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Localizing Public Service Delivery in Bangladesh:The Gap Between Policy and Practice

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Abstract

Public service provision has earned a clearer voice and sparked a renewed interest in the recent discourse of public administration. Conforming to this trend, since 1990s, Government of Bangladesh has also undertaken various policy initiatives to bring services closer to the rural people and to make them responsive through devolving authorities to the local government institutions. But in practice, most of these initiatives still remain confined to mere policy statements rather than seeing any meaningful decentralization of service delivery. This paper seeks to identify the gaps between the policy statements and their implementation, their consequences on the nature of service delivery and the underlying reasons for the prevailing gaps. As a case, the study looks into the delivery of public health services in rural areas. The study relies on both primary and secondary data. Primary data has been collected from both central and local levels while secondary data has been collected from relevant research articles, policy documents and government reports. Findings of the study show that despite the prevalence of the policies and other legal provisions favouring decentralization, health services at the local level are largely being provided through the direct central control, which severely affects the quality of services. Various legal weaknesses, control of central politics over the functioning of local government and local administration, lack of political will for localizing service delivery and the country's highly centralized administrative system have been identified as the key underlying reasons for the poor localization of health service delivery in Bangladesh.

Introduction

Public service provision has earned a clearer voice and sparked a renewed interest in the recent discourse of public administration. New Public Service Model emerged in 2000 advocates that government

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should serve rather than steer and people should be considered as citizens with entitlements to get service from the government (Denhardt &Denhardt, 2007)[2]. There is a growing recognition that a combination of poor-quality provision and unequal coverage of basic services is hampering poverty-reduction efforts and reinforcing inequality (Leni and Foresti, 2013)[3]. The World Development Report 2004, the earliest report by a multilateral organization to focus on the delivery of basic services concluded that "…social services fail for the poor". More recently, Asian Development Bank (ADB) in its policy note concluded that even though many countries in developing Asia had made remarkable progress in expanding access to public services in recent decades, there were large disparities in access across the region and the quality of services was generally very poor (Deolalikar and Jha,2013)[4]. Overall, the ADB report concluded, delivery of public services in developing Asia had lagged significantly behind the region's impressive economic growth.

Development experts agree that to make public services cost effective, accessible and responsive they have to be delivered in a localized manner. Decentralization of the public sector's structure and activities is a widely accepted mechanism for localizing service delivery. Amongst various forms of decentralization, deconcentration and devolution are considered as the widely used mechanisms for transforming policy goals into public service at the grassroots. In order to make public services responsive, since 1990s, Government of Bangladesh has also undertaken various policy initiatives to decentralize public services. These include the promulgation of various local government Acts related to the transfer of a range of public services to the local government institutions at the middle and the lowest tier called the Upazila Parishad (UZP) and the Union Parishad (UP) respectively. Sectoral policies pronounce their commitments for decentralization of service delivery. More importantly, the ongoing Sixth Five Year Plan (2011-15) vows for 'bringing quality public service to the people's doorsteps" (Planning Commission, 2011: 218)[5].

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[2] Denhardt Janet V. and Denhardt B. Robert, 2007. The New Public Service: Serving Not Steering, Expanded Edition, M.E.Sharpe, Ink. Armonk, New York, London, England

[3] Leni Wild and Marta Foresti, 2013 Working with the politics How to improve public services for the poor ,ODI Briefing 83, Sepetmber 2013.

[4] Deolalikar Anil B. and Jha Shikha. 2013 Empowerment and Public Service Delivery in Developing Asia and the Pacific, Asian Development Bank, Manila, May 2013.

[5] Planning Commission. 2011. *Sixth Five Year Plan FY2011-FY2015*. Ministry of Planning, Government of the People's Republic of Bangladesh.

But the practice tells a different story. Public services are still being delivered in a highly centralized manner. This paper seeks to examine the extent to which the policy statements relevant to localization of service delivery have been implemented, how the non-implementation affects the nature of service delivery and the underlying reasons for the prevailing gaps. As a case, the study looks into the delivery of public health services in rural areas. Five key aspects of health service delivery (*facilities /capital infrastructure*; *functionaries*; *operation & maintenance and supplies*; coordination and monitoring; and community engagement) have been analyzed to determine the extent of localization of service through examining the role of deconcentrated local administration and the devolved Local Government Institutions (LGIs) in the process.

The study relies on both primary and secondary data. Primary data has been collected from both the central and local levels through stakeholder interviews and Focus Group Discussions (FGDs). The local level data were collected from five districts: Sirajgonj, Khulna, Satkhira, Hobigonj and Sunamgonj. The interview respondents numbering 52 included the central and local level bureaucrats of the Ministries of Local Government and Health and the local government functionaries at the upazila and union level. In addition to these key informant interviews, at the community level, 4 FGDs were held with the civil society members and the community people. Secondary data for the study has been collected from relevant research articles, policy documents and government reports.

1. Decentralization and Localizing service delivery: The Conceptual framework

As the delivery of key public services often requires direct interaction between the providers and the recipients of these services, many of these interactions take place in a localized manner (Boex, 2012)[6]. While most public service delivery is local in nature, the mechanisms that governments adopt to provide people with public services vary from country to country resulting in variations in service efficiency and quality. Decentralization of the public sector's structure and activities is a widely accepted mechanism for localizing service delivery.

Decentralization has traditionally been defined as the process of transferring decision-making authority, responsibility and financial resources for providing public services to lower levels of government

[6] Boex Jamie (2012) Local Public Sector Initiative: Measuring the Local Public Sector: A Conceptual and Methodological Framework Local Public Sector Country Profile Handbook, The Urban Institute,December 2012

(Litvack and Seddon, 2009)[7]. Decentralization is generally broken down into one of three forms: deconcentration, devolution and delegation (Litvack and Seddon, 2009). *Deconcentration* refers to the distribution of decision making authority and financial and management responsibilities among different territorial-administrative levels or tiers of central government (i.e. a situation in which public services are delivered by line ministries through their local offices). *Devolution* is the transfer of authority for decision making, finance and management to quasi-autonomous local government units with corporate status (i.e. public service delivery through elected local governments). *Delegation* refers to the transfer of responsibility by the central government for decision-making and administration of public functions to semi-autonomous organizations not wholly controlled by the central government but ultimately accountable to it.

