

**Politics and Governance
in the Social Sectors in Bangladesh,
1991-2006**

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SUMMARY

Bangladesh has made impressive gains in poverty reduction and social and human development since 1991 although these achievements are increasingly overshadowed by rising concerns about quality and equity in social service provision. The achievements also contrast sharply with worsening governance over the period. This odd pairing of development success with governance failure has given rise to the so-called Bangladesh ‘paradox’: how were pro-poor development achievements possible, given the poor state of governance?

The paper addresses this question through a review of the evidence on a) safety nets for the poor; b) primary and lower secondary (or basic) education; and c) publicly-provided healthcare services. For each sector, it sketches the main achievements and challenges of service delivery and analyses the key political and administrative issues, with an emphasis on evaluating the impact of corruption, leakage and accountability. The paper concludes by drawing together lessons from across these sectoral experiences. These include that a) achievements of the social sectors during 1991-2006 were substantially achievements of expanded access, which were politically popular; b) progress on improving service quality was limited, reflecting the need for stronger commitment required to address politically difficult governance problems that determine institutional performance; c) evidence about the extent of corruption across the social sectors is uneven and may create a distorted picture of where the substantive governance weaknesses lie; and d) formal accountability institutions do not work – at least not as expected. However, ‘rough’ forms of accountability – from individual complaints and lobbying through social networks, to collective protest and the threat of mob violence – help fill the accountability deficit left by the failures of formal mechanisms to empower citizens to participate in an unregulated and unpredictable way.

One implication of the findings is that governance conditions sufficient to support the achievements of the 1990s will not support reforms slated for the 2000s. Programmes of expansion remain politically popular. They are also administratively more feasible than the deeper institutional changes needed to improve accountability and transparency in the system. Governance conditions have been less conducive of reforms targeted at improving quality and equity in the first half of the 2000s. So while weak governance did not necessarily impede Bangladesh’s social sector achievements in the 1990s, already by the 2000s there were clear indications that deeper institutional and broader governance reforms would be necessary for these gains to be extended or even sustained.

INTRODUCTION: DEVELOPMENT SUCCESS AMIDST GOVERNANCE FAILURE

Why has Bangladesh done well on human development and poverty reduction, while so signally failing to establish adequate governance conditions? How well did Bangladesh really do, and how will weak governance affect further progress? Finally, how did politics contribute to or impede gains in the social sectors?

This paper attempts to answer these questions, through an exploration of Bangladesh's social sector in the period between 1991 and 2006, during which the country experienced its first extended period of multiparty democratic rule. It sets out the achievements in social protection, basic education and health, and describes the main policies and programmes in the social sectors during the period. It goes on to explore how politics (including the perceptions of policymakers, partisan competition, interest group lobbying and patronage politics) and governance conditions (in particular corruption and accountability) shaped the delivery of services between 1991 and 2006.

The Bangladesh paradox

Bangladesh has made impressive gains on indicators of social and human development and poverty reduction, particularly since the return to multiparty rule in 1991. Most of these gains represented the rapid expansion of social services over the decade of the 1990s and early 2000s. The pace of poverty reduction also sped up in the first half of the 2000s. Other gains included the achievement of gender parity at primary and secondary school; rapid declines in infant and under 5 mortality rates, and a narrowing of the rural-urban gap in infant mortality; declining fertility rates; high immunization coverage; and some reduction in the severity and extent of malnutrition (BIDS 2001; World Bank 2003b; World Bank 2005; Deolalikar 2005).

While poverty, vulnerability and deprivation remain severe and widespread, the 1990s saw progress being achieved at such a pace that by the 2000s, Bangladesh compared favourably on some indicators with other countries in the region, and with others at comparable levels of economic development (Table 1). Bangladesh relatively recently compared well against countries with similar income levels in terms of the proportion of public spending going to the social sector (World Bank/ADB 2003). In terms of its MDG targets, however, recent World Bank reports suggest Bangladesh will fail targets on child malnutrition,

universal primary enrolment or completion, and maternal mortality (World Bank 2007).

Table 1. Social sector performance compared to the region and low-income countries

Indicators (based on most recent estimates)	Bangladesh	India	Pakistan	Sri Lanka	Low-income countries
Poverty headcount ratio at PPP\$1 a day	36	35.3	17	5.6	..
Under 5 mortality rate per 1,000	69	87	98	15	122
Ratio of girls to boys in primary and secondary education	106.8	88.5	71.1	102.8	87.2
Primary completion rate	73.3	80.9	..	98.2	71.5
% of population with access to improved water source	75	86	90	78	75.1
Fertility rate (births per woman)	2.9	2.9	4.5	2.0	3.6

Source: World Bank 2006a

Public policy, particularly the rapid expansion of government services and the space allowed NGO activity played a critical role in the achievements of the 1990s (World Bank 2003b). A significant indicator of government commitment to the social sectors was that the share of public spending going to the social sectors rose through the 1990s (Sen 2000; BIDS 2001). These expansionary policies will be discussed in more detail for each sector below.

Challenges in the 2000s

The rapid expansion of the 1990s came with and sometimes exacerbated problems of inequitable access and poor quality of services. Since the late 1990s, there has been a chorus of calls for quality reforms, including within the Poverty Reduction Strategy Paper (PRSP) (Government of Bangladesh 2005); some actions have been taken that suggest a sharpening of the poverty focus of services. But many key reforms in the social sector have remained unimplemented or off the policy agenda entirely. The first half of the 2000s was to some extent a period of stagnation, featuring policy reversals in health, and a slow start to the big sector programme in primary education. Secondary education and

social safety nets fared better, although there was mounting concern about politicisation and corruption in both.¹

Failings in the governance of the social sectors specifically are reasonably well-documented; there is consensus that progress could have been faster in the past and that social policy challenges that persist will require some deep institutional - or governance - reforms. Recurrent concerns include that the flow of new resources that enabled the expansion may have come at some cost of higher corruption; that interventions used in the expansion may have had detrimental effects on quality; and that mechanisms for establishing accountability, particularly between users and providers of services, are weak or failing.² At the point of delivery, service improvements are increasingly recognised to involve complex challenges of reorienting professional incentives and organisational cultures to make teachers, doctors and local officials more accountable to those they are supposed to serve.³

It is too early for a full evaluation of social progress in the first half of the 2000s. But a growing body of evidence suggests that social sector performance – whether judged in terms of expanded access, policy implementation, and improvements in quality – was less impressive in the first half of the 2000s than in the 1990s. This stagnation accompanied or possibly reflected a declining governmental emphasis on the social sectors and pro-poor spending during the first half of the 2000s, compared to the trend of the previous 10 year period.⁴

¹ Problems with quality and governance had been early on identified in the *Education Watch* report series by CAMPE. Both the special issues of *Economic and Political Weekly* (February 4, 2004) and the *Journal of Developing Societies* (vol. 21 (1-2), 2005) devoted to exploring Bangladesh's poverty reduction and human development achievements discussed concerns to do with governance, quality and equity in service provision.

² The literature on the different sectors is referenced in the following sections. There is a large body of literature intended to assess need, support policy design, and evaluate impact and performance of the social sectors. The literature is dominated by the World Bank, although other donors also commission or undertake studies. Some of these are at least nominally jointly sponsored by Government, which also commissions some evaluations, often from the Bangladesh Institute of Development Studies. NGOs and civil society organisations, in particular TIB and CAMPE, have also produced a large body of research, primarily focused at the point of service delivery.

³ The best example of a social policy problem requiring deep-seated reforms is maternal mortality, on which progress has been slow, and on which faster improvements require more comprehensive institutional reforms within the public sector. The evidence suggests that Bangladesh is not likely to meet this particular Millennium Development Goal without significant institutional reforms (see World Bank 2007; Bangladesh Health Equity Watch 2006).

⁴ This trend is most clearly documented in Al-Samarrai 2006 for basic education; see also World Bank (2006c) on the declining emphasis on social

Also by the 2000s, debates about developmental performance in general, not just in relation to the social sectors, were increasingly slotted into debates about the state of governance in Bangladesh. The key features of what has widely been seen as a governance crisis were understood to include the failures to achieve a peaceful political process or establish the rule of law, and connected conditions of systemic political and administrative corruption. Formal accountability institutions throughout the system typically fail due to politicisation. On the plus side of the scale, Bangladesh enjoys an attentive, active media and civil society, effective NGOs, and a politically engaged population. Through numerous informal means, these actors helped ensure some degree of rough accountability was attained during the 15-year period of multiparty rule.⁵

How these issues of weak governance have affected poverty reduction and human development has been a matter of considerable concern and interest in Bangladesh. The lack of fit between Bangladesh's human development achievements and its weak formal governance institutions and processes was articulated by the dominant donor in Bangladesh, the World Bank, as the 'Bangladesh conundrum' (Country Assistance Strategy 2006).

This paper attempts to address questions that arise out of this odd pairing of pro-poor development gains with bad and worsening governance. Focusing on social safety nets, basic education and public healthcare provision, it explores some of the political and administrative factors that drove pro-poor development achievements in the 1990s and since. It also reviews evidence on corruption, leakage and accountability in the social safety net, basic education and health sectors, in an attempt to understand how failures in these areas affect service provision on the ground.

The paper concludes with a discussion of the broader implications of these findings, including the point that governance conditions sufficient to support the achievements of the 1990s may not support reforms slated for the 2000s. Programmes of expansion were – and remain – politically popular. They are also administratively more feasible than the deeper institutional changes needed to improve accountability and transparency in the system. Governance conditions have been less conducive of reforms targeted at improving quality and equity in the first half of the 2000s. So while weak governance did not necessarily impede Bangladesh's social sector achievements in the 1990s, already by the 2000s there were clear indications that deeper institutional and broader

safety nets; World Bank 2003b on reversals in health policy; World Bank (2005; 2007) on overall progress towards the MDGs.

⁵ A version of the present paper was a contribution to the first annual State of Governance in Bangladesh Report (BRAC/CGS (2006), which documents the evidence on governance in Bangladesh, 1991-2006.

governance reforms would be necessary for these gains to be sustained and extended.

The paper is in four sections. The following three sections review the evolution of policy in the public social safety net, basic education, and health sectors since 1991. Each is followed by a discussion of the evidence on corruption, leakage and accountability. The last section draws together the major findings from each sector, and concludes with a discussion of the broader implications, particularly with respect to the relationship between governance and social sector provisioning.

SOCIAL PROTECTION

The proportion of the population living in poverty is estimated to have declined by 9% over the 1990s: by 2000, 50% of Bangladeshis were defined as poor, down from more than 70% during the 1970s. By the same measures, the proportion of the extremely or absolutely poor also declined by around 9%, reaching 34% by 1995-96. It then declined by less than a percentage point over the period until 2000. Other measures suggest 20% of the population was poor in 2000 (World Bank/ADB 2003). More recently, figures from the 2005 Household and Income Expenditure Survey suggest the pace of progress accelerated in the 2000s, with poverty estimated to have reduced by nearly 10% between 2000 and 2005 (BBS 2006; Table 2).

