Governance, Management and Performance in Health and Education Facilities in Bangladesh:

Findings from the *Social Sector Performance Qualitative Study*

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FMRP

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Acknowledgements

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Abbreviations

AEM	Attached Ebtedayee Madrasah
ARI	Acute Respiratory Infection
AUEO	Assistant Upazila Education Officer
BNP	Bangladesh Nationalist Party
CAMPE	Campaign for Mass Education
CIET	*Centro de Investigación de Enfermedades Tropicales (*Tropical Disease Research Centre)
CMMU	Central Medical Maintenance Unit
DD	Deputy Director (district)
DEO	District Education Officer
DPEO	District Primary Education Officer
DRS	District Reserves Stores
EOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunisation
ESTEEM	Effective Schools Through Enhanced Education Management
FGD	Focus Group Discussion
FMRP	Financial Management Reform Programme
GPS	Government Primary School
HSC	Higher Secondary Certificate
IMCI	Integrated Management of Childhood Illnesses
MOHFW	Ministry of Health and Family Welfare
MOPME	Ministry of Primary and Mass Education
MPO	Monthly Pay Order
NGO	Non-Governmental Organisation
PTA	Parent-Teacher Association
RMO	Resident Medical Officer
RNGPS	Registered Non-Government Primary School
SMC	School Managing Committee
SSC	Secondary School Certificate
SSPS	Social Sector Performance Survey
SSPQS	Social Sector Performance Qualitative Study
UEO	Upazila Education Officer
UHC	Upazila Health Complex
UHFPO	Upazila Health Family Planning Officer
UNO	Upazila Nirbahi Officer

UP	Union Parishad
UPO	Upazila Project Officer
USC	Union Sub-centre
USEO	Upazila Secondary Education Officer

Executive Summary

This report presents findings from the *Social Sector Performance Qualitative Study* (SSPQS). The SSPQS was designed as a follow-up to the *Social Sector Performance Surveys* (SSPS), which were public expenditure tracking surveys undertaken in the primary and secondary education and government health and family planning systems between 2004 and 2006. In many respects, the SSPS findings were positive, documenting that systems of health and education service provision were functioning. While there were problems, including of corruption or leakage and poor quality services, the provision of health and education services was found to be reasonably effective within their given goals and resource constraints. The SSPQS was designed to use qualitative methods to triangulate, explore and illustrate selected findings from the SSPS.

The SSPQS or qualitative study was designed to add depth to the understanding of key issues that arose from the SSPS survey. The research was designed to address the following question: how is the delivery of education and health services affected by the management and governance of financial, material and human resources at the level of schools and health facilities? The specific objectives of the qualitative study were to:

- Gain insights into the practices and perceptions associated with the governance and management of resources, including practices relating to corruption and leakage, with the aim of understanding how these might be addressed.

- Understand the incentives, both material and non-material, that shape the motivations and performance of key facility workers.

- Identify institutional patterns and practices associated with performance, by comparing education and health facilities selected from among those surveyed in the SSPS as examples of high and poor performers. Within this, the focus was on comparing models of quality among different participants in the system, governance arrangements, management practices, and resources.

The research on schools drew on the Heneveld-Craig framework for analysing school effectiveness. Applied here, this entailed a focus on understanding how the quality of supporting inputs (parental and community participation, supervision and material inputs) and enabling conditions (the effectiveness of school management and the incentives of teachers), relate to the quality or performance of the facility. To explore the governance of schools and health facilities, the research also drew on the analytical framework developed in the *World Development Report 2004* to unearth accountability mechanisms linking users, providers and policy makers.

Quality and performance are both used here to refer to the value and level of services being produced by facilities: a high-performing or 'good' facility is defined as one which produces a comparatively high volume of services and/or services which are of comparatively high intrinsic value, compared to similarly-resourced facilities. Management is defined as the practices by which the material and human resources are organised and supervised within a facility. As used here, governance refers to the mechanisms that enable service-users to hold service-providers to account for their performance, and to the practices and rules established to protect facility resources and service-users against leakage or corruption.

Research was undertaken by four teams, at the facility level and in upazila and district offices across the country. A sample of six primary schools, six secondary schools, three dakhil madrasahs, six upazila health complexes and six union sub-centres (health) was

drawn on the basis of a ranking of facilities on performance indicators, based on the SSPS data. The intention was to enable an exploration of the differences between facilities with high and poor performance. Research took place between March and July 2006 in 15 schools and 12 health facilities in 15 upazilas and nine districts across the country. Some 582 education and health officials, teachers, doctors, community leaders and members, patients, parents and students were interviewed or participated in group discussions as part of this research.

One methodological challenge was to utilise and reconcile the wide range of different kinds of data about each facility. Even with the large amounts of data at our disposal, it proved difficult to precisely identify many determinants of performance or quality. In the final analysis, it became clear that one reason for this was that many facilities had experienced change between the time of the SSPS surveys (in 2004 or 2005) and the qualitative research (March–June 2006).

The use of qualitative methodologies has both advantages and limitations. The advantages in the present study include that it permitted a focus on processes that govern the delivery of services on the ground, an exploration of the attitudes and experiences of service providers and users, and of the social relationships which in practice govern the delivery of services. The qualitative approach is limited in that not all the findings are generalisable across all facilities, although care has been taken to highlight findings which are supported by the quantitative findings of the SSPS survey, and which illustrate broader patterns of behaviour and practices among service providers and users. A second limitation of the qualitative approach is that the findings have not been turned into policy recommendations. The main reason for this is that the present study is intended to be read as a companion to the main SSPS survey reports. It is expected that the findings will stimulate new thinking among policy-makers in the health and education sector about how to strengthen processes which are demonstrably working well, as well as how to tackle obstacles to improved service delivery.

The main findings of the report are presented in Sections 3 to 5.

Section 3 looks at how financial and human resources are governed and managed, including how these practices contribute to corruption, leakage and the abuse of influence and affect service provision at the facility level. Corruption, leakage and the abuse of influence create a number of problems for the performance of the health and education sectors. Informal charges or ‘speed payments’ are the most common form, so common that they are treated as part of the organisation culture of the public administration. While speed payments do not represent a major leakage from the public purse, they are nevertheless harmful: the practice discourages government from paying realistic travel and other allowances on the grounds that officers cheat on their allowance claims, and officers in turn are unable to undertake adequate field-level supervision, so that the quality of service delivery suffers. Corruption in recruitment is also understood to be common, particularly in non-state schools. This has negative implications for the quality of teacher recruits. However, attempts have been made in the last few years to tackle corruption and undue influence in public sector teacher recruitment, with some reported success.

There is only limited quantitative evidence of drug leakage, as measured through the reconciliation of official records at various levels. However, a comparison of facility records with patient feedback indicates losses at the facility level. The qualitative research illustrates some of the processes by which this occurs. By contrast, corruption and leakage in the stipends programmes has been well-documented, and effective actions have been taken to address these problems in both primary and secondary stipends

programmes. Education administrators, teachers and students all concur that there has been a decline in corruption in the stipends programme. However, the research also found that practices of falsifying student records to ensure they continue to receive the stipend remain both common and acceptable among students and teachers.