Amongst these three approaches, deconcentration and devolution are the most commonly used approaches of localizing public service delivery. In roughly half of the countries around the world, key public services such as basic education and health services are delivered through elected local governments (i.e., devolution) while in roughly half of the countries around the world (including many developing and transition economies) public services are delivered predominantly or exclusively through deconcentrated administrative bodies (Boex, 2014)[8]. Although deconcentration offers the potential for strengthening local service delivery capacity through technical interventions within the sectoral hierarchy, service delivery through devolved local government potentially offers greater discretion, incentives and accountability in the delivery of local services. Neither of these two approaches alone can ensure effective delivery of services at the local level as public services tend to be delivered in a multi-dimensional, multi-level and multi-agency manner.

Question arises, which mechanism is the most suitable for ensuring efficient service provision? The principle that economists use to guide which level of government should perform a public function is known as the "subsidiarity principle". *The subsidiarity principle states that public goods and services should be provided by the lowest level of*

[7] Litvack, Jennie and Seddon, Jessica (ed.). 2009. Decentralization Briefing Notes, World Bank Institute Working Paper Series. Washington, D.C.: The World Bank.

[8] Boex, Jamie (2014), Decentralization and localization in Bangladesh-the role of local governments and local administration in ensuring efficient and equitable health and education services, UNDP study report, Dhaka.

government that can do so efficiently. The principle suggests that the lowest possible level of government that is able to perform efficiently should be assigned functions. This principle also prevents expenditure responsibilities from being assigned to subnational government jurisdictions that are too small or otherwise not capable to efficiently deliver the public service at hand. Thus ensuring efficiency is the main concern of this principle.

From the managerial perspective, public Service has broadly four major dimensions: policy and regulation, financing, provision and production. As per the subsidiarity principle, central government should be in charge of framing policy and regulation while local government should have some control in financing, production and provision of many publicly provided goods or services can often be done at the local level. Financing of the service may be assigned to the central level, in order to ensure that resources are distributed equitably across the national territory. In addition to determining which government level or administrative tier is responsible for the four different dimensions of a specific function (i.e., policy and regulation, finance, provision and production), it is often useful to consider the "provision" dimension in greater detail. In fact, the "provision" of a function is achieved by combining a series of different inputs in order to deliver a specific output. In practice, different entities are often responsible for providing different inputs into the service delivery process. Boex (2014) has identified five different types of service delivery inputs: i) facilities (capital infrastructure); ii) functionaries (staff and human resources management); ii) operation and maintenance; iv) supplies (medicine, medical equipment); v) coordination, monitoring and community mobilization. Extent of localization or decentralization of service delivery can be understood through examining which entity/entities (the central ministry/ deconcentrated local administration/local government) perform which aspects of service.

2. The Administrative Structure for Public Service delivery in Bangladesh

Bangladesh relies on both deconcentration and devolution to provide public services at the local level. Every line ministry has a well laid out deconcentrated organizational structure down to the grassroots level to facilitate service delivery at the local level. The public sector of Bangladesh is territorially deconcentrated into a four-tier field

administration, with administrative units at each of the following levels: division, district, upazila and union. The country is divided into seven divisions, which, in turn, are subdivided into 64 districts (Zilas). Below the district level, at the countryside, there are 491 upazilas, which are further subdivided into 4,571 unions.

Administration at the divisional level essentially performs coordinating functions; while district administration historically has played the most vital role in ensuring central government presence in the locality. Almost all government ministries and departments have their units at the district level under a "vertically" (or sectorally) deconcentrated structure, by which district-level officers continue to belong and report vertically to their respective line ministries. Under the coordination and guidance of different district level officers including the Deputy Commissioner (DC), officials at the Upazila level are charged with actually implementing government policies related to different sectors. A good number of government departments, including agriculture, education, health and family planning, social welfare, fisheries and livestock, public health and others have their offices at the Upazila level. In order to deliver services to the people, some important departments of the government (including education, health and family planning, agriculture) have their lowest-level field staff posted below the Upazila headquarters, i.e. at the union level.

A separate devolved local government hierarchy also parallels the administrative hierarchy of the government. There exist local government bodies at each of the administrative levels except the division. At the top of the three-tier rural local government structure is the Zila Parishad (ZP) at the district level and at the bottom, the Union Parishad (UP) at the union level and the Upazila Parishad at the upazila level-the middle tier. Amongst the three tiers, Zila Parishad is a non-elected body while the remaining two are directly elected by the local people.

The functions legally assigned to the middle tier, the Upazila Parishad (UZP) at the upazila level, which contains about 302 square kilometer area and a population of about 245 thousand. The UZP is headed by a popularly elected chairman and composed of two vice chairmen, representative members (UP chairmen) and women members. Officials of different national departments attend the meetings of UZP, but they are neither members of the Parishad, nor can they vote. The Union Parishad (UP) is the lowest unit of local government is also responsible for delivering public services.

Generally, a union with about 10-12 square miles area, inhabited by about 15,000 to 20,000 people, is divided into 9 wards, with each ward electing a member on the basis of popular votes. The chairman, who heads the UP, is directly elected by the voters of the whole Union. In addition to a directly elected chairman and nine members, three women members are also elected, with each one representing three wards.

3. Policy Initiatives for Localizing Service Delivery

The country has a three tiered local government system through which locally elected bodies have been assigned a wide range of public welfare and development functions alongwith health, education, water and sanitation, agriculture etc. The Constitution of Bangladesh (articles 9, 11, 59 and 60) provides the legal framework for the functioning of local governance and clarifying its role in public service delivery. On the other hand, the ongoing Sixth Five Year Plan (2011-15) also envisions to have local governments delivering greater volume and quality of public services to their respective communities. In recent years, a major effort has been initiated in Bangladesh to strengthen the role and capacity of local government institutions (LGIs) at the union level, called the Union Parishad (UP) and at the upazila level, called the Upazila Parishad (UZP)—to contribute to better service delivery outcomes. Through the promulgation of recent Acts, the responsibility for a good number of public services has recently been transferred formally to the Union Parishad level (7 functions) and the Upazila Parishad level (17 functions). In addition to this, the health policy documents have also been pronouncing the sectoral commitment for decentralization of service delivery. This section provides an overview of the policy initiatives at the local government and the health sector itself for localizing the delivery of health services.

