2009, p. 414).

Kaur et al. (2012, pp. 94-104) examine the impact of centralisation and decentralisation on quality of health service delivery in northern India. The study shows that adequate health service is not achieved when the health system, especially the planning and financing process, is centralised. The study however shows that the decentralised health system through handed over administrative

power from district administration to health society (semi-government bodies), contributes positively to health care quality. For instance, local health administrators enable to take decision making on construction of new operation theatres, new maternity wards and labour rooms, procurement of water coolers, blankets and chairs as the system is adequately decentralised, consequently health service delivery has improved. The study concludes that the improvement of health care facilities is the result of an adequate decentralised health system. However, the health system in Bangladesh is not adequately decentralised due to the influence of politics. For this reason, the evidence of northern India's decentralised health care system could be an ideal example for Bangladesh to improve its quality of health care.

Mariappan and Thakur (2012) conducted a study on user fee management at government hospitals in four states of India in order to understand how these fees have improved service quality. The user fee pricing policy particularly that of fixing and levying fees have been significantly succeed in the state of Rajasthan (78.9 per cent), Karnataka (63.2 per cent), Uttar Pradesh (23.9 per cent) and Gujarat (13.6 per cent). Rajasthan has achieved the highest user fee as this state has collected a large portion through computerised systems instead of manually. Mariappan and Thakur (2012) a survey argues that the majority of respondents believed the current user fee to be acceptable and affordable; conversely, 12 per cent of the respondents from all states indicated that the user fee was high. The survey findings concluded that health care quality improved gradually in all of the selected states which introduced user fees, but significant improvement in quality was achieved in Rajasthan as this state used computers to collect them which were a more efficient procedure (Mariappan & Thakur 2012, p. 228). Therefore, the evidence with regard to computer technology outcomes in Rajasthan could be a good model to promote transparency and accountability in health care delivery in Bangladesh.

Parkhurst et al. (2005) in his study regarding the reform of maternal health care in Uganda shows that the introduction of user fees for public services has both negative and positive impacts on the improvement of quality of healthcare. On the positive side, the effect of user fees in Uganda has been shown to have improved the motivation of health workers as their introduction has improved workers' payment structure, however on the negative side, it has led to a decline in service utilisation. The reasons for decline service utilisation were inadequate and unplanned policy on maternal health service delivery (Parkhurst et al. 2005, p. 135).

The lack of quality governance could be one of the reasons for inadequate health policy in Uganda and examining the causes of poor governance could improve health policy and quality of care. So, understanding the effect of political and bureaucratic factors on health policy process may be useful for this thesis.

Penn-Kekana et al. (2007) have examined the impact of reforms introduced by the South African government to promote the motivation of professional nurses in order to ensure quality of maternal health care. The government introduced an allowance to retain staff in rural areas. However, only the professional nurses who held senior positions and not junior nurses received the allowance, which caused tension among them in the maternity wards. The reform appeared to have had the impact of demotivating the staff who did not get the allowance. On the other hand, the staff who did receive the allowance felt guilty, embarrassed or uncomfortable that their colleagues did not (Penn-Kekana et al. 2007, p. 32). Consequently, reform initiatives in South Africa have not created positive outcomes in enhancing quality of maternal health care services. These policy reforms towards improving staff motivation lacked wider community participation and, consequently, the outcomes were negative. Therefore, this thesis will examine participation of various communities including health professionals and the factors that affect good health policy to understand the impact of governance on quality of health service delivery.

2.4.3 Importance of human resources in the quality of health service delivery

The quality of health service delivery requires an adequate health workforce with sufficient knowledge and skills. Parkhurst et al. (2005) investigated the impact of the quality of human resources in the health workforce on the quality of maternal health care with case studies from Bangladesh and Uganda. Their study shows that the skilled birth attendance rate in Uganda was more than three times that in Bangladesh (39% in Uganda compared to only 12.1% in Bangladesh) during the period 2001-2002; but the estimates of maternal mortality ratio (MMR) tended to be higher in Uganda with 505 maternal deaths per 100,000 live births compared to 322 per 100,000 live births in Bangladesh during same period (Parkhurst 2005, p. 130). One of the reasons for the higher MMR in Uganda is the poor quality of hospital care and the fact that emergencies are not referred quickly or treated effectively due to the lower availability of a health-related workforce to serve emergency patients. Nevertheless, Bangladesh has more physicians (20 physicians per 100,000 population compared to only 5.3 per 100,000 in Uganda), and as a result, the

emergency referral system is quicker and easier in Bangladesh than it is in Uganda. In addition, Parkhurst et al. (2005) study shows that the reduction of maternal mortality relies heavily on the way the health system operates, the availability and quality of staff to handle emergencies, and the strategic placement of birth attendants with access to referral networks. Moreover, the quality of human resources influences the behaviour of health providers resulting in improvements in the quality of care received.

Bangladesh still has a shortage of qualified health professionals. Ahmed et al. (2009) argue that due to this shortage, the poor and the disadvantaged prefer to seek health care from non-qualified health care providers. They further argue that poor rural people in particular seek services from non-qualified providers as a result of a lack of access to information on available services, lack of health awareness, lack of economic opportunity due to exclusion of social and health institutions, cultural factors prohibiting females from seeking care outside the home from male providers, and inability to pay the relatively high fees (Ahmed et al.2009, p. 468). This study also shows that a majority of the population receives poor quality services from non-qualified providers. These service providers lack health education as well as in-service training. Moreover, the training system, particularly that at the sub-district level is politicised and not well planned, which contributes to poor health service quality.

Absenteeism of qualified health professionals contributes to the mismanagement of the health system. Chaudhury and Hammer (2004) identify and examine various factors that influence doctors' absenteeism and vacancies. It might be useful to explain the difference between absenteeism and vacancies. Absenteeism refers to employed doctors staying away from work without approved leave, while vacancy refers to unfilled positions or approved positions of doctors to which no one is appointed. While absenteeism is a form of corruption, vacancies can be attributed to inefficiencies on the part of appointing authorities in the rural health facilities of Bangladesh. Their study shows that the female physicians are absent slightly more than the male physicians in rural health service organisations. Evidence also shows that more experienced physicians prefer to work at urban hospitals rather than in rural health organisations. According to this study, one of the reasons for absenteeism in rural health service organisations can be attributed to lack of electricity supply (Chaudhury and Hammer 2004).

Chaudhury and Hammer (2004, p. 427) also state that on average, 26.2 per cent of the positions of health professionals were unfilled in the country in 2002. In other words, the national vacancy rate was 26.2 percent in 2002. Among the six divisions, the highest vacancy rate was in the poor socio-economic region of Sylhet (37.7 per cent) , and the lowest vacancy rate was in the rich socio-economic region of Dhaka (20.1 per cent). . Their study identified that the reasons for the low vacancy rate in Dhaka were improved socio-economic conditions and a lucrative market for private practice; however, poor management, corruption [18] and inadequate health infrastructure may be the reasons for the high vacancy rate.

Amongst the health workforce, field level skilled community-based health workers are immediately necessary for Bangladesh to reduce maternal and neonatal mortality as the country has insufficient community health workers in terms of population. Bari et al. (2006) have investigated the factors that promote referral hospital services for newborns at Kumudini Hospital in Tangail district, Bangladesh. They particularly examined the role of Community Health Workers (CHW) in promoting a referral system for sick newborns which had a significant impact on reducing neonatal mortality. Data show that compliance with referrals to the Kumudini Hospital by the CHWs increased from 55.7% to 80.1% during the three months due to their actions (Bari et al. 2006, p. 524). This study also found a substantial increase in referral compliance for newborn illnesses which was likely related to the education and training of families concerning danger signs, active surveillance, regular counselling and enhancing linkage between community and the hospital by the CHWs (Bari et al. 2006, p. 527). This study suggests several crucial factors to improve neonatal health services, as well as improved institutional facilities and necessary CHW training can have a significant influence on neonatal services.

Ahmed and Jakaria (2009) argue that the community-based skilled birth attendants have made a significant contribution to rural societies like Bangladesh through servicing the deliveries of nearly 85% of women at home. During 2006-2008, the government implemented a pilot program to recruit and train skilled birth attendants to service the delivery of rural women. This has contributed significantly to the reduction of maternal deaths in Bangladesh (Ahmed & Jakaria 2009, p. 48). This study revealed that the 86 trained community-based skilled birth attendants participated in the program, and of them, 29% were involved in home deliveries,

[18] See Box 6.4 for an explanation of how vacancies can be attributed to corruption.

52% performed antenatal check-ups, and the rest performed postnatal check-ups. Approximately 91% of the 288 women in the area covered who used the services provided were fully or fairly satisfied with them. The data also show that 60% of women who had already received services from community birth attendants preferred to have their next deliveries with them (Ahmed & Jakaria2009, p. 48).

Ahmed and Jakaria (2009) show that while the government plans to enhance the skills of the existing birth attendants by providing them re-training the number of trained birth attendants is still insufficient to meet the local demand. The government should create a permanent cadre post for increasing birth attendants and pay them a salary equal to that of a government employee so that they can work to promote health care quality. However, the efficiency and quality of health service delivery can be ensured through partnership process. For this, Government-Non Governmental Organisations (GO-NGOs) and public-private-based partnership health programs have a significant role in enhancing quality of health care delivery, which is discussed in the next section.

2.4.4 Partnership health care delivery in Bangladesh

This section critically reviews literature on partnership health service delivery and is divided into two parts. The first part reviews literature about the health service deliveries of GOs (Government Organisations) and NGOs (Non-government Organisations), and the second part reviews public-private health service delivery.

a. Service delivery: GO and NGO health facilities

Ahmed et al. (2006) showed the comparison in health service delivery of Government and NGO health care facilities in Bangladesh. One of the findings in Ahmed et al.'s (2006) study revealed that poorer women received more health services from the public providers than the NGO clinics and this was due to low incomes and not being able to afford private healthcare. The study finding also showed that well-off families had good connections with NGO clinics, enabling them to obtain better health services than the poorer families. Moreover, NGO clinics provided a better quality of care than public providers because they were more responsive, better health care providers and offered a cleaner environment (Ahmed et al. 2006, pp. 459-60). Nevertheless, NGO clinics have limited resources and they are not open at all hours, which limits their use for emergency care. Furthermore, NGO clinics provide inadequate information, which affects sufficient health service

accessibility. Besides this, NGOs also have poor health infrastructure that can limit quality health care.

Mercer et al.'s (2004) study examined the effectiveness of NGOs reproductive health care program in rural Bangladesh. The data of this study revealed that NGOs' coverage areas achieved a higher reproductive health performance than the non-NGO areas in Bangladesh (Mercer 2004, p. 187). The reasons for higher achievement of NGOs' areas were: intensive technical support, adequate supervision and close monitoring. Besides this, implementation of a women-focused development program and income-generating activities by the NGOs contributed significantly to lower infant and child mortality (Mercer 2004, p. 194). Moreover, the NGOs' program included community participation, gender equity and local accountability, which contributed to higher reproductive health outcomes. So, the lesson learned from NGOs' reproductive health outcomes could be useful in understanding governance and quality of health care to government health service organisations.

Zafar Ullah et al. (2006, p. 143) discusses the significance of the role of partnerships in health care delivery in developing countries with a case study of a tuberculosis (TB) control program in Bangladesh. This study argues that there is a growing recognition among government and international organisations that the involvement of all stakeholders is needed if health services are to reach the poor. Further, continued bilateral relationships between donors and non-government organisations[19] create a window of opportunity for government-NGO collaboration[20] which may generate synergy and facilitate the flow of information (Zafar Ulla 2006, p. 143). The study reported that the TB control program in Bangladesh suffered from limited capacity and inadequate health care quality, particularly at the Upazila Health Complexes (UHCs) due to a shortage of infrastructure and lack of trained health and laboratory personnel. However, lack of sufficient funds could be one of the reasons for limited capacity. To overcome these constraints, the government decided to collaborate with NGOs to provide better services to the people.

[19] Non-Governmental Organisations (NGOs) have considerable power to improve health seeking behaviour and the capacity of the community. NGOs are considered to be in a better position to impose user fees that can lead to cost recovery and community participation. In addition, NGOs are thought to be closer to people and more aware of community needs (Zafar Ullah et al. 2006, p. 145).

[20] Collaboration is one of the forms of partnership, which can be referred to as joint activity, or working together, where two or more organisations collaborate closely and share resources and responsibility for common goals and purposes (Zafar Ullah et al. 2006, p. 144).

Zafar Ullah (2006) shows that the government and the NGOs provide complementary support in the area of management, operational research and social mobilisation to improve delivery of services. More specifically, the government provides treatment protocols, policy guidelines, logistic supplies, and training while the NGOs provide supervised treatment at the community level, promote active case-finding and raise awareness about TB among the general population. Consequently, there have been gradual but steady improvements in the key areas of TB control. For example, population coverage rose from 90% to 95%, case detection rate increased from 24% to 32%, and the treatment success rate rose from 78% to 84% between 1998 and 2002 (Zafar Ullah et al. 2006, pp. 150-151). This study has shown both success and failure of government-NGO partnerships as evident from the experience of the TB control program. The successes comprise improvement of TB control in order to provide greater coverage and access by the NGOs and the community-based infrastructure.

In addition, the NGOs were able to increase awareness among the general population about TB, leading to an increase in the identification of TB patients in different health facilities. Moreover, the unified reporting system and appropriate operational strategy in accordance with NGO philosophy and thinking appeared to have improved accountability and program performance. On the other hand, evidence also showed that factors such as lack of mutual trust, inadequate freedom to act independently and slowness of implementation affected the successful achievement of the government-NGO collaboration (Zafar Ullah et al. 2009, p. 151). Therefore, both the successes and failures of the evidence could provide lessons learned to understand governance.

Islam et al. (2002) assessed the cost effectiveness of a Government and Bangladesh Rural Advancement Committee (BRAC)-driven TB control program in Bangladesh. The government program is implemented in accordance with the national guidelines through public health officials, but the BRAC-implemented TB control program followed the guidelines of the World Health Organisation (WHO) through community health workers (CHWs). The cost per patient cured was US$64 in the BRAC area compared to US$96 in the government area. This implies that the government program appeared to be 50% more expensive for similar outcomes (Islam et al. 2002, p. 445).The factors that led to the cost-effectiveness of the BRAC program compared to the government run program were community participation, more accountability, close supervision, easier accessibility and less distance of

health care organisations (Islam et al.2002, pp. 447-449). The BRAC initiatives in accordance with WHO guidelines, particularly community involvement in delivering services, contributed to cost effectiveness which could be noteworthy for this study.

A study by Alam (2011) examined the challenges of the implementation of Government and NGO (GO-NGO) collaboration in an urban primary health care project (UPHCP) in Bangladesh, funded by the Asian Development Bank (ADB). Alam (2011) evaluated the views of both the GO and NGO in order to understand the impact of partnerships on the implementation of health care programs. The findings of this study show that NGOs tend to see the government as excessively restrictive, difficult to trust, and bureaucratic in its attitudes with a tendency to interfere in the activities of the NGO. The reasons cited by the NGO for its views are that the GO has rigid rules and regulations, lacks coordination and has very complicated bidding processes and time-consuming partnerships-based health care programs. However, the GO tends to view the NGOs as lacking in capacity, being less accountable and less transparent, involving corruption and being less sincere and less committed to work (Alam 2011, p. 273). Finally, the study concludes that the impact of partnership-based health programs is ambivalent where both parties have negative as well as positive consequences in providing health care.

Although the GO and NGO outcomes are controversial, a study on governance of GO and NGO health service delivery would be very useful to contribute to a model of quality health service delivery in Bangladesh. The approach of public-private health care delivery is a significant understanding for this thesis which is focused upon in the following section.

b. Service delivery: public-private health service organisations

Andaleeb (2000, p. 25) compares the quality of services provided by public and private hospitals in Bangladesh by exploring the significant factors that contribute differently to health service organisations. In this study, the staff of the private hospitals is perceived as being more responsive (that is, willing to be helpful and provide prompt service) than public hospital staff. Similarly, the private hospitals obtained a significantly higher rating than public hospitals in terms of communications and discipline. Moreover, the private providers are more responsive, more communicative and more disciplined so as to earn and maintain their customers' confidence. The mechanisms that enhance the clients' confidence can improve public provider quality.

Andaleeb et al.'s (2007a) study examines the patients' perception of doctor's services of public, private and foreign hospital using a ten-point scale. The findings of this study about perception of public and private hospital are different from Andaleeb's (2000) earlier study. Andaleeb et al.'s (2007a) study shows that the rating scores of assurance (such as knowledge and behaviour of health professionals) and baksheesh (extra compensation) are statistically similar for private and public hospitals as many public hospital doctors are affiliated with private hospitals and private hospitals provide poor health care delivery.

Alternatively, patients' perception of foreign doctors is significantly higher than that of local doctors as admitted patients expressed positive feelings regarding foreign hospitals which reflect on doctors (Andalleb et al. 2007a, p. 262). Management of foreign hospitals should have participation and a delivery of service that is highly transparent which may lead to satisfactory health care delivery.

Afemikhe (2011, p. 141) examined health care provision and patients' satisfaction of public and private health care providers in Benin City, Nigeria. One of the findings of Afemikhe's (2011) study showed that the quality of health care in private hospitals is adequate compared to government hospitals (based on the average score of privacy, cleanness of work environment and waiting time). Besides this, the motivation of health professionals is another factor of quality of health care in private hospitals. Moreover, the factors that influence health care quality can be adequate supervision, monitoring and coordination which are addressed in the thesis for to understand governance. However, the size of public hospitals is larger and the scope of service delivery is wider than they are in private hospitals. In addition, public hospitals are service-oriented while private hospitals are profit-oriented (Afemikhe 2011, pp. 152-153).

As the above evidence suggests, NGOs and private health care management are more participative, responsive and transparent than government health care and consequently provide quality of health service delivery. Therefore, examples and evidence from private and NGO health care delivery could be useful in enhancing governance and quality of health service delivery in Bangladesh. This thesis endeavours to examine governance; therefore, a discussion on accountability, participation and corruption is inevitable and is the focus of the next section.

2.5 Studies on accountability, participation and corruption of health care in developing countries

2.5.1 Assessing accountability in health care

Nurunnabi and Islam (2012) examined accountability dimensions in privatised healthcare in Bangladesh using quantitative methods. Their study revealed that inadequate health professionals' accountability is one of the causes of poor quality of health care. With regard to administration and management dimensions of accountability, thirty per cent of respondents (total respondents were 533) expressed that health care administrators and managers are not adequately accountable to service receivers. As well as legal enforcement and ethical issues, the similar number of respondents argued that nepotism of administrators and managers contributed to long waiting times to secure an appointment. Their study also revealed that patients are well aware of Bangladeshi laws and were able to take legal action for corruption but no evidence was found in the study that a single action had ever been taken. As a result, corruption occurred in the privatised health sector which leads to poor health service quality.

With regard to the government's accountability dimension of their study showed, 51.8 per cent felt the government was not playing a major role in overseeing privatised hospital activities, 34.5 per cent felt that the government has been very lenient in imposing penalties for medical malpractices and the rest of respondents expressed the opinion that adequate patients' bill of rights have not been implemented. Besides this, the reasons for poor accountability were unlawful profit-making by the hospital administrators and managers due to lack of public participation. Additionally, poor implementation of existing regulations and guidelines contributed to poor accountability.

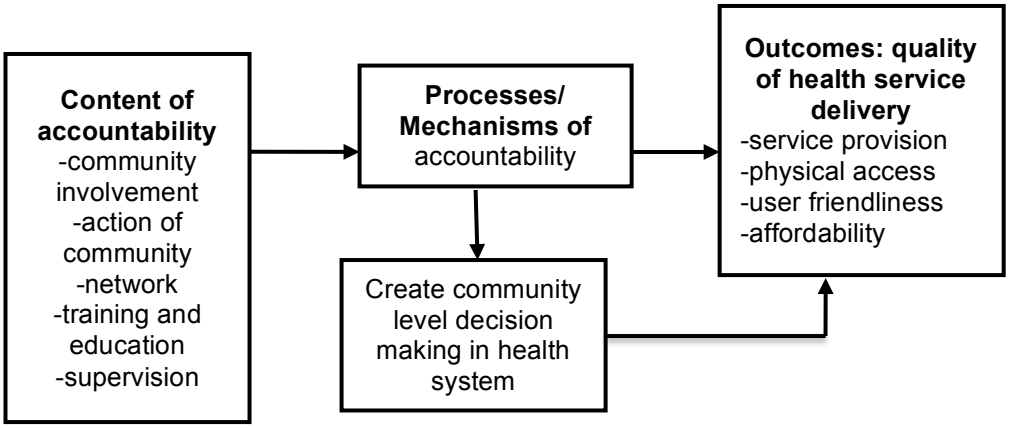
To sum up, Nurunnabi and Islam (2012) showed a number of quantitative factors that contributed to poor accountability and corruption of privatised hospitals based on patients' views. However, through examining the views and experiences of health care professionals and receivers including community leaders, health service accountability and quality of public providers could be significant for this study.

Community accountability is one of the effective forms of improving quality of health service delivery. Molyneux et al. (2012, pp. 1-14) presented a conceptual framework on four significant areas for understanding community accountability in developing

countries. One of these areas is content of accountability which involves various techniques such as community involvement, action of community organisations, community network, promotion of technical knowledge, and training and supervision. The second area is that of contextual issues which refers to the health system at national, international and community levels. These contextual issues can influence the decision-making space to respond to community demands (Molyneux 2012, p. 12). The third area is that of the processes and mechanisms which enable the achievement of health outcomes. Finally, outcomes are the quality of health services which result from processes gained through the health system for example, service provision, physical access, user-friendliness and affordability (see Figure 2.3) (Molyneux 2012, p. 13).

Figure 2.3

Framework of community accountability for quality of health services



Source: adapted from Molyneux (2012, pp. 12-13).

Molyneux et al.'s (2012) model of community accountability and quality of health service delivery was developed through the experience of developing countries. This could be useful for understanding health care governance in Bangladesh.

Brinkerhoff (2004) examines the financial, performance and political accountability to understand quality of health service delivery. Brinkerhoff's (2004) study claims that financial accountability controls mismanagement of public resources, performance accountability supports and promotes improved service delivery and management in organisation through feedback and learning. This is in contrast to political accountability which provides assurance that resources are used and authority is

exercised appropriately, legally and with professional standards. However, accountability can contribute to transparent health care.

Brinkerhoff's (2004) study also found three major challenges that affect accountability in the health sector. The first challenge was inadequate information, poor expertise and inaccessibility. For instance, healthcare providers have excessive control over information, thus thwarting the efforts at central oversight. Due to lack of expertise and experience, service users may be ignorant of treatment and medicines that could harm them, and thus need some form of protection. Moreover, the gatekeeper has the power to determine who can access care, despite official procedures, which might be put in place to protect patients. Secondly, inadequate participation of multiple actors and their interest in health service provision limits the effectiveness of accountability. Thirdly, the gaps of institutional capacity constrain or undermine efforts to increase accountability (Brinkerhoff 2004, pp. 374-375). Politics and local influence can limit health professionals' accountability and an examination of these factors with reference to health service delivery will be useful in the thesis.

Accountability mechanisms promote quality of health care through reducing corruption and the irregularities of health service organisations. George's (2003) study focuses on accountability mechanisms in health care and how they mediate between service providers, communities and different kinds of health personnel at the primary health care level. George's (2003) study showed that the mechanisms of accountability that promote implementation of health policies and programs are consumer charters, hospital boards, village health committees and publicity campaigns. Representation of women is one of the ways to enhance accountability in delivering reproductive health care during policy formulation and implementation. The presence of women in consultation and decision-making concerning reproductive health care enhances its quality and accountability (George 2003, p. 163). For instance, a pilot project undertaken by the Academy of Nursing Studies in India aimed at making the health system more accountable by improving interactions between providers and lower caste women. This evidence from India suggests that improved interaction between the providers and recipients may enhance accountability, which could be suitable for promoting governance in Bangladesh.

George's study (2003) also showed that China and Malaysia promote accountability in delivering maternal health care through evaluating the annual progress reports and the reviews of committee reports. Another significant factor is access to information. George's (2003) study also claimed that people cannot demand adequate services and service providers' accountability without sufficient information regarding their entitlements and the services of the organisation. As a result of this, bureaucracy becomes the main barrier to access to information, which limits improving accountability and quality of health care. Nevertheless, inadequate information technology can affect accountability in health care. China and Malaysia's experience can be useful in enhancing accountability and quality of health care in Bangladesh.

In fact, various studies have been conducted on accountability and its impact on quality of service delivery in developing countries. These studies have highlighted community participation in enhancing accountability, typology of accountability for understanding accountability mechanisms, and various factors that affect accountability at health service organisations. Additionally, only one significant study(Nurunnabi & Islam (2012) has investigated accountability of private health care organisations in Bangladesh, however, none of the studies has addressed accountability of public health service organisations in Bangladesh. Therefore, examining various actors' responsibility and the factors that influence quality of health service delivery could be valuable in understanding the promoting of health service accountability. Participation is another mechanism to enhance governance and health care quality, and is therefore relevant literature in participation reviews in the next section.

2.5.2 Public participation

As stated in Section 2.4.3, participation ensures community voice and enhances empowerment of the community, which lead to decision-making for socio-economic development. Mahmud (2004, p. 1) argued that community participation facilitates the democratic process, reduces the gap between state and citizen, and complements state responsibility through creating public pressure and generating debate for promoting citizens' rights to health services. Mahmud's (2004) study demonstrated that decentralisation and democratic decision-making contribute positively to community participation to enhance quality of health care. Thus, this participation can promote health service governance.

Mahmud's (2004, p. 3) study also claimed that decentralisation is commonly seen as a way of empowerment of communities which can be improved through local level planning, resource mobilisation, administrative and judicial powers. Similarly, she showed that the decision-making of educated women and women earning incomes are more likely to participate in household resource allocation and other decisions, and also to enjoy better health outcomes and reduced gender-based bias in health outcomes for themselves and their children (Mahmud 2004, p. 1). The decision-making of educated women may contribute to good governance, which also leads to quality of health care delivery.

Mahmud's (2004) study found that there were two draw back factors of community participation: inadequate decentralisation and lack of adequate system. Excessive centralisation of power and politics are the main barriers to adequate decentralisation. With regard to inadequate systems, she pointed out the lack of conceptual clarity about the community, who represents that community, the process of community participation, content of community engagement, and the weakness of mechanisms of community involvement (Mahmud 2004, pp. 1-2). Additionally, Mahmud (2004) identified a number of factors such as excessive user fees, poor transport, negative and disrespectful attitudes of health workers, and poor explanations of information for understanding the challenges of community participation. Mahmud's (2004) study has mentioned various factors that affect public participation, however, to what extent these factors contribute to poor governance may be significant in understanding the quality of health service delivery. Besides, politics, bureaucratic mismanagement and poor socio-economic situation of community can have an influence on good governance and health service delivery.

Schurmann and Mahmud's (2009, pp. 540-542) study revealed a number of factors used to examine community participation. Among the factors was poverty which affects community participation. One of the reasons for this is that poorer people often have to work hard over long hours and may have little time to participate in activities that do not contribute to their livelihood. Secondly, poorer people have limited access to formal spaces where their voices can be heard by policy makers and do not have institutional literacy to navigate such spaces. Thirdly, poorer people have little responsibility for or capability of creating a better society. The high level of

poverty and the concomitant low levels of education[21] may limit capacity and confidence that affect community participation, which can be a cause of poor quality governance.

Schurmann and Mahmud's (2009) study also showed participation of civil society organisations (CSO)/community-based organisation (CBO)[22] in understanding the significance of participation in promoting health service delivery in Bangladesh. Their study evaluated the role of community organisations in understanding participation through examining responsibility, capacity, and resources of the three CBOs. From the experience of three case studies, their research argued that CSO/CBOs have some challenges including weak organisational capacity, domination of power politics, poor leadership, unclear official status, intermittent funding and lack of community awareness. All of these negative impacts undermine participatory civil society-based efforts in health, which may also contribute, to poor governance.

Molyneux et al.'s (2007, pp. 381-392) study showed the positive impact of participation of community-based organisations in health service delivery in Kilifi District, Kenya. Their study found that community-based organisations enabled disadvantaged groups to gain access to the financial, human, physical, and social resources that promote household ability to pay health care. Their study also found that CBOs enhanced the ability of households so that they were able to get good health care. As well as this, the ability of the household can play an important role in enhancing good governance, which may contribute to quality of health service delivery. Poor accountability and limited participation are some of the causes of inadequate health care. However, corruption is another source of poor quality of health care, which is focused in the next section.

2.5.3 Cause and effect of corruption in health sector

Afsana (2004, pp. 174-175) conducted an ethnographic study and assessed the cause of an additional charge to gain admission to hospital. Afsana's (2004) study

[21] Education Watch (2002) found that 41% of people aged over 11 years was literate. In addition, 37% of people in Bangladesh remain illiterate or semi-literate even after completing five years of primary education. Studies show that illiteracy clearly indicates a lack of capacity on the part of the populace to participate in ventures of civil society (Schurmann & Mahmud 2009, p. 541)

[22] This study has examined the three case studies of Nijera Kori (Do yourself), Village Community Group (VCG) and Bangladesh Health Equity Watch as community/civil society organisations to understand their role in the enhancement of participation to health care.

showed that medicine and laboratory tests were not available to public hospitals due to massive corruption and illegal private practice; consequently, health care users spent extra money in order to meet treatment related expenses. Afsana's (2004) study also indicated that under-resourced hospitals, inadequate budget and poorly paid staff from doctors to ward boys, created space for corrupt practices such as unofficial fees and theft of hospital supplies in Bangladesh (Afsana 2004, p. 178). Poor governance particularly the lack of accountability can contribute to corruption, which may lead to poor health care quality.

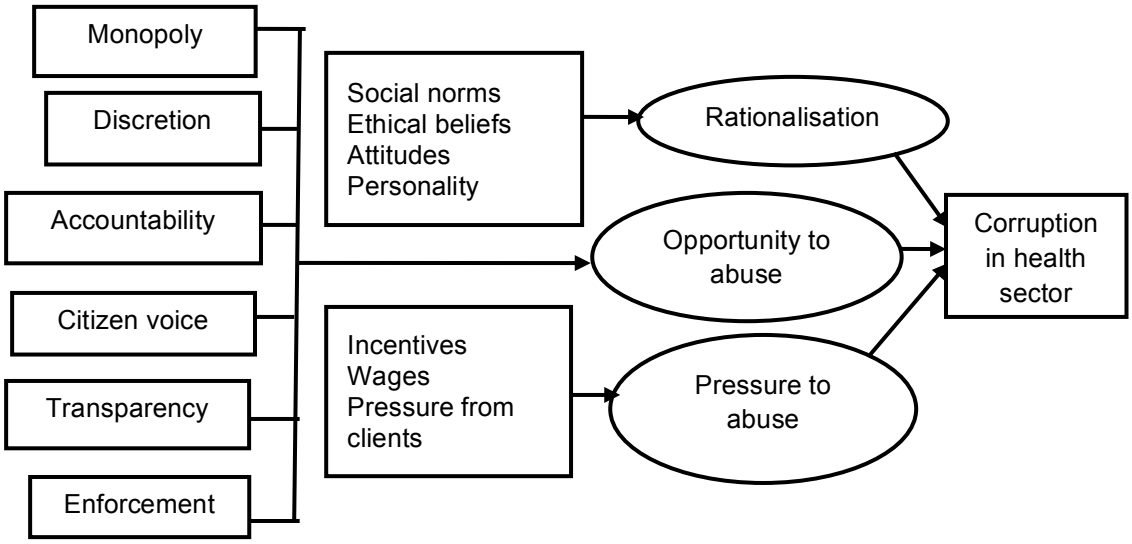
Corruption means abuse of power for private gain, and based on this idea, a conceptual framework is presented by Vian (2008) to understand how the ways of abusing power create corruption in the health sector in Bolivia (see Figure 2.5).This framework demonstrates that corruption is driven by three main forces. One of the forces is lack of incentive and client pressure, which influence government officials to be pressured to become involved in corrupt health activities. The second force is social norms, ethical beliefs, attitudes and personalities, which are created to rationalise their behaviour in order to reduce corruption. The third force is inadequate social and administrative factors, which provide the opportunity to abuse power for corrupt purposes.

Vian's (2008) study showed that socio-economic and administrative factors affect corruption in the health sector. Vian's (2008) study also showed that monopoly creates opportunity by limiting the ability of citizens to choose other providers which leads to corruption. In addition, high amounts of discretion without adequate controls can create opportunities for corruption as shown in Figure 2.4.

Moreover, accountability is government's obligation to demonstrate effectiveness in carrying out goals and producing the types of services that the public wants and needs. However, lack of accountability leads to corruption. Beside this, citizens' voices enhance active participation by stakeholders in the planning and provision of services which promote accountability. Similarly, transparency disclosing information on how decisions are made, as well as measures of performance that improve public deliberation, reinforce accountability and inform citizens' voices. In addition, transparency makes information available to the public which leads to reduction of corruption. The goal of enforcement is to abolish bad agents in order to reduce corruption through strengthening mechanisms for investigation and auditing (Vian 2008, pp. 86-87).

Figure 2.4

Framework of corruption in the health sector



Source: Vian (2008, p. 86)

However, lack of political commitment and inadequate public participation can be the cause of corruption that may limit the quality of governance and health service delivery. The above evidence also showed how the factors create corruption and reduce health care quality in Bolivia, and this understanding can be a lesson learnt for the health sector in Bangladesh in order to promote good governance.

Bhuiyan's study (2011) examined the role of e-governance in the reduction of corruption in developing countries including Bangladesh. He showed that e-governance improves transparency, which leads to corruption control and poverty reduction and, thus, offers opportunities to the effective and efficient delivery of services, which has been presented in Figure 2.5 based on the three case studies.

One of the case studies concerns the benefit of e-governance of the metropolitan government of Seoul and how e-governance contributes to reduce corruption. The Seoul case study showed that urban-based local government introduced OPEN, a web-based Internet service concerning housing and construction, sanitation and urban planning. This service entitled citizens to check the status of their application on the Internet in real time at each step of the administrative procedures. Bhuiyan's (2011) study found that 84% of citizens relied on OPEN and this web-based service led to a greater transparency, which made significant progress for the livelihoods of local citizens. In addition, his study indicated that the introduction of web-based

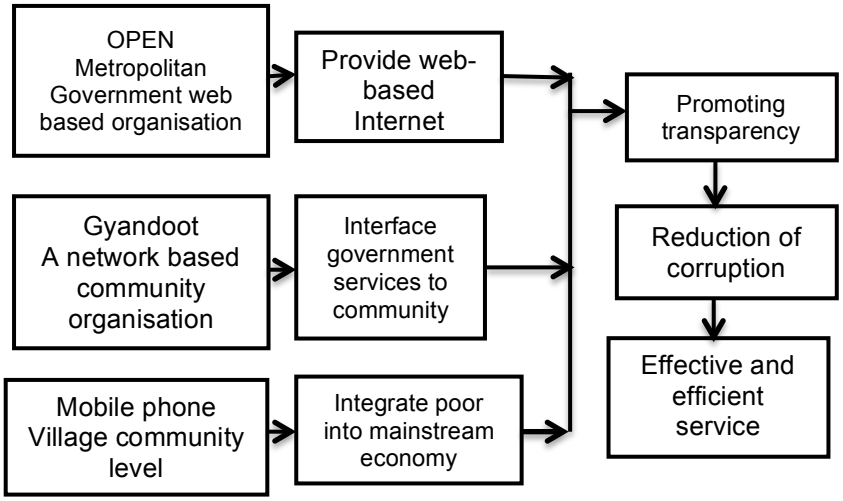
service delivery contributed to reduce the intensity of corruption in Seoul's metropolitan government (Bhuiyan 2011, pp. 59-60). Adequate accessibility of the Internet can make information available to people generally which may ensure transparency in health service organisations and, subsequently, service providers are able to furnish adequate health care.

Bhuiyan's study (2011) also examined the activity of community based e-commerce and e-governance introduced by the Gyandoot (a community based organisation) in the Dhar district, India. This community organisation acts as an interface between the government and the rural citizens through providing useful information and offering a variety of local services at a very low cost (that is, less than one US dollar). Bhuiyan's(2011) study showed that service delivery mechanisms ensure individual public officials are transparent about their actions during their assigned duties in order to reduce corruption. Bhuiyan's (2011) study found that thirty-nine households registered a complaint to the local administration through the Gyandoot community network regarding the maintenance of their drinking water hand pump, and they subsequently received efficient services without bureaucratic complication and corruption. Alternatively, community/civil society organisations can improve governance through raising their voices against corruption in health service delivery which will be a crucial understanding for this thesis.

The third case of Builyan's (2011, p. 60) study examined the effect of mobile phone technology on poverty reduction in Bangladesh. His study showed that information and communications technology (ICT) integrates the poor into the mainstream economy by expanding their market, eliminating the middlemen in their business, creating international job opportunities, bringing information to most remote villages, and empowering the poor through providing better access to information and improving the democratic process. Bhuiyan's (2011) study found that village pay phones enhance three fold the average income which allows villagers to send their children to school and enhance their status in the community. Besides this, mobile phone technology can enhance women's empowerment (as can any other revenue generating initiative), possibly leading to good governance in health service organisations.

Figure 2.5

Impact of e-governance on reduction of corruption in developing countries



Source: adapted from Bhuiyan (2011)

In fact, the three case studies have assessed the role of e-governance differently to reduce corruption and to enhance service delivery in developing countries, which could be significant for this thesis to understand the impact of ICT on health service delivery in Bangladesh.

Corruption can be a cause of poor management, a weak political system, and a lack of participation. Huss et al.'s (2011) study showed that poor governance contributes to corruption in the health sectors. In this regard, their study identified that the several factors that lead to corruption include weak institutional capacity, poor political management, and ineffective use of the justice system, limited community participation, and the bad influence of the private health sector.

Huss et al.'s (2011) study showed that politicians and ministers saw election campaigns as financial investments which had to be recuperated once elected. Health workforce management was targeted for this purpose so that employment, transfer, promotion and development decisions were likened to informal payments. Their study revealed that these costs were passed on from service providers to service users. Huss et al.'s (2011) study also claimed that corruption works as a circling process through involving top level politicians, and health professionals where the service users are regarded as victims because they have no alternative way for avoiding politicians which is result of poor political system (Huss et al. 2011,

p. 479). In addition, a weak institutional capacity is another cause of corruption to the health sector in India. For instance, their study argued that the absence of the Lok Pal institution[23] at the central level, the limited authority of KLA[24] to investigate senior politicians and administrators, the lack of clarity of existing acts of KLA all contribute to corruption. In addition, the KLA was poorly equipped due to inadequate resources and staff shortages.

Huss et al.'s (2011, p. 480) study also argued that poorer public voices were unable to influence political decision makers due to lack of education among the citizens which, in turn, leads to corruption. In fact, the above-identified reasons should be relevant to understand poor governance and corruption in health service delivery in Bangladesh. Nevertheless, poor socio-economic conditions of the community can limit the public voice which may cause corruption in health care delivery. Besides this, various socio-economic and geographical factors have directly influenced health service delivery. This is the subject of the following section.

2.6 Studies on factors influencing health care delivery

This section reviews how factors contribute to quality health service delivery. Therefore, the literature on factors that affect health care delivery is divided into two parts. The first part examines socio-economic factors to understand health-seeking behaviour. The second part assesses the impact of geographical factors on quality health care. Based on the literature review, a brief summary on how factors contribute to promoting and restraining governance and quality of health service delivery is presented.

a. Assessing socio-economic factors for health seeking behaviour

Hoque et al.'s (2012) study examines the costs of maternal health-related complications and its socio-economic effects on daily life from the case study in Matlab, Bangladesh. Their study shows that women with maternal complications (both severe and less severe) have considerably higher out of pocket expenditure (USD 257) compared to women who experience a normal delivery (USD 29). Additionally, their study finds that the loss of productivity of women was higher

[23] Lok Pal is a central ombudsman institution, which is responsible for working for public complaints in order to reduce miss-management.
[24] Karnataka Lokayuka (KLA), a public complaints agency in Karnataka State of India. This organisation was created in 1986 but played a role in controlling systematic corruption only after a change of leadership in 2001.

among the women in the severe (USD 297) and less severe (USD 317) complicated group than that of the normal delivery group (USD 54) (Hoque et al. 2012, pp. 208-209). Moreover, Hoque et al.'s (2012) study shows that the source of financing derives from income and savings of the severely complicated group 35%, less severe group 44%, and the normal delivery group 59%; however, the source of finance derives from loans 36%, 29% and 21% of the severe complicated group, the less severe group, and the normal delivery group respectively (Hoque et al. 2012, p. 209). The study argues that the richest quintile is highly reliant on income and saving than the poorest quintile but poorest households suffer the highest financial burden of cost including loss of resources.

Karim et al. (2006) examined the health inequity between different poverty groups through conducting a study on BRAC reproductive health program. Their study surveyed the inequity of the health care of the extreme poor, moderate poor and the non-poor households which have been classified based on three socio-economic variables, for example, landholdings, the education level of the head of the household, and food security status. Karim et al. (2006) study revealed that 34.6% of moderate poor mothers received treatment from qualified or trained physicians while pregnant. This number was lower than that of the extreme poor (50%) and the non-poor (72%). Their study also revealed that the proportion of those receiving vaccines (children 12-23 months) was lower for the extreme poor (89.7%), than the moderate poor (94.3%), and the non-poor (91.8%).Their study also showed that a lower proportion (56%) of married non-poor women (15-49 years), used family planning methods than the moderate poor (57%), or the extreme poor (59%) (Karim et al. 2006, pp. 197-199).

However, the infant mortality rate of per 1000 live births was higher among the moderate poor (86), than the extreme poor (65), and the non-poor (38). While the crude birth rate was significantly higher among the extreme poor followed by the moderate poor, it was the lowest among the non-poor (Karim et al. 2006, pp. 199-200).

Karim et al. (2006) study concludes that the use of services/facilities that require payment by the user was low among both groups of the poor, implying that they were unable to afford user fees. But the moderately poor appeared to be considerably better in many indicators concerning women and children's health care. Based on these findings, Karim et al. (2006) study clearly demonstrates that

the non-poor have received relatively higher maternal and children's health care compared to other poor groups.

Khan and Kraemer's (2008) study examined the impact of socio-economic factors on understanding the quality of women's health care delivery in slum and non-slum areas of Bangladesh. Their study argued that poor residential status, illiteracy, poverty, and the inaccessibility of mass media are higher (in average %) among women living in slums than those in the non-slum areas. Put simply, slum dwelling women have poorer socio-economic conditions than those living in non-slum areas.

Khan and Kraemer's (2008) study showed that understanding of Acquired Immune Deficiency Syndrome (AIDS) is significantly lower among women in slums (69%) than it is among those women living in non-slum areas (82%). The non-slum residents' women have higher antenatal visits (30.7%), whereas women of slum areas have lower antenatal visits (17.7%). However, condom use in the areas of slums is higher (35.6%) than in the non-slum areas which are lower (25.8%). Their study also found that safe delivery practices assisted by skilled health care workers were significantly higher among women living in non-slums (40.1%) than those in slums (17.7%). As the slum areas have poorer socio-economic conditions, consequently, women of slum areas received poor quality health care (Khan & Kraemer 2008). As their study shows, socio-economic conditions have an impact on health care quality, but women's income and employment facilities can impact on the quality of health care.

Ahmed et al.'s (2010) study assesses women's economic, educational and empowerment status for understanding maternal health service utilisation in developing countries. Their study shows that poor women use less modern contraception, pay fewer visits to antenatal care, and use skilled birth attendance less often than do richer women. Ahmed et al.'s (2010, p. 3) study also demonstrates that educated women have utilised maternal health care more often than less or uneducated women. Similarly, women with the highest empowerment scores used modern contraception more including other maternal health services than did women with a lower empowerment score. Their study clearly indicates that women's household wealth, educational attainment and decision-making power are associated with the use of maternal health services.

In short, Ahmed et al.'s (2010) study confirms that income, employment, education and women's empowerment have significant effects upon quality of health care;

however, poverty can adversely affect good governance and health service delivery. Besides, geographical factors can also impact governance and quality health delivery which are the subject of the next section.

b. Assessing geographical factors of health service delivery

Faguet and Ali (2009) examined the health-seeking behaviour of two case studies, one from wealthier socio-economic conditions (Saturia sub-district), and the other from poorer socio-economic conditions (Rajnagar sub-district) in Bangladesh. Their study showed that service provisions were significantly improved in the Saturia sub-district in terms of proper maintenance and operation of the health facilities, significant field visits, full and regular staffing, and effective community participation. In addition, their study reported that patients were more satisfied with Saturia regarding positive attitudes towards health professionals, as well as adequate physical infrastructure, utilities, cleanliness and hygiene, privacy of treatment, quality of food, minimum waiting times, availability of doctors, availability of drugs and of medical supplies, and were more satisfied with the quality of treatment received. In contrast, the health service organisations were poorly operated in the Rajnagar sub-district, and consequently, this organisation contributes poor health outcomes (Faguet & Ali 2009, p. 213).

Notably, the selected two health service organisations had similar administrative patterns and resources, yet the ways of maintaining and exploiting them were quite different which led to a different quality of services. Faguet and Ali (2009) showed that Saturia had extensive monitoring by higher authorities, with frequent visits to the area due to geographic accessibility, whereas their counterpart in Rajnagar reported no such monitoring. Their study also claimed that the union council chair took steps to facilitate the proper implementation of Saturia's health program, and union officials regularly monitored the quality of service provided in towns and villages. This kind of monitoring activity was totally absent in the Rajnagar sub-district (Faguet & Ali 2009, p. 214). However, the amount of health care budget and its efficient use could have an impact on quality of health service delivery. Additionally, these factors may contribute differently to rural and urban health service organisations, thus, examining these factors to understand governance could be useful in this thesis.

Rahman and Capitman's (2012) study evaluates the factors that affect profit efficiency of private hospitals in Bangladesh. Their study argues that the location of

hospitals is one of the crucial causes of private hospitals' profit efficiency. Rahman and Capitman (2012) demonstrate that hospitals located in major urban settings generate more profit compared to hospitals that are situated in small towns in semi-rural areas. One of the causes of greater profits of urban-based private hospitals is the available access of resources (Rahman & Capitman 2012, pp. 89-90). Furthermore, their study shows that hospitals located in the urban metropolitan areas would be significantly more profit efficient due to their ability to charge their wealthier urban clientele higher fees compared to hospitals located in small towns where the population they serve is relatively poor. Also, urban hospitals could be offering complicated services where the level of profit is likely to be higher (Rahman & Capitman 2012, p. 93). Besides this argument, governance in private hospitals can be improved which may lead to profit efficiency and good quality of health care delivery.

To summarise, the above studies show that improved socio-economic conditions contribute to a better of health service delivery, but such socio-economic advancement can contribute to good governance. Alternatively, poor socio-economic situations of service receivers limit their voices and participation which may lead to poor governance. Besides this, women's empowerment enhances decision-making which may contribute to improved governance in health service delivery. Adequate supervision and monitoring among others could also influence improved health care, as well as enhancing health care governance. Moreover, improved geographical locations particularly urban areas and the adequate condition of communication enhance quality of health care and governance of health service organisations. Addressing these factors to gain an understanding of governance can be useful knowledge for the health sectors in Bangladesh.

2.7 Conclusion: Developing a framework for this study

This chapter reviewed the literature on conceptualisation of governance and service delivery as well as empirical studies of health service delivery of Bangladesh with reference to developing countries. Theoretical issues enable an understanding of the subject matter being studied for this thesis. Also, the empirical studies of available literature offer detailed ideas concerning what has previously been studied on health service delivery particularly in Bangladesh to understand the impact of governance on quality of health service delivery.

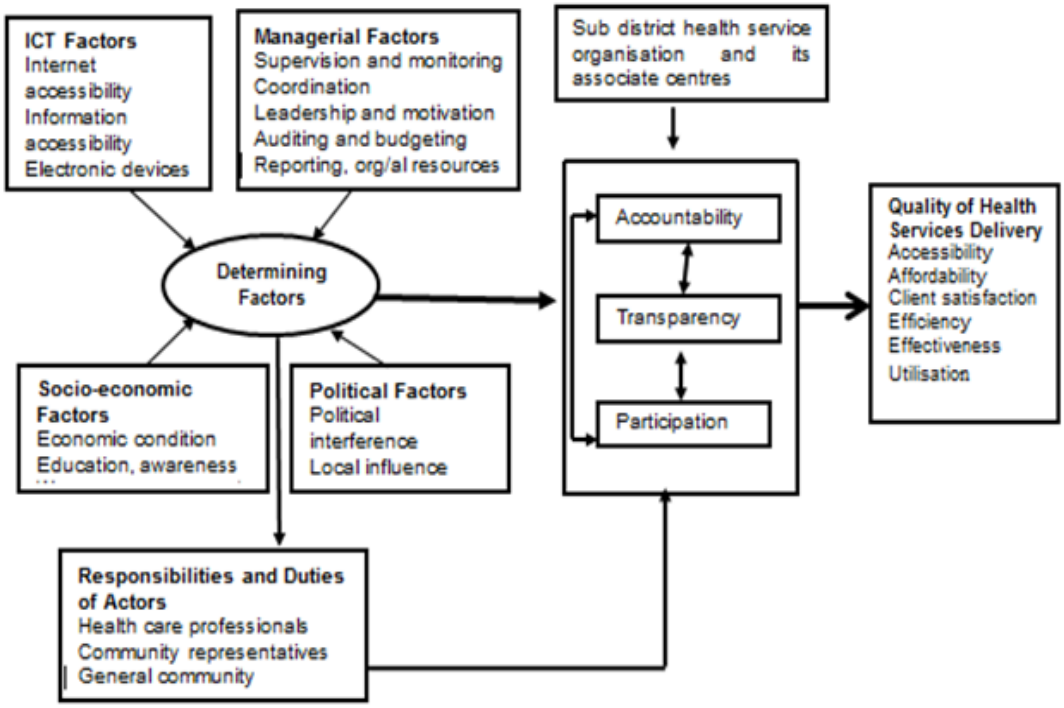
Firstly, the available literature reviews the challenges of formulation and implementation of health policy and how various health actors and the influencing factors contribute to health care delivery. A limited number of studies have been found on poor accountability and corruption which have mainly focused on private health facilities and health service organisations of developing countries. No study has been found on the topic governance with regard to public health in Bangladesh. The literature also reviewed the impact of inadequate human resources, challenges of partnership, and constraints of participation on health service delivery. In addition, research dealing with the impact of socio-economic conditions and geographical factors on quality of health care are reviewed. An analysis of some of the literature on reform of health systems in developing countries has helped to illuminate governance-related factors. From the literature review, a number of issues in health system have been addressed; however, none of the literature has examined the impact of governance on health service delivery in Bangladesh.

This thesis attempts to analyse the effect of governance on quality of health service delivery in Bangladesh. As mentioned earlier (Section 2.4) there are three critical issues of governance: accountability, transparency and participation which are analysed in order to gain an understanding of health care quality. Of the three issues, accountability and transparency assist to improve governance in organisations and, similarly, participation ensures community enhancement and decision-making to promote governance and quality of health care. So, these three critical issues provide the forum to understand governance in this thesis.

A framework is presented in Figure 2.7, depicting how governance elements are linked to quality of health service delivery. It is proposed as a model to address the impact of governance on quality of health service delivery in Bangladesh.

Figure 2.7

Framework of the study to evaluate the impact of governance on health service delivery in Bangladesh



Source: adapted from Blair (2000), Lebovic(2006), Bovens(2007),World Bank(2005), Kemoni et al.(2008), Ahmed et al.(2010),Mahmud(2004), Nurunnabi &Islam(2012),Andaleeb(2000,2007a), Osman(2004),Bhuiyan(2011).

This framework demonstrates the responsibilities and duties of actors and the impact of various factors to promote or limit governance to understand the quality of health care. Using this framework, health care quality will be examined together with the critical elements of governance-accountability, transparency and participation-through an assessment of the responsibilities of actors and factors of sub-district health service organisations.

Accountability ensures actor's liabilities, obligations, and responsibilities through implementing proper organisational power, equal public rights, and transparency in order to provide effective, efficient and affordable health services. An accountability mechanism can also reduce corruption, ensuring that resources are used properly to improve service delivery in the organisation (World Bank 2008, p. 76). The actors of service providers such as health professionals are directly accountable to

organisations for their duty and responsibility to ensure quality of health care, however, political and elected leaders are responsible for ensuring accountability of health care providers to enhance the quality of care (Kakumba 2010, pp. 181-182). The general community promotes accountability through participation and decision-making to safeguard the accessibility and affordability of health care. Moreover, factors such as lack of coordination, poor monitoring and inadequate supervision, power politics, and inadequate resources affect accountability mechanisms and their ability to enhance efficiency and client satisfaction of health care delivery.

Transparency assists the various actors to perform their roles more effectively by participating in health service activities and publishing information about their outcomes. The role of actors particularly health professionals is important in ensuring transparency in the activities of health organisations. They are responsible for disclosing information about the delivery of services and people can easily obtain the information they require from them. In addition, people can better claim their rights to access services if the system ensures transparency through the involvement of the public. On the other hand, lack of transparency can limit awareness, understanding, and access to information which leads to dissatisfaction with health care. This can be caused by the maintenance of office secrecy, a lack of publicity, the hiding of information, and/or the unwillingness to disclose it. A number of issues such as the lack of education and awareness, poor socio-economic condition, the misuse of politics, and the lack of technological facilities can also cause an absence of transparency which leads to poor accessibility of health care.

Participation ensures accountability and responsiveness in health activities which, in turn, improves service delivery to health organisations (Speer 2012, p. 1; Sohail et al. 2004, pp. 62-70). For this, the role of elected representatives and communities are significant to improve participation in health service organisations. A number of factors, for example, poor socio-economic conditions, lack of education and inadequate women's empowerment contribute to limited participation in health care. Additionally, Sarker (2003, pp. 523-30) argues that power politics, corruption and bureaucratic dominance at the local level affect participation levels in the process of local service delivery. He argues that bureaucrats and politicians are quite reluctant to delegate power to local authorities; rather they are more interested in maintaining the domination of the bureaucratic structure over the local community which limits public participation and quality of health service delivery.

Chapter 3

Research Methodology

3.1 Introduction

This thesis explores the effects of governance in health service organisations on quality of health service delivery through analysing field survey data. The data relate to the roles and responsibilities of health professionals, managers of health service organisations, and the participation of local communities including community-based organisations in health service activities. In particular, data are collected on how local politics, corruption and local influences in society contribute to governance and then to quality of health service delivery. Besides this, data on socio-economic conditions, education, employment and women's empowerment of the selected research locations have been collected from the service receivers as well as the Bangladesh Bureau of Statistics (2012ab) and used to assess the impact of governance in health service organisations on quality of health service delivery. The above actors and factors have been addressed and analysed throughout this thesis in order to understand the influence of governance factors such as accountability, transparency and participation on quality of health care. This has been done by comparing rural and urban health service organisations for which the above-mentioned data have been collected through in-depth interviews, focus group discussions, and record searches.

This chapter is organised into three sections. The first section describes the research methodology and the justification of case studies including a comparison of the two cases used in the thesis. This section also contains the issues of addressing the research questions. The second section outlines the methodology used in this study. In addition, this section also describes the selection of the research location, respondents and sampling processes that are used for data collection. The third section presents the techniques of data collection, the ethical issues of the project, methods of data analysis and the challenges of data collection.

3.2 Methodology: qualitative case study

An in-depth understanding of complex social problems relating to the impact of governance on service delivery can best be gained through the qualitative research methods such as open-ended interviews, focus group discussions, analysis of documentary evidence, and the interpretation of their findings (Janesick 2011, p. 12; Yin 1994, p. 93). Knowledge about the impact of participation, accountability, and transparency, particularly in health service organisations regarding the quality of services they provide, is a topical issue that will assist in promoting the quality of health care for a country like Bangladesh. A qualitative interpretive approach provides an appropriate investigative tool of the present thesis as it would enable a deeper understanding of how actors and factors affect governance in promoting quality of service delivery. In addition, a qualitative approach is suitable for exploring how the management of a health service organisation affects governance, to what extent governance works in the NGOs health programs, and how the impact of governance contributes to enhancing the role of the community in order to improve the quality of health service delivery.

The case study design is a type of qualitative research which is used in this thesis to understand how good governance works in the health service organisations. Baum (1995, p. 464) argues that examining the effects of governance through various socio-economic and political factors particularly in public health care is suitable for a qualitative case study. Baum (1995, p. 464) also shows that the impact of governance in the activities of health professionals including communities and individuals are best suited to a qualitative case study. However, case study designs face problems such as what questions to ask, what data to collect, and how to analyse the results (Yin 1994, p. 20).

The case study method is used to study contemporary social phenomena as it allows an investigation to retain the holistic and meaningful characteristics of real-life events (Janesick 2011, pp. 10-11; Yin 1994, p. 3).Yin (1994) also argues that case studies provide an effective research strategy when the researcher has little control over events and when the ‘how’ and ‘why’ questions are being posted for collection of data in order to understand the subject matter being studied.

The present research, based on case studies of an urban and a rural health service organisation enables a holistic examination of health governance and quality of

health service delivery in detail and in depth. This study is based mainly on the responses of various participants interviewed by the author. It also enables a comprehensive account of data regarding governance in the health service organisations studied in this research within their contexts and helps provide a theoretical analysis and interpretation of collected data in order to make the study significant and meaningful (Yin 1994, pp. 29-32). Understanding governance in health service organisations by examining the roles of actors and factors is the prime concern of this thesis for which relevant data are collected as mentioned above, and analysed. In addition, the case study data help produce a model of quality of health care in Bangladesh using real examples.

3.3 Case studies for the present thesis

For the present research, two case studies were conducted by selecting two-health service organisations-one rural and one urban sub-district respectively. In Bangladesh, there are 418 sub-district level health service organisations, which provide primary health care delivery (Directorate General of Health Services 2011). The present research used only one rural and one urban sub-district health centre as case studies. The details of these health centres are described in Chapter 4.