In terms of direct impact on service quality, the most important form of leakage of resources is through time losses, which occur when public servants provide private services in such a way that this diminishes the quality or quantity of official services they provide. The amount of time spent by teachers and doctors on providing public services is a direct determinant of their performance: the schools in which contact time between students and teachers is maximised are also those in which gains in performance have been most rapid. Poor-performing facilities tend to be those in which attendance is substantially a matter of individual discretion. In health facilities, shorter opening hours, fewer doctors, and the intrusion of private practice into public service times mean that non-paying outpatients get very brief and frequently low quality 'consultations' with government doctors. The quality of the facility relates closely to how much time key workers devote to official service provision: in many cases, particularly in the health sector, this is considerably less than they are officially supposed to.

Section 4 explores issues in human resource management. The report divided the motivations of teachers and doctors into material incentives and non-material influences. Teachers appear to be low paid in international comparative perspective, and non-state school teachers are considerably worse off than their state school counterparts. Public sector doctors, by contrast, believe themselves to be financially worse off than they would be in the private sector, but prefer government service because of the advantages of job security and high status. Other than very junior doctors, most government doctors have a lucrative private practice, which is one attraction or compensation of public service. The predominance of private practice is generally believed to reduce the amount of time doctors give to public service, but the present report found that the practice has mixed effects on the performance of health facilities: depending on local conditions, private practice may create incentives for doctors to be present in rural health facilities and to behave well with patients.

Among teachers, the research found that private tuition was not particularly common at primary, and was mainly a significant source of additional earnings for Government school teachers at secondary. Teachers do have other sources of income, however: non-state school teachers are customarily also engaged in land transactions, agricultural activity, or small business. Many of these additional activities take up teaching time or require teachers to take leave during term time.

Other key influences on doctors' and teachers' performance include a) the often excessive burden of their additional public activities and roles; b) the limited scope for professional development (mainly teachers); and c) the impact of their personal social profile on their interaction with and accountability to service users. An important finding of the research was that many teachers and doctors have close personal links to the communities they serve, which help to diminish the impact of social distinctions between themselves and service users. These links also make it possible for community members and service users to exert informal accountability pressures on service providers.

Section 5 explores the relationship between performance or quality and how facilities are governed and managed. It first presents findings from the research which showed differences in perceptions of the quality of schools and health facilities among different stakeholder groups. It then goes on to explore management practices and accountability mechanisms in relation to performance and quality, through a comparison of facilities

identified as high and poor performers. An interesting finding was that many facilities had shown signs of improvement, some in terms of physical facilities and equipment, others demonstrating gains in performance indicators such as examination participation or pass rates. In many cases, these changes were linked to changes in the management and governance of the facilities, such as when incoming personnel introduced innovations to monitor attendance or teaching contact time.

Features of facility management that are compared include a) managers' personal qualities and relationships with staff; b) the presence or absence of a shared plan or vision for change; c) the extent to which rules and regulations are adhered to; and d) the quality of systems for collecting information that enable problems to be diagnosed and progress to be monitored. The extent to which managers set a positive personal example and the presence of a shared plan for facility development appear to be the most important management conditions that help to explain facility performance. Section 5 concludes with a discussion of accountability. It discusses the operation of the formal accountability systems that exist to enable service-users to provide feedback on service provision or to hold service-providers to account. Few if any formal systems for accountability are found to operate as intended. However, there are also some strong informal pressures on teachers and doctors to be present and/or to perform. To some extent, these help to compensate for the failure of formal accountability systems.

Section 6 concludes with a discussion of some of the broader implications for policy and research of the findings of the study, with a focus on the lessons about the definition and measurement of quality and performance in social service delivery.

1 Introduction

1.1 BACKGROUND

Bangladesh has made impressive gains in human development over the last decade, and on key human development indicators now compares favourably with other countries in the region, as well as with countries at comparable levels of economic development. These achievements have been substantially successes of expanded access to health and education services, and concerns have emerged about the impact of rapid expansion on the quality of service provision.

Addressing problems of quality in the provision of health and education services is one of the 'Strategic Blocks' that constitute the Government of Bangladesh's Poverty Reduction Strategy (Government of Bangladesh, 2005). Concern that massive expansion has reduced the quality of instruction in primary and secondary schools has prompted a focus on the need to increase contact time in schools, invest in teacher training, improve academic supervision, and address problems in school management and governance systems at both primary and secondary. The need to address the poor performance of government health services is also recognised in the Government's Poverty Reduction Strategy Paper (PRSP): emphasis is placed on improving the institutional arrangements for the governance of the system in order to tackle problems of staff absenteeism, negligence and mistreatment of patients, and corruption and leakage (Government of Bangladesh 2005; 128-47).

This report presents findings from qualitative research designed to explore issues of the quality of service delivery in health and education. The research was designed to explore further the findings from the *Social Sector Performance Surveys* (SSPS). These nationally representative surveys tracked public expenditure and analysed performance in 231 primary schools, 219 secondary schools and 229 health facilities in 20 districts across Bangladesh in 2004 and 2005. The intention behind these surveys was to stimulate policy debate and support the public sector in becoming more performance-orientated and accountable, with the ultimate objective of increasing the effectiveness and equity of public spending on priority social services.

The qualitative follow-up study to the SSPS, the *Social Sector Performance Qualitative Study* (SSPQS), aimed to contextualise and enrich understanding of key findings from the SSPS, particularly in the areas of financial and material resources, human resource management, and facility governance. The main research question was: how is the delivery of education and health services affected by the management and governance of financial, material and human resources at the level of schools and health facilities? The specific objectives of the research were:

- To gain insights into the governance and management of resources, including the practices and perceptions associated with corruption and leakage.
- To understand the incentives, both material and non-material, that shape the motivations and performance of key facility workers.
- To uncover institutional patterns and practices associated with high and poor performance.

The research explored models of quality and perceptions of quality among different participants within the system, the effectiveness of governance and accountability mechanisms, compared management practices across different types of facility, elicited views and practices on corruption and leakage, and attempted to document the range of incentives of key workers. Research took place between March and July 2006 in 15 schools and 12 health facilities in 15 upazilas and 9 districts across the country.

The research was designed to add depth to the understanding of key issues that arose from the SSPS survey. The analytical framework for the research on schools drew on the Heneveld-Craig framework. This involved a focus on documenting and assessing the quality of supporting inputs, such as parental and community participation, supervision and material inputs, and enabling conditions, including the effectiveness of school management and the incentives of teachers (Heneveld and Craig, 1996). To explore the governance of schools and health facilities, the research also drew on the analytical framework developed in the *World Development Report 2004* to document the formal accountability mechanisms that connect users, providers and policy makers (World Bank, 2004).

The qualitative research did not focus directly on teaching-learning processes or on diagnoses in health facilities; data on these issues are available for our facilities from SSPS, and these issues are addressed in the reports from that survey. The research design was also informed by the growing emphasis in health systems research on unearthing the incentives of key workers in the health sector (e.g. Chaudhury and Hammer, 2003; Lindelow *et al.*, 2005).