Table 2. The reduction in income-consumption poverty over the 1990s (%)

		HIES 1991-92	HIES 1995-96	HIES 2000	HIES 2005*
Food intake method	Poor (consuming less than 2205 kcal per day)	..	48	44	..
	Extremely poor (consuming less than 1805 kcal per day)	..	25	20	..
Cost of basic needs method	Poor (upper poverty line)	59	51	50	40
	Extremely Poor (lower poverty line)	43	34	34	25

Source: Food intake method figures from BRAC 2004; cost of basic needs method figures from World Bank/ADB 2003 and *BBS 2006

Recent analysis of poverty dynamics in Bangladesh shows that while poor households can increasingly help themselves out of poverty, the circumstances which start the downward slide are frequently beyond their control (Kabeer 2004; Sen 2003). Social protection measures remain vital in such a context, to support the poor and vulnerable in crisis and help them to manage risks, usually to prevent deeper impoverishment (Shepherd, Marcus and Barrientos 2004). In Bangladesh, much informal protection has been provided through local patronage politics and semi-formal institutions of governance (Blair 2003; Hossain and Matin 2006). But there is clearly a case for public social safety nets to cover more of

the chronic poor, and to reduce excessive economic inequalities which incur wider social costs and impede (pro-poor) growth (Ravallion 2003).

Political commitment to social protection

Successive governments of Bangladesh have showed commitment to the provision of public safety nets targeted to the poor and vulnerable people. The provision of social protection in the form of a minimum level of food security for the poorest is an important determinant of political legitimacy, at both local and central levels in Bangladesh (Hossain 2005). There are sound historical reasons for the close connection between mass food insecurity and political legitimacy. The 1974 famine was a turning point: until that time, food security had largely meant subsidies to the politically organised and vocal middle class urban groups. A vital lesson donors and government officials drew from the 1974 famine was the urgent need for targeted food aid programmes to protect the poor (Attwood *et al.* 2000). At the same time, the bloody coup and political upheaval that followed the famine and economic crisis of the mid-1970s taught the political elite that famine symbolized political failure of the most unambiguous kind.⁶

Despite strong political incentives since 1974, it is only comparatively recently that large-scale programmes targeted to the poor and vulnerable have dominated the social protection agenda or its budget. A second turning point was with the return to multiparty democracy in 1991, which was followed by a shift towards targeted programmes and away from food subsidies to the relatively privileged middle class former beneficiaries of government rationing programmes. The shift in focus away from the urban middle classes and towards the rural poor has been supported by innovations in targeted food aid programmes, driven by governments headed by both major parties.⁷ One successful, much-discussed innovation is the stipends for poor primary and girl secondary school students.

However, there is no simple relation between political commitment to safety nets for the poor and democracy; it was under unelected military rather than popular democratic rule that the Vulnerable Group Feeding (VGF) programme was established in the 1970s. And democratic governments have been as likely as their authoritarian predecessors to be criticised for tolerating systematic corruption in food aid programmes as a means of rewarding their supporters.

⁶ A fascinating account from the perspective of a then government insider and observer of the famine is Islam (2003).

⁷ Key accounts of the process and politics of food aid reform are in Ahmed *et al* 2000, in particular chapters by Chowdhury and Haggblade and Attwood *et al.*

More recently, targeted safety nets received heightened prominence in the PRSP, as one of four 'Strategic Blocks' for tackling poverty. The PRSP stresses that this is not a 'relief mentality', but a 'net-and-ladder' approach to addressing risk, providing social protection specifically to support a process of graduation out of poverty. The portfolio of social safety net programmes was assessed as 'robust', responsive, and innovative, although problems were identified, including lack of coordination, limited coverage, inadequate resource transfers, lack of attention to gender and finally, targeting and leakages. Minimising the number of intermediaries involved in the distribution of safety net resources, and improving their accountability were flagged as issues worth considering (GoB 2005:58-9;120-7).

Depending on their definition, there are 27 safety net programmes in Bangladesh at present. Table 3 lists the types of programmes categorised as social safety nets in Bangladesh. In terms of budget and coverage, the two education programmes are by far the largest. Whether or not these fall under the category of social protection is, however, another issue. As both will be discussed in the next section of this paper, neither are looked at in much detail here. However, the Food for Education (FFE) programme, replaced in 2003 by its cash version, the Primary Education Stipend Programme, will be discussed below in the section on corruption and leakage, as it has featured in a number of key discussions about food-based safety net programmes. The next biggest programmes are the Rural Infrastructure Development Programme (Food-for-Work or FFW), and Vulnerable Group Development (VGD), with respective beneficiaries of around 1 million and 500,000 annually, and budgets of US\$40 million each. FFW and another large safety net programme, the Rural Maintenance Programme (RMP), both focus on rural infrastructure and employment for the vulnerable poor. In the case of FFW, this is focused around the relief of seasonal unemployment. The RMP, an 18-year partnership between the government and CARE, targeted poor women exclusively.

Allowances in the form of cash transfers for the most vulnerable poor, including elderly, widowed and abandoned women, and the disabled poor, have been established, starting in 1997. While the Old Age and Widows programmes were established under the Awami League government of 1996-2001, its BNP-led successor retained and extended their coverage, and added the Disabled Allowance. While the cash transfers involved are small (around Tk 180 or US\$2.75 per month), the regularity of these cash payments make them a valuable source of support for these groups (Begum and Paul-Majumder 2001). More than one million elderly, and around 100,000 widows and another 100,000 disabled poor people receive these allowances each year.

Table 3. The main types of safety net programmes in Bangladesh

Type	Programme
Cash transfers	Old Age Allowance Widowed and Distressed Women Allowance Disabled Allowance
Conditional cash transfers	Primary Education Stipend Programme (formerly Food-for-Education) Stipends for Female Secondary Students
Public works or training based cash or in kind transfer	Rural Maintenance Programme Food-for-Work Vulnerable Group Development (VGD)
Emergency or seasonal relief	Vulnerable Group Feeding (VGF) Gratuitous relief Test Relief

Aside from whether or not they are sufficiently well-funded to reach enough of those who need support, the impact of safety nets is largely a function of a) how effectively they target the vulnerable and/or poor groups in greatest need; and b) the extent of corruption and leakage in the distribution of the benefits.

Leakage and corruption

The common assumption that corruption is widespread in official safety nets has good historical roots in the tradition of theft from the Public Food Distribution System (PFDS): grain dealers, local political leaders and administrative officials were all understood to have enjoyed an impressive cut from the rationing programmes in this system. The level of corruption was so high that when rationing programmes were finally withdrawn in response to evidence of extensive corruption and pressure from donors, there was no protest from the supposed beneficiaries, who had in fact been benefiting very little (Chowdhury and Haggblade 2000; Adams 1998).⁸ Until its reform in the early 1990s, features of the PFDS supported and institutionalised corruption: for example, in 1989 MPs were brought in to select the grain dealers to participate in *pally* rationing, which they took as a clear signal to use the resources for 'patronage and graft' (Chowdhury and Haggblade 2000:173).

Research-based evidence of corruption in the current system of targeted public safety nets is mixed, however. The source of the most influential evidence of extensive corruption and leakage in safety net programmes is the World Bank. The other significant bodies of research are those by

⁸ Corruption was also rife in the relief programmes of the 1970s (see Hartmann and Boyce 1983).

IFPRI, whose findings are of considerably more modest levels of leakage, and the Bangladesh Institute of Development Studies (BIDS). Below we briefly review the evidence on two programmes: Food for Education (FFE) and Vulnerable Group Development (VGD).

The short life of the FFE programme began in 1993, when the government launched the programme to transfer wheat to targeted poor households whose children met a set of primary schooling conditions. The objective was to encourage poor households to send their children to primary school. FFE was also intended to improve the targeting of government food subsidy programmes, an intention shaped by IFPRI research that had shown that local authorities were effectively able to target the poor (Ryan and Meng 2004:3). Accordingly, the ward Primary Education Committee and School Managing Committee (SMC) were jointly responsible for the selection of poor beneficiaries at the local level. The selection of the poor unions, within which all schools that met a set of criteria were to be eligible, took place in Dhaka. At its peak, the FFE reached more than two million students across 112 *upazilas*.

As a case study of the impact of research on policy, the FFE is of moderate interest, and will be looked at here in some detail.

Table 4. Estimates of leakage in the Food for Education (FFE) programme

FFE leakage estimates	Source
7%	Ahmed and Billal 1994
30%	BIDS 1997
“does not contribute much to the overall cost”	World Bank 1998
up to 75%	World Bank/ADB 2003
14-17%	Ahmed and del Ninno 2002

Estimates of leakage in the FFE programme have varied dramatically depending on the source and period. As Table 4 summarizes, estimates of leakage and corruption were far lower in IFPRI research than by BIDS and the World Bank. A BIDS survey found leakages to be in the region of 30%, inadequate selection of beneficiaries, and no important positive impacts on schooling (BIDS 1997). Concerns about the negative impacts on school quality from the administrative burden on teachers of FFE encouraged the government to implement a BIDS recommendation to distribute FFE resources through grain dealers in 1999. This took place despite previous experience that grain dealers were usually closely implicated in corruption in safety net programmes.⁹ Even higher

⁹ It is possible that it was not so much grain dealers as it was grain dealers associated with opposition political parties whom the Government aimed to undermine through the 1991 food aid reform.

estimates of leakage were arrived at in analysis of the 2000 Household and Income Expenditure Survey (HIES) by the World Bank, which reported that as much as 75% of resources allocated to the FFE reached no households, implying losses to leakage or corruption.¹⁰ Most of this, it was suggested, was due to 'considerably lower' numbers of beneficiaries than the records indicated (World Bank/ADB 2003:75).

These estimates of extremely high leakage were useful to the World Bank, in that they had a major influence on the government's decision to abolish the FFE and monetize the benefits, as recommended by the Bank. There were, however, widely acknowledged concerns about the methodology used to arrive at these estimates (Ryan and Meng 2004:10).¹¹ It is worth noting that the World Bank's most recent statement on safety nets takes a more qualified stance on the issue, noting 'mixed evidence' of leakage (World Bank 2006c:22-3), although previous estimates have not been revised.

The politics of beneficiary selection

Decentralized beneficiary selection is known to involve the trade-off of better information about who is really poor against more scope for local elite capture of the benefits. In this section we look briefly at what the evidence suggests about the politics of beneficiary selection in one relatively well-documented case, that of the Vulnerable Group Development (VGD) Programme. The case highlights features of local

¹⁰ Among other places, this figure was reported in World Bank/ADB 2003. A version of the analysis was later published as Murgai and Zaidi (2005).

¹¹ The World Bank assessment was based on the nationally representative 2000 HIES, in which households were asked how much food grains they had received in the previous 12 months from the VGD, FFE and other food aided programmes. Problems with this methodology include the problem of recall, the time-frame under consideration (this would need to be adjusted to take into account programme cycle issues), and reliance on self-reporting (a common enough practice in surveys of this kind), and the fact that the sample was not representative of either VGD or FFE beneficiaries. VGD and FFE were both targeted to poorer and rural areas. Only 25% of upazilas were covered by FFE at its peak, and around half of all VGD beneficiaries were from only one-fifth of all unions. However, the 2000 HIES provided for rural-urban analysis and comparison between divisions, and is not representative at upazila or union levels. As the distribution of VGD and FFE beneficiaries is not evenly distributed across the Bangladesh population, the population-based sampling weights that the World Bank study used to estimate the total number of beneficiaries and average grain receipts are unlikely to have been appropriate. It is not impossible that the 'blown-up' estimates of the numbers of household participating are roughly accurate, but they are extremely unlikely to have provided estimates as accurate as those of a sample survey of programme beneficiaries.

politics that influence how effectively and directly the benefits reach the poor.