The respondents (participants) in this research consisted of a selected number of patients (users), and doctors/paramedics of each sub-district health centre. In the areas covered by the two sub-district health centres, 39 individuals (service users) participated in focus group discussions, which consisted of five groups each comprising seven to nine participants. In addition, seven elected officials, eight other local informants, and 37 health care professionals, participated in individual interviews in this research. These participants were selected from an extensive range of people comprising health service users and providers, government and elected officials, and lawmakers at sub-district level to obtain the views of people in all capacities to understand perceptions of how governance affects health service delivery. The sample size of the current study is small in terms of the number of respondents, nevertheless, it is deemed sufficient for eliciting important information about governance and the quality of health service delivery.

Case study research designs may consist of single or multiple cases. As mentioned earlier, the present research selected two sub-district health centres, one rural and one urban. These two health centres provide contrasts with respect to socio-

economic, women's and children's health, and administrative characteristics. The urban sub-district health centre is located in Savar in the Dhaka district[25] and Chhatak in the Sunamganj district.[26] These two particular sub-districts have been selected as they are located in rural (Chhatak) and urban (Savar) areas, as well as the fact that these two areas have different health performance and socio-economic conditions which may assist in comparing and contrasting governance and quality of health service delivery (details in Section 3.5.1). More specifically, the selected health centres have contrasting characteristics in terms of availability of resources, physical infrastructure, type of management in providing services, community participation, and socio-economic conditions including education, employment and political background (details in Section 4.4 in Chapter 4).

3.4 Addressing the research questions

This thesis addresses the five research questions (see Section 1.5 in Chapter 1) concerning the impact of governance on quality of health service delivery in Bangladesh in order to meet research objectives identified in this study (see details in Section 1.7 in Chapter1).

The first research question --'How do responsibilities and duties of various health professionals contribute to improving/limiting governance and quality of health service delivery?'-- is addressed through:

a. Assessing job responsibilities of health professionals of the two selected health service organisations with reference to good governance and quality of health service delivery.
b. Examining the managerial duties of health care providers and how their duties contribute to governance and quality of service delivery.
c. Analysing the impact of politics, corruption, and the local elite influence on governance in health service activities at sub-district health service organisations.

[25]Dhaka district is located in Dhaka division in central Bangladesh. This district covers an area of 1,464 km^2 and shares borders with Gazipur and Tangail to the north, Munshiganj and Rajbari to the south, Narayanganj to the east, and Manikganj to the west Dhaka is the capital of Bangladesh (Bangladesh Bureau of Statistics 2012a).
[26] Sunamganj district (Sylhet Division) with an area of 3,670 km^2 is bounded by Sylhet district to the east, Habiganj district to the south, Natrokona district to the west, and the Assam, part of India to the north (Bangladesh Bureau of Statistics 2012a).

The second research question – 'How does community participation contribute to governance and quality of health care in rural and urban areas?' -- is addressed through:

a. Examining how bureaucratic management affects community participation and to what extent this participation contributes to quality of governance and health care.
b. Comparing various roles of communities with reference to quality of governance and health service delivery between the rural and urban health service organisations and how these communities contribute differently to governance and quality of health care.
c. Assessing how the community-based health programs, for example, community clinic (CC) health services contribute to improving governance and quality of health care.

The third and fourth questions – 'How do various factors affect governance and health care delivery?' and 'To what extent does governance work differently in rural and urban health service organisations?" -- are addressed by:

a. Examining how the socio-economic conditions including the associate factors affect governance and quality of health service delivery.
b. Analyse perceptions of the impact of governance on quality of health service delivery with reference to managerial and technological factors.
c. Examining various government initiatives undertaken to enhance women's empowerment for promoting governance and quality of health care.
d. Comparing and contrasting governance and quality of health service delivery with reference to rural-urban factors.

The fifth and last question – 'How is the governance of NGOs' health service delivery conducted? Is service delivery of NGOs more efficient than that of public providers? "is addressed through:

a. Assessing the management of NGOs' health service delivery in order to understand the governance of those NGOs engaged in health care provision.
b. Evaluating the role of communities including those of elected representatives in promoting/limiting the governance of NGOs engaged in providing health care

c. Comparing the governance and quality of health care between the NGOs health service delivery and the solely government-driven health service facilities.

3.5 Research Methods

3.5.1 Selection of cases / research locations

Bangladesh is divided into seven administrative divisions[27] and its health service organisations are decentralised in accordance with administrative hierarchy, that is, central to local level.[28] This study selected two sub-districts as cases with one sub-district in the Dhaka division and the other in the Sylhet division on the basis of their performance in the delivery of health care for women and children.[29] According to United Nations Children's Fund (2009, pp.82-83) the Infant Mortality Rate (IMR) and Under 5 Mortality Rate (U5MR) in Dhaka and Sunamganj districts are 40, 51 and 68, 94 per 1,000 live births respectively. Besides this, delivery patients who receive health care from the qualified doctors in Dhaka and Sunamganj district are 48.3% and 7.7% respectively (United Nations Children's Fund 2009 pp. 108-9) (see Appendix 6: The location of the two case studies in the map of Bangladesh).

Moreover, Table 3.1 demonstrates that socio-economic conditions, particularly the rate of literacy for both sexes, as well as female literacy and employment improved in Dhaka district in 2012 in comparison to Sunamganj district (details in Sections 4.4.1 and 4.4.2 in Chapter 4).

[27] These divisions are Dhaka, Rajshahi, Chittagong, Barisal, Khulna, Sylhet and Rangpur which are part of decentralisation and these divisions provide administrative facilities including public health for delivering services at the lower level. Each division comprises a number of districts and each district has a district-based public health organisation. Public health care is also decentralised to sub-district (upazila) level to provide health care all over Bangladesh.

[28] As part of the administrative hierarchy, there are 418 Upazila Health Complexes (UHC), 1,275 Union Sub Centres (USC), and 10,323 Community Clinics (CC) throughout Bangladesh for the purpose of providing public health care (Directorate General of Health Services 2011, p. 29).

[29] The Dhaka division is the largest of the seven administrative divisions of Bangladesh. This division consists of 17 districts including that of Dhaka. The Sylhet division has four districts including that of Sunamganj. Data shows that each district has minimum of four and a maximum 13 sub-districts *(*upazila), depending on their size and population (Bangladesh Bureau of Statistics 2012a).

Table 3.1

The socio-economic conditions of Savar and Chhatak sub-districts (in %)

Socio-economic conditions	Savar sub-district	Chhatak sub-district
Literacy (both sexes)	68.0	38.8
Female literacy	63.9	36.3
Female employment	32.72	6.97
Household electricity connection	96.6	49.7

Source: Bangladesh Bureau of Statistics (2012a)

The data presented in the above table indicate that the socio-economic characteristics including education, employment (general and female), and availability of household electricity supply are much improved in the Savar upazila (Dhaka district) compared to those in the Chhatak upazila (Sunamganj district).[30] Consequently, based on the above health service indicators and socio-economic conditions, this thesis has selected the Savar and Chhatak sub-districts to understand the impact of governance on quality of health service delivery. Therefore, necessary secondary documents are collected and used from the two health service organisations.

Why a rural-urban comparison?

The rural-urban comparison attempts to investigate how governance works in the health service organisations of Chhatak and Savar to promote or limit the quality of health care and the roles that actors and factors have played in this regard. This comparison would help in understanding how the differences in governance contribute differently in providing quality of health care in the rural and urban health service organisations. The comparison of these health service organisations also provides an understanding of some of the crucial rural-urban differences in education, employment, economic conditions, and public participation in decision making, women's empowerment, and population that contribute significantly to the

[30] Though the evidence is quantitative, these quantitative figures clearly indicate how much better the health performance is in Dhaka compared to Sunamganj. The better quantitative performance of Dhaka implies improved quality of health care; however no studies have yet been conducted on quality of health care, which assists selection of cases. As a result, the cases have been selected for this thesis based on quantitative indicators of health performance.

differences in the quality of health care. In addition, this comparison enables an examination of how and why these factors contribute differently to health service organisations and how accountability, transparency and participation promote or limit quality of health service delivery.

Besides this, these rural-urban case studies furnish information and knowledge on the differences in the governance of health service delivery by examining the manner of supervision, coordination, allocation of budget and motivation of health professionals in the rural and urban health service organisations chosen for this research.

In order to realise this, data have been collected on management of health service organisations, the duties and responsibilities of health professionals in providing quality of health care, community participation in health service delivery, and socio-economic factors including women's empowerment, all of which contribute to participation and decision making in health service activities to enable an understanding of the impact of governance on health service delivery.

Additionally, data with regard to politics, planning, and population through an examination of how local political parties influence decision making, the process of local planning, and the population density in health service organisations have also been gathered in order to gain knowledge on governance and quality of health care.

3.5.2 Selection of participants

This study has used purposive[31] and snowball[32] sampling techniques which are suited to the collection of necessary data to comprehend the impact of governance on quality of health care delivery. The sample was selected from various levels representing five groups of actors including patients: (a) national level actors such as bureaucrats, academic researchers, governance experts, senior officials of planning commissions, and community leaders of women's organisations; (b) elected representatives such as Members of Parliament (MPs), Upazila (sub-district)

[31] Purposive sampling enables the researcher to focus on what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience to achieve the objectives of the study. This sampling is used to describe phenomena about which only a little is known (Kumar 2014, p. 244). This study used purposive sampling, as necessary data are required from some specific informants of selected research areas to understand governance and the quality of health service delivery.
[32] Snowballing is a method whereby researchers initially contact a few respondents and then ask them whether they know of anybody with the same characteristics that they are looking for in their research (Asaduzzaman 2008, p. 83).

vice-chairmen (women), Union Parishad (Union Council) chairmen and members of selected research locations; (c) Health service professionals and staff of health service organisations, for example, the upazila health complex and one of its sub-centres and community clinics located in a union parishad; (d) other local informants including political party leaders, business leaders, NGO personnel, medical representatives, local community leaders, journalists, and social elites; and (e) service users (patients). Appendices 12(a) to 12(e) provide the details of the participants used in this study, the total number of which is 107.

However, data were not collected from a few respondents. For instance, the researcher was unable to collect data from the MP of Savar as he was abroad during the fieldwork. Instead of the Savar MP, substitute data was collected from the local elected officials as shown in Appendix 12(c). Additionally, the researcher could not collect data from the sub-district executive officer of Chhatak as she declined to provide information concerning accountability, transparency and corruption of health professionals. Nevertheless, sufficient relevant data were collected from another selected local informant, which should meet the research objectives.

a. Selection of national participants

Actors such as national level bureaucrats, academic researchers, national level community leader, and program directors who are administering health service delivery Appendix 12(a) were selected through purposive sampling, as these participants have specialisations in the subject matter being studied in this thesis. The sources of recruitment of these respondents were the directorates of health services and family planning, the health wings of the planning commissions, the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), the Bangladesh Institute of Development Studies, Transparency International Bangladesh, Bangladesh Mohila Parishad (Bangladesh women's association), and the University of Dhaka. The data required for the thesis were collected from the eight respondents for the purposes of meeting the research objectives for this study.

This study collects data from the national informants relating to their ideas, experiences and practices of governance of health service organisations in Bangladesh. For this purpose, national respondents were asked experiences on how governance contributes to the implementation of health policies and programs, efficiency of NGO health service management, availability of human, physical and financial resources, efficiency of budgeting processes, and enhancing community

development to promote quality of health service delivery. Conversely, how governance works adversely to quality health service delivery. Moreover, data regarding the impact of politics, supervision, monitoring and coordination of governance of health service organisations were also collected in order to understand the quality of health service delivery.

b. Selection of health professionals

The second type of actors is health professionals at both the upazila health complex and their sub-centres (Appendix 12 b). Initially, the researcher informed upazila health and family planning officer (UHFPO) about the purpose and objective of the study and then interviewed him. The rest of the respondents of upazila health complex were selected based on the suggestions of the UHFPO. Similarly, the union level respondents were selected through purposive sampling with the consent of the upazila health and family planning officer. However, the researcher strictly follows the selection process so that none of biasness can affect the findings of the study. For example, the researcher chose one out of three from the same level of respondent, not to select the specific respondent recommended by the UHFPO.

The health professionals and the staff directly contribute to health service organisations to provide essential health services: therefore, data relating to the processes of accountability, transparency, and participation, and how they affect service delivery were obtained from different levels of health officials. The health service providers offered data relating to the responsibilities and duties of implementation of health policies and programs and how governance affected them with reference to quality of health care. The health service managers were asked their understandings on how governance contributes to formulation of health policies and programs and to what extent the field level health professionals are able to participate to those health policies and programs.

The health professionals were asked information on how governance works in supervision and coordination of health service activities and what is their effect to quality of health care. They were asked on how the mechanisms of transparency such as public complaints, and service charters work in health service organisations. In addition, health professionals were asked their opinions on community participation and NGOs' accountability in order to understand quality of health care. As well as this, the health professionals were asked perceptions on the effects of

socio-economic conditions including women's empowerment, and health service governance with reference to quality of health care.

c. Selection of elected representatives

The third type of respondents consists of elected representatives (Appendix 12c) who are essential actors in enhancing governance and service delivery in health service organisations. They were selected by using the purposive as well as snowball methods of sampling. The selection of Member of Parliament of the Chhatak constituency was realised using purposive sampling. The researcher interviewed one respondent from each upazila parishad (UZP) and two respondents from each union parishad (UP) level. The UZP elected representatives were selected through purposive sampling whilst the UP level elected representative was selected through snowball sampling. For this reason, the researcher primarily approached the UZP vice-chairmen (women) and informed them of the purpose of the fieldwork and interviewed them. Subsequent respondents were reached through the UP chair and members using snowball sampling.

The elected representatives have practical knowledge, understanding, and experience of the governance of health organisations and how actors and factors are involved in health activities. They are also indirectly involved in enhancing governance, and are responsible for providing better service delivery. Elected representatives were asked about their perceptions of how accountability and transparency are ensured by the health care providers in performing their responsibilities and to what extent various communities participate in health policies including service delivery. The significant data which help to assess good governance are how the elected representatives participate in health service organisations in order to make organisational decisions, and to what extent they are involved in implementing health programs. The elected representatives were asked their experiences about how governance works in the implementation of GO-NGOs' health programs. In addition, they were asked on the effect of governance in politics, corruption, and elite influence from the selected health service organisations with reference to quality of health care. Also, data have been gathered on how socio-economic factors including women's empowerment contribute to governance and what their effects are on the quality of health care from elected representatives.

d. Selection of other local informants

The fourth category of respondents comprises other local informants (Appendix 12 d), who are selected purposively. In this category, political party leaders, business leaders, medical representatives, local community leaders, government executive officers, and NGO officials were selected from specific organisations and locations. The social elites and journalists were chosen through approaching the presidents of the local business associations as they are well informed about these informants.

The business leaders selected the individuals mentioned above since they were well informed of the particular respondents and, as such, facilitated recruitment. Once the respondents were identified, the researcher informed them of the objectives of the research and the purpose of the field study and requested their participation in the interviews. The researcher also provided them with copies of the verbal script, the letter of introduction, and the information sheet, so that they could be well informed of the project and could participate in the interviews to provide adequate data for this thesis (See Appendices 7, 8, 9).

Participants of local informants were significant for this thesis as their understanding enables an assessment of the impact of governance on health service delivery which will meet this research objective. The local informants (see Appendix 12 d) offered data concerning the responsibilities and duties of health professionals and staff and how they contribute to accountability and transparency in delivering health service delivery. The local informants were asked their experiences on how mismanagement, politics, misuse of power, and local conflict impact upon the process of service delivery. In addition, data on how women's empowerment, education, and employment contribute to governance and what their impacts are on quality of health care, were also collected. Besides this, data on NGOs' role in enhancing health care were collected with reference to governance and quality of health care.

e. Selection of service users

As mentioned earlier, focus group discussions were also used to elicit information the responses of governance to health service delivery from health service users in the two locations selected for the study. In all, there were five focus groups as shown in Appendix 12e. Each focus group consisted of seven to nine participants (female health service users), who used maternal and child health services during

the year preceding the survey. Focus groups were conducted in Upazila Health Complex (UHC), and the Union Sub Centre (USC) / Community Clinic (CC) of each selected research location in Bangladesh. In addition, the thesis conducted two focus group discussions with the users of NGO health services in order to collect data on the governance of NGOs' health service delivery. Appendix 12e provides the details of the participants of focus groups from whom information was gained concerning corruption, nepotism, political influence in health service delivery and the problems they faced in accessing services from service providers.

The service users were recruited through the snowball method and the survey information pack was sent to service users, with a request to contact the researcher if they wished to participate in the study. The information pack contains a note stating that the information provided by the participants would be used only for research purposes, and the identity of participants and the information they would provide would remain confidential. Only upon hearing from the willing participants, the researcher then contacted them by telephone or personal visit and provided them with copies of the letter of introduction, information sheet, and verbal script for service users.

The service users were asked their understandings about the nature of services they accessed, satisfaction and dis-satisfaction with health care, and participation in service delivery. Data on practical experience of how governance works in implementing health program and to what extent various factors impacted on quality of health service delivery were also collected. Also, data on suggestions to improve governance and health care were collected using practical examples. Additionally, the service users were asked their perceptions regarding the impact of governance on quality of health care with reference to socio-economic factors of the two research areas.

To sum up, this thesis uses diverse participants for data collection that enable a deeper understanding of the impact of governance on quality of health service delivery. The national actors have provided overall ideas of the study particularly on the governance effect on health policies and programs, and budgeting processes for the quality of health care. Data from health professionals facilitate an examination of how they perform their responsibilities in delivering health services and to what extent the impact of governance contributes to service delivery. Data from the elected representatives enabled the researcher to produce a thesis on how quality

of governance can be implemented at health service organisations, how various factors affect governance, and how governance contributes to improving the quality of service delivery. The local informants provided data concerning how health professionals played out their responsibilities to enhance governance and quality of service delivery. Moreover, service users provided data on health care satisfaction and the challenges of quality of health service delivery from their practical experiences. Besides this, most of the participants (Appendices12a to 12e) furnished data concerning how socio-economic factors contribute to governance and what their effects on quality of health care were. Therefore, the respondents' overall data enabled the research objectives to be met (Section 1.7 in Chapter 1).

3.6 Techniques of data collection

This study uses both primary and secondary data related to the impact of governance on quality of women and children's health care in the two selected localities. The primary sources of data were collected by conducting individual interviews and focus group discussions with the participants outlined previously.

In depth interviews are an essential and appropriate method for conducting qualitative case study research (Sarantakos 2005, p. 268; Yin 1994, p. 94 Flick et al, 2004), as data collection through interviews benefits from the formal interaction process between the interviewer and interviewee. This, in turn, helps to obtain practical knowledge, experiences, and perceptions about the subject matter being studied. The interview method is suitable for this thesis given that the selected respondents are well informed of the matter being studied as they are directly or indirectly involved in responsibilities and duties in sub-district health service organisations. This interview method is useful for this thesis to examine community participation, socio-economic and political factors, and their influence on governance and quality of health service delivery. Moreover, data collection through interviews is appropriate for contrasting and comparing quality of governance and health service delivery especially rural and urban health service organisations.

Semi-structured checklists were useful for conducting interviews concerning the impact of governance on the quality of health care. The duration of interviews was between one to one and half hours, depending on the willingness of the interviewees to respond and freely express their views. Four sets of checklists were used for the interview procedure (see Appendix 10) and checklists are written in

both English and Bengali.[33] The interview was conducted in the offices of respondents or other nominated places to facilitate comfortable, frank and open discussions.

This study also used focus group discussions as a method for gathering sufficient data from health service users about the impacts of governance on health service delivery. The views of focus group participants enabled an understanding of how governance contributes to actors' role and responsibilities, and to what extent governance affects various factors in delivering quality of health care. Focus group discussions (FGDs) were desirable in the discussion of the role of service providers as they helped to obtain sufficient data about the practical experience of service users which assists in the assessment of good governance. The homogenous participants who received maternal and child health services prior to the survey were used in focus group discussions to encourage spontaneous interactions among the group members which generated sufficient data for this research.

Moreover, FGDs allowed the researcher to collect data quickly and at less cost, observe non-verbal responses, and also facilitate data collection from respondents who are illiterate. The number of service users in this case study was very high and was difficult to reach everybody and conduct individual interviews to collect data for the study. As a consequence, in order to gain essential data on governance and quality of health care delivery from service receivers, the composition of the FGDs was a carefully selected sample from three types of health service organisations (see Appendix 12e).[34]

The relevant questions relating to the objectives in the study were asked and discussed among the focus group participants. A checklist of relevant questions (see Appendix 10) was presented for discussion by the focus groups (Sarantakos 2005, p. 195).[35] The FGDs were held in a suitable place (school common room/study hall), or where the respondents felt free and comfortable to express their

[33] Checklists were first written in English then translated into Bengali. Bengali checklists were easier for both researcher and respondents to understand as Bengali are the mother tongue for both. Interview responses were translated into English for analysis.

[34] This thesis conducted focus group discussion of service users of Upazila Health Complex, Union sub-centre, and the community clinic. In addition, focus group discussions were conducted with NGOs health care users.

[35] The checklist for focus group discussion used in the Bengali language so that respondents could easily understand topics and expresses their views. The discussion was recorded using an audio tape recorder, transcribed in Bengali then translated into English for analysis.

views. The duration of discussion was one to two hours depending on the willingness of the respondents.

The secondary data consisted of various documents such as books, journal articles, reports, and research papers concerning governance, health policy, management of health organisations, and the roles of both development partners and community actors of health service organisations. These documents were used to examine the impact of governance on quality of health service delivery. Further, different reports concerning women's and children's health care were collected from various private institutions such as the World Bank, WHO, UNICEF, ICDDR, B and the BRAC in order to understand the impact of governance on health service organisations. In addition, the researcher collects information of organisational policies, organisational structure, health facilities, budgets, human resources structure, job descriptions of the two selected health service organisations. This thesis uses qualitative and quantitative data with regard to statistical analysis of women and children's health, socio-economic situations in relation to health service delivery, and recent studies on causes of corruption, and factors of quality of health care. The sources of these data are the Bangladesh Bureau of Statistics, Transparency International Bangladesh, and the upazila statistics offices in Savar and Chhatak. The secondary sources are used to support the analysis based on the primary data.

3.7 Ethics in the research

The basic ethical standards in social research are to provide proper identification of the researcher, offer clear information about the project, free and informed consent by the researcher, and to ensure right to privacy, anonymity, and confidentiality of the respondents (Sarantakos 2005, p. 18). To conduct this study the researcher provided his identification and clear information on the objectives of the project so that it was possible to gather necessary data in a fair and transparent way from the respondents. Informed consent is a significant issue in conducting research, and this refers to the rights of participants to know what is being researched, to be informed of the nature of the research, and to be aware that they are able withdraw at any time.

The other issues of confidentiality and trust are also adhered to in the fieldwork. Confidentiality is the protection of participants' identities by the researcher (Sarantakos 2005).Trust refers to the relationship between the researcher and

participants, and the responsibility of the researcher to ensure that this research will be used only for study purposes. The researcher clearly explained the purposes and objectives of the study to participants. The participants were assured by the researcher and the concerned institutions that all of the information would remain confidential for research purposes.

The researcher ensured participants' anonymity by protecting and coding names and identities in all notes and records, including audio tape recordings. At all stages of the study, the researcher kept documents and computer files under locked security so that no one had access to the information. The researcher obtained due approval from the Social and Behavioural Research Ethics Committee (SBREC) at the Flinders University of South Australia which conducted a rigorous review of the entire survey protocol. For this purpose, a letter of introduction and letter of approval were obtained from the SBREC for use during the field data collection. In addition, a participant information sheet and verbal script were provided to the respondents so that they were confident enough to participate in the interviews and the focus group discussions.

3.8 Method of data analysis

The researcher spent nearly five months conducting fieldwork and gathering field data in Bangladesh. After completing the fieldwork, the researcher started to analyse the data which involves three parts.

Part one dealt with transcribing data of interviews and focus group discussions. As mentioned earlier, the researcher conducted the interviews in the Bengali language. This was to facilitate a better understanding of the conversation. Afterwards, the interview data were transcribed from Bengali to English to ensure its use in the Nvivo software package. Secondly, this thesis used Nvivo software which is appropriate for categorising and organising qualitative field data. Nvivo software assists in the classifying of the collected field data in order to analyse accountability, transparency, and participation as well as NGOs' governance with reference to quality of health service delivery. Finally, data were categorised into five chapters in accordance with the conceptual framework (see Figure 2.7 of Chapter 2), research questions, and objectives for understanding the impact of governance on quality of health service delivery. This thesis analyses the data in five chapters. Each chapter is divided into several main sub-headings which are then categorised into various

sub-headings using Nvivo software. Later, the sub-headings were classified and analysed. This procedure was followed for each chapter in order to understand the impact of governance on quality of health service delivery.

3.9 Challenges of data collection in Bangladesh

At the beginning of the fieldwork, the researcher gained letters of permission from concerned authorities of the selected health service organisations. Some adverse situations (for example, lack of time commitment, political instability, office culture and bureaucratic complexities), arose during data collection, however the researcher tackled those situations carefully and gained useful data for this project.

As an example, the medical officer of Chhatak commented that he would provide the researcher with sufficient time to be interviewed. However, later he expressed helplessness when the researcher met him and finally enabled to interview him. Therefore, the researcher had to spend more time organising and conducting interviews with medical officers. However, the researcher was able to collect data from the health professionals of Savar upazila within a very short time due to the ready availability of health professionals at the health complex.

On the other hand, all of selected health officials of Chhatak Upazila provided detailed information and data willingly. However, the office accountant of the Upazila Health Complex was unable to provide detailed information with regard to allocation of budget and expenditure. He stated: 'the researcher is not a member of the health service organisations; therefore it would not be appropriate to provide a photocopy of the original official documentation'. In this circumstance, the researcher took written notes on budget information by spending more time at the office of the accountants. However, data collection from NGO officials was more forthcoming due to the cooperative environment of organisational culture.

Evidence was also found that the Upazila Family Planning Officer (UFPO) of Chhatak was absent without notice on a number of days and the researcher did not get access to interview him due to this negligence of official duties on the part of the UFPO. In this circumstance, the office assistant of the family planning organisation advised the researcher that he was in the field and may be back to office in the afternoon. Unfortunately, this did not transpire. However, the researcher was able to conduct the interview at his residence during the evening and gained critical data with regard to management, participation, and quality of health service delivery of

local health organisations. However, the administrative culture of the family planning office of Savar was found to be different as the researcher gained easy access to the family planning officer as well as to other health care providers of the Upazila Health Complex and the subordinate organisations at the field level. This allowed for the collection of necessary data and information on governance and health service delivery.

Political leaders and people's representatives spend much time at public functions, private businesses, as well as dealing with various local problems. The researcher collected mobile phone numbers of the vice chairman (women) of upazila parishad and contacted political and elected representatives. The researcher informed them of the purpose and provided a brief outline of the research topic. The researcher use mobile phone for contacting the selected respondents and organise time and place for face-to-face interviews. However, several of the political leaders could not maintain appropriate commitment due to political functions and other urgent activities; nevertheless, the researcher was able to collect the needed data from them by taking extra time and by exercising patience. Similarly, it was challenging to gain access to and conduct interviews with local members of parliament (MPs), as they are so busy with people and politics for the upcoming elections. The researcher, nonetheless, was able to interview only the MP of Chhatak with the help of his secretary.

Data collection from field level health workers was also difficult to obtain. The researcher had to convince workers with a letter and telephone calls from their higher authorities. In addition, the local leaders and their superiors also provided support for conducting interviews; consequently, the researcher was able to gather sufficient data from the field level health workers.

Savar is an urban-based sub-district and service users are normally engaged during office hours in economic activities such as employment. The researcher invited the service users through field health workers of the Upazila Health Complex at office time; however, they regretted their inability to participate during this time. Therefore, the researcher changed the schedule to a holiday which was more convenient for them. Everybody who was invited to participate to the discussion freely attended. The researcher successfully organised the focus group discussions (FGD) and collected useful data which allowed an analysis concerning health service delivery from the experience of health service users.

Data collection from the central health office took time due to the highly bureaucratic procedures in the organisation's management. To realise this, getting permission from the Directorate General (DG) office took the researcher a couple of weeks.[36] However, permission was gained easily and the necessary data were collected from the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), the Bangladesh Institute of Development Studies (BIDS), and Transparency International Bangladesh (TIB) through using the office diary. In addition, the schedule of interviews with the respondents had to be changed several times due to the political instability (strike) of the country, because during the nationwide strike the health workers unable to join their workplace. As well as the health workers have poor commitment. From this fieldwork experience, it can be argued that such problems are common features for developing countries like Bangladesh. The above evidence also shows that the researcher faced adverse circumstances during the fieldwork, but tackled them those situations with patience and played a positive role in obtaining the needed data to complete this project.

3.10 Conclusion

This chapter has presented a detailed methodological account of the data collection in order to understand governance and service delivery in the health sector. Essentially, this is a qualitative comparative case study. This study has selected two health service organisations from two different research locations -one rural and the other –urban. The background of the organisations and the study sites may have a different effect upon governance and quality of health care. This is because characteristics of organisations, management, human resources and organisational budgets as well as the socio-economic and political conditions of the study sites may impact on governance and health service delivery. The following chapter addresses these issues in detail which will be considered in the field data analysis in order to understand governance and quality of health care in Bangladesh.

[36] The researcher submitted the application to the reception office where a lower level employee coded the letter to send to the DG for granting permission. He advised the researcher that it would take a minimum of three days to get an outcome of the application. However, the researcher had to wait for nearly two weeks due to prolonged administrative procedures, which are common in the public organisational culture in Bangladesh.

Chapter 4

Background of Health Service Organisations and the Study Sites

4.1 Introduction

This chapter examines the organisational and socio-economic background of the health service organisations studied and the sites included in this research. As mentioned earlier, two health service organisations were selected from rural and urban areas respectively in order to learn how varying governance affects the quality of health care delivery through differences in management, budget, equipment and human resources. This chapter also presents the socio-economic and demographic characteristics of the local populations as part of the background in which the two health service organisations operate.

Data for the analysis have been collected from informants in Savar and Chhatak sub-districts of Dhaka and Sunamganj respectively in Bangladesh. The two selected health service organisations in Savar and Chhatak have differences in health service characteristics, size of human resources, quality of management, physical resources, and the amount of budget, all of which may influence governance and health care delivery provided by these health service organisations. In addition, the study sites have different socio-economic and political characteristics, which are expected to contribute to promoting or constraining governance and the quality of health service delivery.

The present chapter is organised into four sections. Section One describes the geographic and socio-demographic profiles of the study sites. Section Two outlines the background of the health service organisations in terms of their resources, management styles and budget. Section Three discusses the socio-economic and political background of the study sites. The fourth and final section presents the conclusion of this chapter.

4.2 A Brief Profile of the Study Sites

Savar is the second largest sub-district (*upazila*) of the Dhaka district (*zila*) in terms of area.[37] This is an urban sub-district, which occupies an area of 280.11 square kilometres within the Dhaka Statistical Metropolitan Area (SMA). Its distance from the general post office (GPO) is nearly 26 kilometres (Bangladesh Bureau of Statistics 2012a). Administratively, Savar upazila has one municipality (locally known as *paurashava*), divided into nine city wards (locally known as *paura*); 13 unions which are further divided into 39 rural wards; 380 villages, and 57 city areas (*paura mahalla*). The population of Savar upazila is 1,385,910 with 738,764 males and 647,146 females. The annual population growth rate is 8.83 percent and the density of population is 4,948 persons per square kilometre, however, nationally the density of population is 948 persons per square kilometre (World Health Organisation 2005). The extremely high population growth rate is mainly due to migration from neighbouring areas. Such a large high-density population with rapid growth can have an adverse impact on governance and quality of health care delivery in Savar. The adult literacy rate is 68.0 percent, with 71.6 percent among males and 63.9 percent among females (Bangladesh Bureau of Statistics 2012a).

The other place chosen for this study, Chhatak, is a rural sub-district. It was upgraded to a sub-district (*upazila*) from a police station (*thana*) in 1982. This sub-district occupies an area of 440.48 sq. km including 13.51 sq. km under forest. The distance from the headquarters of the Sunamganj district to Chhatak sub-district by road is 60 km (Hossain 1995, p. 3). The Chhatak sub-district consists of one municipality, which is divided into nine city wards, and 13 unions further divided into 39 rural wards and 539 villages. The population of Chhatak is 397,642 with 197,952 males and 199,690 females. The population density is 903 persons per sq. km. The annual population growth rate is 1.72 percent and the adult literacy rate, 38.6 percent with 40.8 percent among males and 36.3 percent among females (Bangladesh Bureau of Statistics 2012a).

Since the literacy rate in Chhatak is lower than that in Savar, one might expect poorer community participation in Chhatak's health care delivery. Savar's higher density population might provide it with better coverage in terms of healthcare service delivery.

[37] Administratively, Bangladesh has 64 districts (a district is locally known as a *zila)*. The present study has been conducted in two districts, namely (Dhaka and Sunamganj, representing two extremes in order to understand governance and health service delivery.

The above statistical data refer to basic information about the two selected research locations. These data have been used in the following sections to assess the features of health service organisations and the socio-economic background of the study sites in order to understand the governance and quality of health service delivery issues. These data will also assist in understanding the quality of governance and health care delivery of rural and urban health service organisations. The next section describes the background of the health service organisations of the two sub-districts.

4.3 Background of Health Service Organisations

4.3.1 Health service facilities

Savar upazila is a populous, high-density urban-based locality due to its close proximity to the city of Dhaka, the capital of Bangladesh. Many government and non-governmental offices and industries are located in Savar which has also experienced a rapid increase in urbanisation. In addition, Savar is an Export Processing Zone (EPZ) and a significant number of garment industries operate there. As a result, very large numbers of garment workers are employed in the locality. As mentioned earlier, nearly 1.4 million population live in a limited area in Savar , but government health service facilities are insufficient as this upazila (sub-district) has only one 50 bed-upazila health complex (UHC) to provide services to its people. In addition, this upazila has only two union sub-centres to provide health services to remote/rural people. Besides this, nearly 30 community clinics (CCs) have been operating in this sub-district, providing limited health facilities. Moreover, the CCs have been operated by semi-skilled health human resources (Bangladesh Health Facility Survey 2012) which might adversely affect the quality of health service delivery.

The upazila health complex (UHC) provides health services through three departments: indoor (inpatient), outdoor (outpatient), and emergency, and the major services are provided free of cost or at minimal cost according to government provisions.[38] This health complex has its own facilities for X-ray and pathological

[38] The central government has a provision concerning user fees for delivering health services at the UHC. The cost of indoor and outdoor tickets is Tk. 3 and Tk. 5 respectively for seeking health care services and gaining admission. In addition, the cost of a blood test varies between US $ 0.30 and US $0.70 depending on the type of examination; an X-ray costs US$ 0.78 to US $1.00 depending on size of the X-ray plate. But medicines are provided to patients free of cost in accordance with availability.

tests. Nevertheless these facilities have a limited capacity due to inadequate equipment and are able to provide only primary level tests. The health complex provides ambulance service for patients, for which it charges additional fees. Meals are provided to indoor patients three times a day. For this, the government provides Tk. 70[39] per day for each patient. The UHC provides services from 8.00 am to 2.30 pm for outdoor patients except on Fridays and public holidays as per government rules. However, indoor and emergency departments remain open 24 hours, seven days of the week (Transparency International Bangladesh 2008, p. 7). In 2012, the numbers of indoor and outdoor patents of Savar UHC were 3,629 and 97,705 respectively as reported by the Savar UHC record.

On the other hand, the Chhatak upazila health complex has a 31-bed hospital consisting of three wards, one catering for 12 males, one for 13 females, and one for 6 children. No additional fees are required to be paid by the patients. This health complex also provides indoor, outdoor and emergency services with similar service facilities for X-rays and pathological tests as Savar, but on a more limited scale. Patients have to pay for the health tests in accordance with government provisions as mentioned earlier. Additionally, an ambulance service is available which is mainly used for referral and emergency patients and the patients must pay consistent with service charges as per government rules. Not enough medicine is available to fulfil demand and patients claim that they do not receive sufficient free medicine from hospital; mostly, they buy medicines from private shops. The cost of the ambulance service and the limited ability to buy and bear medical costs can adversely affect accessibility and affordability of health service delivery in Chhatak.

From January to October-2012, the numbers of indoor and outdoor patients in Chhatak UHC were 3,458 and 34,841 respectively as reported in the official records. However, unlike Savar, the Chhatak health complex operates during limited hours (8.00 am-1.00 pm), six days a week. Emergency and indoor services are provided 24 hours a day, seven days a week but they are operated inefficiently due to poor supervision, which may be a sign of poor governance. The health complex also provides vaccinisation and immunisation services to children free of cost. However, there is no provision for Caesarean sections as there is no Operating Theatre (operating room). In addition, there are no blood bank services as this health complex is not equipped technically or physically to provide such a service.

[39] At current rates, Tk. 70 is equivalent to US $1.00.

With the efforts of a civil society organisation, namely Transparency International Bangladesh (TIB), a notice board has been placed in the Savar upazila health complex with the approval of the health complex authority. This notice board displays information about the availability and cost of medicines for the benefit of the patients and promotes transparency in healthcare delivery. Yet the information is not up to date, nor is it accurate. On the other hand, no such notice board is available in Chhatak UHC, because there is no civil society organisation active in this rural sub-district. This also reflects a lack of community participation in health care among the people of Chhatak.

The upazila family planning office is located at UHC and provides family welfare and family planning services to clients. For this, a significant number of field officials work to improve motivation and deliver advice to clients through door-to-door service. In addition, the field staffs supply medicines and materials as per organisation rules.

The family planning office in Chhatak reports that maternal and child health (MCH) doctors are not available to offer clinical services which are available at Savar upazila. In this case, Chhatak upazila hires doctors for clinical services from an NGO for a particular time to service satellite clinic patients. The details of the human resources structure of the family planning departments (in Savar and Chhatak) are shown in Table 4.1.

Chhatak lacks MCH doctors to providing clinical services to clients whereas these services are available at the Savar family planning office. As well as this, human resources structure, working environment, and resource availability are different between the Savar and Chhatak sub-districts. All of these factors may contribute differently to quality of health service delivery.

4.3.2 Management

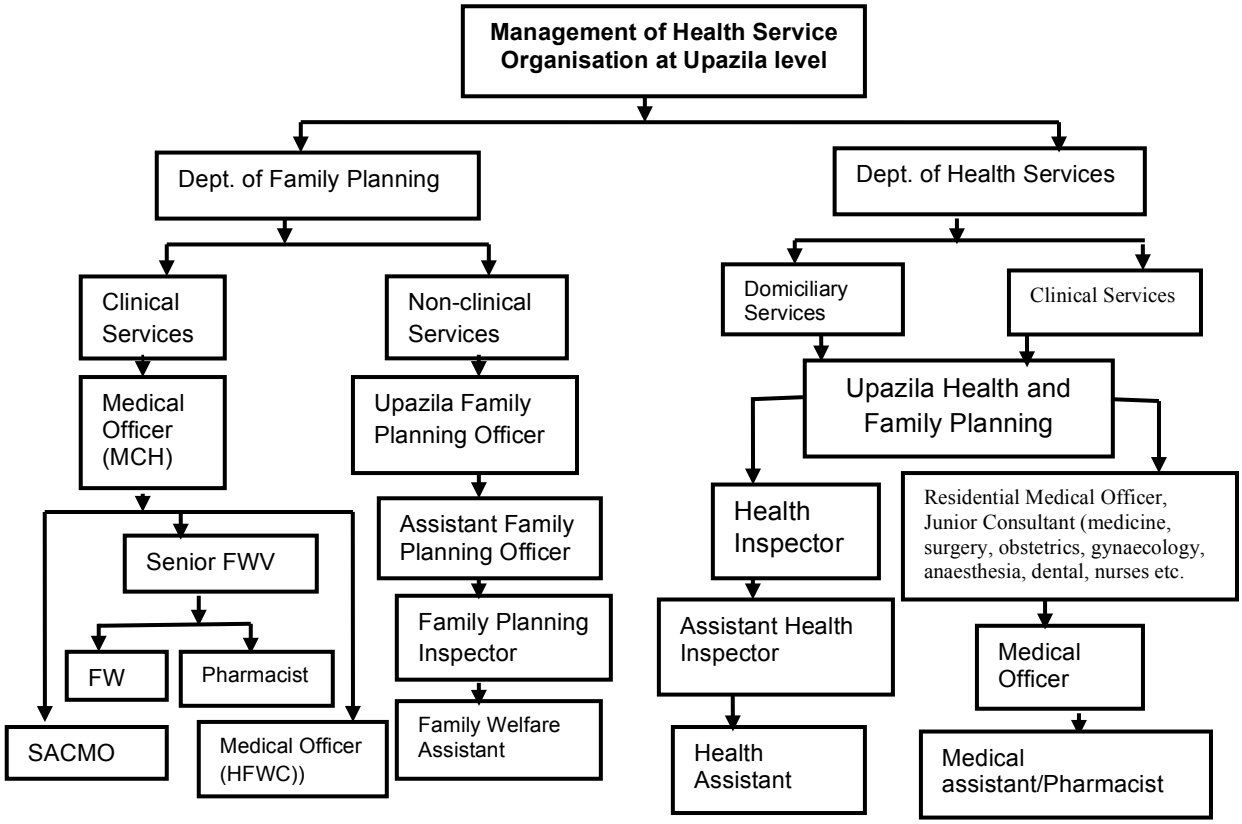
Generally, management can be considered as a set of activities undertaken in an effort to deliver efficient and effective services within the structure of an organisation. Different sets of activities may have to be undertaken for organisations with different structures. The management activities of organisation depend on structure of health service organisation. For example, sub-district health service management can be divided into two styles: bureaucratic management and participative management. Bureaucratic management is basically hierarchical with

directions coming down from the highest authority of a government agency. A study by Mridha et al. (2009, p. 124) shows that health services are provided at the upazila level by the Ministry of Health and Family Welfare through its two wings, namely health services and family planning. The health services department at an upazila provide services through the upazila health complex (UHC). An UHC has under it, union sub-centres and community clinics as the lowest tier of administrative unit (ward level) (Directorate General of Health Services 2014). Domiciliary services e.g., services at the patients' homes are provided through field staff of the department of health service organisations in order to make health services accessible to grassroots people. The upazila health administrator (that is, the upazila health and family planning officer) is mainly responsible for guiding the health staff including field workers to promote quality of health care (Directorate General of Health Services 2014).

The Department of Family Planning provides maternal and child health care services for the upazila and unions under the jurisdiction of the upazila parishad (upazila council). This is a separate department of the Ministry of Health and Family Welfare. The family planning department provides mainly domiciliary services and some limited clinical services with regard to family planning and maternal health. The family planning department has a significant number of field staff from upazila down to the village level. The upazila family planning officer is the Chief Executive Officer for managing family planning staff and services. Figure 4.1 shows the management structure of upazila health and family planning services.

Figure 4.1

Management structure of upazila health service organisations



Source: Adapted from Mridha et al. 2009

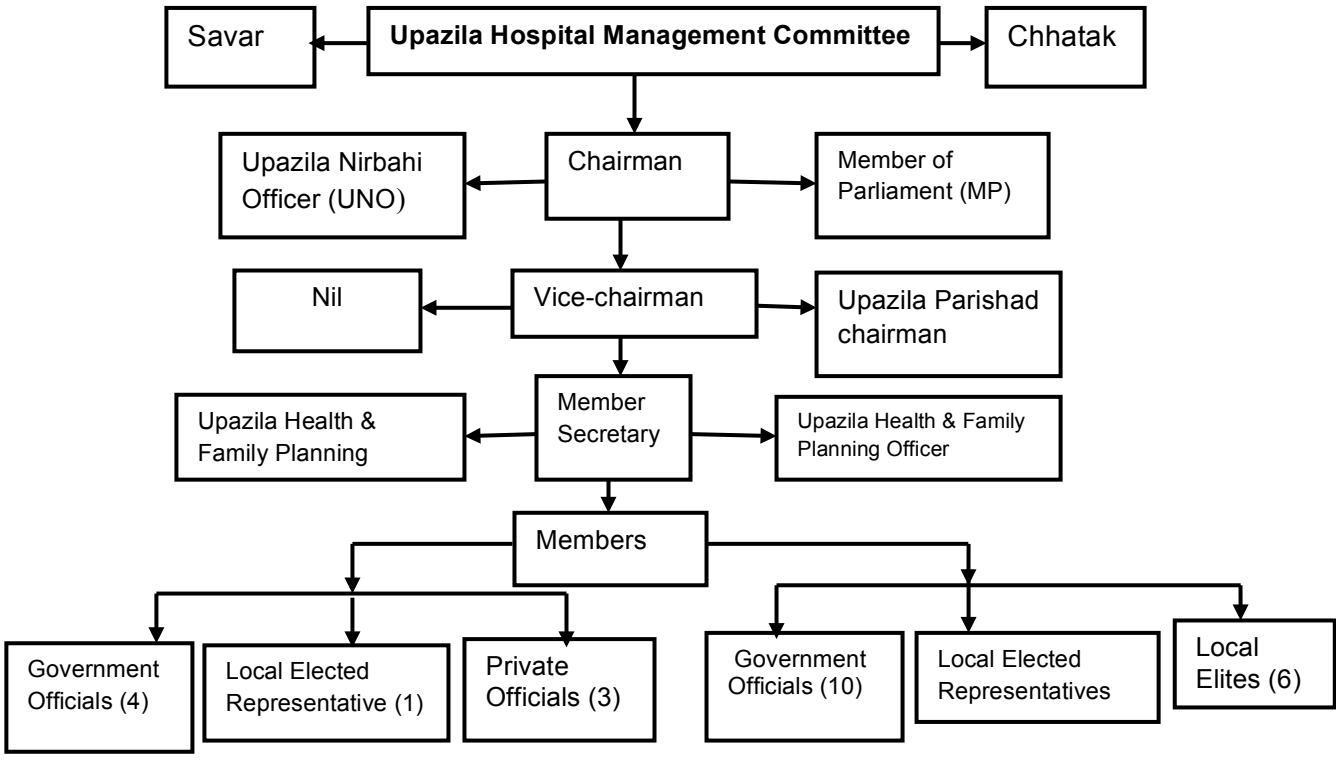
Figure 4.1 shows the structure of the sub-district health service organisations in Chhatak and Savar. The structures of these two organisations are very similar as part of a central bureaucratic organisation. The organisational structure of upazila health management is bifurcated from the top down to the grassroots level, with one cadre of workers engaged in family planning activities and the other in health activities. Both the departments are responsible for implementing maternal and child health care through supervision, monitoring and coordination as guided by the central health administration. However, the organogram of health and family planning services clearly shows the two separate chains of authority between health and family planning services and that the field staff work independently in the same geographical area. The field staff of health and family planning have little contact between them and there is poor coordination among them in delivering health and family planning services due to the separate direction of management which may be

a sign of poor governance and can adversely affect the quality of health service delivery.

On the other hand, the health service committee, which oversees the operation of the UHC, consists of locally elected officials and bureaucrats (health service officials). For this, each upazila health complex has a health management committee to encourage participation of local stakeholders, for example local bureaucrats, elected representatives, local elites and community people in order to enhance quality of health service delivery. Each Savar and Chhatak UHC has a management committee; however, the participation of stakeholders in the committee is different (see Table 4.2). For example, the Chhatak UHC committee has more community participation as the local MP and the elected representatives have on the structure of the committee whereas the committee in Savar UHC has limited community participation. In addition, health service committees work differently in Savar and Chhatak upazila to enhance governance and service delivery as the local elected officials and the permanent bureaucrats have different methods of participation. For instance, elected officials ensure participation through community opinion with democratic process but bureaucrats ensure participation through selection process by the officials. This participation process can influence the creation of good or poor governance, which may affect quality of health care delivery.

Figure 4.2

Committee of health service management of Savar and Chhatak upazila



Source: Field Data 2013

In fact, the method of bureaucratic structure of the Savar and Chhatak upazila health service organisations are almost identical as both organisations are parts of a central government administration and are directed by the central government under the same set of regulations. Nevertheless leadership styles of local health service organisations have different features that notably affect governance and health service delivery. Figure 4.2 also shows that health service management is of similar structure and pattern but the representation of community, elected representatives and local elites is stronger as the health service committee of Savar upazila is highly dominated by the local bureaucracy that ultimately limits participation of communities and elected bodies. The limited participation of elected officials on the health service committee can affect quality of health care. Bureaucrats tend to avoid poor people and work within their own ideas which limit public participation. This means little or low participation of the community which may contribute to poor

quality health service delivery. The reasons for poor community participation have been addressed and analysed in Chapter 8 so as to understand the impact of governance on health service delivery.

4.3.3 Human Resources

Scarcity of skilled health professionals is one of the challenges of adequate facilities of health service organisations in Bangladesh. Rahman et al. (2005) argue that Bangladesh has a shortage of health service personnel with only 246 physicians and 136 nurses per one million populations in 2005. This means that there is one doctor for 4,065 people on average, and one nurse for 7,353 people on average in 2005. In 2013, the ratio of physicians improved (1:3,297) but the nurse ratio decreased (1:11,696) (Directorate General of Health Services 2014 p. 17).

In 2013, Savar upazila had one health professional assigned for 4,017 people on average whereas Chhatak upazila had one health professional assigned for 1,736 people. These statistics are based on the total population as mentioned in Section 4.2 and the number of appointed health professionals (health and family planning) in Savar and Chhatak upazila's, as shown in Tables 4.1 and 4.2

Table 4.1

Human Resources Structure of Savar and Chhatak Upazila Health Complex

Selected Case Studies		**Savar Upazila Health Complex**		**Chhatak Upazila Health Complex**	
Classification of human resources	**Designation/Title of positions**	**Approved positions**	**Vacant positions**	**Approved positions**	**Vacant positions**
Class-I	Upazila Health and Family Planning Officer, Resident Medical Officer, Junior consultant, Medical Officer	30	1	24	13
Class-II	Sub-assistant community medical officer, Nurses, Health Inspector, Medical Technologists, Office Assistant, Store keeper, Pharmacist etc.	49	1	30	8
Class-III	Health Assistant, Community Care Provider	110	13	111	18
Class-IV	Cleaner, Driver, Midwife, Ward Boy, Cooker, Lab attendant, Security/Night Guard etc.	30	1	26	15
Total		**219**	**16**	**191**	**54**
Percent approved positions vacant			7.3		28.3

Source: Office Record (Upazila Health Complexes Savar and Chhatak) (2013)

Table 4.2

Human Resources Structure of Family Planning of Savar and Chhatak Upazila

Selected Case Studies		**Savar upazila family planning department**		**Chhatak upazila family planning department**	
Classification of human resources	Designation/Title of Positions	Approved positions	Vacant positions	Approved positions	Vacant positions
Class-I	Upazila Family Planning Officer, Medical Officer (MCH)	6	0	3	2
Class-II	Assistant Family Planning Officer, Family Welfare Inspector, Family Planning Inspector	27	1	27	4
Class-III	Family Planning Assistant, Pharmacist, Upazila Family Planning Assistant	82	3	83	26
Class-IV	MLSS, Midwife	32	1	18	7
Total		**147**	**5**	**121**	**39**
Percent approved positions vacant			3.4		32.2

Source: Office Record (Department of Family Planning, Savar and Chhatak Upazila) (2013)

Tables 4.1 and 4.2 show that the number of vacant positions of all categories in both health and family planning is larger in Chhatak than Savar, even though Chhatak has smaller numbers of approved positions to fill. Overall, considering all categories, Chhatak has 28% of health positions unfilled compared to 7% in Savar. Similarly, Chhatak has 32% of the family planning positions unfilled compared to 3% in Savar. The higher percentage of unfilled positions of health and family planning professionals in Chhatak can have an adverse impact on its quality of health service delivery. Additionally, the higher prevalence of unfilled positions in Chhatak can itself be considered as an inefficient governance and management issue, as suggested by Rahman et al. (2005).

Some of the reasons for the higher percentage of unfilled positions in a rural health service organisation such as Chhatak are their poor socio-economic conditions and

weak physical infrastructure, which do not attract many potential health service job seekers. These factors are relatively favourable to such job seekers in the Savar upazila health complex as a result of its urban location. Although an urban health service organisation like Savar has a very low percentage of unfilled positions as shown in above tables, the size of the population it has to cover is a great challenge for it in providing adequate healthcare services, although the high population density of Savar may be an advantage in that it can cover a larger population within a limited geographical area. Hanlon et al. (2012) have shown by their extensive analysis that population density positively influences maternal healthcare coverage, and this finding has significant implications for public health researchers, policymakers and demographers.

In addition to the factors discussed above, the quality of health care delivery requires an adequate budget, which is the focus of the next section.

4.3.4 Budgets

The upazila health professionals do not have authority to prepare their own budgets in order to meet local expenses and to enhance quality of health service delivery. The health budget at upazila level is prepared through a top-down process where the central government is responsible for allocating and auditing through their authorised bodies. The national budget for the health sector has been decreased gradually over the last couple of years, reducing the capacity of health service organisations to provide adequate services. This reduction in the health budget also affects upazila health service delivery. For example, the health budget (development and non-development) comprised 4.82% of the national budget for the financial year 2012-13, but it was reduced to 4.26% for the financial year 2013-14 (Protham Alo 2013). However, in terms of money, the allocation of the budget for 2012-13 was Tk. 91.3 billion (approximately US $1.30 billion) which improved slightly in absolute amount to Tk. 94.7 billion (approximately US $1.35 billion) in 2013-14.[40] This is equivalent to Tk.63 (US $ 0.9) per capita (Protham Alo 2013). This poor allocation is insufficient to provide adequate health service delivery. Besides this, accountability and transparency are the other challenges for the implementing health care budget.

[40] '*Taka'* is the local currency of Bangladesh. One USD is equivalent to nearly seventy Taka.

Respondents argue that the size of the population of an area should be considered for budget allocations so that there is an adequate amount of money per person to receive the required health care. Data collected for this research in the field in Bangladesh show that the budget for the selected rural and urban health service organisations are almost equal and that the population of each area has not been considered in allocating budgets. Health professionals argue that the sub-district health service organisation budget is allocated in accordance with an administrative unit rather than assessing the amount of population. For instance, in the financial year 2011-12, the budget allocated for Savar UHC was Tk. 43,570,710 for revenue (salary for office staff) and Tk. 3,037,500 for development (for example, infrastructure, medicines, materials), while the budget allocated for Chhatak UHC comprised Tk. 28,680,781 for revenue and Tk. 2,530,650 for development aimed towards promoting health service delivery. Besides this, population has not been considered in allocating the health budget. For the period 2011-12, the health budget per capita was Tk. 33.63 for Savar and Tk. 78.49 for Chhatak. The combined health and family planning budget per capita was Tk. 40.44 for Savar and Tk. 121.25 for Chhatak (calculated from Table 4.3). These figures imply that the budget allocation is not uniform according to population size. These are inequalities in the health and family planning budget which may be an indicator of poor governance. In spite of the unequal government budget, it will be seen later that Savar performs better in health service delivery, the reason for which is the availability of non-government health services in Savar. In addition, the management of the health service is more efficient in Savar than it is in Chhatak UHC.

However, governance is also affected by the management of the budgeting of health service organisations (see Table 4.3). The preparation of the budget is essentially a central government process, but before preparing the budget, the government consults with representatives of various communities such as the business community, women's organisations, doctors' associations, local communities and civil society organisations (Osman 2004). Local people including community organisations have very limited participation in preparing the budget. For example, although women's communities are consulted before preparing the budget, they have only a limited contribution to the budget preparation. However, the business community has a dominant role in the preparation of budget.

Table 4.3

Budgets for the Department of Health Services and Family Planning in Taka, (Savar and Chhatak) (2011-12) [Tk. 70 =US$1]

Sectors	Savar Upazila			Chhatak Upazila		
	Family Planning	Health Services	Total	Family Planning	Health Services	Total
Revenue Budget[41] Expenditure	94,64,224	4,34,82,811	52,947,035	1,68,20223	2,73.24,886	44,145,109
% Spent over allocation	94.96	99.79		98.99	95.27	
Development Budget[42] Expenditure	70,949	30,36,493	3,107,442	15,43,460	25,26,723	4,070,183
% Spent over allocation	99.70	99.96		89.57	99.84	
Population	1,385,910 (Tk, 40.44 for each people)			397,642 (Tk.121.25 for each people)		

Source: Office Record (Savar and Chhatak Health and Family Planning) (2013)

In summary, the above analysis of budget information and the aforementioned table clearly demonstrate that the UHC budget has been significantly deficient in comparison to other developing countries (for example, India and Sri Lanka as stated Section 1.2.1) to provide adequate health services. With regard to revenue budget of Savar UHC, the health service budget has been used more efficiently than family planning budget. But this organisation used development budget efficiently of both sectors. On the other hand, family planning budget has been used more efficiently in Chhatak than health service budget. However, development budget has been used more efficiently by the health service department than the family planning department. Besides, the size of population has not been considered during the

[41] The money of revenue budget comes from government tax, which generally uses for providing salary of all government officials including health service professionals.
[42] The money of development budget comes from project fund including donor support, which uses for promoting hospital infrastructure including human development schemes.

health budget allocation. Moreover, the general community and community-based organisations have a limited participation in the health budget preparation. The above-mentioned factors that affect budgeting may facilitate an understanding of the impact of governance on health service delivery.

4.4 Background of Study Sites

4.4.1 Socio-economic characteristics of Savar and Chhatak

a. Literacy, education and socio-economic characteristics

In 2011, in Savar upazila the total labour force was 148,778 (population aged 7+ and not attending school). Of this total labour force, the male labour force was 99,935 and the female labour force was 48,839. In the same period, in Chhatak, the total labour force was 47,326 (population aged 7+ and not attending school). Of this total labour force, the male labour force was 43,855 and the female labour force was 3,471. In Savar, the percentage of employed population is higher and the unemployed population is lower in comparison to Chhatak upazila. Table 4.4 shows the literacy, education and socio-economic status of Savar and Chhatak upazila.

Table 4.4

Literacy, education and socio-economic indicators of Savar and Chhatak Upazila (%)

Socio-economic indicators	Savar Upazila	Chhatak Upazila
Literacy of all ages	68.0	38.6
School attendance (aged 6-10)	75.0	75.2
School attendance (aged 11-14)	73.7	68.7
School attendance (aged15-19)	26.0	28.5
School attendance (aged 20-24)	7.0	4.62
Agriculture employed	14.5	72.1
Industry employed	42.5	6.2
Services holders	42.8	21.5
Employed population	99.1	96.4

Source: Bangladesh Bureau of Statistics (BBS) (2012b)

The Bangladesh Bureau of Statistics (BBS) (2012b, p.2) defines a literate person as one who has the ability to write a letter. The significantly higher literacy rate in Savar reflects its urban characteristic and its location in the national capital district. The significantly high literacy rate of Savar is expected to give it an advantage in the quality of health service delivery over Chhatak.