In many respects, the SSPS findings were positive, documenting that systems of health and education service provision were functioning. While there were problems, including of corruption or leakage and poor quality services, the provision of health and education services was found to be reasonably effective within their given goals and resource constraints. Research into school-level accountability structures in Bangladesh has focused mainly on highlighting their shortcomings to date. However, there are signs that many of these structures, in particular the School Managing Committees (SMCs), play a vital role in performance, albeit under adverse conditions. In health, the absence of formal structures of accountability linking users to service-providers in Bangladesh is well-documented (Thomas *et al.*, 2003), but less is known of other pressures on staff to be present or to perform. The research aimed to explore the scope for informal pressures to perform on staff in schools and health facilities.

1.2 MAIN FINDINGS

The main findings of the qualitative research were that:

- **Corruption, leakage and the abuse of influence have a range of impacts on service provision at the facility level**. Informal charges or 'speed payments' between public officials are prevalent, but while the practice does not represent a major leakage from the public purse, it is nonetheless harmful: the practice leads to a situation in which officers are inadequately reimbursed for travel and other costs relating to the supervision of facilities. Corruption in recruitment is also understood to be common, particularly in non-state schools, with negative implications for the quality of teacher recruits. Leakage of drugs at the facility level are believed to contribute to shortages reported by patients and community members. Despite improvements, practices of falsifying student records to ensure they receive the primary and secondary school stipends remain both common and acceptable among students and teachers. An important implication is that this leads to perverse incentives for students.

- **The loss of public service time has the most direct impact on performance.** This occurs when public servants provide private services in such a way that this diminishes the quality or quantity of official services they provide. The research found that the quality of the facility related closely to how much time key workers devote to official service provision: in many cases, particularly in the health sector, this is considerably less than they are officially supposed to.

- **Attempts have been made to tackle different forms of corruption, with some reported success.** Effective actions appear to have been taken to reduce corruption in teacher recruitment, and the stipends programmes. Education administrators, teachers and students all concur that there has been a decline in corruption in the stipends programme.

- **The scope for private service provision and job security are the main material incentives for service-providers.** Teachers appear to be comparatively low paid, with non-government school teachers worse off than government school counterparts. For doctors, the attractions of government service are job security, high status, and the scope for private practice. Although additional income-earning activities of teachers and doctors typically reduce the time spent in facilities, the impacts of private service provision on public facilities are not exclusively negative.

- **Staff performance is also affected by non-material factors**. Public sector workers, particularly teachers, undertake additional public activities which take them away from facilities or compromise their effectiveness within them. Career structures are such that teachers lack prospects for professional development that might motivate better performance. But many teachers and doctors have close personal links to the communities they serve, which help to diminish the impact of social distinctions between themselves and service users. These links also make it possible for community members and service users to exert informal accountability pressures on service providers.

- **Perceptions of quality vary across stakeholder groups**. The research found that definitions and models of what constitutes quality in service provision varied considerably between service users, teachers, doctors, and even between administrators at different levels of the system. This indicates a general lack of agreement on the priorities and targets for improvement.

- **Many facilities had shown recent signs of improvement**. In some cases, the physical facilities and equipment endowment had improved recently; in others there were recent gains in performance indicators such as examination participation or pass rates. In many cases, changes were linked to changes in the management and governance of the facilities, for example, incoming personnel had introduced innovations to monitor attendance or teaching contact time.

- **The management practices of facility managers have a clear impact on performance**. These include managers' personal qualities and their relationships with staff; the presence or absence of a shared plan or vision for change; the extent to which rules and regulations are adhered to; and the quality of systems for collecting information that enable problems to be diagnosed and progress to be monitored

- **Formal accountability mechanisms are weak, but informal pressures can be strong**. Although formal systems exist on paper to make service providers accountable to representatives of those who use the services or service-users themselves, these tend to be weak, partly because of social hierarchies and distinctions which make formal complaint unlikely. However, the research uncovered sources of informal pressure on service providers, which to some extent compensate for the weakness of formal accountability mechanisms.

This report is structured as follows. Section 2 describes the research methods used. Section 3 explores findings related to corruption and leakage, particularly 'speed' payments, appointment and transfer systems, and the distribution of material resources. Findings about the material and non-material incentives of key workers are detailed in section 4. Section 5 discusses the models and perceptions of quality found to be in use among different stakeholders. It also discusses the management and governance practices found in facilities performing well compared with those performing poorly. The report concludes with a brief discussion of the implications of these findings in section 6.

2 Analytical framework, methods and research process

The SSPS survey uncovered a number of issues that merited further exploration or analysis because of their potential impact on service delivery. Not all of these issues could necessarily be explored successfully using qualitative methodologies, however. Those findings from the SSPS survey which experience of research indicated it would be possible to triangulate and shed further light on through qualitative methods were selected as topics for the present study.

The research had three main objectives:

- To gain insights into the practices and perceptions associated with corruption and leakage.
- To understand the incentives, both material and non-material, that shape the motivations and performance of key facility workers.
- To uncover institutional patterns and practices associated with performance, by comparing facilities selected as high and poor performers. Within this, the focus was on comparing models of quality among different participants within the system, governance arrangements, management practices, and resources.

The basis unit of the research was the facility, with interviews also conducted at the upazila and district office levels.

There tend to be many factors, processes, inputs and determinants of quality and performance in institutions as complex as health facilities and schools. Definition is also hampered because, although there are indicators used for official monitoring systems, there is no general consensus about the appropriate indicators for measuring quality or performance of health or educational facilities in Bangladesh. (One of the findings of the present study was that understandings of quality or performance differ among different stakeholders in the health and education sectors.)

To organise this complexity in a way that would make it researchable, two analytical frameworks were drawn on for the research and analysis. The first was the Heneveld-Craig framework for analysing school effectiveness. The Heneveld-Craig framework identifies three categories of factors within schools that influence the effectiveness in terms of student outcomes: a) the school climate or institutional culture; b) the teaching-learning process, including the variety of methods and extent of student feedback; and c) 'enabling conditions', which includes factors relating to the leadership of the headteacher, the extent to which the school is autonomous, flexible and possesses a capable teaching force. A fourth set of factors, 'supporting inputs', come from outside the school. These include parent and community support, support from the education system and material inputs such as books, basic furniture and teacher development activities (Heneveld and Craig 1996). The qualitative research was not able to incorporate a focus on teaching-learning processes or diagnoses in health facilities. However, adapted versions of the Heneveld-Craig inputs and conditions shaped the research and analysis of the performance of both schools and health facilities.

The second analytical framework used was that developed in the *World Development Report 2004* to document the formal accountability mechanisms that connect users, providers and policy makers (World Bank, 2004). For the present research, the focus was on what the *World Development Report* framework terms the 'short route to

accountability', namely the formal mechanisms through which service-users can evaluate, provide feedback, complain about or in other ways directly influence the services they receive at the point at which they receive them. The research design was also informed by the growing emphasis in health systems research on unearthing the incentives of key workers in the health sector (e.g. Chaudhury and Hammer, 2003; Lindelow *et al.*, 2005).

