

CHAPTER 5: INSTITUTIONS AND ACCOUNTABILITY

103. Perhaps more striking than recent decreases in the levels of social indicators in Bangladesh is their continuing and considerable variation across space. The ratio of girls to boys in school is 30 points higher in OU Dhaka than SMA Dhaka, for example, while the primary enrollment and primary completion rates are 54 percent and 62 percent higher in the highest regions of the country than the lowest, respectively. Child malnutrition, measles vaccination coverage and infant mortality also vary significantly across Bangladesh's regions. A significant portion of these variations can be explained by the nature of public health services in Bangladesh, which provide varying levels and quality of service, and which are hampered by accountability and governance problems. There is very little outreach to the community and zero accountability to the clients as all public health service employees are central government employees managed from Dhaka. The situation in publicly financed health services contrasts starkly to that in secondary education where most schools are publicly financed but privately managed with local school committees. In those schools, education outcomes can be monitored by groups of parents who are able to look at overall exam results achieved by the school. No such accountability mechanism exists for publicly financed health services.

104. Such variation—essentially amongst different parts of the public service provision system—is small when compared to that between public and non-governmental service providers. Bangladesh has had success in health services; vertical, public preventive health care programs where accountability is very clear, for example, do reasonably well. Bangladesh has many examples of success in the health sector where the NGO sector has achieved success in both preventive and curative care using clear lines of both *downward and upward accountability*. The largest of these models is Gonoshasthaya Kendra (GK), a pioneer NGO in health care, which is now the second largest health service provider in the country after the Government. A recent study²¹ shows that areas of the country served by GK met the MDG target for infant mortality of 32 per thousand live births in 2003-04, while the country as a whole remained well above 50.

105. What explains such stark differences? Begin with the weaknesses of the formal, government health system. A recent study of public sector health services²² tried to understand the reasons why the public services were failing to deliver despite higher resources and staff salaries. The authors surveyed 15 randomly chosen upazilas and looked at the following issues: (a) misdirection of funds; (b) lack of control over payroll disbursements; (c) illegal payments to accounts officers; (d) purchases at higher than market prices; (e) private practice by doctors during office hours; (f) absenteeism of service providers; (g) negative activities of class 3 and 4 unions; and (h) sale and pilferage of drugs by employees. The study found high rates of absenteeism particularly at the upazila and lower levels.

106. The absenteeism rate among upazila family planning officers was 46 percent whereas that for resident doctors was 23 percent. Even when present, fewer than half the doctors were engaged in addressing patient needs. Sixty percent of doctors were reported to be engaged in private practice in public hospitals, demanding payments from their patients, and almost 67 percent encouraged their patients to visit their private practices. In all upazilas surveyed, private pharmacists reported that hospital personnel sell them drugs. In most cases, the records indicate out-patients received medicines whereas

²¹ Chaudhury, R. H. 2006. "Gonoshayastha Kendra's Experience in reducing Maternal and Child Mortality – An Example of Transparency and Accountability as a Way to Achieve MDG Outcomes," Workshop presentation, Dhaka: The World Bank.

²² Cortez, R. 2006. "Bangladesh – Strengthening Management and Governance in the HNP Sector". Workshop Presentation, World Bank: Dhaka .

they actually did not receive any. With regard to tendering, the large majority purchased goods above market prices and most suppliers reported having to pay commission to staff. The trade unions of class 3 and 4 staff (below clerical level) pay a major role in controlling access to the services providers and sometimes even encourage service providers to be late increasing their chances of collecting side payments.

107. The above problems explains to a large extent why public health services fail to deliver²³. NGOs appear to avoid these problems by generating upward and downward accountability in their delivery systems. The relevant unit of analysis for such questions is the upazila, which has discretion over budgets, staffing, supplies and medical standards for health care at the union and village levels, and hence we shall focus here.

108. The next section examines the institutional underpinnings of service provision in two upazilas, one high-performing and the other low-performing. The section that follows examines the service provision model of GK, with an emphasis on the innovations that have allowed them to reach such high levels of success. Both seek to explain divergent outcomes not in terms of how hard health workers work, nor how well dispensaries are stocked, but rather why health workers expend more effort in one locale than another, and why some facilities are well-stocked and others are not. That is to say, we do not seek to explain differences in outcomes through differences in service inputs, but rather the deeper institutional and social factors that cause services to be provided differently in the first place. We begin with a tale of two upazilas.

I. Satoria vs. Rajnagar²⁴

109. Satoria upazila is located in Manikganj district west of Dhaka, while Rajnagar upazila is located in Moulvibazar district on Bangladesh's eastern border with India. Despite its greater distance from the capital, it is Rajnagar that is wealthier, with an average household income of Tk.7,081/month compared to Satoria's Tk.5,831/month, and more livestock assets per family. This is at least partly explained by the high levels of remittances families in Rajnagar receive from a large diaspora in the UK. Indeed, the nearby airport in Sylhet boasts direct flights to London. Average landholdings are higher in Rajnagar, at 182 decimals per household vs. 137 in Sylhet. And Rajnagar's literacy rate of 64 percent is also higher than Satoria's 58 percent, as is its average household size—6.2 vs. 5.1. But it is also more unequal, with more households in both the extreme poor and rich categories, while 86 percent of Satoria's population is concentrated in the intervening two categories.