A population with better literacy and education can contribute more meaningfully to promote governance and quality of health service delivery. The literacy rate is much higher in Savar compared to Chhatak, although the age-based school attendance rates are only slightly higher in Savar compared to those in Chhatak. Only the school attendance (age group15-19 of population) is higher in Chhatak as this age group population engaged in work particularly garment industry in Savar. Nazneen(1999) and Hossain(1995) have shown that the Sylhet administrative region (of which Chhatak upazila is a part) has a poorer performance in education than that in other regions of Bangladesh. They attribute the poorer performance of Sylhet to several factors such as poverty, child labour, lack of education of parents, poor government concentration, poor communication, and limited supervision (Nazneen 1999, p. 497; Hossain 1995, p. 2). These factors have important implications in assessing the role of governance in the quality of health service delivery.

Besides this, the majority of the employed population in Chhatak upazila work in agriculture, while the majority of the employed in Savar upazila work industries and services in 2011. The higher employment rate and the larger proportion of the employed engaged in non-agricultural work in Savar upazila demonstrate that this upazila is economically more developed than Chhatak upazila. Thus, the lower employment rate of Chhatak, along with its less developed status, would be a valuable factor in assessing the impact of governance on the quality of health service delivery.

b. Building material and household facilities

According to BBS (2012b), as of 2011, Savar had 359,084 households and the facilities available in the households generally varied according to economic conditions and the ability to acquire those facilities. In other words, the housing facilities and the material of the buildings reflected the socio-economic status of the households. According to BBS (2012b) the highest number of household houses in

Savar were built as ' semi-pucka'[43] and more than one half, (54.0%) had good sanitary facilities (water sealed flush toilets).

In comparison, Chhatak had 66,363 households and among them the highest (63.1%) were 'kutcha' houses. Compared to the houses in Savar, a much smaller percentage (11.8%) of the households in Chhatak had good sanitary facilities (water sealed flush toilets), 30.8% had medium sanitary facilities (non-water sealed flush toilets), and 48.3% had no sanitary facility. Additionally, Table 4.5 shows the utility facilities of households in Savar and Chhatak upazila.

Table 4.5

Utility facilities of households in Savar and Chhatak (%)

Utility facilities by household	Savar Upazila	Chhatak Upazila
Electricity connection	96.6	49.7
Piped water supply	32.3	3.3
Tube wells water supply	66.9	78.8
Other sources of drinking water	0.8	17.8
Pucha houses	19.1	16.1
Semi-pucha houses	62.8	17.1
Kutcha houses	17.2	63.1
Good sanitary facilities (water sealed toilet)	54.0	11.8
Medium sanitary facilities (non water sealed flush toilet)	40.5	30.8
No sanitary facility	5.1	48.3

Source: Bangladesh Bureau of Statistics (2012b)

[43] 'Pucka' houses are made of modern construction materials such as brick, cement, iron rods and glass and such houses have higher longevity. The bases of houses that are constructed with only brick and cement are called 'semi-pucka' houses. Generally, the roof of semi-putcka houses is made of wood and sheets of tin and such houses have relatively less permanency than 'pucka' houses. The base of 'Kutcha' houses is made with mud with roofs made from bamboo, wood, polythene and straw. The durability of 'kutcha' houses is temporary.

Drinking water facilities are significantly better at Savar in comparison to Chhatak upazila. Also, more households access electricity in Savar upazila than in the Chhatak upazila. Therefore, the improved facilities of the Savar households refer to better socio-economic condition than those households in Chhatak upazila.

Overall, the above discussion and the chart show that, being an urban-based locality, Savar upazila has better socio-economic indicators, better housing and sanitation, and greater coverage of electricity compared to Chhatak upazila. This difference in socio-economic conditions may affect the difference in the quality of health service delivery in Savar and Chhatak.

4.4.2 Women's empowerment

Harmer (2011, p. 325) argues that empowerment of women is the most influential social determinant for improving quality of health service delivery. Generally, women's empowerment means enhancing the ability of women through education and economic activity (Harmer 2011). Economic empowerment of women refers to employment of women in economic activity, for example, in agriculture, industry and services. Besides this, providing education to women is another way of enhancing women's empowerment. This sub-section addresses the education and economic status of women in Savar and Chhatak upazilas to understand to what extent they are empowered.

Females comprise 46.69% of the population of Savar and 50.21% of the population of Chhatak (BBS 2012b). The female literacy rate of Savar upazila is 63.9%, however the female literacy rate of Chhatak upazila is 36.3%. The higher literacy rate of the women of Savar upazila means that they may be better aware of the political, administrative, cultural and social aspects of their upazila, which will contribute positively to enhancing governance and health service delivery in that upazila. Besides this, the employment rate of women is 32.72% in Savar upazila where as the employment rate in Chhatak is 6.97% which is considerably lower.

The above discussions show that women's literacy and employment rates are considerably better in Savar upazila than those in Chhatak upazila, implying that the women of Savar are more empowered than the women of Chhatak. More empowered women are able to participate in decision-making in health service organisations and contribute to governance and the quality of health service

delivery. Conversely, the less empowered women of Chhatak have limited participation, which may lead to poor governance in health service delivery.

4.4.3 Politics

There are two major political parties in Bangladesh, the Awami League (AL) and the Bangladesh Nationalist Party (BNP). They have been ruling the country in turn since the independence of Bangladesh. From the 1990s to the mid-2000s, a Bangladesh Nationalist Party (BNP) candidate has been routinely elected to the national parliament from the constituency of Savar. However, the Awami League and other political parties continue to have grassroots presence in this upazila. In 2008, an Awami League candidate was elected to parliament from the Savar constituency. Conversely, a BNP candidate has served the Chhatak upazila as a member of the national parliament from 2001 to 2007. At the parliamentary election of 2008, an Awami League candidate was returned from the Chhatak constituency and continues to serve as a member of parliament. Local politics plays an important role in shaping the quality of governance, which depends on how the politicians behave to contribute to governance and health service delivery.

Respondents of this study argue that several factors, such as participation of the opposition political parties and democratic values produce a sound organisational culture, which leads to good governance. In 2012, the elected members of parliament from both Savar and Chhatak upazilas were from the Awami League. Although the MPs in Savar and Chhatak are from the (same) ruling party, the MP from Chhatak is more known for supporting activities for health, women's empowerment and other social issues. These supporting activities of MPs in health service organisations may contribute to different means of governance of those organisations.

4.5 Conclusion

Savar and Chhatak health service organisations have similar patterns of management, human resources and budgeting as both organisations are part of the central Ministry of Health and Family Welfare. The factors that lead to accountability and transparency in health administration to promote good quality of health care might be different due to the practices of management, utilisation of human resources and budgeting in health service organisations.

The two study sites have different socio-economic factors. For instance, employment and literacy are significantly better in Savar upazila compared to those in Chhatak upazila. In addition, women's empowerment is better in Savar than that in Chhatak. Political characteristics are similar in both the study sites, however the participation of elected politicians in health service organisations is different. The above evidence clearly demonstrates that Chhatak and Savar Upazila Health Complexes (UHC) have different organisational features. Moreover, the socio-economic and political factors are characterised in distinct ways in Chhatak and Savar. The organisational, political and socio-economic factors including the role of various actors will be addressed throughout this thesis to enable an understanding of the impact of governance on quality of health service delivery in Bangladesh. As mentioned in Section 3.8 of Chapter 3 that this thesis used Nvivo for categorising, coding and organising field data and then the researcher analyse these data according to own understanding. This procedure of data analysis used in Chapter 5 to Chapter 9 of this thesis. The next chapter focuses on accountability in sub-district health service delivery based on field data.

Chapter 5

Accountability in Health Service Delivery- Its Managerial Aspects

5.1 Introduction

The implementation of accountability is one of the crucial strategies used to improve governance in health service organisations and the quality of health care delivery. The objective of this chapter[44] is to examine the responsibilities and duties of the actors, namely health service managers, field health workers in delivering health services and to investigate how the management and socio-demographic factors contribute to enhancing accountability and quality of health service delivery. In addition, this chapter examines how the above-mentioned actors and the influencing factors contribute to health service delivery differently in rural and urban health service organisations, and why accountability operates in distinct ways in these two areas.

This chapter is organised into three sections. The first section deals with issues of supervision to understand accountability in health service delivery. The second section examines the positive and negative impacts of coordination on accountability in health service delivery. The final section summarises the overall discussions presented in this chapter.

5.2 The system of supervision and accountability in health service delivery

The sub-district health service has two branches of health service organisations, namely the Department of Health Services and the Department of Family Planning under the Ministry of Health and Family Welfare (MoHFW). Essentially, both these health service organisations are located within the same compound of the Upazila Health Complex (UHC) and provide health and family planning services at the grass roots level in accordance with the rules and regulations of each department. The local managers of these departments ensure the accountability of their subordinate health professionals in terms of their job responsibilities which have been assigned by superior organisations. The UHC also has several subordinate health service organisations at the lower administrative tiers such as Union Sub Centre (USC) and Community Clinic (CC) which are located at union and ward levels respectively. These provide quality of health care to the general population. The manager of the health and family

[44] Some findings of this chapter presented in the Global Public Health Conference 2014 and published the paper as conference proceedings as shown in detail in reference (Islam 2014a)

planning office of the Upazila health administration is responsible for supervising and organising health care services of these organisations and also for promoting accountability of health care providers at the Upazila and field organisation levels.

Family planning services have a specific line of authority to supervise field level family planning service delivery. The Director General (DG) of the Family Planning Department supervises overall family planning services throughout the country. A Divisional Director works at the administrative division level and a Deputy Director works at the district family planning office.[45] The Family Planning Officer of an upazila works under the Assistant Director of the District Family Planning Office. The sub-district Family Planning Officer is responsible for supervising all staff under his/her supervision. In addition, a Family Planning Inspector supervises other field staff who works at the union sub-centre and in the field. One of the mechanisms to ensure accountability is submission of performance reports to the Upazila Family Planning Officer with regard to family planning services.

Similarly, the Director General (DG) of health services at the central level is responsible for supervising health care activities under the Central Department of Health Services. Health services in Bangladesh follow a hierarchical structure; therefore, a higher level of health service personnel is responsible for supervising their immediate lower health services, and so on. The line of authority in this hierarchy is as follows: Central DG-Divisional Director - District Civil Surgeon - Upazila Health and Family Planning Officer (UHFPO). Finally, the UHFPO oversees the medical officer and other staff including field level staff at the Upazila Health Complex (UHC). As the officer in charge of a UHC, the UHFPO is also charged with addressing local issues concerning medicine and equipment, which are faced by field health workers (A visual depiction of health and family planning is given in Appendices 3 and 4).

As the relationship is hierarchical among the health professionals, consequently the subordinate officials are obliged to be accountable to immediate higher officials for their responsibility. Performing the appropriate job responsibility by health managers assist to ensure accountability of bottom rank of health professionals and doing so, it is possible to provide optimum health service outcomes as assigned by the higher health service organisation. In addition, the central authority is responsible with regard to promotion, transfer and disciplinary action of UHC health professionals.

[45] Bangladesh has seven administrative divisions, namely Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur and Sylhet.

5.3 Methods of supervision for promoting accountability

5.3.1 Monitoring

The Upazila Health and Family Planning Officer (UHFPO), in both Savar and Chhatak, monitors the progress of health activities including laboratory tests in order to ensure the provision of good quality of health service delivery. This monitoring is conducted regularly through observation during the provision of care so that all members of health staff are present at their desks during working hours at the Upazila office and fulfil their responsibility in performing their jobs as assigned. The civil surgeon of Sunamganj district visits the Chhatak health complex at given intervals to monitor the performance of staff. In addition, the central supervisory authorities also communicate with the UHFPO in order to ensure the Chhatak Upazila health organisation provides service to the people. However, the health inspector in Chhatak interviewed in this study argued that monitoring by the central authority is insufficient as the authority is highly engaged with administrative work. The health inspector also stated that the district or central authority should visit UHC every month, but these authorities did not visit accordingly. In addition, Chhatak UHC is located at remote area, which may affect effective monitoring by the central health service authority.

Generally, the district family planning officer is directly responsible for monitoring the work of the Upazila and field health services. In contrast, the monitoring process in Chhatak has several weaknesses as the officials' responsible lack a clear understanding about the importance of monitoring. Moreover, poor physical communication such as transportation problems also affects monitoring as mentioned in Section 5.4.7. Likewise, the health officials also appear to lack any commitment in monitoring the progress of the health programs. All of these contribute to poor accountability and inadequate health care. Faguet and Ali (2009) study also found almost similar findings as stated in Section 2.6 (b) in Chapter 2.

Poor monitoring encourages corruption, which, in turn, affects the provision of adequate health service delivery. Oversight of medicine stores is a part of monitoring activity. For instance, as reported by the local informants interviewed in Chhatak, the medicines meant for public hospitals are sold at private pharmacies or in other shops. Needless to say, such activity is illegal, unethical and punishable. This mismanagement may be attributable to poor monitoring by higher-level officials.

5.3.2 Field visits

A field visit is one of the important methods of supervision of health service delivery. The Upazila Health Officer is responsible for making regular field visits with regard to job responsibility of health professionals e.g., timely attendance in office, providing services efficiently and effectively, making report on time etc. in order to ensure accountability of the field staff. The Chhatak UHFPO interviewed in this study stated that he is expected to visit the field at least twice a month to monitor the performance of health workers. However, he also claimed that he has to carry out his administrative duties as well as attending meetings at different levels of administration. Consequently, he cannot find sufficient time for field visits. However, he also stated that he does take necessary action, such as recommend for suspending the payment of salaries of staff for absenteeism, if he receives any complaints from responsible officers.

Similarly, the Upazila Family Planning Officer visits the field services office at least two or three times and organises fortnightly meetings at union sub-centres and monthly meetings at community clinics. During a field visit, the Upazila Family Planning Officer investigates if any misdeed by a field worker has been reported and institutes official proceedings for punishment in order to ensure accountability. Besides this, the district health official visits the field to strengthen supervision and monitoring so that adequate health care can be provided to the people. The FPO of Chhatak interviewed in this research stated that the Chhatak Upazila has achieved the optimum target of family planning services for timely field visits by the District Family Planning Officer. The field staff also regularly visits the family planning clients in their houses to enhance supervision. In fact, the adequate field visits by the supervisor's assists to promote accountability which leads to achieve expected family planning outcomes. The study of Mercer et al. (2004) also supports the above finding as adequate supervision and close monitoring improve NGOs reproductive health program which has been stated in Section 2.4.4(a) of Chapter 2.

As the Chhatak Upazila has a lot of rural disadvantages such as poor road communication and poor motivation facility for health professionals, however the family planning department operates extensive field visits through adequate supervision as stated by the Family Planning Officer in Chhatak, consequently this organisation provides required family planning services.

The researcher collected data during field work (2013) and experienced that the field workers of Savar Upazila work regularly in the field. The Health Inspector and the UHFPO supervise the activities of field staff regularly. The Upazila authority has close supervision of field staff. In addition, sometimes the District Civil Surgeon visits Savar Upazila and inspects the activities

of the field staff. The UHFPO and the Civil Surgeon examine the progress of child immunisation, progress in maternal health, and other activities of the health workers through field visits. In addition, the district level officials sometimes conduct surveys in order to examine the progress in maternal and child health care services and how the field staff are carrying out their responsibilities (Field Data 2013). Moreover, the health inspector and other supervising officials regularly visit the field to ensure that the workers are fulfilling their duties, which promotes responsibility among the officials of the health complex and enhances accountability and good quality of health service delivery. Besides this, officials of international health organisations frequently visit the Savar health complex given that it is very close to Dhaka where the main offices of many international organisations are located (Field Data 2013), and even though the international organisations do not have any formal supervisory role, their mere presence in close proximity motivates the officials and health workers of Savar to be responsible and accountable.

5.3.3 Monthly reporting

The field workers prepare monthly reports regarding maternal and child health services in their area and submit them to their assigned supervisor. These reports are a way of ensuring accountability and responsibility of health workers to a higher authority to improve health service delivery (see Figure 5.1). The health inspector at Upazila verifies the report and submits it to health service organisation. The UHFPO examines the report in order to assess the health care performance and then submits it to a district civil surgeon office as well as the central office. The field data show that monthly reporting mainly covers the following three aspects leading to accountability and quality of health service delivery.

(a) Measurement of performance

The head of the Upazila authority conducts a monthly meeting at a Upazila health complex and meetings twice in the field to assess the performance of health workers with regard to immunisation, family planning, and maternal and child health services. The field workers are obliged to provide appropriate answers on their performance report in the meeting.

The business leader and the local elite in Chhatak (see Appendix 12d) interviewed in this study stated that several field workers of Chhatak sub-district have a tendency to avoid/lessen their responsibility due to negligence of duties; consequently, they produce poor performance in the report. Nevertheless, the authority of the Upazila health service organisation has no administrative authority to stop the payment of salary or to take action against the negligence of duties and poor performance of health workers. The central authority is responsible to

suspend salary of health workers as almost every decision is taken by the central authority of health administration. The UHC supervisor can barely enquire as to the reason for their poor performance and can hardly provide necessary advice to recover the poor performance to improve health service delivery. The advice of the field supervisor often works as motivation to enhance performance for the upcoming report. Office records (collected during field work) of the Savar UHC indicate that meetings are conducted twice at the union level and monthly at Upazila level in order to assess the performance report, yet no evidence has been found regarding negligence of duties and poor performance of health workers. Bradley et al. (2010) study shows different factor such as utilisation of resources through organising and managing health service organisation that improves health service performance as discussed in Section 2.2.1 in Chapter 2.

Therefore, creating a provision to assess performance and salary should be provided accordingly to health professionals, which can be a mechanism to improve accountability and health service delivery.

(b) Reward and punishment

The Chhatak family planning organisation ensures reward/punishment based on performance according to organisational proceedings. For staffs who do not perform satisfactorily according to organisational procedures, the Chhatak family planning organisation has, on occasions, recommended to suspend the payment of salary and reported the matter to the central authorities for execution. The family planning department of Savar however takes a different strategy, such as encouraging the improvement of administrative coordination to promote good quality of health care service delivery. This builds good relationships with the health workers and it instils in them the expectation that they will perform better rather than punishing them. Similar differences in reward and punishment can be found in the delivery of health services, as noted by the particular health officers of the two Upazilas. Hence, participative and motivational supervision is useful mechanism instead of regulative method for ensuring accountability and good quality of health service delivery.

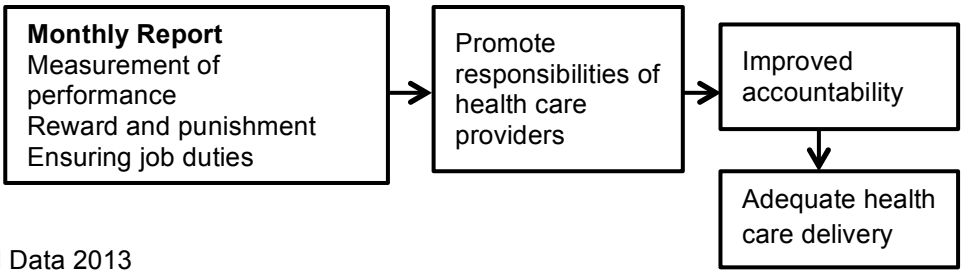
(c) Ensuring assigned job duties

The field workers conduct their daily activities in accordance with plans, programs and schedule prepared in advance. They record their completed work in their monthly report with details about whether the work was related to immunisation, maternal or child health care. The inspector confirms the information during field visits. A Program Director of International Centre for Diarrhoeal Disease Research, Bangladesh(ICDDR,B) interviewed in this research

was of the opinion that reports on daily activities of the field health professional should be submitted to the concerned supervisory authorities at the sub-district health service organisation and a report should be made based on their performance. This would reinforce the responsibility of field health workers and, at the same time make the system more efficient and accountable. Consequently, the health service organisation would be able to provide adequate health service delivery.

Figure 5.1

Monthly reporting to promote accountability and adequate health service delivery



Source: Field Data 2013

In fact, rural field staff have negligence on performing designed duties that affect adversely on health service performance, however, the family planning services at rural organisation perform well because of closely maintaining door to door field visit and organise regular monthly meeting as stated in Section 5.3.2. The field data demonstrate that urban supervision is highly motivating, the relationship of superior-subordinate is friendly, and have a good coordination among the staff consequently; the urban organisation provides adequate health services. The reason for better performance of urban health service organisation could be more urban facilities which are unavailable at rural health service organisations. It is generally argued that good administrative initiatives by health manager and the available of urban facilities are highly related to promotion of motivation leading to better performance.

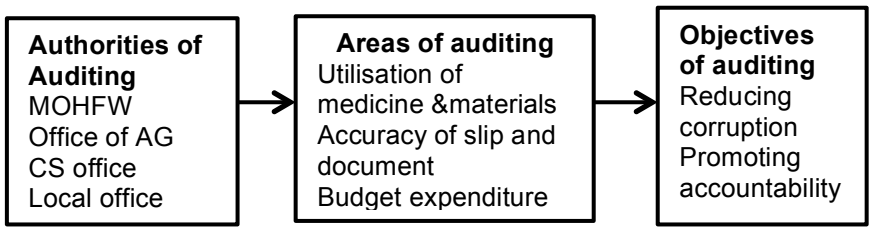
5.3.4 Checking and verifying information

Pharmacists in Chhatak and Savar, interviewed in this research stated that the central authority of the health department and the Office of the Auditor General are mainly responsible for checking and verifying official documents with regard to expenditure of budget, and the utilisation of materials and medicines of health care delivery. The process of verification of office evidence is one of the methods to ensure accountability. Besides this, a national level audit team also audits the health expenditure two or three times a year to ensure transparency. This audit team investigates the distribution of medicine, accuracy of

client payment slips and their relationships with availability of materials remaining in the hospital. In addition, the district civil surgeon office audits the materials and medicines of sub-district health service organisations to promote financial accountability. The aim of these auditing processes is to reduce corruption and promote accountability in health service delivery (see Figure 5.2).

Figure 5.2

Procedure of auditing for promoting accountability of health service delivery



Source: Office Record (UHC, Savar and Chhatak) 2013

Officials of Savar UHC (see Appendix 12b) claimed that they maintain their records accurately in order to ensure responsibility and accountability among its staff. The pharmacist at Savar, interviewed in this study stated that:

> "There is no opportunity here for mismanagement. I have to write and maintain a slip for every medicine and I cannot give any medicine to anyone without a doctor's prescription, because the audit team can come anytime for verification. I maintain the records of medicines distributed in the stock ledger. It is a mechanism to put information of how many medicines are distributed and how many are left. I update the ledger every day. The Resident Medical Officer (RMO) also verifies and signs the ledger every day for keeping the system accountable".

However, a Ward Boy of Chhatak Upazila, interviewed in this study, was of a different opinion:

> "I have watched a number of audits which did not make any positive outcome for promoting accountability. The audit process involves corruption. The audit is conducted by a team from the central office (in the national capital, Dhaka). Previously, the team used to visit each sub-district and audit their papers, but now it conducts the audit from the district hospital, where the papers are brought from the sub-district health complex (Upazila health complex). The audit team examines the office records and marks it with a red ink if there is any miss-management. The UHC authorities put aside funds for the audit team, which is a part of the 'office culture'. In addition, the UHC provides the audit team with free accommodation, good food and free transport. Such audit process does not contribute to enhancing accountability; rather it is a technique of taking money through illegal process".

Auditing the sub-district health complexes from the district hospital may be an efficient way of utilising time and travel funds, however, the culture of providing the audit team with free accommodation, food and transport appears to be a form of bribery. Such evidence

represents weak auditing process of Chhatak UHC. Moreover, health professionals in Savar maintain record management efficiently and perform official responsibilities sincerely, as a result none of corruption evidence has been found by the researcher with regard to negative consequences of auditing process which might be a good sign of improved accountability.

5.3.5 Signature in attendance books

As a mandatory provision, the UHC maintains an attendance book in which the health professionals must sign their attendance. The office records in Savar UHC show that the health professionals sign in at 8.00 am, before they start work for the day. They also sign off at the end of their working day, 2.30 pm. The Upazila Health and Family Planning Officer (UHFPO) verify the signatures in the attendance book. No staff member leaves their work place before 2.30 pm without the permission of the supervisory officer. The same requirement of signing in using the attendance books applies to the union sub-centres of Savar. The regulation requiring staff members to sign in the attendance register should also apply to the Chhatak Upazila health complex, yet it is not implemented properly because of lack of proper exercise of organisational rules and procedures. As well as, the inadequate monitoring of Chhatak UHC contributes to poor attendance of health professionals as shown in 5.3.1. All of this evidence show a lack of accountability among the health staff at Chhatak.

5.3.6 Micro plans

Both the rural and urban health service organisations have micro plans for enhancing health service delivery (see Table 5.1). The health inspector and the assistant health inspector use micro plans to carry out supervision activities. The micro plan provides details of how, where and when a field worker will work in a particular health program to deliver health services. The duration of each micro plan is three months, but its implementation is divided into two parts: weekly and daily. The weekly plan covers six working days of every week and the daily plan is a part of everyday activities. A micro plan contains the list of the health activities that are required to be carried out under the plan. Generally, one health assistant works in three villages or in a particular area in a month in accordance with the framework of the micro plan.

The field workers submit the micro plan to the UHC to define their responsibility to the UHFPO. A copy of this plan is also made available to the health inspector who is authorised to supervise the health assistants. Thus, the micro plan assists to improve supervision which also promotes accountability of the health care providers. The micro plan is an effective tool as it requires the involvement of the immediately higher supervisors and ensures a

responsible performance of duties by the lower level health staff to provide adequate health care.

Table 5.1

Method of supervision of field health care providers in accordance with the micro plan

Administrative unit	Number of health centres	Responsible field workers	Responsible supervisors
Union	24	Health Assistant Family welfare Assistant	Health Inspector Assistant Health Inspector
Ward	8	Health Assistant Family welfare Assistant	Assistant Health Inspector
Village	1-2	Health Assistant Family welfare Assistant	Assistant Health Inspector

Source: Field Data (Savar and Chhatak) 2013

Similarly, nurses work on monthly and daily schedules to perform their responsibilities. The monthly schedule provides information concerning the times of the assignment of duties to patients, while the daily schedule provides information regarding the section/ward to which they have been assigned. The nursing department maintains a register for the assignment of duties, and the nurses fulfil their responsibility to ensure accountability to the UHFPO and RMO as provided in the health service organisation. As the micro plans appear typically to both of rural and urban health service organisations, therefore any difference found in ensuring accountability from the view point of technique followed by the health professionals.

5.4 Factors influencing supervision to promote accountability in health service delivery

5.4.1 Proximity to higher authority

The Savar Upazila health complex is very close in distance to the national capital, Dhaka which makes it comparatively easy for the central government's higher authorities to monitor health care service delivery at Savar. Being aware of the presence of central level supervision in close proximity, the health service professionals of Savar fulfil their responsibilities to provide adequate health care delivery. All of Savar health service professionals interviewed in this research informed this researcher that as Savar UHC is a place where superior officials from the centre visit every week to oversee its functioning; efforts are made to avoid indulging in deception/evasion of duty.

As a result of this scrutiny, the health workers and doctors see patients regularly. In contrast, the Chhatak Upazila Health Complex is situated in a remote area of Bangladesh, although it

is relatively easily accessible from the district and divisional headquarters via reasonably good highways. However, due to its distance, this health complex receives fewer and less frequent monitoring visits by higher level officials compared to the Savar Upazila health complex. For example, the Chhatak UHC receives a maximum of two monitoring visits yearly compared to the eight to ten visits afforded to the Savar UCH as suggested the senior Research Fellow of Bangladesh Development Studies interviewed in this research. Also, the Chhatak UHC does not have any central supervision to promote accountability which is available at Savar. So, the close proximity of central supervision much contribute to improved accountability and health service delivery in urban Upazila health complex in comparison to rural health complex as revealed in field data which also supports the literature as stated Faguet and Ali (2009) in Section 2.6 (b) of Chapter 2.

5.4.2 Quality of leadership

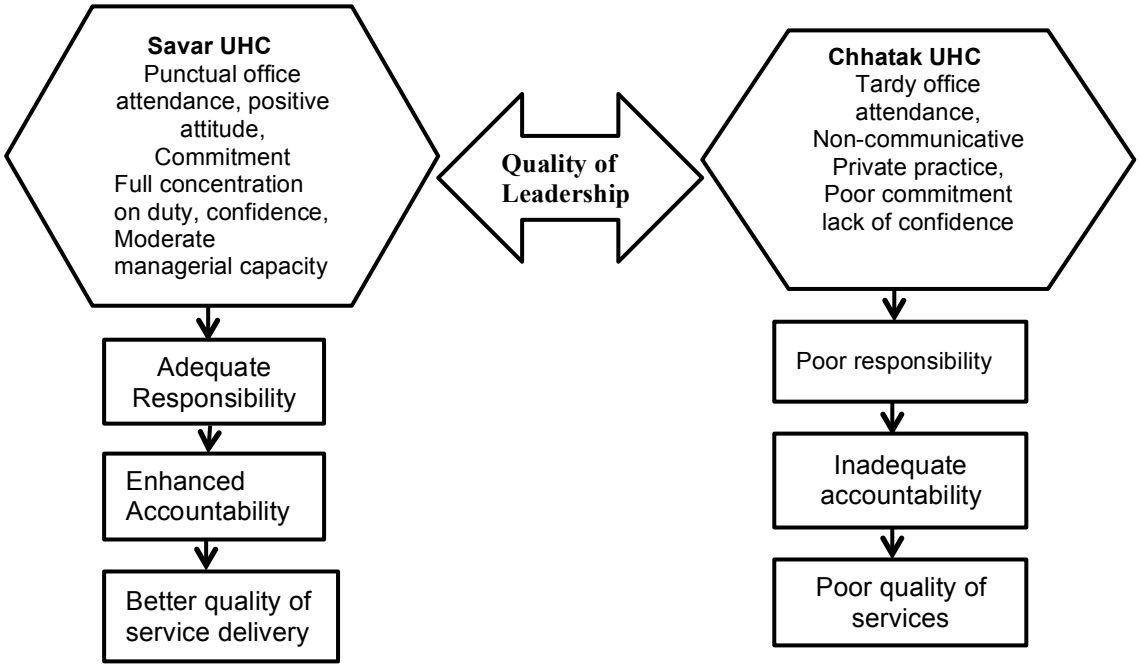
Leaders with suitable qualities are required to enhance the quality of supervision of health service organisations which, in turn, promotes responsibility and accountability among health service professionals. An efficient leader encourages doctors and other health care providers to be responsible in their work and duties in order to adequately provide people their health services. The Vice-Chairperson in Chhatak interviewed in this research stated that the quality of leadership assists in developing the health sector, which promotes 60% to 70% of health service providers' accountability. This refers that the major miss-management will be reduced if the health manager performs job responsibilities effectively and efficiently. A community leader in Savar interviewed in this research argued that the mechanism of supervision has improved due to societal and administrative changes to achieve organisational goals. For example, the health administrator of Savar applies supportive and motivational supervision (also mentioned in Section 5.3.3) to ensure responsibility of health care providers rather than using regulative supervision. Supportive and motivational supervision guides the supervised workers by providing consultation or advice to enable them to be more responsible to their duties.

The field data(2013) show that several attributes of the Savar and Chhatak health administrators vary and contribute differently to their supervisory qualities (see Figure 5.3). The ideas of quality of leadership have been generated through the understanding of respondents interviewed in this research. For example, the UHFPO of Savar comes to the office regularly at 8.00 am and monitors the presence of other health staff which ensures adequate responsibility of health care providers. The UHFPO makes regular visits to the UP sub-centre and to the community clinics (CCs) as a result, Savar CCs are functional and

provide minimum health care delivery. The Medical Technologist (EPI) interviewed in this research stated that the Savar health administrator was sincere and dedicated to the job as the administrator's focus was concentrated full time on hospital work rather than working in the area of private practice. The UHFPO also maintains equal rule for all staff in managing health care delivery. In addition, the medical representative and the newspaper reporter in Savar (see Appendix 12d) also stated that even though the managerial capacity of the UHFPO is moderate, all efforts are made to provide full concentration on the hospital to make health service delivery available to everyone. However, as reported by the respondents of the Chhatak Upazila Health Complex, its health administrator is not a commendable person: supervision is weak, not only at the Upazila level but also at the field level. Health service management has a relatively poor chain of command; subsequently mismanagement is higher and people receive low quality of health service delivery. Therefore, efficiency of leadership is a vital attribute to ensure accountability of health service organisation which clearly mentioned in the above information.

Figure 5.3

Comparison of leadership qualities of rural and urban health service organisations



Source: Prepared by the author based on field data 2013

Savar health care providers are satisfied with the good quality of management of their UHFPO. A health care provider in Savar, interviewed in this study reported:

> "Monitoring management is sufficiently strong at Savar Upazila because the health administrator has good relations with other staff to manage the organisation. The health administrator manages the organisation properly through adequate supervision without the help of the district civil surgeon. He has no failure at field level either, because he is a dynamic supervisor. He works with field level health care providers through supportive supervision to maintain the expanded program on immunisation (EPI). As a leader he works more than a general worker and gives more attention to field work which inspires other officials to do work attentively. He also rewards his staff for good work in accordance with the provisions of the organisation".

The local representative in Chhatak, interviewed in this research argued in a different way with regard to managerial capacity and stated that the shortage in human resources was not the only problem inhibiting the provision of good quality of care. According to him, the great challenge was to use human resources through efficient management to implement health programs which also supported by Kemoni et al. (2008) and Routh et al. (2004) as stated in Section 2.2.1 in Chapter 2. This requires efficient and committed leadership which is virtually absent in Chhatak. In this regard, the Ward Boy in Chhatak, interviewed in this research reported:

> "The UHFPO is a very good person, but he is timid. Even a sweeper does not listen to him. This is a problem of leadership. This hospital recruits its chief office assistant through local influence and the president of the health committee e.g., Member of Parliament for political influence. The UHFPO administers the UHC as a powerless administrator like a 'doll government' (puppet government). He also depends highly on the higher administrative authority particularly on the district civil surgeon for granting recreation leave, earned leave etc. of health officials for which he is authorised in accordance with the organisation. The government authorises this power to the UHFPO in order to the reduce work load of the civil surgeon. But he cannot apply this power which shows his lack of leadership quality".

In fact, the health administrator of Savar is efficient and inspiring as he takes decision using less time, utilise and mobilise organisational and human resources properly whereas the health administrator of Chhatak has less administrative efficiency as the several respondents views interviewed in this study which contributed differently to quality of health service delivery. Besides this, such leadership capacity also differentiates the accountability and health service delivery as shown in the Figure 5.3.

5.4.3 Appreciating the responsibility of supervisors

From the previous discussion in Section 5.2, it is evident that supervision in health service delivery at a sub-district level can be divided into two types, namely, supervisor as the head of the Upazila Health Complex (such as the UHFPO) and a supervisor in the field, who is usually a health inspector (HI) or assistant health inspector (AHI). The field level supervisor is formally

accountable to the UHFPO. Evidence from Savar (Field Data 2013) shows that the UHFPO and HI or AHI collaborate each other by sharing responsibility and exchanging field experience to create better performance all-round. For instance, the field level superior and subordinate sharply organise a plan schedule on immunisation program and work out accordingly which makes the event successful.

Interview with Upazila Health and Family Planning Officer (UHFPO) in Savar, the researcher assumed that the UHFPO's main function is to ensure that subordinate health professionals are accountable and responsible for their duties to promote health service delivery. In addition, the Savar UHFPO works on improving staff efficiency by providing them with appropriate guidance. Moreover, necessary action is taken by the UHFPO during the initial stages of identification of poor performance among staff members. When required, a written notice is sent to the staff member as an extreme form of punishment as is a report to the higher authority for necessary action. The community clinic and the UHC of Savar work well together through regular visits and effective communications via mobile phones. As a result, the health care providers are always present at the Savar UHC and most health care professionals take responsibility in providing adequate health care. However, even though the same processes are available in Chhatak, they are not adequately followed by the UHFPO due to a lack of responsibility and duty as stated the majority of respondents in Chhatak interviewed in this study (see Appendices 12c and 12d). Consequently, poor accountability appears in Chhatak UHC and a very few community clinics provide health services. Burke (2006) study also demonstrated (Section 2.2.1 in Chapter 2) the impact of positive role of health professionals' responsibilities and how they contribute to quality health service delivery. In addition, he showed that lack of coordination and corruption affects the achievement of organisational goals.

Generally, field supervision is supported and motivated by the field workers themselves. The elected representatives in Savar and Chhatak (see Appendix 12c)interviewed in this research stated that the Savar Family Planning Inspector (FPI) appears sincere in supervising the family planning workers in the field, where he frequently visits. He provides useful advice to the field workers and offers solutions to their problems faced by them in concerning health service delivery. Similar supervision of family planning workers is done in the Chhatak Upazila where both the field supervisors and the head of the Family Planning Organisation take care to visit the field and perform person to person supervision in order to achieve the targets assigned by the district office (also stated in Section 5.3.2).

5.4.4 Human resources requirements

The Health and Family Planning Officers in Savar and Chhatak, interviewed in this study stated that the provision of adequate health care is a challenge in the sub-district of Savar as a small number of health workforce provides services to a large population as stated in section 4.3.3. Similarly, lack of human resources is one of the obstacles in delivering adequate health care in the sub-district of Chhatak as supported by the study Ahmed et al. (2009). For example, the Sub-Assistant Community Medical Officer (SACMO) of Kalarukha union sub-centre (USC) of Chhatak, interviewed in this research stated that this centre requires six health officials to promote family planning services although currently only four people are working there; several of the vital positions are still vacant. Besides this, a significant number of positions remain unfilled in the UHC of Chhatak. This lack of human resources limits adequate supervision, which contributes to poor quality health care. The sub-district of Chhatak provides poor quality of health services particularly at the grass roots level due to lack of adequate staff. A study by Ahmed and Zakaria(2009) argued that due to lack of skilled health workforce in Bangladesh a significant number of rural people receive health services from the un-skilled health care providers as stated in Section 2.4.3 in Chapter 2. Their study also found different findings that affect accessibility of health care are lack of access to information, lack of health awareness and lack of economic opportunity. The Health Assistant (HA) of Chhatak explained (see Box 5.1):

Box 5.1

Impact of inadequate human resources on quality of health service delivery

> 'I work in a ward and provide health services to 296 children and 1,672 women. One health assistant is not sufficient to provide services to such a large number of patients, for which at least two health assistants are required. I cannot cover this entire ward within the working days as expected. For example, during the immunisation program (a two day program) I have to visit at least 450 families, which are absolutely difficult for me. I try to work with my best effort; however it is difficult to provide efficient service for me. Currently I work in Non-Communicable Diseases (NCD), attend weekly meetings and participate in training. I also have to register the clients' details. At times, such as in the EPI program, I have to work continuously for two hours on my feet. It takes time, which affects service delivery. If there were two health assistants, one could register the client's details and the other provide immunisation and advice on health care'.

The Savar UHC has very little vacant position and only a small number of unfilled vacancies of field level health care providers as stated in Tables 4.1 and 4.2 in Chapter 4. Although most of the allocated positions are filled, they are not sufficient to provide adequate services to Savar's high-density population. The health care providers work very hard and provide

sufficient time to their patients, but they cannot cope with providing care to all their patients. . However, one of the national health respondents interviewed in this research added that the lack of quality health services is attributable to not only a shortage of human resources but also to inadequate supervision and lack of responsibility among the health service professionals in the sub-district organisation. In this regard, he also pointed out that the field supervisors are mostly absent in rural areas and, therefore, not able to keep the field workers on task.

Generally, shortage of human resources is a big challenge in both of Savar and Chhatak UHC which affect adversely the quality of health service delivery. Savar UHC has limited absenteeism in comparison to Chhatak UHC; one of the causes could be improved accountability. But the health professionals of rural health centre has poor accountability which contribute to lack of supervision subsequently rural health service organisation provides inadequate health care delivery.

5.4.5 Motivation

The provision of good quality health care depends, among other things, on effective supervision. As discussed above, effective supervision depends on the adequacy of the number of supervisory staff. It also depends on the motivation of the supervisory staff themselves. Interviews conducted in the field with health professionals in Savar (see Appendix 12b) for this study showed that the supervisors of Savar UHC are sufficiently motivated to work there. One of the reasons for their motivation is the availability of urban facilities in Savar, which encourages health professionals (including the supervisory staff) to work sincerely. Particularly, for the supervisory staff, this motivation makes them more responsible to perform their duties of supervising the health officials in the field. A posting at the Savar Health Complex is much sought by doctors and paramedics alike as doctors can avail themselves of multiple opportunities such as private practice, higher studies and other urban facilities by dint of being posted there. Local informants such as business leader in Savar, interviewed in this study stated in order to be posted to this UHC in Savar, this highly competitive situation requires political influence. Nevertheless, these motivations are not available in a peripheral sub-district like Chhatak, which lacks most of the facilities mentioned above for Savar. Consequently, there is high rate of absenteeism of health professionals in Chhatak UHC and the limited health professionals provide poor quality of health service delivery (details in Chapter 6). However, the study by Penn-Kekana et al.(2007) in Section 2.4.2 in Chapter 2 showed that improvement of motivational facilities for rural health professionals contribute negative outcomes particularly in improving quality health care

delivery, because the motivational payments were not given all levels of staff, consequently those who did not receive such payment lost their motivation to improve and those who did receive such payment felt guilty and did not it perform well because their colleagues were not given motivational payments.

The health care professionals interviewed in these two rural and urban health service organisations (see Appendix 12b) show the motivational factors differently. For example, rural health care providers argued that working at a rural health service organisation requires additional motivation to provide adequate health service delivery. The health care providers of Chhatak who have to work in marshy areas naturally face different hurdles than those working in the plains. According to the rural health care professionals (who work in marshy area), the government should offer special allowances to those officials who work in the marshy areas, thereby making them less eager to be posted to an urban health care organisation. A posting to a remote area such as Chhatak is generally considered punishment for officers and makes them much less motivated to work there. On the other hand, health care providers of Savar interviewed in this study noticed that their responsibility and workload have increased significantly due to the introduction of new health programs and a rapidly increasing population at this urban Upazila. Therefore, while their supervision load has increased in the last couple of years, there has been no corresponding increase in honorarium and transport facilities. The government does not provide any additional facility to enhance the motivation of the supervisory staff, which adversely affects the quality of health service delivery.

In short, motivational facilities improve supervision and quality health service delivery. The urban health service organisation has more motivational facilities, but they are not highly satisfied because health professionals have more needs as they live in urban environment. With regard to improved motivation, the rural and urban health professionals' claim are rational and appropriate as the working environment are different, therefore demand of health professionals should be different. For this, necessary policy initiatives based on urban-rural locality need to be taken for promoting accountability and quality health care delivery as stated in Chapter 10.

5.4.6 Size of the population and budget

The government has a provision that one domiciliary worker at ward/village level is supposed to work for the population of 5,000-6,000 in order to provide quality health service delivery (Directorate General of Health Services 2013, p. 30). However, a health care provider in both Savar and Chhatak has to cater for a much larger population than that which is stipulated in the government regulation. Health Assistants in Savar and Chhatak reported that on average,

a health care provider has to provide services to 17,000 persons in Savar and 9,000 in Chhatak. The ratio of population to health care provider is extremely large for the sub-district of Savar. Similarly, the numbers of doctors, nurses and other health care providers are not sufficient to deliver a good quality of health care for the large population. One of the reasons for the increase in population in Savar is the huge number of migrants from other parts of the country. People move here for the purpose of employment due to growth of the garment and other industries; therefore, population numbers fluctuate as people continue to arrive and depart. That being said, the government does not have any additional initiative to provide health care to the migrant population.

The Health Assistant in Savar, interviewed in this research pointed out that she cannot discharge her responsibility to the entire population in a proper manner. One of the reasons for this is the large population making it beyond her capacity to provide good quality of services, despite the work effort. As mentioned above, one health assistant is expected to visit every household in his/her allocated area and provide services to 6,000 people in a month. The health workforce has not increased sufficiently in the last fifteen years, yet the population of Savar has rapidly grown from 0.8 to 1.3 million (Bangladesh Bureau of Statistics 2012b). Notwithstanding that, no new post has been created to meet the demands of the additional population. Similarly, nurses and doctors are limited in number in comparison to population size (see Table 4.1 in Chapter 4), but the local informant interviewed in this study reported that only 10% of the population has access to minimum public health care. Therefore, people are compelled to visit NGOs and private facilities. However, this is possible only for people who have the financial capacity to seek private health care (see Section 6.4.1 of Chapter 6).

The UHFPO pointed out that the government allocates a budget to each Upazila based on the number of beds in the UHC. This budget allocation method is a great challenge to provide health service quality for the sub-district of Savar as, according to the UHFPO, the number of beds in a UHC is not sufficient to cater for the total population of the Upazila. This implies that the number of beds in the UHC should be increased consistent with the growing population. For example, there is a large difference between the populations of Savar and Chhatak. The population of the Savar sub–district is more than 1.3 million whereas that of Chhatak is nearly 0.4 million. However the difference in the allocation of budget between Savar and Chhatak is not commensurate with the difference in their populations. Sometimes, the local elected representative of Savar is able to manage additional medicine as stated by the Vice-Chairperson of Savar Upazila for the UHC by pursuing higher authorities in the Ministry of Health and Family Welfare, but it does not fully satisfy the local need for medicine.

A Family Welfare Assistant (FWA) in Savar was interviewed in this research reported:

> "Previously I worked for 500-700 clients in a unit of Savar Upazila (an Upazila consists of 30-36 units). While the population of Bangladesh has increased from 80 million to 160 million in the last couple of decades, every unit of an Upazila has doubled in population and the number of clients has likewise doubled. It is not possible for one FWA to serve this huge number of clients efficiently, For example, one FWA, who is expected to visit/contact every family two times each month is currently able to contact a family only once every three/four months. The reason is that while the number of clients has increased the health workforce has not expanded accordingly. Therefore, the quality of family planning services has declined significantly"

Due to the increase in population, health care providers cannot provide sufficient time to each of family/client as necessary. At present, the health workers have to divide their allocated time to a much larger population as stated by the FWA which affect adversely on quality of health service delivery. Although other studies (Hanlon et al. 2012) have found that high density populations (such as those in Savar) allow more efficient coverage in health care, the Family Welfare Assistant (FWA) in Savar interviewed in this study argued that the volume of clients in Savar is too large for one FWA to work efficiently. As the population has increased rapidly over the last decade but the health workforce has not been increased accordingly therefore, quality of health service delivery might be impossible by the existing number of health professionals.

The Upazila Health and Family Planning Officer (UHFPO) of Savar, interviewed in this research stated that the budget is allocated at the same rate (that is, per bed) among all Upazila hospitals in Bangladesh whether they are rural or urban (see Table 4.3 in Chapter 4). The UHFPO further stated that health care providers' salaries are also paid at the same rate in rural and urban Upazila hospitals and no allowance is made for the difference in costs of living between urban and rural hospitals. According to the UHFPO, this is one of the causes of dissatisfaction among the healthcare providers of urban Upazila hospitals. The majority of the health professionals in Savar (see Appendix 12b) interviewed in this research claimed that a busy and densely populated Upazila such as Savar has a greater workload and, therefore, a higher salary package could enhance the health professionals' motivation for supervision leading to better accountability and quality of health care. On the other hand, the family planning officer of Chhatak, interviewed in this study was of the opinion that Chhatak healthcare providers should be paid an allowance for living and working in a remote area. He also claimed that the budget allocated for the running of the Upazila hospital was not sufficient, as it does not take into account the additional resources needed to cover the remote and extensively marshy area. Moreover, he stated that only a limited amount of budget is

allocated to organise national programs such as World Population Day; however this amount is insufficient to motivate the field workers.

The Savar Family Planning Officer (FPO) interviewed in this research pointed out that the family planning budget, which covers the delivery of family planning materials and medicines, the organisation of training of field workers, and the preparation of reports, is not sufficient to carry out all of these activities and that the budget should be increased ten times. Another study Shetty and Pakkala (2010) argued that not only sufficient resource (budget) but also efficient use of resource affect positively on quality of health service delivery. The FPO also argued that the budget for office management is not sufficient for a place like Savar. He went on to claim that there are unbudgeted items of expenditure. The FPO gave the following example:

> "Suppose the Director of Family Planning in Dhaka visits Savar to organise a program. Generally, high officials come with a number of their staff to accompany them. So, the office has to arrange entertainment for the Director and his companions and end up spending approximately Tk.10, 000. However the government budget has no specific item for entertainment of this kind; consequently, the office collects this money through private contributions from the Upazila administrative staff and colleagues in the family planning office".

Talking to the FPO gave the impression that such unbudgeted expenditure is a cultural matter[46] and it is not certain whether it has an impact on the quality of health service delivery. Basically, budget is allocated based on bed capacity of UHC whether the health service organisation is located either rural or urban areas. Even the density of population is not considered for budget allocation. As a result, local demands are not met with this traditional procedure of budget allocation, which affects the quality of health service delivery. Perhaps such entertainment items should be included in the regular budget of every organisation.

5.4.7 The road transport system

The Chhatak Upazila health professionals are not able to provide 100% good quality service to people in the very remote areas due to a poor communication system which contributes to low quality supervision and inadequate health care delivery as reported by the Health Inspector in Chhatak. He also mentioned that the field workers are unable to move from one place to another quickly as a result of poor transportation facilities. Due to the non-availability of public transport in rural areas, people have to walk for at least four to five kilometres in order to access the nearest health care centre. For instance, one Chhatak health assistant

[46] Those familiar with the situation in Bangladesh and indeed the entire sub-continent and other Asian countries would know that these types of "entertainment expenditure" are never parts of official budgets. At the same time, visiting officials expect the local staff to provide such "entertainment". That is why it is termed a cultural matter.

interviewed in this research claimed that moving medicine from the UHC to a rural area during the expanded program of immunisation (EPI) takes at least two hours due to poor transport. Due to good transportation, it is easier to come to Chhatak from the district headquarters in Sylhet, but it is difficult to go to Chhatak from a rural area. Poor transportation particularly affects women health workers who experience great difficulty in visiting the rural families/clients and provide adequate health services as reported by the Health Inspector in Chhatak.

The Family Planning Officer (FPO) in Chhatak, interviewed in this study stated that during the rainy season, the field supervisors use boats, which make it even more difficult to visit remote areas as often as required. He also explained that sometimes the government organises emergency camps to provide services to the hard to reach areas however such services do not meet people's expectations. Some areas of Chhatak are inaccessible due to the fact that the distance from one village to another is about five to ten kilometres and they are not connected by roads. These areas have been surrounded by water for most of the year. On the other hand, the Savar UHC has a well-developed transport system which makes supervision easier leading to better accountability by the health care professionals in comparison to the Chhatak UHC as experienced by the Health Inspector in Savar. With reference to private hospital, Rahman and Capitman (2012) study demonstrates that hospitals located in major urban settings generate more profit (presumably provide better health care because of improved governance) compared to hospitals that are situated in rural areas as stated in Section 2.6 (b) in Chapter 2.

In practice, supervision is one of the aspects of managerial responsibility which affects accountability and contributes to quality of health care delivery. The nature of supervision mechanisms such as monitoring, field visits and micro plans are almost similar as the rural and urban health service organisations are run through the same government rules and regulations. However, some of crucial factors as mentioned in the above analysis e.g., management, proximity of health service organisation from central health administration, physical communication, leadership attributes, motivation contribute differently to rural and urban health service delivery. The field data show that the above mentioned factors work constructively as the health professionals perform duties appropriately in urban health service organisation in comparison to rural organisation. Consequently, urban UHC contributes to improved accountability and health service delivery. Similarly, coordination is another important aspect of managerial responsibility which influences accountability and service delivery. This is examined in the next section.

5.5 The role of coordination in promoting accountability in health service delivery

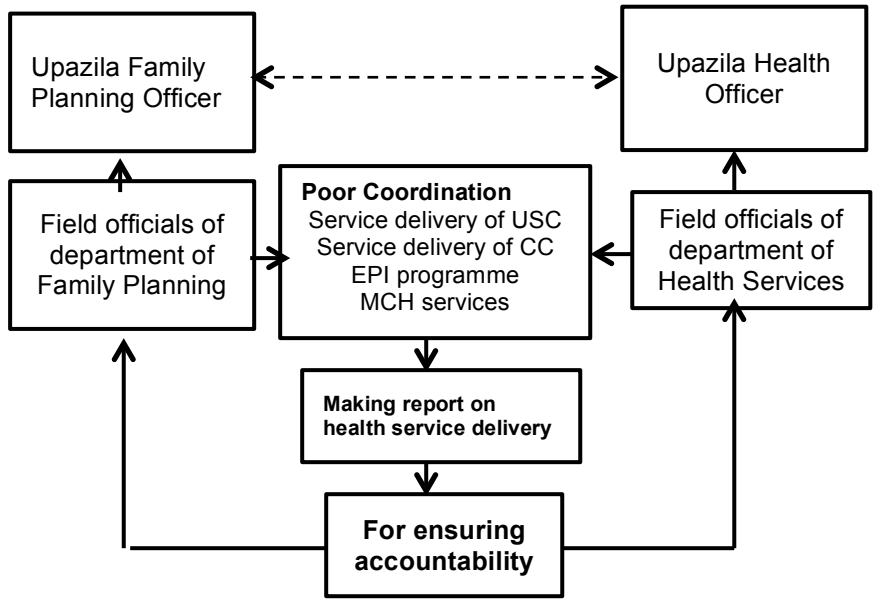
Coordination promotes accountability that leads to adequate health care. In this regard, the Program Director (governance) of ICDDR, B interviewed in this study stated that quality of health service delivery at an Upazila level involves multiple agencies, service providers and their management skills. The Program Director also stated that coordination is one of the management tools that promotes not only accountability of health professionals but also enhances the quality of health service delivery. Field data (data collected for this study in the field) show that health service delivery at an Upazila health complex promotes accountability through coordination between the Departments of Health and Family Planning.

Being parts of the Ministry of Health and Family Welfare, the Health and Family Planning departments of an Upazila are located in the same health complex. They provide health and family planning services under the management of a team which consists of health and family planning workers at the field level as required by the Ministry of Health and Family Welfare (Directorate General of Health Services 2013). These two departments jointly provide services at union sub-centres, community clinics, the expanded program of immunisation (EPI), and some maternal and child health (MCH) programs (Directorate General of Health Services 2013). Data from the records of the Chhatak and Savar UHCs show that the field health workers are officially responsible for their own departments with regard to their job responsibilities and duties. For example, a family planning field worker would report to the Upazila Family Planning Officer (FPO) and a health field worker would report to the Upazila Health and Family Planning Officer (UHFPO).[47] The FPO and the UHFPO do not share these reports between them, rather they forward them to their next higher level officer (see Figure 5.4). Two national level respondents interviewed in this research (Faculty member of the Department of Public Administration, Dhaka University, and a Senior Research Fellow in the Bangladesh Institute of Development Studies) stated that the current rules and regulations of a UHC do not provide for effective coordination between the Departments of Health and Family Planning. This adversely affects accountability and quality of health care delivery. Besides this, the lack of teamwork and poor understanding among the health care professionals contribute to poor coordination.

[47] The official designation of an Upazila health officer is Health and Family Planning Officer (UHFPO), which could create some confusion in the reader's mind. This point will be discussed later.

Figure 5.4

Mechanism of coordination for promoting accountability in the departments of Health services and Family planning Services



Source: Prepared by author based on field data 2013

Missing coordination

Existing coordination

In fact, the heads of the Health and Family Planning Departments of a UHC should be responsible for enhancing coordination between their departments to ensure a good quality of health service delivery. Effective teamwork in management promotes coordination which leads to accountability. However, the existing lines of authority under which the UHFPO and the FPO work do not encourage such coordination.

The Health Inspector at Chhatak UHC stated that effective coordination between the Departments of Health and Family Planning would provide adequate information concerning new clients, schedules of immunisations, satellite clinics[48] and EPI camps[49] that would help

[48] A satellite clinic is a mini mobile health and family welfare centre at union level run by field level health staff in the Department of Health and Family Planning. This clinic provides health care services, particularly to those people living far away from the union centre. The main objective of the satellite

count the patients accurately and deliver health services quickly. He also stated that coordination creates good teamwork, which strengthens the human resources capacity of the centre to provide adequate health care. For example, field workers of health and family planning work jointly on the implementation of EPI programs and cooperate well with each other. This contributes to the success of that program. Besides this, the Family Planning Inspector (FPI) in Savar stated that health service organisations have poor resource availability such as medicines and materials. He also stated that coordination helps to reduce mismanagement and promotes organisational resources through using management appropriately to provide efficient and effective health care delivery. For example, human resources can be used efficiently through working health and family planning staff in together for implementing immunisation program. Similarly, Burke (2006) study shows that lack of coordination and non-cooperation are the challenges to achieve organisational goals as stated in Section 2.2.1 in Chapter 2. The next section discusses on challenges of coordination and its impact of quality of health service delivery.

5.6 Challenges of coordination in health service delivery

5.6.1 Organisational conflicts

As mentioned earlier, the Health and Family Planning Departments have very limited coordination between them. In this context, a national respondent in the Family Planning Department (Deputy Director, Finance and Field Services), interviewed in this study stated:

> "Both the health and family planning departments purchase iron and folic acid tablets for pregnant women, and the field staff of both departments distribute these tablets when they visit the field. This creates duplication and conflict between the staff of the two departments. To avoid this, it is essential to have a coordinated approach by the two departments to estimate how much iron-folate tablet each department will purchase in order to use the medicine efficiently. But none of the departments takes the initiative to have such coordination. Consequently, the two departments purchase much more than is required. This also results in the purchase of inadequate (or no) supply of other useful medicines. As a result, the field level clients do not get adequate services as required".

Moreover, although the respective departments (Health and Family Planning) have their own roles and duties well specified within each of them, there are some items of work, which are

clinic (SC) is to serve mothers and children and to create people's awareness of the services available (Haque et al. 2001, p. 41).