VGD emerged as a food aid-supported development programme targeted at very poor women in the mid-1980s, after a brief incarnation as a relief programme, starting in 1975. It is a national programme, reaching some 500,000 women per year. Participants selected by local government representatives participate in an 18 month programme involving a monthly wheat ration and training, savings and income-generating inputs, principally from NGO partners. Evidence indicates that VGD has been effective in terms of targeting the poorest women and in helping many 'graduate' from relief to participation in mainstream development (Halder and Mosley 2004; Hashemi 2001).

A review of the relevant literature suggests that where bias and corruption are successfully controlled in the VGD programme, it is because formal and informal accountability pressures help keep local politicians in check.¹² Formal pressures include regular WFP monitors and the close scrutiny of beneficiary lists by NGO partners. There are also informal political pressures that mitigate unbridled corruption or overt leakage, including:

- As VGD programme areas contain high proportions of food insecure households, many of whom are eligible for selection, beneficiary selection takes place under close community scrutiny.
- Sympathies for very poor and/or young widowed mothers may strengthen the moral case for fair selection processes (the VGD programme targets this group) (Matin and Hulme 2003).
- Proper implementation of programmes for the poor – as distinct from other programmes - may make good political sense in rural areas with a high concentration of poor people. Even local leaders who are willing to divert resources from road-building or construction projects may seek to show their good leadership by ensuring resources intended for the poor reach the poor (Hossain 2005).
- Local political leaders face such consistent pressure to provide for the poor in their roles as factional leaders or patrons that they may use official safety net resources to reward their poor supporters.

Political bias and corruption in the selection of VGD beneficiaries is widely reported (Mannan and Paul-Majumder 2003; Bode 2002; Hopley 2003; Matin and Hulme 2003). Such findings contrast, however, with another body of research which has shown that the VGD is effectively targeted to poor women (BBS 1992; WFP 1999; del Ninno 2000; Webb *et*

¹² Undertaken as a background paper on 'The Politics of What Works', for the Second Chronic Poverty Report.

al 2002). But the selection process can be both biased and target the poor, as long as the bias works in favour of poor supporters.

The biggest targeting challenge faced by most safety net programmes in Bangladesh is exclusion: the scale of need dwarfs provision. What this means is that all selected beneficiaries may be eligible, while many more are excluded – perhaps even 90% - despite their eligibility (World Bank 2003a; Matin and Hulme 2003). This ensures that political competition and selective patronage can carry on without any formal corruption or bias against the poor. The more problematic issue then arises if the same poor people are included repeatedly, and less well-connected poor people are left out.¹³

Recent research into local party politics in two *upazilas* undertaken as part of the State of Governance report project suggests that relief goods and safety net resources (VGD, VGF, old age and widows' allowances) distributed by *Union Parishads* roughly followed a formula of distribution to each of the following:

1. Needy eligible people,
2. Eligible poor or vulnerable people with good political connections or votebank potential, and
3. Ineligible, often wealthy people with local political influence or relations.¹⁴

Recently completed research into the politics of beneficiary selection¹⁵ in the government's Old Age and Widowed/Abandoned Women's Allowance schemes also suggest a similar political formula is followed. Arguably, this represents a political settlement in which political representatives seek to use public resources intended for the poor to a) demonstrate concern for the poor; b) build their own political capital as well as that of their party; c) finance party or personal political activity; and d) serve personal and family interests.

¹³ Staff on BRAC's CFPR-TUP programme, which aims to target an even poorer group than that reached by VGD, consider the difference between the two ultra poor groups to be that those who do not get selected for the VGD programme usually have weaker social capital and political connections.

¹⁴ Draft research report by Mrinmoy Samadder, researcher on the Local Party Politics research project in 2006, entitled 'The local politics of development in two *upazilas*'.

¹⁵ Undertaken by BRAC Research and Evaluation Division with support from the Chronic Poverty Research Centre, Manchester University. The research comprises a survey of 6500 people eligible for government allowances for the elderly and widowed or abandoned and community-based analysis of social networks and lobbying in the schemes. The purpose is to understand the process of beneficiary selection, in order to shed light on the mechanics of targeting and leakage in social safety nets.

How the shares are allotted between these three groups is a matter most likely to be determined by how effectively programme leakage and targeting is monitored, as well as by the local politics of poverty in the area. Evidence has shown that prospective beneficiaries have a greater chance of joining the VGD programme if they are vociferous and articulate—if they are in a position to make it politically costly to exclude them. VGD participants exert considerable agency in their selection: Matin and Hulme found women actively lobbying local elites and NGO staff to be selected (2003), while in another site, those who failed to be selected were told their turn would come: ‘persistent expression of demand by applicants played a very important role’ (Ahmed *et al.* 2004:96).

Questions of accountability are clouded by the fact that VGD - and other safety net programmes administered by local elites - are firmly part of the local political-patronage system in Bangladesh. Calls for more stringent targeting and less partisan bias in selection processes fail to recognise that while this would remove the political advantages of the programme from those who implement it, it may likely reduce their incentives to prevent leakage or to implement it properly. Thus, enforcing more selection discipline may reduce programme efficiency, a case of ‘more for the poor means less for the poor’ (Gelbach and Pritchett 1997; see also Pritchett 2005). The challenge then is to design programme selection mechanisms that accommodate or do not directly conflict with the motivations and other incentives facing local administrators.¹⁶

Curiously, the World Bank has recently recommended reforms to public safety net programmes in Bangladesh on the grounds of ‘weak capacity to both administer and monitor the system – often leading to leakages and inefficient targeting of beneficiaries’. Rather than advocating strengthening the accountability mechanisms in service delivery, ‘outsourcing’, possibly to the private commercial sector, is recommended (World Bank 2006c:37). This preference does not take into account a) the overwhelmingly negative experience with private sector food grain dealers in food aid programmes to date; or b) the extent to which local accountability pressures may be effectively exerted on local authorities under the present system.

¹⁶ Galasso and Ravallion (2000) found that where targeting was successful in the FFE programme, this was because of processes within communities, rather than targeting of poor areas from the centre. Targeting from the centre could result in non-poor households being selected if these happened to be the poorest in wealthy areas.

EDUCATION

The expansion of educational access

The expansion of primary education enrolment was the great social policy success story of the 1990s. The policy elements of the primary education expansion story are by now familiar:¹⁷

- The 1990 Jomtien conference stimulated political commitment; the Education For All (EFA) plan focused on a massive community mobilisation thrust.
- Both democratic governments of the 1990s drove the expansion, in part the result of party political competition over the content of the curriculum and the popularity of the expansion policy.
- Massive investments in schools and teachers: over one 5-year period in the 1990s, an additional million school places were created every year.
- Innovative demand-side programmes like the FFE from 1993, replaced by the cash-based Primary Education Stipend Programme (PESP) in 2002, which successfully attracted poor children to school.
- Planning and overall direction was highly centralised, but space was permitted for non-state providers; NGOs were able to enlarge their own provision of pioneering non-formal schools and simultaneously acted as a competitive spur to the government to maintain the pace of expansion in the formal system.
- Donors proved willing to finance the expansion of a sector which enjoyed strong domestic commitment and was a cause they could support; in particular, the General Education Project (GEP; 1992-7) united multilateral and bilateral donors to strike an effective balance of support and donor coordination without reducing national government ownership.

¹⁷ See Hossain, Subrahmanian and Kabeer (2002) and Hossain and Kabeer (2004) for a fuller account of the politics of the expansion process.

Table 5. Primary and secondary educational enrolment in Bangladesh by gender, 2000s

Primary (2005)						Secondary (2003 and 2005) (Class 6 to 10)					
Total enrolments		Gross enrolment rate (%)		Net enrolment rate (%)		Total enrolments (Class 6 to 10)*		Gross enrolment rate (%)*		Net enrolment rate (%)	
Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys
8.1	8.1	96	91	90	85	5.2	4.6	69	60.2	50.6	39.6
million million						million million					
16.23 million		94		87		9.8 million				45	

Sources: Primary: DPE (2006); secondary: *total enrolments are for 2003, from BANBEIS (<http://www.banbeis.gov.bd>); gross and net enrolment rates are for 2005, from CAMPE (2006)

Supporting conditions included positive attitudes towards mass education among policy and civil society elites, and a strong predisposition among ordinary Bangladeshis to invest in their children's education as the best prospect for social mobility. A civil society 'watchdog' in the form of the Campaign for Popular Education (CAMPE) has provided a critical monitoring role since the late 1990s, in addition to independent information and analysis on education sector performance through its annual *Education Watch* reports.¹⁸

The expansion meant that gross enrolment rates almost doubled in the first 30 years of independence. In 2005 there were more than 16 million primary school places - in theory enough for the entire school-aged population - in addition to more than 2 million children enrolled in NGO schools. Taking into account enrolment outside the official system, the primary gross enrolment ratios exceeded 100% as early as the mid-1990s (CAMPE 1999), and gender disparities in enrolment are now in favour of girls. The expansion of enrolments at primary has also fed the growth of secondary. Table 5 summarises the enrolment situation in primary and junior or lower secondary (class 6 to 10). Bangladesh now boasts one of the largest primary school systems in the world.

The expansion is widely recognised to have come at a cost to quality, which by the late 1990s was squarely on the policy agenda. CAMPE's 2000 *Education Watch* report confirmed what many suspected:

¹⁸ See Unterhalter, Ross and Alam (2003) for an overview of the impact of research on education policy in Bangladesh. Civil society activism on education appears to have blossomed in recent years, with the promising emergence of the *Sushikkha Andolon* - a 'movement for quality education' - which plans to publish *Halkhata*, an annual report on the state of primary education.

educational attainments were abysmally low, with less than one per cent of Bangladeshi children growing up with the basic competencies as defined by the national curriculum (CAMPE 2000). The PRSP confirmed the new priority of quality, outlining concerns that included CAMPE's finding that one-third of children completed primary without functional literacy and numeracy skills (GoB 2005, citing CAMPE 2002). Nor have concerns about access fully disappeared: low enrolments among children from urban slums and ethnic minority communities and boys from ultra poor households demonstrate that access is by no means universal (CAMPE 1999).

The donor response has been twin-track: the two major externally-financed development programmes after GEP, Primary Education Development Programmes (PEDP) I¹⁹ and II (1997-2003; 2003-9) both aimed to improve access and raise quality. PEDP I suffered from its own internal governance problems, including poor donor coordination,²⁰ and the ongoing PEDP II was initially slow in starting implementation, although progress appears to have been more rapid. Other recent projects include the World Bank's Reaching Out of School Children (ROSC) project, which addresses access for the most disadvantaged children; the WFP School Feeding Programme, which aims to improve learning capacities through nutritional inputs; and ESTEEM, which focused on improving school and system management.

Secondary attracted far less attention during the 1990s, despite impressive progress in participation over that decade net enrolment rates are estimated to have risen from 33% in 1998 to 45% in 2005 (Table 4; CAMPE 2006). The major success in secondary has been girls' educational achievements, and girls' net enrolment now outstrips that of boys by more than 10 percentage points (CAMPE 2006). In 2003, Khandker *et al* estimated that girls' participation had increased by 13% per year since 1994, compared to only 2.5% for boys (2003).

