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# *Political economy of policy and implementation in the Bangladesh health sector: Implications for reducing maternal mortality*

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## Abstract

This paper discusses the politics of maternal health in Bangladesh. It seeks to relate the paradoxical combination of weak governance and strong progress towards maternal mortality reduction to the nature of its political settlement. Typical of 'competitive clientelist' settlements, the effectiveness of maternal health policies tends to be diluted by ineffective coordination and poor discipline of public sector personnel. However, in Bangladesh, state ineffectiveness is at least partly alleviated by donor engagement, NGO and private provision, and pockets of state effectiveness – phenomena that can be traced to the historical origins of the Bangladeshi state.

**Keywords:** Bangladesh, maternal health, maternal mortality, political settlements, clientelism, pockets of effectiveness

**Note:** Simeen Mahmud, the lead author of this paper, sadly passed away in March 2018. This was before full revisions to the paper had been completed. For this reason, there may be minor imperfections in the text below. Nevertheless, within ESID we believe that the broader analysis and conclusions are sound, tally with the findings across the politics of maternal health project, and that the paper contains much of value that deserves publication in our working paper series. We are grateful to Wahid Mahmud for encouraging us to publish this paper.

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## Acronyms

| | |
|---|---|
| AL | Awami League |
| ANC | Ante natal care |
| BBS | Bangladesh Bureau of Statistics |
| BNP | Bangladesh Nationalist Party |
| BRAC | Bangladesh Rural Advancement Committee |
| CC | Community clinic |
| CEOC | Comprehensive emergency obstetric care |
| CHCP | Community health care provider |
| CS | Civil surgeon |
| CSBA | Community-based skilled birth attendants |
| DG | Directorate General |
| DGFP | Directorate General of Family Planning |
| DGHS | Directorate General of Health Services |
| DHS | Demographic and Health Survey |
| ECNEC | Executive Committee of the National Economic Council |
| EOC | Emergency obstetric care |
| EPI | Expanded Programme on Immunization |
| FGD | Focus group discussions |
| FP | Family planning |
| FPI | Family planning inspector |
| FWA | Family welfare assistant |
| FWV | Family welfare visitor |
| GK | GonoShasthya Kendra |
| HA | Health assistants |
| HI | Health inspector |
| HIES | Household Income and Expenditure Survey |
| HS | Health Secretary |
| LGED | Local Government Engineering Department |
| MA | Medical assistant |
| MCH | Maternal and child health |
| MCWC | Maternal and child welfare centre |
| MDG | Millennium Development Goals |
| MMR | Maternal mortality rate |
| MNHI | Maternal and neonatal health initiatives |
| MO | Medical officer |
| MoF | Ministry of Finance |
| MoHFW | Ministry of Health and Family Welfare |
| MP | Member of parliament |

| | |
|---|---|
| MR | Menstrual regulation |
| NGO | Non-governmental organisation |
| OGSB | Obstetrical and Gynaecological Society of Bangladesh |
| PHC | Primary health care |
| PM | Prime minister |
| PNC | Post-natal care |
| PS | Political settlement |
| RMO | Resident medical officer |
| SACMO | Sub assistant community medical officer |
| SWAp | Sector wide approach |
| TBA | Traditional birth attendants |
| UFWC | Union family welfare centre |
| UH&FPO | Upazila health and family planning officer |
| UHC | Upazila health centre |
| UHFWC | Union health and family welfare centre |
| UN | United Nations |
| USC | Union sub centres |
| WB | World Bank |
| WHO | World Health Organisation |

## 1. Introduction and overview

Bangladesh has often been described as a 'development surprise', because of its considerable achievements in both economic growth and human development, despite serious problems of governance dysfunction and weak accountability mechanisms at all levels. Health sector performance in Bangladesh has been even more remarkable. The country has made exemplary progress towards Millennium Development Goal (MDG) 4 in child mortality, and only narrowly missed the maternal mortality reduction goals of MDG5. Partly in consequence, it has been praised by the UN as an example of 'good health at low cost' (Chowdhury et al. 2013).

The Bangladesh 'development surprise', or perhaps 'paradox', has attracted academic and research interest, and recently has received some policy attention. In particular, Bangladesh's remarkable achievements in health have been examined in the context of health systems and health innovations. One influential explanation is that these gains have been possible due to the pluralistic health system with multiple stakeholders, featuring partnerships between government agencies and non-government organisations, and community-based approaches that deliver innovative low cost interventions to all segments of the population (Chowdhury et al. 2013).

In this paper, we show that this can be understood as the somewhat predictable consequence of a political settlement in which two main parties, though sharing an ideological commitment to pro-poor development, nevertheless compete for supporters through clientelistic means. The result is a rather anarchic, unregulated and pluralistic health sector, in which real gains exist alongside considerable inefficiency and sub-optimal resource allocation.

The paper draws upon secondary literature and evidence, two stakeholder workshops, key informant interviews with current and past health ministry bureaucrats, a former health minister and health secretary, health sector activists and academics, a World Bank health sector specialist, and field evidence from two districts. The paper is organised as follows: the next section describes the nature of the national political settlement in Bangladesh; Section 3 describes the health sector political settlement at national and local levels, followed by how this shapes health policy generally and maternal health policy in particular; Section 4 examines successes and limitations in reducing MMR; Section 5 presents evidence from the local level on implementation of maternal mortality reduction policy and strategies; and Section 7 draws conclusions

## 2. Nature of the political settlement in Bangladesh

Bangladesh emerged as a nation state from a war of secession with Pakistan in 1971. The new government, struggling to rebuild the war-ravaged economy, welcomed the efforts of individuals and groups who had been active in the struggle for independence to contribute to the national development process. Some of the large NGOs providing humanitarian relief and health services (BRAC, GonoShasthya Kendra, Proshika) were founded by these individuals, who

were motivated by the ideals of socialism and democracy that underpinned the country's constitution, and sought to combine 'conscientisation' with organising and mobilising the poor (Kabeer et al. 2010). Since then, a remarkable feature of the national political settlement has been that the government has welcomed the talents of civil society and pursued a liberal policy of 'institutional pluralism and civil dynamism, creating space for many stakeholders, government, non-governmental organisations (NGOs), informal providers, international donors, and commercial enterprises' (Chowdhury et al. 2013: 1734; see also Ahmed et al. 2011). This has contributed to Bangladesh's image of a developmental welfare state, committed to the goals of achieving poverty reduction and promoting the wellbeing of the vulnerable sections of its population (Mahmud and Mahmud 2014).

Despite these progressive trends, sustained multi-party competition did not take root in Bangladesh until 1990, when the two major political parties of the country, Awami League (AL) and Bangladesh Nationalist Party (BNP) cooperated to oust General Ershad's military regime. For the next 20 years, with a brief hiatus of non-elected government, politics in Bangladesh could be encapsulated by the following phrase: 'conflict and cooperation'. Another way of putting that is to say that Bangladesh had a 'competitive clientelist' political settlement, in which the two main parties agreed to an electoral truce, or alternation in power, without descending into all-out warfare (Levy and Walton 2013; Levy 2014).

During this period, the BNP and AL were alternately elected every five years to form a government, usually by forming coalitions with other smaller parties. Hassan has characterised Bangladesh's political settlement as an 'overarching elite political settlement which has three distinct lower-level elite settlements' (Hassan 2013, 7). These elite groups not only bargain and establish institutional arrangements among themselves, but also compete to control resources and generate rents by limiting access to critical resources. The presence of these elite groups can be observed in all political, social and economic spheres, including in the health sector of Bangladesh (see Figure 1).

Typical of most competitive clientelist regimes, short time horizons and competing centres of power have made it difficult for politicians to direct and discipline civil servants, diluting state effectiveness (Levy et al 2013). The pro poor image of social policy (health, education, social protection) and the government's well publicised commitment to achieving the MDGs have allowed the simultaneous existence of a largely benevolent state with a corrupt and often inefficient bureaucracy that facilitated a 'widespread culture of patronage politics, in which spoils and privileges are parcelled out to different client groups as an essential tool of political management' (Mahmud and Mahmud 2014: 3).