[49] The Expanded Program on Immunisation (EPI) camp is the vaccination campaign/schedule in Bangladesh, which is organised by the Department of Health. This program offers vaccines against nine diseases for children of Bangladesh. In addition, this program provides Tetanus Toxoid (TT) vaccine and Measles and Rubella (MR) vaccine for women of reproductive age (15-49 years)(Directorate General of Health Services 2014).

present in the duty statement of both departments, creating duplication of work and conflict between them with regard to areas of service.

The family planning officer in Savar, interviewed in this study, mentioned that a silent conflict also exists with regard to office space between the Departments of Health and Family Planning in the sub-district organisations, which affect accountability and quality of health service delivery. The Department of Family Planning has no separate building for its office; rather it uses a part of the building of the health complex to conduct its activities, which is resented by health department staff. The officials of the Family Planning Department feel that they have no right to the space they are working from which badly affects their performance. The two departments do not have separate office spaces because initially, when the Family Planning Department was created within the Ministry of Health, the two departments operated as a unified organisation. This continued for the first couple of years, but later they became separated due to changes in health policies and programs or details, (see Section 1.2.3 in Chapter 1). As mentioned, currently, the two departments operate from different offices located in the same building but they conflict with each other.

Another area of silent conflict is the designation of the head of the Department of Health Services at an Upazila health service organisation as stated by the Upazila Family Planning Officer (UFPO). Currently, the health department head has the designation Upazila Heath and Family Planning Officer (UHFPO). The Family Planning and the Health Department pursue different activities and they are not unified as mentioned earlier. However, the health officer uses 'family planning' officer as part of his designation. The Family Planning Officer in Chhatak interviewed in this study, considers it wrong that the Head of the Health Department uses 'family planning' as a part of his designation. This conflicting issue is well known to the higher authorities, yet they cannot settle it due to bureaucratic problems.

As the health and family planning departments have an organisational conflict with regard to office space and official designation, which is a challenge of effective coordination in implementing health service delivery. Therefore, the real coordination is a challenge at UHC, which limits good governance and quality health service delivery. The following section argues that inadequate organisational policies create poor coordination between health and family planning, leading to poor accountability and suggests policy initiative to make effective coordination to promote accountability.

5.6.2 Inadequate organisational policy

The UHFPO of Savar, interviewed in this study, claimed that the Health and Family Planning Departments have no consolidated policy for the effective coordination between the two departments to promote accountability. In contrast, the Family Planning Officer in Chhatak, argued that even the family planning department has an administrative problem with regard to who should be the head of the (family planning) department. He stated that his department has two sections, clinical and non-clinical, which each have separate heads. Usually, the head of the family planning section is appointed as the overall head of the Family Planning Department, however the head of the clinical section, which is of the same rank as the head of the family planning section challenges this arrangement and claims that he should be appointed as the head of the Family Planning Department. Such internal organisational conflicts could be avoided if there were clear directives from the ministry should hold the position of overall head of the Family Planning Department as pointed out by the Chhatak FPO. The Family Planning Department needs separate hierarchy for the clinical and non-clinical wings to enhance job satisfaction and to promote coordination. The Family Planning Officer of Chhatak interviewed during this research reported:

> "The Upazila level in the Family Planning Department has two heads, one is a doctor and another is a general civil servant. The Family Planning Department would work smoothly if there were one head for an Upazila office. Two heads lead to a lack of coordination in delivering family planning services. Two officers are sufficient for a department, but there should be one executive head who will maintain everything with regard to administrative responsibilities. The executive head could be either a clinical or a non-clinical person but there should be a clear directive from the Ministry about this".

The inadequate organisational policy creates poor coordination which ultimately leads to poor accountability and health service delivery. For this, necessary policy initiative requires to make effective coordination for promoting accountability as suggested in Chapter 10.

5.6.3 Lack of teamwork

Two groups of doctors, the medical officer (MO) and sub-assistant community medical officer (SACMO), are attached to the Upazila health service organisation to provide emergency health services (Field Data 2013). The Medical Officers of Chhatak UHC lack cooperation with SACMO to perform emergency duties as reported by the SACMO in Chhatak. Further, Chhatak hospital has high absenteeism among its medical officers as stated in section 6.3 in Chapter 6. This is, however, totally different in the case of the Savar Upazila health complex, where a medical officer including a SACMO is present 24-hours a day for emergency services (Field Data 2013). They have also good understanding among them in delivering services that

contribute to effective health care delivery. However, non-cooperation from the lower class employees[50] is one of the challenges of teamwork for Savar UHC as stated by the medical officer there. The medical officer also claimed that some employees, such as the midwives and ward boys, provide inadequate assistance leading to delays in delivering services. She further claimed that in these circumstances, the doctors have to provide services without any assistance from support staff.

With regard to teamwork at the field level, the health service organisations of Savar and Chhatak have similar disputes between the Departments of Health Service and Family Planning (FP) as experienced by the researcher during field work. Health department officials regard the family planning officials with contempt as they generally do not have knowledge of clinical matters, for example, how to provide immunisation as they have no clinical experience and training as reported by the Health Assistant in Chhatak in this study. The family planning assistant provides advice on the importance of family planning and distributes medicines and materials for pregnancy planning however, they do not know how to confirm registration of clients and fill in immunisation forms.

The Chhatak Health Assistant claimed that family planning field workers provide very little assistance to the EPI program. He also stated that while the health assistants come to the EPI centre early between 8.00 am to 8.30am in accordance with office rules and regulations, the family planning assistants come to the centre rather late, between 10 .00 am to 11.00 am. According to the above Health Assistant, the family planning assistants do not regard immunisation or other clinical work as a part of their duties and therefore are not serious about their participation in the EPI camps. Similarly, the Savar Health Inspector (HI) complaint against the family planning workers and reported:

> "Family planning (FP) workers of Savar work according to their will. They claim that they work in the EPI program and work from 8.00 am to 3.00 pm. In reality, they come to work at 11.00 am and work only for one hour but sign their attendance in the attendance book. They do not carry vaccination bags from one place to another place. In addition, they do not ensure their reporting and leave the place as soon as possible. So, to what extent do they assist us? They want to take credit without working".

However, the FP field officials argued differently with regard to teamwork in delivering health services. They claimed that FP workers assist the health department in the EPI program and other health services, but that the workers from the Department of Health provide no significant assistance with family planning services. Such conflicting claims weaken the team

[50] In the Bangladesh civil service hierarchy, 4th class employees constitute the bottom rank of workers who provide assistance to the higher-ranking officials.

spirit of health and family planning workers which really make not only poor coordination but also poor accountability. This lack of teamwork appears in both rural and urban health service organisations. But good coordination appears in between the two types of medical professional in Savar which could be an ideal example for promoting quality of health service delivery.

5.6.4 Lack of role clarification

The terms of reference of the *union parishad* (UP), meaning union council, do not clearly explain to whom the health care professionals are accountable for delivering health services (Local Government Division 2015). As vaguely defined the role clarification, sometime the field workers are confused about whether they are accountable to the elected representative, to the head of the health/family planning department, or to the Upazila Nirbhai Officer (administrative head of a sub-district). The role clarification is very unclear concerning to whom the health professionals, particularly field workers, submit their report with regard to their job responsibilities to ensure accountability as pointed out by the Program Director (Governance) of ICDDR.B. This is a significant challenge for accountability at local health service delivery. The UP chairmen (Savar and Chhatak) believe that local health professionals are accountable to them as they work in the chairperson's premises/locality. Thus, the UP chairman guides field officials. Each health official is of the opinion that s/he is not working under the chairman, and is formally accountable to his own organisation. In this regard, a respondent at ICDDR,B(Program Director) interviewed in this research reported:

> "Theoretically, health care providers are accountable to the UP chairman. According to the rules and regulations of the government, field level health workers have to be present at UP meetings; however, they do not know that they should attend the meeting. They think that they are not accountable to the UP and the people. They are government officials and are responsible for ensuring accountability to the health department".

Actually, the inadequate role clarification in the existing local government is one of the causes of poor accountability of local health service delivery. This happens while the field level health and family planning workers serve their clients in the premises of the Union Sub Centre (USC). As this problem appears at the local level, it's a big challenge to ensure accountability of local health service delivery.

5.6.5 Lack of understanding and trust

The Upazila administration comprises a number of departments, for example, health, education, family planning, and women affairs. Coordination among these departments can

improve quality of health care service delivery (Asian Development Bank 2003); however there are misunderstandings among officials of these various departments due to power inequality and distribution, lack of close cooperation, and poor leadership qualities as reported by the Vice-Chairperson in Savar. The Vice-Chairperson of Chhatak similarly reported that the Upazila elected body has limited administrative power for working, decision-making and developing coordination to promote quality of health service delivery. She also stated that for this, the head of health department needs to maintain relationships with other departments including the elected representatives in order to enhance coordination. She further claims that very few people are working honestly with regard to promoting coordination.

As misunderstanding among the departments limits coordination, which is also, a threat to improved accountability and adequate health service delivery. The inadequate dialogues and poor personal interactions among the staff can be caused of poor understanding, which needs to be improved to enhance coordination.

5.6.6 Challenges of unification

The national health official (Deputy Director, Health and Education), interviewed in this study argued that coordination is not the most appropriate method to promote health service delivery as the two wings (the directorate of health services and family planning) have separate chains of command with limited coordination between them. Unification of the two departments can promote governance and a good quality of health services, not only at the national level but also at the local level. The integration of two departments into one reduces the problem of human resources shortage. An academic of the Dhaka University, interviewed in this research gave similar ideas with regard to integration of two departments and suggested to reduce bureaucratic complications for promoting accountability.

However, the family planning officials interviewed in this research claimed differently and reasoned that a unified system would lack coordination. If family planning belonged to health, health service officials would monitor the Family Planning Department, and create a sense of deprivation among the family planning staff, because they (family planning staff) feel that family planning would be treated as being less important and therefore, would get less resources. During the time of unification,[51] the progress of family planning services was unsatisfactory due to conflict and lack of coordination. The Family Planning Department has

[51]At the time of the Fifth Five Year Plan (1997-2002), the Ministry of Health and Family Welfare unified health and family planning wings at the sub-district level and under. This was done instead of the top to bottom unification in order to avoid duplication and overlapping of Maternal and Child Health (MCH) services and to provide health and family planning services in a package to ensure efficiency gains (Osman 2008, p. 265).

limited administrative power in comparison to the Department of Health Services. FP officials lost their motivation to work appropriately due to lack of administrative power. Besides this, unification would make it difficult to control FP staff.

The above discussions show that, supervision works ineffectively in the rural health service organisation due to poor management, poor communication and poor leadership behaviour compared to the urban health service organisation. Coordination has a positive impact that contributes to effective health outcomes, yet lack of coordination is the cause of organisational conflict, lack of team work, poor role clarification and mistrust that are all conducive to poor accountability and inadequate health care. Overall, management is not as efficient and effective as required to provide good quality of health care but some factors such as health professionals' responsibility, motivation, and physical communication work positively in the urban health service organisation which contributes to a slightly better quality of care delivery.

5.7 Conclusion

The management of the sub-district health service organisation is bureaucratic where decisions are made as a top-down process to promote accountability and quality of health service delivery. As respondents interviewed in this study stated, bureaucratic management in health services limits participation, cooperation and coordination which all affect accountability and adequate health care delivery.

Based on the respondents' views mentioned above, the summaries of findings in this chapter are as follows:

Monitoring and auditing systems are poorly functional to rural health service organisations due to inadequate organisational policy, poor understanding of monitoring management, unethical practices, and the negligence of duties of the health administrator. Consequently, corruption and mismanagement have widely run through health service organisations which reduce not only accountability but also good quality health service delivery. In contrast, the Savar conducts field visits regularly such supervision has significant effects on enhancing accountability and health service delivery. Supervision factors such as proximity of higher authority, improved leadership qualities have significantly contributed to the promotion of accountability and improved health service delivery however, these factors worked poorly in rural health service organisations.

Urban health service organisations have good motivational facility, strong supervision, additional facilities, and improved communication compared to rural organisations which

contributes significantly to improved accountability and health care delivery as shown in section 5.4. However, the high density of population is the major obstacle to promote quality of health service delivery due to limited health workforce and organisational resources that limit adequate supervision and subsequently provide poor quality of services. In general, health service organisations (urban and rural) have an insufficient budget which affect accessibility and affordability of health service delivery.

Effective coordination improves human resources efficiency that assists the health service organisation to improve quality of care. Nevertheless, health service organisations lack team work, inadequate policy initiatives, and organisational conflict that contribute to poor coordination. This in turn lead to less effective and efficient health service delivery. Moreover, rural and urban both of health service organisations have limited coordination as they are operated through same line of government authority. A slightly bit of improvement has found on teamwork in Savar.

This chapter has examined the managerial aspects required to understand accountability and the quality of health service delivery. Nevertheless, understanding accountability from a professional responsibility is critical as the quality of health service delivery depends on the behaviour of health care providers. Thus, these issues will be addressed and examined in Chapter 6.

Chapter 6

Accountability and Health Service Delivery- Its Professional Aspects

6.1 Introduction

The obligations and responsibilities of health professionals play significant roles in health service delivery as they directly contribute to enhancing accountability in, and quality of health service delivery. Managerial and professional accountability are two separate dimensions, which has given clear understanding of health service accountability. The earlier chapter (Chapter 5) analyses accountability from health service management, however, professionalism of health care providers is crucial aspect, which is highly relevant to quality of health services delivery. Therefore, this chapter deals with several critical aspects that affect professional responsibility including health care professionalism[52], behaviour of health care providers, reasons for absenteeism, the impact of private practices, and the causes and effects of corruption in understanding accountability and health service delivery. Additionally, socio-economic and political factors and their impact on professional accountability are also examined. The objectives of this chapter are to analyse how various factors shape the behaviour of health professionals in promoting/limiting accountability, and quality health service delivery in sub-district health service organisations.

This chapter is organised into four sections. Section One examines the factors that influence professionalism of health care providers in understanding accountability and health service delivery. The second section deals with absenteeism, private practice and corruption of health professionals to assess accountability and quality of health care delivery. The third section discusses the socio-economic and political

[52] The term professionalism is used in this research to understand how health care providers perform their responsibility through practicing good manners, ethics, obligations and the rules and regulations of health service organisations. Professionalism is a quality of health professionals, which assists them to serve their clients (patients) efficiently and effectively to achieve the goals of health service organisations.

impact on accountability and health service delivery. The final section provides a summary of overall findings of this chapter.

6.2 Professionalism and accountability in health service delivery

6.2.1 Motivation, ethical consideration and commitment of health professionals

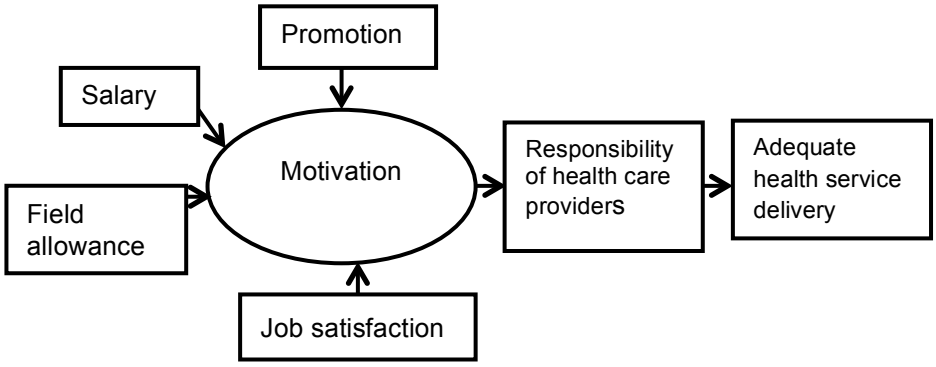
This section deals with several factors such as salary, promotion process, motivation, transport allowance, ethics and commitment, appreciation of government subsidies for understanding accountability and health service delivery.

Low salaries as a factor which, by eroding motivation, is eroding accountability in rural health service organisations. Most doctors interviewed in this research (see Appendix 12 b) noted that the amount of salary plays a crucial role in enhancing accountability as well as accessibility to health care delivery (see Figure 6.1). Currently, the government pays a graduate doctor USD $243 per month (Field Data 2013) which is low and insufficient to maintain the expenses of even a small sized family. The salary for a graduate doctor in Bangladesh is three times lower than that of its neighbouring country India and twenty four times lower in OECD countries like Australia.[53] The Family Planning Inspector in Savar, interviewed in this research claimed that another cause of low motivation to work in rural areas is salary discrimination. For instance, a family planning worker in the Department of Family Planning gets lower salary and field allowances than a health service worker, even though both have the same level in the official classification. At the same time, the Family Welfare Assistant (FWA), interviewed in this study claimed that they have to work more than the health workers. This inequality of salary leads to frustration and job dissatisfaction among the family planning workers which adversely affects not only their motivation but also in their adequacy of health service delivery. Besides this, the FWA claimed that the promotion process is so slow that it demotivates them from working appropriately.

[53] As per government provision, a graduate doctor receives USD $243 per month as salary, but the same qualified doctor in India receives USD $714 (Interview with a Doctor, Chhatak). In addition, the average annual wages of General Practioner (GP) in Australia is USD $70050(OECD, 2015).

Figure 6.1

Factors affecting motivation and responsible quality health service delivery



Source: Prepared by author based on field data 2013

The majority of Savar's field health care providers interviewed in this study (see Appendix 12 b) stated that field workers needed transport allowance to provide adequate health care. Savar is an urban-based locality where the cost of living is much higher than that of remote areas. Yet no additional allowance is provided for maintaining urban-based living standards. Similarly, the rural field workers in Chhatak, interviewed in this research argued that in rural areas very inadequate infrastructure (Transport) is provided for health service delivery. The Chhatak field workers claimed that the local office has no authority to mobilise resources, nor does it have the opportunity to create resources to improve quality health care delivery. Health care providers in Chhatak pointed out that additional allowance can promote accessibility of health care to clients especially in hard to reach areas (details in Section 5.4.5 of Chapter 5).

A Faculty Member in Public Administration at Dhaka University, interviewed in this research reported that doctors have to take an oath in order to maintain minimum ethical standards to provide efficient service. As a part of the ethical considerations, doctors have to sign an agreement with the Bangladesh Medical and Dental Council (BMDC) before offering formal services.[54] This agreement bears ethical and

[54] The BMDC is a regulatory government organisation, which is responsible for providing registration for doctors to work legally. This organisation is able to ban registration of doctors if it finds any irregularities.

professional guidance which should be respected by the doctors but professionals have poor ethical values that affect their responsibilities and duties, as stated by the faculty member. Most doctors provide services that suit their own interests rather than the interest of the patients. A Ward Member (elected representative) in Chhatak, interviewed in this study found that a health worker had used an expired vaccine in the provision of paediatric services which is totally unethical. Nevertheless, most of the health care providers interviewed in this research (see Appendix 12 b) claimed that they had a sense of responsibility and worked to the best of their ability. With regard to ethical considerations, one of social workers at Chhatak sub-district reported:

> "Everybody should understand that we have accountability to Allah (God). Doctors should have the realisation that they are appointed to public hospital for servicing poor people. Doctors should have humanity, morality and sense of responsibility to serve people. Otherwise, none of political/social movement for promoting accountability will gain success".

As the doctors work to maximise their own benefits instead of serving the community, so do the health workers who indulge in unethical practice, which contributes to poor health service delivery. This happens due to lack of accountability among the health professionals.

The majority of elected representatives and local informants in Savar and Chhatak interviewed in this study (see Appendices 12c and 12d) pointed out that most of the doctors take for granted the fact that they have received government sponsored facilities e.g., medical students pay government-subsidised tuition fees to obtain their medical qualifications. In other words, their qualifications are largely paid for from public taxation. They also spoke out that most doctors grew up in urban areas and would like to work and live in urban localities rather than thinking about fulfilling their professional commitments and responsibilities to the communities in rural areas.

A Member of Parliament (MP) from Chhatak, interviewed in this research, noted that many facilities have been provided for doctors in the rural areas such as improved roads, better communications and adequate supply of electricity; but the , doctors claim that such facilities are not sufficient for them to live in rural areas. The MP also remarked that the doctors need to change their mentality and required a stronger commitment to provide services to the rural people. He also spoke out that patriotism and a love for the people are fundamental qualities that make doctors work effectively in rural environments. The local Newspaper Reporter in Chhatak,

interviewed in this study stated that complaints from graduate doctors[55] regarding problems with rural hospital environments and the misbehaviour of rural people are completely wrong. Local informants (business leaders and the social elite in Savar and Chhatak), interviewed in this research, are of the opinion that doctor's lack in their commitment in providing effective health services. Kemoni et al. study (2008) expresses a similar view and shows that service providers' commitment and ethical values are some of the crucial factors in providing quality of health service delivery which is discussed in Section 2.2.1 of Chapter 2.

The Resident Medical Officer (RMO) of Savar, interviewed in this study reported that some of the junior consultants have tended to serve very few patients and leave the hospital immediately after work to attend their private practice. However, the RMO also claimed that several doctors are very dedicated and continue to work in the hospital even in the face of nationwide strike called by political parties. The local Chhatak newspaper reporter pointed out that the Upazila Health and Family Planning Officer (UHFPO) lacks commitment as he avoids responsibility, which contributes to inefficient administration and leads to poor health service delivery (details in Sections 5.4.2 and 5.4.3 of Chapter 5).

As mentioned earlier, the doctors complete their medical qualifications under government subsidy. Therefore, they are expected to take responsibility to provide health services to the rural people. However, they have a lack of commitment because of a lack of loyalty to their organisation and a lack of devotion to serve the people, as mentioned by the respondents in this study. Also, doctors are not mentally prepared to work with poor rural people. But some doctors' work enthusiastically in Savar UHC as the health centre is located in an urban area and doctors get extra motivation to work there.

6.2.2 Monetary interest

A focus group discussion of service users in Chhatak, conducted in this study revealed that government doctors are not willing to think about the public and their suffering. Rather, the doctors give much more attention to making money through private practice (see Section 6.3.5). The service users also reported that the other

[55] Graduate doctors have four years institutional education from the approved medical college in Bangladesh. The name of the degree is Bachelor of Medicine, Bachelor of Surgery (MBBS).

source of monetary interest derives from the income of medical representatives who supply medicine on behalf of the pharmaceutical companies. In this regard, business leader in Chhatak explained that most doctors have informal contract with medical representatives (drug sales representatives). The pharmaceutical company pays a specific amount of money (around Tk.10, 000 or US$ 142.85) to doctors each month so that doctors prescribe that particular company's products as there is no essential medicines list in Bangladesh (this is also stated by the business leader). The pharmaceutical companies convince doctors so that doctors prescribe medicines of a particular company as doctor has freedom to prescribe medicine of any approved company. As doctors are able to prescribe any approved company medicine, therefore doctors prescribe medicine of specific company where they have financial agreement with medical representatives. Through this corrupt financial arrangement the doctors are obliged to prescribe specific medicine to patients without considering the best items of medicine for patients. Service users further claimed that doctors do not consider affordability for patients and even prescribe costly medicines to satisfy or fulfil the demands of pharmaceutical companies. Service users also claimed that a limited items of medicine are free of cost provided by the UHC, mostly doctors prescribe company medicine and patients require to purchase it from medicine shop. The service users claimed that sometimes the prescribed medicine by the doctors is in fact not required and is absolutely unnecessary. However, doctors in Chhatak, interviewed in this research claimed differently and reported that to improve their reputation and build a more noble career, doctors do not prescribe low quality drugs that might adversely affect their patient

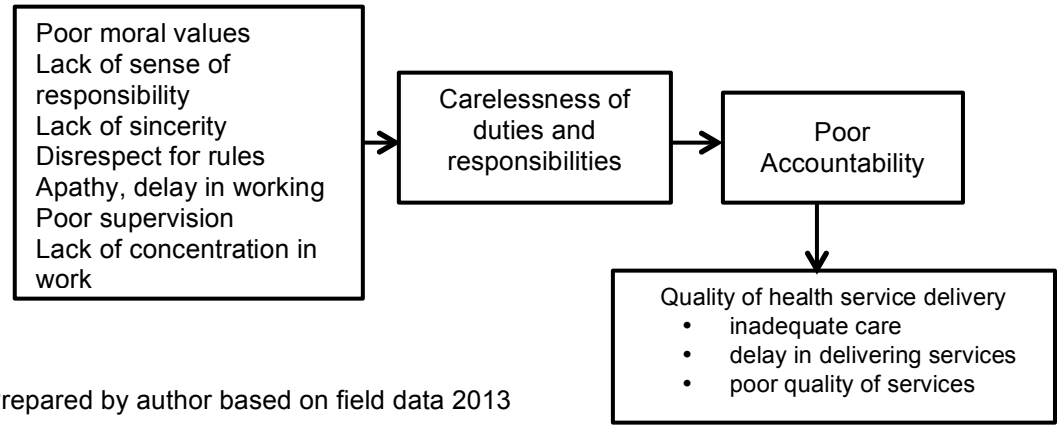
In fact, the claims of the service users and the doctors were contradictory. For example, the service users think that the doctors' derive monetary and other benefits by prescribing particular brands of costly medicines, but the doctors think that they prescribe good quality medicine as a part of quality of health service delivery.

6.2.3 Negligence in providing services

The Manager (Governance) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B) interviewed in this study spoke out that rural health service organisations have inadequate supervision, which limits accountability and inadequate health service delivery (see Figure 6.2).

Figure 6.2

Factors of negligence of responsibilities and duties and their impact on quality of health service delivery



Source: Prepared by author based on field data 2013

The dutifulness of health care providers in Savar and Chhatak are s slightly different from each other. In this regard, the Medical Technologist (MT) in Savar, interviewed in this research said that doctors and other assistant staff in Savar hospital's Emergency Department possess a good sense of responsibility and perform their duty appropriately due to sufficient supervision as previously mentioned (in Chapter 5). He claimed that medical officers perform their duties in Savar UHC at all hours. However, the senior staff nurse in Savar, interviewed in this study stated that nurses are much more reliable and responsible than doctors. The head of the nursing supervisors at Savar hospital interviewed in this study observes:

> "I did not see absence of anyone during my career of 30 years. However, if anyone needs casual leave, they inform us and we manage it according to organisational provision. Nursing jobs are highly technical and sensitive and it is not possible to replace the people in these positions with other employees who do not have the adequate knowledge".

Alternatively, with regard to doctors' responsibility of Chhatak UHC, a local Newspaper Reporter interviewed in this research told of his experience as follows:

> "One day I saw that a patient was screaming in pain inside the hospital but none of the doctors gave her any immediate response/treatment. The patient's situation was becoming very critical due to bleeding and other health complications. It was difficult to know whether any doctor was present there. Afterwards, a doctor came but referred the patient to Sylhet Osmani medical college which is far away, although, in fact the patient had a minor injury and such treatment was possible at UHC. But unfortunately, doctors refer such general patients to district/specialised hospitals by ignoring responsibility".

Generally, doctors have negligence their responsibilities and duties as experienced by most of the respondents in this study. But nurses are professionally more

dedicated than doctors and other health professionals. As the supervision is better in Savar UHC than that of Chhatak UHC, the health care professionals are more responsible in the urban health service organisation of Savar.

As the UHC doctors are permanent full-time health professionals, they feel responsible for working only to observe the government health service organisation's regulations (Directorate General of Health Services 2013). The Chhatak Ward Boy, interviewed in this research, claimed that the graduate doctors work one or two days a week on a rostered basis at the Chhatak UHC while the rest of the days they work in private hospitals. The Ward Boy also spoke out that the graduate doctors are absent from hospital most of the time and the Sub-Assistant Community Medical Officer (SACMO) who is less qualified, provides health service delivery in their absence. Consequently, people receive poor quality health service delivery particularly complicated cases. In addition, the absence of graduate doctors might result in more cases being referred than need to be referred. A Medical Representative (MR) in Chhatak, interviewed in this study remarked that graduate doctor's only pass time and draw a salary at the end of month, which is totally unfair and unethical. Besides this, the President of the national ruling political party, Awami League (Chhatak wing) interviewed in this research pointed out that graduate doctor partially but minimally fulfils their responsibilities to protect their jobs which meet the limited demand of people. However, the Medical Representative in Savar, interviewed in this study pointed out that graduate doctors are fully equipped in Savar, that all doctors are generally present at the health service organisation, and provide required services.

In practice, due to lack of supervision and accountability, rural doctors, particularly in Chhatak UHC perform duty as part-time basis negating the organisation rules, consequently serve poor health services. On the other hand, Savar doctors perform responsibilities as per government regulations and the manager of UHC look after the health professionals carefully. As a result, doctors are available in Savar UHC and provide improved health service delivery.

6.2.4 Time for patients

According to office records collected by the researcher during the field work, doctors are unable to give patients sufficient time as each doctor is responsible for providing services to at least 60 patients in Savar and even more in Chhatak, all within 3 hours from 10.00 am to 1.00 pm (Field Data 2013). A doctor in Chhatak interviewed

in this research claimed that the hospital environment is very noisy and such a situation makes it difficult to concentrate on patients properly. He also claimed that while every patient requires a minimum of 10-15 minutes check-up, doctors are only able to provide less than five minutes which affects quality of health service delivery. Similarly, service users in Chhatak claimed that doctors provide a much-limited time for patients as reported (see Box 6.1):

Box 6.1

Services user's experiences on the quality of health service delivery

> "I have a bitter experience with government doctors and now I regularly go to a private hospital to get services for my child. Private Doctors take money but provide adequate treatment. On the other hand, a government hospital doctor serves poorly. The hospital also provides insufficient medicine; as a result the disease is not cured quickly". As stated by a service user, Chhatak.
> "I visit the government hospital even my sickness recovers slowly. I am highly dependent on medicine from the government hospital because I cannot afford private health service expenses. I wait long time (morning to noon) to visit doctor". As stated by another service user, Chhatak.

The Health Inspector (HI) in Chhatak interviewed in this research stated that field workers also face similar challenges especially in providing maternal and child health care services. He also spoke out that during the Expanded Program on Immunisation (EPI), health workers provide immunisation and at the same time have to write basic health service information of the patient including the client's name, address and date of next appointment, and location for health care to be provided. In order to do this, a great deal of time is spent on high volumes of patients, which are extremely difficult given the existing levels of human resources. As a result, the services provided by health assistants are of very poor quality and are unsatisfactory. Moreover, the limited time given to patients is not possible to provide efficient health service delivery.

6.2.5 Patient's attitude and the nature of health service quality

The Chhatak doctors interviewed in this study (see Appendix 12b) reported that patients express their sentiment and comments badly at times. They are of the opinion that good quality health service is not possible unless the behaviour of the patients in general changes. Most people lack education and have poor awareness and this make them aggressive at times. For example, they disobey queues and waiting lists and exert local influences in seeking services. The Chhatak Ward Boy

interviewed in this research pointed out that a doctor has even been physically assaulted by some local people in the region. One of the doctors interviewed said that at the beginning he handled the patients very courteously but changed his attitude within a week due to his local clients' bad behaviour.

Similarly, the Family Planning Officer (FPO) also argued that the people of Chhatak lack health seeking behaviour. This means, most pregnant women and adolescents do not have enough knowledge of, or education about health and the services they require, as stated by the FPO in Chhatak (see the conceptual framework in Section 2.7 in Chapter 2). With regard to patients' attitudes, one of the doctors in Savar argued that patients are not communicative and that this makes it impossible to do work smoothly. Therefore, the behaviour of patients adversely affects the motivation of health professionals to do work responsively which contributes to poor quality of health service delivery particularly in Chhatak Upazila.

A Senior Research Fellow in the Bangladesh Institute of Development Studies (BIDS) interviewed claimed that patients do not get sufficient medicine. They get only prescriptions from a qualified doctor. He also claimed that generally, clients purchase medicine and complete major medical examinations such as X-rays, electrocardiograms (ECG), and blood tests outside the hospital. For this, the clients have to spend a huge amount of money. A focus group discussion of service users in the Chhatak conducted in this study explained that the doctor provides services and prescribes medicine without examining or the checking patients' health. The service users also pointed out that doctors prescribe medicine based on discussing patients' problems and give very short time to examining the patients (2-3 minutes), therefore such delivery of services is not satisfactory(see Box 6.2). On the other hand, one of the Savar hospital service users reported:

> "One day I went to hospital for treatment and bought a ticket Tk.3. The ticket writer asked me to go room no.27 where doctors were providing services. One of graduate doctors provided me health advice. I usually come to this hospital and receive good services from doctors. The behaviour of doctors and nurses are satisfactory for me. I have never had any bad behaviour from them so far. In general, I get some medicines from the hospital and buy the rest of the required medicine from outside".

Box 6.2

Case studies of quality of health service delivery in UHC, Savar

> We (service users) are happy to get services from graduate doctors, although they provide limited time. We are able to purchase ticket Tk.3 that is affordable for us. We also get some free medicine. For example, doctors listen to our problems taking very little time (maximum 3 minutes) and then prescribe medicine. But we did not receive bad behaviour from doctors. Sometime we stand in queues for a long time. **Source**: Focus Group Discussion, Savar.

In fact, the way doctors provide health services is not enough because doctors only provide prescriptions, but no medicine, because the UHCs are not sufficiently equipped with medicines, and medical equipment. Actually, the services provided by the doctors are focused primarily on counselling rather than on clinical treatment. The service users in Chhatak expressed the opinion that such services are not as satisfactory as they expect. To add to their disadvantage, the majority of service users in Chhatak are poor and they are unable to seek health services from private facilities, therefore they have to depend entirely on the health services provided by the UHC. On the other hand, the service users of Savar are satisfied with the health care provided by the doctors, presumably because the doctors behave nicely and treat their patients courteously.

6.2.6 Training promotes doctor's behaviour

The Manager (Governance) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B) interviewed in this research suggested that training is one of the tools to promote good behaviour among the doctors in order to enhance good understanding between them and their patients. He also stated that training enables the doctors to understand about their patients' socio-economic conditions, attitudes, and needs so that they can provide services which meet with their patients' satisfaction. He further stated that it was unfortunate that no such training was provided to the doctors. The Deputy Director (Health and Education) of the Directorate of Health Services pointed out that doctors are only provided two months' foundation training as a requirement to make their jobs permanent and to understand office management. But, as suggested above, the doctors require sufficient training to understand their patients and the management of the UHC so that which would help the doctors to deliver improved health services. In addition,

there are some critical issues such as absenteeism, private practice and corruption which affect negatively on the quality of health service delivery. This is discussed in the next section.

6.3 Absenteeism, private practice and corruption in health service delivery

Several factors are caused of absenteeism of doctors particularly in rural health service organisations, which affect quality of health service delivery. These factors are: inadequate policy, improper referral system, lack of better working environment, inadequate facilities, and the lack of opportunity for higher studies. These issues are significant affecting factors of absenteeism, which have been analysed in the following sections.

6.3.1 Lack of adequate planning

The local Chhatak Newspaper Reporter interviewed in this study stated that there are several factors with regard to planning that affect doctors' absenteeism in their health service organisations. One of these factors is inadequate policy on posting or transfer. A planned posting mechanism may reduce absenteeism. For instance, the Reporter explained that two Chhatak UHC doctors are from the local area and have relatively better attendance at their hospital compared to the doctors who is from outside Chhatak. Posting the local doctors is also a very helpful strategy to reduce financial pressure of the locally employed doctors as local postings help in cutting down the cost of living.

Sub-district health service organisations require an adequate referral system. For this, the Senior Research Fellow at the Bangladesh Institute of Development Studies (BIDS), interviewed in this research suggested that elementary level of training in health services e.g., basic health care delivery would enable someone to work as a paramedic or a medical assistant, while secondary level training in health service for common diseases and/or primary clinical treatment such as that in Bachelor of Medicine / Bachelor of Surgery (MBBS) would enable someone to work as a doctor (general practitioner) and tertiary level training e.g., specialisation in particular diseases would enable someone to work as a specialist. This process can balance the system and reduce absenteeism. The Senior Research fellow also explained that paramedics have low financial expectations in comparison with graduate doctors as they only have a diploma qualification and are used to living in

rural areas. Moreover, he claimed that most of the upazilas have the same family planning program, but rural and urban upazilas have different features: such as different density of population, different economic condition and different characteristics of the locality. None of these issues has been considered in the making of plans for improvement, which adversely affects the quality of health service delivery. But Osman (2004) study shows that donors, bureaucrats, politicians and health professionals influence policy formulation and implementation of health policy for getting benefit which been discussed in detail Section 2.4.1 of Chapter 2.

Further, a strong referral system is required for improving the quality of health service delivery. For this, the density of population and rural-urban location of the UHC should be considered for preparing health policies. This recommendation is discussed in Chapter 10.

6.3.2 Suitable working environment and opportunities for higher study

The Vice-Chairperson of Upazila Parishad, Chhatak interviewed in this research reported that Chhatak has several community clinics (CC), but those clinics do not have a friendly environment and are not suitable for doctors or even for community care providers to work in. The Sub-Assistant Community Medical Officer (SACMO) in Savar, interviewed in this study, nevertheless argued that the graduate doctors work at the CCs and the union sub centre at Savar upazila for 2-3 days a week as per their schedule. He also argued that one of the reasons for this is the good working environment of the Savar CCs, and that, therefore, people receive sufficient health service delivery. In addition, he claimed that doctors are available and present at the CC due to adequate supervision (see Section 5.4 in Chapter 5).

The Medical Representative in Chhatak interviewed in this research noted that graduate doctors receive medical education from medical colleges which are located in district centres; some of medical colleges are located at the Divisional Headquarters level. Thus, working in sub-district rural health care organisations might be uncomfortable for graduate doctors. Several local informants in Chhatak pointed out that the graduate doctors tend to get used to urban living while working in an urban-based organisation and it becomes difficult for them to adjust to rural living when they are posted in a rural health care organisations. Chaudhury and Hamer's (2004) study however shows that female and experienced physicians are unwilling to work in rural health centre; that is one of the reasons for higher doctor's

vacancy in rural health centres. This is discussed in detail in Section 2.4.3 of Chapter 2.

The Medical Technologist (X-ray) in Chhatak, said that graduate doctors have a tendency to move to urban-based health care organisations, as rural hospitals have no surgical instruments, and doctors are unable to use their practical knowledge and skills beyond providing treatment in primary healthcare. For example, a doctor graduating from the Dhaka Medical College receives high level training but if this doctor works at an elementary level healthcare centre such as an Upazila Health Complex (UHC), he cannot use his learned skills due to a lack of medical provisions and instruments at the UHC.

Additionally, it was also argued that the doctors' absenteeism in the rural UHC is in part due to inadequate educational facilities for their children. Chhatak Upazila does not have good educational institutions; consequently doctor absenteeism is high there. For instance, the majority of Chhatak UHC doctors live in Sylhet city where there are better educational facilities. The Senior Staff Nurse in Savar, interviewed in this study, claimed that doctors and other health care providers are happy to work at Savar UHC due to the availability of good educational facilities for their children, either in Savar or in Dhaka. In sum, this lack of adequate educational facilities for children is a factor that leads to high absenteeism of doctors at the UHC in Chhatak.

In fact, all rural health centres have a lack of facilities including those for good education for children and the qualified doctors are unable to adjust and work in the rural centres because the UHCs do not have sufficient medical accessories where the graduate doctors can apply their knowledge and experience to serve patients. Basically, the insufficient equipment and the poor working environment are the main causes of doctor's absenteeism which leads to inadequate health service delivery.

The majority of field health care providers in Chhatak pointed out that doctors have tended to move to urban health care organisations from rural organisations for the purpose of higher studies. They claimed that this was identified as one of the major reasons for lack of interest in working in Chhatak. Conversely, the field health care providers in Savar, interviewed in this research claimed that doctors can avail themselves of training facilities, higher studies, and improved information from working in the Savar UHC which ultimately enriches their career. Key informants and focus group participants, when asked to compare Savar and Chhatak, perceived that absenteeism was lower in Savar compared to Chhatak.

As has been stated in various sections in this chapter, the sub-district health service organisation provides poor quality health service delivery, those clients able to afford to do so move to private facilities in order to access a better quality of health service delivery. The following sections examine how private practice affects accountability and quality health service delivery in the UHC.

6.3.3 Why do clients move to private health service organisations?

The President of Chamber of Commerce in Savar, interviewed in this research, stated that generally wealthier people do not take services from the UHC of Savar. They tend to get services from private facilities in Dhaka for good quality health care. Moreover, private hospitals provide special care, which is not available to public providers. The President explained that as well as this, Savar is an industrial area where people are able to afford to spend money on medical expenses.

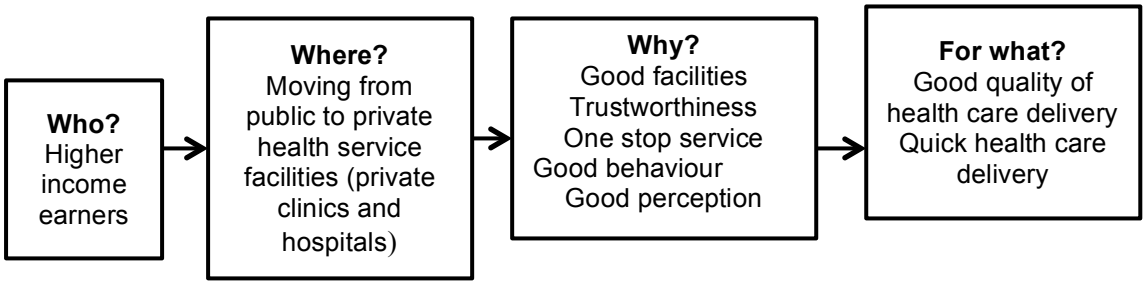
On the other hand, the President of Chamber of Commerce pointed out that poorer people go to public hospitals, as they cannot afford private treatment expenses. They have a limited income, which does not allow them to spend money on private facilities. He explained that the public health facility is the only option for poorer people to obtain health care. Low-income earners may frequent public hospitals to acquire free medicine. Service users in Savar and focus group discussions in this research argued that they get services free of costs, but services from private facilities cost more which is not affordable for them. A Social Worker in Chhatak interviewed in this research emphasised on public facilities and explained that the government has a moral obligation to poor people who have no means of accessing private facilities.

A local Newspaper Reporter in Savar, said that higher income earners are more private service-centred as they lack trust in public health care and the health professionals. He also said that richer people believed that private hospitals provide improved services as several private hospitals have digital machines for X-rays, ultra-sonogram that provide patients with efficient health service delivery. He further stated that the majority of Savar clients are garment workers who believe that public hospitals indulge in corruption and have doctors who are rude to the patients and lack in sincerity, and have long queues and waiting times that contribute to inadequate health service delivery. Additionally, inadequate human resources, inefficient ambulance services, and insufficient equipment discourage clients from going to public health care organisations.

The Medical Representative in Savar interviewed in this research noted that some clients believe that they do not get good services from UHC, although this hospital (Savar UHC) has sufficient consultant doctors and an improved operation theatre, which are not available at the rural-based Chhatak UHC (see Figure 6.3).

Figure 6.3

Sequential mechanisms of clients moving from public to private health care facilities



Source: Field Data 2013

Additionally, the majority of local informants in Chhatak interviewed in this study pointed out that hospital staff are unfriendly and they mostly annoy the clients (see Appendix 12d). They also remarked that doctors were negligent and provided limited time to clients which contributed to poor quality health service delivery. Conversely, doctors from private clinics behaved in a friendly manner, which leave the patients feeling very satisfied with the services provided. Moreover, a private clinic provides incentives to patient for recommending other patients to come to the private clinics. Afemikhe's (2011) study also found higher satisfaction of private health service delivery because of motivation of health professionals as well as adequate supervision, monitoring and coordination, which are discussed in Section 2.4.4 b of Chapter 2.

The Manager (Governance) in ICDDR, B interviewed in this research noted that clients go to private hospitals as a result of a lack of one stop services in the public health care organisations (see Figure 6.3), where the service users receive only prescribed advice from the specialised doctor. He also noted that a limited number of medicines and medical tests are available at UHC which do not fulfil client demand. For example, the UHC is able to provide very simple examinations such as urine and blood tests whereas it is unable to provide services regarding ultra-

sonogram. Consequently, clients move to private facilities where one stop services are available.

As mentioned earlier, the poorer people generally visit government health service organisation because the government offers health services that are affordable to the poor, and the poor use these services because they are more affordable than private health services. The wealthier clients choose private facilities because government sub-district health service is not sufficient to meet their demand as the government provider's behaviour and delivery of services are not satisfactory to private health service users. The Savar health care is better because some consultants and operation facilities are available there which are absent in Chhatak UHC, but client perception on government health service delivery is not positive therefore, some clients opt to get services from private facilities.

6.3.4 The impact of private practice and middlemen[56] on government health service delivery

Most government-employed doctors indulge in private practice which does not benefit the poor people. This was stated at a focus group discussion comprising service users of Chhatak, conducted in this study (see Box 6.3). The Vice-Chairperson of Chhatak interviewed in this research noted that private practice offers a means of earning money for doctors, but it weakens the health system. The Vice-Chairperson also noted that the main cause of uncontrolled private practice is the result of poor accountability of health service management. The President of Chamber of Commerce interviewed in this study claimed that several Chhatak UHC doctors work in private clinics during office hours. However, doctors are only able to do private practice off office hours. He also claimed that in the absence of graduate doctors, the Sub Assistant Community Medical Officer (SACMO) provides services to clients, which are not of the same quality as those provided by a doctor. Thus, private practice by doctors affects the quality of health service delivery.

[56] Middlemen are agents who facilitate a patient's appointment with the doctor or health provider and charge the patient a fee for this "service".

Box 6.3

Private health service increases the sufferings of poor people

> Most doctors are not available in rural hospitals due to their high involvement in private practices. Public doctors become private doctors during office hours of duty and we have to go to a private doctor to get necessary services. None of the doctors would give any prescriptions without money. If we cannot pay, this makes the doctor angry. Sometimes hospital doctors provide services only at his/her residence and we need to pay Tk.150 to Tk.300 for every visit. One day I visited a public doctor in his private chamber and paid less than Tk.50. The doctor threw the money at me. Doctors do not understand the suffering and pain of poor people. Doctors prescribe medicine and its cost is Tk.1000.We cannot afford to buy this medicine and we borrow money from our friends and relatives in order to buy medicine and pay the doctor's fee. **Source**: Focus Group Discussion (FGD), Chhatak.

The Senior Research Fellow in Bangladesh Institute of Development Studies (BIDS), interviewed in this research concurred with the above statements and said that clients go to private clinics in the absence of public doctors. This gives doctors an opportunity to earn extra money; such a trend is a threat to ensuring accountability. He also explained that if a patient spends Tk.5 on adequate health services, that patient would not have to spend Tk.1500 for private facility services. However, the President of the Chamber of Commerce in Savar interviewed in this study argued that even though private practice affects adversely on public services but people get more benefit even clients require paying money for getting health services. The President of the Chamber of Commerce emphasised the better quality of private health services, a view shared by Andaleeb (2000, 2007a) and Afemikhe (2011) as discussed in Section 2.4.4 of Chapter 2. But the Union Parishad Chairman of Savar, interviewed in this research argued differently and stated that doctors' private practices reduces the quality of public health care as the doctors do not willingly provide services to public health service organisation (see Figure 6.4).

The Medical Representative in Savar interviewed in this research stated that the nature of private practice is slightly different between rural and urban areas. One of the reasons for this is adequate supervision and another is the ethical values of doctors. In the case of Savar, most doctors are from Dhaka where they have their private practice, and a limited number of them work in Savar's private clinics after office hours as permitted under government provisions. On the other hand, the President of the Chamber of Commerce in Chhatak, interviewed in this study claimed that most of the Chhatak doctors are involved in private practice during office hours, which is unethical and contrary to organisational regulations. This

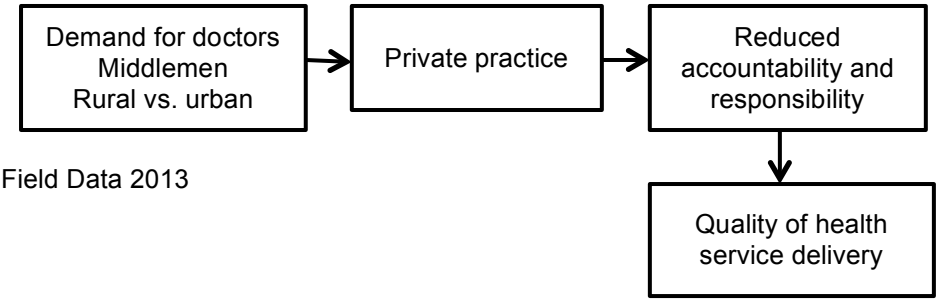
happens due to these doctors' poor accountability to their higher authorities in rural organisations (see Figure 6.4).

The provision of private practice affect doctor's accountability because doctors are highly involved on private practice for earning money refuting the rules of the organisation, however, some respondents (see Appendix 12d) argued positively about the benefits of private practice as the government provides inadequate health service delivery. In addition, the rural health service organisation has a lack of supervision, leading to poor accountability and health service delivery.

The Savar Newspaper Reporter interviewed in this study claimed that middlemen help clients to transition from public to private hospitals. He also claimed that sometimes doctors refer patients to private clinics, even when these services are available in public organisations. He further claimed that private clinics tempt public doctors by offering them good salaries to work there. This motivation affects the doctors' accountability to the public organisation (see Figure 6.4). This also reduces the quality of health service delivery.

Figure 6.4

Private practice factors reducing accountability and quality of health service delivery



Source: Field Data 2013

The influence of middlemen (people who work as agent) is present in both Savar and Chhatak UHCs. However, the situation has improved in Savar in recent times as a result of effective supervision and monitoring. Currently, doctors work in the hospitals during office hours and concentrate on their private practice after hours. However, the conditions in Chhatak have not improved due to a lack of adequate supervision (discussed in Chapter 5). Besides this, corruption is another important factor contributing to poor quality of health service delivery, which is discussed in the following section.

6.3.5 Corruption in health service delivery

Elected representatives and local informants of Chhatak confirmed evidence of financial corruption in the recruitment process for lower level employees at the Chhatak UHC. For instance, the local Chhatak MP, interviewed in this research pointed out that the recruitment process for hiring new employees in Chhatak did not maintain appropriate official procedures due to dishonest and irresponsible behaviour on the part of the district civil surgeon as well as the recruitment committee members (see Figure 6.5).[57] The MP also pointed out that the Ministry of Health and Family Welfare accused the civil surgeon of many complaints concerning corruption. As a result, the government initially postponed the recruitment process and subsequently cancelled it due to massive financial corruption. With regard to financial corruption, one of the Ward Boys recounted how the corruption process works in the recruitment system[58] (see Box 6.4).

Box 6.4

Corruption in Chhatak's UHC recruitment process

The Sunamganj civil surgeon's office recruited a total of 120 Class 4 (supportive staff). To get a job at the UHC, each employee provided between Tk.2, 80,000 and Tk.3, 00,000 to the recruitment committee. Five Sunamgaj district MPs have been elected from the Awami League (AL) political party. However the MPs are locally divided into two groups due to local politics, which is well known by the local residents. These five MPs have political influence over the recruitment committee and they received money from the job seekers to gain employment. The dominant group received more advantages from the recruitment committee than other group, which created conflict between the two. This conflict between the groups is the main cause of a release of hidden information about the MP's involvement in corruption. Besides this, the members of the recruitment committee (the district civil surgeon, director of district health services and the district commissioner) were also involved in corruption.
Moreover, the quota system, which is a provision of recruitment, was not followed appropriately. After releasing the information in the newspaper, the Ministry of Health and Family Welfare investigated the matter and found evidence of corruption. The ministry postponed and later on cancelled the recruitment process. **Source:** Interview with Ward Boy, Chhatak.

The district Civil Surgeon's office has a committee to purchase materials for the Upazila hospital and its sub-centres. Besides this, the DG health service has a

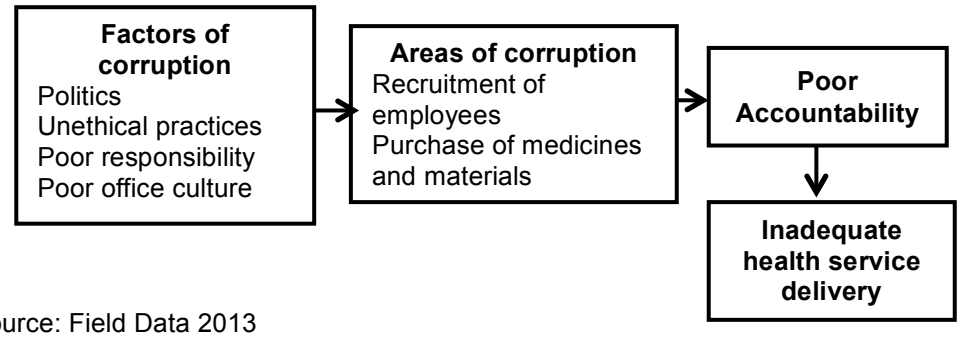
[57] The civil surgeon is the head of the district health administration who is authorised to recruit Class 4 employees (supportive staff) for sub-district health service organisations.

[58] The recruitment Class 3 and Class 4 employees have to follows a government quota system under which disadvantaged groups of the society can avail of the opportunity to earn their livelihood.

Tender Procurement Committee, which is formulated through political consideration as noted by the Deputy Program Manager of Transparency International Bangladesh (TIB) who was interviewed in this study. The Deputy Program Manager also noted that this politically biased committee also became involved in corruption and purchased poor quality products at cheaper prices. The medical representative in Savar, interviewed in this research reported that politics is not the major factor; the Tender Committee takes illegal money from pharmaceutical companies subsequently, and then supplies poor quality medicines. Nurunnabi and Islam's (2012) study also found the inadequate implementation of patients' bill of rights as well as the lack of public participation are causes of corruption in health services as discussed in Section 2.5.1 of Chapter 2.

Figure 6.5

Factors contributing to corruption and poor accountability to the UHC



Source: Field Data 2013

As the above discussion shows, corruption affects the quality of health service delivery particularly the rural health service organisation because of lack of ethical values of politician as well as their poor political commitment. The researcher did not find evidence of corruption in Savar such as that in Chhatak Upazila. This implies that Savar has better health service management and better accountability to control the risk of corruption in the delivery of health services.

The above discussions demonstrate how the health care providers carry out their responsibilities to ensue professionalism in health service delivery. Besides this, absenteeism, private practice and corruption contribute to poor accountability and health service delivery especially in rural health service organisations. Data in this chapter also show that accountability and health care quality of urban health service organisations are more improved than in rural organisations. However, several crucial factors such as socio-economic characteristics, politics and bureaucracy affect professional accountability, which is the focus of the next section.

6.4 Factors affecting accountability and health service delivery

6.4.1 Socio-economic factors affecting accountability

Local informants in Chhatak, interviewed in this study explained that affluent people receive better services and even extra care from doctors of government health care organisations as they have both economic resources as well as political influence. The local informants also said that doctors are uncaring towards poor people as these low income earners have a limited capacity and voice, and lack participation (also discussed in Chapter 8). Consequently, they are not able to take action against the doctors' mismanagement. A number of studies on socio-economic factors and their impact on health-seeking behaviour have been discussed in Section 2.6a of Chapter 2.A focus group discussion comprising service users in Chhatak, conducted in this study revealed that males and females have equal access to health service delivery although the elite and wealthier people are prioritised where health services are concerned.

The socio-economic gap between doctors and the poorer clients is another factor that generates different behavioural attitudes among health care professionals. In this regard, the Senior Research Fellow of BIDS interviewed in this study said that the doctors mainly come from elite families, they have a good educational background but they have to work with common people in rural areas. He also said that doctors consider the life style of rural people as primitive. In this circumstance, doctors ignore their responsibility and try to refer patients to less qualified Sub Assistant Community Medical Officer (SACMO) or other health service organisations (also discussed in Section 6.3.2). Interestingly, the interaction of medical technologists and paramedics with poor patients is much better than that of the graduate doctors with poor patients, probably because the former group of health workers come mostly from rural backgrounds.

The focus group participants in Chhatak in this study claimed that they have a limited source of income, land and are extremely poor. Most participants in this study also mentioned that their socio-economic condition does not allow them access the supposedly better health services from private facilities. They also claimed that good quality of health care is a distant dream for poor people.

However, according to Bangladesh Bureau of Statistics (2012b), Savar is a highly urban-based populated area and people of this area are socio-economically better off as shown in Section 4.4.1 of Chapter 4. The Vice-Chairperson in Savar, interviewed in this study reported that a significant number of garment workers live in Savar, who have migrated from neighbouring areas. The Vice-Chairperson also reported that garment workers live in Savar for the purpose of working and among them are some workers who receive health services from the Upazila Health Complex (UHC).The Vice-Chairperson further pointed out that as they are migrants and they are busy with their work in garment industry, their priorities may not be the promotion of accountability and improvement of health service delivery (for a detailed discussion see Chapter 8).

The MP of Chhatak Upazila interviewed in this study claimed that the infrastructure of this upazila has improved significantly over time and that recently the hospital has been upgraded from a 30-bed hospital to a 50-bed hospital. He also claimed that the quantities of medicine have increased, although it is difficult to keep doctors at the health centre as they are psychologically not well prepared to work in the rural-based Chhatak Upazila. However, a local Newspaper Reporter in Chhatak interviewed in this research noted that Chhatak is a pleasant place to work in, and has basic facilities such as a good school, and is a sub-district with a sound environment and is an enjoyable place to pass one's time. The Newspaper Reporter claimed that the doctors are absent from this rural health centre, not because of poor facilities, but mainly because of a lack of commitment on their part. However, the Reporter said that several graduate doctors, who are residents of Chhatak are happy to work at the Chhatak Upazila Health Centre (this is discussed in Section 6.3.1). With regard to rural absenteeism (as also discussed earlier) the Chhatak Health Inspector interviewed in this research reported:

> "Government sends graduate doctors to rural areas and all of the facilities are also available there. I have seen that some of doctors are working in Chhatak hospital and afterwards they were posted to Sylhet medical hospital but still they do private practise in Chhatak. Some doctors live in urban areas but work in rural areas. People of rural areas respect graduate doctors. I think, doctors can do better living in rural areas. Some local doctors live in Chhatak and they are doing well".