The most important factor behind this achievement is the intervention known collectively as the Female Secondary Stipends project. Starting in 1994, after a pilot initiative in the early 1980s, all girls in rural *upazilas* across the country who meet a set of minimum requirements are eligible

¹⁹ PEDP I was a collection of 25 donor and government projects, amounting to US\$750 million, half of which was externally financed. External financing has risen for PEDP II, with US\$654 million of the budgeted US\$1.815 billion from donors. The budget for ROSC is US\$ 58 million; the recently completed School Feeding Programme was budgeted to spend more than US\$30 million, including food aid. Information on education programmes are from summary data published on the Education sub-group of the Local Consultative Group website (www.lcgbangladesh.org/education).

²⁰ See Sedere (2000) for an insider's account into the shortcomings of PEDP I.

for cash scholarships and tuition-free education,²¹ under four (later five) different projects, three with donor financing. The evidence suggests a number of important impacts, including delayed marriage among girls (Arends-Kuenning and Amin 2000) and rising enrolment among girls (Khandker *et al* 2003). However, Mahmud (2003) notes that systematic impact assessment has not taken place, and that there have been some contradictory effects, including declining examination performance and continuing high rates of dropout among girls. The positive impact on attitudes towards girls' education from signals from government about the high value it places on girls' education through the scholarships scheme is, however, identified as a major step (Mahmud 2003; Hossain and Kabeer 2004).

Documentation and research into the secondary sector has been less extensive than at primary. The World Bank's 2000 sector review identified the sector's strengths as including expanded access, gender parity, and the flexibility associated with private management (the overwhelming majority of secondary institutions are in the private sector), including scope for resource mobilisation. The weaknesses were understood to include the relevance of the curriculum; equity of access and outcomes; low learning achievement levels, poor examination results, and high dropout and repetition rates; inadequate incentives to improve quality and ineffective management and supervision arrangements (World Bank 2000).

In both primary and secondary education, raising quality is increasingly seen as a matter of improving the governance of the education sector. PEDP II is not centrally focused on governance, but failures to take the weakness of existing accountability mechanisms into account have been identified as a source of potential risk to its implementation (Wood *et al* 2003). By contrast, the US\$100 million Education Sector Development Support Credit agreed by the World Bank in 2006 has as its central aim addressing governance issues. It aims to address accountability (linking school subventions to performance, strengthening SMCs) and equity; to devolve implementation and introduce better monitoring and evaluation; and to raise teacher quality through certification and improve the transparency of textbook production (World Bank 2006d). A number of key actions against corruption in education were also taken during the first half of the 2000s:

- the closure of the Department for Non-Formal Education in 2003 after evidence emerged of the failure of the Total Literacy Movement,

²¹ Amounts range from Tk. 25-60, depending on year; school fee waivers; and lump sum payments of Tk. 250 in classes IX and X to cover exam costs and books. Students need a) to be unmarried; b) attendance records of at least 75%; b) to score 45% in school tests.

also reports that NGOs contracted under the 'Hard-to-Reach' Project were 'briefcase (i.e. fake) NGOs',

- a clampdown on leakage in both stipends programmes, including through closer adherence to the performance and attendance criteria, and
- a new certification body for secondary school teachers was introduced. This should reduce the scope for cash-for-jobs that prevails in the previously unregulated non-government secondary schools. It may also have knock-on effects by making SMCs less attractive as business options.

While it is too early for a full evaluation of performance in the 2000s, emerging evidence suggests performance in the 2000s has been considerably less impressive than in the 1990s. Al-Samarrai (2006) found that total enrolment in primary stagnated in the 2000s, with enrolment in recognised government and non-government primary schools declining by 13% between 2001 and 2005, and reported enrolment in madrassas more than doubling during the same period. This development gives rise to questions about why madrassas have become relatively attractive compared to either government or NGO schools over this period; this appears to be particularly the case for poor boys.

At secondary level (classes 6-10), total enrolment increased in the 2000s, but there were signs of a slow down by 2003. This may have been the impact of declining enrolment at primary level. In terms of educational achievements in basic education, a smaller proportion of children were completing school by the end of the period than during the 1990s. The share of the government budget devoted to basic education also stagnated over the period, although it continued to increase in absolute terms. Bangladesh devotes a slightly higher share of the government budget to basic education than other countries in the region, although this is comparatively low as a share of national income. But in absolute terms, government spending per student has increased over the period (Al-Samarrai 2006).

Corruption and leakage in the education system

Ahmed's (1998) comprehensive review of the 'crisis in governance' in education in the 1997 Independent Review of Bangladesh's Development, noted corruption as a side issue, focusing instead on the administrative and political roots of the crisis. But by the 2000s, problems in the education system were increasingly viewed as rooted in governance, and governance was increasingly glossed as 'corruption'. The media gave extensive coverage to research activities that uncovered evidence of bad governance and corruption. High profile reports on corruption at this time included:

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- TIB's 'Report Card' survey and 2002 and 2005 Household Surveys, which reported findings of illegal fees; bias and leakage in the selection and implementation of the FFE programme; and bribery and delays in service provision by education officials (Karim 2004),
 - TIB's Corruption Database Reports (2004, 2005) findings that education ranked as a 'most corrupt' sector in terms of frequency of media reports of corruption, and
 - The World Bank's analysis showing up to 75% leakage from the FFE programme (World Bank/ADB 2003; as discussed above).

These reports and studies were enormously successful in terms of raising awareness about the general problem of corruption in education. They were not designed to, nor did they substantially improve our understanding of how corruption occurs, nor of its impact on service delivery. At the same time, there were concerns that their methods may overestimate the extent of some forms of corruption, while effectively ignoring others. We saw above that concerns about the World Bank analysis have rendered their estimates of the (massive) extent of corruption in the FFE suspect. The limitations of the TIB 'Report Card' work are different: the apparent reliance on unsupported attitudinal data, while not in itself a problem, means the results can only reasonably be interpreted as findings about reported corruption, and not of corruption per se.

Similarly, the frequency of media reports of corruption (the TIB Database method) suggests that education comes under closer scrutiny by the media than other, less accessible sectors. It does not necessarily follow that education is one of the most corrupt of these sectors, in terms of losses to the public purse or bribes from the public. Corruption in education may be more obvious because more people have daily contact with schools than with land administration authorities, for example. Another factor may be the enormous popular interest in school authorities since the introduction of the cash stipends. Reliance on perceptions, it should be noted, means more attention is given to individual experiences. While this is important in its own right and as an advocacy tool, forms of corruption which are less easily perceived or researched – in infrastructure procurement and contracting, for example – have not received as much attention.

Research into school management systems has also been undertaken, in an effort to provide a more contextualised and detailed understanding of the mechanisms by which corruption and leakage occur. CAMPE (2005) found a widely corroborated belief, including among education officials, that corruption featured in the construction and repair of primary school buildings; this finding has serious implications for the large-scale classroom building planned for PEDP II (Wood *et al.* 2003). The CAMPE

study also found that illegal fees were charged, including for textbooks. This practice was, however, situated in the context of inadequate and uncertain maintenance and administrative budgets: illegal fees were described as ‘creative ways’ of mobilising local resources to cope with the routine shortfall (2005: 54). Contextualising illegal fees in this way avoids demonising what are undoubtedly often constrained school authorities, helping to explain the practice in a policy-relevant manner. That school authorities are not legally permitted to raise local funds may thus contribute to and legitimise these additional charges.

Large-scale qualitative research undertaken in 2006 also attempted to develop a fuller understanding of how corruption and leakage work in the education system. The Social Sector Performance Qualitative Study (SSPQS) explored findings of a series of nationwide public expenditure tracking surveys in health and education (the Social Sector Performance Surveys, conducted in 2004 and 2005).²² Taking into account the perspectives of different actors, the SSPQS study provides a more detailed picture of the mechanics and processes of some forms of leakage and corruption in the education sector. This evidence suggests that some types of corruption are indeed institutionalised within the system, but there are others against which action has been taken.

In order to understand the evidence on corruption in a way that permits more meaningful understanding of the scale of the problems and its implications, we will take a closer look next at corruption in the stipends programmes and teacher appointments procedures.

The stipends programmes

Public concern about corruption in the Primary Education Stipends Programme (PESP) runs high, no doubt because of the ethical dimensions of theft of resources intended to encourage poor children to attend school. There are similar concerns about the Female Secondary Stipends Programmes (FSSP), and indeed, the two types of programme are not always clearly distinguished, including in some of the published literature. The main concerns appear to be about a) beneficiary selection; b) resources (now exclusively cash) being diverted away from beneficiaries; and c) beneficiaries being charged illegal payments in return for receiving benefits.

²² These were public expenditure tracking surveys that covered the primary and secondary education and the health and family planning sectors, undertaken as part of the ongoing DFID-funded Financial Management Reform Programme (FMRP) with the GoB Ministry of Finance. The qualitative follow-up study to further explore some of the governance dimensions of the SSPS findings was undertaken in 2006 (FMRP 2007) and involved research with nearly 600 stakeholders in 18 facilities in 9 districts across Bangladesh.

A closer look at how both of these stipend programmes operate in practice suggests, however, that lack of transparency about the programmes should be a key concern. Misunderstanding and lack of accurate information about the programme feeds both perceptions of corruption and its practice.

One common misunderstanding about the stipends programme is that either or both of them are exclusively targeted to the poor. At secondary level, it is not only the poor but all unmarried girls who meet attendance and performance criteria in qualifying schools who are eligible for stipends. At primary level, the PESP is not targeted to the 40% poorest students as is widely believed, but in effect to the 40% poorest students in each qualifying rural school. This means that even when selected correctly, not all beneficiaries will necessarily be poor, particularly in the wealthier areas. At the same time, many poor students in poor areas will also be excluded, even if the selection is accurate.

While the lack of targeting by poor area may explain some of the large ‘targeting error’ – the fact that many recipients of the primary education stipend are not poor – it cannot explain it all. Another complicating factor is that poverty is only one of the criteria for receiving the primary stipend; there are also performance and attendance criteria. Focus group discussions and interviews with students, parents, teachers and SMC members as part of the SSPQS study identified a conflict between selecting ‘meritorious’ students able to meet the academic and attendance criteria on the one hand, and poor students on the other. This, it seems, is frequently resolved in favour of the more educationally-inclined among the *madhyabitta gorib* – the moderate or middle poor.

A second little-known fact about the primary stipends programme is that primary schools frequently receive less funds from Dhaka than they have claimed for their stipend beneficiaries. Schools are then required to adjust the stipend amounts to meet the shortfall. This has at least three serious governance implications. Firstly, perverse incentives are set up with respect to student attendance and performance, as it is students who are supposed to receive the full amount of Tk. 300²³ whose payments are most likely to be reduced. Secondly, parents have good reasons to distrust teachers, whom they suspect of ‘eating’ the shortfall in the stipend money. Third, transparency is reduced, as the scope for community-based scrutiny is affected by unclear and changing criteria on which the distribution of resources is decided. Where corruption is actually occurring, this is hard to detect.

²³ Students receive the stipend for those months in which they have qualified in terms of attendance and enrolment.