Quality and performance are treated here as interchangeable terms to refer to the value and level of service being produced by a facility. This means that a high quality or 'good' performing facility is one which produces a comparatively high volume of services, or services of comparatively high intrinsic value compared to similarly-resourced facilities. The research focused on understanding why some facilities perform better than others with similar levels of resources, and in particular how different kinds of management and governance enable a higher volume or quality of services to be delivered with the same resources. The management of facilities is here used to refer to the practices by which the material and human resources are organised and supervised within a facility. As used here, governance refers mainly to a) accountability mechanisms within or which affect facilities, upward from facilities to upper levels of administration and to political representatives, and horizontally and downward, to patients, students, parents, and members of the community; and b) the informal and formal practices and rules established to protect the facility and service-users against leakage or corruption.

2.1 RANKING PERFORMANCE AND SELECTING FACILITIES

A nationally representative sample of education and health facilities drawn from the quantitative survey provided the sampling frame. This made it possible to rank facilities according to performance indicators collected through SSPS. Once facilities were ranked according to performance, a good, average and poorly performing facility were selected from each facility type. This provided the foundation for the qualitative study sample.

The performance indicators were used to measure the quantity and quality of service delivery in each facility (see Table 2.1). These indicators were used to rank all SSPS sampled facilities in each sector. In education, schools were ranked separately according to school type (i.e. government and registered non-government schools) to ensure equal representation of each school type in the qualitative study. In the SSPS, dakhil madrasahs, which include both primary and secondary education levels, were sampled. For the qualitative study, dakhil madrasahs were ranked according to their secondary level indicators (see Table 2.1) but ebtedayee sections were also included in the primary sample.

Table 2.1 Variables used to rank facilities for sample selection

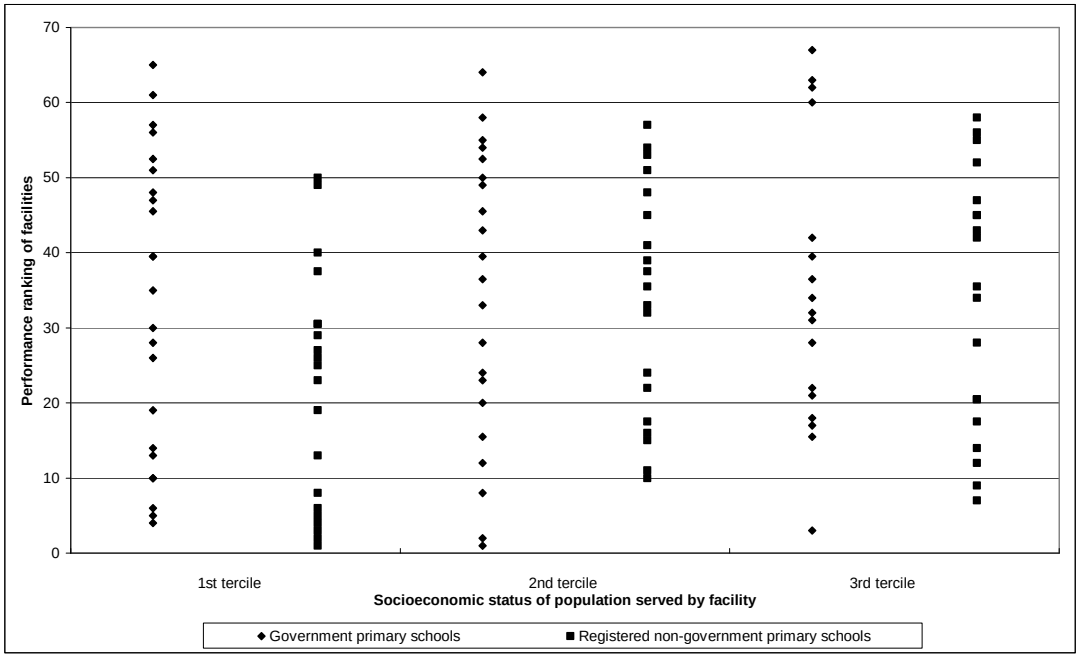
Upazila health complexes	Secondary schools and madrasahs	Primary schools (GPS and RNGPS)
Average monthly outpatient figures per 1,000 under-5 population	Average combined SSPS test score for Class 9 students	Average combined SSPS test score for Class 5 students
Measles immunisation rate per 1,000 under-5 population	SSC pass rate in 2004	-
Under-5 ARI contacts per 1,000 under-5 population	Class 6–10 attendance rate in 2004	Class 1-5 attendance rate in 2005
Percentage of drug regimen details appropriate for sampled patients	Total school repetition rate in 2004	Total school repetition rate in 2005

Source: SSPQS. Note: In the SSPS education surveys students were tested in Bangla and mathematics and the average combined score of students in each school was used as part of the ranking exercise. For details on each of these indicators and average levels see the SSPS final reports for each sector (FMRP 2006a, 2006b and 2006c).

It is reasonably safe to assume that the socioeconomic status of service users is likely to influence their health and educational outcomes: a school serving a poor population usually has poorer performance than a similar school serving a wealthy population. To control for variations in performance due to population characteristics an attempt was made to choose facilities that served similar populations, by grouping facilities into terciles according to the socioeconomic status of users[1]. Facilities in the same tercile can be expected to serve populations with roughly similar socioeconomic characteristics. However, it should be noted that this process relied on predicting household consumption from proxy indicators, and there may still be substantial variation in the populations served within each tercile.

[1] Consumption information from households of approximately 10 students in each school was used to calculate a *per capita* consumption aggregate. Using this consumption aggregate and information on household characteristics, consumption *per capita* was predicted for all Class 5 (primary) and Class 9 (secondary) students present during the survey. Average predicted consumption *per capita* of users was used to group schools and UHCs by socioeconomic status for the qualitative study. Only facilities that had socioeconomic information for at least 10 users were included in the sampling frame. See Annex 2 of the secondary education report, and Annex 3 of the primary education and primary health care reports for further details.

Figure 2.1 Ranking of SSPS sampled facilities in primary schools



Source: SSPS data.

Information on performance ranking and socioeconomic tercile provided the basis for sample selection. As an example, Figure 2.1 shows how the original SSPS sampled primary schools ranked on performance and user socioeconomic status. Government and non-government primary schools were first ranked separately according to performance (see Table 2.1) and then the average socioeconomic status of students was used to assign schools to a tercile. According to their performance ranking, good, average and poor performing facilities were selected amongst facilities serving populations with average socioeconomic characteristics (e.g. primary schools in the second tercile in Figure 2.1). Before selecting the facilities to be visited a review of the facility data collected as part of the SSPS was conducted to pick facilities that were suitable to address some of the key objectives of the study. A similar process was undertaken to select UHCs. Unlike the SSPS, the qualitative study did not cover family planning services provided by the Ministry of Health and Family Welfare (MoHFW). Once UHCs had been selected, union-level facilities providing health services that had been visited as part of the SSPS were also included in the sample. Table 2.2 provides information on the number and type of facilities selected in each sector.