In practice, affluent people receive better health care as they have local influence and financially better off. However, the poor patients receive less care from the doctors because poor clients are less able to protest against the misbehaviour and mismanagement of the doctors. Moreover, the socio-economic gap between

graduate doctors and poor patients is very high, whereas the relationship of patients with paramedics is friendly. The research believes that such evidence is highly relevant for case of Chhatak UHC as discussed in earlier in this Section. But this is not so in Savar. The better interpersonal relationship between the doctors and their patients in Savar is another factor in the better health service delivery in Savar UHC.

6.4.2 Influence of bureaucracy on accountability

The Upazila Health and Family Planning Officer (UHFPO) in Chhatak, interviewed in this study reported that higher level officials from the Directorate General Health Services (DGHS) issue office orders and sometimes make phone calls to sub-district health service organisations and issue instructions for transferring doctors/health care staff to other health service organisations. The UHFPO claimed that sub-district health service organisations have too little power and authority to go against these instructions. He further claimed that some of the local doctors are sometimes able to manage official orders/recommendations from higher authorities through their political or administrative connections. Such doctors may not feel the necessity to be accountable to their UHC. In this regard, the local MP in Chhatak pointed out that by dint of bureaucratic influence, a significant number of doctors manipulate the office rules to get released from the Chhatak UHC Subsequently doctors' absenteeism is higher and people receive inadequate health service delivery.

6.4.3 The influence of politics on accountability and health service delivery

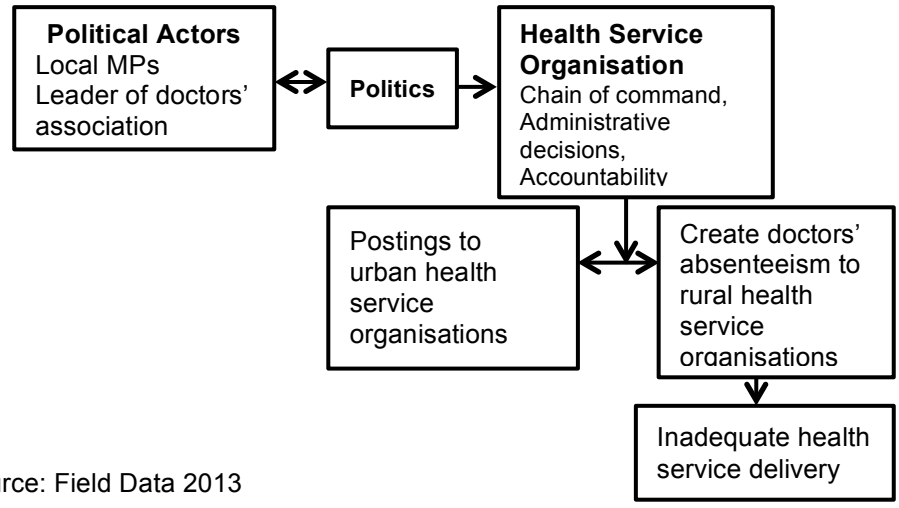
a. Politics in doctors' posting

With regard to postings at urban health care organisations, a doctor's political connection is more important than professional performance. Several local informants interviewed in the field said that some eligible and highly qualified doctors are unable to join health service organisations of Dhaka city or urban health service organisations due to a lack of political connection. At the same time, doctors with strong political connections can manage to be never transferred outside Dhaka, as mentioned by some local informants (see Appendix 12d). Local informants also claimed that some of the doctors have been officially posted at remote areas, but in fact they work in urban areas.

The President of the Chamber of Commerce in Chhatak, interviewed in this study reported that doctors get positions in urban areas through the recommendation of Members of Parliament (MP), health ministers or any of the dominant political officials. In fact, he claimed that policy makers want their relatives and friends to work at the central/urban level. Local MPs interfere in decision-making of health administrations and force the administration to make decisions that favour the vested interests of the MPs (See Figure 6.6).

Figure 6.6

The impact of politics on doctor's absenteeism to health service delivery



Source: Field Data 2013

The President of the Chamber of Commerce additionally claimed that the representative of the Bangladesh Medical Association (BMA) also influences the transfer of doctors from rural to urban health service organisations. As organisational rules dictate, every doctor is required to work for at least two years in a rural area, but evidence in Chhatak (office record collected during field work) indicates that some female doctors work for only two to three months and then are transferred to Dhaka city, presumably with the influence of leaders of the doctor's association.

Actually, the positing and transfer of doctors are politicised where doctors use different channels for getting benefit from urban health service organisation. Such system not only affects the quality of health service delivery but also limits the doctor's accountability. The researcher experienced (Field Data 2013) that Savar doctors want to stay longer there because of urban facilities; on the other hand, Chhatak doctors want to get posting in urban health service organisations. The

doctors of both places have to have involvement in politics as they volunteer for party activities because this is the key to gain their expected goal.

b. The influence of local politics

The local Newspaper Reporter as well as the Social Worker in Chhatak, interviewed in this study reported that the people's voice is a very effective mechanism to make doctors accountable to the people in order to promote health service delivery. They also reported that politics is the main barrier to ensure a doctor's accountability. They further claimed that the health sector is heavily politicised in Bangladesh. For example, adequate public facilities including health services can be obtained for people who have connections with local political leaders. The Newspaper Reporter explained that politics divides people e.g., make different groups through local political leaders as well as political ideology. Consequently, people cannot strengthen their ideas collectively to fight against mismanagement in order to promote accountability. The Reporter also stated that malpractice of politics makes people apathetic and angry towards government activities as people do not have adequate access to services and such political practices discourage them from fighting against mismanagement.

One of the local representatives in Chhatak, interviewed in this research stated that the people have constructive opinions to improve the society and accountability mechanisms, but they cannot express their opinions due to lack of mutual trust and poor integration among other members of the community.

The Secretary of the Committee of Concerned Citizens (CCC) in Savar, interviewed in this study stated that politics can assist people to make money and become rich through various illegal means. The Secretary also noted that good and honest people are unable to adequately promote accountability of doctors because they are not highly appreciated by the existing social system. Moreover, the Secretary claimed that the politicised social system does not allow honest and efficient people to improve socially. Therefore, the majority of the people suffer in silence and do not take action against the mismanagement because of the negative use of local influence and politics. This issue is also addressed in the conceptual framework of this study in Figure 2.7 of Chapter 2.

In practice, local politics is influential in decision-making. However politics confines the integration of general community, which limits accountability. Politicians use

local politics as means of gaining own benefit rather than enhancing accountability of health service delivery. Moreover, local politics limits the voice of honest and trustworthy people, as they are not welcomed for improving health service delivery.

c. Politics in private practice

One academic in the Department of Public Administration at Dhaka University, interviewed in this research stated that politics is one of the factors that work favourably to allow the private practice of doctors. The academic also said that the government has direct or indirect support from the doctors' association in order to gain political power; consequently, adequate strong initiatives cannot be taken with regard to a doctors' mismanagement. This is a challenge for the health administration to ensure accountability and provide adequate health service delivery. The academic also gave an example during the period of President Ershad's government (1982-1990). A rule had been made that doctors must work eight hours in hospital and that no public doctor is allowed to do private practice outside the hospital. The main objective of this rule was to make the doctors accountable to the hospital to promote adequate health service delivery. Doctors however, jointly protested against this ruling, some of them resigned from their jobs and created pressure on the government to repeal the rule. Meanwhile, the opposing political party made this issue a part of their agenda and worked in support of the doctors. As a result, the government cancelled the provision and the doctors got the opportunity to undertake private practice. This continues until today. Therefore, political influence assists doctors to earn money through private practice that limits the accountability of doctors. As a result, improvements in the health service provided by the sub-district health service organisations in Bangladesh require longer time and optimistic initiatives by the respective policy makers.

To summarise, the quality of health service delivery depends on doctor's behaviour as well as the socio-economic conditions of people. Evidence has found that rural people, who generally have poor socio-economic backgrounds, are deprived of good health services from the graduate doctors. But this not so in the Savar UHC, because the health service seekers in Savar are socio-economically more developed which enables them to receive good behaviour and good quality of health services from the doctors. Besides this, bureaucratic influences limit accountability and quality of health care. Moreover, political factors are highly influential mechanisms in terms of the doctors' postings and private practice. All of these

activities are done through the political influence. As the politics works as a tool of influence, negating the organisational rules, the existence of such a politically biased system does not make it possible to ensure accountability and quality of health service delivery.

6.5 Conclusion

Rural health service organisations have insufficient facilities due to poor resource provision. Professionalism of doctors is poor because of lack of ethical values, impolite behaviour, and a lack of commitment and motivation to work with poor people. Evidence shows that the rural health professionals share these traits, which critically affect their accountability to their organisation and the people and the quality of health service delivery. Motivation and strong supervision have been seen to enhance a doctor's professionalism, particularly in the urban UHC and this is seen to contribute to better health care delivery. Moreover, the doctors in the urban UHC, Savar respect their organisational rules and regulations as set out by the government. As a result, they show better accountability and deliver better healthcare.

Absenteeism of doctors is higher at Chhatak compared to that in Savar UHC, because of better facilities such as scope for the doctors' own higher education; their children's education and private practice are available in Savar and other urban health service organisations. One of the causes of absenteeism is inadequate government policies and planning to meet the expectations of doctors who work in rural areas. Private practice affects the doctors' responsibility and contributes to poor accountability. Data show that healthcare seekers, who can afford to do so, seek health services from private facilities, as they do not trust the level of efficiency and the quality of public health care. But poor people have limited capacity to spend; therefore, they depend heavily on public providers and medicine, which are free. However, still a few of the poor patients use private facilities due to the shortage of doctors (due to absenteeism) in the public health service organisations.

Corruption is a common phenomenon in the provision of health service delivery due to lack of accountability which adversely affects the quality of rural health service delivery. However, unlike Chhatak, there is no evidence of corruption in Savar. Therefore it can be assumed that the doctors in Savar UHC are more accountable and provide better health service delivery. On the other hand, the poorer people get

a lower quality of health service. Politics makes the health service organisation weaker and less accountable. The poor socio-economic conditions of health care seekers, particularly in Chhatak, are taken advantage of by the doctors by being less accountable to their patients. In other words, the Chhatak doctors are professionally less accountable than Savar doctors.

This chapter has examined the causes and the impact of professional responsibility on understanding accountability; however, transparency also affects quality health care, which is the focus of the next chapter.

Chapter 7

Transparency and Health Service Delivery

7.1 Introduction

The majority of respondents interviewed in this research[59] stated that, in order to promote transparency and maintain a good quality of health service delivery, there needs to be an effective Citizen's Charter (Ministry of Health and Family Welfare 2008), an appropriate reporting system and an efficient record keeping system. Additionally, communication technology makes information available to service providers that enable health system and service delivery transparency, and accessible and affordable service to receivers (Information Act 2009). The health service professionals and the elected representatives interviewed in this research believed the management of an organisation or bureaucracy, and its available health service resources have an impact on the promotion of transparency and the quality of health service delivery. Finally, the health service users, local informants and community leaders also interviewed stated that socio-economic conditions of the people and the prevailing political climate significantly affect transparency in, and the quality of, health service delivery.

The objective of this chapter[60] is to examine how the aforementioned factors contribute to accessibility of information to promote transparency and quality of health service delivery in the two sub-districts studied in the research.

This chapter is organised into four sections. The first deals with organisational mechanisms for understanding transparency and health care delivery. The second examines how modern technology affects transparent health care delivery. The third section analyses the managerial factors to enable an understanding of transparency, and the final section provides a summary of the findings.

[59] A list of persons interviewed in this research is given in Appendix 12.
[60] The findings of this chapter presented at the 14th National Immunisation Conference, Public Health Association in Australia (PHAA)(Islam 2014c) and also published some of findings in the GSTF Journal of Nursing and Health Care (JNHC) (see detail in reference Islam 2014 d).

7.2 Mechanisms for promoting transparency

This section deals with billboard and citizen charter, information accessibility, supervision of satellite clinic, necessity of help desk, and preservation of office record as mechanisms for understanding transparency and the quality of health service delivery.

7.2.1 Billboards and citizen charters

The Deputy Program Manager of Transparency International Bangladesh (TIB) interviewed in this research stated that the government introduced a citizens' charter in 2008 for public health service organisations in order to display useful information concerning the availability of services and the specific cost of each service. The Deputy Program Manager also stated that the aim of this charter was to inform clients of the amenities provided by the health service organisations in order to facilitate transparency. The Vice-Chairperson of Chhatak, interviewed in this research claimed that both the Chhatak UHC and Kalarukha Union Sub Centre (USC) have very old citizens' charters, which are non-functional and inadequate. The Chhatak Pharmacist interviewed in this research pointed out that he maintains a list of medicines available at the UHC and the doctors prescribe medicines to outdoor patients (who expect only doctor's advice) according to this list. However, he stated that patients are unaware of this list because this is internal matter of hospital. On the other hand, the Pharmacist expressed that most of the patients are illiterate or semi-literate and therefore, unable to read and understand what is written in a citizen's charter or on the list of medicines. In addition, he expressed that patients are not interested in the charter or list as such; they come to the hospital to obtain treatment after which they go home.

Nevertheless the Pharmacist stated that the patients should know about the citizen's charter and the medicines available in the health centre as a matter of rights. He further suggested that one of the ways for the patients to find out about the citizens' charter is to build awareness of it through mass campaigns, which are currently non-existent. A report published by Transparency International in 2008 shows that the Savar hospital has a noticeboard to inform people of the availability of medicine in the health complex. The Store Keeper in Savar, interviewed in this research reported that the pharmacist of Savar UHC provides the doctors with a list of medicines available there so drugs can be prescribed according to their availability.

He also stated that this list is updated from time to time and that this updating is overseen by adequate supervision from higher level authorities.

A health professional interviewed in this research, confirmed that while the Savar hospital has a sign out the front, which indicates the type of services provided, the hospital is unable to furnish all services due to its limited capacity. The Medical Technologist (EPI) of Chhatak UHC, interviewed in this study reported that the government provides leaflets and posters regarding immunisation of women and children, but that the immunisation department in UHC has no specific citizens' charter to publish its messages about health service delivery.

A senior official in ICDDR,B, interviewed in this study stated that no posters or leaflets are displayed at hospitals to inform patients of the information available there; this reflects negligence on the part of hospital authorities. He said that it should be a part of hospital policy to ensure that all relevant information is made available to patients as a matter of right, yet hospital management does not implement this policy. He further stated that the patients may request services if they are aware of what are available. The President of Chamber of Commerce in Chhatak interviewed in this study claimed that health care providers deliberately hide the information so that they can impose extra charges on patients for particular services, which they would not be able to do if the information were freely and fully available. He further claimed the healthcare providers' part time private practice would be reduced if information regarding all available hospital services were to be made public.

In fact, health professionals are accustomed to concealing information to avoid clients' enquiries and to gain personal benefits through private practice. The citizen charter in Chhatak is inadequate and incomplete, as information has not been updated for public use whereas the Savar UHC has a clear signboard displaying the necessary health service information. Therefore, Savar's UHC health service information is enriched due to the oversight of higher authorities, the responsibility of health professionals and the awareness of the community. All of these issues contribute to improved transparency in the Savar UHC.

7.2.2 Field workers promotion of information accessibility

There are several ways of promoting access to information about the services available at health centres. The Health Inspector (HI) in Savar of UHC, interviewed

in this research stated that the health and family planning field workers constitute one important source from which people can obtain current information about the availability of health services at their health centres. This is because the health and family planning field workers visit door to door to inform people of these services. The HI also argued that field health and family planning workers visit the villages equipped with portable loud speakers which makes it easier for them to publicise information about the various health services including maternal and child health services so that the relevant information is available to the target population through mass communication. The Family Planning Visitor in Chhatak, interviewed in this study mentioned that the school program is another channel to provide information about health services. In the school program, the field workers provide information on health services to the school teachers, who then convey the information to their students and ask them share the same with their parents. Lebovic's (2006) study also concurs that accessibility of information promotes transparency as discussed in Section 2.3.2 in Chapter 2.

The Upazila Family Planning Officer of Savar, interviewed in this research, stated that most of the family planning workers of this health sub-centre are from Savar and know the health service users well as they all live in the same area. Therefore, the field workers have good and close relations with the health service users. The field workers make house-to-house visits which gives the health service users the opportunity to get to know the field workers well. The Family Planning Officer of Savar also said that the health service users know the field workers well because the latter have been working there for a long time. In addition, people now have mobile phones, which is another way to inform people of family planning services (see details in Section 7.3.2). In addition, the Family Planning Officer stated that the Department of Family Planning frequently organises country-wide awareness programs in order to inform people of the available family planning services. However, he argued that resource constraints, meagre travel allowances, and the lack of local supervision are several of the major challenges in providing adequate information to bring about the transparent delivery of health services.

Generally, Health and Family Planning Department field workers are a great source to make information on health services available to clients. Additionally, school programs and mobile phones improve the access to health service information and enhance transparency, as the respondents have stated in this research. However,

resource constraints in the UHC are one of the challenges in availability of health service information and improved transparency.

7.2.3 Field inspection and management of satellite clinics

The Savar Health Inspector (HI) also reported that field visits ensure that information is current and complete as field workers carry with them a schedule of times and dates for the provision of each type of health service offered. The HI also mentioned that senior officials visit the field to inspect the activities of the field workers according to a given schedule so as to ensure transparency. The HI interviewed in this research reported:

> "I visited the expanded program on immunisation (EPI) in a ward which consists of some of the camps (generally 3 wards have 8 EPI camps). I visited most of the wards and saw how they are working. It is the responsibility of the health assistant to visit each and every house, inviting the household members to bring their children for immunisation and confirm the registration of children prior to beginning the EPI program. The health assistant does this on the day before the program by visiting the place. On other days they visit door to door to promote health education. The field workers also visit schools to provide health education".

However, the Ward Member (elected representative) from Chhatak, interviewed in this research argues that the process of field visits is not transparent. In this regard, the Ward Member claims that the Upazila Health and Family Planning Officer (UHFPO) and the Medical Officer do not visit the field, nor do the nurses visit the community clinics in Chhatak. However, according to the Ward Member, in their office records and reports to their supervisors the health professionals still indicate that they have completed the field inspections according to government regulations. This reflects dishonesty and a clear lack of transparency. The Ward Member also argued that such dishonesty and insufficient transparency are caused by poor ethical values of health care providers, bureaucratic mismanagement and the low level of inspection practices of the senior health professionals. As field inspection is a process used to promote transparency, but dishonesty to deliberately mislead affects the real transparency as the respondents in Chhatak in this study observed.

The Family Planning Visitor (FPV) of Chhatak expressed at her interview that the satellite clinic program is a temporary arrangement to provide health services. It is organised at Upazila Sub-Centre or in a place to provide health services to pregnant women and newborn children, especially those living in remote areas. The satellite clinic also provides immunisation to children and provides family planning services.

She explained that the satellite clinic program is the easiest means of taking services from field health workers.

The satellite clinic is an effective method for circulating useful information which is also a way of promoting transparency and improving rural health service delivery. The application of this method is adequate in rural health service organisations, although such methods have limited use at the urban level as urban clients receive information in a different way.

7.2.4 Necessity of the UHC helps desk and organisation of meetings/seminars/symposia

One of the problems of the Upazila Health Centre (UHC) is that there is no "helps desk" to provide information to service users. In this regard, the Resident Medical Officer (RMO) of Savar, interviewed in this research spoke out that, as yet, a receptionist position has not been created at either a UHC or at a Union Sub Centre (USC). The RMO stated that patients who are poorer and less educated than others are unable to find a doctor or access useful information about whom to contact for their treatment. He also stated that literate clients are able to read and ascertain the name, address and the room number of doctors to acquire appropriate information. The literate clients can also read notices and are able to search for the required information. However, the illiterate clients, of which there are many, even in urban Bangladesh face problems in getting their required information. The Medical Technologist (MT) of Savar UHC interviewed in this research stated that sometimes the hospital authorities use an existing staff member to perform the job of a receptionist to provide information to clients. The MT however claimed that the UHC authorities cannot provide satisfactory services due to limited human resources which supports various studies including Ahmed et al.'s (2009), as mentioned in Section 2.4.3 in Chapter 2.

In practice, clients face difficulty in accessing accurate information due to the lack of help desk at UHC/USC which is one of the challenges of transparent health service delivery. The Savar UHC viewed this problem as human resources crisis.

When interviewed for this study, the Family Planning Inspector of Chhatak reported that the Department of Family Planning organises meetings with the local elected representatives. This is done so that the Department of Family Planning is able to convey messages to the residents of the representatives' locality. The Chairman of the Union Parishad (UP), Kalarukha, Chhatak stated in an interview that he

conducts meetings with the UP council, which Health and Family Planning officials attend, and he provides useful information in relation to maternal and child health care. Such meetings are a means of ensuring transparency in health service delivery. The Family Planning Officer (FPO) of Savar stated in his interview that the Department of Family Planning also organises seminars to observe 'World Population Day' and disperses information concerning the problems associated with large populations and rapid population growth in order to make the people aware of the population problem and motivate them to use family planning.

The FPO also mentioned that the Department of Family Planning organises a service week once every two or three months in order to ensure wide publicity of the department's work. During these meetings, posters and leaflets are distributed to convey useful information to the target audiences. In addition, this department also conducts workshops in the Upazila Health Complex, school programs and meetings with religious leaders. According to the FPO, these programs are aimed at providing useful information to service recipients and make health services transparent and accessible to all.

As noted, different methods such as meetings, seminars and workshops are effective mechanisms for making information available to improve transparency in Savar and Chhatak. These methods are general mechanisms and no significant difference has been found with regard to mechanisms leading to a contribution to transparency and quality of health service delivery in rural and urban health service organisations.

7.2.5 Accuracy of reporting system and record keeping

The Health Assistant in Savar, interviewed in this study argued that the annual/monthly report provides a clear record of how doctors and nurses work to provide the services they are employed to provide. He further stated that these reports contain detailed information of service performance of health professionals, the location from where the health care provider works, the types of health services available at each health post, and the records of deaths of women and children (see Box 7.1). The Health Inspector in Savar interviewed in this study stated that adequate supervision is one of the mechanisms used for checking whether the reports by the doctors and nurses are accurate.

Box 7.1

Promotion of transparency and responsibility through reporting of monthly plans

Health workers prepare their monthly plans in advance which indicate what, where and when they will work. One health assistant generally works in three villages in a month and submits the monthly plan to his/her office, UHFPO and the health inspector to make their job responsibility transparent to the higher authority. This plan is divided into two parts: weekly and daily. The weekly plan covers six working days of every week and the daily plan is a part of everyday activities. This plan shows information on place, time and number of patients each health worker has to cover to make their responsibility transparent and accountable. **Source:** Interview with Health Assistant, Savar

The Savar UHC has adequate supervision and responsibility for health professionals, and the report on health services is accurate and well organised. Consequently, the delivery of health service is transparent. Nevertheless, Chhatak UHC may contribute to inaccurate reporting leading to poor transparency as inadequate supervision is mentioned in different sections in this study.

A good filing system ensures transparency by recording accurate information regarding materials and medicines. In this regard, the Store Keeper of Savar Upazila Health Centre (UHC), pointed out in his interview that higher level officials first visit the store section of the UHC in order to inspect its inventory. Therefore, it is necessary to keep the store documents current for the visiting higher level officials in order to promote transparency of office documents. The Store Keeper also stated that the UHC files should contain information about the annual requirements of medicine and materials and their allocation. The Store Keeper confirmed that he sends one copy of the file to Headquarters and keeps one copy in his office. He also maintains reports on purchases; receipt books and records all such information in the UHC registers in order to ensure transparency.

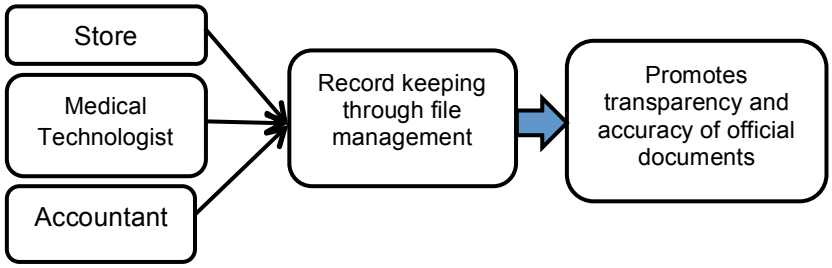
The Upazila Health and Family Planning Officer (UHFPO) of Savar, interviewed in this study stated that the Accounts Officer (AO) of the Upazila Health Complex (UHC) maintains a register as required by the Department of Health, which contains clear information with regard to health services. The UHFPO further stated a client has to pay Tk.3 (equivalent to 5 US cents) to purchase a ticket to meet a doctor to register his/her name for a visit to the UHC. Every ticket has a serial number which is recorded in the register maintained by the AO so that an auditing team can easily

and transparently understand the workings of the health centre. The Accounts Officer of the Savar UHC said that he maintains the accounts based on the departments of the UHC such as pathology, x-ray, and nursing as required by the Department of Health. For example, the accounts of drugs and medicines for arsenic poisoning, tuberculosis or other medicines are maintained separately in different files.

Likewise, the Medical Technologist (Pathology Department) of Savar stated when interviewed that he takes money for pathological services against receipts. He also reported that he maintains a register in which he keeps information about monetary transactions in order to ensure accountability and transparency. The Medical Technologist further stated that the Pathology Department provides the money received from patients regularly to the Account Officer. He also noted that the UHC Accountants Officer maintains financial statements and deposits all monies in the bank regularly. This money goes directly into a government account as at every stage of the transaction, the responsible officials maintain proper office records. He further stated that the hospital authority is unable to withdraw and use this money as it is deposited into a government account. The processes of filing and record keeping are shown in Figure 7.1.

Figure 7.1

Filing and record keeping in Savar UHC



Source: Field Data 2013

As the respondents' views show, Savar UHC maintains adequate record keeping and file management in order to make health service information available. This means that Savar UHC provides health services, which are adequately transparent; however, such evidence is unavailable to Chhatak UHC. Therefore, the researcher

assumed that the Savar health service is more transparent than that of the health service delivery in Chhatak.

To summarise, citizen charter is one of the ways to make information available and accessible for service users, which assists to promote transparent health care delivery. The Savar UHC has an effective and visible citizen charter therefore the health care delivery is more transparent, but such citizen charter is absent in the Chhatak UHC leading to poor transparency in health care. The mechanisms through which the field health professionals provide available message to rural residents are important ways to promote transparent health care but resource constraint and poor supervision contribute to poor transparent health care delivery in Chhatak. Importantly, Savar has improved transparent health care as the officials keep all health service record update and available for higher authority. In addition, the health service manager provides strong supervision and performs professional responsibilities, adequately.

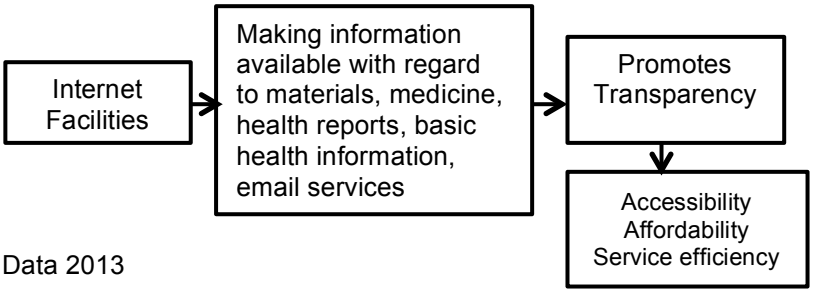
7.3 Modern technology and transparency

7.3.1 Internet access

The Health Inspector of Savar, interviewed by this researcher stated that Upazila health service organisations have Internet connections that enable staff to collect useful health service information, which significantly improves health service delivery (see Figure 7.2). He also stated that if the Government announces a Vitamin 'A' camp and announces this on the Ministry of Health website, the field office staff of all Upazila health complexes (UHC) would be able to obtain this information via the Internet and would know what items will be covered in this particular program. Such facility enhances healthcare information management and transparency of service. The Upazila Health and Family Planning Officer (UHFPO), Savar, pointed out that internet accessibility also helps to promote online services such as annual reports, health updates, and basic health information, for example, more efficiently.

Figure 7.2

Internet facility promotes transparency and quality of healthcare



Source: Field Data 2013

Additionally, the UHFPO stated that the Ministry of Health and the Directorate of Health Services send useful information to all district and sub-district offices through online facilities to make it readily available and transparent. He also stated that the Internet makes it easier to obtain reports including other database documents quickly and transparently. The UHFPO however claimed that technological equipment and materials are not always available at the Upazila Health Complex (UHC). He noted that the UHC staff have limited access to the Internet, computers, and to insufficiently skilled technicians which all affect health service quality. Despite this limitation, the UHFPO claimed that the Savar staff are able to use the Internet to organise meetings. The Resident Medical Officer of Savar informed the researcher that monthly meetings are organised online for all medical officers and other staff. Figure 7.2 shows that the Savar office staff are able to communicate with other organisations using emails, which assists rapid information collection. The Family Planning office in Savar is up-to-date with the use of Internet for health service delivery. The Family Planning Officer of Savar stated that the Prime Minister's office has opened a website to make service-related information available. On this website, the Family Planning Department staff have been placed in the first position in ranking by the government based on their performance of using internet services. The Family Planning Officer of Savar reported that basic services on matters such as education and health, which are provided via the Internet are supervised by staff of the Information and Communication Technology (ICT) department.

In practice, some of the common services such as immunisation programs, which are run throughout the country, are available via the Internet. This Internet service makes the information accessible to clients which improve transparent health service delivery. However, technical staff and technological equipment is the major barrier in promoting transparent health care. As reported the Savar Upazila health

complex organises monthly staff meetings using email services, therefore the UHC provides efficient and improved transparent health service delivery, which is lacking at the Chhatak UHC.

7.3.2 Mobile phones

Figure 7.3 show that mobile phones improve communication in promoting accessibility and health service affordability and ensuring transparency. The UHFPO of Chhatak reported that mobile phones are used for organising health programs at the field level; that is, a health inspector might send a message via a mobile phone to organise a micro plan for scheduling a grassroots health program including an expanded program on immunisation (EPI) to make services available to clients. The Health Inspector (HI) of Chhatak spoke out that some healthcare providers are able to use smartphones to make communication quicker and easier by sending health service messages. Service users claim that sometimes the field workers cannot transmit information quickly enough to people living in remote areas. In such cases, mobile phones play a significant role in informing these users. The HI also confirmed that health assistants have the mobile phone numbers of immunised children, which enables them to communicate with patients effectively.

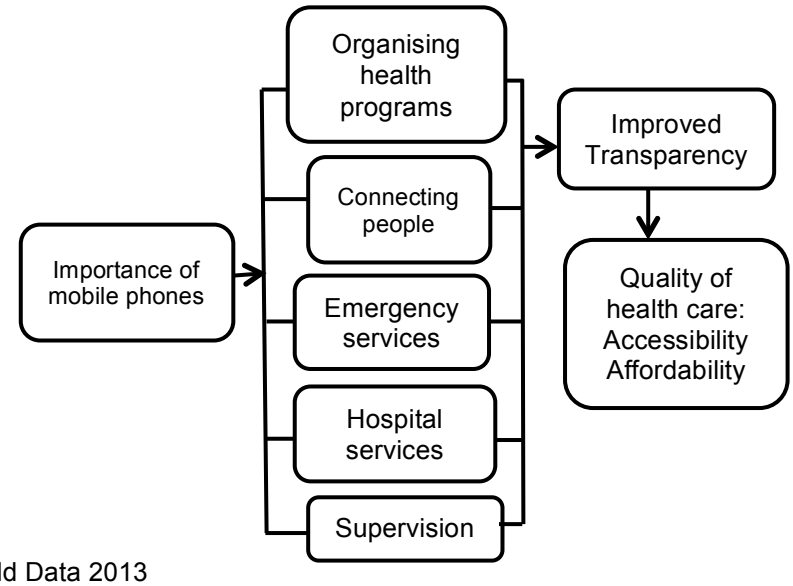
Currently, most people in remote areas have mobile phones, which enable people to connect with service users easily and rapidly. One Assistant Health Inspector interviewed in Chhatak, pointed out that a mobile phone is an easy way to mobilise people generally and service users particularly. She stated that health assistants can send their messages rapidly. Smartphones offer an easy way to contact healthcare staff as they can send adequate medical advice quickly through mobile phones. They can also refer emergency cases to hospitals via mobile phones. A local Newspaper Reporter interviewed in Chhatak stated from his own experience that such referrals through mobile phones help reduce maternal and child mortality, particularly in the remote areas. Mobile phones are used to communicate with community health workers to provide emergency healthcare by bringing people from rural to urban localities. He also stated that this enables health assistants to promote maternal and child health service delivery through emergency services. For instance, the evidence from India demonstrates that mobile phones allow women to actively participate in health service organisations and their family's healthcare (DeSouza et al. 2014). This study also demonstrates that mobile phones facilitate communication and decision-making in reproductive health. Service users

expressed that mobile phones improve awareness among women through communicating with healthcare providers, which not only empowers them but also facilitates them to make decisions.

The Deputy Director (Health Education) in the Directorate of Health Services told the researcher that every Upazila Health Complex (UHC) has a mobile phone provided by the Head Office to enhance supervision and to monitor doctors' availability at the hospital. He stated that sometimes the Head Office calls a Medical Officer/UHFPO at UHC to determine his/her location, presence and current activities. The UHC doctors provide general medical advice over the mobile phone. The Deputy Director claimed that mobile phone numbers are available to hospital staff so that clients have access to services. A mobile phone is carried by a doctor on duty and allows the provision of health services such as counselling regarding medicine in accordance with clients' needs. In addition, the Health Inspector stated that community health workers can communicate with service users who live far away and have difficulty accessing a hospital. He also said that mobile phones enable health workers to provide useful medical advice and primary health care services.[61]

Figure 7.3

Impact of mobile phones on transparency and quality of health care



Source: Field Data 2013

[61] The doctor provides services such as oral counselling based on hearing problems over the mobile phone; consequently, the doctor may suggest taking some common medicine for pain and fever if required.

The Health Inspectors of both Savar and Chhatak stated that extra allowances for mobile recharge calls can improve accessibility of mobile phones to promote healthcare delivery. One Family Planning Inspector in Savar pointed out that every employee should have a mobile phone and that the government should pay for calls related to official matters to promote communication and to enhance healthcare accessibility. For example, it is mandatory to keep pregnant clients' mobile numbers to maintain an awareness of their health condition. The Health Inspectors also pointed out that health and family planning workers sometimes provide emergency services for pregnant women or bring them to the nearest health centre by communicating on mobile phones. The Health Assistant in Chhatak claimed that providing such services requires additional monetary allowance which must be paid for by the government given that it is a crucial means of healthcare delivery.

In fact, mobile phones used in the various ways as stated in Figure 7.3 which promotes health service transparency in UHC and such other services are equally significant in rural and urban health service organisations. Service delivery through mobile phones has been significantly improved in rural health services as noted by the respondents in the study. Byuiyan's study (2011) also shows the positive impact of mobile phones on women empowerment and socio-economic development in rural society in Bangladesh in Section 2.5.3 in Chapter 2.

7.3.3 Improvement of administrative efficiency through computers

The Resident Medical Officer (RMO) of Savar interviewed in this study stated that computers are innovations, which can make the health services more accessible by enhancing quality of care in health services. He also stated that sub-district health service organisation staff has limited computer access to perform administrative work. The RMO claimed that computers help to generate reports for the Directorate of Health Services and enable staff to communicate with the directorate via email. He also confirmed with the researcher that the Savar UHC EPI department staff use computer software provided by the government to calculate demographic information including health service data easily, quickly and appropriately. The Health Inspector in Savar, interviewed in this research pointed out that computers are available only for administrative purposes in the organisation. He argued that healthcare providers at the field level have limited computer facilities. As a result, they write their field reports manually and are only able to send hard copies of their reports to higher authorities. However, he mentioned that although computers make

administrative jobs easier and more convenient, no patient record is preserved on computers. The UHFPO in Savar stated that the government has a scheme to provide a sufficient number of computers and skilled staff gradually to enhance quality of health services. However, he also stated that the implementation of the scheme has been very slow owing to bureaucratic complexities and weak political commitment.

Although computers are modern technological innovations used to make administrative work more efficient, the UHC has limited access to computers therefore field health professionals produce reports manually and this could affect transparent health care delivery. Moreover, the UHC is unable to preserve patient records on computers due to their limited use and, consequently, the desired transparent health system has not been yet achieved as expected. Besides this, the bureaucratic complexity and lack of political will affect the technological improvement leading to transparency and quality of health service delivery.

7.3.4 Enhancement of transparency through electronic media

The Family Planning Officer of Chhatak noted that the electronic media can play a significant role in enhancing transparency in health services. In this regard, he suggested that the television medium can be used for broadcasting health activities to expand health programs. Such broadcasts can contribute to enhancing public awareness and enable the reception of information quickly. The Family Planning Officer (FPO) of Chhatak, interviewed in this study stated that the private *Channel i* and Bangladesh owned the television broadcast information regarding family planning, maternal and child health programs. Consequently, the awareness of about family planning has improved significantly. The FPO further stated that the radio channels broadcast plays to promote health education, awareness and family planning activities. Furthermore, he stated that the family planning department staff also organise cinema and documentary films to promote awareness among the people. Free media enhances transparency, which is supported by Kjaer's (2004) study as discussed in Section 2.3.2 in Chapter 2.

The Assistant Family Planning Officer of Savar UHC stated that newspapers publish information about family planning methods and circulate important facts about maternal and child health services. Electronic devices in the UHC can have an important effect on information accessibility through publicising hospital information and health awareness programs. The Medical Officer (MO) of Savar spoke out that

electronic devices can be useful mechanisms for providing information regarding maternal and child health, and for patients who seek hospital services. In this circumstance, patients are able to gain necessary health information while waiting for services. However, the MO claimed that this facility is not available in public health service organisations, which limits access to information and reduces transparency.

Basically, electronic channels have a significant role in making information available to people as it is very convenient and transparent. These electronic media are used by the Health and Family Planning Department to circulate useful information promoting awareness, which enhances accessibility of health care delivery. Respondents in this study suggest that electronic devices in the UHC can contribute to health service information available which may enhance transparency and quality of health service delivery.

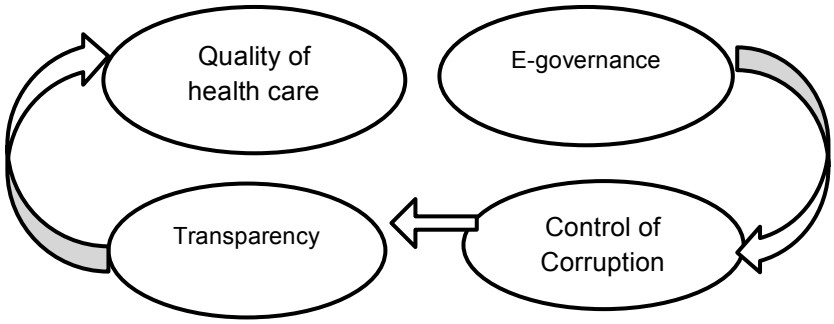
7.3.5 Health service quality promote by E-governance

E-governance means delivering information over Internet or web to citizen so that service users are able to access health care delivery. Islam (2009) study shows that e-governance is a computerised based administrative functions, which makes Internet based useful information available to citizen. The United Nations Education and Scientific and Cultural Organisation (UNESCO) (undated) defined e-governance as the performance of governance via the electronic medium in order to facilities an efficient, speedy and transparent process of disseminating information of the public, and other agencies, and for performing government administration activities. A senior official in ICDDR,B interviewed in this study pointed out that technological innovations such as the Internet and electronic devices promote e-governance and health service quality. He also pointed out that e-governance is a useful mechanism for promoting good quality health service delivery by reducing corruption and increasing transparency within public organisations (Figure 7.4). Nevertheless, the UHFPO in Chhatak, interviewed in this research argued that in reality, poor technology and inadequate resources limit e-governance and service delivery at the Upazila Health Complex (UHC) and the Union Sub Centre (USC). He claimed that the Union Parishad (UP) information centre should be providing healthcare information, however unfortunately the responsible office staff are mostly absent and unable to deliver information. Additionally, the Medical Technologist in Chhatak expressed the researcher that transparency requires updated and enriched

information to make the services more people-centred. He also said that some medicine and health services information have not been updated for clients which consequently limits accessibility of healthcare.

Figure 7.4

Impact of e-governance on quality of health service delivery



Source: Field Data 2013

Figure 7.4 shows that the introduction of e-governance to a health service organisation makes its information available to people which controls corruption and promotes transparency in those organisations. This transparent system makes health service delivery available so that people can avail themselves of quality health service delivery from the organisations. Similar views reported in the study by Byuiyan (2011) demonstrate the role of e-governance in the reduction of corruption and its impact on transparency and service delivery in developing countries in Section 2.5.3 in Chapter 2.

A senior official of Transparency International Bangladesh (TIB) interviewed in this study stated that another matter to consider is the skilled workforce in promoting e-governance. He also stated that managers should make available technology training to staff so that they can provide efficient services. The Manager (Governance) in ICDDR,B interviewed in this research argued that users do not trust e-services as users do not have enough understanding of such services nor are they familiar with them. He also argued that electronic documents sent by e-mail do not bear anyone's signature and a document without a signature is not recognised as a valid document by the people. The manager further argued that there is a poor understanding of modern technology and its application as people are not sufficiently educated to use it. The reason for this, he claims, is that society is not adequately advanced and is still developing to adapt to modern technology and

services through technological innovations. Moreover, the Manager (Governance) stated that confidence needs to be developed through promoting technology education and awareness so that its application in the promotion of good quality healthcare is understood.

Overall, e-governance reduces corruption and promotes transparency; however the UHC is not adequately equipped to establish e-governance due to poor technology and inadequate resources to promote quality of health service delivery. Moreover, service users have a poor understanding of e-governance that affects efficient health service delivery.

7.3.6 Technological advancement in the UHCs

The UHFPO in Savar, interviewed in this research stated that due to the advent of new technology people's demands for efficient and good quality health services have increased. However the UHC still uses analogue machines for medical examinations and reporting. These machines do not produce efficient reports to meet the demand. The UHFPO also stated that currently, the government has digital machines at district level hospitals as well as in medical colleges, but that the government is planning to supply digitalised X-ray machines to all UHCs for medical examinations to make health services efficient and affordable. He claimed that digital machines produce medical reports very quickly and accurately and the production cost of the report is minimal. Consequently, service users gain access the medical reports with minimum cost. The Medical Technologist (X-ray) in Chhatak reported that their UHC has an old X-ray machine, but it still works and therefore, service providers are satisfied. The junior consultant in Savar interviewed in this study stated that the Savar UHC has an operating theatre (OT) and provides efficient caesarean deliveries but it is not available in the Chhatak Upazila, as stated by the Medical Technologist in Chhatak. The junior consultant in Savar also argued that no modern technology is available in the Savar hospital. Nonetheless, Savar hospital has primary care instruments for surgery if required for delivering babies, which is rare in a rural Upazila hospital.

E-services have not been developed at the Upazila level yet. In this regard, the Deputy Director (Health Education) interviewed in this study said that the office of the Directorate General (DG) is currently planning to introduce e-medicine services by developing new software. This is not popular however as people have no understandings of e-medicine services. He also said that technology is often

misused at a UHC. This happens due to lack of education and understanding of usage procedures of the machine or electronic devices. Most elected representatives interviewed in this research expressed that this wastes government resources. The Deputy Director (Finance and Field Services) interviewed in this study claimed that many developmental activities have been conducted through technological devices. For example, the Family Planning Directorate General has a section or division devoted to a management information system (MIS), which operates through online services. He also claimed that section staff communicate with each Upazila using online services. The Deputy Director also claimed that family planning staff at every union level are provided with laptop computers which have installed software for sending out relevant information. This scheme definitely assists in strengthening information management to provide quality of health care. He further claimed that the Upazila Family Planning Officer allocates money to enhance technology from the development budget. Yet a local Chhatak Newspaper Reporter spoke out that Information and Communication Technology (ICT) is still at an initial stage and it is too much to expect an outcome through the use of such technology. He also stated that the government invests money although it is not used efficiently. Consequently, achievement is limited and is invisible. A study by Meijer (2009) supports the application of technology and his study demonstrates the impact of modern technology and access to information on transparency and service efficiency in Section 2.3.2 in Chapter 2.

To sum up, technological improvement is not sufficient at UHC as both rural and urban health professionals use analogue machines for medical examinations. However respondents view that digital machines enable the production of efficient reports which are also transparent and affordable for clients. Savar has some improved health service facility such as operating theatres and primary surgery instruments which are not available to Chhatak UHC. Therefore, in comparison to Chhatak, Savar has developed technology and, consequently, the quality of health service delivery is improved there.

7.4 Organisation and management

7.4.1 Availability of health care providers

The Secretary of the Bangladesh Women's Association (BWA), Savar, interviewed in this study stated that a regular presence of health care providers in health service

organisations improves professional integrity and allows transparency in the organisation to promote the quality of health care. A Ward Member in Kalarukha Union Parishad, Chhatak told this researcher that paramedics work at the Union Sub Centre (USC) regularly but he starts work in late and finishes his duty early, for example he starts work at around 11.00 am instead of 8.00 am and leave early at around 3.00 pm or earlier instead of 4.00 pm. They do so due to a lack of strict supervision and monitoring. According to the same Ward Member, the paramedics at Upazila Health Centre (UHC) report to work on time, provide services as required, and stay longer at the centre as supervision is stronger there. However, the Ward Member stated that doctors do not attend the Union Sub Centre (USC) regularly. As a result, the paramedics are more popular among local residents for their regular presence and dedication to duty of service delivery. A local political leader (Secretary, Bangladesh Nationalist Party) in Chhatak pointed out that graduate doctors are not regular at the health centre due to lack of supervision and inadequate monitoring. The result of the irregular presence is that the poor people are deprived of quality health care. A senior official of Transparency International, Bangladesh (TIB), interviewed in this study informed the researcher that none of the doctors is present in a rural UHC at night which is a sign of negligence of responsibility.

On the other hand, a medical representative in Savar, interviewed in this study said that the doctors are regularly available at the Savar Upazila Health Complex. Patients get twenty-four hour medical service as the organisational rules are systematic and it is compulsory for the doctors to work on the hospital premises. The medical representative attributed the regular presence of doctors to their own sense of responsibility and the strict supervision by the doctors' managers (see Figure 7.5). A Health Inspector in Savar, interviewed in this study reported:

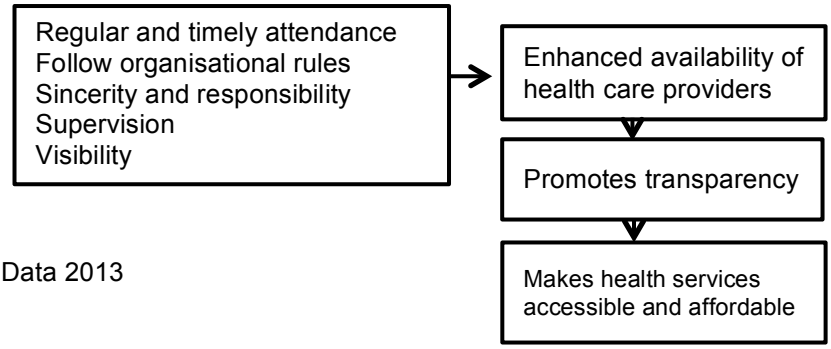
> "Savar UHC consists of 50 beds and this hospital is near Dhaka city so doctors are more accessible to this organisation. Other rural health care centres have almost similar human resources but doctors are rarely present. Higher authorities such as the District Commissioner or the Civil Surgeon visit Savar hospital time to time, therefore, doctors must be present and work in the hospital".

A Senior Staff Nurse in Savar, interviewed in this research reported that nurses were present in the hospital more often as they have a significant responsibility to their organisation. In this regard, she quoted the speech of former president H. M Ershad and he said: 'I visited the hospital several times and found the nurses are responsible on duties', which means that nurses are more regularly available in

hospitals compared to other health professionals. Besides this, the speech indicates that nurses perform their responsibilities in a dedicated fashion as well as in a professional manner. The Senior Staff Nurse also pointed out that the enthusiasm of nurses' service delivery may serve as a good example for other professional workers. In addition, nurses of public health care organisations are devoted to their work as they do not work in private hospitals as do doctors, an issue that has been discussed in detail in Chapter 6.

Figure 7.5

Factors leading to availability of health care providers to promote transparency and quality of care



Source: Field Data 2013

The service users of Chhatak who participated in focus group discussions in this research stated that field workers regularly visit rural areas at least twice a month and provide advice and useful health care that ensure accessibility and affordability of services to users. One Chhatak Social Worker supported the point made at the focus group discussions and stated that good doctors and their regular presence in the hospital improve accessibility of health care and enhance confidentiality, trust and the connection between service users in health service organisations.

7.4.2 Corruption and transparency

(a) Recruitment process

One of the manifestations of corruption is non-compliance with official procedures. As noted in Section 6.3.5 in Chapter 6, the lack of accountability is one of the causes of corruption that reduces quality of health service delivery. However, lack of transparency contributes to corruption. For example, the Member of Parliament (MP) in Chhatak commented that the Civil Surgeon (CS) of Sunamganj district lacks

transparency in the process of recruitment, which he is accused of as a result of the many irregularities including corruption. The MP told the researcher that on one occasion, the Ministry of Health and Family Welfare investigated the process of recruitment and found non-transparency and corruption in the process. Consequently, the government cancelled the recruitment made by the Civil Surgeon. This findings support Vian's (2008) conceptual framework as he shows how the lack of transparency contributes to corruption in the health sector in Section 2.5.3 in Chapter 2.

Political interference also makes the recruitment process non-transparent as stated by the opposition political leader in Chhatak, who argued that 4th class employees of a UHC and the community care provider for the community clinic are recruited through political influence. Although the corruption of recruitment process has been published in the newspaper but the system was lack of transparency. In this regard, the political leader interviewed in this study reported that:

> "Recruitment was not transparent; therefore it was stopped on the grounds of mass corruption. The Health Minister said directly that none of the candidates will be recruited without political affiliation to the Awami League (AL). This statement was published in the newspaper. It is difficult to maintain discipline and transparency in the health sectors if the system involves political interference".

Similarly, the Medical Representative in Chhatak interviewed in this research said that the process of the posting (placing) of doctors also lacks transparency due to political influence. As a result, less qualified health staff get posted to better health service organisations. The Medical Representative further said that some doctors pay money or bribes to the higher authorities to get posted to urban health care organisations.

(b) Patients' diets

Generally, a local contractor should be appointed by the Upazila Health Complex through the guidelines of bidding process who is responsible for supplying diet plans to patients for a particular period. The President of Chamber of Commerce in Chhatak, interviewed in this study spoke out that the patients' diets at sub-district hospitals lacks transparency, which contributes to low quality of food. This lack of

transparency can be attributed to an unfair bidding process[62], which prevents all eligible bidders from participating in the sub-district dieting process. The business leader claimed that mostly the local MP appoints a contractor on political considerations and the contractor provides low quality of food to the patients in order to achieve a higher profit. However nobody talks about this as the contractor has a local political connection.

(c) Provision of services

A local Newspaper Reporter in Chhatak, interviewed in this research noted that the sub-district hospital authorities hide correct information regarding the availability of beds in order to extort unfair payments from patients. This statement was corroborated by a Social Worker of Chhatak interviewed in this research. The elected representatives from Chhatak agreed with these statements but were unable to intervene due to a lack of sufficient administrative authority over hospital management. The Vice-Chairperson of Chhatak Upazila Parishad reported in this study that corruption has been reduced due to the improvement of the information system. Nevertheless, the Vice-Chairperson also reported that corruption is still evident in the hospital and stated that this was a part of human nature.

Similarly, the Secretary of Bangladesh Nationalist Party (Chhatak wing), interviewed in this research pointed out that the field workers' duty schedules are unclear and they do not work regularly to service their rural clients.

To summarise, political interference and the lack of clear information contribute to corruption in the recruitment process. In addition, doctors' postings and transfers involve political interference which leads to a less transparent health service delivery. Moreover, the bidding process does not adhere to the appropriate rules and regulations and the process is politicised all of which lead to poor quality of diets. The health service organisation hides basic health information such as limiting clients' rights to access information which leads to corruption and poor health care quality.

[62] The bidding process has guideline, however the guideline is not being followed due to influence of local politics. Besides this, the rules of bidding process do not work appropriately due to political influence.

7.4.3 Availability of medicine information

The Vice-Chairperson of Upazila Parishad in Savar, interviewed in this research noted that appropriate information regarding the medicine stock is not available to all staff in UHC. She also noted that people do not know how much medicine is allocated to the health service organisations nor do they know how the authorities use it. Only a limited number of officials (for example, store keepers, pharmacists and health administrators) who are responsible for managing medicines have information about the allocation, distribution and preservation of medicines. The Resident Medical Officer (RMO) in Savar said that the pharmacist provides the store keeper with requisitions for medicines each day and obtains the medicine according to stock availability. The pharmacist and the storekeeper work with each other as a team and have full information about the quantity of medicine. The Store Keeper informed this researcher that the hospital allocates a daily supply of medicine based on people's expected needs, but the service users complain that they do not get enough. Thus, there is a gap between demand and supply of medicine at the hospital. Moreover, the Store Keeper stated that the system is so rigid that people have no way to have information about medicines.

A focus group discussion with service users in Savar revealed a gap between doctors' prescribed length of medication and its supply in order to meet the appropriate dosage. For example, if the doctors' advice is to take a course of medicine for thirty days, the health centre only provides medicine for ten days. The Pharmacist at the health centre claimed that doctors prescribe medicine only for ten days; therefore the pharmacy cannot provide the patient with more. This vagueness in the prescription confuses the service users who claim that they do not get adequate and transparent health services.

In practice, information on medicine is not available for clients as the system is rigid and makes it difficult to gain accurate information. The health service management at UHC allows limited health professionals to access information which limits its accessibility leading to poor transparency and health service delivery.

7.4.4 Purchasing committee

The UHFPO in Savar interviewed in this research stated that the district health service organisation has a purchasing committee in order to acquire medicines and materials for the UHC and the sub-centres under the hospital. This committee

consists of seven to nine members including a district civil surgeon (CS) who is the chairman. The UHFPO also stated that the UHFPO is one of the members in the purchasing committee. This committee organises the tender process in order to purchase medicines and instruments. The UHFPO in Savar said that as a member of this committee, the UHFPO has a minor responsibility while the chairman of the committee (CS) has a major responsibility to justify the quality of medicines and materials.

The UHFPO of Savar stated that normally, the UHC gets high quality medicine yet the quality of machineries and instruments such as those required for blood pressure and weighing is poor and renders the tools not completely usable. He also stated that sometimes the committee forcefully allocates several medicines which have neither a high demand and nor are they significantly useful for clients; however, the committee does this to meet budgetary requirements. In addition, the UHFPO claimed that the responsibility of the tender committee is so unclear, non-transparent and non-participative that this contributes to the poor quality of the products. Medical representatives of Chhatak interviewed in this research reported that:

> "The government supplies medicine through a tender process. They supply low quality of medicine from a below standard company. Consequently, patient sufferings are not cured in a timely way. The tender committee takes illegal money from the medicine company and they supply poor quality of medicine".

With reference to product quality, the Manager (Governance), ICDDR,B pointed out that the tender committee has political influence, limited accountability and inadequate transparency; consequently, this committee is unable to purchase quality products. Conversely, a Savar Medical Representative interviewed in this study stated that politics is not the major factor; the officials of tender committee are corrupt therefore, they purchase poor quality of products.

A Ward Boy in Chhatak interviewed in this research stated that the UHFPO of Chhatak spends money for the purposes of training and workshops without seeking the participation of other members of the hospital. The RMO in Savar however stated that the Savar UHC has a committee, which consists of officials of the organisation. This committee works for the enhancement of hospital, but none of the outsiders (such as elected representatives, community organisations and social elites for example) participate in the committee. The Secretary of the committee of concerned citizens in Transparency International Bangladesh claimed that the

committee formation is so rigid that people know very little regarding the expenditure of the UHC. This evidence is supported by Vian's study (2008) and demonstrates that limiting the voices of citizens contributes to poor transparency leading to corruption as discussed in Section 2.5.3 in Chapter 2.

The purchasing committee is non-participative and bureaucratic in nature and the head of the committee influences the decisions. Besides this, the tender process for purchasing medicines and materials is unclear, which limits transparency and increases corruption. Consequently, the committee supplies poor quality of health service accessories. Moreover, information of the purchasing committee at UHC is not available to community, which also limits transparency.

In short, medicine information is not available to people because the existing system is very rigid. As well as, the prescription provided by the doctors in hospital is vagueness, as patients do not get either sufficient medicines or adequate information. Besides this, the formulation of medicine purchasing committee is bureaucratic where decisions made by the committee are rigid, non-participative, political biased, such procedures contribute to corruption and non-transparent health service delivery. The lesson learned from the above information that the mechanisms of health system are weak, less accountable, and non-transparent which contribute to poor governance leading inadequate health service delivery.

7.5 Conclusion

The above discussions demonstrate that the citizens' charter is one of the mechanisms used to publish information with regard to health services. However, this appears not to be functional as the given information provides inadequate explanations. On the other hand, people lack awareness of the citizens' charter. Health care providers hide information in order to gain personal benefits and this affects transparency and quality of health service delivery. However, the introduction of billboards or signboards to the Savar UHC enriches health service information which means the health service delivery in Savar UHC is improved and transparent compared with that of Chhatak UHC.

The discussions also show that organising field level meetings and file management are the more effective mechanisms to promote transparency. However, field visits and reporting procedures are normal processes to ensure health service delivery transparently as experienced in the Savar UHC. That being said, inadequate

supervision, mismanagement and poor ethical values of service providers all have adverse effects on transparent health care particularly in the Chhatak UHC.

The availability of computers at the health centres has made official duties easier, yet only a limited amount of administrative work is done on them. Critically, mobile phones have made close communications between health care providers and service users possible, which also enable the provision of quick health care delivery. This has definitely helped to provide better maternal and child health services in the last few years, which is aimed at reducing maternal and child mortality, as stated by the majority of health and family planning service providers in this study. Besides this, e-governance is another transparent method to promote quality health care. However, lack of resources and people's poor understanding limit a more widespread use of e-health services.