110. But paradoxically, Satoria has systematically superior health indicators than Rajnagar. Under-five mortality in 2005 was 40 per thousand in Rajnagar, compared to 13 per thousand in Satoria; the prevalence of illnesses in Rajnagar is 36 percent, compared to 25 percent in Satoria; and the notional maternal mortality rate over the previous 5 years²⁵ was 791 per hundred thousand live births in Rajnagar, compared to 0 in Satoria. The statistics on complications during childbirth tell the same story: mothers in Rajnagar suffered more from long labor, excessive bleeding, high fever and convulsions than mothers in Satoria. In light of this, it is not surprising that Satoria has had considerably more success in reducing its maternal and child mortality rates over the past few years than Rajnagar.

²³ Despite this, there are motivated workers in the public sector particularly those who can see the outcomes of what they do – for example those working on immunization campaigns.

²⁴ The data in this section comes from Ali, Z. and T. Rahman. 2006. "A Tale of Two Upazilas: A Study of Spatial Differences in MDG Outcomes in Bangladesh," Workshop Paper, Dhaka: The World Bank

²⁵ This is notional because such a low-frequency phenomenon as maternal mortality requires a larger sample or longer time frame for accurate calculation.

111. It is also not surprising that much of this is due to better infrastructure and the superior provision of health services in Saturia. Access to sanitary toilets, for example, is higher in Saturia (90%) than Rajnagar (69%). Pregnant mothers receive more antenatal care in Saturia (91%) than Rajnagar (73%). More mothers are informed about the signs of pregnancy complications in Saturia (83%), and where to go when they occur (87%) than Rajnagar (63% and 73%). More mothers receive vaccinations and nutritional supplements during pregnancy in Saturia, and more have a post-partum check-up, and more quickly, than Rajnagar. Table 5.1 summarizes additional data on child health interventions and outcomes in the two upazilas.

Table 5.1: Child Health Indicators by Upazila

	Saturia	Rajnagar
Baby given colostrum immediately after birth (%)	90.9	84.7
Vitamin A given to child (%)	82.9	72.7
Diarrhoea - last 2 weeks (%)	25.4	42.5
Chest problems - last 2 weeks(%)	12.9	24.2
Breathing difficulty - last 2 weeks (%)	18.2	28.4
Rapid breathing - last 2 weeks(%)	19.1	29.7
Cough - last 2 weeks (%)	35.1	59.3

Source: Ali and Rahman (2006)

112. If economic variables do not explain such divergent health outcomes, what does? The answer cannot relate to the structure of the health sector in each upazila, nor to the quantity nor design of the physical infrastructure available, as this is all common to both upazilas. Both Saturia and Rajnagar are served by the Ministry of Health and Family Planning, which in Bangladesh employs a particularly standardized, homogeneous model of health provision that deploys assets uniformly, allocates resources mechanically, and is as a result insensitive to local characteristics or variations in local demand. Hence variations in performance must be due to something else.

113. If the answer is not local health “hardware”, is there something in the “software” that might explain differences in performance? A visit to each upazila is telling in this regard. There are numerous, obvious differences in the maintenance and operation of the health facilities at hand. Field visits to each Upazila Health Complex (UHC) found that Saturia’s was well-maintained and clean, with more bathrooms available, all clean and in working order, the operating room in good repair and used regularly, and staff absenteeism was 1 percent. In Rajnagar, by contrast, most of the rooms, wards, windows and doors were damaged, its toilets were so dirty they had become unusable, the operating room was unused and abandoned, and staff absenteeism was 10 percent. Unfortunately for the residents of Rajnagar, health authorities made far fewer community visits than in Saturia, leaving them more reliant on this degraded infrastructure. When interviewed in much detail, patients in Saturia were quite happy about the quality of services they received, while in Rajnagar patient opinion was decidedly mixed.

114. These differences grow sharper at the union level.²⁶ The Union Health and Family Welfare Center (UHFWC) visited in Rajnagar was badly understaffed, with no doctor in charge. This forced it to close when staff attended at Satellite Clinics (SCs) in the villages, leaving it open only three days a week.

²⁶ Unions visited were Munshibazar in Rajnagar and Dhankora in Saturia.

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The UHFWC in Saturia, by contrast, was fully staffed and open 5 days a week. Facilities were well maintained and clean in Saturia, but badly maintained and dirty in Rajnagar, with the toilets once again unusable. Both have electricity, but almost no lights or fans worked in Rajnagar, rendering the operating room inoperable. In Saturia all of the above did work, and the operating room was in regular use. The tubewell did not function in Rajnagar, and the water supply lines were damaged, while Saturia's water infrastructure was in good repair. In Saturia medicines and family planning supplies were well stocked and regularly replenished, whereas Rajnagar received family planning supplies but no medicines from the Ministry. As we might expect, the combination of superior facilities and happier patients led to greater popularity amongst the population – the Saturia facility treated 8,000 patients in 2005, while the Rajnagar facility managed only 4,400, despite a larger overall population. These differences were reflected at the village level, where the Saturia SC was better endowed with health and sanitary equipment, including a toilet, which the Rajnagar SC did not have. On the day each was visited, 85 patients were treated at the Saturia SC compared to just 24 at the Rajnagar SC. The dysfunctionality of Rajnagar's UHFWC, of course, contributed to heavier use of its upazila health complex, despite the problems identified at the latter. Because a UHC is a higher-cost installation than a UHFWC, the upwards deflection of patients in Rajnagar led to higher overall costs for a given number of treatments. In Saturia, by contrast, better functioning of the health services pyramid not only extended services to more patients, but effectively reduced unit costs.