One issue worth raising here is that research which only measures leakage in terms of the gap between what official project documents state will be distributed, and what beneficiaries actually receive will not be able to identify this issue. At least some of what looks like corruption from outside a system is likely to involve a deviation from officially recognised practice which is not documented, even if it has become standard procedure. Often these deviations occur because the programme is under-funded, as in this case and in the case of VGD as discussed above.

A third reason to believe findings about illegal charges overstate the extent of corruption is that there is some ambiguity about deductions from the secondary stipends: a routine practice is to deduct 'exam fees' or 'session charges' from stipends. Implications of this are that when informal payments for stipends are reported, they may include these deductions. Whether students and parents present this as corruption or not may depend on how the question is framed. But even if these practices are innocent, the ambiguities they introduce into the system both increase the scope for concealing corruption and the perception of corruption.

The SSPQS research, undertaken in mid-2006, also identified a widespread belief that corruption and irregularities in the stipend programmes had declined as a result of clamping down by central government (apparently starting in the two years previous to 2006). There was objective support for this view, in the form of improved provision for supervision and monitoring (monitoring officers at district level; AUEOs now cross-check attendance and examination scores); the eligibility criteria relating to performance and attendance have been re-publicised, and adherence tightened up by the authorities; and parents have become more aware about the purposes and requirements of the programme. The number of beneficiaries in the secondary stipends programme declined by some 60% over 2002 and 2003. The role of the media in preventing this form of corruption was highlighted by an *upazila* education official interviewed for the qualitative research who bluntly explained: 'no head teacher wants his face in the paper for taking money from students.'

One issue which further clouds the matter of corruption is the sensitive issue regarding the extent to which parents and students are complicit in practices that subvert programme goals. At secondary, both the practice of registering 'ghost' students, who do not actually attend school, and that of false certification of student eligibility for receiving the stipend may involve some student collusion (FMRP 2006b). This seems to represent the bigger problem in terms of extent. The finding that good schools were involved in helping students to cheat is, perhaps, a related governance problem (CAMPE 2005).

Teacher appointments

Concerns about governance and school quality are linked with concerns about corruption in teacher appointment. Despite the perception that corruption in the system of recruiting teachers is systemic and generalised, discussions with officials and teachers suggest that there may be considerable variation within the sector in terms of the extent, severity and impact of corruption. Overall, it seems to be a less common problem in the government schools compared to non-government schools.²⁴ At primary, 'unfair means' in recruitment of the government teachers has reportedly become more difficult since 1997, when the present process was established. About 75% of marks in the recruitment process are now based on an anonymous test on which it is reportedly difficult to cheat (unless others are brought in to take the test), and 25% of marks are allocated for the viva, which means that bribes to the viva board do not guarantee a post, as the final decision depends on the combined score. Bribe-givers who fail to gain posts can expect to have their bribes returned, suggesting that the system of corruption is weak: the payment is for being considered as a candidate, rather than an assurance of a post (which the viva board cannot guarantee).

By contrast, the rapid expansion of education appears to have had negative impacts on the integrity of SMCs: reports of payment being accepted in exchange for posts²⁵ are routine in both primary and secondary non-government schools. It is clear that there are SMCs in which members' principal interest is in the potential material and political gains; many sector insiders see this as a growing phenomenon (World Bank 2006d, Annex D). Again, an ambiguity arises in cash-strapped non-government primary and secondary schools, in which corruption in appointments merges almost imperceptibly into a school fund-raising exercise, exploiting the authority to accept community and private contributions. The practice appears to be particularly well-entrenched in non-government secondary schools. The new centrally-administered examination/certification process for secondary teachers seems to be a response to realistically widespread concerns about corruption in teacher appointment at secondary.

The main impact of corruption in appointment lies in the extent to which the quality of entrants into the service is believed to be compromised. This varies: sector insiders believe that despite corruption, the government schools recruitment procedure remains highly competitive, because of high application numbers and because the written test weeds out the weakest candidates. But teaching quality is clearly compromised,

²⁴ Findings from the SSPS surveys for primary and secondary supported the qualitative research findings on this point.

²⁵ Official oversight is provided in the form of final approval of a shortlist of candidates being made by the *Upazila* Education office.

particularly in non-government secondary schools and *Dakhil madrassas*, where common complaints are that teachers are not trained in the subjects they teach.

Accountability: the changing face of SMCs

One point that emerges from this discussion is that lack of transparency and information provides rich nourishment for perceptions of corruption. An interesting side-effect of the stipends programmes, which has probably been strengthened by TIB's successful advocacy work, is that parents and the wider community have become more engaged in scrutinising the activities of school authorities now that they handle cash resources intended for the poor. One teacher interviewed for the FMRP qualitative study complained that, 'The way people abuse chairmen and members, that's how they abuse teachers now.' That is, people now assume teachers are corrupt, just as they assume local politicians to be (FMRP 2007). Responsibility for stipend disbursement has had negative consequences for teachers, whose collectively high status and previously unassailable respectability has taken a serious knock. On the positive side, this may reduce the social gap between poor parents and teachers, bringing the practicalities of holding school authorities to account within closer reach.

Where they have been shown to function, Parent-Teacher Associations (PTA) have a positive impact on school performance (CAMPE 1999; FMRP 2006b); however, in the main, they exist on paper and play little role in the management or governance of schools (CAMPE 2005). Why is parental participation in schools so limited? One explanation is that there is a reasonable flow of information between schools and parents, through formal and informal channels, including school visits. Unschooling parents may not have additional ideas about or expectations of their children's schools that they would wish to articulate in a PTA. However, it seems clear that PTAs can only under specially supportive circumstances enable poor parents, particularly women, to work through the social hierarchies of gender, class and social differences that govern the relations between themselves and teachers (which persist, although the gap may be diminishing), as well as those between themselves and School Managing Committees (SMC).²⁶

It is widely acknowledged in the literature that SMCs play an important role, and that they are relied on much more to deliver good school governance than would be the case were PTAs not so weak (Wood *et al.* 2003). Where SMCs are led by respected individuals who are responsive to their communities' needs and motivated by civic purpose, this is all

²⁶ For evidence that women can be more involved in school management with support, see ESTEEM's action research report (ESTEEM 2004).

well and good (Nath *et al.* 2004). But field-level education officials plainly feel SMCs are an anachronism, a throwback to a time when there were few educated villagers and authority was unquestionably concentrated in the hands of the traditional landed elite. SMC headship was then a position of respect, an honorary function associated with social leadership. The expansion of the school system, the diversification of the rural elite, and the infiltration of party politics into all levels of public institutional life have changed this context. SMC headship is now prized as a rich source of political capital: SMC headship is sought among those thinking of reviving or establishing a political career (FMRP 2007). There is of course also scope for corruption, with rents routinely earned through control over appointments and construction contracts, particularly in the weakly regulated non-government secondary schools and *madrassas* (World Bank 2006d).

However, the growing role of local political competition in SMCs is not all bad in terms of its impacts on school performance - regardless of whether or not it constitutes good governance. CAMPE makes a sensible, safe case for de-politicising school management, but the FMRP case studies suggested that while an element of competition over the governance of a school may be a good thing, both too little and too much competition could be detrimental. The better schools, including those in which improvement was most rapid, tended to be those in which SMC management was a matter of local political interest. But where competition had descended into conflict and featured individuals involved in corruption and criminality, this had paralysed school development plans, and little progress was made. By contrast, where there was no competition over the SMC, this tended to signal either the headteacher's monopoly of authority, or a lack of local initiative with respect to the school (FMRP 2007).

HEALTH

Achievements in health since the 1990s

Bangladesh has performed relatively well on a number of key health indicators since the 1990s (Table 6). The infant mortality rate fell rapidly during the 1990s, and is currently lower than in India, although Bangladesh has only half the per capita income of India (World Bank 2005). While the child malnutrition rate remains one of the highest in the world, impressive gains have been made, particularly since the late 1990s (World Bank 2005; Deolalikar 2005). After almost a decade of stagnation, the 2004 Bangladesh Demographic and Health Survey found that the total fertility rate had declined to around 3.0, so that Bangladesh had a lower rate than Nepal, Cambodia and the Philippines, but was higher than India, Indonesia and Vietnam (NIPORT 2005). While improvements in the maternal mortality rate is one Millennium Development Goal Bangladesh is not likely to meet (World Bank 2007), there have been rapid recent gains in access to antenatal care: half of women received some type of trained antenatal care in 2004 compared to one-third in 1999-2000 (NIPORT 2005).

Despite these improvements, significant inequalities still exist, and progress in key areas has been disappointing. Bangladesh's child malnutrition and maternal mortality rates remain among the highest in the world, and access to safe motherhood care is skewed towards the better-off. The public sector plays the predominant role in financing and provision, and it is the only source of modern care affordable by the rural poor. But there is growing evidence that the vulnerable people have poor access to public health services, particularly maternal health services, even though these services are nominally free or subsidized (MOHFW 2005; Osman 2004a). There are distinct differences between regions and between ethnic and socioeconomic groups in access to services (Chowdhury *et al.* 2002 on immunization; World Bank 2005 and 2007 on other health service inequalities). There are also signs of reversal: access to sanitation increased in rural areas from 11% in 1990 to 29% in 2002, but in urban areas access actually fell from 71 to 56% (World Bank 2007).

While economic growth and declining poverty levels play a part in overall health status improvements, the expansion of public and NGO health services targeted towards the poor and public health more generally

appear to have been critical factors driving these gains.²⁷ However, the overall quality of health service both in the public and private sectors is low and uneven. Poor management, sub-optimal location and staffing, the lack of accountability of government staff and inadequate provision of medical supplies lead to low quality services, particularly at the *upazila* and union levels (World Bank 2003e; World Bank 2005c).

Table 6. Selected health indicators, 1991 – 2005

Indicators	1991	1996/97	2003	2004-05
Infant Mortality Rate (per 1,000 live births)	92 (Fifth Five Year Plan 1997-2002)	77 (Fifth Five Year Plan 1997-2002)	66 (IMED 2003)	65 (BDHS 2004)
Under-5 Mortality Rate (per 1000 live births)	---	116 (Fifth Five Year Plan 1997-2002)	94 (IMED 2003)	88 (BDHS 2004)
Maternal Mortality Rate (per 1,000 live births)	5.7 (Fifth Five Year Plan 1997-2002)	4.1 (Fifth Five Year Plan 1997-2002)	3 (IMED 2003)	3 (BDHS 2004)
Life expectancy at birth (in years)	56 (Fifth Five Year Plan 1997-2002)	60 (Fifth Five Year Plan 1997-2002)	60 (IMED 2003)	62.8 (Human Development Report 2005)
Total Fertility Rate (per women aged 15-49 years)	4.3 (Fifth Five Year Plan 1997-2002)	3.3 (Fifth Five Year Plan 1997-2002)	3.3 (BMMS 2001)	3.0 (BDHS 2004)
Delivery care by trained personnel (in %)	---	8 (Fifth Five Year Plan 1997-2002)	12 (IMED 2003)	13.4 (BDHS 2004)
Percentage of fully immunised children (at 12 months)	--	46.9	56 (Streatfield et al 2003)	73 (BDHS 2004)
%of Under 5 Underweight	----	Moderate 35.7 Severe 20.6 BDHS 1996/97	Moderate 34.8 Severe 12.9 BDHS1999/2000	Moderate 34.7 Severe 12.8 BDHS 2004

Source: Streatfield et.al (2003), Health and Population Sector Programme 1998-2003; IMED (2003), Ministry of Planning, GOB, Health and Population Sector Programme Evaluation.