Upazila Parishad (UZP) Acts / Circulars

Local Government (Thana Parishad and Thana Administration Reorganization) Ordinance 1982, for the first time, introduced a massive program of devolution of powers and decentralization of administration in the country through which UZP was created and was transferred with the services of seventeen central ministries/departments. However, due to the change of political power, UZP discontinued to function for a while. In 1998, with the objective of reintroducing the UZP, Upazila Parishad Act 1998 was promulgated under the democratically elected government, which was later amended in 2009 and 2011. Schedule 3 of the UZP Act 1998 has

transferred the services of ten ministries (12 departments) to the UZP including health and family welfare, youth and sports, fisheries and livestock, department of primary education, ministry of agriculture, social welfare etc. The 1998 UZP Act has backed this transfer by the devolution of financial authority and staff support from the central government and by a considerable increase in the resources made available to Upazila. The Act mentioned that the officials, staff and their functions of the ministries would be transferred to the UZP. All officials of transferred departments will be placed at the disposal of UZP meaning the officials dealing with transferred subjects have been made accountable to the UZP with their services deputed to it. As per the section 34 of UZP Act 1998, UZP will also be authorized to appoint officers and staffs as it deems fit to assist it in discharge of its functions on such terms and conditions as may be prescribed by the rules, subject to the prior approval of the government. On the other hand, rule 24 of the Act requires that Annual Performance Report (APR) of the officials of the transferred departments will be written by the UZP while Annual Confidential Report (ACR) will be written by their departmental superiors. In addition, Schedule 2 of UZP Act 1998 clarifies the role of UZP in delivering the transferred services by saying that UZP will be responsible for the implementation of the programs of the transferred departments and to supervise and coordinate the activities of those departments. Fourth schedule of the 1998 Act has authorized UZP to mobilize its own resources through taxation.

The UZP Act 1998 has been amended twice. The first amendment took place through the Upazila Parishad (Reintroduction of the Repealed Act and Amendment) Act, 2009, which revised Rule 24 of the UZP Act 1998 bringing slight changes in certain provisions. The major change brought about by this amendment was allowing the Members of Parliament (MPs) to get involved in the decision making process of UZP (Section 19 of the Rule 27). It states that MP of the concerned area will be made the adviser to the UZP and the Parishad will accept the advice of the MP.

Further amendment of the UZP Act took place in 2011 with a view to expanding the scope of functional assignments to the UZP. The UZP Act 2011 (section 22) added 5 more ministries/departments under the fold of transferred subjects.

UP Acts/Circulars

The UP Act 2009 was a big advancement towards devolution of powers and decentralization of public services to the local level. The

UP Act 2009 has conferred the UP with the authorities for local economic and social development. To this effect, the Act confers the UPs with broadly defined powers to handle 'local affairs' and meet basic needs. More importantly, Schedule 3 of the Act states that the functions of seven line ministries will be transferred to UP. The transferred ministries are: Local Government Division, Ministry of Agriculture, Ministry of Health and Family Planning, Ministry of Primary and Mass Education, Ministry of Fisheries and Livestock, Ministry of Social Welfare, and Home Ministry. The Act also requires transferring the officials and staff of these departments/ministries providing service to the UP. For example, with regard to health and family planning services, the Health Inspector and Assistant Health Inspector, Family Welfare Inspector and Family Welfare Assistant and manpower of Health and Family Planning Departments and their functions were legally transferred to the UP. Section 63(1) of the Act further states that the transferred officials and staff will accomplish their duties and responsibilities under the management and control of the UP. On the other hand, the same section (2) also states that if UP deems fit to undertake disciplinary action against any official transferred to the UP, it will conduct enquiry and send report to the concerned agencies. In order to coordinate, plan and implement all development activities, to review the progress of all departments and review the service delivery conditions, Union Development Coordination Committee (UDCC) comprising all the line ministry officials and staff transferred to the UP level has been formed at the Union Parishad in 2013, which is supposed to meet at least once in two months. Conforming to the Constitutional provision UP has been bestowed with some power to generate revenue through taxation.

The Health Policy Commitments for Localization

The health sector has a vision of providing basic services to all. The National Health Policy 2011 aims to ensure the provision of quality and accessible health service for the poor living in both urban and rural areas and for the disadvantaged population. The 2011 policy admits that centralized management system is a prime obstacle for adequate utilization of public health facilities and its efficient management. As a strategy to reach primary health care (PHC) services to all and to improve the quality of health services, the policy pronounces the strategy of health system decentralization and peoples' participation in planning, management and provision of service delivery. The policy stresses on strengthening the Upazila-level health system as a means of reaching health service to the village level. The policy favours the

strategy of engaging local government in providing health services at all levels. The Sixth Five Year Plan (2011-15) also pronounces the strategy of strengthening the Upazila health system i.e. the functioning of the Upazila health complexes, union health and family welfare centers/sub-centers through providing adequate human resources, drugs and other medical aids. The plan has also assured strengthening the Government's effort towards decentralization of budget and management. Thus the national health policy and the Sixth Five Year Plan have focused on decentralization in the form of deconcentration rather than devolution.

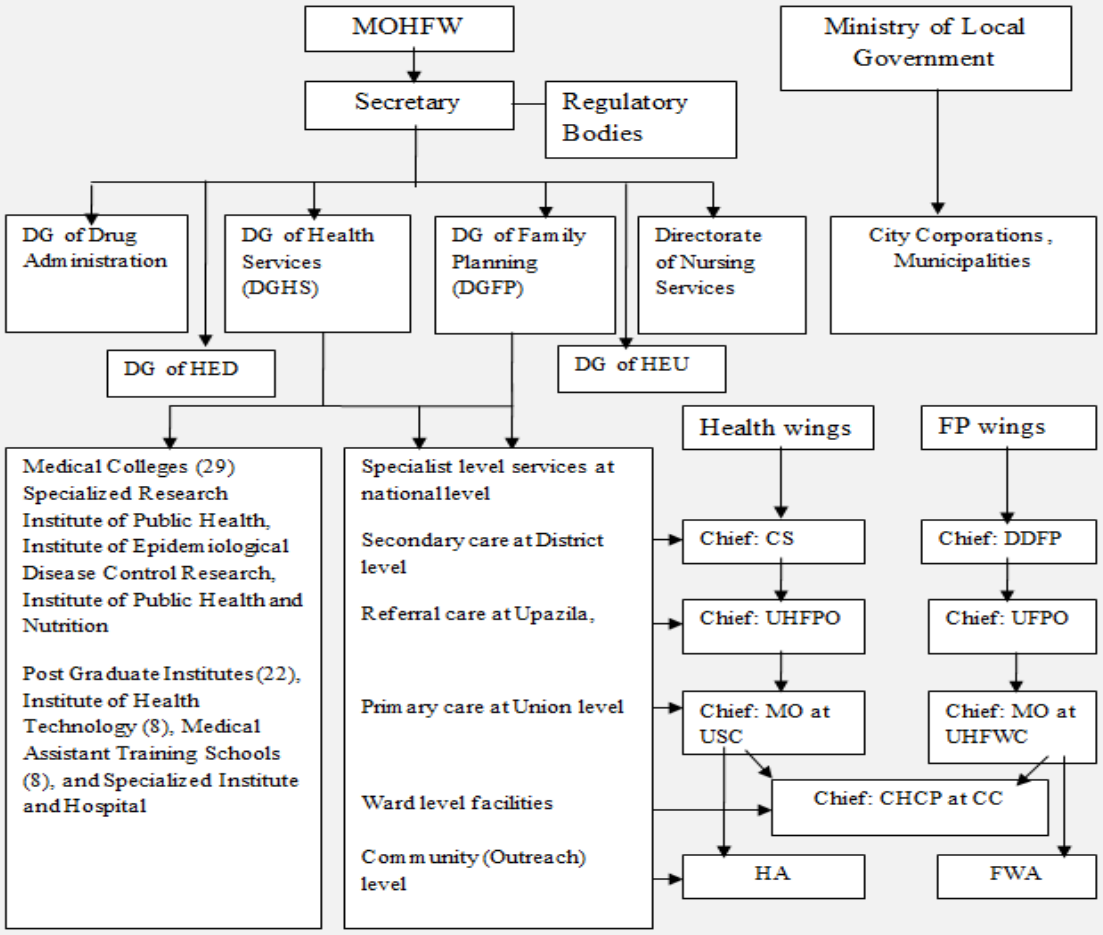
4. Health Service delivery at the local level: The practice