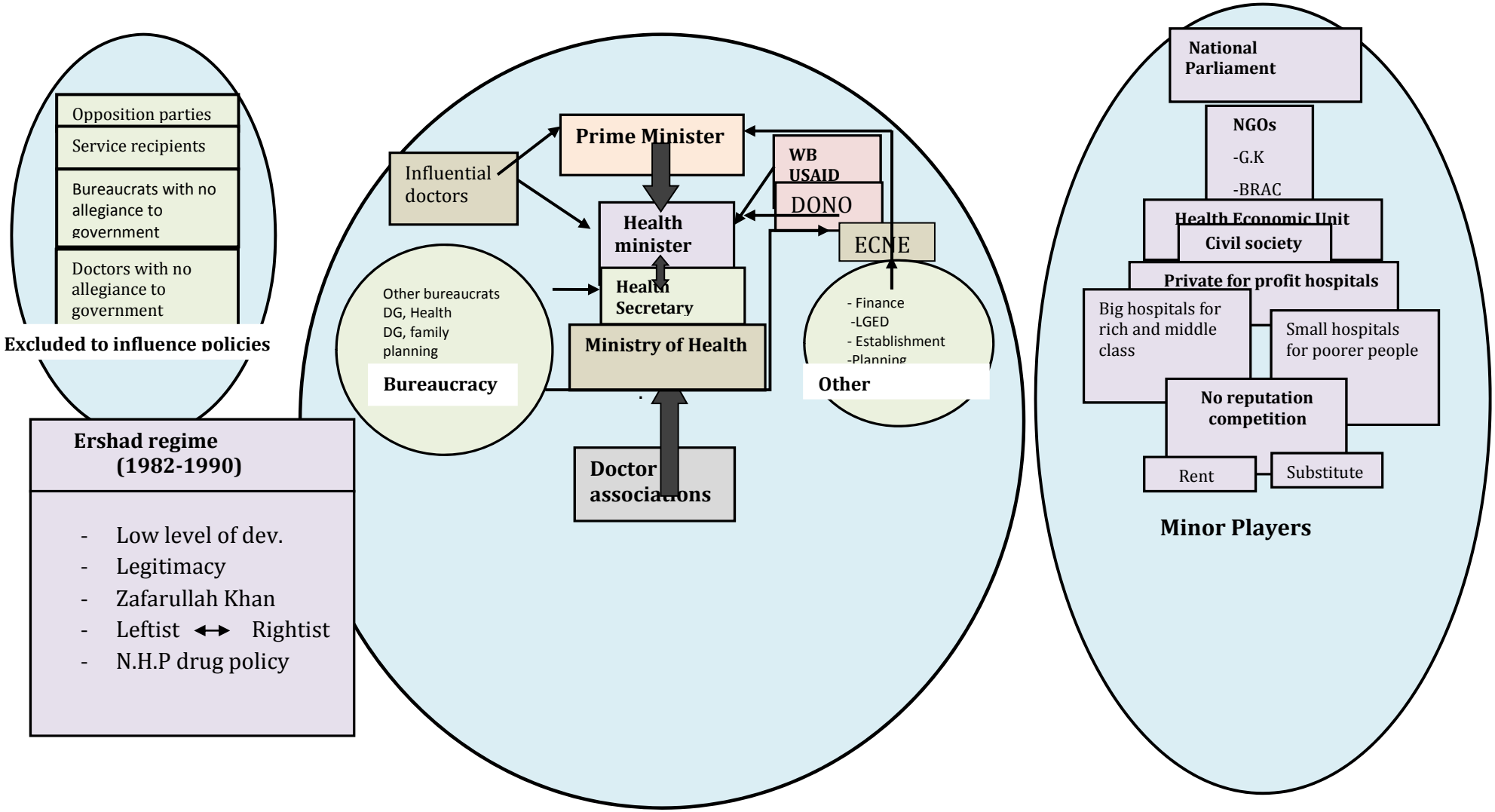



**Figure 1: Bangladesh national health policy mechanism**

## 3. The political settlement in health in Bangladesh

The health sector political settlement (PS) of Bangladesh can be divided into two major levels: the national policy formulation group and the sub-national implementation group. The national PS consists of players from the elite classes, who represent their own class and professional interests, but also include developmental and pro poor needs (See Figure 1). The major players form an inner circle, where the health minister, usually an influential leader of the political party in power, tries to maintain supreme authority. His role is particularly important with respect to the private sector, which through him lobbies and engages with the government policy process. Another important actor in this inner circle is the health secretary (HS), who links the minister and ministry bureaucrats. Also included are the director general of health services (DGHS), the director general of family planning (DGFP), and other influential government secretaries (e.g. in finance, local government).[1]

The prime minister (PM)[2] and the executive committee of the National Economic Council (ECNEC)[3] also belong to the core policy group at certain times when national and party priorities are involved. The ECNEC, chaired by the PM, allows inter-ministerial interaction and also serves as the platform where conflicting interests at the national level become evident and get resolved. The Ministry of Finance (MOF) is an important actor, in terms of influencing government development budget allocation. A noteworthy trend is that the share of health in the government's annual development plan (ADP) budget has been declining, from 6.87 percent in 2007-08 to 4.26 percent in 2013-14[4] (see Annex, Figure 4).

The Bangladesh Medical Association (BMA), the Obstetrical and Gynaecological Society of Bangladesh (OGSB), and the Bangladesh Medical and Dental Council (BMDC) are some of the politically well-organised and active professional bodies that represent their interests in the policy group, despite failing to perform their oversight role on professional performance and conduct, due to lack of both authority and intention. Some individual doctors with personal affiliations with the high-level officials of the ministry are important stakeholders, their weight in the PS determined by the fact that they are often the personal physicians of the PM or other ministers and high-ranking bureaucrats.

Donor agencies are also a major stakeholder in the core policy formulation group. They exert influence on policy formulation, not only via their pooled and non-pooled funds, but also by

[1] Insights obtained from stakeholder workshop, 9 March, 2015.
[2] The majority of approvals for private hospitals and medical schools lie with the PM, and hence act as an important mechanism for distributing favours and rents in exchange for party donations and allegiance. These provide exclusive services to one segment of the population and represent a vivid example of extracting rent from various sources by limiting access (Hassan 2013).
[3] The ECNEC is the highest authority that approves long-term development programmes for the country.
[4] Health sector per capita spending is relatively low, even in comparison to per capita public health expenditure in neighbouring South Asian countries.

providing technical assistance for writing project reports, planning documents and evaluations. In the case of maternal mortality, their huge presence at both policy and implementation levels of the Safe Motherhood Programme is evident from the large number of donors and international agencies that are involved: the World Bank, WHO, UNICEF, UNFPA, JICA, USAID, Caritas Australia, DFID. Donors exert influence on implementation by maintaining a tight rein on fund release and through strict procurement guidelines, but often ministry bureaucrats can manoeuvre around those guidelines.[5]

Academics, sector specialists, private sector health professionals and other members of the civil society of Bangladesh have also initiated significant pro poor reforms in the healthcare sector. Examples include: the Bangladesh national drug policy of 1982 (under the Ershad regime) spearheaded by Dr Zafrullah Chowdhury (founder of GK); scaling up menstrual regulation services, and others.

Minor players at the national level include the health economics unit of the ministry, private hospitals, and civil society and large NGOs that provide primary healthcare. They have significant but occasional effects on the policy formulation procedure and hence do not share centre stage with the major players. For example, the National Parliament is the main platform where citizens' opinions are voiced, with the help of the local member of parliament (MP), but this voice is merely token. Large NGOs, such as BRAC, GK and others, shape policies in their individual areas of work, by interacting with government officials through stakeholder workshops and round table conferences (Hassan 2013).

Together, these diverse stakeholders have helped government to pursue a collaborative and complementary strategy of innovative low-cost and often low-technology products and processes that could be customised to adapt to the local social context and delivered relatively easily (oral saline, immunisation, sanitary latrines, vitamin A capsules). These were piloted, rapidly adopted and widely disseminated, and were scaled up to the entire country through the 'massive and unprecedented deployment of diverse cadres of mostly female frontline health workers reaching every household' (Chowdhury et al. 2013). The major successes in health outcomes (reductions in infant and child mortality) are directly related to some of these strategies (see Annex, Figure 5). In sum, this national policy coalition has, since the 1970s, been responsible for steadily transforming a narrow, urban-based and secondary/tertiary-care-dominated healthcare delivery system to a more broad-based rural primary health care delivery system, aimed at reaching the poor and vulnerable, especially women and children.

These achievements notwithstanding, there are many deficiencies in Bangladesh's healthcare system, especially when it comes to implementation. The political settlement at the local implementation level is more conflictual, although it also allows considerable rent generation

[5] Interview with KII official in Planning Commission, May 2015.

and distribution to maintain policy continuity and stability, made possible by allowing a hybrid organisational structure, with substantial crossover between public and private elements. However, the emphasis has been on visibility and quantity, rather than quality and sustainability, limiting the effectiveness of 'exemplary' policy and strategies. As one government official at the Planning Commission commented: 'health care quality issues are much more downstream: there is post creation, recruitment, posting, attendance, service, then quality of service'.

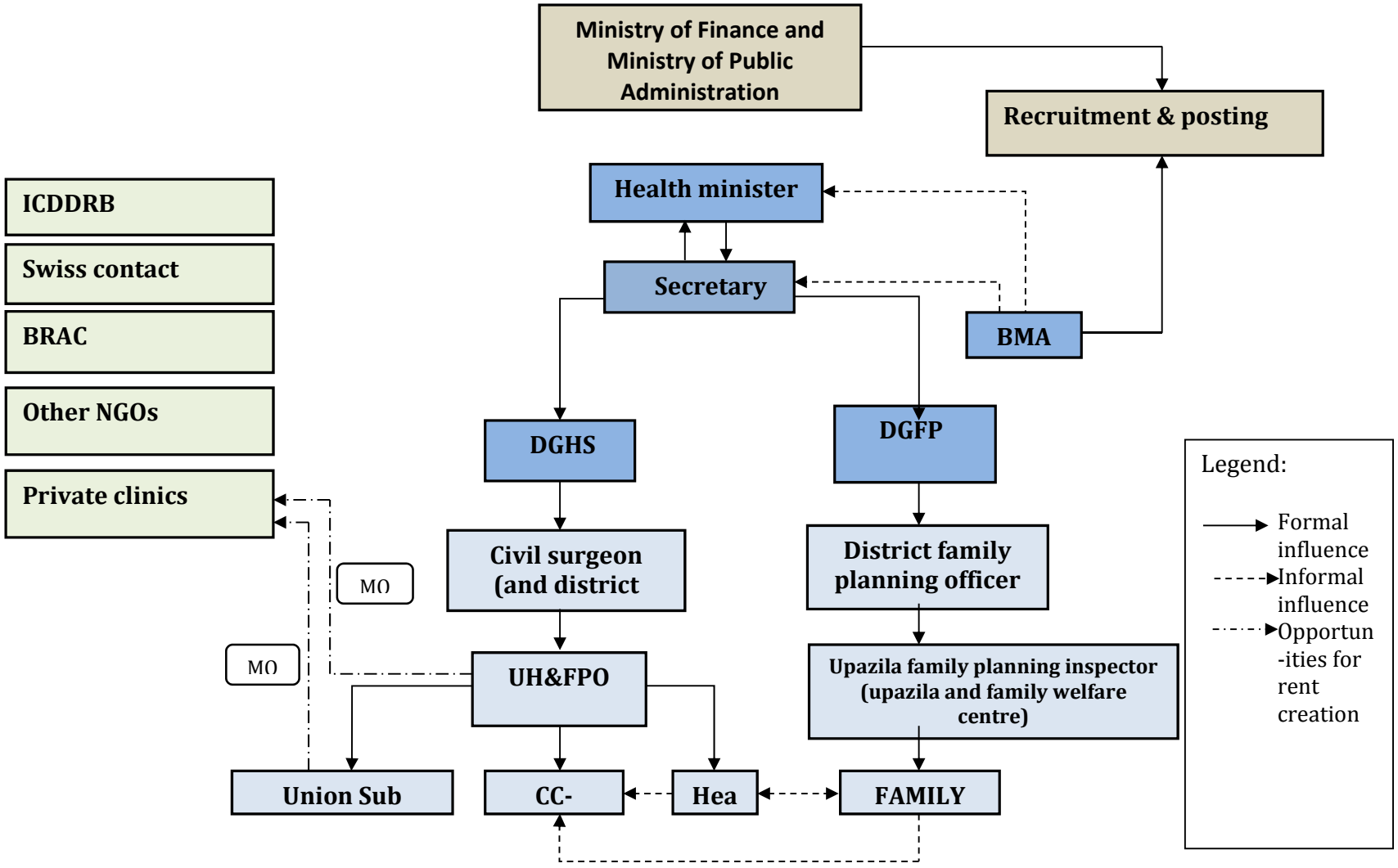
The major actors in the local-level political settlement (see Figure 2) are the civil surgeon, who is the health manager responsible for the delivery and oversight of secondary and primary care services in the district and below;[6] the upazila health and family planning officer (UH&FPO), health manager of all secondary and public-health programmes in the upazila, including front-line community health workers; and the family planning inspector (FPI), who oversees all family planning activities in the upazila. The civil surgeon and UH&FPO have a certain social standing at local levels, in view of their official designations, but have limited authority over the respective staff under their immediate jurisdiction and no autonomy in hospital administration or staff allocation.