115. The objective differences in healthcare provision between the two upazilas translate directly into subjective measures of the quality of healthcare received. Patients in Saturia reported far higher satisfaction with a number of important factors, including: the attitudes of their doctors and other service providers, attitudes of office staff, physical infrastructure, utilities, cleanliness and hygiene, privacy of treatment, quality of food, waiting time, availability of doctors, availability of drugs, availability of medical supplies and the quality of treatment received. Patients in Saturia reported much shorter waits for treatment than those in Rajnagar, and 72 percent thought they would be able to follow doctors' instructions, as compared to 56 percent in Rajnagar.

116. In summary, the structure of the public health system, and the quantity and design of its assets, were quite similar across both upazilas. But these assets were maintained and exploited in quite different ways, leading to significant differences in the quality and quantity of services provided in the two upazilas. These differences led to important differences in real health outcomes, and explain why people in Saturia suffered from fewer diseases, and had healthier children and mothers, than those in Rajnagar. The link between better health services and improved outcomes is further supported by a detailed econometric analysis of the two areas.

117. So far we have good proximate causes of the variation in health outcomes. But we must go further. Why were infrastructure and equipment deployed differently in the two districts? Why were they cleaned and maintained in one but not the other? To answer these questions we must dig deeper into the local institutional context in which the health sector operated, and identify the deep incentives and behaviors at work.

118. Begin with monitoring. Focus group discussions revealed important differences in the way that public services were monitored in the two upazilas. Health authorities in Saturia reported extensive monitoring by their superiors at the district level, with frequent visits to the area, whereas their peers in Rajnagar did not report such monitoring. This establishes upwards accountability for Saturia's health system, but not for Rajnagar's. Accountability also works in the downward direction in Saturia, with the active involvement of Union Parishad²⁷ (UP) officials in health delivery issues. Focus groups testified that the UP chairman takes steps to facilitate the proper implementation of Saturia's health program, and

²⁷ The institution of local government, usually covering several villages.

Union officials regularly monitor the quality of services provided in town and villages. Independent researchers corroborated this when they found the chairman observing immunizations in different areas of his union on National Immunization Day. When asked why, he responded, “As the local people’s elected representatives, it’s our responsibility to monitor whether they’re getting the services they’re supposed to receive. We keep tabs on whether health authorities are providing proper services to the people or not, and visiting villages in a timely fashion or not.” No evidence of any of this was found present in Rajnagar, whose health officials were left operating in an institutional vacuum, disconnected from both their superiors and from the elected representatives of their target population. In such a context, it is not surprising that their performance was indifferent and unresponsive.

119. This level of involvement and oversight on behalf of the people was reflected in the attitudes and behaviors of the people themselves. Sauria’s citizens were found to be extensively involved with the delivery of health services in their upazila. Interviews and direct observation uncovered regular and intense interactions between health workers and community people in Sauria. There was very little evidence of this in Rajnagar. As a result, health workers in Sauria were able to maintain quite close relationships with the people they were meant to serve, and involve them closely in decision-making. By contrast, ordinary people in Rajnagar were kept at arm’s length by their authorities, leaving them less informed about local problems and less involved in their solution.

120. One would expect a population with more vigorous, active institutions, and higher quality and more responsive public services, to hold different ideas and attitudes about these services, reflected in a higher level of social demand. And this is in fact the case. In Sauria, men now encourage women to participate in health programs and immunization drives, as one NGO worker testified. Social norms do not intervene, as a focus group participant pointed out:

“Women can go to the hospital alone if required. Nobody minds about pregnant mothers receiving vaccines or about women using birth control. Because it has now been accepted by all – rich and poor alike. Husband and wife take these decisions together. All now realize that having more children is the cause of poverty.”

121. This situation is all the more remarkable for the change it marks with the status quo ante in Sauria. In earlier times there were many superstitions, especially regarding maternal health. But now attitudes have changed. People no longer resist or delay medical intervention when a pregnant mother is sick, but immediately seek assistance from a doctor or health center. “It was not like this ten years ago,” a respondent observed. “The changes are due to the rising rate of education, and to awareness programs broadcast on radio and television, and also by health workers.”

122. These new attitudes and dispositions operate not just at the individual level, but at the group level as well. “We all are aware,” declared one woman.

“We share our experiences regarding maternal health issues among ourselves, and also try to take care of each other. For example, when I become pregnant then my sister-in-law (*nanod*) takes care of me. On the other hand, when she becomes pregnant I take care of her. Our husbands are also aware.”

In this way, attitudes conducive to better health, and the information on which they are based, are reinforced in the population. New ideas circulate, and new standards of health care are adopted by the group, which can then mobilize its efforts in aid of a needy members, further reinforcing the importance of medical care. As a number of authors have pointed out,²⁸ institutions do not operate in a psychological

²⁸ Perhaps most famously by Bourdieu (1986).

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vacuum, but rather rely on attitudes and dispositions compatible with their core ideas. In Saturia, health-compatible attitudes exist and are reinforced by a dense web of social and institutional relationships.

123. Such relationships unfortunately do not exist in Rajnagar. And as a result, local ideas and attitudes towards health care are decidedly more primitive. Contraceptive use is lower, and faith in traditional and spiritual healers much more apparent than in Saturia. Witness one villager's comment on ante-natal care:

“Pregnant mothers are given some tablets by family planning workers. But the problem is, when mothers take those tablets, the baby becomes unusually healthy. As a result, child delivery is not possible without surgery. So we do not like to give mothers those tablets provided by the government for free. Another problem is that a mother cannot conceive more than three times if the delivery is with surgery.”