The Savar UHC uses emails to organise monthly meetings thus contributing to efficient and improved transparent health service delivery, however such effective mechanisms are lacking at the Chhatak UHC. Medical equipment such as machines and instruments are not adequately provided at the UHC, although urban UHCs have a slight advantage in this respect compared to rural UHCs. Resource constraints, limited budget and mismanagement are the major challenges for improving technology that affect transparency and quality of health service delivery.

One of the causes of corruption is the non-transparent recruitment process due to mismanagement in administrative procedures and political influence. Politics affects a transparent bidding process in contracting out the preparation of food for the patients which in turn contributes to poor diet management. Inadequate information is one of the major causes of corruption in Chhatak UHC, which is in addition to poor accessibility of hospital beds as well as the availability of medicines. The purchasing committee is too bureaucratic and politicised and this affects transparency and quality of products as stated by the UHFPO in Savar. That being said, such evidence is not available in the Chhatak UHC. Overall, politics, bureaucratic mismanagement, and inadequate information negatively affect transparent health care delivery.

Community participation is another significant aspect of quality of governance and health service delivery, which is analysed, in the next chapter.

Chapter 8

Community Participation and Health Service Delivery

8.1 Introduction

Community participation refers to knowledge, energy and commitment of community members. The community members are the various local actors such as politicians, local elected representatives, and common people who contribute to health programs to promote quality health service delivery. The local politicians and the elected representatives represent the local community and their views are essential for understanding community participation. This chapter examines the role of these actors in promoting participation as well as how different factors such as organisational procedure, bureaucracy, politics, decentralisation, and women's socio-economic empowerment affect participation so as to understand quality health service delivery. Community participation is crucial for ensuring good quality health service activities, as it ensures adequate responsibility and accountability of health professionals, which, in turn, leads to good quality health service delivery.

The objective of this chapter is to analyse the role of the above-mentioned actors and factors in understanding how they contribute to participation and quality health service delivery. To do so, this chapter is divided into four sections. The first section examines the organisational procedures in health service delivery. The second section deals with politics and decentralisation of the health system to understand participation and health service delivery. The third section examines the role of communities and the factors, which influence community participation and health service delivery. The final section deals with a brief summary of this chapter.

8.2 Participation in health service delivery: organisational procedures

This section deals with community participation of health service programs, health policy processes, and the budgetary processes as organisational procedures for understanding health service delivery.

8.2.1 Participative health service programs

The Chhatak Field Data (2013) collected by the researcher during field work show that the Department of Health Services and Family Planning organises various health programs to promote people's participation (see Table 8.1). Such participation enhances the community's understanding concerning health programs as stated by the Health and Family Planning Officer (HFPO) in Chhatak, interviewed in this study. The HFPO stated that one of the mechanisms for encouraging participation is organisation of seminars, symposia and rallies (discussed in Section 7.2.4 of Chapter 7). He stated that the Family Planning Department observes a 'World Population Day' and organises educational and cultural programs in order to ensure wider publicity so that people are well informed about the consequences of unplanned population growth. He further claimed that the department also observes a 'Service Week'[63] every two to three months in which people participate.

The Family Planning Inspector (FPI) in Savar interviewed in this study stated that School Program is another method of ensuring community participation. He also stated that during the School Program, family planning staff visits schools in order to provide information with regard to heath education. Female staff regularly visits girl's schools and the adult female students can share their health problems with those staff. Similarly, the FPI in Chhatak, interviewed by the researcher stated that the Family Planning Department also organises meetings with elected representatives of the concerned locality. Additionally, the elected representatives organise meetings in which Health and Family Planning staff participate. The FPI also pointed out that while the Family Planning Officer participating in the field meeting addresses the population situation of the country and their effect on the society, the problems of population, and their possible outcomes. As a result, the initiative taken by the Family Planning Department enhances motivation and improves awareness of service users and the elected representatives. Besides this, meetings with religious leaders also play a significant role in promoting participation, as noted by a Family Welfare Assistant (FWA) in Chhatak who was interviewed in this research. Rowe and Frewer (2005) study supports the above evidence, as consultation is a typology of participation, which discussed in section 2.3.3 of Chapter 2.

[63] Service week is an event organised by the Department of Family Planning to discuss different aspects of family planning services where local people participate and share their views.

In addition, the FPO in Chhatak, interviewed in this research pointed out that the Family Planning Department organises a Behavioural Change Communication (BCC) program which public representatives, religious leaders, stakeholders and social elites attend. He also pointed out that this program concentrates on the main stream of civil society in order to enhance knowledge on the effect of population on society and development. The FPO claimed that this program has improved awareness for civil society significantly.

Table 8.1

Participation at field level health programs at UHC

Health programs	Target participants	Goals and objectives
Population Day	People	Promote participation Enhance awareness/motivation Quality of health care Maternal and child health
Service week	People	
School program	Students	
Local meeting	Elected representatives	
BCC	Civil society	
Satellite clinic/EPI	Remote clients/elected representatives	
Mother's Day	Women/female students	

Source: Field Data 2013

The Health and Family Planning field staff in Savar and Chhatak (see Appendix 12b), interviewed in this study stated that people in remote areas access services through a satellite clinic which is a good mechanism to access health care easily. The health professionals also stated that the Health Service and Family Planning Department jointly organise this program. Additionally, the Health Department organises an Expanded Program on Immunisation (EPI) in which the Upazila executive officer locally known as Upazila Nirbahi Officer (UNO), local representatives, local elites and the general community participate. Moreover, the health professionals claimed that the FP department often organises yard meetings (discussed in Section 8.4.2) where performance is poor and unsatisfactory and, in such situations, the family planning officer visits for discussion if necessary.

The Program Director (Advocacy) in the Bangladesh Mohila Parishad (National Women's Organisation) stated that they organise a program on the 28th May every year to celebrate 'Mother's Day'. She remarked that this organisation arranges

meetings, discussions and seminars to promote awareness about on maternal and child health programs. In addition, the Program Director claimed that they also organise meetings with general members of the organisation. On program day, community leaders discuss maternal and child health care issues.

In short, the health service programs are significant mechanisms for promoting community participation, which improves client's awareness, motivation and interaction with regard to health and family planning services. As well as this, participation represents the community voice and empowers community, which contributes to improving quality health service delivery. The role of community participation is useful in health policy processes, which is examined in the next section.

8.2.2 Community participation in health policy processes

Health policy is formulated centrally where the general population has limited participation. In 2000, the government had a national health policy. According to the Faculty Member of Public Administration at Dhaka University, this policy was revised several times in 2008, 2009 and 2011. For the purposes of the health policy revision, the government has posted the policy document on its website in order to seek and accommodate public opinion (Ministry of Health and Family Planning 2015). The Manager (Governance) of ICDDR,B interviewed in this research stated that accommodated public opinion in the budgeting process is definitely a sound initiative, however the lay people have limited or no access to information technology and also have a poor understanding of how to use technological innovation to give comments. However, the use of digital technology within and between health service organisations has helped improve the quality of health service delivery as mentioned in Section 7.3 of Chapter 7.

The bureaucrats in health service delivery guide community participation. For example, the Deputy Director (Health Education) in the Directorate of Health Services, interviewed in this study claimed that the formulation of health policy ensures participation through field administration. He also stated that the District Commissioner (DC) organises workshops with the participation of social and political elites of the concerned locality. However, the general people are excluded from this process. One of the community leaders in Savar interviewed in this study said that the community has no direct participation in health policy-making as everything that affects effective public participation is politicised. Community leaders also

emphasised that there is a potential for proactive roles of politicians and the civil society in promoting people's participation to make health policy publically friendly. Osman's (2004) study however demonstrates the influence of bureaucrats on the formulation of health policy, which has been discussed in Section 2.4.1 of Chapter 2.

A Faculty Member of the Department of Public Administration at Dhaka University, interviewed in this study stated that mass participation is possible through making the Upazila Parishad system more effective, which can be done through enhancing political decentralisation. She also stated that the Upazila Development Coordination Committee (UDCC) meeting is an appropriate platform to enhance participation, which requires effective coordination, cooperation and communication with local people. Similarly, the Faculty Member mentioned that the union level standing committee is not effective or functional; participation of local people can make this committee effective. Therefore, a decentralised health system is needed to promote public participation (details given in Section 8.3.1) which may be one of the mechanisms to enhance a participatory health policy. The local informants (see Appendix 12 d) in this study expressed the view that the formulation of health policy is bureaucratic and politically-biased, and only a limited number of stakeholders can participate in this process and share their opinions on improvement of the health policy process. In addition, the general community has a poor understanding and limited technological capacity to articulate their opinions on health policy. Besides this, the existing local government system is not strong enough to engage community participation in the process of health policy. Therefore, the formulation process of health policy is not truly community participative.

In fact, community people have a limited accessibility of health policy processes, as the system involves bureaucratic procedure and is controlled by the existing politics. Besides this, the common people have limited access to technology, which affect their participation. Moreover, the weakness of local government limits community participation. As a result, these limitations of community participation contribute to poor governance leading to poor quality of health service delivery.

8.2.3 Community participation in budget processes

The Senior Research Fellow of the Bangladesh Institute of Development Studies (BIDS), interviewed in this research stated that decision-making with regard to various aspects of the budget such as priority of budget allocation need to be discussed with the community and doctors. He also stated that the opinion of the

community in the process of budgeting can promote quality health care delivery, as this directly reflects community voices.

The Faculty Member in Public Administration of Dhaka University, interviewed in this research suggested that organising workshops at central, regional, district, upazila, and union levels through community participation can be an important mechanism to ensure a participatory budget. She mentioned that, in reality though, participants are not true representatives of current budget processing which is the main challenge of a participatory budget. The Faculty Member also stated that currently, participants are the elite people who have formal connections to the administration and the current government where the general communities are absent in the process.

The Family Planning Officer (FPO) of Chhatak, interviewed in this research suggested that the Upazila budget should be made by incorporating the opinions of lower level participants/mass people so as to meet the public demands of a specific locality. This process is known as bottoms- up process. He also stated that the top to bottom planning procedure creates problems as the existing plans from the central organisation contribute to an unequal budget for health service organisations in rural and less developed areas. The FPO mentioned that the top to bottom process is conducted through bureaucratic management and none of the local organisations participates with regard to budget processing.

The Secretary of the Committee of Concerned Citizens (CCC) in Savar, interviewed in this study stated that none of the community organisations (for example, the CCC, women's association) participates in the budget preparation for the Upazila Health Complex. He also stated that community organisations work only to enhance governance and the quality of health service delivery. The Deputy Program Manager of Transparency International Bangladesh (TIB) said that representation of the civil society organisation is required at Upazila level to promote good governance and quality health service delivery. Bario and Rabbani (2011) study support this finding as they demonstrated that CBOs have a meaningful involvement in make people participate in development process.

As with the health policy, the health service budget is made through the bureaucratic process. No local opinions of either health professionals or local communities have been assessed in budget preparation. That being said, the majority of respondents argue that community views are very useful tools to prepare improved budgets in order to promote the quality of health service delivery.

To summarise, organising health service programs can be a very effective mechanism for promoting community participation. As the evidence (Section 8.2.1) shows, people are directly involved in the health programs as recipients, since the field health professionals communicate frequently with the general community. Thus, this program does involve the community as recipients and is similar in both the rural and urban Upazila Health Complexes. However, the other aspects such as decision-making in organisations, policy formulation and budget preparation have no direct community participation as these processes are highly centralised and bureaucratic. Overall, community participation is elusive to health service organisations and consequently, the quality of health service delivery is not satisfactory.

8.3 The political context of participation in health service delivery

This section deals with the contribution of various political actors of health services to the promotion of participation, and the effect of politics on participation and quality of health service delivery.

8.3.1 Decentralisation of the health system

A Faculty Member in Public Administration of Dhaka University, interviewed in this study confirmed that policy makers understand that centralisation is a major problem in the health sector to ensure accountability and transparency because none of mechanism remains in the process that could ensure the local people's opinion.. Moreover, the democratic government of the country shows no interest in decentralising the health system. For example, Mahmud's (2004) study shows that decentralisation and democratic decisions can contribute significantly to quality of health service delivery as stated in Section 2.5.2 in Chapter 2. Mahmud also said that the government lacks political will to implement a decentralised health system that would be significant to promote good quality health service delivery. Besides this, the Faculty Member claimed that bureaucracy is one of the obstacles for ensuring a decentralised health system. She further claimed that bureaucrats are unwilling to share power with elected representatives to make the health service delivery participative. Gazi et al.'s (2005) study however shows not only community participation as a tool of effective implementation of health plans but also the sufficient funds and efficient management which are stated in Section 2.4.1 of Chapter 2.

The Resident Medical Officer (RMO) in Savar, interviewed in this research claimed that the central authority often wishes to reduce the power of local administrators. However, he suggested that the quality of health services could improve if the UHC had control in mobilising a part of their budget for hospital expenditure. Similarly, the Deputy Program Manager of Transparency International Bangladesh, interviewed in this study pointed out that the Upazila health service committee could be strengthened through decentralising power at the local level. To enable this, the Upazila Parishad (UZP) Chairman should be authorised to take decisions so that effective health service delivery may be quickly promoted. A political party leader (Local wing) of the Bangladesh Nationalist Party (BNP), interviewed in this research suggested:

> "Decision-making and implementation of health service delivery should be decentralised. The Upazila health service committee needs to be powerful. For this, the Upazila Parishad chairman should be authorised with the power to take decisions so that he can take decisions quickly in order to make health service effective. The Upazila Parishad chairman should be the head of the health service committee as he is responsible for doing this job as the local government representative. The MP can be an advisor of the committee but functional duties should be conducted through the Upazila chairman. The union Parishad chairman (the lower tier of Upazila Parishad) will be a member of this committee so that the overall clear picture of the union level can be obtained. So, adequate decentralised power to elected representatives can promote accountability and quality health service delivery".

However, doctors do not want to be accountable to an elected chairman, as stated by the Junior Consultant in the Savar UHC interviewed in this study. According to this Consultant, one of the reasons for this is that some of the Upazila Parishad Chairmen are have low or no education. This would exclude them from being in a position to make doctors accountable because doctors think UZP Chairman is not enough capable to supervise them . Besides this, the Junior Consultant claimed that an elected representative tends to dominate over the doctors and other health staff which affect their duties and responsibilities. This, in turn, contributes to poor quality of health care delivery. Moreover, she also claimed that local representatives have a poor understanding of hospital administration.

In reality, the health system is not adequately decentralised which reduces the power of the authority of elected representatives and affects their participation in health service activities. In addition, the local health professionals are not willing to share their views with the elected body in order to avoid the influence of local politics and that of the elected representatives who have low levels of education. Besides

this, the poor political commitment of elected representatives reduces their responsibility to promote participation and quality of health care.

8.3.2 Participation in the Upazila health service committee

At the Upazila level, there is a health service committee to promote accountability and quality health service delivery. In Chhatak Upazila the Member of Parliament (MP) supervises the committee. This committee plays an important role in relation to health service delivery (Field Data 2013). However, the committee has no power to recruit doctors or transfer health care providers. Such power is vested in a Directorate of the Ministry of Health, as stated by the Chhatak MP interviewed in this research. The MP also claimed that the administration of the Directorate approves letters of transfer and sends them to the concern authority in the Ministry of Health for execution of the orders. The MP of Chhatak, interviewed in this study said:

> "I am the chairman of the Upazila health service committee but I cannot take action on mismanagement of doctors as the committee does not have sufficient administrative power. The Minister of Health can suspend and transfer doctors because he has constitutional power. The Minister is the leader of the Health Ministry and I am a member of the ruling party. My recommendations do not reach the health ministry because this is a very busy organisation. The committee should have some power in order to make doctors accountable".

On the other hand, the committee organises only occasional meetings (not every month). In this regard, the Chhatak Ward Boy who was interviewed in this research pointed out that constructive discussion by organising meetings can produce suitable solutions to promote accountability and good quality health service delivery by the reporting of problems in health service delivery. The Ward Boy in Chhatak further stated that none of the elected representatives including the MP, Upazila Parishad Chairman or Union Parishad Chairman is interested in organising such meetings. Consequently, very few meetings were organised by the Health Service Committee in 2012.

Besides this, a party leader of the political party, Bangladesh Nationalist Party (BNP) in Chhatak, interviewed in this study claimed that decision-making of the committee is related to politics as the major decisions are made through local political influence. He also claimed that the local MP and the Upazila Parishad Chairman (UPC) influence this decision making. This committee has a limited participation of opposition political parties' representatives (see Section 8.3.4). In addition, the opposition cannot play an active role in decision-making.

The local Newspaper Reporter in Chhatak, interviewed in this study claimed that the Member Secretary, (the Upazila Health and Family Planning Officer) of the committee is not compelled to attend the meeting since he does not have to report to the committee. On the other hand, information from the Office Records (2013) of Savar UHC (collected by researcher during field work) demonstrated that the Savar Upazila officially has a committee, but it has not been functional for a long time. The Savar UHFPO claimed that he has asked the local MP to make the committee functional but the MP does not have time for this, and would rather use the time to travel abroad. Therefore, the health service committee is not functional in Savar due to lack of political responsibility on the part of the MP. Consequently, participation is limited to the Savar UHC, even though it is an urban-based organisation and the area is well developed.

To sum up, although the Chhatak Health Service Committee is politicised and the major participants in the committee are locally affluent people but the committee is active and participative. Unfortunately, the Savar health service committee is non-functional therefore, none of its activities to promote health service delivery has been carried out. This happens due to lack of responsibility of the crucial political actors particularly, the local MP.

8.3.3 The role of elected representatives

According to the political structure of the government, the Member of Parliament (MP) is the highest political authority in an upazila (sub-district) who advises the Upazila Administration (Local Government Division 2013). The MP holds the top position and the highest social status and is received well by the people which enable him to lead all of the public organisations under his constituency (reported by the Senior Research Fellow of the Bangladesh Institute of Development Studies - BIDS, interviewed in this study). The Research Fellow stated that participation of the MP in the health service organisations puts him in a good position to enhance the quality of health service delivery which can be promoted through communications with local elected representatives such as the Chairman and Vice-Chairpersons of Upazila Parishad as well as the Upazila Health and Family Planning Officer (UHFPO). Such involvement with local actors can reduce mismanagement and promote good governance in the health service organisation.

One of the aims of the MP is to mobilise local politics in order to retain and consolidate political power, as stated by a local informant in Chhatak interviewed in

this study. The Upazila Vice-Chairperson of Savar interviewed in this research stated that the MP is the adviser of the Upazila Parishad (UZP) and he is responsible only for enhancing development policy as the MP's role is that of a policy maker. However, he wishes to take all of the responsibility for local government activities which should be authorised by the elected representatives such as the Chairman and Vice-Chairpersons of Upazila Parishad. The Upazila Vice-Chairperson of Savar also pointed out that the Upazila Chairman and the MP are at conflict with each other as the MP thinks that if all of power goes to the hands of the Upazila Parishad Chairman, his popularity and activities will be reduced. The MP wants to maintain local politics by controlling all of these activities. The Vice-Chairperson also stated that although the MP and Chairman have the same political ideology, yet they have conflict due to financial interests. She further said that both the elected representatives (MP and UPZ Chairman) want to exercise local power and position in order to achieve political advantage and the financial benefits which are available at the Upazila level. The Vice-Chairperson suggested that cooperating with each other, instead of confronting each other can promote governance and quality of health service delivery.

The majority of local informants in Savar (see Appendix 12d), interviewed in this study stated that the MP likes to organise meetings and is only half-heartedly active in local activities. The MP wants to publicise his name at public forums, but he has little interest in the sufferings of the people or their interests including the improvement of health service delivery. The local informants also said that the MP never visits hospitals to see whether the health care professionals are fulfilling their responsibility and being accountable to their health service organisation. According to the Secretary of the Bangladesh Women's Association, Savar, interviewed by the researcher in this study, the MP goes to the UHC if the UHC's authority provides him a formal invitation to visit hospital and he only delivers a public speech to motivate people rather than the improvement of health service delivery. The Secretary also said that the MP recommends the posting or transfer of doctors based on public complaints or political influence. He also said that the MP is more active on infrastructural development such as making new roads and buildings which involve money and people's support for upcoming elections. Moreover, the MP expects more public gatherings in the meeting in order to circulate political dialogues and development propaganda for articulation of people who are in favour of his politics, but does not emphasise his political commitments to improve the quality of health services.

The local informants in Chhatak interviewed in this study claimed that sometimes the Chhatak MP visits the hospital. He also conducts meetings with doctors and provides guideline for improvement of doctor's accountability as well as exerts pressure (in extreme situations) in orders to enhance the presence of health care providers at the organisations. Nevertheless, most of the local informants in Savar, (see Appendix 12d) interviewed in this research confirmed that the Savar MP visits the hospitals, yet never takes serious action to promote accountability of health care professionals.

The Upazila Vice Chairperson of Chhatak, interviewed in this research noted that the Upazila Parishad itself lacks functionality, as the elected representatives of the UZP do not have sufficient authority under the current provisions of Upazila Parishad. The MP has political power with a high social position and the Upazila Parishad works under his supervision therefore, the MP should perform responsibly in accordance with his position. The Vice-Chairperson also pointed out that she observed much mismanagement with regard to health services but was unable to take the necessary action due to her limited authority.

The Upazila Vice-Chairperson in Chhatak, interviewed in this research claimed that she participates in various programs such as maternal and child health programs, yard meetings, and expanded programs on immunisation. She also argues against social inequality and its effects, and argues for the roles and responsibilities of parents towards children when they participate in these programs. It was also stated that while she does not have enough authority to take decisions on health service delivery improvements, she tries to provide constructive advice to enhance hospital activities. The Vice-Chairperson also remarked that it is necessary to gather positive opinions through participation in order to solve the health service organisation's problems.

On the other hand, the Vice-Chairperson of Savar, interviewed in this research claimed that she has regular communication with the hospital and, consequently, the UHC provides good quality of services. She is also the chairperson of the Health Service Standing Committee of Upazila Parishad and conducts meetings with hospital authorities in order to promote governance of health service delivery. With regard to family planning services, the Vice-Chairperson of Savar said that the Department of Family Planning (FP) works well as it organises meetings with the health officials in which where Upazila elected representatives, including the Vice-

Chairperson, participate. The Vice-Chairperson in Savar interviewed in this study also reported that:

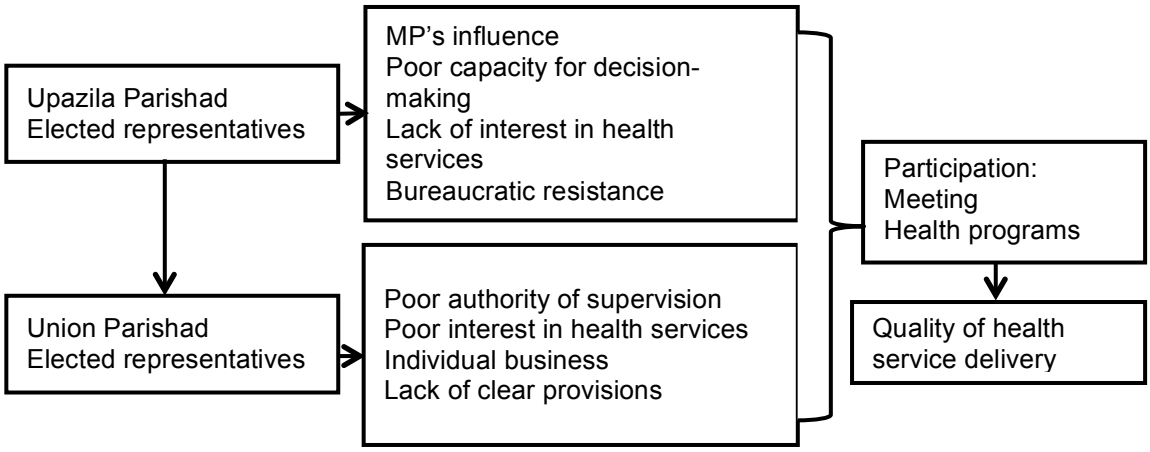
> "As Chairperson of Health Standing Committee, I am able to conduct meetings and participate in most meetings in order to promote governance. I take some decisions in relation to health service delivery in the meeting; however, some of the decisions are made by the office through administrative procedure".

A Ward Boy of Chhatak UHC, interviewed in this research noted that much mismanagement is found in the Upazila health complex (UHC), however the Upazila Parishad Chairperson, including elected representatives, do not organise meetings for discussion on problems of health service delivery. Similarly, a Social Worker in Chhatak, interviewed in this study claimed that elected representatives do not participate in health activities due to their lack of interest in health service delivery, as opposed to their interest in participating in meetings for infrastructure development such as roads, buildings etc. where there is more money. The Social Worker also said that members of the Upazila Parishad should be forthcoming with constructive discussions for solving the problems of inadequate health service delivery.

The Union Parishad Chairman of Savar, interviewed in this research stated that he has no authority to supervise health officials as per the current provision of Union Parishad. It is the health department which is mainly responsible for supervision of their field officials. The elected representatives are able to observe their activities; however, they have no authority to examine them or their job responsibility, or to participate in decision-making (see Figure 8.1). The field health professionals work according to their planning but sometimes they inform elected representatives of their activities. The health professionals organise meetings generally every two months and invite the local elected representatives who participate in the meetings.

Figure 8.1

Challenges of participation of elected representatives in health service delivery



Source: Field Data 2013

The Family Planning Officer (FPO) in Savar, interviewed in this study pointed out that the participation of elected representatives does not happen in Savar as it is an urban Upazila. In this regard, the FPO argued that the Union Parishad Chairman is very busy with his personal business. Several of the elected representatives are very busy in local politics and development activities such as roads and construction; thus, health care delivery is of a lower priority to them. However, the Union Parishad Chairman said that women members are very active and have continuous participation in the health programs. Similarly, the Health Assistant of Savar, interviewed in this research remarked that the field health professionals are very close to the local elected representatives; therefore, the local women members have made a significant contribution and engaged in cooperation with the health program. The Health Assistant also stated that people are more likely to listen to the elected representatives and pay attention to what they are saying. Therefore, the participation of women members makes the job of field health professionals easier in that it promotes better health service delivery.

To sum up, respondents argue that participation of elected representatives in health service programs is important to promote quality health service delivery. However, the elected representatives have limited authority and, as a result, are unable to take necessary action either to promote accountability of health professionals or to take action on mismanagement of health service delivery. Savar elected representatives including the MP participate less in health service activities than they do in Chhatak as they are more busily engaged in politics and personal

business instead of improving health service quality. Importantly, women elected representatives participate more often than do male representatives, and one of the causes for this could be the fact that the field health professionals are mostly female.

8.3.4 Participation of political parties

The President of the Chamber of Commerce in Chhatak, interviewed in this research pointed out that mismanagement is ingrained in local politics and that the ruling and the main opposition political party were both involved in corruption. He stated that the political parties are not concerned with people's rights or facilities. He also added that politicians make commitments before elections as a strategy to win, yet when elected they do not honour their commitment. Moreover, the President stated that money and local power dominate the elections making democracy weaker which leads to poor governance. He further stated that politicians invest a huge amount of money to become a Member of Parliament member and that, after winning the election they intend to reap more than they have already sown during the campaign. Politics is like a business to make money.

The local MP of Chhatak, interviewed in this study claimed that opposition political parties do not participate in heath service committees. However, the MP pointed out that as part of local government the Upazila Parishad Chairman and the Vice-Chairperson (opposition political party supporters) participate in meetings but such participation is irregular and very limited. The MP also stated that the opposition political party leader always concentrates on negative politics, which is not useful for the improvement of the health service delivery. For example, the current government has made significant changes to the health sectors through the introduction of community clinics to promote rural health service delivery. However, the opposition political party does not seem to care much for this project, as it was cancelled while they were in government. According to this MP, this community clinic based health care has been highly appreciated by the United Nations Secretary General and its major development partners.

The Union Parishad (UP) Chairman of Savar, interviewed in this research said that most of public services is politicised and considered on the basis of party politics. Opposition political supporters are in no position to comment on health service delivery. In addition, their opinion is not even considered when it comes to enhancing quality of health service delivery. Similarly, the Upazila Parishad (UZP)

Vice-Chairperson of Savar, interviewed in this study stated that there is no political consensus between the ruling and opposition political parties due to the lack of democratic values in politics. The Vice-Chairperson remarked that opposition political parties have no participation in government activities (see Box 8.1).

Box 8.1

Participation to opposition political party in Savar

> The ex-MP who is now an opposition political leader in Savar lacks adequate power and participation in local activities including health care when compared with the supporter of ruling party Union Parishad Chairman. This happens as power politics is exercised by the ruling party leaders. Politics helps to make money and enables political leaders to become wealthy through different illegal means while good people in the society are neglected. **Source**: Interview with Business leader, Savar.

The President of the Chhatak branch of the ruling Awami League, interviewed in this study said that although there is no conflict with the opposition political party, they are automatically absent from government activities including health service delivery. This findings support by Waheduzzaman and As-Saber (2015) study as they found that political manipulation is one the causes of failure of community participation in local development projects. The President believed that participation of the opposition political party is required to enhance democracy and good governance in the health service organisation.

Indeed, local politics is influential and non-participative. Such influential politics helps to benefit the ruling party leaders and supporters which reduce the democratic rights of opposition political party supporters. This political attitude negatively affects effective participation and health service delivery in Savar and Chhatak.

8.4 Community participation in health service delivery

8.4.1 Community clinics (CC)

The delivery of health services through community clinics is a participative process, which aims at providing remote health services (Ministry of Health and Family Welfare 2015). Health professionals in the field level in Chhatak, interviewed in this research (see Appendix 12b) stated that due to the high volume of population, people have limited accessibility to graduate doctors and even paramedics at sub-district level (see Section 4.2 of Chapter 4). Due to this, community clinics are

suitable and effective mechanisms to provide health services to rural and remote people. The majority of elected representatives in Chhatak, interviewed in this research however, claimed that most rural CCs are completely non-functional as a result of the inadequacy of resources such as lack of human resources and medical equipment, and poor supervision. The elected representatives of Chhatak suggested that the CC could be effective if it were well-equipped and provided sufficient human resources and instruments. The respondents also claimed that without such initiatives, the outcomes of the CC would not be satisfactory. A Health Assistant in Savar, interviewed in this study said that effective CCs are one means of promoting community participation through shaping a management committee and a support group.

As a provision of the Ministry of Health and Family Welfare (2015), the community clinic has a management committee which is composed of seven members: the local UP member is the president; the land lord who provides land for the CC and a woman who are both vice-presidents; a business man who is a treasurer; and the three executive members are: a local freedom fighter; a landless person; and an employee of the Answar & Village Defence Party (VDP). One community clinic serves a population of 6,000, which consists of seven to nine villages. People's participation in the CCs from all over these villages can promote quality health service delivery.

The objective of the CC is to provide quality health services to people, - a mission that depends on an effective management committee. However, the Vice-Chairperson of Chhatak Upazila, interviewed in this study pointed out that the CC committee is formed by a political process in order to strengthen local party politics. The Vice-Chairperson also noted that the increasing the number of CCs is not as important as their success that is dependent on efficient management, quality of services, and effective public participation. A Newspaper Reporter in Chhatak, interviewed in this research claimed that the CC committee is not active, nor is it even aware of its responsibility or duty. This is because the committee never organises a meeting to ensure public participation. Nevertheless the Savar Health Inspector, interviewed in this study argued that the Savar CC committee is active as a result of adequate supervision. Consequently, most CCs contribute to good quality health service delivery.

Community Clinics have support groups, which consist of 13-15 members from various sections of the society. Each CC has three such support groups (Ministry of Health and Family Welfare 2015). Support group members are accountable to the people to promote adequate health services, as these are part of operating the community clinic. The government provides training to members of the support groups so that they are able to motivate field health care providers. The aim of the CC is to provide adequate health services that enable rural people to reduce cost and time (Ministry of Health and Family Welfare 2015). Besides this, the community support group enables a mobilisation of local funds to meet local expenses.

The Chhatak Health Inspector, interviewed in this research claimed that a CC works well and provides good health care because of effective community participation. As well as this, the CC support group is very strong and effective and this enables it to collect fees from the villagers to meet the local expenses such as the purchase of furniture and the provision of electricity bills. In addition, the presence of CC service users is also satisfactory.

A local informant in Chhatak, interviewed in this research claims that the community clinic is unable to serve people appropriately. The local informant also claimed that the CC is only able to serve a maximum of 20% of people's demand. In addition, he said that as a result of politicisation and corruption, supervision and accountability of the CC are lacking. The Vice- Chairperson of Chhatak, interviewed in this research stated that the CC has limited community participation. The Vice-Chairperson also stated that several CC buildings are aesthetically very pleasing yet are non-functional as service users are not the recipients of any services. In addition, the local informant argued that some CCs do not function due to poor road communication.

Community clinics are one of the most important ways of promoting participation. However, the majority of community clinics in Chhatak are not in effective service due to lack of resources and poor management. The local CC managing committee at Chhatak is poorly functional as the process of committee formulation is political and the committee does not organise meetings as per rules which affect efficient community participation. In contrast, the Savar community clinics are functional and provide useful health services as the supervision and management are effective and efficient there.

8.4.2 Yard meetings

Yard meetings are very popular events for ensuring community participation in health service programs. For this, field officials of the Health and Family Planning Department organise this yard meeting at field level in order to enhance participation (Field Data 2013). Field Data (2013) also show that various health issues are addressed in the meeting by the field health professionals and each field worker (health or family welfare assistants for example) organises yard meeting regularly in their area twice a month in order to promote community participation.

The Family Planning Officer (FPO) in Chhatak, interviewed in this research stated that some of the critical items to be discussed in the meeting are those of maternal and child health, immunisation schemes, and the challenges of nutrition for pregnant women and children. In addition, the health professionals of the Family Planning Department discuss the impact of population, the details of family planning methods, and the consequences of family planning for society and development. The FPO also stated that the field health officials discuss local problems in the meeting and share their experiences with local elected representatives. One of the Family Welfare Assistants (FWA) in Chhatak, interviewed in this study said that she assists in clients' understanding of family planning and the impact of more children for to family and social life. Besides this, she claimed that the family planning worker helps the clients to understand that both male and female children are equal and are able to contribute to the family equally. In addition, the FWA advised clients that nobody should discriminate between male and female children. Moreover, the yard meeting enhances personal interaction and communication among the clients. In this regard, the FWA presented an example of a woman in a village that had undergone tubal ligation. Due to the exchange of information regarding the procedure, other clients were encouraged to seek ligation which in turn leads to a promotion of the family planning program. Besides this, the yard meetings assist in the dispersal of information at the root level which promotes motivation and understanding of the clients.

The participants of the yard meeting comprise elected representatives, health care providers, women, female students, and volunteers (Field Data 2013). Among others, the major participants are women who are the key service recipients as stated by the FPO in Savar. The FPO also said that volunteers give invitations to clients to come to the immunisation program through house to house visits. Many

female students work as volunteers to provide health services, and elected representatives give speeches to make the event significant and participative. Field supervisors including the Upazila Health and Family Planning Officer attend the meetings from time to time to provide encouraging words to participants. Nevertheless, the FPO admitted that no males attend the meetings. In this regard, the Family Welfare Assistant (FWA) in Savar, claimed that men are busy working during the day/office hours. She also added that sometimes educated and affluent women also participate in the meeting and convey message to other villagers to keep them update with the health services.

A Village Leader in Chhatak, interviewed in this research pointed out several significant aspects of yard meetings that lead to the promotion of participation. The Village Leader stated that the yard meetings enhance interactions among the participants through the circulation of information. This meeting enables a discussion of the local challenges in order to investigate the possible solutions. Yard meetings promote knowledge and understanding of participants. Baroi and Rabbani (2011) study shows that community people has the capacity to improve their conditions by using their knowledge and indigenous skills. However, the Village Leader argued that there are several factors, which contribute to the limited participation of the community in yard meetings. One of these factors is lack of motivation. Besides this, Village Leader pointed out that poverty and lack of education affect participation in the field meetings.

In brief, health professionals organise yard meetings and discuss various family planning services, which promote community participation. This participation improves family planning services as stated by the health professionals. However, a lack of motivation and the poor socio-economic conditions of the community affects its participation.

8.4.3 Factors influencing community participation

The Senior Research Fellow of the Bangladesh Institute of Development Studies (BIDS), interviewed in this study stated that bureaucratic culture is one of the reasons for poor community participation in health service organisations. He also stated that doctors tend to avoid poor clients to provide services which are a part of bureaucratic culture in the organisation. The Research Fellow further stated that such bureaucratic rigidity makes people unable to participate in the meeting. Service users in Chhatak claimed that doctors in the public health service organisation do

not show adequate honour/respect to patients; consequently, patients who can afford to do so move on to private facilities which take less time but provide better services and assess the patients' conditions appropriately (discussed in Section 6.3.3 of Chapter 6).

The Vice-Chairperson of Upazila Parishad in Chhatak, interviewed in this research pointed out that community participation in the health service program is not socially developed. She mentioned that most of the Chhatak CCs are non-functional as the community is not motivated to participate in CCs to make health services effective. The Vice-Chairperson also said that one of the reasons for this was inadequate government initiatives, and the other was a lack of local initiatives. Besides this, local people are not sufficiently aware to participate in health programs. As Swapan (2016) found that the challenges of community participation in developing countries are: individual's lack of awareness, involvement in informal networks, discoursing perceptions about participation outcomes and lack of trust in the planning system. A local Newspaper Reporter in Chhatak, interviewed in this study argued that politics is not the main reason for the lack of participation because politicians do not force people either to participate or to avoid participation in the health programs. The Reporter pointed out that the main cause of limited participation is poor awareness. He mentioned that some people use a good initiative to make health services participative but such an initiative does not work effectively due to politics. Moreover, people are unlikely to take part at the Upazila Health Complex as they are not adequately united to share opinion and have limited education.

The Vice-Chairperson of Chhatak, interviewed in this research argued that poor people have no local leadership and that, consequently, they receive very poor services. Moreover the time people have for attending health programs is limited. Poor people are mostly busy with day labouring work and do have not enough time to attend the health program. Poor socio-economic conditions are one of the main causes of limited public participation. The Vice-Chairperson also said that local people are controlled by the social elite, which limit community voices to take action against mismanagement. Similarly, Schurmann and Mahmud's (2009) study found that the role of civil society promotes community participation, however poverty is one of the affecting factors of community participation which discussed in Section 2.5.2 of Chapter 2. However, the Secretary of the Savar wing of the Bangladesh Women's Association interviewed in this study stated that people's participation can play a significant role in reducing corruption in health service delivery.

The Ward Member in Kalarukha Union Parishad, Chhatak, interviewed in this research said that the general population does not participate in health programs willingly. The Ward Member claimed that organisational support needs to encourage the people to participate, who otherwise believe that there is no benefit for them from participating in the programs. The Ward Member also mentioned that community participation is politicised and that, subsequently, people who are not directly involved in politics are sometimes unable to get adequate health service delivery from the UHC. Similarly, the President of Chamber of Commerce in Savar, interviewed in this research claimed that participation in local committees promotes democracy which leads to good governance in the health service organisation, although such participation is politicised and affects quality governance and health service delivery.

Several factors such as bureaucratic complexity, the influence of local politics and poor socio-economic conditions of the community affect community participation. Moreover, local people are not united to fight against corruption and have limited time to participate in health service delivery.

8.4.4 The role of civil society/community organisations in promoting participation

As mentioned earlier, Savar has a Committee of Concerned Citizens (CCC) under the supervision of Transparency International Bangladesh (TIB).The TIB report (2008) demonstrates that the civil society organisation conducts a meeting twice a year and invites the participation of doctors, service users, and local elites so as to enhance transparency and reduce mismanagement of health service delivery. The Upazila Health and Family Planning Officer (UHFPO) of Savar noted that the role of the CCC is useful as the health service organisation is able to discuss the problems of clients, complaints concerning doctors' absence, and the weakness of health care providers. This assists in enabling of quality health care delivery. For instance, in the meeting with CCC a client has a complaint regarding the misbehaviour of a staff member accordingly; the UHFPO takes the necessary steps to solve the problem. Therefore, the role of CCC is significant for promoting governance in the health service organisation.

The business community has no direct participation in the Chhatak Upazila Health Complex (UHC). The President of Chamber of Commerce in Chhatak stated that participation and decision-making of the UHC is a top-down process and none of the

business community gets an opportunity to share views with regard to either improvement or mismanagement of health service delivery. The Chhatak business leader also stated that everything is done through bureaucratic procedure as part of office management. The local Newspaper Reporters of Savar and Chhatak claim that newspaper reports have been regularly published on the mismanagement of health services several times but no action has been taken by the health administration yet.

In addition, the Savar branch of the National Women's Organisation participates in various public forums including in the health service program as reported by the Secretary of the Bangladesh Women's Association (Savar Branch). The Secretary also claimed that the women's organisation always protests against the misdeeds and misbehaviour of doctors in order to improve quality health services. Consequently, the initiative of the women's organisation creates a positive outcome with regard to doctor's accountability and health service delivery.

Some local informants in this study (see Appendix 12d) claimed that Chhatak lacks community organisations. There are several organisations registered in Chhatak, but they are not active, and do not participate in health service delivery in anyway. They are very similar to the community organisations referred to by Schurmann and Mahmud (2009) which have challenges such as poor organisational capacity and leadership that undermine their participation and contribute to poor governance (see Section 2.5.2 of Chapter 2). Savar too, has very few Community Based Organisations (CBO) /Civil Society Organisations (CSO) that are active. For instance, the CCC and women's organisations are actively working to promote governance. Molyneux et al.'s (2007) study shows the important role which community organisations can play via their positive impact on health service delivery (see Section 2.5.2 in Chapter 2). The local Newspaper Reporter in Chhatak interviewed in this study explained:

> "Civil society organisations have a lack of responsibility and they are unable to create pressure on the health care authority. They can protest against the mismanagement of health care, but the actions they take are not collective. They have a lack of unity and also have a poor capacity. But they should take a collective initiative and other necessary action which may create positive outcomes for the health sector".

In practice, some of civil society and community-based organisations are operational in Savar Upazila for promoting accountability which is absent in Chhatak Upazila.

This evidence implies that participation of civil society organisation is better in Savar in comparison to Chhatak.

8.4.5 Participation of social elites in the UHC

The Upazila Health and Family Planning Officer (UHFPO) of Savar reported that local elites are not interested in participating in the UHC, and even if they do their participation only indirect. But it cannot be denied that their participation can promote good quality health service delivery. The Secretary of the Chhatak branch of the Bangladesh Nationalist Party, interviewed in this research also stated that mismanagement can be reduced by involving social elites in the UHC. A Medical Representative of Chhatak reported:

> "A local man sold fake medicine using the name of a prominent drug company, 'The Square Private Limited'. I informed a powerful local elite of the matter who investigated and asked the man not to continue doing it. The local elite also told the man that people of this locality were taking the medicine which might also affect his own relatives or friends. The salesman understood his mistake and stopped the illegal business immediately. He was selling the fake medicine because of his lack of awareness, poverty, and unemployment. The initiative of the local elite can bring positive outcomes, but such initiatives are very rare in rural societies".

A Newspaper Reporter of Savar interviewed in this research explained that the affluent social elites do not use public hospital services as, because they are wealthy and able to use superior health service facilities of private hospitals. In addition, the Reporter said that social elites lack trust in government health service delivery (see Section 6.3.3 of Chapter 6). The reporter said that the poor people have no alternative but to obtain services from public providers no matter what the level of quality provided by the UHC, because they are unable to get good quality services from alternative sources such as private hospitals. The reporter also stated that the doctors treat the poor people unfairly, as they do not have the ability to demand good treatment because of their low socio-economic status. All of this contributes to poor participation and mismanagement in health service delivery.

8.4.6 Women's participation in health service delivery

The Health Inspector (HI) of Chhatak, interviewed by the researcher argued that women are unable to participate freely in the health program because they are much dependent on their husbands' opinions as Bangladeshi society is dominated by males. The HI also stated that women attend health clinics or get health check-up only with the permission of their husbands or senior male members of their families.

Male domination of society is both a cause and a consequence of poor socio-economic condition of women as well as conservative religious values of the society. A local Savar informant, who is the Secretary of the Bangladesh Women's Association, Savar Branch, interviewed in this research claimed that males control the money which helps them to influence decision-making on all matters, including healthcare. In addition to this, the conservative tradition prevailing in the rural society is another cause for limited participation of women in the health program. These are also the factors responsible for the differential treatment of boys and girls with respect to healthcare and other matters. In this regard, the senior research fellow of Bangladesh Institute of Development Studies (BIDS), interviewed in this study pointed out that:

> "Male children get preference for seeking health services. It is a custom of rural society. Parents go to doctors quickly if their sons become sick because (the perception is that) male children will save their future generation. For this, parents take special care of their sons. On the other hand, daughters get less priority and parents bring their female child only to a rural paramedic for treatment. They neglect their daughters from providing good health care delivery. Besides this, abortion of female foetuses is a common trend in rural areas".

Education is one of the means to empower women, through participation in economic and political activities (Islam 2008). Women's empowerment enables them to understand their rights and privileges which ensure participation in health activities and other development programs (see Box 8.2). Balir's (2000) study reveals similar findings but he shows a sequential formula e.g., participation leads to empowerment of all communities, which are discussed in Section 2.3.3 of Chapter 2. Eventually, women's participation would reduce mismanagement in health services and promote quality of health service delivery.

Box 8.2
Women's empowerment and the promotion of social change and development

Half of the population in the country is women and development is not possible without women's participation in the development process. Development will be halved if women are unable to participate in the process. Government initiatives for participation of women in local government make significant changes to society and development. For example, the Upazila level has 482 women vice-chairmen and they have been elected from all over the country. It is a good example of women's political empowerment and they are working to change society. They participate in development activities. Women chairmen are working equally with male colleagues in administration. Women's education is one of the important factors for creating/managing/changing society and a significant part of women are working at NGOs, in primary education and in garment factories to promote social development. **Source:** Interview with vice-chairperson, Savar.

A local informant of Chhatak, interviewed by the researcher claimed that women have a poor understanding of their health rights due to lack of education. As stated in Chapter 4, the literacy rate of women in Chhatak is low (36.3%), because of inadequate transport and communication facilities and socio-economic barriers (Nazneen 1999). The local informant also stated that people of remote areas have limited education and awareness that affects participation in health service organisations. Mahmud's (2004) study shows that educated women can participate in decision-making in household resource allocation and enjoy better health outcomes for themselves and their children (see discussion in Section 2.5.3 of Chapter 2).

In contrast, the literacy rate of women in Savar is better (63.9%) (Bangladesh Bureau of Statistics 2012b) and women's socio-economic conditions are also better. However, the participation of women in the UHC, as well as in community-based organisations, is still not satisfactory as reported by some local informants interviewed in this study. One of the civil society leaders in Savar interviewed by the researcher stressed that woman are not aware of the need to participate in the CCC because of religious barriers. He pointed out that religious obstacles equally affect female participation in both the rural and urban health service activities. Civil society leaders suggested that women's participation can be increased by promoting education and self-awareness among women.

Socio-economic conditions of the people are strongly related to the quality of health services. In this respect, the service users in Chhatak, expressed the view in a focus group discussion conducted in this study, that economic capability is necessary for acquiring quality health services. The family planning officials in Chhatak argued that people of this locality are poor, and women are basically the poorest as they have limited income from agriculture and day labouring or no income at all if they are not working.

The Savar area is industrialised and urbanised and has many garment factories and other business organisations. Consequently, people of this area are better off both socio-economically and educationally. A woman Ward Member in Savar interviewed in this study argued that women's empowerment in this locality is satisfactory but women are not interested in joining social activities including health service programs. Also, female garment workers have little interest in participating in the

health programs of Savar, as they are immigrants and their main purpose is to work in the garment factories.

8.5 Conclusion

Health professionals of lower rank have limited participation in official meetings and decision-making at the Upazila Health Complex; only the executive and supervisory officials participate in meetings and take decisions concerning health service activities. One of the important causes of this is power distance between superiors and subordinates in the organisations and decisions are made via a top-down process. The process of health policy and budgeting are highly politicised, centralised and bureaucratic and such processes limit adequate participation leading to poor quality of health service delivery.

The health system is not truly decentralised due to lack of political will and bureaucratic resistance. Consequently, elected representatives of local government have limited participation in health service delivery. The Upazila Health Service Committee is influenced by the local MP, is highly politicised, and irregularly organised which leads to inadequate participation. Elected representatives are not interested in organising meetings or in taking part in health service programs because of a lack of authority of supervision, and a lack of commitment and responsibility for improvement of health service delivery. However, the role of women elected representative is found to be significant and participative for improving health service delivery.

The Chhatak Health Service Committee is functional as the local MP and the elected representatives participate in the meeting. This means that participation of elected representatives is better in Chhatak; however, none of the health service committees is functional in the Savar Upazila Health Complex which limits participation significantly. Moreover, the elected representatives in Savar are highly engaged in personal business instead of participating in health service activities. Generally, local politics is influential and the lack of democratic values in both rural and urban health service organisations lead to inadequate participation. This political culture also affects democratic participation and quality health care delivery.

Community clinics play a part in the promotion of health care in rural remote areas, however the managing committees of community clinics are politicised and locally influenced. The Savar community clinic is more participative as a result of its

adequate supervision and good management which is absent in Chhatak. Yard meetings enhance people's interaction and motivation which is also conducive to participation. Women clients and elected representatives frequently participate in yard meetings.

Civil society organisations have an essential role in the promotion of governance. Evidence shows that the urban Upazila Health Complex (Savar) enjoys the participation of civil society organisations; consequently, accountability and health service delivery are better in Savar. But no civil society organisations or social elites participate in decision-making in rural health service delivery (Chhatak). Moreover, women's empowerment promotes participation which leads to decision making and quality health care delivery. However, women have poor participation rates in rural society due to their poor socio-economic conditions, lack of education and conventional religious values. Conversely, Savar has better education and economic conditions; however, women's participation is not adequate as the majority of the population is migrant and highly engaged in the garment industry.

As governance of sub-district health service organisations has been examined in the earlier chapters, however governance of NGOs health service delivery could be different which is discussed in the next chapter.

Chapter 9

Governance in NGOs Providing Health Services in Bangladesh

9.1 Introduction

NGOs' roles are crucial for promoting socio-economic development including delivery of health services. As several NGOs work in the selected Upazilas, however two specific NGOs - BRAC and Gonoshastha Kendra (GK) have been selected in this thesis, which are responsible for providing health services. Each NGO provides health services according to their own policy as their financial mechanisms and the process of delivery of services are separate and some primary health programs are operated in partnership government and on contractual basis. This chapter[64] deals with NGOs health service delivery and the chapter has two objectives. The first is to examine the contribution of governance to the quality of health service delivery in non-governmental organisations (NGOs) engaged in the health sector. The second is to compare the same with the contribution of governance to the quality of health services provided by the government-operated Upazila Health Service Organisations (UHSOs). Findings from interviews of respondents and focus group discussions conducted in this study (see Appendices 12a - 12e) have been used to meet this objective. These findings are supplemented by information concerning the influence of socio-economic, political, and women's empowerment factors on the governance of NGOs to provide health services.

Chapter Nine is divided into four sections. The first section analyses the impact of management on accountability of NGOs in delivering health care. The second section examines the accessibility of information provided by the NGOs to understand the role of transparency in NGO health service delivery. The third section is divided into two parts. The first assesses the role of actors, and the second part deals with the influence of socio-economic, political and women's

[64] Some findings have been presented in the International Pacific Health Conference 2014, Health Research Council of New Zealand (Islam 2014e).

empowerment factors in understanding the participation of NGOs in delivering health care service. The fourth and final section summarises the chapter's findings.

The socio-economic background of the two locations (Savar and Chhatak) has been provided in Chapter 4 section 4.4 to understand governance and health service delivery of government health service organisation. This evidence is also applicable for understanding governance of NGOs in Savar and Chhatak. Moreover, all the socio-demographic or contextual factors do not really matter after all to examine governance and health service delivery.

9.2 Management in NGOs in promoting accountability

This section deals with NGOs' managerial aspects such as supervision, coordination and human resources to understand how these factors affect accountability and health service delivery.

9.2.1 Supervision

The BRAC Program Manager in Chhatak,[65] interviewed in this research stated that the supervision process of this NGO is hierarchical, bureaucratic and top-down similar to that of the government health service organisation as discussed in Section 5.2, Chapter 5. The office records (2013) of BRAC in Chhatak show that in this NGO's hierarchy, the Program Manager (PM) of health services, the leader at the sub-district level, is responsible for supervision of field supervisors and field workers to provide quality health services. The field supervisors are mainly responsible for overseeing the field health service programs. They visit the field to supervise health workers and mobilise clients to attend meetings. The field supervisor in Chhatak, interviewed in this study noted that the field workers at the lowest level make house to house visits in order to provide health services to women and children. The field supervisor also stated that according to BRAC provisions, BRAC field workers provide health care to a specific number of clients based on location, number of patients and the number of family members in each household, but a field worker of a government health service organisation has to provide services to particular administrative units such as unions and wards of the health service organisation,

[65] BRAC is the acronym for Bangladesh Rural Advancement Committee, an NGO involved in providing health care services

regardless of the number of clients in each union or ward. On the other hand, Gonoshasthaya Kendra (GK) provides maternal and child health services including family planning services at the filed level (Banglapedia, undated). The article of Banglapedia also shows that the Program Director is the chief of field health services where the Health in Charge (Program Coordinator) supervises all of field staff. Besides this, birth attendant and paramedic work at the grassroots level with clients under the supervisor of Program Coordinator. GK also works in partnership with local government. The elected women members of Union Parishad become chairperson of GK health service committee and a signatory for GK local bank account. Thus, a government field worker may end up providing services to a large number of clients. The supervisor concluded that the mechanism of supervision and the methods used to deliver health services in BRAC were slightly different from those of a government organisation, as BRAC provides very intensive and individual follow up of patients through close supervision which is absent in government services.

A BRAC field supervisor in Chhatak interviewed in this study reported:

> "I visit every place in the Union Parishad allotted to me to supervise the activities of field workers under my charge. BRAC has a master plan about the activities of field workers, and as a supervisor it is my duty to make sure that the field workers are working according to this master plan. From my observation, I have found that some of the field workers work according to the plan but some others do not. In such situations, I contact the errant field workers over mobile phone to make them dedicated field workers so that the quality of health care can be ensured".

The BRAC Program Manager interviewed in this research claimed that BRAC health care performance is better than that of a government health care organisation as a result of good supervision. He further stated that the supervisory system in BRAC is very strict from the top to the bottom of the organisation. To illustrate his point, he cited the success of the Tuberculosis (TB) program under BRAC (details in Section 9.5.1) in which close monitoring of TB patients by field health workers ensures that the patients take their medicine regularly and comply with the doctor's instructions. In the absence of such close monitoring, patients will not be cured, leading to an increase in BRAC's expenditure as it is responsible for covering patients' economic losses such as the cost of medicine if patients take longer than usual to recover from the disease. Therefore, health workers must care for patients appropriately so that patients can be cured in a timely fashion. Islam et al. (2002) enumerate the factors such as community participation, more accountability and close supervision which contributed to the cost effectiveness of BRAC's TB program which has been

discussed in Section 2.4.4(a) of Chapter 2. The Program Manager mentioned above noted that supervision in government health service organisations is weak due to poor management and lack of responsibility of health care providers (for details please refer to Sections 5.4.2 and 5.4.3 in Chapter 5).

The BRAC field supervisor stressed that she is committed to her job and bears responsibility to fulfil her duties, which inspire her to do her work effectively. She added that as a BRAC official, it is not possible to neglect duties because of strict supervision. The field supervisor claimed that in comparison, government officials are not as responsible to their jobs as are BRAC officials. She identified two factors contributing to the efficiency and effectiveness of BRAC in delivering health services. One of the factors is time commitment, which enables BRAC to deliver timely quality health care services. The other factor is sufficient supervision of staff which promotes good management in delivering health services.

Different actors have diverse roles in supervision in BRAC health services at the sub-district level. The Vice-Chairperson of Chhatak, interviewed in this study explained that she supervises health services by sharing her task with local government committees formed for that very purpose and by conducting meetings with NGOs officials and clients in order to provide quality health services. The Upazila Vice-Chairperson of Savar, also interviewed in this study stated that she supervises Gonoshastha Kendra (GK) health services as part of her regular responsibility.[66] Both the Vice-Chairpersons (Savar and Chhatak) claimed that NGOs supervise their activities themselves but sometimes NGOs communicate with them to inform the health service programs as local elected representatives.

The Family Planning Officer (FPO) in Chhatak and Savar, interviewed in this research stated that the NGO staff provide health services and supervise their workers in smaller geographical areas and the NGOs work very well, serve people properly, and provide medicine to patients at no or minimum cost. Similarly, the BRAC health worker in Chhatak, interviewed in this study claimed that BRAC supervises and monitors its patients through good management and concentrates

[66] In Bangla, Gonoshastha Kendra signifies a health centre for people. Gonoshastha Kendra (GK) is a non-governmental health service organisation situated in Savar, Dhaka. It started functioning after the war for the liberation of Bangladesh in 1971.The core objective of GK is to develop a people-oriented health care management program by making people aware of health issues. It also aims to provide training of rural people in basic medical skills to make them self-reliant.

on each of patients appropriately. On the other hand, government field workers do not provide sufficient care to patients as required to make them better and healthy as claimed by the BRAC health worker.

A local informant (Newspaper Reporter) of Chhatak, interviewed in this study argued that BRAC health care providers are more active than public health care providers in providing health services to the general community. He also mentioned that BRAC field workers offer good family planning services and provide intensive supervision at field level in order to deliver women and children's health services. In addition, he further argued that BRAC health workers are directly accountable to higher authorities as per the provisions of the organisation (details are given in Section 9.3). Similarly, a politician in Chhatak, interviewed in this study argued that supervision in BRAC is accompanied by guidance and support that contributes to good quality health service delivery.

In a focus group discussion, the BRAC service users in Chhatak reported that BRAC officers visit their locality regularly to investigate whether patients receive their medicine and how field workers provide service delivery. In addition, the service users stated that the field health workers make home visits at least two or three times a month. Sometimes the field health workers visit a patient's house informally as they live nearby and have a close relationship with them. This helps in enhancing transparency.

Indeed, the type of NGO supervision is hierarchical as are government health service organisations. BRAC provides supervision of specific areas with a limited number of clients whereas the government provides supervision of large administrative units with limited health workers and supervisors. Therefore, while NGO supervision is intensive, which leads to improved accountability, such supervision is absent in government organisations. Besides this, NGOs have good supervision due to commitment and good management.