Table 2.2 Sampled facilities

	Number of facilities visited	Range of performance ranking of sampled facilities (total number of facilities selected from)
Primary education		
Government primary schools	3	8-64 (67)
Registered non-government primary schools	3	11-57 (58)
Ebtedayee sections of dakhil madrasahs	3	36-55 (75)
Secondary education		
Government secondary schools	3	21-53 (68)
Registered non-government secondary schools	3	13-67 (70)
Secondary section of dakhil madrasahs	3	9-30 (33)
Health		
Upazila health complexes	6	3-55 (61)
Union level facilities	6	6-55 (62)
Rural dispensaries	2	
Combined health and family planning facility	4	

Source: SSPQS. Note: Dakhil madrasahs were selected based on their secondary school (Classes 6-10) performance. Only 33 dakhil madrasahs made up the sampling frame because of the lack of information on socioeconomic status of student households. The performance ranking for the ebtedayee section of madrasahs and union health facilities are reported in the table but were not used to select the sample. Annex Table A1 provides a detailed list of the performance characteristics of the sampled facilities in each sector.

Limitations to selecting facilities in this way include that indicators used to rank performance were given equal weight, which sometimes meant that selected facilities had poor values for one or more of the ranking indicators. For example, in secondary a 'good' school may have a low Secondary School Certificate (SSC) pass rate if the repetition rate, attendance rate and the combined score on the SSPS test were high. Secondly, the information on performance was collected up to two years prior to the qualitative study and, as we see below, there were changes that affected the performance ranking of selected facilities over this period. On returning to the facilities more up-to-date information was collected, where possible. On the whole this showed that there had not been major changes in these indicators for selected facilities, although there were instances where performance had changed significantly. This is discussed further in section 3.

2.2 RESEARCH INSTRUMENTS

Before research instruments were developed, visits to facilities were undertaken to discuss areas of interest with key informants. A set of research instruments were compiled and then developed further by the research team during training workshops and additional visits to facilities. The main research instruments consisted of interview and focus group discussion (FGD) schedules, as outlined in Table 2.3.

Table 2.3 Research activity outline

Level	Primary school	Secondary school	Upazila health complex	Union health facility
District	District primary education officer interview	District education officer interview	Civil surgeon interview	
Upazila	Upazila education officer and assistant upazila education officer interviews	Upazila project officer (Upazila secondary education officer) interview	Upazila health and family planning officer and Resident medical officer interviews	
Union Parishad representatives	Chairman and members FGD	Chairman and members FGD	Chairman and members FGD	
Facility staff	Teacher FGD	Teacher FGD	Medical officer interviews	Medical officer interview
	Head teacher interview	Head teacher interview	FGD with nurses	Medical assistant and pharmacist interviews
			FGD with support staff	
	Observation	*Observation*	*Observation*	*Observation*
Community	FGD with School Managing Committee	FGD with School Managing Committee		Local elite interviews
Service-users	FGD with Class 5 students	FGD with Class 9 male and female students separately	FGD with community women in catchment area	User interviews and community FGD
	FGD with Parents Teacher Association and / or mothers	FGD with Parents Teacher Association and / or mothers	Patient interviews	Patient interviews

Source: SSPQS.

Interviewers recorded information gathered in interviews and FGDs, which were reviewed and consolidated after each interview or FGD. In addition to these interview and FGD notes, the following additional information was collected:

- An institutional history or timeline, describing major incidents and events.
- A map of the governance structure of each facility, showing participants within the system and levels of influence over facility management.
- Users' accounts of their experiences.
- Key workers' accounts of their career history and experiences.
- Using SSPS questionnaires, information on performance in 2005 was collected from facilities where possible.

2.3 FIELDWORK AND ANALYSIS

Fieldwork took place between April and June 2006. In each school, teams of four worked for three to four days, and for the health sector a week in each upazila (to cover both the UHC and union health facility). These three teams of four were supported by four additional researchers, including one education and one health expert, who also undertook interviews with officials and monitored the quality of the fieldwork. After fieldwork was completed, a series of workshops were conducted for the sectoral teams to analyse and discuss the main findings on the study's themes. In addition to these workshops further detailed analysis of the information gathered during fieldwork was undertaken.

Comparative work of institutions as complex as school and health facilities is always difficult: contextual factors often seem to explain everything (see Heneveld and Craig, 1996). The first challenge was that assessing the role of management and governance in the performance of facilities entailed limiting the impact of the context on the facility. This was dealt with by selecting user-communities of broadly similar socioeconomic level for each facility type. Inevitably, however, selecting facilities on the basis that they serve people of similar income levels did not entirely eradicate the differences of context. These emerge as important factors throughout the analysis of the research. For example, the scope for private medical practice and the willingness of doctors to be posted to rural areas are directly affected by the remoteness and infrastructure of an area.

A second challenge was to make sense of the large amounts of qualitative and quantitative data we had generated for each facility. This was frequently difficult because the different approaches and methods sometimes yielded contradictory perspectives: the qualitative researchers did not always agree with the ranking of facilities as set out by the sampling procedure, which was based on SSPS indicators.

Most disagreements about whether a facility was high-, poor- or average-performing were finally resolved. This was possible because analysis of both types of data enabled us to arrive at a fuller picture of how the facilities were performing. In the final analysis, comparisons and rankings of facilities were based on a team-wide analysis that combined 'hard' quantitative data and 'soft' qualitative evidence. At the primary level, the most fruitful comparison was found to be between broadly poor-' and high-performing schools, with government and non-government facilities featured in both. The original sample had included attached ebtedayee (AEM) sections of dakhil madrasahs among the primary schools, but systematic comparison between these and other primary institutions proved difficult, as these are not managed and governed as schools in their own right[2]. At the secondary level, the relevant comparison was found to be within school types, as the contexts were otherwise too different for meaningful comparison. For each type of school, however, marked differences between the high-, average- and poor-performers were identified. In health, the original sample was of three pairs of high, average and poor performers. The qualitative research finally ranked the upazila health facilities from best to worst, with two facilities in joint second place, leaving four categories of performance [3]. These are set out in Annex Tables A1 to A3.

[2] This has implications for the quality of primary schooling being delivered by these AEMs, in particular that targets are set and inputs distributed with a stronger focus on the upper sections. In the worst dakhil madrasah, classes 1-3 actually share a classroom.

[3] Only five of the six UHCs are included in the comparative analysis, as we were not permitted to interview managers and staff in one UHC. However, the data from research with users and community members are used elsewhere in this report. The Union Sub-Centres (USCs) were sampled on the basis of the ranking of the UHCs in those upazilas, and so while a comparative analysis was made of USCs, we do not present it here. However, some evidence regarding accountability pressures and mechanisms is drawn from that data.

2.4 A NOTE ON THE QUALITATIVE APPROACH

The use of qualitative methodologies has both advantages and limitations, in this study and more generally. An advantage of the qualitative approach is that it permitted a focus on the processes that actually govern the delivery of services, as opposed to official expectations of how services should be delivered. This enables greater understanding of why some types facilities perform well, as well as fresh insights into why others do not. A second advantage is that the qualitative approach enabled an exploration of the attitudes and experiences of service providers and users, and of the relationships between these two groups. This produced some vital new understandings of the real life social relationships which govern the delivery of services, again shedding light on why some types of facilities and service-providers are more effective than others.