124. Even in the home, special foods and nutritional supplements are spurned in Rajnagar, as families choose instead to rely on their normal daily diets. Visits to health centers and medical staff are avoided by villagers who shun pre-birth medical tests. Hence pregnant women requiring interventions tend to arrive at the UHC in a near-critical state. Thus another respondent:

“Many people do not care about the health condition of pregnant mothers. In a house nearby a pregnant mother once became sick. Her husband was abroad at that time, and her guardians did not want to take her to the doctor. As a result, that mother had to suffer for a long time, and the guardians ended up spending thousands of taka for her treatment.”

In some villages, pregnant women are not allowed to venture outside of the house even if gravely ill. And in most cases mothers must be accompanied by a close male family member. Some evidence suggests that such attitudes are beginning to change in Rajnagar. But the change is painfully slow.

125. Some observers may attribute differences in behavior, and hence outcomes, between Saturia and Rajnagar to exogenous cultural, especially religious, factors. To be sure, Rajnagar is more religiously traditional and conservative than Saturia, and this contributes importantly to how women are treated there. But this study takes the view that much more is explained by the enmeshing of Saturia's service delivery model in a web of local relationships and interactions that impose binding upwards and downwards accountability on her health providers. Perhaps the more important point is that questions surrounding the institutional basis of service provision are patently susceptible to reform, as the case of Saturia shows, and hence are the proper object of policy. And so when confronting the failures of health care in Bangladesh, we do well to ask ourselves not how conservative are her Muslim people, but rather what are the institutional foundations of success in Saturia, and how can they be replicated not only in Rajnagar but throughout the country.

126. Saturia teaches us another lesson as well, and it is a subtle but important one. This is that a number of the behavioral traits that we think of as “cultural”, and hence exogenous to policy analysis, are in fact sustained by certain institutions, and can thus be undermined by institutional reform. Consider how the two upazilas treat their pregnant women. Rajnagar's are kept indoors and discouraged from visiting health workers, regardless of the sickness, suffering, and death this causes. But Saturia's are free to leave the house unaccompanied, and encouraged to seek medical attention by family and friends, far more knowledgeable about the health consequences of their actions than their similars in Rajnagar. Is this difference a cultural one? A religious one? Not in their own eyes. “It was not like this ten years ago,” a resident of Saturia effectively answered. Change came through education, outreach, and the efforts of health workers. But this was in turn the product of an institutional framework that enmeshed such efforts, and the individuals who undertook them, in a dense web of relationships that both strengthened their

actions and made local society more susceptible to their message. Sauria's "cultural" behaviors changed, its people became healthier, and its women became more free.

II. Learning From the Non-Government Sector

127. Despite the problems in public health service delivery, Bangladesh has done very well in moving towards attaining some of the health MDG outcomes including difficult ones like maternal mortality due to the work of the non-government sector. The size and scope of activities of the non-government sector in Bangladesh is unique in the world. This report uses Gonoshasthaya Kendra (GK) as a model which can be expanded nationwide in a cost-effective manner for the following reasons: (a) GK has been actively applying the same basic model since 1972 and the model is time-tested; (b) GK provides the whole range of health care from a specialized teaching hospital to community workers and is thus most comparable in scope with the public system; (c) GK's unit costs are low and thus replicable across the country; (d) GK has kept full records of its patients and their background since its early days and currently there is a statistically reliable household data series covering fifteen years allowing us to look at impact and examine the dynamic impact of changes over time; (e) GK carries out detailed verbal autopsy on all cases of maternal mortality and is thus a very useful source of data; and (f) unlike many NGOs GK works in partnership with local Government in a way which allows the model to be replicated across the country. Thus, use of GK as a model for this study does not mean to take away from the successes of others – rather it has been selected for the above reasons.

128. Gonoshasthaya Kendra²⁹, the pioneering NGO from Bangladesh, was founded in 1972 with a project in Savar upazila that aimed to improve the quality of life, and especially the health, of the rural poor by ensuring affordable health services. From this modest start it has expanded impressively over the last 35 years to cover a broader range of services, including reproductive and child health, and basic education, as well as tertiary care to over a million people in 592 villages located in 16 upazilas across 11 districts. It is now the second largest health service provider in the country after the Ministry of Health and Family Welfare. But what impresses most is not so much the scale of GK's services, but rather their quality and the results they produce. These results can be validated because GK has wisely compiled one of the most detailed datasets available on health outcomes and socioeconomic correlates. It has done so by collecting detailed information over the last decade about each of the households in its jurisdiction, including all major life and health events. Using this data source, which has been validated statistically through a recent survey, it can be seen that in its areas of activity GK has already exceeded the MDG for infant mortality a decade ahead of time, while the rest of the country remains at a level two-thirds higher. On maternal mortality, GK has achieved a rate of 186 per 100,000 live births, 42 percent lower than the national average. An additional decrease of 23 percent, or 43 deaths per 100,000, is required to meet the MDG—well within its reach given the decline of 113 deaths that GK achieved between 1993 and 2002. Part of the reason for this success is surely that GK's coverage includes 100 percent of the poor, including the very poor and destitute. And it does all of this at very modest unit costs, estimated at the level of the formal state sector. How does GK do all of this? What lessons can we learn from them? The best way to answer these questions is to examine the GK system of service provision.