Other major players are medical officers/doctors posted at district, upazila and union facilities, who have strong bargaining power vis-à-vis their supervisors (the civil surgeon and UH&FPO); private providers and owners of private clinics, who are largely unregulated but tacitly encouraged by the civil surgeon and UH&FPO, since they provide them opportunities for private practice; and local influential elites, who are generally supporters of the ruling party and have credibility and moral authority as residents. Minor players include front-line community health and family planning service providers; NGO healthcare providers (GK, BRAC, Grameen, Marie Stopes, etc.); and the community clinic management committee.

Conflicts of interests arise at implementation level, because although the two directorates, DGHS and DGFP, are the main agencies for field implementation, the central ministry controls recruitment, posting and transfer of human resources, procurement and fund disbursement. Conflict also stems from the fact that, despite administrative integration at the highest level (ministry) and functional integration at the lowest level (community), the division of labour and authority between the DGHS and the DGFP at upazila and union levels is parallel and complex. Thus, the upazila family planning inspector reports not to the civil surgeon, the health manager.

[6] There are on average eight or nine upazilas in a district, and six or seven unions in an upazila.

**Figure 2: Policy implementation mechanism at local level**



in the district, but to the deputy director of family planning in the district. Family planning workers posted at the upazila health centre (UHC) and union facilities and the frontline workers (family welfare assistants and family welfare visitors) are supervised not by the UH&FPO, the upazila health manager, but by the upazila family planning inspector, although at the ward level both HS and FP frontline workers provide integrated services (immunisation, family planning, antenatal care, infant care) through the community clinics. Historically, hostility between the directorates has also existed, due to the relatively greater donor funding that has been available for 'population control' and family planning since the mid-1970s, leading to visible differences in access to 'perks', like transport and vehicles, foreign trips, and so on, between the personnel of the two directorates. This may be a common feature of settlements in which donors have a large influence, but the central government lacks the will or capacity to coordinate them.

Partly as a consequence, the impact of health policy is less efficacious, and less pro poor, than official ideology/policy implies. We have already touched on some of the rent-seeking opportunities that the political settlement in health sustains. As we shall see in the next section, another feature is competing centres of bureaucratic power and influence, with multiple principals sometimes undermining the effectiveness of frontline service providers

## 4. How does the PS shape policy on maternal health and implementation? Successes and limitations in reducing MMR

The health system in Bangladesh is mandated to cover the entire country, with facilities at district, upazila (sub district), union and ward level. Ministry policies are implemented through a variety of authorities and regulatory bodies[7] (Ministry of Health and Family Welfare 2014), but the main authorities for managing and delivering public healthcare at the primary, secondary and tertiary levels are the DGHS and the DGFP. The DGHS and DGFP implement the health sector programmes through well entrenched, vertically segregated service delivery infrastructure, facilities and human resources throughout the country. The DGHS is by far the largest implementing authority of general health services, while the DGFP is responsible for maternal and child health and family planning services.

### Policy approach to maternal healthcare

The commitment to increase access to maternal healthcare and reduce maternal mortality evolved gradually in Bangladesh. Following the international commitment to Health For All in

[7] The implementing authorities include: DG Health Services, DG Family Planning, National Institute of Population Research & Training, DG Drug Administration, DG Health Economics Unit, DG Health Engineering, Directorate Nursing Services, Revitalisation of Community-based Healthcare Initiatives in Bangladesh Project (Community Clinics Project), Essential Drugs Company Limited (EDCL), Transport and Equipment Maintenance Organisation and National Electro-medical and Engineering Workshop. The five regulatory bodies include: Bangladesh Medical and Dental Council (BMDC), Bangladesh Nursing Council (BNC), State Medical Faculty, Homeo, Unani and Ayurvedic Board and Bangladesh Pharmacy Council.

1978 up to the mid-1980s, government policy was to provide maternal healthcare through integrated maternal and child health (MCH) services for the rural population, taking a primary healthcare (PHC) approach. Implemented initially through a number of vertical projects the PHC package evolved into the 'Intensified PHC' programme, which integrated health and family planning services and added community mobilisation by involving community-based health workers and traditional birth attendants (TBAs). In the late 1980s, maternal and child health was integrated into the mainstream healthcare provided through upazila health complexes, union family welfare centres, and 30,000 mobile satellite clinics, using an army of 73,500 field workers (see below).[8]

Maternal mortality continued to be high, however, with a maternal mortality ratio (MMR) of around 450 until the late 1990s. The need to reduce MMR was articulated with greater urgency in the mid-1990s, with the realsation that the high rate of maternal deaths could not be tackled through the low-cost primary healthcare approach alone – it required more complex arrangements with specialised equipment, supplies and medically trained human resources. Further impetus was provided in 2001, when the National Strategy for Maternal Health was announced, and the government declared its commitment to the MDG5 of reducing the MMR by 75 percent by 2015.

Since the mid-1990s, trends in maternal health care utilisation show tremendous improvement, in particular antenatal care use, facility births and use of comprehensive emergency obstetric care for maternal complications (evident from births from caesarean operations).

**Table 1: Distribution of births (%) in the last three years preceding the survey by type of delivery and assistance at delivery, DHS 2004-2014**

| | 2004 | 2007 | 2011 | 2014 |
|---|---|---|---|---|
| Antenatal care | 51 | 53 | 55 | 64 |
| Delivery by medically trained provider | 16 | 21 | 32 | 42 |
| Facility birth | 12 | 17 | 29 | 37 |
| Caesarean | 4 | 9 | 17 | 23 |
| Home delivery | 88 | 83 | 71 | 62 |
| All births | 100 | 100 | 100 | 100 |

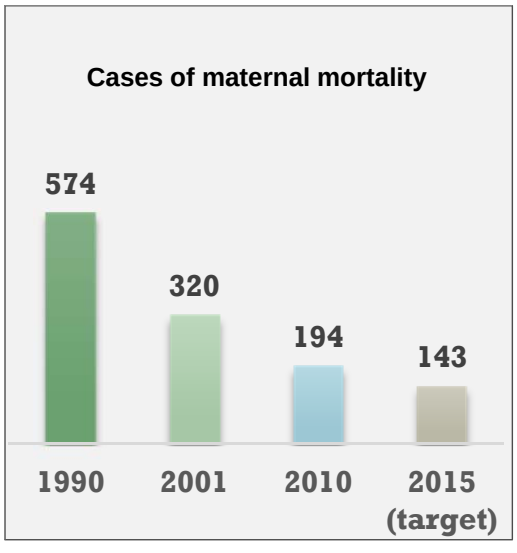
*Source*: Demographic and Health Surveys.

[8] The primary focus was to promote antenatal care, tetanus toxoid immunisation, iron supplementation, clean delivery practices, and family planning.

Antenatal care coverage by medically trained personnel doubled during 1993-2011 and appeared to be plateauing at about 55 percent, but again jumped to 64 percent during 2011-2014. Nearly one-third (31 percent) of women with a live birth in the three years preceding the survey in 2014 had availed four+ antenatal care visits from a medically trained provider, which was targeted to reach 50 percent by 2016 under the ongoing HPNSDP. There was a nearly threefold increase in deliveries by medically trained providers between 2004 and 2014 (from 16 percent to 42 percent), while facility births increased from 12 percent to 37 percent of all births, targeted to reach the MDG of 50 percent by 2015. Facility births started rising fast from 2007, with a more than 100 percent increase in 2014. The use of post-natal care from medically trained providers within two days of delivery doubled from 16 percent to 34 percent of all births (DHS 2014). Generally speaking, the use of health facilities for maternal complications increased from 16 percent to 29 percent between 2001 and 2010 (NIPORT et al. 2012).

Partly as a result of these initiatives, the MMR continued to fall from 322 deaths per 100,000 live births in 1998-2001 to 194 deaths in 2007-10, an annual rate of decrease of 5-6 percent. Implementation of maternal health services has been hailed as a success story in Bangladesh, and the past decade has witnessed a significant increase in uptake of maternal healthcare services. Much of this expansion in utilisation is seen as being related to community-based approaches and innovative low-cost service delivery using paramedics and community health workers, held up as models for other developing countries (Mridha et al. 2009; Arifeen et al. 2014; Sikder et al. 2015).

**Figure 3: Bangladesh is on track to achieve MDG 5**




*Source*: NIPORT 2012.

**Strategies for improving access and reducing MMR**

According to the ministry, maternal healthcare delivery infrastructure is in place at all tiers of service delivery, and services are delivered through both community-based and facility-based approaches. The facility-based approach gained momentum in 1987 only after the commencement of the Safe Motherhood Initiative (Mridha et al. 2009). With the commitment to reach MDG 5, the main strategies since 2000 have been: tasking existing family welfare visitors to provide antenatal care and identify high risk pregnancies for referral through satellite clinics; training family welfare visitors and female health assistants (health assistants) as community-based skilled birth attendants (CSBAs) to provide safe normal home deliveries and refer cases of maternal complications to upgraded union and upazila facilities; upgrade one-half of union family welfare centres to provide basic emergency obstetric care (EOC) by posting a medical officer (MO) and a trained nurse midwife or family welfare visitor trained in midwifery at the union family welfare centre; upgrade one-third of upazila health centres and 70 percent of maternal and child welfare centres (at district and upazila level) for comprehensive emergency obstetric care (comprehensive emergency obstetric care); and, most recently, making provision for normal deliveries in a limited manner from community clinics (CCs). In addition, investments were made to stimulate demand for maternal health services through demand-side financing projects, which are being scaled up (Ministry of Health and Family Welfare 2014; Anwar et al. 2009; Arifeen et al. 2014).