²⁷ An important recent study demonstrated that interventions such as immunization, increasing women's literacy, improved energy supply and safe water all played a significant part in the gains in health and nutrition since the 1990s (World Bank 2005b).

Policy developments, 1990-2006

The steady progress in terms of health status has been attained due to some policy shifts and massive sector-wide interventions since 1990 that have drawn together government, donors, NGOs and private health service providers. The first National Health Policy of Bangladesh was formulated under the Ershad government, which fell shortly after, in 1990. As will be looked at in more detail below, the powerful doctors' association, the Bangladesh Medical Association (BMA), critically objected to proposals to restrict government doctors' private practice. The policy was repealed by the Caretaker Government that took power in December 1990, and the newly elected democratic government led by the BNP went on to form the national Health Policy Formation Committee in 1993; no new health policy was prepared, however. The Awami League-led government which came to power in 1996 again formed a Committee to formulate a National Health Policy. This was finally drafted in 2000. By that time, the Health and Population Sector Strategy (HPSS) had been adopted in 1997, and its operational plan, the five-year Health and Population Sector Programme (HPSP) launched in 1998. HPSP contained a long list of reforms, which closely influenced the National Health Policy of 2000. The main features included: a) a shift towards sector-wide instead of project-based management; b) provision of universal access to primary health care services and an Essential Services Package; c) functional unification of health and family planning wings of the Ministry of Health; d) establishment of Community Clinics to bring services to the doorsteps of the people; and e) discouraging private practice of government doctors, including through the introduction of non-practising allowances and new rules and regulations.

Health and Population Sector Programme (1998-2003)

The Health and Population Sector Programme (HPSP) was focused on:

- a) a transition from a projectised bifurcated approach to sector-wide integrated management,
- b) unification of health and family planning wings of the MOHFW to provide health and family planning services in a package under the provision of ESP to ensure efficiency gains,
- c) achieving greater health impact per taka spent by serving women, children, and the vulnerable and poor through the Essential Services Package (ESP); this contained five basic maternal, child and public health services to be delivered from a single service point, and
- d) construction of community clinics, in an effort to take the health care service structure closer to the people at the grassroots.

The period of HPSP ended in June 2003 having achieved some successes in introducing fundamental changes in planning, management and the pattern of service delivery. However, the overall outcomes and impact were uneven and in some key respects, disappointing. Users' reported levels of satisfaction with and use of government health services actually declined over the period, while their use of and satisfaction with other providers improved (CIET 2004). An assessment of the ESP component found that access to services increased by only 1% to 14% during the period, against a target of 80% for 2003 (Streatfield *et al.* (2003). Another assessment found that while there had been significant achievements in terms of orienting resources towards poorer and more vulnerable groups at the central and district levels, the process of care at the primary facility level was impeding improved access by poorer groups (Ensor *et al* 2002). Efforts to take facility-based provision closer to the people also suffered from a number of problems: a study by London School of Hygiene and Tropical Medicine (2002) found the operation of Community Clinics was hampered by inadequate drug and other supplies, poor supervision, erratic staff availability and poor construction. Interventions to improve accountability by a strategy of involving citizen participation through Community Groups set up with official guidelines were found in one study to 'appear to have had negligible positive impact or outcomes' on service delivery (Mahmud 2007:68).

The most glaring failure of the HPSP was that one of its central objectives, the unification of the health and family planning wings of the Ministry of Health and Family Welfare, faltered and was finally abandoned. A critical factor in the failure to integrate the health and family planning wings of the ministry from the top to bottom of the hierarchy was that bureaucratic interests effectively blocked this (Osman 2004b). Integration was achieved at *upazila* level and below as *upazila* level family planning officials (UFPO) were already of lower official status than the *upazila* health officials. However, the unification was not popular among family planning officials, whose status it degraded in two ways: i) by making UFPOs accountable to UHFPOs; and ii) by giving UHFPOs the entire responsibility for supervision and coordination of health and family planning services at the *upazila* level, in the process withdrawing authority from the UFPOs for managing family planning services. The conflict that ensued led to disruptions to normal service provision. At levels above this the situation was even more intractable: from the district up to the directorate level, officials of the two wings were of comparable official status and neither group was inclined to compromise on their position (Osman 2004b). A study commissioned by IMED (2003) stated that the limited progress on unification was a major impediment to achieve the expected results from HPSP.

Despite these constraints and failures, an in-depth survey of health and family planning public expenditure management and service delivery

performance undertaken in 2003 and 2004 found that primary health and family planning services were functioning reasonably effectively, taking into account the low level of spending on services at the *upazila* level and below (Tk. 80 per capita). The Social Sector Performance Survey for the health and family planning sectors found that *upazila* and union level facilities were generally open, staffed and stocked with essential supplies, and a number of services were widely used by the surrounding population. Some of the problems identified in the survey included that the quality of care was extremely low, facilities offered services for considerably fewer hours than are officially supposed to be available, some services were under-utilized, and there were considerable problems with human resource availability, particularly of doctors at union level facilities (FMRP 2006a).

Health, Nutrition and Population Sector Programme (2003-2010)

The Health, Nutrition and Population Sector Programme (HNPSP) followed on from the HPSP for the period of 2003-2010. Major areas for reforms planned under HNPSP include:

- (i) strengthening health sector management through pro-poor targeting measures and sector-wide approach,
- (ii) Health sector diversification through the development of new delivery channels for publicly and non-publicly financed services, and
- (iii) Stimulating informed demand for essential services by poor households through health advocacy and demand-side financing options.

HNPSP has also incorporated nutrition into its programme activities. The plan is to continue with the earlier sector-wide approach, the Essential Services Package (ESP) and the client-centred focus on a service delivery system, with modifications (GoB 2005), to include the return to the previous system of separate health and family planning wings and restoration of domiciliary services. In addition to the previous five components, the Essential Service Delivery Package under HNPSP includes nutritional aspects of the health of mothers and children, control of emerging communicable diseases such as dengue and arsenic.

Progress on HNPSP's goals appears to have been slow to date. The percentage of births attended by skilled personnel improved slightly from 12% in 2003 to 13.4% in 2004, but infant and maternal mortality rates have almost stagnated (Table 5). The first Annual Programme Review of HNPSP held internal governance problems responsible for slow implementation of the programme. These include bottlenecks in the financial management system resulting in slow disbursement and use of programme funds (World Bank 2006e). Another problem was the delay in

donor support to HNPS, apparently after disagreement between donors and government over the unification of the health and family planning wings. Progress of many initiatives suffered a setback until donor funds were released: for example, three key new agencies for capacity building within the MOHFW were only starting to be established in 2005 (World Bank 2006e).

Issues in the governance of the health sector

Bangladesh's achievements in health have included the well-known success story of fertility control, and 'vertical' programmes such as immunization. Partnerships with NGOs have often been prominent in these and other successful public health campaigns. These achievements are in contrast to the failure to deliver the essential services package adequately at the facility level (World Bank 2005b). This failure is in turn attributed to problems of governance in the health sector. Next we review some of the key governance issues for which evidence is available.

Interest group politics

The single most powerful interest group in health sector politics is the Bangladesh Medical Association (BMA). According to its constitution, the BMA aims to protect the interests, rights and privileges of its members and to encourage them to play a political role in national life. The medical profession through the BMA and doctors serving in the directorate of health services have maintained a powerful role in policy making over the years. This routinely included consultations during the Five Year Plan formation process which provided policy guidance until the National Health Policy was passed in 2000.

The powerful influence over policy has been exercised in longstanding resistance to efforts to decentralize the health administration through transferring power to local bodies. The BMA has also wielded its political clout to powerful effect in resisting policies to restrict private practice by government doctors, first in 1988 and then again in 1990. In 1990, the resistance of the BMA to the proposed first National Health Policy ultimately contributed to the fall of the Ershad regime. Their objections to the policy included that the BMA had not been adequately consulted in the preparation of the policy;²⁸ they were also opposed to the decentralization of health services with powerful local bodies, and banning private practice. Government efforts to appease the BMA failed: the BMA called a strike and many senior government doctors tendered resignation letters to the BMA. The government finally withdrew the policy (Chowdhury 1995; Reich 1994; Osman 2004). Fearing opposition

²⁸ Despite the fact that the Member-Secretary of the Health Policy Committee was a member of BMA's Executive Council.

by BMA, the National Health Policy passed in 2000 and HPSP and HNPSF have treated decentralization and private practice issues with care.

The BMA became politicised along partisan lines during the 1991-2006 period. The politicisation of the BMA is evident in i) the informal division of the BMA into the Awami League supported wing ('Shwadhinata Chikitshak Parishad', formed in 1993) and the BNP group, known as Doctors' Association of Bangladesh (DAB, since 1989) and ii) the tendency for BMA leadership to go to the group supporting the ruling party.

As is the case throughout the public sector, politicisation has been associated with partisan control over appointments and other opportunities for corruption. During the immediate past BNP regime, DAB is believed to have exercised pervasive power over appointments, transfers and promotion within the medical profession. Services by DAB to the BNP were rewarded by the President being granted a BNP nomination to contest the cancelled January 2007 elections. The Awami League also sought to politicise the BMA, controlling its leadership during its 1996-2001 tenure. The then-Secretary General of the BMA remains close the frontline party leaders of the League's Central Committee. Such close and strong party support has also made BMA excessively powerful in sectoral decision making throughout the period 1991-2006.

Leakage and corruption

The major areas where corruption are widely believed to be endemic include procurement and management of drugs, equipment and supplies, informal payments for services from patients, absenteeism, and private practice on government time.

Procurement, drugs and medical supplies

Drugs, equipment and supplies are areas of high expenditure, with most procurement taking place centrally.²⁹ It is frequently alleged that public health facilities fail to provide quality services due to inadequacy of their supplies. An obvious implication is that supplies are subject to leakage or corruption. The mechanisms by which this occurs are not well-documented, although there is evidence of leakage or corruption from many points in the system.

²⁹ Roughly 70% of the Medical and Surgical Requisites (MSR) for DG health services in each *upazila* is procured centrally, by district Civil Surgeons, with the remaining 30% procured locally (FMRP 2006a).