The Gonoshasthaya Kendra System

129. The GK program consists of three elements: (i) health, (ii) basic primary education, and (iii) women's development, implying especially non-traditional jobs and roles. When it enters a new community, the point of entry is usually health, but can sometimes be education. From the start GK

²⁹ The data in this section comes from Chaudhury, R. H. 2006. "Gonoshasthaya Kendra's Experience in reducing Maternal and Child Mortality – An Example of Transparency and Accountability as a Way to Achieve MDG Outcomes," Workshop presentation, Dhaka: The World Bank.

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establishes a Village Development Committee to oversee activities in the three categories above. Each committee consists of one member from the Union Parishad (local government), one from GK or another NGO active in the area, and other members elected from the village at large. The UP member must be a woman. She automatically becomes head of the committee, and thereafter serves as signatory for GK programs generally. Such engagement is part of a larger strategy by GK to involve local government in its activities in order to facilitate problem solving in the medium and long term.



130. But the anchoring of GK programs within the local community goes far beyond formal institutions. Health workers are chosen from amongst villagers and put through an extensive, specialized training program for which GK is well-known within Bangladesh. Indeed, such training acts as a magnet in itself for potential staff, who accept low wages during the three year minimum service commitment that follows in exchange for the prestige and future earning potential associated with being “ex-GK”. Trained health workers are then sent back to the areas whence they came, often for decades, where they provide care for locals and help to train new generations of recruits. In this way, GK exploits their local knowledge and credibility/legitimacy amongst the population for the provision of local services. And by keeping them *in situ* for extended periods, GK acquires detailed knowledge about local health and education problems, as well as the economic and environmental risks faced by villagers. Lowest-level GK staff become to a large extent the institutional memory of both the organization and the village, and so an integral part of the planning and problem-solving apparatus that the organization has so successfully deployed throughout its area of influence.

131. GK’s highly pragmatic philosophy is illustrated by its approach to birth attendants. The organization originally tried to improve the poor quality of medical attention during birth by introducing skilled birth attendants from outside the village. But when this proved unsuccessful, the organization switched to the Traditional Birth Attendants (TBAs) that already existed in villages, and were responsible

for many of the poor practices that endangered the health of mothers and newborns. By giving them detailed, continuing training, thereby converting them into Trained TBAs (TTBAs), GK in one fell swoop eliminated bad traditional delivery practices, introduced new, superior delivery practices, enlisted the enthusiasm and good will of important local authorities (the TBAs), and attached the legitimacy and trust that TBAs enjoy within the village to their own activities. This is all the more important as only six percent of rural births are attended by doctors or nurses. In a similar vein, GK trains village women to do caesarean sections in its medical college, so as to be able to intervene immediately in an emergency. In all of these ways, GK has demonstrated how much can be done in the absence of doctors, with trained low-level staff. And in doing so, it has earned the enmity of the Bangladesh Medical Association. Such efforts are a large part of GK's enormous success in reducing infant and maternal mortality, a point to which we return below.

132. GK's *modus operandi* is one of repeated and regular village visits every month by health workers, who often work in senior-junior pairs and carry simple medications with them. The frequency of visits can be stepped up or down depending on the severity of the health problems occurring at any particular time. GK staff use informal means of gathering information. Upon arriving, they ask residents how many women are pregnant, how many people ill, how many elderly frail, etc., relying more on trusted informers with whom they have established relationships. In this way they can ascertain the major problems faced by the community with a few well-judged conversations, and save time and resources by going directly to the households affected.

133. The services GK offers include a wide range of health care and family planning services, including: (i) registration of all pregnant women and births; (ii) regular follow-up of pregnant mothers for ante-natal and post-natal care, and identification of high-risk mothers for referral; (iii) monitoring the development of newborns; (iv) promoting additional nutrients and a balanced diet for pregnant mothers and newborns; (iv) immunization of pregnant women against tetanus, and children under age one against six major killers: Diphtheria and Whooping Cough (DPT), Polio, BCG, Measles and TT; and (v) distribution of iron tablets amongst pregnant women, amongst others. Non-health areas such as indigence and unruly or dangerous youth are also tackled. Interventions in all of these areas incorporate not only health, but also education and water and sanitation components, making for integrated, cohesive responses to the problems of village well-being.

134. GK is not a substitute for government health services, but rather a supplement for them – so as to make them work for the rural poor, as they otherwise largely do not. Hence when GK health workers encounter a case requiring a more advanced intervention than they can supply, they escort the patient to the appropriate health facility, and monitor both treatment and progress. But one area in which they do substitute outright is in record-keeping, a particular weakness of the official system. GK health workers keep detailed records on all patients, which over time will encompass essentially all villagers. Even when advanced health care is required outside the village, GK records all. As a result, GK has the best records available on village health status in its areas of operation. When government doctors or nurses visit a village, they stop first at GK offices to speak to GK staff, and if possible accompany them for door-to-door visits.

135. GK classes villagers by income into five categories: Rich, Middle Class, Poor, Very Poor and Destitute. The bottom three groups comprise 60 percent of a typical village; much of the rest is middle class, though even distant rural villages usually have some residents who are outright rich. A site visit to Savar found that all of the poor-to-destitute used GK services, as well as 60 percent of the middle class. How does GK finance such a heavy service load? The key mechanism is GK's health insurance, administered by Village Development Committees. This covers most of villagers' health costs when they require medical attention, and villagers buy it at rates graduated by income level, as follows:

Table 5.2: Annual Cost of GK Health Insurance

Income Group	Cost (US\$ 1 = Tk.68)
Middle Class	Tk. 80
Poor	Tk. 50
Very Poor	Tk. 10
Destitute	Tk. 7

136. The insurance covers between is supplemented by co-payments of Tk.24 for outpatient treatments (in health clinics), and Tk.200 for in-patient treatments (in hospitals) per patient, collected at the point of treatment. Co-payments are waived for the poorest. Universal subscription rates amongst the poorest villagers are testimony to the benefits and good design of this insurance scheme. Its simplicity and transparency suggest that it could be scaled up easily across Bangladesh.