Facilities at upazila, union and lower levels cater to the vast majority of patients seeking healthcare from public facilities. However, the full potential of these facilities for maternal healthcare provision is often not achieved, as there is underutilisation of existing capacity in most public facilities at upazila level and below and overutilisation in some.[9] Moreover, underutilisation of capacity is far higher at the upazila level compared to the district hospitals, which are generally over-utilised,[10] leading to overcrowding and poor quality of care (BHW 2011). Underutilisation of upazila and union in-patient facilities commonly indicates inadequacy of medically trained staff, due to both vacant positions and unauthorised absenteeism (Mannan et al. 2013; Sikder et al. 2015). For example, Sikder et al. found that staffing constraints emerged as the major barrier to provision of emergency obstetric care services in the public facilities such as upazila health centres and UHFWCs in Khulna, Sylhet and Habiganj districts (Sikder et al. 2015).

[9] Bed occupancy rates were near full (80-100 percent) in one-third (31 percent) of upazila health centres and 11 percent had over full occupancy, while the remaining 58 percent were underoccupied (less than 80 percent bed occupancy) (Ministry of Health and Family Welfare 2014).
[10] 117.3 percent bed occupancy rate (Ministry of Health and Family Welfare 2014),

A flourishing non-public sector for maternal healthcare, far outnumbering public facilities, is growing very fast to fill the gap in utilisation of public facilities at these levels.[11] The commercial health service is mostly located at district level and above, while not-for-profit NGO services are concentrated at the community and union/ward levels. Access to these services has expanded over time, due to both expansion in number and improvement in road transport that has reduced time needed to reach a private facility, critical in the case of pregnancy-related complications.[12] Since services provided by the private sector are relatively more expensive, this has critical implications for access to maternal healthcare for poorer women. The number of NGO health facilities providing free maternal healthcare increased substantially, but their share remained small, 12 percent and 7 percent, respectively, for normal delivery and comprehensive emergency obstetric care facilities (Arifeen et al. 2014).[13]

The majority of private clinics at district and upazila levels are staffed by government doctors, consultants and medical officers, who are allowed to have private practice after official duty hours. In fact, lax administrative monitoring permits doctors to extend 'market forces' into public facilities through informal payments for free services, that add up to about 80 percent of what is spent more formally on fees in private sector facilities (Ahmed et al. 2013; Mannan et al. 2013). One recent survey of the public health delivery system found that 22 percent of surveyed patients (1,820 in total) at district hospitals and 17 percent at upazila health centres had to consult the doctor in their private chamber to get admission (Mannan et al. 2013).

Thus, with respect to increasing accessibility to facility births and emergency obstetric care services, it appears that the government is increasingly relying upon private and, to a lesser extent, NGO health services to meet growing demand. The critical question is whether this reliance indicates a genuine inability of the ministry and its directorates to deploy adequate staff in a rational manner, for example because of resource shortage, or whether it is a feature of the existing political settlement, in which higher-level actors openly overlook and even justify unauthorised absenteeism .

[11] In 2013, there were a total of 630 public hospitals at all levels, including the upazila health centres at the upazila, employing 21,533 doctors and 13,235 nurses in filled positions (Ministry of Health and Family Welfare 2014). In comparison, according to DGHS there were 2,983 registered private for-profit secondary and tertiary care hospitals and clinics (and 5,220 diagnostic centres) employing around 40,000 doctors and 5,000 nurses (Ahmed et al. 2013). These figures do not include the unknown numbers of unregistered hospitals, clinics and diagnostic centres flourishing at district and local levels.

[12] In a 2010 survey of pregnant women 69 percent of respondents claimed they were able to reach a private facility within one hour, a proportion that was only 20 percent a decade earlier (Arifeen et al, 2014).

[13] The role of NGOs is growing as donors channel significant and increasing amounts of funding directly to them, and pressure government for developing partnerships with NGOs. It is estimated that there were about 5,000 NGO paramedics and 105,000 NGO community health workers working out of nearly 1,000 clinics or health centres in 2007 (Ahmed et al. 2013).

Low demand for services continues to be a problem: one-third of pregnant women did not receive antenatal care and 58 percent of births were delivered by untrained persons, even during 2011-14. A major factor in non-use of services is the perception of women and their families that these services were not needed, as well as the perception of costs involved (Koblinsky et al. 2008). The government has identified this as a 'lack of demand' for services, prompting the ministry, in collaboration with WHO, to introduce an innovative maternal health voucher pilot scheme (Schmidt et al. 2010; Ahmed and Khan 2011). It was found in earlier evaluations that schemes were promising, but implementation was complex and put an extra burden on health workers. This conditional cash transfer scheme had been scaled up since February 2015, but was to be implemented by the local government engineering department, raising serious opposition from the ministry, the MoF and the Planning Commission at the ECNEC meeting where this was placed for PM's approval.

These problematic features are only partly mitigated by the presence of the CCs at ward level, the lowest tier of the community, serving an average population of 6,000. The community clinic project is upheld as the flagship project of the ministry to extend safe motherhood services to women at the very local level. The CC is staffed by a community healthcare provider (CHP) and supported by the existing domiciliary staff of both DGHS and DGFP (health assistants and family welfare visitors) posted at the union UHFWC, who are supposed to attend the community clinics in that union for three working days a week, alternately. CC activities and performance are under the supervision of the UH&FPO at the upazila health centre and by the health inspector posted there. As mentioned previously, CCs also serve the purpose of establishing a sort of 'functional integration' of services of the DGHS and DGFP that is one of the objectives of the SWAp in the health sector. It is supposed to be managed by 15 to 17-member management committees, with at least four women members and local government members, selected from the respective communities, and supported by community health volunteers (non-paid). Normal deliveries are available in a limited manner since 2011 from CCs located at ward level. Service statistics suggest that the number of births at CCs shows a rising trend, but these represent only a miniscule portion of all facility births (Arifeen et al. 2014). It seems, however, that government may have responded to rising demand for normal delivery services from CCs, reported in both the field sites, by increasing budget allocations to them.

**Limitations/challenges**

Despite policy emphasis on reducing maternal mortality and putting in place infrastructure for service delivery, development and implementation of services has not proceeded in a very coordinated manner. The major limitations/challenges with respect to implementation have to do with: balancing quality and equity; ensuring readiness; improving affordability; balancing need to meet short-term targets and patient interest; and managing and retaining staff.

### *Balancing access and equity*

The policy emphasis on community-based approaches to increase equity in access is not adequately translated into implementation. While there has undoubtedly been an increase in births attended by medically trained providers, many rural areas remain without adequate coverage of comprehensive emergency obstetric care, and pregnant women have to travel to district towns if they wish to obtain public comprehensive emergency obstetric care services that are more affordable (Anwar et al. 2009; Sikder et al. 2015).

### *Ensuring readiness for comprehensive emergency obstetric care from public facilities*

Despite favourable policies to extend the scope of work of many frontline providers, ensuring readiness of public facilities for basic emergency obstetric care and comprehensive emergency obstetric care provision has proved difficult (Koblinsky et al. 2008; Anwar et al. 2009). Staffing constraints prevented readiness of service provision for comprehensive emergency obstetric care in upazila-level facilities, due to seemingly intractable problems in the management of medically qualified human resources (Ministry of Health and Family Welfare 2014). The problem has been exacerbated by key staff absenteeism and unwillingness to stay in the post at union and upazila levels, especially on the part of MOs (junior consultants and assistant surgeons) (FRMP 2005).

### *Ensuring affordability*

The Bangladesh Health Accounts estimate that overall 64 percent of total health expenditure in Bangladesh is incurred by households, of which the major share is household expenditure in the private (formal and informal) facilities (BNHealth Assistant 2013). Women and their households incur out-of-pocket (OOP) expenses for availing maternal healthcare services at both public and private health facilities in Bangladesh, despite the claim that public facility services are ‘free’ (Khan et al. 2009; Rahman et al. 2013). For those who use services, there are costs involved in birth, even in the public sector, in the form of demands for unofficial fees that are widespread and common (Koblinsky et al. 2008; Mannan et al. 2013). One study found that, while medicines were reportedly free at public facilities, these facilities were not always stocked in essential emergency obstetric care medicines, yet all medicines required for C-section were found to be available, for a price, at nearby pharmacy shops (Sikder et al. 2015).

These costs contribute to significant socio-economic status differentials in the use of all maternal healthcare services, causing persistent rich–poor gaps in access and use. Thus, although the use of health facilities for maternal complications doubled, even among the poorest, the inequity was sustained between the richest and poorest quintiles (Arifeen et al, 2014). The poor–rich ratio in facility births has improved, however, from 1:8 in 2007 and 1:6 in 2011 (DHS 2014).

### *Managing staff (retention and absenteeism) and dealing with resistance*

A major human resource management issue that is common to the health sector generally, but that has especially plagued comprehensive emergency obstetric care readiness, is the retention of qualified staff at upazila and union levels, due to absenteeism, a high level of turnover of doctors and a short average duration of key workers in post. There is open flouting of rules on recruitment, posting transfers, and doctors' private practice (Oxford Policy Management 2005; Rawal et al. 2015).