In line with thie top-down vision of service delivery, the pattern of Bangladesh's public health service delivery system is hierarchically structured from the national level to the village level.

At the central level, the Ministry of Health and Family Welfare (MoHFW) is responsible for policy formulation and planning, regulating medical professional and standards, managing and controlling drug supply, providing health services, preparing budget and allocation funds and many more of the health sector, although there are other ministries having health care responsibilities and infrastructures.

At the field level, the health sector has been organized as per the territorial-administrative structure of the country. The healthcare infrastructure comprises six tiers: national, divisional, district, upazila (sub district), union, and ward. At the national level, there are institutions both for public health functions as well as for postgraduate medical education/training and specialized treatment to patients. District level with district hospitals (50-200 beds) provides tertiary care while upazila level provides secondary care through Upazila Health Complex hospitals (with 31 beds). Union and ward levels provide primary care services. At the union level, three kinds of health facilities exist: Rural Dispensary (RD), Union Sub Centers (USC), and Union Health & Family Welfare Centers (UHFWCs). In addition to these three types of union level health facilities, at the ward level, Community Clinics (CCs) serving 6000 rural residents. Table 1 presents the vertical structure of the health service delivery across various administrative tiers

Figure 3.1: Vertical Organization of the Health Sector in Bangladesh



Derived and modified from the Bangladesh Health System Review, year 2013; Page -24
Health Bulletin 2014, DGHS, P- 29/30

Alongside this health service delivery infrastructure, as mentioned before, the local government institutions have also been made responsible for heath service delivery.

To determine the degree of localization in practice, this section examines which entity plays what role in five key aspects of health service delivery: facilities, functionaries, operation and maintenance, supplies, monitoring and community engagement.

Responsibility for Facilities/ Capital Infrastructures/Funding:

Decision regarding the construction of new facilities i.e. the decision how many new facilities to construct (and where) is a policy-level decision made at the central government level, while local government institutions hardly play any role in the process. Ministry of Health and Family Welfare performs this function through the Directorate of Health Engineering. Procurement and construction of local-level

(upazila and below) health infrastructure is done by district-level Health Engineering Departments (HED). HED is also responsible for supply of new furniture for new facilities. Currently, the most significant construction of facilities in the health sector refers to the construction of Community Clinics (CCs) at the village level. Although the CCs are established through community partnership with government (community donates land), but the local bodies especially the Union Parishad does not have any decisive power about its construction.

The MOHFW is responsible for distributing the resource envelope received from the Ministry of Finance between the revenue and development budgets and among the administrative units and health facilities at different administrative levels. Although both top down and bottom up approaches are followed for preparing revenue budgets, ultimate allocation decisions are made centrally. In practice, the allocation decisions are often based on the previous year's actual expenditure levels, availability of resources and the policy focus of the government.

Both UZP and the UP have a small budgetary allocation for health service, mainly for small logistic support. UZP has a poor tax base and relies almost solely on central government fund. The amount of ADP allocation from the central government to the UZP depends on the size of population and area. ADP block grant has a guideline for spending about 10-15 percent of the total fund for health and education but often this expenditure varies from place to place and more importantly, expenditures are mostly made for infrastructure development. Present study found that in 2011-12, Hobigonj UZP did not incur any expenditure for health while in Jagannathpur UZP, around 6% of its development budget was spent for health service in 2012-13.

Responsibility for service delivery staff (functionaries)

As per the UZP Act 1998 and the UP Act 2009, all the issues related to health and education services (along with other transferred services) and also the service providers are supposed to be managed by these LGIs. But there is a wide gap between the policy and practice in this regard. Neither UP nor UZP recruits any health/education staff. All the frontline service providers are recruited centrally by the concerned ministries[9]. UP/UZP does not have any authority to make any

[9] Urban municipalities, on the other hand, have the government sanctioned posts of 1 doctor, 2 Health assistants, 1 FWV, 1 Health Inspector and 4 vaccinators. Amongst all,

readjustment in the staffing pattern of schools or health facilities even in case of emergencies.

The health service providers are the civil servants. The Ministry of Health and Family Welfare (MOHFW) defines the human resource policy and has the ultimate authority to decide on issues regarding hiring, promotion and dismissal. Employment conditions, salary level, allowances, other employment benefits and staff development practices are centrally determined by the ministry. With respect to payment of salary and allowances, district and upazila health and family planning administration work as Drawing and Disbursement Officers (DDOs) for the staff under his/her jurisdiction. Regarding training, district and upazila health and family planning administrations organize and/or oversee staff training as per instruction of DGHS and DGFP of central ministry.

Within the deconcentrated administrative structures of DGHS and DGFP, staffs are accountable to their respective line department supervisors from local level to central level. While all health workers are accountable to the Ministry of Health and their respective Directorates, there are hierarchies of accountability at different levels of central ministry.