9.2.2 Monitoring and reporting

The Program Manager of BRAC in Chhatak, interviewed in this study stated that the UHC field supervisors monitor BRAC activities and oversee government-distributed medicines and materials for use in the immunisation program. He also stated that the BRAC official hands over the field report to the UHC who verifies whether government materials are distributed properly. BRAC itself monitors the

implementation of the health service budget. Further, BRAC uses an efficient process to follow up on its patients by using mobile phones, which helps BRAC to ensure accountability.

The Manager (Governance) of ICDDR B, interviewed in this study as a national level respondent, stated that NGOs have limited resources in terms of human resources, medicine, and equipment including surgical instruments. Nevertheless, they use their resources efficiently due to adequate monitoring. On the other hand, he stated that while the UHC has more resources than NGOs like BRAC, they do not utilise them effectively due to a weak-monitoring system. Consequently, people have greater confidence in NGO health services. A study by Zafar Ullah et al. (2006) found the limited capacity of NGOs' health services (see Section 2.4.4 in Chapter 2), yet the manager also claimed that NGOs make maximum efforts to use their resources efficiently and carry out effective monitoring. Consequently, people are provided good services, which are absent in government health service organisations. The study by Mercer et al. (2004), cited in Section 2.4.4(a) of Chapter 2 also identifies reasons such as intensive technical support, adequate supervision and close monitoring for the higher achievement by the NGOs in providing health services.

A village leader of Chhatak, interviewed in this study reported that BRAC monitors its patients' details very well and maintains updated information about all its patients, which helps the organisation to provide good services. The village leader also stated that BRAC health professionals have a better sense of responsibility to health service delivery compared to government health professionals and this contributes to the better monitoring and accountability in BRAC. That being said, BRAC health care providers are not accountable to Upazila health service organisations (details are given in Section 9.3).

A focus group discussion of Gonoshastha Kendra (GK) health service users in Savar, reported that they have frequent contact with the health care providers which helps clients to access good quality health services. The service users also claimed that most field health care providers live in close proximity to the service users which enables easy and quick communication with users. A focus group discussion with BRAC service users in Chhatak mentioned that BRAC health care providers visit the service users at intervals of 15 or 20 days as scheduled in order to provide good health services.

In principle, BRAC monitoring management is very efficient. Consequently, they use their health service budget and human resources appropriately to deliver health services. However, the government has a poor monitoring system which leads to mismanagement. As the monitoring system of NGOs is better than that of the government, the NGOs provide improved accountability and health service delivery.

The Family Planning Officer of Chhatak, interviewed in this research reported that BRAC is formally held accountable to the government. It is mandatory for BRAC to show their performance report to government officials. BRAC fulfils this responsibility by submitting monthly reports to promote accountability in health service delivery. Government officials are able to review the BRAC health service reports and appraise its performance. A positive assessment of the report by government officials enables BRAC to renew their registration that allows them to continue with their work. Similarly, the Vice-Chairperson of Savar Upazila Parishad, interviewed in this research stated that NGOs provide accurate monthly reports on women and children's mortality including primary health care information, whereas government organisations lack provision of such information due to their negligence of duties and lack of responsibility. The Vice-Chairperson also claimed that the government uses NGO reports on health as the reports bear accurate and reliable information.

However, the field health professionals in Chhatak, interviewed in this study (see Appendix 12b) mentioned that BRAC is accountable to their own organisation and submits their completed report to the higher authority (see also Section 9.3). The Health Inspector in Chhatak pointed out that a lack of coordination between the government and BRAC health service management is a challenge in promoting adequate accountability of health services.

The Deputy Program Manager of Transparency International Bangladesh (TIB), argued that government activities have inadequate reporting as they lack integrity and do not produce transparent reports in accordance with their activities. She hinted at the possibility that NGOs over report their activities. The Program Manager also claimed that the NGOs health activities are not satisfactory as they produce reports based on quantitative indicators yet the quality of health service delivery is not mentioned. For example: according to the Health Assistant in Chhatak, each pregnant woman requires five Tetanus Toxoid (TT) injections during her pregnancy to prevent infection to her and her new-born baby. The NGOs provide only one or

two injections to some of clients and count such information as 'completed' in the performance report. Essentially, the services provided by NGOs are incomplete and the quality of service delivery is not ensured accordingly. The Family Planning Officer of UHC Chhatak, interviewed in this research stated, 'NGOs emphasise the flamboyant rather than the reality and quality of work'. He also added that NGOs provide much importance to paperwork in order to strengthen their documentation for obtaining foreign assistance. Moreover, the NGOs participate in seminars, symposia, photo-shoots and workshops, rather than paying attention to the quality of health service delivery.

The BRAC Program Manager in Chhatak, interviewed in this study argued that the BRAC rules are very strict with regard to reporting. The Program Manager also argued that all BRAC officials are responsible for making accurate reports based on field information they receive. One of the reasons for losing one's job position at BRAC staff is poor reporting based on incorrect data. The Program Manager claimed that if there is ever an incorrect report, he gets it counter-signed by the field officials and sends the same to the BRAC higher authority. This knowledge prevents any health worker from making incorrect reports which in turn helps maintain accountability and transparency. The Program Manager further claimed that the accuracy in its reporting system assists BRAC to promote good quality health care which is not found in sufficient amount in government health service organisations.

The Officer in charge of Programs at the Gonoshastha Kendra (GK) Savar, interviewed in this study reported that the field employees ensure their accountability regularly by means of achieving their targets such as those on immunisation, maternal health and family planning services. He mentioned that the GK field workers provide reports on their daily activities after completing their work and retain one copy of the report in order to ensure accountability and transparency. The Officer in Charge further argued that as a supervisor he checks the outcome of the field reports. To quote the Officer in Charge:

> "Field workers give me reports regarding daily activities they have completed. I verify the reports at field visits and check their accuracy and the evidence that field workers provide. As a part of my responsibility, if I find any inconsistency in the report, I later bring this to the attention of higher authorities, such as the Director of Health Programs, for necessary action".

In brief, the BRAC report is more reliable than the government provided report as the BRAC works determinedly to ensure accountability. However, government

officials produce reports, which lack integrity and responsibility leading to poor accountability. Respondents also claim that NGOs reports highlight quantity of health service delivery instead of quality of health services. Moreover, GK provides reports based on updated and verified information, which assists to ensure accountability.

9.2.3 Mismanagement

The Resident Medical Officer (RMO) of Savar, interviewed in this research claimed that NGOs use money efficiently and honestly to pay the salary of officials and the costs of delivering health services. Similarly, one of the BRAC officials interviewed in this study stated that BRAC is committed to providing quality health care and services to people in remote areas. The BRAC official also remarked that they have no scope to be negligent in their duties or avoid their responsibilities. Additionally, the Program Manager of BRAC interviewed in this study stated that BRAC officials would lose their jobs easily on the grounds of poor performance or being involved in miss-governance.

However, the Secretary of the Committee of Concerned Citizens (CCC) in Savar, interviewed in this study stated that NGOs highlight the importance of meetings rather than the delivery of quality health services. He claimed that the NGOs organise meetings with people and get public support for themselves so that NGOs can source sufficient funds from donor organisations. The Secretary also claimed that although NGOs receive money from donor countries/agencies for enhancing health services, they mostly misuse these funds on other things such as office maintenance. Also, NGOs participate in social awareness programs such as anti-corruption campaigns with banners to put up a show their name in order to convince the donors to obtain more funds.

The message from NGOs is, however different. The Officer in charge of Health in GK, Savar, interviewed in this research argued that he checks the financial matters of his organisation very carefully to ensure accountability. He also pointed out that staff could lose their jobs immediately for indulging in mismanagement. He elaborated that a GK health professional could lose his/her job for three reasons: smoking, lying and stealing. The Manager (Governance) of ICDDR, B interviewed in this study however, maintained that NGOs' misuse of foreign funds for the purpose of training and selecting non-qualified people for training is often due to nepotism.

The participants of focus group discussions consisting of clients of GK complained that they have to pay money to purchase tickets for health examinations, which should be free of cost. One of the clients argued that she pays Tk.5 yet she is eligible to access free services according to the GK rules. She added that no one could have access to services without paying money. Another client claimed that she was an "A" category client as per rules of GK (see Box 9.2),[67] and therefore, she expected to get some discount (reduced cost of services). However, she received no such discount on any dental services from the GK health service centre.

A Junior Consultant (Gynaecologist) in Savar, interviewed in this research argued that NGOs send pregnant women to government hospitals for antenatal check-ups, but they send women for delivery to private clinics in order to get financial benefits, a benefit which also goes to the patient if she is referred by an NGO worker. Afemikhe (2011) study shows that private hospitals provide satisfactory health services as the health professionals working in private hospitals have higher motivations. Moreover the management of private hospital is much more efficient, which was discussed in Section 2.4.4(b) of Chapter 2.

To summarise, BRAC strictly follows the performance of health care providers, which makes them accountable and responsible. Some respondents claim that NGOs highlight paper-based documents to fund receiving agencies, which is not an accurate method of ensuring accountability. However, NGO health professionals claim differently and argue that GK examines financial matters carefully to promote accountability. Based on the above evidence, the researcher concludes that NGOs' health service accountability is questionable.

9.2.4 Coordination

The Manager (Governance) of ICDDR, B interviewed in this research stated that good coordination between the government and NGOs reduces the workload of health professionals and lowers mismanagement in health services to enable the provision of quality health service delivery in health service organisations. The Family Planning Officer in Chhatak, interviewed in this study stated that coordination

[67] As per its provision, GK classifies clients as A, B, C categories according to their socio-economic conditions. The clients receive services and medicine from GK at progressively reduced costs. 'A' category clients receive the largest reduction in costs, followed by 'B' and 'C' category clients in that order. Details on category of clients are presented in Box 9.2 of Section 9.6.2.

of government-BRAC activities should not pose a great challenge for delivering family planning services given that both organisations work to achieve the optimum target for promoting family planning services. However, the Health Inspector in Savar interviewed in this research argued differently and reported that government and NGO officials approach things differently due to differences between the two organisations in terms of management style and procedures, even if they are providing similar types of services.

The Health Inspector (HI) of Chhatak, interviewed in this study reported that BRAC health workers are not available at the field level and mostly work in accordance with their own organisational policies that hinder effective coordination. However, the Government runs its TB program in collaboration with BRAC and only a BRAC health worker attends a TB patient at the UHC, which provides sufficient cooperation. Sometimes the BRAC Program Manager participates in Upazila meetings, but none of the BRAC officials coordinates significantly with the Upazila health centre to enhance health service delivery. The HI suggested that good coordination could enhance quality of health services; therefore, a better understanding of GO-NGO relationships is required for strengthening coordination and cooperation in health service programs. Most health professionals in Chhatak (see Appendix 12b) interviewed in this study however, reported that government organisations do not get adequate NGO support because of a lack of GO-NGO coordination in health service delivery. A study by Alam (2011) found a list of challenge e.g., rigid rules and regulations, lack of coordination, poor capacity and inadequate accountability and transparency in Government-NGOs collaboration and their effect on health care delivery (See Section 2.4.4 (a) in Chapter 2).

The Family Planning Officer (FPO) in Savar interviewed in this research stated that in Savar there is good coordination and cooperation between GO and NGO in the area of supervision to make create a strong and effective quality health care delivery. The Vice-Chairperson of Chhatak however suggested that more administrative initiatives at policy/higher level are required promoting GO-NGO coordination and enhancing accountability in health service delivery.

The Health Inspector (HI) in Savar UHC interviewed in this research reported that Gonoshastha Kendra (GK) has a contract to work with the government in public health programs in particular areas. Specifically, the GK works with only three unions and provides assistance to public health care providers. This makes the job

easier, service more accessible for government health care provider and better for all concerned and contributes to overall improved health care performance in Savar. However, the HI did not give any information about whether he faced any challenge in working with GK.

The BRAC health worker interviewed in this research claimed that they coordinate and work with various government health schemes such as satellite clinics, community clinics and EPI centres. The BRAC health worker further stated that BRAC communicates with Upazila health service organisations and government field workers to assist them in providing health services. A representative of BRAC attends Upazila coordination meetings and submits a progress report to his office to ensue accountability. The Program Manager of the BRAC health care program in Chhatak interviewed in this research argued that there is no policy to stop healthcare seekers from using either a public or a private health facility like BRAC, and that service users can avail themselves of any service of their choice. He also explained that all health service programs in the country are covered under the umbrella of the Ministry of Health and Family Welfare, therefore improved coordination between the government and BRAC (or any other NGO providing health care services) can contribute significantly to promoting accountability in health service delivery. The study by Zafar Ullah et al. (2006), however pointed out that the lack of mutual trust, inadequate freedom to act independently and the slowness of implementation affect the success of the government and NGO collaboration in health services.

As previously mentioned, coordination of GO-NGOs promotes good governance and the evidence of the Tuberculosis (TB) program shows quality health service delivery as. Nevertheless, the overall GO-NGOs coordination is weak as the style and procedure of government and NGOs health service delivery are different and each organisation works according to their own organisation policy. Therefore, this issue contributes to inadequate coordination leading to poor quality of health service delivery.

9.2.5 Human resources, training and motivation

The UHFPO of Savar, interviewed in this research claimed that NGOs provide better quality health care, as they have sufficient human resources for a specific field area. For example, GK appoints 40 field workers to a union and, consequently, GK staffs are able to make proper house-to-house visits to enhance the quality of health

service delivery. This is in contrast to the government, which appoints a maximum of 10 field staff to a similar-sized same area to provide similar services. Such a shortage of human resources in government health service organisations makes it impossible to provide quality health service delivery (see details in Section 5.4.4 of Chapter 5). The BRAC Program Manager (PM), interviewed in this research however argued that currently BRAC operates a large number of health projects for which BRAC requires adequate number of permanent field workers and supervisors to promote supervision so as to provide quality health services.

With respect to training, the PM of Chhatak mentioned that the BRAC office of Chhatak sub-district provides foundation training (duration 21 days) to 61 Shastha Sebika (health worker) in order to enhance their knowledge and understanding of primary health care delivery. Besides this, he remarked that BRAC provides a six-month training for permanent field staff. The PM claimed that BRAC training enables health workers to provide services more efficiently as well as to a maximum number of patients. The person in charge of Health at GK in Savar, interviewed in this research argued that GK provides training to field workers so that health care providers contribute to work efficiently. The HC also argued that every worker receives two types of training: theoretical and practical/field training. For theoretical training, they attend only classes and learn about theoretical issues with regard to maternal and child health services. After completing three months of theoretical lessons, they then go to the field to share their practical experiences with clients for another three months. At the end of a probation period, the GK gives the trained workers the responsibility to provide services so that they are able to work efficiently and effectively. The health staff at government health service organisations receives very little basic training, which is not as intensive and practical as that of the NGOs.

The Health Inspector (HI) of Chhatak, interviewed in this study stated that health professionals who work in management positions in BRAC are paid better salaries and allowances compared with their counterparts in government health services, although the salary of field staff and health workers is very poor. The HI suggested that BRAC needs to reduce its number of volunteer field staff, increase the number of permanent staff, and provide permanent staff with sufficient salary and allowances to improve their motivation. The BRAC Program Manager agrees with the evidence of HI and pointed out that the BRAC office provides counselling to inspire the field staff to work with motivation.

The BRAC Program Manager also said that BRAC has introduced a new scheme in September 2012 to motivate health care providers by helping them earn additional income. For example, a Shastha Sebika (SS), a volunteer female health worker, would receive an incentive of Tk.20 for identifying a new pregnant woman and will receive Tk.30 when this woman has given birth. This is a source of income for an SS. Similarly, an SS would receive an incentive payment of Tk.500 for organising proper treatment of a TB patient. Previously, this incentive amount was Tk.150. Further, BRAC provides Tk.50 to any SS who brings in a cataract patient for eye surgery as part of the vision Bangladesh program of BRAC.

On the other hand, according to the above-mentioned Program Manager of BRAC, permanent health workers of the organisation receive a regular salary. In addition, a pregnant patient pays the health worker Tk.100 to Tk.200 as 'bokshis' (tips) after she has given birth. However, the ultimate incentive for a health worker is the recognition of good performance in his/her Annual Confidential Report (ACR), which helps him/her in gaining promotion in the job with better pay. The incentive improves the motivation of health staff and leads to better outcomes in the delivery of health services. In a focus group discussion conducted in this research, the service users in BRAC stated that BRAC provides good quality services which consist of health checks, blood tests, and antenatal checks for pregnant women and Post Natal Care (PNC) for the newborn child. Most clients expressed to the researcher during the focus group discussion that they were satisfied with the services of BRAC. They pay BRAC Tk.5-Tk.10 for getting primary services but need not pay any additional charges, while BRAC provides medicine at low cost. The clients of BRAC expressed their happiness at the good behaviour of Shastha Sebikas (SS) because they are sincere in their duty and always available to take care of the patients. A study by Ahmed et al. (2006) (see Section 2.4.4 of Chapter 2) describes the behaviour of NGO health care providers and the patients' positive perceptions of their quality of health service delivery. Ahmed (2006) however pointed out that NGO clinics provide inadequate information and they have poor health infrastructure, which limits quality of health care. A small number of clients claimed that the overall quality of health services provided by GK has declined (see Box 9.1) due to the careless behaviour of health care providers. However service users have a good connection with field health professionals in comparison to nurses, doctors and official staff.

Box 9.1

Satisfaction on quality of health service delivery

> The quality of health service delivery was satisfactory in the past. But now health care providers do not take proper care and nurses are not so cordial in giving services. A few days ago I visited GK, but I did not receive good quality service. We go to hospitals as patients. We expect good behaviour from doctors and staff. Good behaviour of health care providers may reduce 50% of the disease. On the other hand, bad behaviour increases suffering. **Source**: Focus Group Discussion, Service users of GK, Savar.

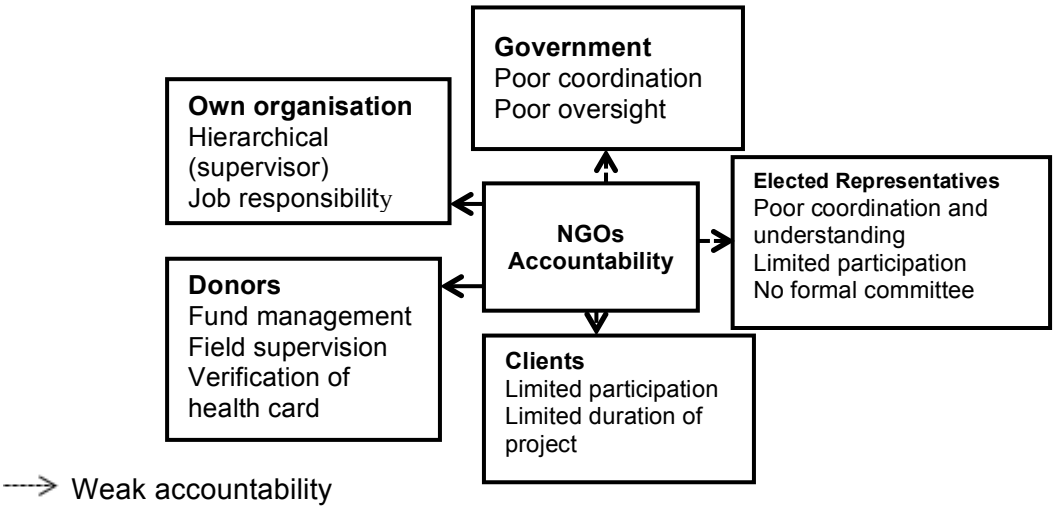
To sum up, NGOs have adequate field staff, therefore they are able to provide good quality health service delivery. Evidence shows that NGOs workers receive practical training, which assists them to serve health service delivery effectively and efficiently. Such practical training is inadequate for government health care professionals. Besides this, NGOs health service managers receive good salaries but field workers get lower ones. As regards provision, NGOs offer for field workers incentives in order to motivate them to provide health service delivery. Moreover, NGOs' health professionals have good behaviour; therefore, most service users are satisfied with NGOs health care delivery.

9.3 Role of Actors and Factors in Promoting NGOs' Health Service Accountability

NGOs work with multiple actors and factors to provide quality of health service delivery. This figure 9.1 shows that NGO has lack of coordination with government and other actors, however NGOs have strong accountability with donors and higher authority of their own organisation. This lack of accountability appears due to weak organisational structure, poor coordination, inadequate planning and the gap of legal framework.

Figure 9.1

Factors affecting accountability in NGOs in health service delivery at sub-district level



Source: Field Data 2013

Figure 9.1 demonstrates the factors that influence NGOs' accountability and health service delivery. The Vice-Chairperson in Chhatak stated that government health professionals do not have much awareness and professional responsibility of health projects run by NGOs because of inadequate GO-NGO coordination. She also stated that NGOs connect well with local affluent people in order to get local support so that they are able to work on health projects effectively. For this, the NGOs offer expensive gifts to local elites to gain their support. The Vice-Chairperson also claimed that NGOs delivery of health services is adequately accessible and affordable as their management is participative but they are not directly accountable to clients. Besides this, NGOs health programs have a limited number of client's participation. In addition, she claimed the NGOs health project lasts for a very limited time of perhaps a couple of months, therefore service delivery from this project is not adequate. Consequently, clients' limited participation and the short duration of the NGOs projects contribute to inadequate accountability.

The Health Assistant (HA) in Savar, interviewed in this research claimed that NGOs mainly assist in motivating people to ensure participation of service users in EPI programs. NGOs have no formal responsibility or accountability to the Union Sub Centre (USC). The HA also stated that NGOs are used to working according to their

organisation's policies and are ultimately accountable to their organisation. Similarly, the Family Welfare Assistant (FWA) in Chhatak, interviewed in this research reported that NGOs are accountable to their own higher authority and organisations. She also stated that NGOs work for yet are not accountable to people which is similar to what happens in government organisations as explained in Section 5.2 in Chapter 5. NGOs attest to their success in their reports but these reports discuss highly on quantitative indicators of health services (e.g. the number of patient) provided by them. The HA of Savar further claimed that in their report, the NGOs highlight only their quantitative health indicators, that is, the number of patients they have served. Moreover, the government has a limited oversight of the NGOs activities as NGOs operate through their own rules and regulations. The Family Planning Visitor in Chhatak, interviewed in this study pointed out that the fear of losing a job is higher in BRAC in comparison with that in government organisations; this makes BRAC workers more accountable and responsible to their organisation.

The local politicians, elected representatives and the local informants interviewed in this study observed that the NGOs' budget practice is non-participative and non-transparent as people have no participation in the process. In addition, the Secretary of Bangladesh Nationalist Party (local wing, Chhatak) interviewed in this research claimed that NGOs are politicised which limits their accountability.

Under the local government organisation policy, NGOs are not legally accountable to locally elected representatives. For example, even though the BRAC officer in Chhatak confirmed that BRAC works in all unions including Upazila, a Ward Member at Kalarukha Union Parishad in Chhatak, also interviewed in this research said that BRAC health workers are not accountable to them. Moreover, the ward members are not fully aware of BRAC activities in their locality. However, a Ward Member in Kalarukha Union Parishad confirmed that an NGO named 'Friends in Village Development Bangladesh' (FIVDB) works in their locality and organises field meetings in which the elected representatives participate. However, this NGO is formally not accountable to the elected representative as the Union Parishad has no legal requirement for this.

The Member of Parliament (MP) of Chhatak, interviewed in this research argued that the promotion of accountability and quality of health service delivery require good understanding and effective coordination. Local elected representatives should be well informed of NGOs' activities. He also asserted that NGOs should take

advice from the elected representatives. The MP further argued that the understanding between NGOs and elected representatives promotes accountability, which leads to quality health service delivery. The Union Parishad Chairman in Savar stressed to the researcher that NGOs work at the grass roots level on the basis of permission of the local administration. The Chairman also stated that NGOs invite local elected representatives occasionally when they organise meetings and seminars, but that NGOs have no formal committee to report to the union level to ensure accountability.

However, the Officer in Charge of Health (OCH) at GK in Savar provided a contradictory opinion and argued that Savar has some community-based health clinics that are supervised by the local elected representatives. This NGO community clinic (CC) also reports to a committee under the supervision of the local representative. He claimed that health professionals who work under the CC require the signature of the elected representative to draw their salary and allowances. The CC has to provide reports about maternal and child mortality and other health information to the elected representatives. From the information given by the Officer in Charge of Health (OCH), it can be inferred that such a mechanism of ensuring accountability can be an ideal example of quality of health service delivery.

The Vice-Chairperson of Savar Upazila Parishad, interviewed in this research pointed out that because NGOs receive funds from donor organisations, they are accountable to their donors. She also said that the donor organisations want to know whether the local Parishad (local council), local public administration, and the local community where NGOs work expect feedback from all those involved in the NGOs activities. The Officer in Charge of Health (OCH) at GK in Savar, interviewed in this study stated that one of the mechanisms used by the donors to ensure accountability is supervision of health service programs through field visits. He also stated that a delegated officer of the donor organisation visits the field from time to time to examine the activities of the NGO (GK) and gets an account of the cost to provide health services. The field data support by the Afemikhe (2011) study as the study revealed that the private health care supervision has an influence on the quality of health service delivery (See Section 2.4.4(b) in Chapter 2). Additionally, donor organisations collect information from the local administration including elected representatives in order to assess an NGO's accountability. Moreover, the OCH argued that representatives of donor agencies physically check the health

cards of service users through field visits in order to ensure accuracy for promoting accountability.

The Family Planning Officer of Chhatak, interviewed in this research argued that NGOs survive mainly on funds received from donor organisations. For this, NGOs need to show records of good performance in order to convince the donor organisations to donate funds. The Family Planning Officer also stated that the roles of NGOs are not sufficient, as NGOs work in a limited area. However, they contribute significantly to society in promoting social and economic development. For instance, NGOs contribute to creating employment for large numbers of people. In addition, the NGOs work as partners in government health programs that enable NGOs to achieve expected outcomes in relation to maternal and child health.

In short, NGOs' health programs have limited coordination with government that affects accountability. Besides this, elected representatives have restricted control over NGOs as local government regulations do not allow NGOs to be accountable to elected representatives. Further, NGOs run through their own rules and regulations. NGOs work with selected clients but those clients have no direct participation in the NGOs' decision-making process. Such evidence is similar to government health service organisation. As NGOs work according to their own organisational policy, they are accountable to their own higher authority as shown in Table 9.1. NGOs run through the donor's support and subsequently, are formally accountable to donor agencies. As NGOs work for the community, effective supervision by elected representatives can improve NGOs' governance and health service delivery. Besides, NGOs transparency is significant for understanding health service delivery that is discussed in the next section.

9.4 Transparency in NGOs' Health Service Delivery

The local Member of Parliament (MP) of Chhatak, interviewed in this research said that NGOs have poor organisational and physical infrastructure for providing health service as NGOs work in a temporary building for operating health services. The MP also stated that he does not have sufficient understanding of NGO activities, as he is not fully aware of where and how NGOs are working in Chhatak Upazila. The MP further stated that the local elected representatives (the UZP and UP chairmen and Ward members) also have poor understanding of NGOs activities. According to this local MP, all of these factors tend to reduce the transparency in the NGO health

care delivery and consequently, lead to a lack of confidence among the clients. The Village Leader of Chhatak, interviewed in this research argued that as NGO health care delivery is less transparent, the village leaders do not recommend that any patient go to an NGO health care provider. A study by Ahmed et al. (2006) corroborates the points made above about poor health infrastructure among NGOs that affects their health service delivery. However, the Village Leader in Chhatak stated that information on BRAC health services particularly, the BRAC TB service is adequate and people are well-informed because BRAC provides services for TB patients that helps people to go UHC to make use of such services.

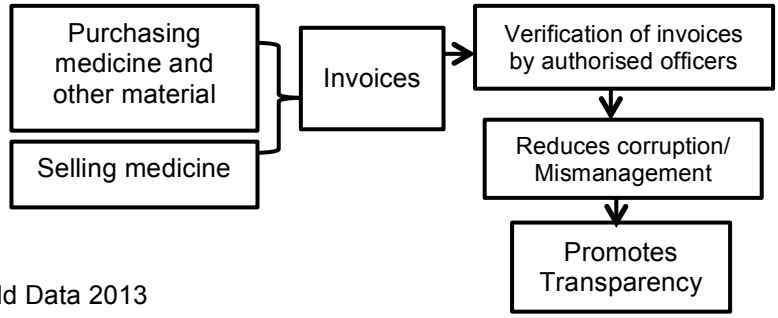
The BRAC Program Manager (PM) in Chhatak, interviewed in this study pointed out that the submission of reports to the donor organisations is one of the mechanisms to ensure transparency in BRAC. BRAC submits monthly and quarterly progress reports on project activities. These reports provide detailed information about how much work has been completed, and the expected dates of completion of a project. These reports are verified by the central office of BRAC to ensure transparency. This system works well in BRAC, therefore BRAC health professionals in Chhatak, interviewed in this research, claimed that the services they provided are transparent and good.

Senior officials of BRAC examine field workers' activities by checking official documents, verifying invoices and by studying performance reports to ensure transparency. BRAC field health professionals have a monthly plan similar to that of the government. The BRAC field worker interviewed in this research claimed that they work according to the plan and submit organised plan schedules to the superior officers for ensuring transparency. Thus, according to the Program Manager of BRAC in Chhatak, all activities of BRAC are organised into a schedule that helps to ensure transparency and quality of health service delivery.

A BRAC Health Worker (HW), interviewed in this research stated that verification of receipts is another mechanism to ensure transparency. To do this, the BRAC office preserves in its records, the invoices submitted by the health workers and other staff for the sale of medicine and the invoices for all purchases to ensure transparency.

Figure 9.2

Methods of NGOs financial transparency at local level



Source: Field Data 2013

The Officer in Charge of Health (OCH) of GK in Savar, interviewed in this research stated that GK supplies medicine to its field staff according to demand. The field staff sell medicines at the prices fixed by GK. They must give copies of receipts to the clients and deposit the money received from the sales and the receipts to the responsible officer to ensure transparency. The receipt is issued in triplicate: one for the client, one for the office and one for preservation in the central office. Such an organised system enables GK to reduce corruption and mismanagement, which assists to promote transparency (see Figure 9.2).

Organising various social events are ways to inform people about health services. In this regard, the Program Manager in Chhatak, interviewed in this study stated that BRAC organises to enhance health awareness programs where social and political elites including the general population participate in social events. Besides this, the village doctors as well as field workers also share information with clients about health services.

The Health Assistant of Chhatak, interviewed in this study said that billboards constitute another mechanism to publicise services for tuberculosis. However, BRAC does not use any billboards to publicise its health programs. The BRAC Health Worker, interviewed in this study claimed that door-to-door visits assist health professionals disseminate information about its programs. In addition, she stated that organising yard meetings (meetings held in the open yard of a house to discuss health service issues) by the field health professionals is another mechanism to inform people about BRAC health services. She further argued that yard meetings also assist service users to seek advice on health, the importance of cleanness, childcare and family planning services. In addition, the Health Worker argued that BRAC service users communicate with health care providers through mobile phones

to seek health advice. Government health care providers also provide health advice in the field via mobile phones, which is described in Section 7.3.2 of Chapter 7.

Indeed, a poor understanding of NGOs activities by the elected representatives limits transparency. Yet some of the mechanisms used by NGOs to promote transparency are very effective such as submission of reports to donor organisations, checking information through the central NGOs, and verifying invoices by the local office. Such mechanisms are operated poorly in the UHC and, therefore, corruption and inadequate transparent health service delivery have been found there. Conversely, none of the billboards has been used by NGOs to publish information on health programs, which affect NGOs' transparency as stated in Table 9.1.

Table 9.1

The major features of two selected NGOs governance

NGOs Governance	Main features
Accountability	• Poor coordination with government, elected representatives and clients, • Strong connection with donors and internal management. • Participative management • Politicisation • Poor legal framework, inadequate policy and planning
Transparency	• Poor understanding • Efficient reporting • Effective information management • Poor institution (building) • Verification of invoice
Participation	• GO-NGO collaboration • Meeting, field visit, social events • Women empowerment • Service user's socio-economic conditions • Politics

Source: Field data 2013

Participation is an important element of promotion of quality in NGO health care and is influenced by various actors and the factors associated with socio-economic and

politics. The following two sections (9.5 and 9.6) analyse the role of actors and factors respectively for understanding participation and health service delivery.

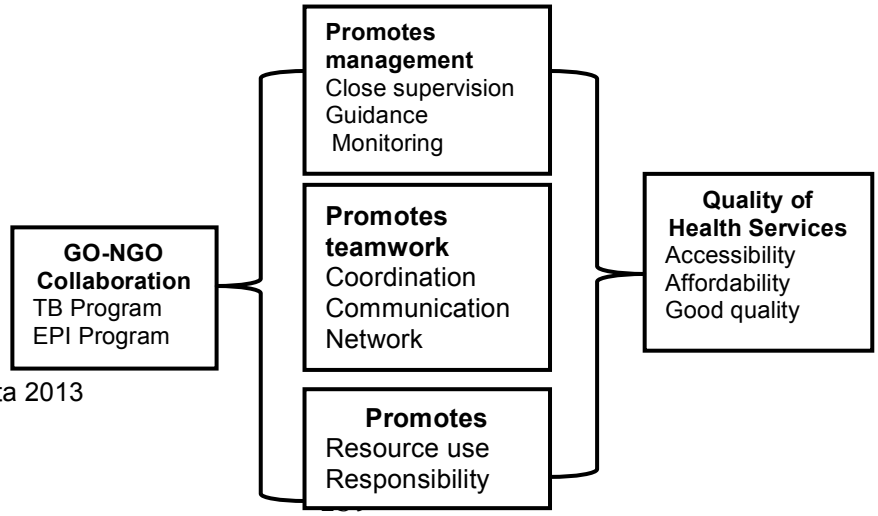
9.5 The role of actors in promoting NGOs' participation

9.5.1 Government-NGO collaboration in health service delivery

The Health Inspector (HI) in Chhatak, interviewed in this study stated that the Tuberculosis (TB) program is based on a Government-BRAC collaboration, which has contributed successful outcomes due to close supervision and adequate follow up. Besides this, the Government-BRAC, TB program has strong network-based communication among the government and non-government health care providers. Zafar Ullah et al, (2006) study support this evidence as Government-NGO collaboration promotes quality of health care which describes in Section 2.4.4 in Chapter 2). Similarly, the Expanded Program on Immunisation (EPI program) is a successful partnership-based health service, which is organised under the collaboration between the government and NGOs. The BRAC Program Manager of Chhatak stated that there has been an improvement in health care in the TB program since the start of the collaboration. He pointed out that before the start of the collaboration, no TB patient had received adequate service from the government only health care providers; however, after the collaboration began the responsibility for servicing TB patients came under the joint program and BRAC's involvement started providing quality health care as a result of adequate supervision, proper guidance and monitoring (see Figure 9.3). He also pointed out that this improvement of service delivery is highly accepted by government authorities as well as society as a whole.

Figure 9.3

GO-NGO collaboration and their impact on quality of health services



Source: Field Data 2013

The Vice-Chairperson of Chhatak Upazila Parishad (UZP), interviewed in this study pointed out that a partnership-based health service is better than solely public services as partnership-based service delivery involves management founded on teamwork, which assists in achieving good quality health care. Similarly, the Vice-Chairperson in Savar UZP, interviewed in this study argued that collaboration provides great support for enhancing health outcomes. She also argued that in partnerships, NGOs share government activities in order to enhance quality health service delivery.

The Family Planning Officer of Chhatak, interviewed in this study argued that the family planning department hires surgeons from NGOs to provide the family planning services that require surgical procedures. Moreover, he stated that the support of donor organisations plays a significant role in improving health services. He also argued that donors are considered associate partners of government health service organisations. The Upazila Health and Family Planning Officer (UHFPO) of Chhatak, interviewed in this study explained that BRAC supplies the required human resources and the government provides medicine in order to serve the TB program. The UHFPO argued that such coordination and support from BRAC make it possible to have an effective collaboration between government and non-governmental organisations for the success of the TB program. Another NGO, Gonoshastha Kendra (GK) works on the government-run EPI program in Savar through collaboration with the Savar UHC which enhances not only coordination but also assists in effectively implementing field health programs.

The Manager (Governance) at ICDDR, B, interviewed in this research argued that collaboration-based health services contribute significantly to urban health care although such collaboration is limited at the rural level. He also argued that a partnership can assist in ensuring good governance and quality of health service delivery only if it clearly explains which organisational resources are available and what the roles and responsibilities of the partners are. The Manager at ICDDR,B further argued that a collaboration-based project must have sufficient expertise (skilled human resources) and the needed resources to ensure good quality of services (see Figure 9.3), but that sole government health care projects are characterised by poor management of resources that affect the quality of health service delivery (discussed in Section 2.4.4(b) in Chapter 2). However, the Secretary of the Committee of Concerned Citizens (CCC), Savar, interviewed in this study pointed out that in collaborative projects the partners usually focus on self-

interest rather than common benefit, which affects the quality health service delivery.

In fact, GO-NGO collaboration has a few limitations, yet this is a very effective mechanism which improves supervision, coordination, and teamwork and resource efficiency leading to quality of health service delivery as described in Table 9.1.

9.5.2 Community participation in field meetings

The BRAC Program Manager in Chhatak, interviewed in this study stated that BRAC organises meetings to promote community participation and also participates in government health service organisations' meetings to share their views in order to enhance quality health service delivery.

BRAC organises yard meetings with service users as claimed by a BRAC Field Supervisor. The Family Planning Officer in Chhatak interviewed in this study stated that BRAC meetings are aimed at motivating clients towards accepting family planning services and at disseminating information about the EPI program and other valuable health care services.

The Health Worker of BRAC interviewed in this study argued that BRAC conducts meetings in accordance with its organisation's rules, with initial meetings of larger groups, followed by small group meetings to provide quality health care. The larger group meetings comprise service users from 35 households and the smaller group meetings focus on five to seven households chosen randomly from a list in order to promote accessibility of health care. The Health Worker also stated that BRAC organises meetings with local religious leaders to ensure participation in health service programs. Schurmann and Mahmud's (2009) study provides detail understanding that influences participation of community organisation in promoting governance and quality of health care delivery (see Section 2.5.2, Chapter 2), which hardly addressed in field data.

The BRAC Program Manager of Chhatak, interviewed in this research argued that the field supervisors organise three meetings a week to disseminate information about their work on health service delivery, particularly since meetings give the clients an opportunity to express their views on the strengths and weaknesses of current health care programs. He also argued that BRAC organises cultural events

including folklore, rural songs, and popular dramas to inform people of their services and to raise their awareness of health services.

Moreover, the Officer in charge of Health (OCH) at GK, Savar, interviewed in this research stated that the GK delivers its health services under a committee and organises its meetings at community clinics (CC) once every three months.[68] The field staff are invited to participate in these meetings which discuss the income of the CC, activities of the committee, supply of medicine as well as strength and weakness of health service delivery. A focus group discussion of GK health service users conducted in this study pointed out that they were able to participate in the meetings, which enabled them to understand the importance of good health for family and society. The OCH added that the participants in these meetings discuss the health problems of the community and ways and means of making health services more accessible to poorer people.

The UHFPO in Chhatak, interviewed in this study stated that the UHC also organises monthly meetings with NGOs to discuss the issues faced by the NGOs in delivering health care. According to the UHFPO, the monthly meetings organised by the Upazila administration provide a platform for NGO participation in the wider community. The MP of Chhatak, interviewed in this study claimed that sometimes, the NGOs meet the expenses of the meetings in order to please the local elites and bureaucrats. The meetings also provide the NGOs with an opportunity to submit their performance reports to get recognition for their success. However, the Family Planning Inspector in Chhatak claimed that the majority of public health officials are suspicious of or lack confidence about the performance of NGOs as the reports prepared by the NGOs tend to be inaccurate.

The Vice-Chairman in Chhatak, interviewed in this study remarked that poor education and the lack of family support affect women's participation in health programs. She also claimed that NGOs' community participation is very limited, as they organise meetings particularly for specific people of a locality that do not reflect the overall opinion of entire community. The Vice-Chairperson further claimed that local elected representatives participate in NGO meetings when they receive formal

[68] The committee is made up of 11 members such as local elites, school teachers, ward members, and farmers with a female member as chairperson. In addition, one of the members is from the landless poor people in the locality.

invitations and in the meeting they are able to share information with the local community.

Indeed, NGO meetings are participative where clients can participate and express their views on health service delivery; however the participants in the meeting are very limited as shown in Table 9.1.

9.6 Factors influencing NGO participation in health service delivery

9.6.1 Women's empowerment

The Ward Member of Savar Union Parishad, interviewed in this study pointed out that women's empowerment is better in urban areas, as a significant number of women are working on NGO health projects, in primary education and in the garment industry. She said that this empowerment contributes positively to promoting society and family, which leads to, improved health service delivery. A BRAC health worker in Chhatak, interviewed in this research argued that women's education and awareness have improved because of social change, which contributes to improve family planning services. However, she also said that rural women still have poor education, inadequate employment and lack motivation, which adversely affects women's empowerment leading to poor participation in health care activities (discussed in Section 2.6(a), Chapter 2). The BRAC health worker further stated that the government should implement necessary development programs to promote women's empowerment to enable their participation in health service delivery as shown in Table 9.1.

Based on his field experience, the BRAC Program Manager in Chhatak, interviewed in this research pointed out that the head of a family's poor understanding, lack of independence, and poor decision making role are the obstacles preventing women to participate health service programs. He claimed that participation in meetings enhances women's awareness of basic health care, health information and how women's health contributes to enhancing family life. A focus group discussion with health service users of BRAC, conducted in this research revealed that the head of a family such as the husband or mother-in-law take crucial decisions on family affairs including health services. However the service users also mentioned that they are able to provide their opinion on family affairs before a final decision is made.

The BRAC Program Manager in Chhatak stated that BRAC has a scheme that provides money to poor clients for purchasing a cow or a goat or for renovating or building one's house in order to enhance the socio-economic conditions of poorer women who have a limited amount of land (that is, less 10 decimal or 0.09 acre). He also said that any beneficiary of the microcredit programs is entitled to get health services from BRAC field workers/doctors at a low or minimal cost. However, the service users of BRAC claimed that no financial support is provided to pregnant women for childbirth services.

Factors such as education, employment, and motivation affect women's empowerment and health service delivery and this is similar to the government health service organisations. Women's decision-making concerning health services is guided by the family head (are mainly male members) as women are not sufficiently empowered. Therefore, economic development schemes can promote women's empowerment enabling them to make decisions on better health service delivery.

9.6.2 Socio-economic characteristics of clients

A BRAC field worker interviewed in this study argued that poor socio-economic conditions are one of the causes of malnutrition in children that leads to increase maternal and child mortality particularly in rural areas. The study done by Ahmed et al. (2010) however found that women's household wealth, education and decision making power are associated with the progress of maternal and child health services which is reported in Section 2.6 of Chapter 2. Additionally, she also argued that a significant number of poor mothers give birth to unhealthy children every year due to malnutrition. However, the health worker claimed that the people's poor socio-economic conditions are not a barrier to accessing BRAC health services, as BRAC allows equal access to all healthcare users.

A Medical Representative (MR) in Savar, interviewed in this study reported that, compared to people in rural areas, urban dwellers have better socio-economic conditions such as higher educational levels, income and knowledge of health which promote participation in health care programs and lead to good quality health service delivery. The Secretary of Bangladesh Women's Association (local wing, Savar) interviewed in this research made a statement similar to that of the medical representative.

A focus group discussion comprising BRAC service users in Chhatak, conducted in this study revealed that due to poverty they have to borrow money at high interest rates to obtain health services, particularly for caesarean section delivery. Similarly, the GK Savar service users claimed that also due to poverty they are not able to purchase medicine from outside the hospital (which they are required to do). A similar view was expressed by the users of government health services in both Savar and Chhatak (see Section 6.2.5 of Chapter 6). They do get medicine available at the hospital, but it is not sufficient to cure their ailments. The GK service users also claimed that a couple of years ago pregnant women used to receive free medicine and iron tablets, but currently such services have been stopped. The service users of GK stated that their families have limited sources of income such as from fishing and day labouring, and such income is not sufficient to afford the cost of medicines bought from outside the hospital. A service user of GK in Savar interviewed in this research reported: 'People who have money get medicine but poor clients have no access to free medicine'. The Officer in charge of Health (OCH) at GK, Savar stated that GK makes health care affordable by providing primary services free of cost, reducing the cost of medicine as well as ambulance services. This concession depends on the socio-economic conditions of the clients as stated by the OCH (see Box 9.2).

Box 9.2

Affordability of Health Service Delivery of GK, Savar

GK offers six categories of health insurance card based on the socio-economic conditions of the users. These six categories are divided into two parts: extreme poverty and the non-extreme poverty and include the classes A, B and C. The category 'A' is for landless people, 'B' is for people of poor residential facilities and 'C' is for people who have limited land. The non-poverty class is also divided into 3 categories: D, E and F - lower class, middle class and upper class/rich class of people in the society respectively. According to GK insurance policy, many fewer fees for services are charged from extreme poverty clients than non-poverty clients.

The service users of BRAC interviewed in this study claimed that obtaining government health care is time consuming and that the UHC provides low quality of medicine, but service users of BRAC receive efficient services and medicine of good quality that cure diseases quickly. The service users also claimed that government doctors prescribe a list of medicines that one needs to buy from outside the health centre, and this requires a substantial amount of money. Conversely, BRAC health

care providers prescribe a short list of good quality medicine that assists in curing the disease quickly.

In principle, service users' poor socio-economic conditions are a challenge to the quality of health service delivery. However, the GK insurance policy of providing health care delivery is economic. Moreover, the socio-economic condition of NGOs service users does not significantly affect the access to quality health service delivery as with the government health professionals.

9.6.3 Politics

No middleman or the influence of local politicians is required to obtain healthcare from BRAC, but the same is not true of government health care (reported by BRAC service users in Chhatak). The BRAC Program Manager (PM) corroborated the views of the BRAC service users and added that the participation rate is highly satisfactory. He also stated that BRAC invites participants who are able to provide opinions on the improvement of health service delivery. Service users of GK, in a focus group discussion in this study claimed that both the rich and the poor get equal service and that everyone has to wait in a queue, but emergency patients and patients requiring medical examination get priority. Nevertheless, well-known local people gain an advantage in receiving health care.

9.6.4 Efficiency and affordable services

The Officer in charge of Health (OCH) at Gonoshastha Kendra (GK), Savar, interviewed in this research said that the GK provides services quickly in order to satisfy its clients and to instil in them a sense of confidence and trust about the organisation. In addition, the OCH stated that GK has sufficient skilled human resources as it provides good training that enables it to provide efficient health care. This statement is corroborated by Chen (2009), as discussed in detail in Section 2.2 of Chapter 2. Similarly, service users of BRAC argued that health care providers provide antenatal checks for pregnant women every month and supply medicine and advice such as to maintain a balanced diet in order to deliver a healthy baby. Cost efficiency is another positive initiative of BRAC health care, as this organisation provides medicines, iron tablets and vitamins at genuine prices, which the clients find to be cheaper than those if they had buy the medicines elsewhere. The service users also said that BRAC health workers are dedicated to providing services and observe privacy in delivering these services, which is not available at public health

service organisations. The Gonoshastha Kendra (GK) also received approving comments from its service users for its excellent service in delivering babies at no or minimal charge, which saves money for the service users. Nevertheless such services are expensive at private hospitals.

The GK service users also mentioned that no additional money needs to be spent on gifts for GK health care providers and that the GK field workers are friendly, more responsible and easy to communicate with. In addition, service users also commented that there is no delay in obtaining medicines from the GK, but it takes longer to get medicine or healthcare services from public hospitals or laboratories. The service users also reported that public providers offer very limited time to patients and, in fact, government doctors only prescribe medicines without checking disease or giving sufficient advice. Thus, service delivery of GK is relatively better to clients although, they have to pay a fee.

9.7 Conclusion

The supervision process in NGOs' health care delivery is hierarchical but the mechanism of supervision is cooperative, supportive and accompanied by appropriate guidance for the staff being supervised. This enables the staff to provide good quality health care delivery. NGOs have very good cooperation with local elected representatives compared with that of the government health care providers. Data show that NGOs have limited resources (for example, medicines and equipment to promote health care), yet they use these resources judiciously due to strong monitoring. NGOs also take their responsibility seriously and monitor their patients carefully. In addition to this, the key findings in this chapter are as follows:

a. NGOs are accountable to their higher authorities and to funding agencies and organisations to perform their jobs responsibly. Poor coordination, lack of policy, and the inadequate legal framework are the main causes of poor accountability of NGOs to the government as well as elected representatives. In addition, the process of community participation is too limited to promote NGOs accountability.
b. Verification of receipts including official documents reduces corruption and promotes transparency, which is a good example of NGOs governance. Moreover, meetings, field visits and social events are very effective methods that contribute significantly to NGOs' transparency. However, poor

institutional structure e.g., NGOs operate health services in a temporary building that is one of the drawbacks of the NGO's transparency.

c. Government-NGO collaboration is an effective mechanism and as it improves supervision, coordination and resource efficiency to promote quality of health service delivery. However, such collaborative health care delivery is very limited.
d. Women's poor decision-making roles in family and society affect the empowerment of women as women have poor education and dependency on family head which, in turn, affect their participation in health service programs.
e. Service users are satisfied with NGOs' health care, although they pay money as NGO services are more affordable and efficient than government health service delivery. Moreover, the GK insurance policy contributes to affordable health care. Finally, politics have no direct impact on the NGOs' health service delivery.

Chapter 10

Conclusion

10.1 Introduction

This thesis has examined the influence of governance on the quality of healthcare delivery in Bangladesh. This final chapter of the thesis summarises the major findings of the research and presents recommendations for policy and further research on the subject.

The main objective of this thesis is to understand the influence of governance on health service delivery in rural and urban areas of Bangladesh. For this purpose, three main components of governance, namely accountability, transparency and participation have been examined in the rural sub-district health service organisation of Chhatak in Sunamganj district and in the urban sub-district health service organisation of Savar in Dhaka district. For comparison, these components of governance have also been examined in two non-governmental organisations (NGOs) providing health services in Chhatak and Savar. These NGOs are the Bangladesh Rural Advancement Committee (BRAC) and Gonoshastha Kendra (GK).

Data were collected from an examination of office records and through in-depth interviews and focus group discussions of selected respondents (actors) comprising: (a) national level actors such as bureaucrats, academic researchers, governance experts, senior officials of planning commissions, and community leaders of women's organisations; (b) elected representatives such as Members of Parliament (MPs), Upazila (sub-district) Vice-Chairperson, Union Parishad (Union Council) Chairmen and Ward Members of selected research locations; (c) Health service professionals and staff of health service organisations, for example, the Upazila health complex and one of its sub-centres and community clinics located in a Union Parishad; and (d) other local informants including political party leaders, business leaders, NGO personnel, medical representatives, local community leaders, journalists, and social elites.

In-depth understanding as well as a critical analysis of governance at sub-district health service organisations has enabled the researcher to propose policy

recommendations concerning the quality of governance in health service delivery in Bangladesh.

The section 2.2.1 in Chapter 2 shows the conceptual issues of the quality of service delivery (Anwar 2009, Mazta and Thakur 2012) however none of studies described the impact of accountability, transparency and participation on the quality of health service delivery, which is useful understanding for strengthening health policy in Bangladesh.

Various literatures (Chapter 2) show that the causes of poor implementation of health policy are resource constraints, managerial inefficiency, an overcentralised health system, poor technology and socio-economic and political barrier among others. These factors particularly focus on health policy implementation, but this thesis analysed how these factors influence governance and the quality of health service delivery. In addition, corruption, poor coordination in management and lack of integrity of doctors are the most significant factors that contribute to poor quality service at the government-run hospitals (Schurmann and Mahmud 2009,p.538). However, this thesis explored the responsibilities and duties of health professionals for understanding the influence of governance on the quality of health service delivery. In addition, this thesis explored governance and quality of health care through community views that reflect people's expectations and such knowledge is very contemporary particularly in Bangladesh health sector. Moreover, rural-urban including Government-NGOs health care delivery with reference to governance is absolutely a new understanding in Bangladesh.

The present chapter is organised into three sections. The first section summarises the major findings of the thesis in relation to the research questions. The second section outlines policy recommendations based on the major findings of this research, and the third section presents recommendations for future research.

10.2 Summary of the Research Findings

As mentioned in Section 1.5 of Chapter 1, this thesis incorporates five research questions, which are as follows:

a. How do responsibilities and duties of various health service professionals contribute to improving/limiting governance and quality of health service delivery?

b. How does community participation contribute to governance and quality of health care in rural and urban areas?
c. How do various factors affect governance and health service delivery?
d. To what extent does governance work differently in rural and urban health service organisations?
e. How is the governance of NGOs' health service delivery conducted? Is service delivery of NGOs more efficient than that of public providers?

The following discussion summarises how these research questions have been addressed in this thesis.

10.2.1 How do responsibilities and duties of various health service professionals contribute to improving/limiting governance and quality of health service delivery?

The promotion of good quality of health care requires professionalism and positive ethos among health service professionals in delivering health services. However, the findings of this research show that most health professionals lack professionalism, integrity and motivation. Inadequate salary and mismanagement in the promotion and transfer system are factors in their lack of motivation and poor professionalism. Their poor professionalism is reflected in their lack of a sense of responsibility and disrespect for organisational rules. Poor supervision and monitoring by superior officials, especially in the rural health complex, allow the health service professionals to get away with their lax performance.

This thesis has also identified the following major contributing factors that have adversely affected the responsibilities and duties of the health managers and health service professionals, and their ability to carry out their jobs. This has led to poor governance and low quality of health service delivery:

- Bureaucratic set-up of the healthcare system and the influence of political parties in matters of administration (such as transfers and postings)
- Insufficient infrastructure, inadequate facilities, the need for the doctors to undertake private practice to offset their low incomes, poor management, a lack of appropriate policy to address these issues, all of which are conducive to a poor working environment and an increase in absenteeism of doctors.
- Various factors such as lack of professionalism among the doctors, lack of ethical values, impolite behaviour, and a lack of commitment and motivation to work with poor people, all of which critically affect their accountability to

their organisation and its people, and the quality of health service delivery. This is particularly true of rural health professionals.

These points were covered in Chapters 5 and 6.

10.2.2 How does community participation contribute to governance and quality of health care in rural and urban areas?

One of the important mechanisms of community participation is involving elected representative to local health service delivery because people directly elect them. Therefore, necessary actions for improving health services should be taken through people's opinion by the elected representatives. Moreover, good governance can ensure citizen voice for making better health services.

Community participation in the delivery of health services in Bangladesh is very low. The elected representatives (Upazila Chairmen Union Parishad Chairmen and Ward Members) are not interested in meeting with health service professionals or participating as observers in the delivery of health services that would make the health professionals accountable and improve the quality of health service delivery. Besides this, the health system is not decentralised enough to facilitate community participation in health services at the sub-district level. There is also a lack of political will and bureaucratic resistance against community participation. As a result, the elected representatives do not have enough authority to work against mismanagement and poor accountability. All of these factors reduce community participation in health service delivery. The other issues identified in the thesis that affect community participation are:

- Lack of empowerment especially that of women for promoting health service accountability; although the elected female representatives have been found to participate and play an effective role in improving health service delivery.
- In the current situation, the right political support can assure good health care, even for people with poor socio-economic status. When such political support is not there, people with poor socio-economic status cannot speak out against the lack of accountability of health care providers. Besides this, the civil society organisations are not empowered enough to make the health service professionals responsible and accountable to the people to deliver good quality health care.

- Policy formulation and budget preparation in the health services are politicised, elite-oriented, centralised and highly bureaucratic.
- Community clinics can play significant roles in promoting health service delivery in rural and remote areas, however the management of these clinics is politicised and locally influenced, which limits community participation.
- The top down approach in the decision-making process and the exclusion of members of the community in that process contribute to poor community participation.

These points were covered in Chapter 8 of this thesis.

10.2.3 How do various factors affect governance and health service delivery?

Managerial, socio-economic and political factors affect governance in healthcare and health service delivery. These have been discussed throughout this thesis where relevant. This section specifically outlines the following critical factors that affect governance and health service delivery.

- The monitoring and auditing functions of health service management are poor in rural health care organisations; consequently, financial corruption and mismanagement are widespread in these organisations.
- The high density of population in urban areas (Savar Upazila) is one of the major obstacles as it increases the workload of health service workers and resources needed to provide good quality health services, whereas the health service organisations have limited human, budgetary and organisational resources that limit supervision and contribute to poor quality of services.
- Insufficient training of healthcare providers (including doctors) in interpersonal relations with their patients creates dissatisfaction among the patients, which, in turn, affects the quality of healthcare. Doctors in government-run health facilities have to provide services to a high volume of patients in a limited time, which causes poor quality of health services. To overcome these problems, the richer patients seek private healthcare while the poorer patients have limited access to private health facilities as they cannot afford them.

- Health service organisations lack in team work, inadequate policy initiatives, and organisational conflict that contribute to poor coordination, which leads to less effective and less efficient health service delivery.
- Citizens' charters can promote transparency in health service delivery in general, but such charters do not function well, particularly in rural health service organisations as information about citizen's charters is not adequately explained to the people in rural areas.
- Mobile phones and internet connections have made it possible for health care providers to communicate directly with health service users and provide prompt health care delivery. This is acknowledged by the World Bank (2013) as a facilitating factor in the rapid decline in maternal and child mortality in Bangladesh. However, a lack of resources, limited budget, mismanagement and poor understanding of digital technology among the people pose major challenges in improving such technology affecting transparency and quality of health services.
- Better socio-economic conditions of women can promote their participation and decision-making in health services and improve the quality of health care delivery. However, women have poor participation rates in rural areas due to their poor socio-economic status, and traditional religious values. On the other hand, even though women have higher levels of education and better economic conditions in the urban area of Savar, their participation in health services is not adequate as the majority of the population are migrants from neighbouring areas of Dhaka who are heavily engaged in their work, mostly in the garment industry.
- Information provided to clients in the health service organisations is deficient, particularly in the rural areas where the health care providers are reluctant to supply the clients' with the required information. This contributes to poor transparency leading to unsatisfactory health service delivery.

These points were covered in Chapters 5, 7 and 8 of this thesis.