137. Insurance fees and co-payments generate about 70% of GK's annual income. Much of the rest comes from businesses it owns, the profits of which are in large part plowed back into the GK service model. Perhaps the most prominent of these is a pharmaceutical company (GK Pharmaceuticals), which manufactures cheap medicines for the poor, and generates important profits. Unlike some other prominent Bangladeshi NGOs (e.g. BRAC and the Grameen Group) it derives no revenue from microcredit schemes, in which it does not believe. CIDA is its only major external donor. GK manages to survive on such modest resources in part because it pays its workers less than the government sector. A senior health worker with twenty years of experience earns about Tk.8,000 (about US \$120) per month. The decentralized, highly transparent administration of resources by elected village committees also helps to cut waste and graft and husband scarce resources. All of this suggests that the GK model, so successful not only in improving village health indicators, but also in reaching the rural poor, is highly sustainable. In fact, it is in all likelihood more sustainable than the government health system, which benefits from much larger foreign aid flows.

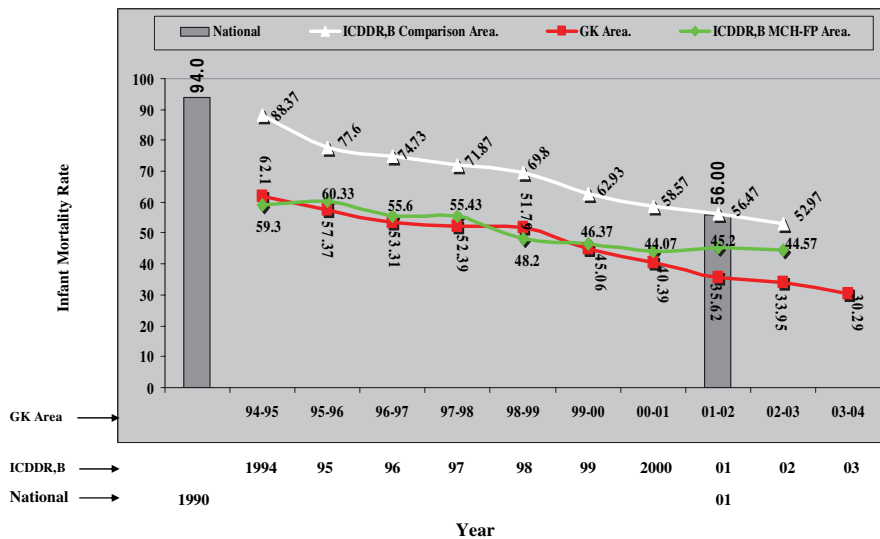
Village-Level Accountability

138. But perhaps the most impressive aspect of the GK system is the simple yet powerful framework it has developed to foment accountability not only for its own workers, but for government health staff as well. Whenever there is a death in a GK-attended village, a whole-village post-mortem is done to establish the detailed facts of what happened and why, determine responsibility, and suggest improvements. The high degree of village solidarity and self-knowledge ensure that with the participation of all, informed answers can be found. The causes of death, and the role of individual mistakes, are made well understood by all, so as to ensure they are not repeated in the future. Upazila Health Officers are invited to post-mortems, and they mostly attend, sure in the knowledge that absence will be met with GK queries at the following Upazila-wide health meeting, where the officer can be gently but comprehensively shamed for ignoring such an issue. These "soft" forms of pressure are preferred to formal sanctions or appeals to the legal system. GK is involved in a long-term symbiotic relationship with the government health sector, and so it doesn't pay to involve itself in punishment and formal sanctions, given the pressures and divisiveness they bring. This post-mortem practice, which is embedded in an institutional framework that provides a system of checks and balances among institutional actors, provides an excellent example of what this report calls *creative tension*, where mutual oversight and complementary roles create productive rather than confrontational interactions among

stakeholders. This report argues that such *creative tension*, when properly facilitated, can significantly improve accountability mechanisms that enhance the quality of service delivery.

139. This is a good example of GK’s approach to accountability more broadly. As with government, GK is involved continuously in village work, and so is not interested in stoking up tensions or social conflict there. Hence it eschews formal punishments and the court system for its own staff and villagers alike, relying instead on transparency and the dissemination of information to generate gentle but persistent pressures for high performance, professional responsibility, and—especially—accountability to villagers. Information acts via reputation effects, and by shaping social opinion and expectation, which in a cohesive village environment can exert powerful pressure even on relatively high-status people. In fact, by bringing the local status of such people into play, this system is capable of generating powerful incentives for GK and Upazila health authorities.