Responsibility for service delivery operation, maintenance

The ministry of Health and Family Welfare (MOHFW) exercises exclusive control over operation, maintenance and repair. Three different organizations under the MOHFW are responsible for construction, large maintenance and repair works related to public health facilities. First, the Health Engineering Department (HED) is responsible for construction as well as for doing minor repair and maintenance of public health facilities including community clinics, Union Sub-centres, UHCs, UHFWCs, 100-bed district hospitals. Second, the National Electro-Medical Equipment Maintenance Workshop (NEMEW) is responsible for maintaining biomedical equipment in public sector health facilities including medical colleges and third, the Transport and Equipment maintenance Organization (TEMO) is responsible for maintenance of transports and equipment of health facilities. This organization does not have any field office and

1st and 2nd class employees are recruited by the line ministry while the 3rd and 4th class employees are recruited by pourashava. Some pourashavas administer schools with their own funds.

its manpower is also very limited. At facility levels, district and upazila health managers are also responsible for minor repairs but do not have discretion of maintenance-related funds. As a result, facility-level managers mainly depend on HED for minor repairs.

Special funds (UZGP and ADP funds) are given to the UZP for small schemes for infrastructural extension works but for maintenance there is no specific fund. For maintenance cost, Upazilas need to rely on the central government. The UZP is allowed to spend 10-15% of the ADP Fund for health and education expenditures, but in practice, most of these funds are spent for road construction. Although neither UZP nor UP has any budget earmarked for maintenance and repair, in special circumstances both the local bodies appear to be able to finance some small repair and maintenance from its development budget. Besides this, in general, the LGIs provide limited logistic supports to the facilities including furniture, latrine, tubewell and sometimes builds or repairs approach roads to the facilities and communicates local demands to the Upazila coordination meeting for action. Satellite clinics are sometimes also facilitated by the UP (making sitting arrangements for the providers and patients)

Responsibility for supplies

The central government is responsible for procuring all supplies and pushing to facilities. Central Medical Stores Depot (CMSD) of the government procures medicines and supplies including medical and surgical requisites **(**MSR) for the public sector hospitals and facilities where the consumers get it free-of-cost (WHO, 1985). CMSD and Essential Drug Company Limited (EDCL) of MOHFW are responsible for providing medical supplies to District Reserve Stores (DRS), which operates under the control of the district health administrator called the Civil Surgeon (CS). Civil Surgeon (CS) at the district level also has some authority to purchase medical and surgical requisites (MSR) that includes standard packages of medicines and other supplies (equipment, X-ray film, ECG paper, gauze, bandage, etc.) for the facilities within the jurisdiction of the district. The drug supply system is ostensibly a 'pull' system, i.e. upazila and union managers submit request and items are supplied via an indent system. Requisition and supply is normally made on a monthly basis for UHCs and a quarterly basis for union facilities (i.e., UHFWC and USC). The Upazila health administration (UHFPO) is responsible for collecting supplies from DRS and distributing to service delivery points at UHC (indoor, outdoor and emergency sections), USC and UHFWC.

Neither UP nor UZP does play any role with regard to the supplies for service delivery. Supplies of materials (medicines and other medical supplies) for primary health centres are decided by the Ministry. For instance, whereas a Community Group (CG) for a Community Clinic may be in a position to identify certain problems (eg., the absence of medical supplies), neither the clinic staff, nor Upazila level staff are typically in a position to address these concerns without intervention or support from the district level. Similarly, the concerned Upazila Committee may place its request for supplies to the concerned departments, but obtaining the supplies depends on the decision of the centre. Sometimes, in response to some critical needs UZP provides some small logistic support (fans, bench for patients to sit, cycle stand for the staff) considering the lengthy process involved to obtain them from the ministry.

Responsibility for coordination, performance monitoring of front-line services and community mobilization

Accountability and monitoring follows the hierarchical structure of the sector. Local level health officials are accountable to their immediate higher line management within the (central) government administration. Although at the UZP and at the UP there exist various committees linking the government service providers and the local government representatives but these committees do not have the required authority to monitor the performance of the officials. Even if they do it, it hardly carries any meaning. As a means of ensuring accountability of service providers at the local level, although there is a legal provision (in the UZP Act 1998) for Upazila-level departmental officials to obtain Annual Performance Report (APR) from the UZP Chairman, this is not being practiced or enforced everywhere.

To coordinate the service delivery functions at the local level, at the upazila level, two committees exist: (i) Upazila committee on the services concerned, and (ii) Service related Committee at the UZP. These committees are supposed to have monthly meeting to have discussion about the problems and issues related to service delivery between the local health officials and the local government functionaries. At the UP level, the UDCC performs such coordinating job. On the other hand, the district health administration is supposed to coordinate the health service related activities in the upazilas within the jurisdiction of a district.

UP has some formal involvement with the CCs. Female ward members at the UP are responsible for overseeing the Community Clinics at the village level. Concerned ward member is the president of the CC Management Committee (CCMC), which meets once a month. CCs receive one carton of medicine supplies containing 29 essential medicines in three months interval, which is unpacked by the CC in presence of the UP Chairman/ward member. Although UHFWC and Union Sub-Centres are other types of health facilities at the local level, the UP does not have any formal involvement with their functioning. Formally, the UP does not have any monitoring authority over the UHFWC. UPs were found even unaware of how many staffs were supposed to provide service at the UHFWC. Services are informally monitored through the visit by the local representatives to the health facilities but it is rare and it gets even rarer in hard-to-reach, geographically disadvantaged areas. Poor communication often discourages the UP functionaries to supervise the facilities as they are not provided with any logistic support. On the other hand, due to poor communication, availability of the line agency staff in these areas also remains quite limited.

With respect to community mobilization and engagement, local government bodies play important role. Upazila and Union Parishads take some initiatives for community mobilization on the eve of special events like National Immunization Day (NID). Not-for-profit or nongovern-mental organizations also play key role in service provision as well as advocacy, community mobilization and communication. On the other hand, the front-line health facilities and their staff are also assigned the responsibility for community engagement and mobilization as they work at ward/village level.

Thus the above account informs that as opposed to the recently promulgated local government Acts favouring devolution, health services at the local level are in practice being delivered through a highly centralized management. All the key issues related to service delivery i.e., managing functionaries, finance, facilities, supplies, maintenance and repair- are virtually being controlled by the central ministries and their field offices. The LGIs play a minimal/limited role in the process through small maintenance works, and limited coordination and monitoring the facilities and social mobilization. It is also important to note that the degree of deconcentration within the government administration is also quite limited. The field level presence in both education and health sectors can be described as an

extension of their respective central directorate, with the role of mere carrying out instructions from the center rather than taking planning and management decisions of any significance or exercising authority over budgetary resources. Thus there also remains gap between the vision of the health policy documents for having true deconcentration is yet to be achieved. Table 1 presents a summary overview of the *de facto* functional assignments for localized health and education services in Bangladesh.