At the upper levels of the system, evidence emerged during the HPSP period of corruption in tenders for purchasing medical equipment. Newspapers reported that the Public Estimates Committee (PEC) of the Parliament had detected massive corruption in accepting tender bids worth Tk. 1,000 million for purchasing medical equipment for government hospitals, medical colleges and training institutions. The Project Management Unit had been implicated in accepting higher bid prices in return for payments. In one case, the lowest bid price was about 50% higher than the estimated cost, while in another, the bid price had been 100% higher than the estimated cost.³⁰

The Report of a Sub-Committee of the National Health Policy Formation Committee in 1993 admitted irregularities in procurement were common, and that the system of purchase was not closely linked to need. On occasions, the Report noted, more equipment is procured than is needed, and on others, the opposite happens.³¹ It is widely believed that patients benefit from only a portion of the total, and the rest is sold. One study found service users reporting that they had to buy medicines that were supposed to be supplied free at the facility but which had been put on the market (CIET 2004). Another study found a number of different practices through which medicines arrived on the market via local facility staff, as well as reports that supplies may be sold by *upazila* health officials to cover the costs of 'speeding' up the arrival of supplies or bribing audit officials (FMRP 2007). It is less easy to detect corruption higher up the system, however. For example, close scrutiny of the financial and supplies accounts indicates that drugs leakage on a large scale does not show up in the records of transactions between the district and *upazila* facilities. There is some evidence that union facilities receive less (around 93%) of the supplies recorded as having been sent, however (FMRP 2006a). A comparison of the average drugs issued to patients as recorded by facilities compared against that reported by patients, however, suggests that it may be through inflated patient numbers that the leakage is adjusted for. The Social Sector Performance Survey of primary health found that facilities were recording drug issues of two to three times that patients reported receiving (FMRP 2006a).

Other evidence has emerged of corruption in drugs and equipment in the public hospitals. A recent report by Transparency International Bangladesh (TIB 2006) shows that in Dhaka Medical College Hospital (DMCH), the country's largest hospital, 65% of indoor patients and 68% of outdoor patients receive free medicine. An earlier TIB study had found that in district hospitals in Rajshahi division, only 4% of outdoor patients and 6% of indoor patients reported receiving free medicines, on grounds that they were not available in the hospital store (TIB 2005).

³⁰ Report in the Daily Star, 28th March 1998.

³¹ For one detailed report of irregularities of this kind in Dhaka Medical College Hospital, see Daily *Jugantar*, 8th March 2002.

A number of studies report finding that fourth class and other lower-ranking government employees sell costly medicines and other equipment (TIB 2006; FMRP 2007). The TIB report on DMCH states that:

There is a designated form to give free medicine to the patients. Only those patients are eligible to get free medicine whom doctors give prescription on this form. The fourth class dishonest employees involved with medicine smuggling manage to steal these forms. Then they write down the names of medicine on them, copy the signature of doctor, draw medicine from the store and sell them in outside pharmacies (TIB 2006:iv).

Illegal payments for services

Corruption in the form of bribery limits both the indoor and outdoor services in city hospitals. The TIB report estimates that payments of around Tk. 4 million in bribes are made annually in order to get beds for patients in DMCH. The report also identifies a group of third class staff who control important sections of DMCH, and who ensure that no help is received, even in emergencies, without payment. The situation is similar in other tertiary, district and thana level hospitals, in which timely doctor's visits, buying tickets required for service, obtaining beds and access to essential medical equipment are all purchased through an organised group. Third and fourth class employees also solicit 'tips' for transporting patients, administering injections or saline, for meals and for cleaning (TIB 2005).

The evidence on illegal payments for services suggests that this is a common problem. TIB's household survey on corruption in 2005 found that almost 30% of the population who received treatment from outdoors of government hospitals paid Tk. 60 on average to the doctor for each visit. Other illegal payments in government hospitals included paying for xrays and pathological tests, which had been free for outdoor and free bed patients until the recent imposition of charges in November 2006.³² The Service Delivery Survey found similar proportions of the population reporting having paid for tickets to receive service (25% in 2003, down from 40% in 1999) and somewhat smaller proportions reporting having paid for services (16% in 2003 down from 22% in 2000; CIET 2004).

The matter of illegal payments for services may not be as straightforward as it seems. A patient exit poll conducted for the Social Sector Performance Survey in primary health and family planning facilities found that only around 3% of patients reported having had to pay for services. However, around 25% of communities in focus group discussions conducted for the same study reported the need for routine payments at their local *upazila* health complex, and 20% at union level

³² 'New Fees in government hospitals', Daily Star, November 2, 2006.

facilities. These differences in reported payments suggest a dual system of consultation is going on at the facility level, in which there are normally free, quick consultations during the short actual opening hours, during which some free drugs may be given, and another form of consultation, often conducted in private but on the facility premises, for which a fuller consultation is given, a private consultation fee taken, and a written prescription given (FMRP 2006:22). High levels of informal payments may thus reflect the lack of separation between private and public service provision in health facilities: both take place on the same premises, by the same practitioners, and often during opening hours (FMRP 2007; Osman 2004a).

Absenteeism and loss of service time

The availability of doctors is a major problem for service quality and access. The problem is worst in rural areas, and particularly acute in the most remote union and *upazila* facilities. Part of the problem is that many sanctioned government doctor posts are not filled – 39% of *upazila* health complexes lacked a Resident Medical Officer (head of *upazila* indoor service facilities) and nearly 60% of union sub-centres lacked a doctor in 2003-04 (FMRP 2006a). In one particularly serious case, that of Patuakhali General Hospital, a newspaper reported that out of 33 posts, only 10 doctors were in post, of whom only 5 were regularly available.³³

It is generally recognised that it is difficult to attract doctors to work in rural areas, in large part because career and family imperatives draw this group of educated middle class professionals to the larger cities where postgraduate and professional training and schools and other amenities are available. However, a section of doctors from rural backgrounds who seek civil service careers have more incentives to be posted in the rural facilities, including the possibility of building a lucrative private practice away from the more competitive urban health services markets (FMRP 2007).

But even when doctors are officially posted to rural health facilities, there is ample evidence that they are often absent or give less time to official service provision than they are supposed to. A World Bank survey in 2003 found that absenteeism among doctors of 41% for *upazila* health complexes and 44% for union facilities (Chaudhury and Hammer 2003). However, the Social Sector Performance Survey in health found the situation to be slightly less serious, with absentee rates of 35% at *upazila* and 42% at union facilities. Of these, only 8% at the *upazila* level and 22% at union level were unexplained or instances of absence without permission (FMRP 2006a). This suggests that while there is a serious

³³ 'Patuakhali General Hospital: 10 Doctors against 33 posts, 5 available', Daily Star, January 25, 2006

problem of absenteeism among doctors, much of this includes permitted absences – for further study, leave or administrative purposes.

All studies concur that even while in post and present in the facility, doctors devote less time than they are supposed to. A study conducted by the Ministry of Health showed that the majority of respondents agreed that they were unable to access doctors' services during opening hours (Ministry of Health and Family Welfare 1997), while the TIB study of DMCH found that 71% of outdoor patients reported that doctors were not in attendance at the specified time (8:30 am to 1.30 pm). The FMRP survey found that many facilities were open for fewer than 4 hours per day, and none were reported by community group discussions to be open for more than 6 hours (2006a).

Many factors contribute to the short hours and high absenteeism among government doctors. Recent qualitative research found a number of factors contributed to this problem:

- Junior doctors take time off from the facility or in their quarters preparing for postgraduate training,
- Doctors with families resident elsewhere work short weeks in order to spend time with their families back in the city; arrangements are made among colleagues to 'cover' each others' shifts, and
- Many, in particular specialist, doctors have lucrative private practices in big cities where the demand for costly specialist services is greater (FMRP 2007).

An estimated 80% of the government doctors engage legally in private practice (Gruen *et al.* 2002). Although doctors typically report that their private practice is conducted in the afternoons and off facility premises, there is strong evidence that private and public service provision tend to be provided on the same premises and during office hours (Osman 2004a: 305).

Accountability

Problems of corruption, informal payments and poor service quality are linked to weak accountability. Weak accountability is in turn a problem relating to a large number of other aspects of management: an accurate job description, performance-evaluation based on objective criteria and a functioning system of reward and punishment (Osman 2004; Shahid 1997).

At the field level, the chain of supervision and command is messy and complex. In most cases, field workers are accountable to one person but supervised by the other. For example, Family Welfare Assistants are

accountable to Family Planning Inspectors at the union level but supervised by Health Inspectors at *upazila* level. Health Assistants at the union level are accountable to the Health Inspectors at *upazila* level instead of Medical Assistants or Medical Officers at the *union* level. Such complex reporting relationships weakens the chain of accountability.

The chain of accountability of doctors is also not clear. Absence of any effective mechanism of making the doctors accountable to local authority has created scope for them to do private practice during office hours or to remain absent in hospitals. At the local level, no immediate supervisor has the ultimate authority to punish any misdeed of doctors. Although various misdeeds of professionals are complained about by the local administration from time to time, it requires direct involvement by the Ministry for any action to take place (Osman, 2004a).

Lack of accountability of the third and fourth-class employees of tertiary, district, and *upazila* level hospitals tremendously hampers health service delivery through varied forms of corrupt practices. The jobs of these employees are non-transferable. As a result, they consider themselves as the permanent employees of the hospital and doctors as the 'guests' (Osman 2004a). The chain of accountability of these employees is also problematic. They are rarely held to account by their immediate superiors in part out of retaliatory union action.³⁴ On one occasion, the Director of DMCH took punitive action against an employee. As a consequence, he was himself transferred in face of fierce agitation by third and fourth-class employees.³⁵

Accountability relationships between health service providers and users are particularly weak. There is virtually no effective formal provision for patient, community or patient representative participation in the management or governance of health facilities at *upazila* or union levels. The experiment with officially-sanctioned community groups to introduce citizen participation in clinic management under HPSP was not a success and has been discontinued (Mahmud 2007). NGOs, in particular Nijera Kori, have had greater successes in facilitating citizen participation and creating more accountability in local health facilities (Mahmud 2007). However, in the absence of any effective authority by local health facility managers to hire, fire, reward or punish staff, the impact of initiatives to encourage citizen participation has been limited (Thomas *et al.* 2003).

Recent research into accountability in local health service provision found that the only formal accountability mechanism through which patient and community views may be articulated is the *Upazila* Health

³⁴ 'Extreme shortage of manpower and medical equipment in the only general hospital of the capital city', *The Daily Bhorer Kagoj*, 5 June 1997.

³⁵ 'Patients in Mymensingh medical are neglected', *The Daily Bhorer Kagoj*, 28 July 1997.

Services Improvement Committee, officially chaired by the local MP and supposed to include patient or community representatives. However, these are rarely more than ornamental, and committee meetings usually are the formal functions to honour the visit of the MP (FMRP 2007).

Interviews with doctors and other service-providers found that they typically rejected the view that systematic patient participation through service user groups was necessary. Views among medical staff included that a) patients are mainly poor uneducated people who do not understand medical issues; b) the usual complaint is that medicines fall short which facility staff cannot address; c) facility staff are already well-informed about community health needs through their interactions and field health workers; and that d) patients are already welcome to complain directly to doctors, nurses or health officials (FMRP 2007).

The research also identified additional informal pressures on medical staff to perform. These included

- *Union Parishad* representatives monitoring services in union facilities and local community-based initiatives to informally monitor health facilities (without NGO involvement).
- The good reputation necessary to build a large and successful private practice appears to encourage some doctors to provide satisfactory services.
- Public complaints by dissatisfied patients. The mass mode of consultation commonly practiced in UHCs provides dissatisfied patients with an audience and the potential to embarrass the service-provider into better performance.
- Fear of violent reprisal in cases of severe negligence or poor service. Doctors believe mob violence against members of their profession to be reasonably common, and the media regularly carries stories which support such fears (FMRP 2007; also Gruen *et al.* 2002).