Figure 5.1: Infant Mortality Rates for National, GK and ICDDR areas



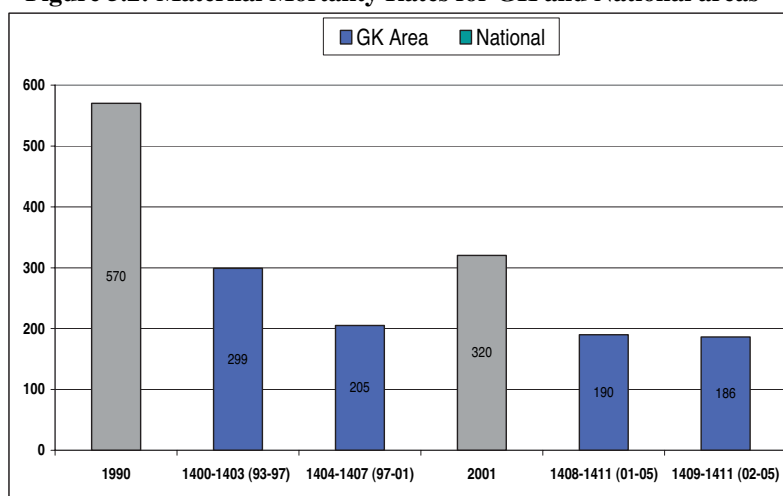
Source: Chaudhury (2006)

140. Where GK workers and villagers are concerned, accountability is generated not only via information and social expectations, but also through education, training and—for want of a better term—indoctrination (consciousness-raising) concerning professional standards and the meaning of success. GK training serves to set its staff’s standards and habits of mind, and also adjusts villagers expectations about the types of services they should expect and demand. This accountability system is so remarkable not only because there is abundant evidence that it works. It is also remarkable because—contrary to institutional theory—it is not anchored by any formal, “hard” incentives, such as explicit punishments or fines, relying instead entirely on the “soft” incentives of reputation and collective opinion. The question of whether such a regime is extendable to urban settings is an open one, and it is worth noting that GK has so far not done so. But it is also true that a regime of soft incentives is much cheaper to sustain than one that relies on formal incentives, and hence the judicial system with all of its associated contracting and legal costs.

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141. What has all of this accomplished? Figure 5.1 shows the evolution of infant mortality rates for Bangladesh, GK program areas, and those areas attended by another health NGO, the ICDDR (both treated (MCH-FP) and non-treated (B comparison) areas). We see that Bangladesh as a whole is still far off the MDG target, as is the ICDDR non-control group. The ICDDR treatment group is somewhat closer. But GK has already exceeded the MDG target of 32 deaths per thousand live births in its areas. And this has happened 11 years before the goal. On maternal mortality, the overall pattern is similar. Figure 5.2 shows that MMR rates were similar for GK areas and the nation as a whole in 1990, at 570 per 100,000 live births, but then descended by 67 percent in GK areas to 186 by 2002-05. The decline for the country as a whole, though important, was much less – to 320 by 2001. The MDG target of 143 is clearly in sight in GK areas, but unlikely to be met across the nation.

Figure 5.2: Maternal Mortality Rates for GK and National areas



Source: Chaudhury (2006)

142. Hence, by changing how health and education services are delivered at the village level, the GK system is taking health care to people who previously had no access, and is multiplying the impact of existing state staff and infrastructure, all at a small incremental cost. The effects of this on key indicators of well-being, such as child and maternal mortality, are enormous. It is no exaggeration to say that GK's achievements are transforming the life prospects of the people lucky enough to live in their area of operation. Table 5.3 provides further insight into why they are so successful. We see that over 80% of maternal deaths come from direct causes, having to do mostly with complications during labor and childbirth. These are precisely the sorts of medical conditions that can be successfully attended at low cost by a trained health worker, who is sufficiently knowledgeable to address more straightforward complications and can also refer more serious ones immediately to facilities that provide emergency obstetric care (EOC). In other words, a majority of these interventions are of the sort for which well trained low-level personnel, working with good information and access to EOC infrastructure, in a system fortified with upwards and downwards accountability, can excel. The remaining 19 percent of maternal deaths are more difficult to prevent, and will tend to rely on more expensive tertiary care. But it makes no sense to focus on these phenomena when so many more mothers die of more easily preventable conditions. The low-hanging fruit should always be picked first, and what GK has done is to provide us with a system for doing so that is widely tested, credible with villagers, resilient to a variety of external shocks, and cheap to operate.

III. BRAC – Another example of institutional innovation for service delivery

143. BRAC's evolving understanding of health service provision now emphasizes the critical importance of downward accountability to constituents as well as upward accountability to BRAC management and government hierarchies. At the outset of its health care activities, BRAC strove to provide services in neglected areas by using the existing facility-based paradigm that focused on doctor-run clinics, standard clinical approaches to family planning, hospital-based treatments for tuberculosis, etc (BRAC, 2005). This approach proved itself to be both ineffective at reaching marginalized segments of the population and expensive. Subsequently, BRAC shifted to a more community-oriented approach that utilized paramedic workers and local community members themselves. Doing so helped to establish greater downward accountability in the same way that GK hires and trains local women to become paramedics in their own communities. BRAC's local credit groups have become an important locus of influence on health care provision, which helps to select and guide the frontline field workers (in contrast to the lack of influence on government services) and thereby reinforces the downward accountability mechanism. The costs of this approach, similar to the GK model, are shared through insurance schemes, the premiums for which being collected immediately after the harvest when incomes are relatively high.