A particular aspect of the health sector PS manifests as an implicit 'elite consensus' around the issue of doctor absenteeism at the local level. The consensus accommodates both election pledges to doctors (recruitment) and makes visible the government's stated pro-poor stance on delivery of healthcare. In 2014, 1,486 MOs were recruited by DGHS for posts at the union sub centres created by the past BNP government just before the end of its tenure.[14] The recruitment of so many junior doctors at one go was justified on the grounds that sanctioned posts were lying vacant and the new doctors could be appointed to the unions to serve as assistant surgeons, especially to provide emergency obstetric care services. The recruitment was under pressure from the doctors' association aligned with the AL ruling party.[15] Since most of these union facilities do not have adequate physical infrastructure and equipment (operating theatres, safe blood supply, anesthetist, nurse) to deliver such services, this mass recruitment has raised questions about the government's, and in particular the ministry's, seriousness regarding improvement of quality of maternal healthcare at local level. It is a common perception that the UH&FPO often turns a blind eye to absent MOs at upazila and union levels, since the fewer the number of qualified practitioners in the locality the less is the competition for private practice.[16] In fact, senior doctors at the upazila level often tell the junior MOs, 'you are young and should move around here and there, go live in Dhaka. We are here to take care of things, if there is an emergency or someone comes for a visit we will call you back, you can come the night before'.[17]

These 'accountability' arrangements within the ministry are ideally suited for managing the conflict of interest between senior and junior doctors. The short-term training of MOs in anaesthesiology and obstetrics faced resistance from senior doctors, and the implementation of task sharing of responsibilities between non-specialist doctors and lower-level health cadres was opposed by doctors' associations, which had lobbied against task sharing, apparently due to concerns over compromised quality of care (Arifeen et al. 2014). CSBAs feel they do not have a very conducive environment to perform normal home deliveries and the perception is that the senior doctors in facilities where these community health workers are posted are not

[14] Interview with KII medical assistant, May 2015.
[15] It allowed the general secretary of the association to consolidate his position within the association and provided the AL government with an opportunity to fulfil some election pledges. Hence, the AL government is reaping the fruits of the seeds sown by the BNP government.
[16] Stakeholder meeting, and interview with medical assistant, May 2015.
[17] Stakeholder meeting, and interview with medical assistant, May 2015.

supportive. For example, community-based skilled birth attendants are allowed to perform safe home deliveries only after their routine official duties, and their higher authorities do not encourage this service (BHW 2007).

### *Hostility between DGHS and DGFP and how this affects maternal healthcare delivery*

Maternal healthcare delivery is a particular victim of the bureaucratic politics and hostility between DGHS and DGFP, which has failed to resolve in the past 40 years, because services like antenatal care, post-natal care, home delivery by trained personnel, and emergency obstetric care at the union and ward levels is provided by both DGHS and DGFP health personnel and community-based workers, most recently through an extended programme on immunisation/satellite clinics at the community clinics. But staff of the DGHS and DGFP work independently, even when working in the same geographical area, and there is no sharing of performance and management information at the community level. More importantly, the family planning accountability structure at district and below clearly depicts a dual chain of authority through the upazila family planning officer (UFPO), who supervises the family welfare visitor/family welfare assistants working in the field, and the medical officer formaternal and child health at the upazila health centre, who supervises family welfare visitor/family welfare assistants at the union-level facilities. This hampers coordination and referral services.

## 5. How can we illustrate/elaborate on this by means of local case studies?

### Methodology for local-level comparison of implementation

In order to illustrate the implications of the health sector PS for service delivery at local levels, we examined implementation processes in depth in two districts. Out of 64 administrative districts, we selected one high-performing and one low-performing district, based on health indicators (maternal mortality, infant mortality and other variables). The rationale for choosing districts that are different with respect to performance was to understand whether ‘local accountability’ processes influence social/organisational behaviour of both users and providers of health services, and thereby determine health outcomes.

The districts selected were Patuakhali (Barisal division in the south west) for high performance and Moulvibazar (Sylhet division in the north east) for low performance. According to official statistics (Ministry of Health and Family Welfare Health Bulletin 2013), the infant mortality rate and under-five child mortality rate (both per thousand) were 46 and 66 in Moulvibazar and 35 and 61 for Patuakhali, respectively.

Both the selected districts, however, are similar with respect to a number of economic characteristics. According to the Bangladesh Bureau of Statistics household income and expenditure survey (BBS 2010), the average per capita monthly expenditure in Moulvibazar was 2,300 Taka, compared to 2,470 Taka in Patuakhali, although income disparity was higher in Moulvibazar than in Patuakhali. However, the poverty rate for both districts was similar: 25.7

percent in Moulvibazar 25.8 percent in Patuakhali. Interestingly, the literacy rate is also very similar: 51.1 percent and 54.1 percent in Moulvibazar and Patuakhali, respectively.

In terms of geography, Moulvibazar is hilly and has a large area covered by tea estates (33.2 thousand hectares, which is 57 percent of total area under tea estates in Bangladesh), with a significant ethnic minority (Monipuri) population (3 percent, compared to 1 percent nationally) and a large Hindu population (24.6 percent, compared to 8.5 percent nationally). Moulvibazar has traditionally been a high international migration area, sending adult male migrants to the UK and other European countries. Patuakhali is low lying, situated on the active delta of the Padma river on the coast of the Bay of Bengal, surrounded by rivers and subject to tidal flooding and natural disasters. Major activities include agriculture and fishing. Both communities live in harmony with religious and ethnic minorities, despite rising evidence of religious intolerance in some parts of the country.

In order to understand implementation success and limitations/challenges and the related governance explanations (if any) at local level, we examined the actual delivery of maternal healthcare services through public health facilities and healthcare providers at upazila level and below for two upazilas, namely Kamalganj in Moulvibazar district and Patuakhali Sadar in Patuakhali district, where the latter was the better performer with respect to health outcomes. We restricted our data collection to public health facilities and public healthcare providers. In Kamalganj we visited the upazila health centre in Gopalnagar and two community clinics in Baligaon and Choikut (unions 5 and 1); in Patuakhali Sadar, we visited two community clinics in South Bohalgachia and Madar Bunia (unions 7 and 11) and one union family welfare centre (Kalikapur), as well as one union sub-centre at Lebukhali and the maternal and child welfare centre in Patuakhali town. There was no upazila health centre in Patuakhali Sadar. The community clinics in Patuakhali Sadar were roughly 7-8 km from the district town, while those in Kamalganj were 13-22 km from the district town.

We interviewed the following healthcare providers to collect information about actual delivery of services: MOs and health inspectors at the upazila health office in Patuakhali Sadar, staff nurses in the gynaecology/obstetric ward, and family welfare visitors in the maternal and child health-FP unit of Kamalganj UHC, family welfare visitors in the maternal and child welfare centre in Patuakhali town and the community-based health workers, family welfare visitor/family welfare assisants and health assistants at the community clinics and the union family welfare centre. We interviewed the following health managers to gain their perception regarding improvement in access to maternal healthcare and reasons for reduction in MMR in areas under their jurisdiction: two UH&FPOs and two civil surgeons. We interviewed local residents and had FGDs with local women users as well as community clinic committee members in villages where the community clinics were located, to get their perceptions on the quality of care at public and private facilities they use, their preferences and their perceptions about decline in maternal mortality in their area and reasons.

### Comparison of health outcomes and health infrastructure

The official statistics and DHS data show a declining trend in both national and district[18] level MMR, also evident for the two districts studied in this research. Patuakhali district overall has more than four times lower MMR than Moulvibazar district (Table 2). The MMR in Moulvibazar is higher than the national average of 143 (in 2015), while the MMR in Patuakhali is much lower. One factor that may contribute to the higher MMR in Moulvibazar is the existence of a tribal population (Khasia), who work in the 92 tea gardens/estates in the district, and who have much higher MMR than the rest of the population. The civil surgeon of Moulvibazar claims that the MMR in Moulvibazar had declined to 200 by 2015 and that the higher MMR in Moulvibazar could be due to better reporting of maternal deaths in the district.[19] The civil surgeon of Patuakhali said that there are differences in MMR by region in Patuakhali, with 'char' (island) areas near the sea having higher MMR because of remoteness and difficulty of reaching services.

**Table 2: MMR for Patuakhali and Moulvibazar districts (per 100,000 live births)**

| Year | Patuakhali | Moulvibazar |
|---|---|---|
| 2012 | 61.79 | 263.64 |
| 2014 | 58.41 | 250.74 |

*Source:* Local health bulletin, civil surgeon's office.

According to official statistics (Table 3) the MMR in 2012 was 373 in Kamalganj upazila in Moulvibazar, compared to 44 in Patuakhali Sadar upazila in Patuakhali, so that Kamalganj had higher MMR compared to its district average, while Patuakhali Sadar had lower. Mortality rates (neonatal, infant and child) were higher in Kamalganj, too. However, the number of reported caesarean operations was 1,568 in Patuakhali Sadar, compared to zero in Kamalganj. In other words, Patuakhali Sadar upazila appeared more successful than Kamalganj upazila in improving health outcomes generally and reducing MMR specifically.

[18] This statistic is not available before 2012.

[19] There is a special project implemented by an NGO (Maternal and Paediatric Death Review) in 17 districts (of which Moulvibazar was one) to record maternal and neonatal deaths based on verbal autopsy by the health inspectors.

**Table 3: Health outcomes in Kamalganj and Patuakhali Sadar Upazilas, 2012**

| Health outcomes | Kamalganj | Patuakhali Sadar |
|---|---|---|
| Total population | 257,070 | 269,049 |
| Child (1-5 years) mortality rate *per 1,000* | 25.67 | 5.89 |
| Infant (0-12 months) mortality rate *per 1,000 live births* | 20.69 | 2.36 |
| Neonatal (under one month) mortality rate *per 1,000 live births* | 16.96 | 0.88 |
| Fully vaccinated under 12 months(%) | 98 | 83 |
| Antenatal care (all) | 5,135 | 3,739 |
| Number of deliveries | 5,973 | 2,053 |
| Maternal deaths | 24 | 3 |
| Normal deliveries | 5877 | 485 |
| Caesarean sections | 0 | 1568 |
| MMR *per 100,000 live births* | 373.37 | 44.19 |

*Data source*: MOHFW,Health Bulletin-2013, Kamalganj upazila health complex.
MOHFW,Health Bulletin-2013, Patuakhali(Sadar) upazila health office.

The main healthcare providers in the public delivery system at the two upazilas are at the community/ward level (community clinic), union (union sub-centres, union family welfare centre) and upazila level (UHC). The difference in availability of healthcare personnel at the two upazilas is shown in Table 4. Patuakhali Sadar does not have a fully-fledged UHC, as it is located in the district capital, which has a 250-bed Sadar hospital, hence there are only two MOs posted there to carry out administrative tasks and oversee the community-based domiciliary health workers in the upazila.