10.2.4 To what extent does governance work differently in rural and urban health service Organisations?

The health service manager of an urban health service organisation visits the field regularly to monitoring of the activities of field health workers. This results in strong and adequate supervision, which has a considerable effect on enhancing the accountability of field workers and the quality of health services. The findings of this

study show that close proximity to higher authorities, better leadership qualities and sincerity to work among the staff members of Savar UHC have a significant effect on accountability and provision of good quality health care. Besides, the good road communications in the Savar Upazila Health Complex (UHC) facilitate better supervision and the availability of health care providers in their posts, leading to better accountability among its workers and clearer transparency in their work. The key findings with regard to rural and urban governance in healthcare and health service delivery are:

- Corruption was found to be a common phenomenon in the provision of health service delivery due to lack of accountability, which adversely affects the quality of rural health service delivery. However, unlike Chhatak, there is no evidence of corruption in Savar. Therefore it can be assumed that the doctors in Savar UHC are more accountable and provide better health service delivery.
- Despite its poorer socio-economic indicators, the rural Chhatak upazila has a slightly better political participation in its UHC as this upazila has a health service committee in which various communities and health professionals participate to improve the delivery of health services. This is not true of the socio-economically better off Savar UHC, an urban area, where especially the community members are too busy with their daily activities. However, as far as community clinics are concerned, the Savar community clinic is more participative as a result of its adequate supervision and good management, which is absent in the Chhatak community clinic.
- The urban Upazila Health Complex (Savar) enjoys the participation of civil society organisations; consequently, accountability and health service delivery are better in Savar. Nevertheless, no civil society organisations or social elites participate in decision-making in rural health service delivery (Chhatak).
- There is no participation of opposition political parties in decision-making and other matters of the UHC in either Chhatak or Savar.

These points were covered in Chapter 5, 6, and 8 of this study.

10.2.5 How is the governance of NGOs' health service delivery conducted? Is service delivery of NGOs more efficient than that of public providers?

The process of supervision among the NGOs providing healthcare services is hierarchical, similar to that among government health service providers. But the NGOs work with particular groups of clients who are registered by the NGOs in their locality, which enables them to ensure good quality of health service delivery. On the other hand, the government health service organisations are responsible for providing services to all types of clients in their jurisdiction, which makes it difficult to ensure good quality of health service delivery due to limited resources and inadequate human resources. Besides this, the government resources are not used efficiently due to mismanagement, and although the NGOs also have limited resources to promote health care, they use them appropriately and efficiently because of strong monitoring. Moreover, although the NGO field workers have only short-term training, such training is focussed and effective for enhancing good quality health care delivery.

The thesis contains the following additional findings for understanding governance and health service delivery among the NGOs:

- Accountability among the NGOs is better than that in government organisations, as NGOs keep their paperwork up to date, and display transparency in their work by organising public seminars and meetings to report on their activities, which they have to do to obtain funds from their donors. NGOs follow very strict rules and regulations, which reduce corruption and promote quality of governance.
- Collaboration between governmental and non-governmental health service organisations can contribute to successful health outcomes and mutual accountability, nevertheless the two types of organisations have separate policies and strategies for delivering health services that preclude the possibilities of fruitful collaboration. However, one of the NGOs considered in this research, the Bangladesh Rural Advancement Committee (BRAC) operates its tuberculosis (TB) program in partnership with the Upazila Health Complex, and this TB program is reported to be implemented well.
- In fulfilling their job responsibilities, the NGOs in the field are accountable only to their own higher authorities, their headquarters and the funding

agencies, which fund particular projects. There is very little scope for the community to participate in NGO activities and ensure accountability.

- Regular submission of reports to donor agencies enables transparency among NGOs. Nevertheless, their poor organisational structure may pose challenges to transparent health services among NGOs.
- There is no community participation in decision-making or improving health service delivery in either government or NGO health service organisation. However, management in the NGOs is better than that in government health service organisations, and the process of management in NGOs is flexible whereas the process of management in government health service organisation is rigid.
- The organisational culture of BRAC does not differentiate between rich and poor people in delivering health services. The service users are satisfied with health care delivered by this NGO, as the behaviour of the providers is better than that of Government health providers. Moreover, the insurance scheme of the other NGO considered in this study, the Gonoshastha Kendra provides for affordable health care. Politics do not appear to have any direct influence on health care provided by the NGOs.

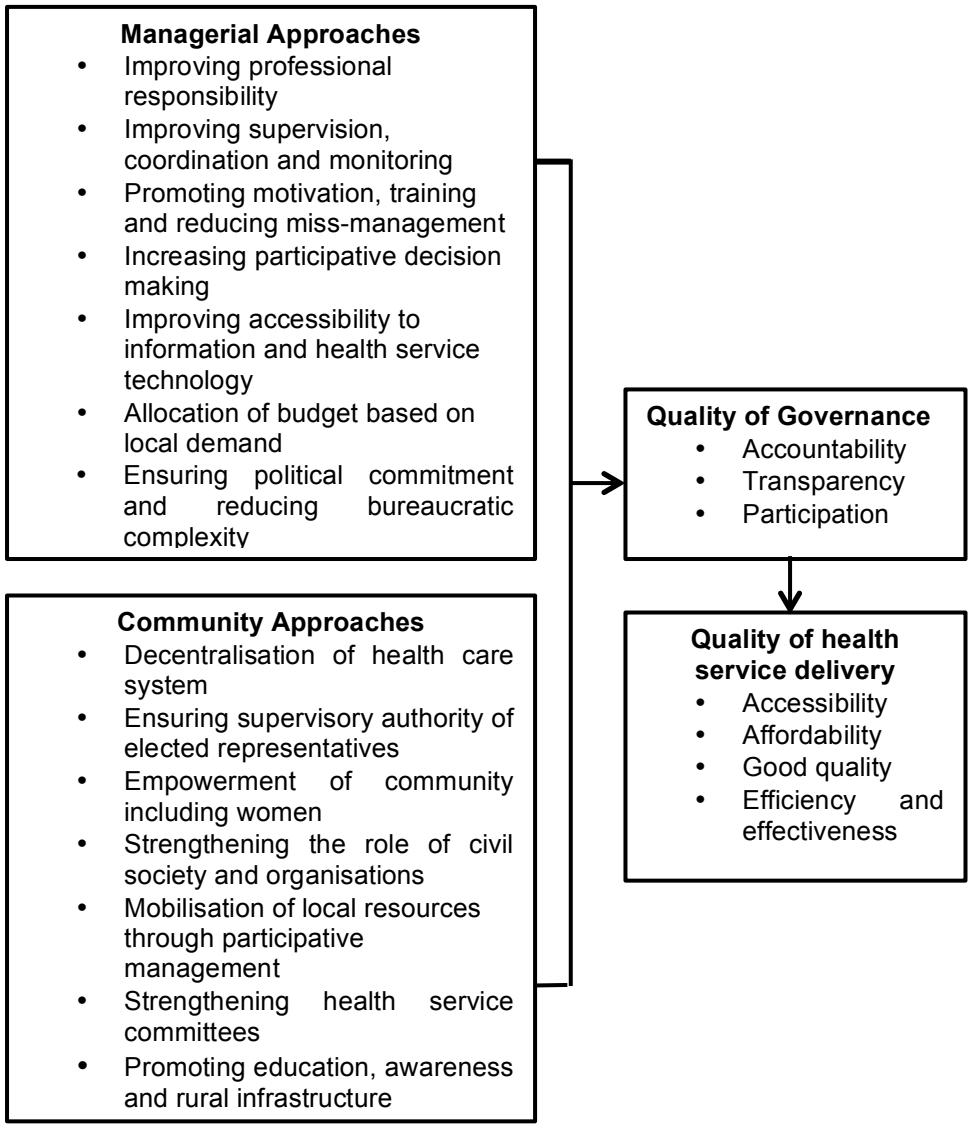
These points were covered in Chapter 9 in this thesis.

10.3 Policy Recommendations

This study has found that the quality of governance in the urban heath service organisation is better than that in the rural health service organisation. However, the overall quality of governance is less than desired in the Upazila Health Complex of both the urban and rural areas. It has been proposed in the thesis that policy initiative incorporates two approaches: that managerial and community approaches be adopted to promote the quality of governance and health service delivery at the Upazila Health Complex (see Figure 10.1).

Figure 10.1

Policy recommendation for improving the quality of governance and health service delivery at the Upazila Health Complex



Source: Field Data 2013

Figure 10.1 contains an outline of broader managerial and community approaches to policy initiatives of health service organisations for promoting good governance and quality of health service delivery. Based on this outline, suggestions are made for the following specific policies for use by practitioners and the policy makers for promoting good governance in health service organisations:

1) Introduce effective and efficient supervision to ensure the availability of doctors at hospitals/health centres and make them more accountable to make health services available and affordable for all health service seekers. An example of effective and efficient supervision could be to allow independent professional associations such as the Bangladesh Medical and Dental Council (BMDC) to monitor the doctors' day-to-day activities, thereby reducing any political influence that might be utilised by the doctors to avoid being reprimanded for negligence of duty.
2) Strengthen the government monitoring management including its chain of command to promote good governance at the Upazila Health Complex (UHC).
3) Improve the resources and capabilities of sub-district hospitals by providing sufficient budget, human resources, equipment and medicine and by training the health service professionals in health service management to foster trust and understanding with health service users.
4) Strengthen the coordination among various government departments and NGOs to create better teamwork and understanding and ensure the quality of governance of health service organisations. This would enable better fostering of trust, understanding, teamwork and minimising conflict, all of which would contribute to better governance. Effective coordination would also promote efficiency of resource use in providing good quality health care. To make such coordination effective, local policies should be developed based on local problems.
5) Clearly define appropriate policies about the roles and responsibilities of elected representatives to enable them to supervise and coordinate field workers and ensure accountability among health service professionals.
6) Introduce partnership based health systems in the UHCs, similar to what BRAC has done in its TB program, in order to facilitate enhanced coordination among government, NGO and private organisations. A technical committee could be formed at the national level for making policy guidelines to create partnership based health systems.
7) Reduce the gap between doctors and patients by providing the doctors and other health care providers' with appropriate training in quality of health care and interpersonal relations to change their attitude and behaviour towards patients.
8) Improve the working environments and provide better educational facilities for children, particularly in rural sub-districts to improve the doctors'

motivation and attitude to work, especially in rural UHCs. Introduce incentive schemes to reduce absenteeism of doctors at rural health care organisation.

9) Stop political and bureaucratic interference in the jobs of doctors and health service professionals to enhance their professional responsibility.
10) Review and reform the policies for private practice of doctors to make doctors accountable to their health service organisation. A post of executive officer from non-medical background should be created at UHC to monitor the hospital administration and all of medical professionals must be accountable to the executive officer.
11) Decentralise the delivery of healthcare and formulate local health care programs through participative decision making with the involvement of local communities.
12) Prepare UHC budgets through a bottom up process instead of the current top down bureaucratic process, to promote grassroots participation of the general community.
13) Make the audit team accountable to local Upazila Parishad to reduce corruption with the further provision of openly publishing any report on corruption to enhance transparency.
14) Improve the Internet facilities at upazila and union levels by building infrastructure, acquiring equipment, allocating budget and recruiting skilled human resources in order to improve governance.
15) Affix electronic billboards in the UHCs to display information for service users about doctors on duty, and the availability of health services, medicines and other relevant matters.
16) Formulate specific guidelines for the sub-district health service organisations for mobilising and utilising local resources.
17) Form a committee comprising local elites such as members of the business community, elected representatives, landlords and leading members of the local community, to raise funds (in addition to government budgets), and manage the same to improve health care delivery.
18) Strengthen primary healthcare and health education in remote localities with the help Community Clinics (CC), which have been founded to make health services accessible to people in remote areas. To make this recommendation standard throughout the whole country, the CCs should be provided with the required human resources, medicine and equipment. In addition, citizen's active participation can improve the activities of CC and provide essential primary health care to local residents.

19) Initiate necessary government initiatives to empower people through education, training and motivation to enable them to challenge any mismanagement the organisation.
20) The data from pilot project of Medicine Transparency Alliance (MeTA) shows that participation of multi-stakeholder groups such as government, private sectors and civil society in medicine supply chain would increase accountability and promote better access to essential medicines. The lesson learnt of MeTA could be useful for Bangladesh to ensure good governance and quality of health service delivery.

10.4 Recommendations for future research

This thesis has predominantly utilised a qualitative research method. However, governance of health service organisation should also be examined through the use of quantitative methods to gain a better understanding of the quality of health care. For this, the components of governance, such as accountability, transparency and participation can be measured quantitatively by examining the key performance indicators (KPI) of each health service organisation to understand the quality of health service delivery, complemented by qualitative studies. Moreover, in the present thesis, the opinions of only female health service users have been used, yet the opinions and experiences of both males and females would provide a better understanding of governance and health service delivery. Further, since this study investigated how the managerial, political and socio-economic factors influence governance and quality of health service delivery, a future research in this area could incorporate cultural factors influencing governance in health service delivery. Besides this, a study to understand the improvement of quality of governance and health service delivery during the last two successful political regimes in Bangladesh could be a new research agenda. Moreover, a comparative study on governance and quality of health service delivery with reference to public and private health service organisations could be useful knowledge in Bangladesh.

10.5 Concluding remarks

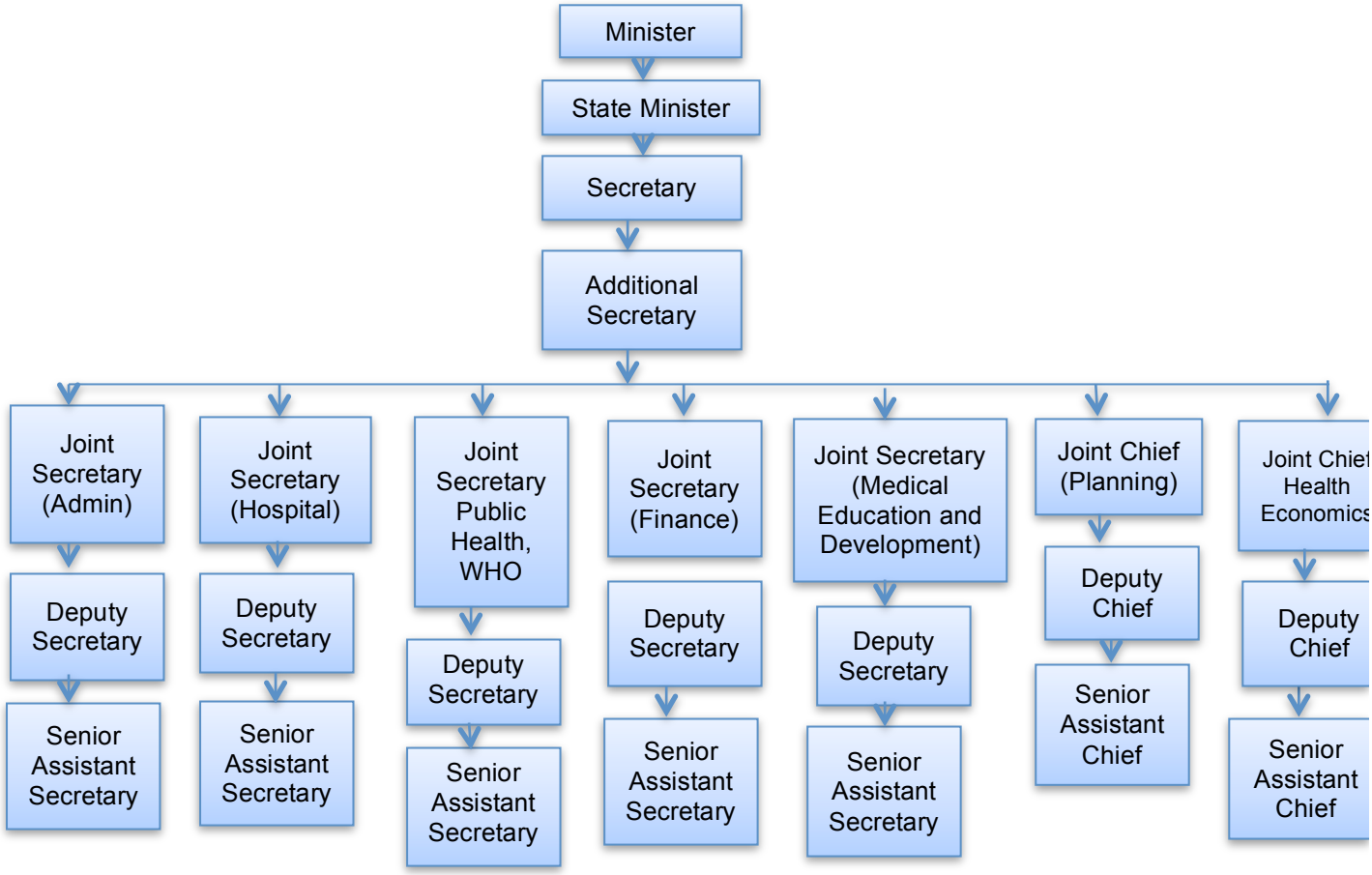
A large number of recommendations have been made for ways and means to improve governance in healthcare delivery in Bangladesh. Not all of them can be attempted simultaneously in a resource-poor country like Bangladesh. However, as a priority, the following recommendations should be followed as a first step:

- Improve the resources and capabilities of the sub-district hospitals and strengthen the coordination among various government departments and NGOs.
- Introduce partnership-based health systems in the UHCs between governmental and non-governmental health service organisations.
- Decentralise the delivery of healthcare and decision-making to develop local health care programs with the involvement of local communities.
- Improve the internet facilities at upazila and union level.
- Strengthen primary healthcare and health education in remote localities with the help Community Clinics (CC).

Appendices

Appendix 1

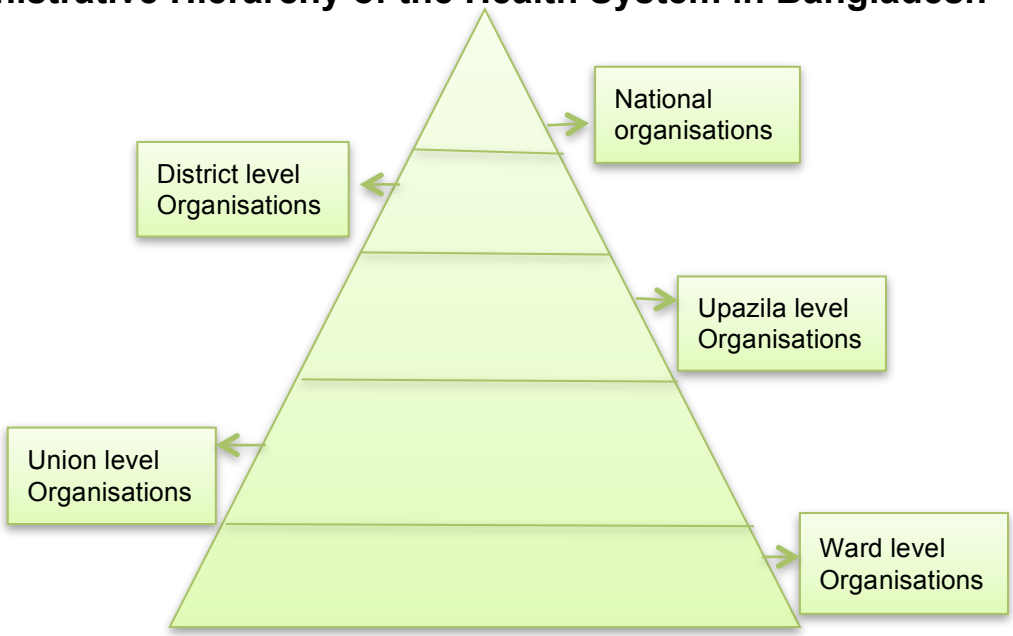
Hierarchy of Personnel in the Ministry of Health and Family Welfare (MoHFW)



Source: Directorate of Health Services (2011, p. 7)

Appendix 2

Administrative Hierarchy of the Health System in Bangladesh



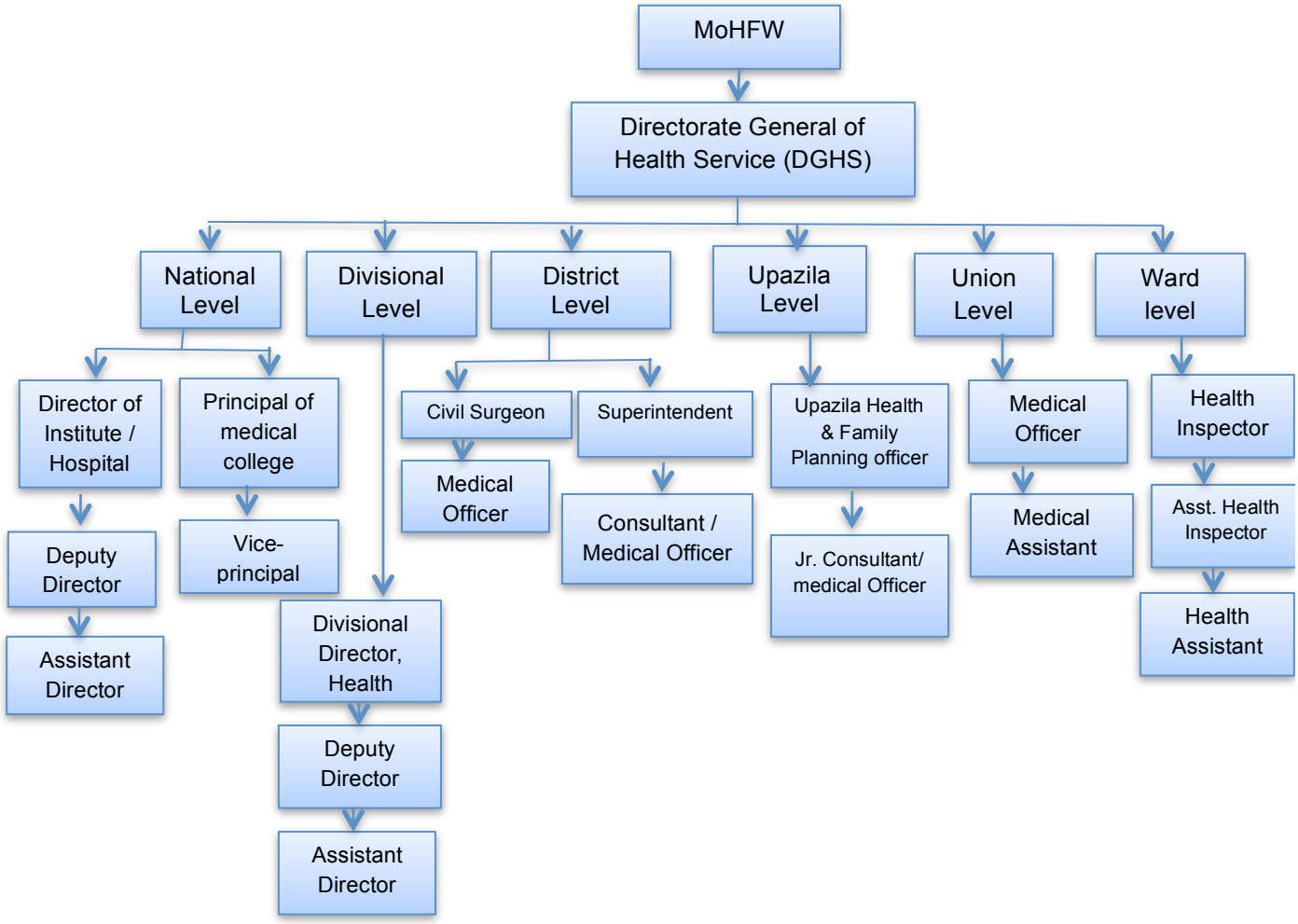
Source: Directorate of Health Services (2011, p. 13)

Notes:

National level	District level	Upazila level	Union level	Ward level
• Medical College Hospital (300-500 beds) • Specialised Hospitals • Post graduate Medical Institutes	• District Hospitals (50-200 beds) • Medical College and Hospital • Specialised Hospital	• Upazila Health Complex (31-50 beds)	• Rural Health Centre • Union Sub-centre • Union Health and Family Welfare	• Community Clinic

Appendix 3

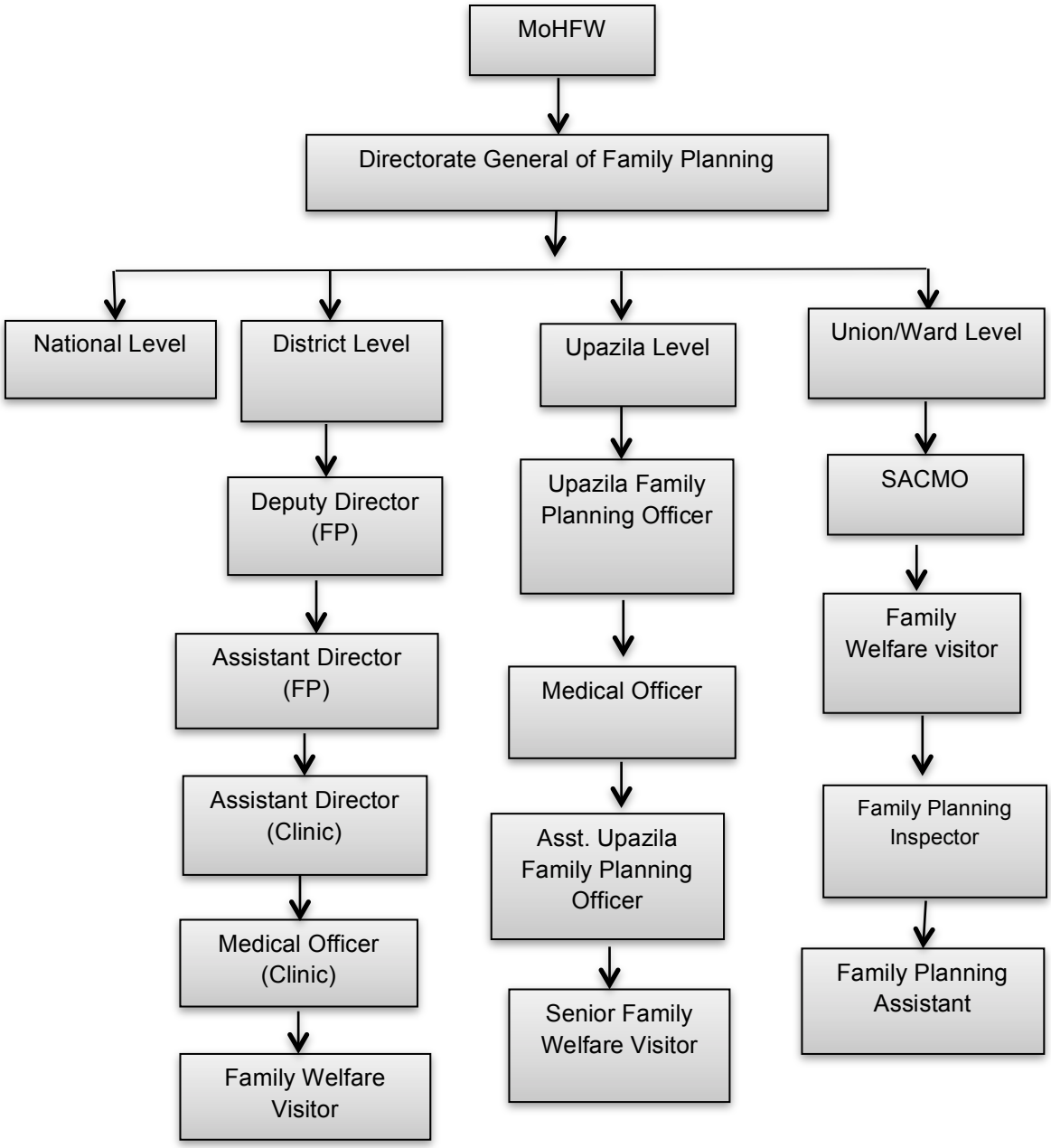
Managerial Hierarchy from National to lowest level under the Directorate General of Health Services



Source: Directorate of Health Services (2013, p. 12)

Appendix 4

Managerial Hierarchies of Family Planning Services in Bangladesh



Source: Directorate of Family Planning 2013

Appendix 5

Major Policies and Programs relating to changes of Health System in Bangladesh (1971 to present)

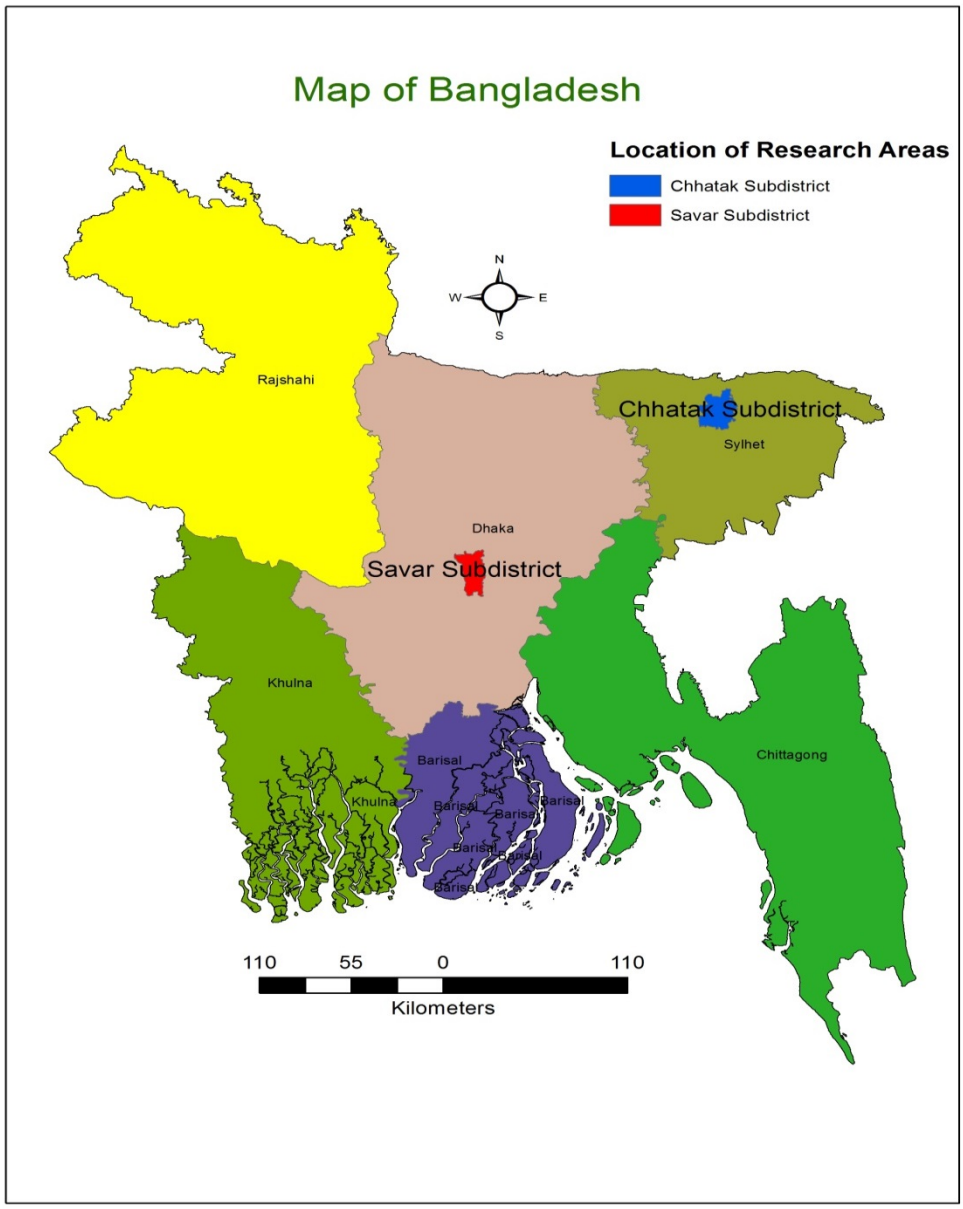
	Objectives/Goals	Major Actions/Innovation	Changes in Health System
First Five Year Plan (1973-78)	The specific goal is to control population; however, the general goal is to provide basic health services to all citizens.	Priority has been paid to population control and has provided minimum healthcare to the entire population. For this, management capacity has been strengthened and training facilities have been expanded to provide effective service delivery.	Special emphasis has been given to capacity building through establishing a Thana Health Complex (THC) (presently known as Upazila health complex) with 31 beds in all rural thanas / upazilas. In addition, medical colleges and hospitals, training institutes and a separate administrative structure of family planning have been set up during this period.
Population Policy (1976)	Integration of population and family planning activities for the purpose of improving living standard and enhancing socio-economic development	Population control to enhance family planning services through clinics and domiciliary workers. In addition, encouraged participation of private sectors and NGOs to promote family planning programs.	Various social and legal measures were undertaken to reduce population growth. A new cadre of female field workers was created to provide domiciliary services, which increased easy access to free of cost health, and family planning services. In addition, partnership-based health and family planning services have been developed.
Second Five Year Plan (1980-85)	Improving infrastructural development in rural areas in addition to reduction of population growth rate.	Health for all by the year 2000 through primary healthcare approach. Public private partnership for health and family planning services were given emphasised.	By the year 1985, THCs in each thana and UHFWCs in each *union* had been constructed. Additionally, private health facilities started to grow rapidly due to flexible rules and NGOs became active partners in many health programs.
Third Five Year Plan (1985-90)	Primary Health Care (PHC) to provide a minimal level of health care to all.	Maternal and child health care were emphasised to provide PHC and to strengthen services in population control.	Emphasis on EPI, control of diarrhoeal disease, vitamin 'A' distribution. In addition, UHCs and UHFWCs were to deliver both family planning and MCH services.
Fourth Five Year Plan (1990-95)	Promotion of reproductive health, human resources and infrastructure.	MCH and PHC services were emphasised	Broader action relating to health and family planning was made during this period in order to develop maternal, child and public health care.
Fifth Five Year Plan (1997-2002) Health and Population	Universal access for the people to essential health care and services of	Priority of resource allocation to an ESP of public health, reproductive health and limited curative care. Family planning wings were	Introduction of ESP to make health services cost effective. Partial unification of health and family planning wings at the thana level and below instead of top to bottom unification.

Sector Strategy (HPSS) (19 August 1997) Health and population Sector Program (HPSP) (The operational plan of SPSS) (1998-2003) Health Policy (14 August 2000)	acceptable quality To further reduce population growth.	united to the Ministry of Health and established one-stop health services to enhance service efficiency and effectiveness. Sector-wise approach was given priority instead of project-driven approach to provide a particular focus on population and health.	All basic services under ESP are being delivered through one-stop service centres at the upazila (UHCs), Union (UHFWC) and partially at the village (community clinics) level.
Health, Nutrition and Population Sector Program (HNPSP) (2003-2010)	Sustainable improvement of health, nutrition, and family planning for the people, particularly of vulnerable groups.	Health sector development through partnership process. Introduction of DSF to provide maternal health services to poor women. Provision of nutritional care in addition to other health service delivery. Continuation of doorstep delivery of services.	Voucher scheme being implemented with provisions for antenatal and birthing care at home and in public or private sector facilities. Health and family planning wings have again been bifurcated and domiciliary services have been reinstated.
Sixth Five Year Plan (2011-2015) Perspective Plan of Bangladesh (2010-2021)	Poverty reduction through access and utilisation of HPN services for every citizen of the country particularly women, child, the poor and disadvantaged	Stronger partnerships with private sector was emphasised to improve the health sector service delivery. A new post of community health organisers was created in each of 13,500 community clinics to strengthen service delivery and create employment opportunities for rural women. Upgrading bed capacity of rural health organisations through providing adequate human resources, drugs and other medical aids. Strengthening urban level hospitals through appropriate HRM and establishing new hospitals under its PPP initiatives. In addition, ESP will be prioritised to the poor urban and slum dwellers for enhancing urban service delivery.	MBBS doctors are deployed to community clinics at union level to access quality health care for the rural people.

Source: Osman (2008, pp.269-271); Planning Commission (1998 p.70); Planning Commission (2011); General Economic Division (2010).

Appendix 6

Location of the two Areas in Bangladesh



Source: adapted from Directorate of Health Services 2013

Appendix 7

Verbal Scripts (For Interview and Focus Group Discussion)

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GPO Box 2100
Adelaide SA 5001

Tel: +61 8 8201-2429
Fax: +61 8 8201-3321

Web address: www.flinders.edu.au

CRICOS Provider No. 00114A

Verbal Script for Interview

I am Mohammad Shafiqul Islam, currently doing research at Flinders University for my PhD degree. My research project examines the impact of governance on health service delivery in Bangladesh. The purpose of this study is to assess the key issues in governance such as accountability, transparency and participation in quality of health care.

You have been selected as a respondent/participant in this research because of your knowledge and experience in the area of the research. Your opinion will be highly valued to conduct this project.

Although every effort will be made to maintain your anonymity and confidentiality in this research, it might not be possible to guarantee the same in cases where the size of the population pools from which participants such as you are selected, is small (for example, members of parliament (MP) and upazila executive officers (UNO)].

I assure you that the information you will provide will be based on your informed consent, it will be regarded as strictly confidential, and it will be used only for this research leading to my PhD thesis.

With kind regards

Mohammad Shafiqul Islam
Student ID: 2058267

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee, Project No.5880. For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

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Web address: www.flinders.edu.au

CRICOS Provider No. 00114A

Verbal Script for Service Users œFocus Group Discussions (FGD)

Health workers at the selected health centres will be requested to inform the health service users about the focus group discussion and state that the key points to be discussed in the focus groups will consist of service users' satisfaction and dis-satisfaction; management, politics and corruption, all of which significantly affect governance and quality of health service delivery. The Health workers will be requested to ask the health service users to voluntarily participate in the FGD with their informed consent. The participants chosen for the FGD will also be informed that the information/opinion given by them during the FGD will be used in strict confidence and only for research purposes leading to the production of my PhD thesis and that the participants' identity will not be revealed in the thesis.

With kind regards

Mohammad Shafiqul Islam
Student ID: 2058267

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee, Project No.5880. For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 8

Letter of Introduction for Respondents in the Study

Associate Professor Gour Dasvarma
Director
Graduate Program in Applied Population Studies
School of the Environment
Flinders University
GPO Box 2100
Adelaide SA 5001

Tel: +61 8 8201-2429
Fax: +61 8 8201-3521
E-mail: gour.dasvarma@flinders.edu.au

CRICOS Provider No. 00114A

Dated: 11.01.2013

Dear Sir/ Madam

This letter is to introduce Mohammad Shafiqul Islam who is a PhD student in the School of the Environment at Flinders University. He will produce his student card, which carries a photograph, as proof of identity.

He is undertaking research leading to the production of a thesis and other publications on the subject of "The Influence of Governance on the Quality of Health Service Delivery in Bangladesh: A Comparative Study of Rural and Urban Health Service Organisations".

He would be most grateful if you would volunteer to assist in this project, by granting your participation in an interview/focus group discussion which covers certain aspects of this topic.

Be assured that any information provided will be treated in the strictest confidence and none of the participants will be individually identifiable in the resulting thesis, report or other publications. You are, of course, entirely free to discontinue your participation at any time or to decline to answer particular questions. Please also note that you have the opportunity to review and edit your response before any report will be produced.

Since he intends to make a tape recording of the interview/ focus group discussion of participants, he will seek your consent, on the attached form, to record the discussion, to use the recording or a transcription in preparing the thesis, report or other publications. He will also deliver participant information sheet and verbal script for participants which carry necessary information, enable you to understand more details about the project.

Any enquiries you may have concerning this project should be directed to me at the address given above or by telephone on +61 8 8201 263 or by email (gour.dasvarma@flinders.edu.au).

Thank you for your attention and assistance.

Associate Professor Gour Dasvarma

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number: 5880). For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 9

Participant Information Sheet

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Fax: +61 8 8201-3321

Web address: www.flinders.edu.au

CRICOS Provider No. 00114A

Participant Information Sheet

Title of the Project

The Influence of Governance on the Quality of Health Service Delivery in Bangladesh: A Comparative Study of Rural and Urban Health Service Organisations.

Researcher: Mohammad Shafiqul Islam, Student ID-2058267, Ph.D Student, School of the Environment, Flinders, University, South Australia.

Information:

1. This study specifically focuses on governance and quality of health service delivery in Bangladesh with reference to rural and urban health service organisations, which will contribute to the enhancement of public health. Moreover, this study will assist national and international organisations who are directly or indirectly involved with policy implementation concerning maternal and child health care in Bangladesh.
2. This research will be monitored by the supervisor based on the regular correspondence between the researcher and the supervisors.
3. Consenting participants will be interviewed on certain aspects of the topic based on the open-ended questions outlined in the interview guide. Participants will not be required to answer all questions in the interview guide, or any question that they choose to decline.
4. The participants will have the choice to remain anonymous or to be identified in resulting thesis, report or other publications.
5. The participants have right to withdraw from further participation at any stage. In this circumstance, the data already provided by them will be withdrawn from the study.
6. In order to conduct this study participants will be requested their willingness to be audio tape recorded to support this research.
7. The duration of Focus Group Discussion / Individual Interview will be one and half hours to two hours.
8. The researched will be contacted via E-mail: isla0016@flinders.edu.au and phone number: +8801719287907(Bangladesh) and +61423069305(Australia).
9. This research will enhance policy suggestions for government and its particular organisations that are responsible for quality of health service delivery. However, the health service users/common people will benefit from the outcomes of this study.

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee, Project No.5880. For more information regarding ethical approval of the project the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.researchethics@flinders.edu.au

Appendix 10

Checklists for Interviews

[**Note:** The list of the checklist is not rigid; it might be modified depending on the situation in the field and appropriate questions will be asked of the respondents (participants) depending on their knowledge about the subject]

Respondents: National level Actors

[Ministry of Health and Family Welfare, Directorate of Health Services, Directorate of Family Planning, Bangladesh, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), Bangladesh Rural Advancement Committee (BRAC), University of Dhaka, National Women Organisations].

Aim of the survey: To examine governance of quality of health service delivery from opinion of central level actors.

Accountability

1. (Only for Government Officials) what policies have been put in place to ensure a health official's accountability? How are these policies expected to impact on quality of health service delivery? In what way can these policies modified to improve health official's accountability?
2. What are the reforms/changes concerning women and child health sector? Do these reform initiatives improve quality of health care? If yes, how? If not, why? Do these reform initiatives promote accountability? If yes, how? If not, why?
3. How should finance be used for the implementation of women and children's health project? What are the mechanisms followed to ensure accountability in using finance? How do they impact on quality of health service delivery?

Transparency

4. Do you think, usage of finance of health care delivery is transparent? If yes, what are the procedures? Are there any weaknesses of the procedures? Please provide example(s). If no, what are the challenges? How does transparency enhance quality of maternal and child health care? Could you please provide suggestions to improve transparency?

Participation

5. In your opinion, what are the areas that should get priority in the health budget? Why? Who are the participants in budget preparation? Do women/women's organisations ensure participation to budget making? If yes, how, which levels? If not, why?
6. Why is there a lack of coordination at the local level? What are their types? Who are responsible? How does lack of coordination affect implementation of partnership based GO-NGO health projects? How can participation be promoted to co-ordinate with health service delivery? How can quality of health services be improved from this participation?

7. (Only for Development partners, NGO and Community organisations) how does participation work for formulation of health policy? To what extent do politics affect health policy formulation? How do politics affect the implementation process? How does bureaucratic complexity contribute to poor quality of maternal and child health care? Please provide evidences.
8. How does the involvement of donors/NGOs enhance accountability and transparency in health projects? How do they enhance community participation? Do you think partnership-based health care enhances quick delivery of services? Yes/No, If yes, how and why? How does it reduce bureaucratic complexity? Is it cost effective? Yes /No? Please provide argument in support your answer. If not, why? Please provide examples and evidence.
9. (Only for NGO) how does good governance work in implementing health projects? Do you visit sub-district/ union levels? If yes, can you tell me your field experiences? What are the outcomes? If you not yet visiting, why? Does good governance promote quality of health care? Please explain.
10. How do the strategies of poverty reduction and women's empowerment promote women's participation in and accountability to health service organisations? How do these enhance health service access to women?

Respondents: Health Professionals and Staff

[*Upazila* (sub-district) and *Union* level Health Service Organisations]

Aim of the survey: To evaluate the impact of governance on quality of health service delivery from demand perspectives.

Accountability

1. In your opinion, how does accountability work in your organisation? What kind of impact do you think it has on quality of health service delivery? What are the factors that make the accountability process weak? Can you see ways that it could be improved?

2. (Only for Medical officer/Family planning officer), Are you able to conduct supervision at *Upazila* and *Union* level health service organisations regularly? Yes/ No? If yes, how do you ensure accountability from your staff? Do you have any problems with supervision?
   If yes, what are the problems of supervision?
   What do you do to resolve them? In your experience, how does accountability improve supervision and quality of health care? If not, why?

3. (Except doctors) there is a feeling that doctors would like to be posted to better areas (i.e. district/ central level)- Is this true? If yes,
   Is this a common feeling? Does it happen a lot? How could this be prevented? How can they be made accountable? How does it affect quality of health service delivery? If yes, how? If no, why?

4. How do NGOs ensure accountability in delivering health services? What are the mechanisms? What are the weaknesses of the mechanisms? Can you provide examples/evidences? How can be NGOs' health activities be accountable to clients/ government?

Transparency

5. Have you received any public complaints during the last six months? If yes, what type of complaints? Give example(s). How do you deal with the public complaints? What are the official procedures for this? What are the limitations of official procedures? Do you think dealing with public complaints helps improve service delivery? How does transparency resolve public complaints?

6. What are the methods to inform people about the health services from you/your office (e.g., Is there a service charter?)
   Are people well informed about this? How is this information transmitted to the public? Is it sufficient? Have you any other sources? Has this charter improved delivery of services? Could you please tell me briefly how information technology ensures transparency in delivering services?

Participation

7. Why do women's opinions seem to be less significant in promoting service delivery? How does women participation enhance health service delivery? What initiatives can be improved in women's participation? Do you think that women's participation of rural and urban health services are different? If so, what factors make this difference? Please provide a short description.

8. Who are the communities that participate in health programs? Why are poor communities unable to participate? How does participation of poor communities improve quality of health care?

9. How does decision-making happen relating to (specific area of person e.g., Doctors, nurse, family planning staff)? How is it working? Could it be improved? How? How is feedback from clients incorporated into the decision-making?

10. Do you feel you are able to deliver your services freely?
    Do you have any pressure (from anyone) that influences the way you deliver services?
    How do they influence you? Why do you think this happens? How are you approached/ contacted? Could you please provide information with example?

11. Do you think health service delivery can be improved through the GO-NGO partnership process? If so, what factors make this improvement? What is different from the solely government-driven health care (e.g., cost, time, access)? How does accountability work in GO-NGO partnership-based health service delivery? Could you please explain how the lack of coordination affects GO-NGO health project?

12. Can you provide any evidence about the improvement of service delivery (e.g., quality of services, quicker services, easy access, cost efficiency etc.) for the last two years? If yes,
    What are the improvements?
    How does it happen?
    What factors have made this improvement?

Respondents: Elected Representatives

[Members of Parliament, *Upazila* chairmen and vice-chairmen, UP chairmen and members]

Aim of the Survey: To examine how governance promotes or limits quality of health service delivery from the opinions of the elected officials.

13. In your opinion, how do health professionals perform their duties and responsibilities? Are you able to ensure their accountability? If yes, how? If not, why? What are the reasons of poor accountability? How can be accountable them to people/organisation?

14. Are you able to participate to health service organisations/health programs in your locality? If yes, how? If not, why? How do you participate to decision making on organisational activities?

15. In your experience, how NGOs contribute to women and child health care? Do you think NGOs activities are participative? If yes, how and why? If not, how they work? How can be NGOs accountable to client/government? Please provide the exact evidence with examples.

16. Could you please provide information on how the following challenges affect quality of health services? (a) Organisational conflict (b) Lack of coordination (c) Poor supervision, How do these challenges limit accountability in health service delivery?

17. In your opinion, do the local people participate in women and child health care schemes? If so, at what stage(s) do they get involved? How do they participate? Are they able to share views/opinions? Yes/No, how or why not?

18. Why lay people have limited participation to health organisation? How does it affect quality of health care? How can be improved people's participation to health organisation?

19. Can you provide any evidence how corruption works in the women and child health care? How do you play role for anti-corruption? How can be strengthen community based organisations/ civil society organisations / general people to curb/ reduce corruption?

20. Do you think GO-NGO partnership based health services are better than solely government driven services? If yes, what are the reasons? If not, why? How does accountability enhance cost efficiency and accessibility of GO-NGO health care delivery? Give concrete examples.

21. Why the service providers (doctor, nurse, health worker) serve differently between the rich and poor people? How it works to your locality? Why it happens? How do poor accountability and transparency contribute to service inequalities? Could you please provide examples?

22. What are the reasons of gender inequality in providing quality of health services? Do you think male role is dominated in decision-making? If yes, why? How do women opinions work in decision-making? How can be women empowered to reduce inequality in delivering health services?

23. Do you think that poor people are excluded from health policy/ health activities? If yes, why? If not, how they participate? How does exclusion of poor people increase corruption to health sector? How poor people can be empowered to fight against corruption?

24. How does Community Clinic (CC) contribute to service efficiency (reduce time, cost and labour)? How it works to your locality? How does participation work to CC? Does it promote health service delivery? If yes/ not, Please give supportive arguments.

Respondents: Other Local Informants

[Political Party Leaders, Business Leaders, NGO Official, Medical Representatives, Local elites, Journalists, Committee Members, Women organisers, Community Groups]

Aim of the survey: To understand the effect of governance of quality of service delivery from supply side of perspectives.

25. Do you think health professionals ensure their accountability? If yes, how does accountability work? If not, what are the reasons for poor accountability? How can there be accountability for health professionals? What are the good outcomes of accountability?

26. How do service charters work within the health service organisations? Do you think they are important mechanisms to promote transparency? Are there any mechanisms to inform people regarding health services? Are people well informed about health facilities? If yes, how? If not, why? How can transparency be promoted to health organisations? Please provide example(s).

27. Do local people participate in health programs? If yes, who are the communities that participate to health programs? At what stage(s) do they get involved? How do they participate? What are the impacts of people's participation on quality of health care? Are they able to share views/opinions? Yes/No, If yes, how, if no, why not? Can you provide any evidence/example where have effective people's participation? If not, why do you think so?

28. What is the nature of relationship between elites and general people in society? How does this relationship work in delivering health services? What are the limitations for getting good quality services? How do politics and elite influence work in delivering health services? How does accountability ensure political change and reduce elite influence?

29. Do you know (if any) of any mismanagement in the process of health services? If so, what type of mismanagement? How does it happen? What are the factors responsible for this? How does accountability reduce mismanagement? Give an example. How does transparency improve quality of health care? Please provide example/evidence. How can participation promote good management of health service organisations?

30. What is the role of the main opposition party in local health service delivery? Does the opposition party get a chance to share their opinion on implementation of health services? If so, how do they participate? If not, how does participation work? Why?

31. Do you think that health service delivery can be improved through implementing GO-NGO partnership process? If so, why do you support this? How do GO-NGO partnerships work in this locality for promoting quality of health care? If you are disagree about partnership, why? What are the main weaknesses of solely government-driven services? Could you please explain how the lack of coordination affects GO-NGO health activities?

32. In your experience, how do NGOs contribute to women and children's health care? Do you think NGOs activities are participative? If yes, how and why? If not, how do they work? How can NGOs be accountable? Please provide the exact evidence with examples.

33. Why do women's opinions seem to be less significant in promoting maternal and children's health care? How does women's participation enhance quality of health care? What are the mechanisms that can be improved in women's participation? How does women's participation work at the rural and urban level? Why is there a difference? What factors make this difference? Please provide a short description. If women have not participation, why? Please explain.

34. Do you think that poor people are excluded from health policy/health activities? If yes, why? If not, how do they participate? How does exclusion of poor people increase corruption in health sectors? How can poor people become empowered to fight against corruption?

35. How does Community Clinic (CC) contribute to service efficiency (reduce time, cost and labour)? How does it work in your locality? How does participation work for CC? How does CC empower the community? Does it promote health service delivery? If yes/ no, give supporting arguments.

36. Could you please provide your experiences of how and why the following ideas work within the health service organisation? a) Underused (means the organisation and its resources are not used appropriately e.g., health organisations are used at limited time) b) Overused (means the health professionals' guidelines is not appropriate e.g., unnecessary advice, medicine) c) Misused (means mismanagement e.g., corruption, irresponsibility).

Appendix 11

Checklists for Focus Group Discussions (FGDs)

Respondents: Health Services Users at Upazila, Union Parishad and NGO level (FGD)

Aim of FGD: To understand governance and quality of service delivery from the community views.

37. How many times (for the last one year) have you visited the *Upazila/UP/NGO* health complex? Were you able to receive appropriate health services? What is your perception about the behaviour of the doctors/ nurses/ technicians/health workers? In your opinion, how do they provide services to people?

38. In your opinion, how do the health officials perform their duties? Could you please describe your level of satisfaction and dissatisfaction with health service delivery?

39. (This question is for UP/NGO level respondents) How many times (during the last three months) have health officials visited your locality? What are the methods to communicate with them? How do health officials deal with your problems? How do you/people get benefit from the field level staff? Can you give an example?

40. Do you know what type of services (e.g., medicines, x-rays, doctor services) are available at Upazila/ Union/NGO health centre? How do you know about the services? Are the service providers (doctors, nurses and health workers) accountable to health service users? If not, how can they be made accountable?

41. Do you/people participate in health service delivery? If not, who participates? Why do ordinary people/service users not participate? What could be the methods of participation? How can people's participation promote health service delivery?

42. Do you think the Upazila/Union/NGO health centre provides adequate/quality health services? If not, what are the problems/shortcomings (e.g., modern machines, useful medicine, specialist doctors, nurses). Can you provide some suggestions to improve health service delivery at Upazila/ Union/NGO health centre?

43. Are all people able to access health service equally? If yes, how? If not, why? Can you differentiate the nature of services between poor and rich people? What factors are responsible for this? What initiatives can promote equality in delivering services?

44. Have you observed any corruption at Upazila/ Union/NGO health Centre? If yes, what is the nature/type of corruption? Who is involved in corruption? How does it happen? Please give a concrete example.

45. (Only for Upazila level respondents) how does the patronage process work to gain better health care from the Upazila health complex? Why do you

need this patronage process? How do you observe the activities of middlemen for service delivery? Could you please explain your experience? Could you please explain how the influence of the local elite works for health service delivery?

46. How do gender inequalities work in health service organisations? How can women be empowered to promote quality of health service delivery?

Appendix 12

Lists of Respondent Used in this Thesis

(12a)Participants at the National Level

Type of participants	Organisations	Designations (Titles of positions)	No. of Respondents
Govt. official	Directorate of Health Services	Deputy Director (Health Education)	1
Govt. official	Directorate of Family Planning	Deputy Director (Finance and Field Services)	1
Govt. official	Planning Commission (Health Wing)	Joint Chief Officer	1
Senior Official	ICDDR, B	Manager (governance) Program Director	1
Community leader	Bangladesh Women's Association	Program Director (Advocacy)	1
Researcher	Bangladesh Institute of Development Studies (BIDS)	Senior Research Fellow	1
Faculty member	Dhaka University	Professor of Public Admin.	1
Senior Official	Transparency International Bangladesh	Deputy Program Manager	1
Total			**8**

Source: Field Data (2013)

(12b) Health Professionals

Designation	Organisations	Savar	Chhatak
Upazila Health and Family Planning Officer	Upazila Health Complex (UHC)	1	1
Residential Medical Officer	UHC	1	-
Medical Officer	UHC	-	1
Junior Consultant (Gynaecologist)	UHC	1	-
Junior Consultant (Child Specialist)	UHC	1	-
Family Planning Officer	UHC	1	1
Senior Staff Nurse	UHC	1	1
Sub Assistant Community Medical Officer (SACMO)	UHC	1	1
Pharmacist	UHC	1	1
Ward Boy	UHC	1	1
Medical Technologist (EPI)	UHC	1	1
Medical Technologist (X-ray)	UHC	1	1
Medical Technologist (Lab)	UHC	1	1
Family Planning Visitor	UHC	1	1
Assistant Family Planning Officer	UHC	1	-
Store Keeper	UHC	1	-
Medical Officer/Sub assistant community medical officer	Union Sub Centre (USC), Savar/Kalarukha	1	1
Health Inspector	USC	1	1
Family Planning Inspector	USC	1	1
Family Planning Visitor	USC	-	1
Family Welfare Assistant	USC	1	1
Health Assistant	USC	1	1
Total		**20**	**17**

Source: Field Data (2013)

(12c) Elected Representatives

Type of Respondents	Organisations	Designations (Titles of positions)	Savar	Chhatak
Member of Parliament	Constituency of Savar and Chhatak	Politician	-	1
Vice-Chairman (women)	Upazila Parishad	Local Leader	1	1
Chairman	Union Parishad (Savar and Kalarukha)	Local Leader	1	1
Ward Member	Union Parishad (Savar and Kalarukha)	Elected Representative	1	1
Total			**3**	**4**

Source: Field Data (2013)

(12d)Other Local Informants

Type of Respondents	Organisations	Designation (Titles of positions)	Savar	Chhatak
Political Party Leader (Local Wing)	AL/BNP	President/Secretary	-	2
Bangladesh Women's association (local wings)	Bangladesh Mohila Parishad	Secretary	1	-
Business Leader	Chamber of Commerce	President	1	1
NGO Officials	BRAC/GK	Manager/Health workers	2	2
Govt. Administrator	Upazila Administration	Upazila Executive Officer	1	-
Medical	Square Pharmaceutical	Sales Promotion	1	1

Representative	Ltd.	Officer		
Social Elite	Committee of Concerned Citizen/Village leader	Social Worker	1	1
Journalist	Local Newspaper	Reporter	1	1
Total			**8**	**8**

Source: Field Data (2013)

(12e)Participants of focus group discussions in the study

Name of Focus Group	Type of Respondents	Number of participants
Group 1	Health Service Users, UHC (Savar)	7
Group 2	Health Service Users, UHC (Chhatak)	7
Group 3	Health service users (UP sub centre, Chhatak)	9
Group 4	Health Service Users (NGO provider, Chhatak)	8
Group 5	Health service users (NGO provider), Savar	8
Total	**All groups combined**	**39**

Source: Field Data (2013)

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