Table 1: Responsibilities of local health administration and LGIs

Issues of health service	Levels of administration				
	Central Min.	Zila Admin	Upazila Admin	UZP	UP
Facilities (Capital exp.)	Main	Min.	None	None	None
Functionaries (local HRM)	Main	Limited	Min.	None	None
Operation & maintenance	Main	Limited	Min.	None	None
Sectoral supplies (meds)	Main	Limited	Min.	None	None
Coord. & comm. Engagement	None	None	Limited	Limited	Limited

Thus the study reveals a big gap between the policy and practice. Despite the policy of devolution of power to the local level, neither the administrative nor financial authority enjoyed by LGIs is adequate for them to deliver services in a devolved manner. LGIs do not have any managerial control over staff, supplies, maintenance, and infrastructure development. LGIs do not have any effective authority or incentives to monitor performance of the front line service providers and to make the providers accountable to them. The role that LGIs play with regard to the delivery of services is mere facilitative.

5. Impacts and Consequences

The current centralized management is one of the root causes for poor health service delivery in Bangladesh. The centralized hierarchical system by its very nature lacks flexibility and responsiveness in service delivery.

Due to the centralized management of functionaries, the study finds a crisis in the human resources of the health sector at different levels of front-line health facilities (UHC, UHFWC and USC), both in quantity and in quality, which should be considered as an important barrier to providing quality health and family planning services. Almost all the

health facilities visited, particularly the UHCs, were found to have a large number of vacant posts of doctors and more importantly, a significant number of positioned doctors were found to be out of the work place. One Upazila Health Complex in a study area was found running only with one doctor in place of sanctioned nine doctors. This happens because the path of accountability of the doctors is upward and it is too long. Indeed, when asked about vacancies, an Upazila-level stakeholder informed that the decision to fill or not to fill vacancies is made by authorities above the Upazila level.

The centralized health financing mechanism results in less efficient distribution of the scarce resources. Central funding based on "one-size-fits-all" norms, hurts remote and disadvantaged areas. The number of health facilities, the number of hospital beds and the number of health staff are typically considered for budget allocations for local health facilities and public hospitals. While allocating resources to the UHCs, important factors such as demographics, geographic location (remoteness), needs (e.g., higher poverty), or disease profiles of the area were not considered. This results in an inefficient and inequitable distribution of health finances. In particular, places that are more remote and hard to reach will have fewer health facilities and staff, and thus, get stuck in a vicious cycle of under-staffing, under-funding and weak services. Moreover, the rigid nature of fund flow from the centre makes the local health officials unable to address the local problems in a timely manner. On the other hand, Upazila Parishads have limited resources (especially compared to the legal responsibilities assigned to them); that they have weak capacity to plan, prioritize and spend resources in accordance with local service delivery priorities. Thus local needs are left unaddressed for long. There are virtually no accountability mechanisms in place to make sure that Upazila Parishads spend their resources in line with either sectoral priorities and/or with the priorities of their constituents.

As a part of the centralized system relied upon, the MOHFW is responsible for covering the cost or providing operational items for local health facilities, like fuel for generator and other such items and local responsibility for maintenance and repair is quite limited. Upazila Health Complex does not get sufficient operational cost for maintaining a generator during frequent power cuts from the center, which means that nonoperational generators cannot be repaired and even functioning generators cannot be run when the fuel runs out. Doctors from the Kazipur UHC of Sirajgonj district informed the study

team that the absence of a working generator is a major obstacle to provide expected health services, as this means that medical equipment cannot be used.

The current centralized structure does not perform maintaining and repairing health facilities in a responsive manner. Although Upazila-level health managers and DDFP do not have any funds to manage maintenance cost, District health administrations are given a small budget for funding minor repairs for UHCs and local-level health infrastructure up to a ceiling of Taka 2000 (US$30). A health official informed, "It takes a long time for maintenance of health facility from departmental funds. Sometimes we manage minor repairing from our own pocket". Expressing dissatisfaction expressed dissatisfaction with this top-down arrangement, an upazila manager said, "I informed HED about the need for plastering of some parts of the upazila health complex and some parts of doctors' residential buildings over six months month ago but no action on the part of HED is yet visible. Such unresponsive top-down system disrupts service delivery at the front-line".

The top down system also affects timely supply of medicines. Community Clinics are supposed to be provided with 30 drugs but in most cases supplies are limited, which seriously affects service to the rural community. "*I have only two types of medicines. People come to community clinic and I have to tell them that there are no medicines. It is risky... some time they abuse us and express concern why are we being paid by the government for doing nothing"* – stated by a *CHCP*. The arrangements for supply of drugs to CCs have failed to achieve even a reasonable level of availability. Indeed, every health facility visited as part of this study informed us that the supply of medicines is inadequate.

Thus the study observes overall poor quality health service at the local level, which can largely be attributed to the centralized management of services or in other words to the negligible role of local government in service delivery.

6. What led to this Gap?

The above account clearly depicts a wide gap between the legal provisions and the service delivery on the ground. The paper has identified some underlying reasons for the gaps between the policy of localizing health service and the practice, which are as follows:

i. Legal weaknesses cause a lack of enforcement of the functional assignments to the LGIs

The current study finds some legal weaknesses causing the lack of enforcement of the local government Acts transferring health services to the UZP and UP, which include: contradictions in legal provisions and lack of clarity/ gaps in legislations. These include:

Contradictions in the UZP Acts and Circulars.

Although UZP Act 1998 introduced the transfer of authority and responsibility for services to the UZP but its amendment in 2009 imposed central control over the UZP through allowing the Members of Parliament (MPs) get involved in the decision making process of the UZP (Section 19 of the Rule 27). The 2009 Act has seriously undermined the spirit and essence of devolution expounded by the 1998 Act and its mother law-- the 1982 UZP Ordinance. Afterwards, various Circulars issued by the MOLGRD generated more contradictions with the existing law mainly with regard to the issues of *managing human resources* and exerting *central control* over UZP activities. Although the UZP Act 1998 advocated for transferring services to the UZP by placing the officials and staff of the concerned departments at the disposal of the parishad, but in practice, with regard to the management of the deputed officials UZP does not enjoy any authority. In addition to this, although the UZP Act 1998 requires devolution of authority and responsibility to the UZP, but contrarily, certain circulars have imposed central control over the UZP. Table 2 presents the main contradictions in the local government Policy, Acts, and Circulars with regard to the transfer of service delivery responsibilities to the UZP.