Table 5.3: Causes of Maternal Deaths

Causes of Death		Number	Percent of Direct Causes	Percent of All Causes
Direct Causes of Death	Direct complications of labor and delivery	48	68.6	55.8
	Post-partum hemorrhage with retained placenta	19	27.1	22.1
	PPH without retained placenta	9	12.9	10.5
	Obstructed labor	8	11.4	9.3
	Ruptured uterus	4	5.7	4.7
	Antepartum hemorrhage	8	11.4	9.3
	Pre-eclampsia/eclampsia	19	27.1	22.1
	Abortion	3	4.3	3.5
	Subtable Total	70	100	81.4
Causes of Death		Number	Percent of Indirect Causes	Percent of All Causes
Indirect Causes of Death	Anemia	6	37.5	7.0
	Jaundice	4	25	4.7
	Cardiac failure	3	18.8	3.5
	Snake bite	1	6.3	1.2
	Acute diarrhea	1	6.3	1.2
	Respiratory failure	1	6.3	1.2
	Subtable Total	16	100	18.6
Table Total		86	100	100

Source: Chaudhury (2006)

144. According to BRAC, improving the government's health services is a key component of its health strategy. It tries to improve the government health system by serving as a type of operational research and training arm of the government health system, which helps to identify the needs of the poor and provides information on inconvenient service hours, lack of outreach, inadequate drug supply, and poor management (BRAC, 2005). BRAC has also played an important role in motivating and facilitating

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use of family planning and other health services, as with the government TB program or the boost given by BRAC involvement to the national immunization campaign in the 90s. This model of engagement requires substantial facilitation by BRAC, which is able to improve utilization of government services and provide some limited technical recommendations. Nevertheless, it depends on the presence of an external agent—an NGO—to facilitate better functioning of the government health system, and it does without changing in a substantive manner the accountability of the government health providers to the communities they serve. The BRAC health program thus serves as an excellent model of NGO-facilitated health care provision, which demonstrates, as does the GK model, the need to work closely with government service providers, local government structures, and local community members to improve accountability in service delivery and reach better health outcomes.

IV. Conclusion: National Implications

145. The cases of institutional innovation teach us much that is useful if Bangladesh is to reform its service provision and reach the MDGs by 2015. The story of Saturia and Rajnagar shows the importance of embedding public services in a dense web of institutional relationships that facilitate downwards as well as upwards accountability. This report recommends that basic services can be improved by harnessing *creative tension*, whereby service users are provided a mechanism for providing constructive feedback to service providers, and whereby a system of checks and balances structures a productive institutional framework in which various institutional actors contribute to specific development goals, such as improving a given health clinic or school. At the core of this idea lies increased accountability with community driven development. In operational terms, enhanced *creative tension* can be implemented by fostering partnerships between service providers, elected local government, beneficiary groups, and community based organizations, as the GK and BRAC approaches demonstrate. Moreover, the GK and BRAC experiences highlight an important feature of creative tension, especially in the context of Bangladesh: the institutional framework must be established so that interaction among stakeholders is constructive rather than adversarial.

146. If services are to respond to a population's particular – and changing – needs, and be credible in the eyes of that population, then the elected representatives of that population should be involved in their production. They should have a degree of voice, or other leverage, over the way those services are provided, including the application of positive and negative incentives to directly responsible staff. Of course, such representatives must themselves be the product of elections that are free, fair and transparent if they are to have credibility and act with moral weight. And they use moral weight to communicate community problems and expectations upwards to service providers and their superiors, as well as the substance of policy reforms *and their motivations* downwards to the grass-roots. In this way, not only are specific policies made credible in the eyes of the people, but the changes in social behavior that underpin progress can begin to occur.

147. What the tale of two upazilas does not tell us, however, is how to endow a Rajnagar with Saturia-like success. The story is compelling, but seems idiosyncratic. Perhaps Saturia is special in some way that our research design failed to capture? What exactly would we do to generate more Saturia's throughout Bangladesh? This is where the GK story is illuminating, as GK is explicitly, emphatically a model of village health care and education—one that is designed to be standardized, flexible and inexpensive. The GK experience is *meant* to be replicated across all the villages of Bangladesh. The GK system works by changing the nature of the relationship between health care providers and beneficiaries, so as to insert the former in a more complex web of relationships with individuals and intermediating organizations composed of the latter. These relationships generate both the information and informal, “soft” incentives (reputation, social expectation) that make downward accountability binding on GK health workers, without need for fines or recourse to the legal system.

148. Could this be applied nationwide? And if so, what could it achieve? The answer to the first question is certainly yes. This is not to say that such a dramatic scaling-up would be easy – it would not. But among the GK model’s virtues are simplicity, transparency and economy. What they have done is apparent for all to see, and takes the form of a straightforward quasi-recipe. A development committee and so many health workers per village, multiplied by so many villages, and it can be done. The major challenges are likely to be training all the workers needed, and administering the entire, enormous effort. This suggests a gradual program, and not a big bang. But in principle it is eminently feasible. And it can be afforded. Remarkably, GK achieves the outcomes it does at a cost of US \$1 per capita, 75 percent less than the US \$4 that the Ministry of Health spends. The founder of GK, Dr. Chowdhury, had stated emphatically that with the participation of local governments, GK could extend its reach from 1 million people to 5-10 million in 2-3 years.³⁰ What all of this could achieve is quite simply the radical improvement of health care and health outcomes in Bangladesh, leading the country to attain its millennium development goals. A combination of such GK-like measures institutionalized across Bangladesh through the participation of local governments, couple with reinvigorated economic growth, must surely be the country’s best hope for attaining and surpassing the MDGs.

³⁰ Dr Zafrullah Chowdhury, GK’s founder, in a spoken intervention at the workshop “Towards A Strategy for Achieving the MDG Outcomes in Bangladesh”, Dhaka, June 5-6, 2006.