Table 4 shows that there are 27 community clinics in Kamalganj (of which only 20 are functional with a community healthcare provider posted) and 30 in Patuakhali Sadar, all of which are under DGHS jurisdiction. The numbers of union health and family welfare centres under DGFP are five in Kamalganj and 12 in Patuakhali Sadar, while there are three union sub-centres under DGHS in Kamalganj and none in Patuakhali Sadar. There are no NGO clinics in either upazila. In 2011-12, the extent of vacancy was 23 percent (30 out of 131 sanctioned posts) in Kamalganj and 17 percent (19 out of 109 sanctioned posts) in Patuakhali Sadar, with relatively more vacant posts at the union and community levels. It is noteworthy that in Kamalganj, seven out of 10 medical officer posts remained vacant. If the number of MOs and other staff absent (which is not recorded) were added, no doubt the lack of trained healthcare personnel at local level would be higher. Thus, even with a roughly similar population size, Kamalganj has fewer public health facilities per capita than Patuakhali Sadar and relatively more vacancies in critical posts.

**Table 4: Public healthcare providers in Kamalganj and Patuakhali Sadar upazilas, 2012**

| Facility | Human resources | Kamalganj | | | Patuakhali Sadar | | |
|---|---|---|---|---|---|---|---|
| | | Sanctioned | Filled up | Vacancy | Sanctioned | Filled up | Vacancy |
| Total population | | 257,070 | | | 269,049 | | |
| Community clinic | Community healthcare provider | 27 | 20 | 7 | 34 | 34 | 0 |
| | Health assistants | 45 | 38 | 7 | 51 | 44 | 7 |
| Union sub-centres/UHFWC/RD | Physician/ medical officer | 10 | 3 | 7 | 12 | 8 | 4 |
| | Medical assistant | 10 | 9 | 1 | 12 | 9 | 3 |
| | Assistant health inspector | 9 | 9 | 0 | 0 | 0 | 0 |
| Upazila health centre | Physician | 9 | 8 | 1 | 2 | 1 | 1 |
| | Nurse | 11 | 6 | 5 | 0 | 0 | 0 |
| | Medical assistant | 2 | 2 | 0 | 0 | 0 | 0 |
| | Medical technologist | 5 | 3 | 2 | 1 | 0 | 1 |
| | Health inspector | 3 | 3 | 0 | 3 | 3 | 0 |
| | Assistant health inspector | 0 | 0 | 0 | 10 | 10 | 0 |

*Source:* 1.MOHFW,Health Bulletin-2013,Kamalganj upazila health complex.
2.MOHFW,Health Bulletin-2013,Patuakhali(Sadar) upazila health office.

**Implementation of maternal healthcare services at upazila and below**

To examine actual implementation at local levels, we collected information on the delivery of the following maternal health services: a) registration of pregnant women and antenatal care delivery; b) attendance of normal deliveries by trained healthcare providers, whether at home or in a facility; and c) availability of comprehensive and basic emergency obstetric care and trends in caesarean operations.

***Moulvibazar, Kamalganj***

*a) Registration of pregnant women and antenatal care delivery*

In Moulvibazar, we found serious shortcomings in the registration of pregnant women by frontline staff, due to poor coordination on this issue. There was also poor coordination around the provision of antenatal satellite clinics. Although some provision appeared to be taking place, it was patchy. For example, women in Baligaon village complained that health and family planning workers were not very active in the community and did not make regular field visits, and that family planning services were poorly delivered. They said that pregnant women from better-off households chose to go for check-ups to private doctors in Moulvibazar town, rather than the UHC, because there was a gulf in quality; pregnant women who cannot afford the cost of private care do not receive antenatal care.

*b) Attendance of normal deliveries by CSBAs and facility births*

According to the health inspector at the UHC, there were 19 female health assistants and 11 family welfare visitors in Kamalganj upazila with training in skilled birth attendance. However, government staff accepted that skilled birth attendance was far from universal, while women we spoke to in Baligaon and Ujirpur villages and in the FGD confirmed that, in Kamalganj, home delivery is the common practice, with traditional birth attendants, often relatives of the family, assisting most of these births. Even where trained health assistants were on hand, deliveries were normally conducted at home, since most community clinics did not have delivery rooms and equipment. At union level, there were five union family welfare centres, but no medical officers, and the minimum facilities (electricity, water) for normal delivery were absent. Only at Kamalganj UHC were normal deliveries performed, by two senior staff nurses, assisted by three junior nurses appointed under the maternal neonatal health initiative project.

*c) Emergency obstetric care and caesarean sections*

There was no facility in Kamalganj upazila to provide comprehensive emergency obstetric care and caesarean operations, nor in any other UHC in Moulvibazar district. This explains why official statistics recorded zero caesarean operations at Kamalganj UHC. We were told that women with complicated pregnancies who came to the UHC were referred to the Sadar hospital in Moulvibazar town. Better-off women avail themselves of comprehensive emergency obstetric

care from private clinics in Moulvibazar town, where most public physicians/MOs, including the upazila health and family planning officer, have private practices. Poor women have no option but to go to the Sadar hospital, where service quality is poorer and waiting times are longer, and even then government doctors send them to private pathologists for tests.

***Patuakhali, Patuakhali Sadar***

*a) Registration of pregnant women and antenatal care delivery*

Our field observations suggested that both registration of pregnant women (for follow-up for antenatal care check-ups and birth planning) and listing of pregnant women for tetanus vaccination was fairly high in this upazila. The family welfare assistant at the Bohalgachia community clinic in Kalikapur union and the family welfare visitor from the union family welfare centre in Kalikapur both registered pregnant women and provided them with cards, either at the community clinic or at satellite clinics in the villages under their jurisdiction. The family welfare visitor also registered pregnant women who came to the union family welfare centre for antenatal care. The family welfare assistant visited the community clinic two days a week and provided family planning services, while the family welfare visitor from Kalikapur Union family welfare centre provided antenatal care to pregnant women once a month, and from the six satellite clinics she conducts in the villages in that ward. Women in the upazila can also obtain antenatal care from the maternal and child welfare centre in Patuakhali district town, which is close to most villages under Sadar upazila and appears very active.

*b) Attendance of normal deliveries by trained personnel and facility births*

Overall, the evidence suggested that normal deliveries assisted by trained personnel were fairly common in Patuakhali Sadar upazila, but, as in Moulvibazar, the community clinics in the areas we visited were not equipped to provide normal deliveries. Even though health staff reported that clinics in Patuakhali district were increasingly being equipped, it appears many skilled deliveries are conducted at home and merely reported as being clinic-based.

At union level, out of 12 union family welfare centres, five were upgraded to provide normal deliveries and basic emergency obstetric care. Our visit to the union family welfare centre at Kalikapur revealed that, although there was currently no facility for normal delivery there, construction was going on to build a delivery room with the financial support of an NGO (Marie Stopes), which was upgrading several other union family welfare centres in the upazila for normal deliveries.[20]

[20] The family welfare assistant from Kalikapur union family welfare centre said that there was only one normal delivery in the union family welfare centre in September 2015, but none since then, possibly because of renovation.

*c) Emergency obstetric care and caesarean sections*

Pregnant women in Patuakhali Sadar upazila had access to basic emergency obstetric care (24-hour normal delivery facilities) from the five upgraded union family welfare centres, according to the family welfare visitor at the union family welfare centre at Kalikapur, but comprehensive emergency obstetric care and facilities for caesarean operations were not available within the upazila, despite official statistics.[21] Comprehensive emergency obstetric care services were available from facilities at Patuakhali town, which is merely 7-8 kilometres away: the maternal and child welfare centre and Sadar hospital (where four to five gynaecologists were posted). The maternal and child welfare centre in Patuakhali district town appeared very busy when we visited. Four family welfare visitors performed normal deliveries and one MO provided comprehensive emergency obstetric care and caesarean operations.[22] Although there was supposed to be an MO at the Kalikapur union family welfare centre, she was informally deputed to the Sadar hospital in Patuakhali town, the reason being that she had no support or equipment to do so, a general complaint of all MOs posted at union family welfare centres.

Apparently midwives had also been appointed to 12 union sub-centres in the district to provide normal deliveries and basic emergency obstetric care. However, the physical condition of the union sub-centres we visited indicated that there was no facility to perform deliveries there.

**Comparison of the two cases: Probable explanations for differential implementation and performance**

In summary, and despite some limitations, delivery of maternal healthcare is considerably superior in Patuakhali Sadar upazila compared to Kamalganj upazila. Coverage of registration of pregnant women at community level is higher and delivery of antenatal care from village satellite clinics, community clinics and union family welfare centres is far better in Patuakhali Sadar, as was availability of normal delivery facilities within the ward and union. The latter are almost non-existent in Kamalganj Sadar. With respect to availability of trained assistance for home deliveries, too, women in Kamalganj are relatively more deprived. Women in Patuakhali Sadar have access to basic emergency obstetric care, but women in Kamalganj do not. Neither upazila, however, has facilities that provide comprehensive emergency obstetric care.

Despite differences in service delivery, the relative rating of service quality and availability of health facilities in the area by residents/users was very similar in Kamalganj and Patuakhali Sadar upazilas: the community clinic was the most preferred, because of proximity and

[21] Table 2 shows that 1568 caesarean operations were done in Patuakhali Sadar upazila in 2012. These surgeries could be those performed by MOs at the Sadar Hospital in Patuakhali town, who are on paper posted at the Union Family Welfare Centres in the upazila and under jurisdiction of the UH&FPO.
[22] In the previous month there were 30 caesarean sections and 18 normal deliveries at the Maternal and Child Welfare Centre.

availability of the community healthcare provider, saving time and hassle for women. This was followed by the UHC in Kamalganj, and then the Sadar hospitals in the district capital, while union-level facilities were least preferred. In Patuakhali, private clinics featured next, possibly because of the large numbers located in Patuakhali town and its proximity to the upazila.

The reasons for the relatively poorer delivery of maternal healthcare in Kamalganj appear to be related to both social/cultural context and governance failures.