Table 2: Contradictions in the local government Policy, Acts, and Circulars

Issues	Act	Circular
1.Management of the officials and staff by the LGIs	UZP Act 1998 states that the officials, staff and their functions of the ministries will be transferred to the UZP. All officials of transferred departments will be placed at the disposal of UZP.	Dated 4th May 2009: • Upazila Chairman can ***propose*** measures for control, supervision, withdrawal, transfer, disciplinary action against an official to the concerned authority. • Chair will have the authority to take disciplinary action against any official or staff of

Issues	Act	Circular
		the UZP other than the officials deputed by the government.
	UZP Act 2011 stressed using the term 'transferred' in place of 'transferable' and added 5 more departments as transferred to the UZP	Dated 6 January, 2013: • Matters related to human resource management and control will be retained by departmental heads at the central level.
2.Central control	Policy (Sixth Five year Plan) commitment of having strong autonomous local government with discretionary power to carry out their responsibilities.	Dated 20 June 2010 • UZP has to send a copy of its approved budget to the government along with the local MP and the Deputy Commissioner (DC).
		Dated 19 September, 2010: • Officials of transferred departments will submit all the official files for approval to the UZ Chairman through UNO.

Contradictions between the policy positions of local government and the sectoral policies. The study also finds contradictions between the policy of local government (manifested in various legal documents eg., Acts) and the sectoral polices. The Sixth Five Year Plan (2011-15) rightly stresses that the implementation of devolution is to take place in coordination with sector development strategies, particularly for social services. In reality, the study finds a sheer gap between the policy focus of local government and that of the health sector. *While local government policy emphasizes on devolution, the health sector policy systematically advocates for promoting deconcentration*. Agenda wise, involvement of local government in service delivery is a remote issue in health sector policy. Such contradiction in policy focus affects the effective transfer of services to the LGIs.

Lack of clarity/Gaps in legal provisions

Legally, all tiers of field administration and all LGIs are responsible for delivering services but the legal provisions lack clarity about the division of functional responsibilities between the two entities. The UP Act 2009 has not mentioned specifically what role would UP play in delivering the services transferred to it which creates confusion among

the functionaries about their role with regard to the delivery of services. On the other hand, the sectoral policy also does have certain gaps. The health policy 2011 remains vague about the nature of involvement of local government in service delivery. Table 3 presents the responsibilities of local administration and LGIs for health services, which is indicative of local administration being the key player in service delivery while on the other hand, responsibilities for the LGIs have been mentioned in such a broad manner that LGIs might also be considered as the key service provider at the local level. In the recent Acts relevant to the local government tier, responsibilities of LGIs have been mentioned while the Circulars of the concerned Directorates are the sources of the responsibilities assigned to the district and upazila administration. Table 3 shows that responsibilities of zila parishad and district health administration overlap in supervision issues (shown in bold form). On the other hand, at the upazila level, the role of upazila parishad with respect to health service is unclear and in fact overlaps with upazila health administration. By saying that upazila parishad will be responsible for "ensuring the provision of health and family planning services" it actually covers all aspects of service provision that have been pronounced in detail in case of the functions of the head of upazila health administration called the UHFPO. Such lack of clarity in legal provision causes confusion and finally results in non-functionality of upazila parishad in health service delivery. Similarly, at the union level also, responsibilities for both health services have been kept broad while the functionaries of local administration actually manage the delivery of services.

Table 3: Lack of clarity/overlapping of responsibilities between LGIs and Local Administration

Tiers	Responsibilities of LGIs	Responsibilities of Local Administration
District	**<u>Health</u>** **Zila Parishad** **(Zila Parishad Act 2000) (Optional functions)** Improvement of health education, -providing grants to the institutions facilitating medical care -Formation of satellite medical	**Responsibilities of District Civil Surgeon (Head of District Health Administration)** -Coordinating all health and family planning activities in the district -Ensuring proper functioning of all health institutions in the district and carrying out inspections periodically or as may be specified. ***-Supervising all health activities and programs in the district***

Tiers	Responsibilities of LGIs	Responsibilities of Local Administration
	team -Formulation and implementation of programs for prevention of infectious diseases -***Supervising the health workers*** -***Establishment, maintenance and supervision of the health centres, maternal and child health centres,*** imparting training to the traditional birth attendants	-Accounting officer in respect of health services officers in the district -To ensure procurement of supplies, maintenance of district reserve store and distribution of supplies to all peripheral health units. -Dealing with medico-legal cases in the district and to be responsible for the overall administration and enforcement of health legislation in the district. -To initiate disciplinary cases against all officers and staff working in the district.
Upazila	**Upazila Parishad (UZP)** **Upazila Parishad Act 1998** **Responsible for *ensuring the provision of public health, nutrition and family planning services***	**Upazila Health and Family Planning Officer (UHFPO)** -To work under the guidance of upazila parishad as coordinated by the UNO. -Supervising health and family planning activities at the upazila level and below. -Sanctioning authority for expenditure of funds for both health and family planning divisions and ensuring proper utilization of these funds. -Responsible for the management, administration and maintenance of Upazila health complex -***Responsible for the implementation of family planning programs in the upazila*** -Allocation of duties among the health and family planning staff in the area -Managing training for the health and family planning staff in the upazila -Maintenance of necessary information and statistics in the Upazila health complex -Visiting the unions and villages

Tiers	Responsibilities of LGIs	Responsibilities of Local Administration
		regularly to get acquainted with the problems and achievement of the ongoing health programs -Regular inspection of the unions under the upazila -Responsible for procurement, distribution and proper utilization of stores. -To initiate ACRs of the officers and staff working in the upazila -Responsible for the supervision of enforcement of health legislation
Union	**Union Parishad (UP Act 2009: 2nd Schedule)** Implementation of programs related to health and family planning Arranging health centres for primary health care services.	Field level health workers provide both domiciliary and static health and family planning service.

Local Government Acts are also unclear about the distribution of vertical responsibilities among LGIs- almost all levels have similar types of responsibilities. Table 4 informs the health service related responsibilities assigned to the LGIs and identifies the overlapping and vagueness in the assigned functions.

Table 4: Overlapping of responsibilities between the tiers of LGIs

Tiers	Responsibilities of LGIs	Overlapping
Zila Parishad (ZP) (Zila Parishad Act 2000)	-Improvement of health education, -Providing grants to the institutions facilitating medical care -Formation of mobile medical team -Formulation and implementation of programs for prevention of infectious diseases -Supervising the health workers -Establishment, maintenance and supervision of the health centres, maternal and child health centres	Supervision of health workers and health centres by the ZP overlaps with the similar responsibility of UZP.