A limitation of the qualitative approach taken here is that, in common with other qualitative studies, not all the findings are necessarily generalisable across all facilities. However, care has been taken to highlight those findings which are both supported by the quantitative findings of the SSPS survey, and which illustrate patterns of behaviour and practices that were found to be common across all the areas studied. A second limitation of the qualitative approach is that, in isolation, it is not possible to turn the findings of the study into policy recommendations. Instead, it is hoped that the findings will stimulate new thinking among policy-makers in the health and education sector about how to strengthen processes which are demonstrably working well, and how to tackle obstacles to improved service delivery. Read in conjunction with the SSPS survey reports, it should shed light on some of the processes, relationships, and attitudes which govern the successful delivery of services, but which standard quantitative survey methods are unable to study.

It is expected that the present study will be of most value when read as a supporting or companion study to the SSPS survey reports, as its primary purpose was to enable further exploration of key findings from the SSPS survey. In conjunction, the combination of qualitative and quantitative evidence should provide rich insights into the successes and limitations of education and health service delivery in Bangladesh.

3 The Governance and Management of Resources

3.1 INFORMAL CHARGES OR 'SPEED PAYMENTS'

The practice of making informal payments to accounts offices to 'speed' up or release payments was found by the SSPS surveys to be common (see Table 3.1).

Table 3.1 Proportion of government officials reporting having to make at least occasional 'speed payments' to accounts offices (%)

District Primary Education Officers (DPEOs)	Upazila Education Officers (UEOs)	Government Secondary School Head teachers	Civil Surgeon	Upazila Health Officials
38	43	38	73	67

Source: SSPS reports

The qualitative research findings support those of the SSPS survey. They also help refine our understanding of why and where this occurs, as well as revealing some of the systemic features of 'speed payments'—that is, the causes of this practice and the factors ensuring that it is continually reproduced.

As noted in the SSPS Health report, figures reporting occasional payments are likely to be biased downwards. The qualitative research findings support this view. Some of the respondents were reluctant to discuss the practice of speed payments as occurred in their own offices, and we often discussed the situation 'in other places'. But many discussed the issue freely, because the near-universality of the practice ('everyone knows') put it beyond secrecy. Its almost-endemic nature meant it was often described as a 'system' or a 'culture'. Officials frequently pointed out that making informal payments to move bills was common across the government system, and by no means limited to health or education.

The standard form of a speed payment is that the dealing clerk or assistant in the relevant accounts office requests a payment of between 5% and 10% of the bill being passed; failure to make payment results in the bill being delayed. A wide range of bills attract speed payments: travel, daily allowance, contingency, repairs, time scale, leave prior to retirement, salary fixation, and efficiency bar cross. More simply, there is only one bill that never attracts speed payments: the regular salary bill. But even 'irregular' salary bills (e.g. starting salary bills in a new post, final salary payments, maternity and sickness pay) often require extra payments. Health system audit teams – the 'band of robbers', according to one health sector manager – also expect payments.

Some bills always and others rarely require extra payments, yet these transactions occur between precisely the same individuals and offices. This prompted us to explore the differences. Long familiarity with this system meant that few officials had given much thought to these practices, and that they found our questions odd. However, most officials readily identified features that made speed payments possible. The response to 'why do you **not** have to make extra payments for salary bills?' typically raised two points. First, practical and administrative: there are too many people collecting salaries, and some salary bills include many people so it would be hard to collect a percentage from each. Secondly, a political issue: our salaries are our rights (adhikar). We work for these salaries, we have to feed our families on these salaries, and accounts office staff would not dare to try it because they know there would be a rebellion (andolon). Few officials

felt a 'right' to their allowances, and we found little resentment about small amounts going to accounts officers in this way. Some suggested this was mere friendly form between officers, a small courtesy.

It was a district education office clerk who reluctantly explained that it is when there is 'weakness' (durbolota) in the bill being passed, there is scope for some cheating or, as it is known, 'number two' (dui number). 'Weakness' might mean, as with maternity or illness, that the individual is in no position to play a waiting game with the accounts office. But it also refers to the expectation that officials themselves cheat on these bills. It is therefore routine for officials whose role involves travel to share the spoils with those who lack such opportunities. One RMO explained that the payment could reach as much as 50% if the bills are false or exaggerated.

Box 1 Gender and corruption

Gender biases are often used to justify corruption and leakage-related practices, including by women themselves. The way in which corruption practices are shaped by gender may be an increasingly important issue, given the rising proportion of women staff in the health and education sectors.

'Speed payments' are often demanded by clerks and officials in accounts offices from officers who cannot afford delays in the accounts office because they have been transferred, or are sick or claiming maternity pay. These situations frequently put officers at a disadvantage, because accounts office staff are aware that they may be unable to wait for their salary or other payments, and will therefore feel forced to make speed payments. Speed payments seem to be applied to women disproportionately. One education official described it as 'having one's back against the wall', being forced to pay Tk 6,000 to recover salary arrears owed her from a period of illness. The accounts office clerk said she should not object to paying, as her father or husband in any case provided for her. The assumption that professional women's incomes are merely supplementary may make them more obvious and perhaps easier targets for extortion. Interestingly, the SSPS survey found that female government primary school teachers were twice as likely as their male colleagues to be owed outstanding salary and allowance payments.

On the other hand, gender roles and biases can also work in women's favour. Women seem more inclined and may be better placed to take unfair advantage of personal connections to achieve desirable jobs. These are usually those in more centrally or conveniently located areas, which may be important to women because of travel safety and domestic responsibilities. One education official felt that women would use all kinds of political connections, relatives, local leaders and anyone they could enlist to help them. As middle-class people themselves, officials were often sympathetic to concerns about the safety and domestic constraints of middle-class professional women.

Source: SSPQS.

The incentives that a practice of speed payments set up are as follows: the expectation of having to pay a percentage of the bill should lead to an inflation of the amount being claimed. In turn, accounts officers come to believe that such bills are usually inflated, and therefore feel confident in claiming a percentage. The practice is likely to discourage central government from providing officials with realistic travel and related allowances, and may help to explain why such allowances are so grossly inadequate for officials' needs[4]. Speed payments may not involve any actual and direct leakage from the public

[4] The amount and cost of travel varies depending on the area and its transport links, while the amounts officials receive for their travel allowances depend on their posts and therefore on seniority rather than on how much travelling is involved in their role. However, a number of officials in different posts made rough estimates for us of the costs of their work-related

purse, but they encourage officials to attempt to make up such costs through other forms of corruption or leakage, as we will see below. They may also discourage them from visiting schools and health facilities when the cost of doing so may have to be incurred personally or recouped through inflated allowance claims.

Nobody could recall an effort to tackle speed money. One District Primary Education Officer (DPEO) explained that no such efforts would ever occur because 'everyone up to the DC (Deputy Commissioner) is afraid of the Accounts Office'. Some district level officers asserted that they resisted making such payments. In his youth, one had set up the 'Ten Per Cent Club' with some colleagues, a humorous effort to resist making extra payments. But small efforts of this kind have no discernible impact on the system as a whole. New recruits are quickly drawn in, either briefed by superior officers, or learning from experience. A group of new recruits sheepishly reported having paid up after a four-month stand against speed payments.