**Social context**

Despite having a significant proportion of households with international migrants, people of Kamalganj upazila appeared to be religiously conservative and more traditional in practice, so that preference was for relatively larger family size (four or five children) and home delivery with traditional birth attendants. Cultural barriers also prevented women from seeking routine antenatal care. In other words, although there are claims by all the healthcare providers/managers that we interviewed of greater awareness about health services, the demand for antenatal care and trained assistance during delivery in Kamalganj appears low, which is confirmed by the fact that Kamalganj is one of the upazilas where the demand-side financing scheme of maternal voucher is implemented. The degree of local activism around healthcare delivery in Kamalganj appeared minimal and residents seemed resigned to poor service delivery and the fact that better service had to be purchased. The land donor for the community clinic did donate his land, but did not seem proactive in its performance, and in fact was abroad when the building was constructed.

In contrast, people of Patuakhali Sadar upazila appeared more open to modern facilities and services. They readily accepted family planning methods and antenatal care for pregnant women, and were far more likely to break tradition and seek the assistance of community-based skilled birth attendants for home deliveries. The fact that many community clinics performed normal deliveries indicated that the demand for facility delivery, even for normal births, was rising. Hence, the demand for maternal healthcare generally was relatively higher in Patuakhali Sadar, and the presence of many private clinics and the maternal and child welfare centre in Patuakhali town seemed to put some kind of pressure on the performance of local-level facilities. The level of activism around healthcare delivery was relatively higher, as evident from the behaviour of the land donor of Bohalgachia community clinic, who had personally visited the project director in Dhaka to get approval for the community clinic and personally supervised the construction of the community clinic building. He, together with his friend the mayor of Patuakhali town, was also very active in the overall maintenance and performance of the community clinic, and in motivating residents to use it. From a political settlement point of view, some of the weaknesses of state service provision appeared to be ameliorated in this case by a combination of local political/community activism, and private sector involvement.

**Coordination between health and family planning fieldworkers**

Coordination of work between health and family planning workers at the community and union levels (health assistants and family welfare visitors) is of utmost importance. However, we found little evidence of coordination between health assistants and family welfare visitors with respect to providing services to pregnant women in Kamalganj upazila. Thus, while officially there is 'functional' integration of services of health and family planning staff at the community level, in reality, health and family planning field staff in Kamalganj appeared reluctant to cooperate. In a context of low demand for services, this further dampens uptake of antenatal care and trained personnel to attend home deliveries.

A possible explanation for the coordination problems is that the staff recruitment process was highly politicised, leading to conflict of interest clashes. In particular, the delivery of antenatal care at the community level (village and union) in Kamalganj appears to be caught in the 'hostility' between DGHS and DGFP that has plagued implementation of maternal healthcare delivery more generally. The fact that family welfare visitors no longer attend the community clinics to provide antenatal care through a monthly satellite clinic, and that the family welfare assistants who are posted have multiple work areas, could indicate reluctance on the part of family planning community workers to provide antenatal care services from community clinics that are under the jurisdiction of DGHS. On the other hand, a claim by the civil surgeon that MOs posted at the union sub-centres (under DGHS) provide antenatal care from the community clinics sounds like an attempt to compete with family planning workers in the provision of antenatal care services. The feeling of hostility is reflected in the comment of the civil surgeon: 'The grief of China is the river Hwang-Ho and the grief of health sector is the family planning wing'.

In Patuakhali Sadar, lack of coordination and cooperation between health and family planning community staff did not surface as a problem, and there was no conflict regarding their joint responsibilities for conducting the satellite clinics and Extended Programme on Immunization clinics (EPIs) at the community clinics. Arguably, one explanation for this could be that in both the satellite clinics and EPIs staff generally came directly from the local community and were familiar to each other. However, hostility did emerge with respect to medical officers, who were posted at the union family welfare centres. More research would be needed to establish exactly why; according to the civil surgeon, since the union family welfare centres were under the jurisdiction of DGFP, the family welfare visitor and SACMO posted there had developed a sense of ownership and command over the centre, and are well known in the locality. The new MOs were young and inexperienced and although they were in charge of the centre, they were not able to exert authority and found it uncomfortable. It is worth noting that the civil surgeon of Patuakhali seemed to want to claim some of the success in reducing MMR, by trying to demonstrate that normal deliveries were also done in DGHS facilities (community clinics and union sub-centres) and by DGHS staff. Thus, he claimed that in community clinics, normal

deliveries were done by the community healthcare provider and health assistants with community-based skilled birth attendants training, who are DGHS staff.

**Supervision of field staff**

Existing governance arrangements at Kamalganj lead to poorer quality of maternal healthcare compared to Patuakhali Sadar. We found that since health assistants and family welfare visitors with community-based birth training, who assist home deliveries in the same villages, are independently supervised by the health inspector (under DGHS) and family planning inspector (under DGFP), respectively, health managers in Kamalganj are not aware of the absence of coordination at the field level, evident also from the interviews with the UH&FPO and the civil surgeon. Monitoring o of community-based workers' activities through on-the-spot visits is also not regular there, as the community clinics are sometimes visited by the civil surgeon and infrequently (never) by the UH&FPO. The health inspector from the UHC visits each community clinic once a month to conduct the EPI day, but monthly coordination meetings at the UHC for all staff under DGHS in the upazila are not held.

By contrast, Patuakhali Sadar community clinics are regularly visited by either the UH&FPO or the medical officer (disease control) or SACMO from the UHC. The community healthcare provider and health assistants mentioned that monthly monitoring meetings for health field staff are also held regularly. The UH&FPO believes that there is very good field coordination with respect to registration of pregnant women and their follow-up, either by the family welfare visitor or health assistants, and since the community healthcare providers report monthly to the upazila health office, all information regarding pregnant women in the upazila is available at the upazila health office. However, there was no way of verifying his claim.

**Vacancies and absenteeism**

The other governance problem is the issue of vacancies and absenteeism at the union facilities. In Kamalganj, the general impression of village residents and community health workers was that the medical officers were mostly absent, which is why they had to go to private clinics in the Sadar (district capital) when there were pregnancy-related complications. The absence of MOs from their posts at union-level facilities is also seen in Patuakhali Sadar upazila, for example in the union family welfare centre at Kalikapur, the medical officer has an office that she never attends, as she is serving at the Sadar hospital. According to the civil surgeon this is a common occurrence in Patuakhali district, because the union family welfare centres do not have the facilities and support staff, including residential quarters, that MOs need to perform their routine duties. One informant complained that the health minister at the time (who came from that region) had lobbied with the director general of HS to have the MOs posted to the newly established medical college in Patuakhali, possibly to hand out favours.

**Community clinic sustainability**

Finally, even such a high-profile intervention as the community clinic project that had gained such popularity among users, was facing sustainability issues, possibly due to emphasis on quantity rather than quality, which has resulted in the construction of 'visible' buildings and hiring of personnel without providing adequate equipment and resources for ensuring service quality. While all the four community clinics in both upazilas were ranked as the first preference of villagers for treatment of minor illnesses, the numbers of patients had dropped drastically over the six months since our field work in May/June 2015, reportedly because of a shortage of medicine. In addition, in Kamalganj, community clinic users felt resentful about having to pay 2 Taka per visit, as they saw it as a government clinic, where they should not have to pay. The practice of charging patients was not observed in the community clinics in Patuakhali Sadar.

The establishment of the community clinics has created opportunities for rent generation and political interests, too. In Kamalganj upazila, the niece of the land donor was appointed the first community healthcare provider of Baligaon community clinic. The donation of the land may also have served to safeguard his political position, as he was a member of the opposition political party. In Patuakhali Sadar upazila, the land donor was extremely politically active, belonging to the ruling party, and it seemed his reason for land donation was to consolidate his position locally, by making a highly visible contribution to the village. He has also established a primary school beside the community clinic and has plans to build a high school. All these actions are possibly to establish his control in the village (in fact, he had put a fence around the community clinic premises on his own account and made a vegetable plot) and to demonstrate his local power.

Party political clout is also evident from the construction of apparently unnecessary infrastructure and facilities in both districts. In Patuakhali a 10-bed hospital was constructed, due to the political influence of a former MP near his village home, which according to an FGD with women residents hardly provides any service and is not used by them. In Moulvibazar, the Sadar hospital was upgraded to a 250-bed secondary and tertiary care hospital (only 18 districts out of 64 have one), due to political pressure from the then finance minister, who came from that district.

The relationship between the local-level situation and the national political settlement is complex. Upazila chairmen do not run for the post under the banner of a national party, so cannot formally be associated with national party politics. However, there tend to be informal 'blessings' from national parties that make it evident to voters which party an upazila chairman candidate is indirectly affiliated with. Thus, national party politics is still relevant, particularly in the sense of the relationship between the MP, on the one hand, and the upazila chairman and local mayor, on the other hand, which can be mediated by party politics and other factors.

In Patuakhali, the MP was from the current opposition party (Jatiyo party). As a high-ranking party member, he tended to be away and busy in the capital, and was out of touch with local-level development. Moreover, as a member of the opposition party, his ability to influence decision-making at the local level was limited. This allowed a degree of space for the really significant factor, which was the role of the upazila chairman and the local mayor of Patuakhali, who appeared to be dedicated to making a genuine impact on the community.

In Kamalganj, a quite different set of circumstances operated. The MP, Syed Mohsin Ali, was an influential minister (of social welfare) in the government.[23] In contrast to Patuakhali, Ali was close to and popular with his district's people, and often liked to take matters in hand personally. This made it hard for the upazila chairman, who was from an opposition party, to function. The serious lack of coordination between them arguably had adverse effects on the health sector.

## Conclusions

This paper has shown how a 'political settlements plus' framework can help illuminate some general features of health policy performance in Bangladesh, in particular with reference to maternal health. It has detailed how pro-poor NGOs assumed a position of considerable importance in the post-war reconstruction of Bangladesh that accompanied the state's inception. Subsequently, with the transition to democracy in 1990, the main political parties, despite their elitist origins, continued to espouse a pro-poor, pro-rural, welfarist ideology. This has helped earn the parties legitimacy with the poor at home, and with donors abroad. A number of more or less successful programmes have been undertaken, with NGO and donor support, with the aim of reducing maternal mortality, involving considerable investments in recruitment, training and infrastructure. The dominant strategy for incorporating elite and non-elite followers into the political settlement has, however, been clientelistic.