Tiers	Responsibilities of LGIs	Overlapping
	-Training to Traditional Birth Attendants (TBAs)	
Upazila Parishad (UZP) (Upazila Parishad Act 1998)	Ensuring the provision of public health, nutrition and family planning services	It appears that UZP will be responsible for managing everything in order to "ensure health and family planning service provision" including the responsibilities assigned to the zila parishad.
Union Parishad (UP Act 2009: 2nd Schedule)	Implementation of programs related to health and family planning ; Arranging health centres for primary health care services.	Implementation of programs related to health and family planning overlaps with UZP which is assigned to ensure the provision of public health, nutrition and family planning services

The health service related functions assigned to the Zila Parishad mentioned in Table 4 are optional functions. However, its supervisory functions overlap with the upazila parishad. On the other hand, responsibilities for health services of UZP overlap with those of UP as the functions are mostly broad, open and vague in functional terms. For example, mandates like "ensuring the service provision", and "functions related to primary and mass education services" cause overlapping and confusion. Particularly at the union level, responsibilities for health services have been kept largely broad and unspecified, which do not reflect the actual role of UP (service provider and supervisor of local administration). Such lack of clarity in functional assignments significantly contributes to the nonfunctionality of LGIs in service delivery.

Legal provisions are also unclear about the distribution of vertical responsibilities among local administration. Table 5 has cited some examples of such lack of clarity. Table 5 shows that in the health sector, there are some overlapping of functions between the district and upazila administration particularly with regard to inspection, supervision of health and family planning activities and procurement and distribution functions.

Table 5: Lack of clarity in the distribution of responsibilities among the levels of local administration

Services	District Administration	Upazila Administration
Health	-Ensuring proper functioning of all health institutions in the district and carrying out inspections periodically or as may be specified. -Supervising all health activities and programs in the district -To ensure procurement of supplies, maintenance of district reserve store and distribution of supplies to all peripheral health units. - Responsible for the overall administration and enforcement of health legislation in the district.	-Regular inspection of the unions under the upazila -Supervising health and family planning activities at the upazila level and below - Responsible for procurement, distribution and proper utilization of stores. -Responsible for the supervision of enforcement of health legislation

The above mentioned contradictions and lack of clarity in legal provisions cause confusions, unresponsiveness and nonfunctionality of both the local administration and the local government entities, the ultimate result of which is poor quality service for the rural people.

ii. Control of central politics over the functioning of local government and local administration

Although the UZP Act 1998 has transferred health services to the UZP but the parishad has not been devolved with adequate authority to provide services instead, central control has been imposed on the parishad by making the Member of Parliament (MP) of the concerned area as the adviser to the parishad. Involvement of MPs as the adviser to the UZP coordination committee is one of the major obstacles for the UZP to play a stronger role in delivering services. Particularly with regard to the economic projects like infrastructure development, MP's voice becomes stronger than the UZP or the local administration. This practice generates conflict between UZP Chairman and the local MP, which ultimately makes the UZP Chairman reluctant about service delivery. Besides, each and every committee at the local level has MP or a "representative" of MP as its adviser or member with heavy influence. For instance, Upazila Hospital Management Committee, which is the lone functional upazila level committee on health service, is headed by the local MP and all the UZP committees having

relevance with finance have MP as the adviser. This practice seriously disempowers and demotivates the local bodies to get involved in service delivery.

iii. Lack of political will for localizing service delivery

The study reveals a sheer political unwillingness for devolution or transferring authority to local bodies regarding social services. Two examples can justify this claim. First, the 1982 UZP Ordinance was explicit about transferring the responsibility for the management of government deputed officials at the upazila level to the UZP and had no mention about the MP's "advisory" role to the UZP. But the UZP Act 2009 (amendment) has introduced the provision of making MPs to the advisers to the parishad and a Circular issued by the MOLGRDC in 2013 asserted that the issues related to the management of deputed officials would be under the control of central government. Second, the health sector policy does not have any clear policy position about the involvement of local government in service delivery. These raise doubts about the willingness of the successive governments to localize services through devolution in true sense. As a natural consequence, the initiatives for localization of services through devolution continue to remain half-hearted and fail to produce the desired results.

iv. Highly centralized administrative system

Inherited from the colonial rule, the vertically organized administrative system leads to a highly centralized management of sectoral services. Both health and education services at the local level are solely controlled by the central ministries or the directorates concerned. Central control over financial resources along with other aspects of service delivery like maintenance, repair and procurement of supplies demonstrates a strong presence of colonial legacy of administration through control. Centralization has taken such an extreme form within the vertical structure that the central ministries retain all the budgetary and staff management authorities leaving the subnational entities as mere the implementing agencies with minimal authority. All the sectoral staffs are recruited centrally even the field level health and family planning staffs are also recruited by the Directorates. Thus the current administration is still solely engulfed with the centralistic attitude of colonial administration.

7. Concluding Remarks

Policy wise, Bangladesh is in favour of decentralizing health service delivery. Both the local government and the health sector have pronounced the promise of localizing health service delivery through decentralization—in the form of devolution (envisioned by the local

government sector) and deconcentration (promised by the health sector). In practice, as the above account shows, neither devolution nor deconcentration has been implemented successfully.

The finding of the present study refers to the near-absence of local government institutions (UPs and UZPs) in local health service delivery indicating a wide gap between the legal provisions (UZP Act 1998 and UP Act 2009) and the practice. LGIs do not have any direct involvement in delivering health services other than providing small logistic supports and paying visits to the facilities.. Beyond their minimal involvement in community engagement and (in some places) the allocation of a tiny portion of local block grants to health-related activities, UPs and UZPs do not play any meaningful role in health service delivery. Given that the provision of health service is under the firm control of the field administration of the MOHFW while the interest in local health service delivery issues among local government functionaries is limited. This situation does not bode well for the devolution of responsibilities for local health services that is envisioned under the recently revised local government Acts. On the other hand, the degree of deconcentration within the government administration is also limited. All the decisions regarding service delivery mechanisms (functionaries), capital (facilities) as well as funds are exclusively controlled from the central ministry. Excessive centralization of functional responsibilities for health infrastructure, financing staffing at the upazila level and below level is contributing to persistent gaps in the availability of health facilities at the local level in the form of absenteeism of the health staff, lack of medicine and supplies, absence of proper maintenance of the facilities.

As the underlying reasons for the gap between policy and practice the study has identified some legal weaknesses causing overlappings and confusion about the responsibility of local administration and local governments for service delivery, excessive interference of central politics, lack of political will for devolving power to the local level and the centralized administration of the country. Overall, the study observes that country's political culture and history, economy and administrative system are central to all these maladies, which should be examined in future studies.