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travel. In most cases, travel costs far exceeded the allowances. In some cases, the entire annual allowance could be spent in a typical month. Women AUEOs interviewed for this research seemed most likely to have to find their travel allowances inadequate; this group of officials travels regularly, and women are more likely to travel by what are perceived to be safer or more culturally appropriate modes of transport; these also tend to cost more.

Box 2 Informal payments reported in the secondary school system by qualitative interview sample

Government secondary schools	Non-government secondary schools	Dakhil madrasahs
Transfers from teachers to Directorate Tk 20,000	Salary bill Teacher to bank / accounts office Tk 100-200	Monthly Pay Order (MPO) registration Head teacher to Madrasah Board
Salary bill fixation From teacher to accounts office Tk 500-550	Appointment Teacher to SMC, Upazila Secondary Education Officer (USEO), Upazila Nirbahi Officer (UNO) Tk 50,000-220,000	Appointment Teacher to SMC and UNO Tk 50,000-100,000
Appointment Candidate to Ministry officials and / or MPs Tk 200,000–400,000	Stipend Student to teacher / UPO Tk 5-10 every six months or refreshment	Madrasah to accounts office Tk 300
Promotion from teacher to Ministry Amounts not specified	Salary fixation after completion of BEd (pass) Teacher to SMC Amount not specified	Funds are available but need to pay cash to draw bill Tk 1200-1500
Increase budget allocation From head teacher to Ministry officials Tk 5000	Demanding cash to withdraw flood bills	
Registration form submission School to Education Board Tk 150 for submission, Tk 150-200 for return		
SSC Examination Scripts School to Education Board Tk 100-150		
Retirement payments / pension Teacher to Division officials/Ministry officials / Accounts Office Varying large amount, unspecified		

Source: Interviews undertaken as part of SSPQS. Note: the exchange rate at the time the research was undertaken was Tk70 per US$ (Bangladesh Bank).

3.2 APPOINTMENTS AND TRANSFERS

Entry into public service is highly competitive, and the perception is that corruption in recruitment is pervasive. Our interviews corroborate the SSPS findings about teachers' experiences of recruitment: while common, corruption and unfair means in recruitment are not universal. Table 3.2 presents findings from the SSPS survey of secondary education. One-third of secondary school head teachers expressed the view that procedures to appoint head teachers were unfair (32%), or that informal payments were required (33%). Interestingly, while government secondary school head teachers were more likely to believe procedures were unfair than head teachers in non government schools (46% compared to 36%), informal payments were reported more often in non government (44%) than in government schools (15%). With respect to the recruitment of

assistant teachers at secondary level, it was in non government schools that both unfair means and informal payments were more likely to be reported.

The situation appears to be more favourable in primary education, where 81% of head teachers and acting head teachers felt procedures were fair. As was the case at secondary, primary non government school head teachers were more likely than their government school counterparts to express the view that it was common for teachers to make an informal payment to be appointed or promoted to the post of head teacher (38% compared to 29%). Interestingly, however, only 3% of government and 10% of non government primary school head teachers reported having personally made such a payment.

Table 3.2 Teacher views on recruitment conditions in secondary schools

	School type			Total
	GSS	NGSS	DM	
Head teachers (%) who believe that:				
Procedures followed to appoint directly an individual to post of head teacher are unfair	46	36	26	32
Individuals appointed directly to post of head teacher usually have to make an informal payment	15	34	31	33
Assistant teachers (%) who believe that:				
Procedures followed to appoint directly an individual to post of assistant teacher are unfair	15	44	37	42
Individuals appointed directly to post of assistant teacher usually have to make an informal payment	19	48	47	47

Source: SSPS secondary report.

The qualitative research supported and helped to explain these interesting differences in corruption in recruitment to government compared to non government schools. The research found a strong, consistent belief that the most corruption occurs in appointment to non-government schools (both primary and secondary), in which the recruitment process is controlled by SMCs[5]. Those in the best position to compare across different types of schools and areas are, of course, government officials, who themselves have good reasons to promote the comparative cleanliness of the public sector. Nevertheless, when explored closely, the views and experiences of teachers support and help to explain this finding.

At the primary level, the qualitative research found that many officials and teachers believe that corruption has declined or disappeared from government recruitment processes. This belief seems to involve comparison with the period up to 1997, when the present process was established. This now involves an anonymous written examination for which 75% of marks are allocated, followed by an oral examination conducted by a viva board of relevant district officials, for which 25% of the total marks are allocated. It is reportedly difficult for 'irregularity' to occur in the written examination, although it is believed that some candidates hire other individuals to take the examination for them[6]. It

[5] Upazila-level officials play a rubber-stamp role by approving shortlists of candidates drawn up by SMCs.
[6] Our research team encountered a young woman applicant for a teaching job who was re-writing her application form in the district primary education office. It seemed there had been a 'mismatch' between the handwriting and signatures on written portions of her applications. She was now rectifying this situation, with assistance from the district primary education officials. This was taking place without any secrecy. According to the officials, they were helping her rewrite her form

is in the viva that the most 'irregularities' are believed to occur. The amount understood to change hands is typically Tk 50,000-100,000. This money goes to the viva board. Interestingly, bribes do not guarantee a post, as the final decision depends on the combined score (the written test score + the viva score); those bribe-givers who fail to gain posts can expect to have their bribes returned. Influence and connections may also be traded, and DPEOs complained bitterly of pressures from local and even national political figures to grant jobs or favourable postings. Some felt this was one of the worst problems they faced professionally.

Although the process of recruiting teachers for Government secondary schools is centrally conducted through the Public Service Commission, it is not above suspicion. In one Government secondary school, teachers stated that corruption was rife in appointments and transfers, and that Ministry officials and MPs use their influence in these matters, for which they can charge between Tk 200,000 and Tk 400,000[7]. Again, influence and political or personal connections may be as effective as cash, and may be used instead of cash. One government secondary school head teacher claimed to have given no bribes in her working life, and to know of no other teachers who had done so. Instead, her experience had been that people use connections to get things done, perhaps reflecting her own good connections.

It is in non-government school recruitment that unregulated financial contributions were most discussed. SMCs were reported by teachers and education officials interviewed for this research to accept payments in exchange for posts[8]. A DPEO stated that in non government primary schools, 'the SMC controls the whole recruitment process. At the time of recruitment they take Tk 50,000 to 100,000, or land or use personal relationships' to bring about the appointment. In a non government secondary school, an assistant teacher claimed that the SMC chair, who had been in that role since the school was founded, made demands of between Tk 120,000 and Tk 150,000 from applicants during teacher recruitment. What the qualitative research was unable to fully establish is to what extent these transactions involved corruption for venal purposes, and to what extent they included motivations of resource-mobilisation for the school. What did emerge from the research was that in non-government primary and secondary schools, it is difficult to distinguish between simple corruption for personal gain and school fundraising activities. The authority to accept community and private contributions for school welfare, in the absence of any transparent process for governing the use of such resources, makes this weak financial management possible. The difficulty of disentangling motivations is clear in this example from the head teacher of a non-government secondary school:

> 'Some money must be spent for appointment. For example, at the time this school was hiring a computer teacher, two computers had to be provided for the school. If a school is short on furniture and equipment, then Tk 40-50,000 has to be given for a teacher to be appointed. That money goes to the school fund. If money has to be given anywhere else, I do not know about it.'