Government-NGO partnerships

Bangladesh's health programme has been considerably enriched by the contributions made by NGOs in primary, secondary and tertiary health services. The NGOs were identified as important partners in the implementation of the Community Health Clinic (CHC) programme and Community Empowerment Projects (GoB 2003). Major services of the National Nutrition Programme (NNP) and HIV/AIDS programme are being delivered by NGOs, and contraceptives and requisites are distributed through NGOs registered with the Directorate General of Family Planning (DGFP). Due to lack of decentralization and proper management the emergency maternal health care centres established by the government are not functioning well. In the cases where these have been activated

often with NGO initiative, there have been qualitative improvements in outcomes (Rahman 2006). Bangladesh has achieved impressive successes in government-NGO collaboration, most notably in immunization and treatment of diarrhoeal diseases (Begum 2003). Successful collaboration with BRAC further encouraged the government to develop new areas of collaboration in health sector, including tuberculosis control. Initial steps have also been taken to contract NGOs to manage union health services in 350 *upazilas* under HNPS; to involve NGOs in supervision of CCs on a pilot basis, and to manage around 300 UHFWs and CCs by Gonoshasthya Kendra, another leading NGO in Bangladesh (MOHFW 2003). Progress towards contracting management of government services to NGOs is proving slow, however.

DISCUSSION

This section draws together the findings from across the three sectors, and attempts to analyse the role of politics in the successes and failures of each. Each of the three sectors has a different story to tell, in the 1990s and since. However, findings common to all three sectors include the following.

Firstly, the achievements of the social sectors during 1991-2006 were substantially ones of access: more schools, wider access to health services, and more safety net programmes for the vulnerable poor. These were likely to have been popular with citizens and service-providers, and enjoyed the support of local and central political elites and the donor community. In sum, policies to expand services from the 1990s did not face significant political or bureaucratic opposition.

By contrast, addressing problems such as declining service quality and systemic corruption, both of which are likely to have been exacerbated by expansionary policies, has not attracted strong commitment. In the education and health sectors, in particular, the most serious concerns relate to the poor quality of services.

Secondly, concerns about corruption presenting an obstacle to service delivery were also important across the sectors. However, evidence about the extent of corruption is uneven, and may lead to a distorted picture of where the substantive governance problem lies, for the following reasons:

- Some of the most influential estimates of leakage and corruption are less robust than evidence suggesting lower losses.
- Most evidence is focused on 'retail' corruption (at the point of service delivery) rather than on grand corruption (in procurement or civil works). Yet diagnostic studies have identified specific areas of concern in procurement and civic works. The case of drugs and medical supplies is a case in point. The popular perception is that drug supplies run short because facility staff sell these; yet there are good reasons to believe that the major leakage occurs higher up the system, at the point of procurement.
- Estimates of high leakage have had an impact on public policy. Efforts by government to tackle corruption in the social safety net and the education sectors documented above suggest there was a limit to official tolerance of corruption in the social sectors. Efforts by

governments to control corruption have received limited attention to date, however.

- The mismatch between officially-sanctioned implementation plans and what happens on the ground encourages perceptions of corruption to flourish. The review above highlighted how some types of informal charges for social services fall into a grey area: not exactly bribes, but not officially-sanctioned either. An important issue here is the under-resourcing of the social sectors: in all three sectors, there is strong evidence that inadequate resources leads to distortions of programme goals or processes. Schools charge informal fees (possibly) to pay for administrative costs; the supply of drugs that reaches facilities is often inadequate to meet demand, whether because of corruption higher up the system or because the system is supply- rather than need-driven; the population eligible for the social safety net vastly outnumbers the numbers who can receive it; and frequent shortfalls in the stipends programme lead to beliefs in teacher/education official corruption.
- The universal lack of transparency around government service provision also nourishes perceptions of corruption. The public have little information about their service entitlements or about the official processes of (for example) beneficiary selection or the delivery of resources. Under conditions in which there is rising awareness of entitlements and an increasingly alert media, shortages, charges and any other unpopular aspects of service delivery are understandably interpreted as corruption.

While this does not prove that corruption was less prevalent or serious than has been perceived, it does indicate that more caution is warranted with respect to assumptions about the extent to which corruption impeded service delivery in the social sectors. It is plausible to suggest that the situation with respect to corruption has been both more (in procurement and civil works) and less (at the point of service delivery) serious than is assumed.

A third finding is that formal accountability institutions represent systemic failures. None of the institutions intended to enable service-users to give feedback and hold service-providers to account function as intended. For social safety nets, no such institution exists, formally. However, evidence is growing to suggest that in the gap left by this failure, service-users and communities find other means of influencing services. These include informal or 'rough' forms of accountability such as individual complaints, lobbying through social networks, collective protests and the threat of mob violence. In at least one case, that of the VGD programme, this situation has been formalised to some degree, so that the more than 10,000 BRAC-supported organisations of the rural

poor, the *Palli Shamaj*, are now officially sanctioned as assisting beneficiary selection at the ward level.

There is also evidence that the media has contributed to this situation, by amplifying accounts of corrupt administrators or errant teachers or absent doctors. The media seems to play a preventive role through the exposure of corruption, waste or gross inefficiency. These help to fill the accountability deficit left by the failures of formal mechanisms to empower citizens to participate, albeit in an unregulated and unpredictable way. These pressures are not sufficiently widespread to constitute an alternative to formal mechanisms. But they are often present, exerted through traditional patronage or social structures, and frequently strong enough to effectively substitute for more egalitarian or participatory systems. The power of informal pressures on service-providers to fill at least part of the accountability deficit has resulted in a kind of substitute, not for good governance, but for a kind of governance that has been adequate to deliver the social services received so far. Informal accountability pressures may not amount to 'good enough' governance of the kind that are expected to be necessary to produce the difficult quality reforms that are urgently needed, however. These will in any case need to occur throughout the system, and not just at the frontline facility level.

A final issue that merits discussion here is the role of politics in the social sectors. It is unlikely to have been a coincidence that many major innovations in the social sectors which were to support the highly popular expansion of social services came about in the early years of democratically elected governments. The FFE and the secondary school girls' stipend were innovations of the early part of the BNP regime of 1991-6. The Awami League established the pensions for the elderly in 1996, and attempted to create a tier of health services within communities through the HPSP. The BNP-led government of 2001-6 monetised and expanded the FFE in the form of the primary stipends programmes. Interestingly, given the perception that when the party of government changes, policies are likely to be overturned, most of these innovations enjoyed continuity over this period. If anything, incoming governments demonstrated a tendency to scale-up and to try to improve on their predecessors' efforts. This suggests that there was political capital to be acquired at the national level in improving access to services by the poor and marginal: there was a strong competitive element between the major parties on their contribution to social sector service provision.³⁶

³⁶ For an analysis of how partisan competition contributed to the expansion of primary education in the 1990s see Hossain, Subrahmanian and Kabeer (2002).

A growing body of evidence shows that partisan competition at the local level also influenced service delivery. Research conducted for the State of Governance 2006 suggested that local politics became increasingly rooted within national party competition over the period. This had three impacts on service provision. The first was that areas in which the local *Union Parishad* member, chairman or MP were of the ruling party were often favoured in terms of the flow of resources. School and health facility managers that were able to draw on connections to local or national politicians from the ruling party attracted additional resources (FMRP 2007). The selection of unions and wards for distribution of relief goods is also widely believed to be influenced by the party affiliation of the local chairman and ward member. The second impact of the local politicisation of services is that it enabled party-based control over the fruits of corruption: there is evidence to show that local party personnel increasingly sought to control the distribution of construction contracts and relief goods, to influence government doctors (vital to political leaders because of the scope for certificates of injury to be used in criminal cases against political opponents), and to sit on SMCs in order to access teacher recruitment payments and other school resources. Interestingly, stronger party control of the distribution of such resources appears to have co-existed with the expansion of service provision.

Electoral politics, and in particular the intensity of the competition between the two major parties that ruled during 1991-2006, are part of the story of what worked for Bangladesh to make the gains it did during that time. But there are two caveats to this happy story of democratic governments responding to the needs of the poor. First, it is clear that expansionary programmes also entailed collective benefits to teachers, health sector workers, and local government representatives. Increasing numbers of teachers and health sector workers strengthened the associations of these professional groups, and granted their leaders greater political clout with respect to central government. Local government representatives and teachers also gained importance as distributors of public resources through the expanded safety net system, and to a less significant degree, the two stipends programmes. The opportunities for corruption and patronage among these local elites also rose substantially through these programmes. In short, expansionary reforms made the reforming government popular with a large swathe of the population, not just the poor.

A second, related issue is that the positive-sum story that held for the expansionary gains was limited to access. It is widely believed that the expansion was implicated in the decline in the quality of services, as more students and patients crowded into classrooms and clinics inadequately supplied with staff and supplies. And there are as yet no reasons to believe that quality reforms will attract the kind and degree of political support enjoyed by the expansion of access. Part of the reason

for this is that whereas the benefits of access reforms are widely distributed, the benefits to quality reforms are typically diffuse and the costs concentrated, often among the service-providing groups themselves (Corrales 1999). Areas in which quality reforms have been discussed or attempted in the past have faltered, primarily because the actors whose behaviours most need to change – medical and teaching staff – are disinclined to do so. This is most obvious in the case of attempts to reform doctors' private practice, which, as discussed above, have failed to date to make it on to the agenda because of the strength of well-organised resistance. But the mere fact that political resistance to quality reforms exists does not mean they cannot take place, however. As Grindle demonstrates for the education sector in Latin America, 'difficult' reforms can take place: the strategies of reformers, policy design, how political opposition is handled and institutional constraints are addressed all make a difference to the success of the reform (2004).

Finally, it is worth flagging the emerging evidence that social sector gains have slowed down, in some cases stagnated, and in others, very possibly reversed. It is still too early to fully evaluate the performance of the 2000s, but the evidence so far suggests that some of the reforms of the 1990s may be fragile. It is possible that it is in the maintenance and stability of social sector gains that the constraints of governance may start to show their power.

CONCLUSION

This paper has explored the achievements of Bangladesh's social safety net, basic education and government health services over the 15 year period of multiparty democratic rule, 1991-2006. Focusing on an attempt to understand how and the extent to which governance conditions influenced the performance of the sectors, the paper looked in detail at evidence on corruption and accountability in the implementation of key programmes over that period. A final discussion section draws together the findings from across the sectors in an attempt to arrive at some more general findings about the relationship between governance and social sector performance.

The paper opened with a question: how did Bangladesh make gains in its social sector, given the weak state of governance that prevailed during the 15-year period? The answer to this question, as set out through the argument of this paper, is in three parts. Firstly, the achievements were mainly limited to access reforms, which enjoyed political support and which were rarely administratively complex: in brief, the objectives of the reform were broadly aligned with the conditions of governance, which therefore did not present a major obstacle to their achievement. Secondly, quality reforms have yet to make it onto the policy table (particularly true for education and health), possibly reflecting the perceived difficulties of tackling the interests of well-organised professional public servants. And thirdly, there were already signs of stagnating progress in the social sectors by the end of the 2000s. In at least one case, that of declining enrolment in primary in the 2000s, there are reasons to believe that the failure to raise standards of quality may be part of this reversal: governance constraints could yet undermine even the achievements of access that were such significant indicators of Bangladesh's progress on poverty reduction and human development in the last 15 years.

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