This has manifested in a number of ways, including: leverage of the private sector for political rent generation, leading to a burgeoning and poorly regulated private sector; expanding public sector employment for political as much as service-delivery reasons; a reluctance or inability to discipline public sector staff, leading to absenteeism, under-the-table payments and irrational human resource allocation; inability or unwillingness to bring competing centres of power effectively under a central authority, leading to coordination failures between different directorates; a laissez-faire attitude to public staff moonlighting in private facilities, leading, among other things, to high out-of-pocket costs and a surge in non-medically indicated caesarean births; an inability or unwillingness to confront professional associations, leading to the domination of maternal health services by elite interests; and a preference, at times, for making high visibility infrastructural investments, such as t10-bed hospitals, without supporting staff or services.

[23] After his sudden death in 2015, his wife became MP instead.

All these trends have diluted the effectiveness of public programmes and skewed the distribution of maternal health gains in favour of the better off. Doubts must be entertained, then, over whether the current combination of ostensibly pro-poor but practically inefficient public service with freewheeling private provision will reduce the MMR much beyond current levels. At the same time, it is not clear what the drivers of more efficient and equitable improved maternal health services would be under the current political settlement. Perhaps the solution lies in some recent demand-side initiatives, or, more radically, in efforts to conscientise and politically empower the poor, the success of the latter hinging, among other things, on broad trends in Bangladeshi demography and political economy.

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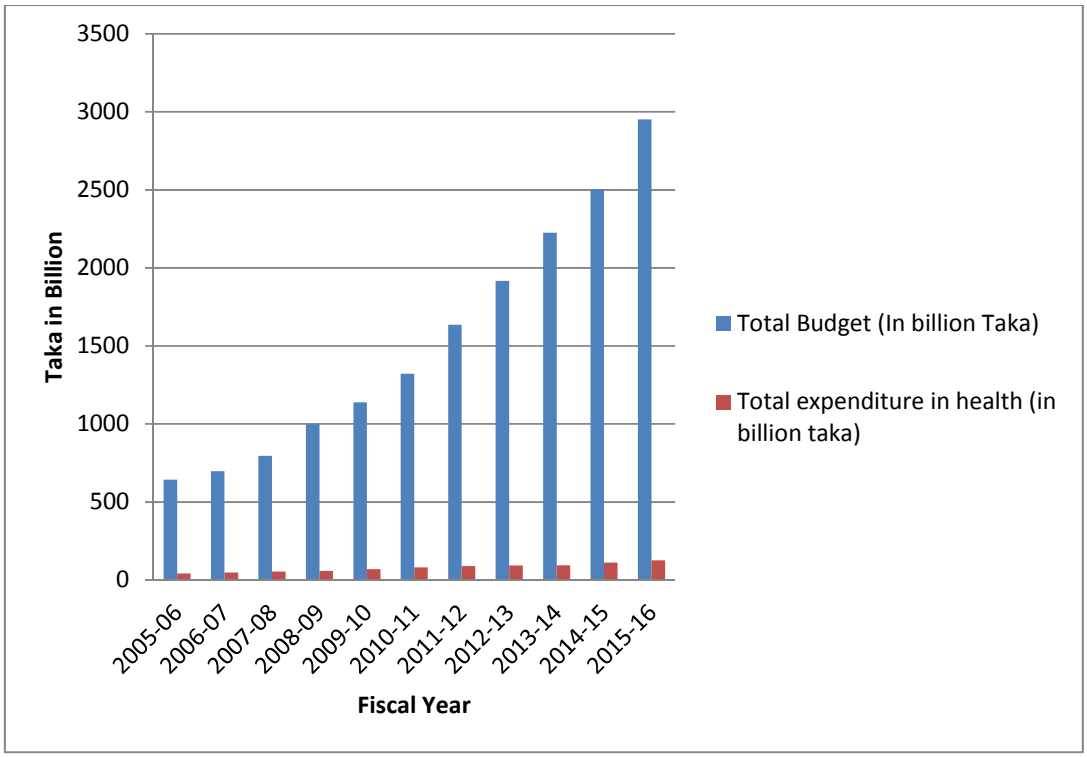
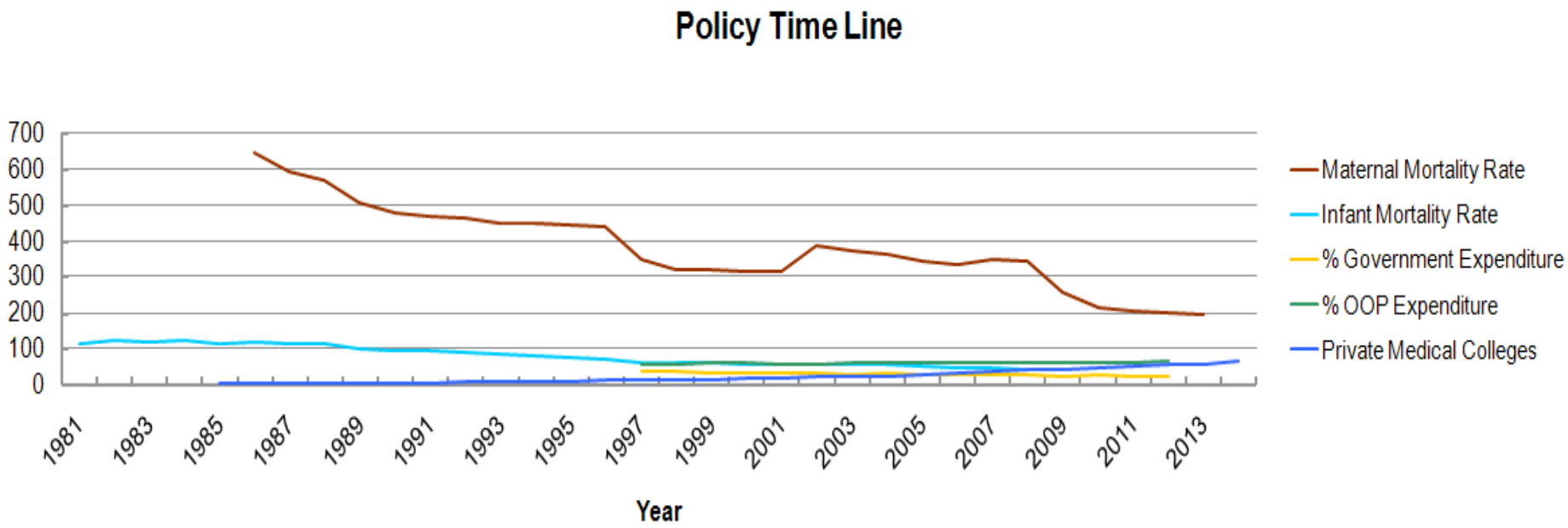
## Annex

**Figure 4: Total budget and total expenditure in health**



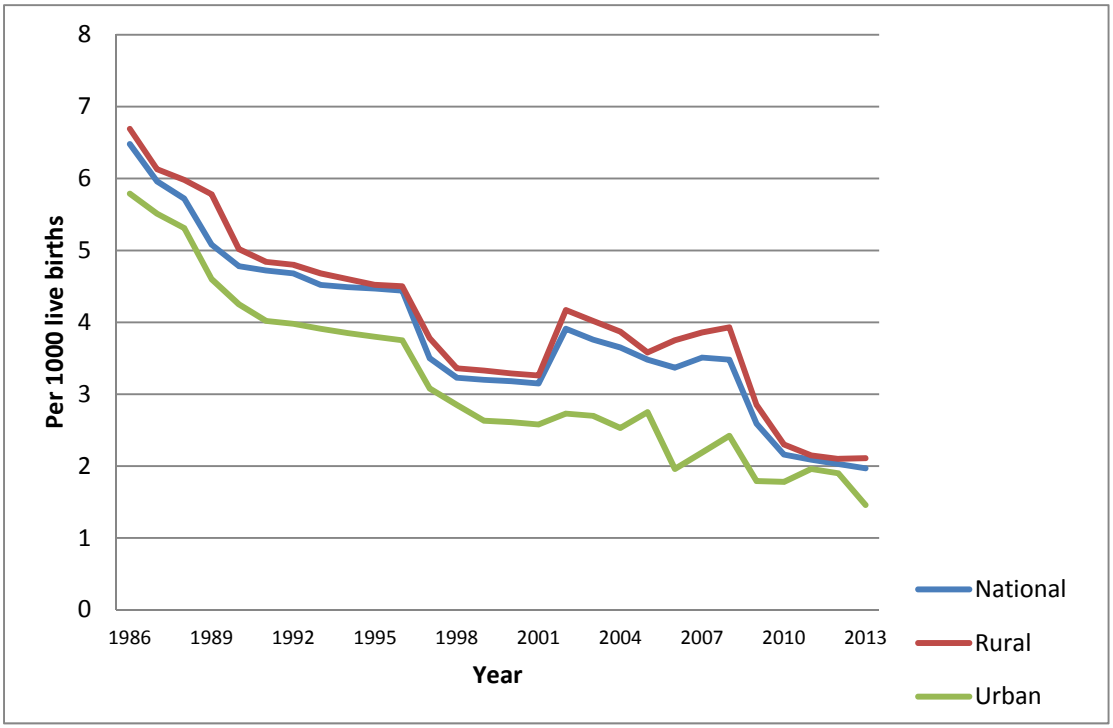

*Source:* Ministry of Finance's 'Bangladesh Economic Review', 2013, available at https://mof.gov.bd/site/page/44e399b3-d378-41aa-86ff-8c4277eb0990/Bangladesh-Economic-Review (accessed 3 December 2019).

**Figure 5: Policy timeline**




Source: Authors' calculation based on Bangladesh National Health Accounts, available at http://heu.gov.bd/national-health-accounts/

**Figure 6: Maternal mortality ratio**




*Editor's note*: The source(s) for this table were not noted in the draft. We imagine that it is likely to be the author's calculation based on data available in, for instance, the NIPORT Bangladesh Maternal Mortality and Health Care Surveys, the Demographic and Health Survey programme for Bangladesh, and the Bangladesh Ministry of Health and Family Welfare annual 'Health Bulletins.

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