In another school, assistant teachers confirmed that they had all made 'donations' at the time of their appointments. These were made with the aim of raising the quality of the school, they said, but the SMC Head takes these and 'spends very little on school

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because they felt sorry for her as a young widow with no father who needed a job. Under ordinary circumstances, they assured us, they would not have permitted such an irregularity. Our team suspected that she may not have written her own examination, although we had no way of verifying this.

[7] These amounts far exceeded those cited to us elsewhere: this may be exceptional, as these teachers were based in a highly desirable metropolitan location.

[8] Official oversight is provided in the form of final approval of a shortlist of candidates being made by the Upazila Education office. Other studies and reports have reported finding that SMCs were implicated in corrupt practices and the inappropriate use of influence in recruitment processes (see for example, CAMPE (2005); World Bank (2006)).

development'. They noted there was one high school in their upazila in which it was not standard practice for 'donations' to be made in return for appointments. Others spoke plainly of bribes (ghush), typically of approximately Tk 50,000, having to be made to SMC members. One secondary education official estimated the range of bribes to be between Tk 50,000 and Tk 200,000. The new centrally-administered examination / certification process for secondary teachers seems to be a response to widespread concerns about corruption in teacher appointment at secondary level.

Bribery and influence are also used in transfers. (There is no system of transfer within the non-government school systems.) At primary level, amounts mentioned ranged from Tk 500 to Tk 5,000, depending on the desirability of the post. At secondary level, amounts are larger, perhaps reflecting more intense competition for fewer posts: reports ranged from Tk 20,000 to the hundreds of thousands. For doctors, the most desirable quality of a posting is typically its proximity to Dhaka, and failing that, to one of the larger cities. But doctors may also try to get a repeat posting to a place in which they have established a good private practice. One Resident Medical Officer (RMO) explained that there were often pressures to appoint particular individuals who were deemed to be supportive of a particular political direction. A doctor reported paying Tk 1,500 to the Divisional Office clerk to secure her posting to the upazila of her choice.

Recruitment of doctors was not tackled in precisely the same way as that of teachers in the SSPS surveys, so the present study also did not address it. One reason for this is that there are fewer concerns about corruption and unfair means in the recruitment of doctors to the public service than there are in transfers, promotions, and access to graduate training. In any case, the doctors with whom we interacted were unlikely to have paid bribes or used influence to secure their comparatively unattractive rural postings.

The main impact of corruption in appointment lies in the extent to which the quality of entrants into the service is believed to be compromised[9]. This varies: in the government schools the recruitment procedure is highly competitive. According to one DPEO, the degree of competition was so high in their district that of 11,000 applicants for the written test, 3,800 passed, and only 400 got in through the viva. As we saw above, bribes do not necessarily guarantee a pass if the applicant's written marks are too low, and so may not seriously reduce the quality of appointments to government primary schools. Nor does corruption appear to be so widespread in teacher recruitment as the system of speed payments. But teaching quality does appear to be compromised by the weak regulation of teacher appointments. This is particularly notable in non-government secondary schools and dakhil madrasahs, where common complaints are that teachers are not trained in the subjects they teach.

3.3 CORRUPTION AND LEAKAGE OF RESOURCES

Most government health and education facilities have little authority over the spending or distribution of financial or material resources. The major exceptions are the two stipends for schoolchildren, and the drugs distributed by upazila and union facilities.

Drug supplies

The experience of not being able to access drugs from government health facilities was widely reported by patients and community members in the qualitative research. The

[9] Although government teachers at primary level performed only slightly better than non-government school teachers on the profile test undertaken as part of SSPS (see SSPS primary report, pp. 108-9).

results of other surveys confirm the widespread view that the drugs intended for free distribution at government health facilities are not always available, as well as the view that part of the explanation for this is that drugs are sold by facility staff[10]. The simple fact of not being able to access free drugs does not in itself suggest that leakage or corruption occurs in drug supplies, however. It is both possible that drugs are supplied properly but do not meet demand adequately or in all seasons. It is also possible that there are leakages, but that these occur higher up the system, and not at the point of the upazila or union facilities. With its focus on the facility level, the present research was unable to assess possible leakage at higher levels. The SSPS health survey searched the formal records thoroughly for any evidence of leakages. It concluded that the correct amounts of drugs were accounted for from the Central Medical Supplies Depot down to the upazila, although at the union level, the records showed that more drugs were officially documented as having been sent than were being received and accounted for at the union level. However, at the facility level the SSPS survey compared the drug supply per patient (as recorded in the outpatient department drugs register) with that recorded in interviews with the patients themselves, on their return from the facility with drugs in hand. This comparison revealed that between 2.5 and 7 times more drugs were recorded in the register than were recorded as having been received by patients.

The qualitative research was able to provide some, albeit limited, supporting evidence on some of the processes by which drug supplies suffer from leakage at the facility level. Different points at which leakage had occurred were identified by interviewees and focus group discussants. It should be emphasised that in the absence of more information about this process, and in particular in the absence of more quantitative evidence about the extent to which these processes occur in other contexts, these findings should be treated as purely illustrative. First, drugs were reported as sometimes being sold from facilities themselves. One Upazila Health Family Planning Officer (UHFPO) explained that in 'many facilities', the pharmacist will overstate the number of patients (write 50 extra 'chits') and sell the resulting medicines to unlicensed local practitioners. It is also possible, as was sometimes claimed by facility staff, that some patients hoard free medicines to sell; the qualitative research was unable to verify this perception. From what we know of how government drugs are viewed, the market for open sales of packaged government drugs is likely to be limited, first because many people believe government drugs to be of low quality and only worth having because they are free; and secondly, because the packaging easily identifies the medicines as government drugs [11]. Palli chikitshak (rural healers or 'quacks') and small village pharmacies are reported to be most likely to end up with government drugs on their shelves, and they sometimes conceal such illicit wares from literate customers or outsiders. Our team spotted government-issue drugs in a local pharmacy; patients and other community members also gave examples. Government oral saline sachets in their distinctive blue and white packaging is particularly easily identified. One way in which sales from facilities occur was explained by an RMO, who said that fourth class staff used to claim expensive antibiotics for their own illnesses and then sell these on to palli chikitshaks. A sub-centre medical assistant also reported that children's cough medicine was particularly likely to be sold by sub-centre staff.

Only at the union level did the official accounts show any signs of leakage or short supplies. The SSPS survey found that instead of receiving Tk 75,000 worth of drugs as they are supposed to, union sub-centre records showed that on average they recorded receiving Tk 64,771 worth of drugs, or 14% less than intended. Short supplies of drugs were found in two of the six sub-centres studied in the qualitative study. In one case, a Union

[10] See CIET (2004); TIB (2005).

[11] (i) Not all government drugs are pre-packaged: some pills are supplied in large containers and distributed in paper bags. (ii) The opposite view, that government drugs are better, can also be heard. Overall, however, it seems to be the fact that government drugs are free that makes them appealing.

Parishad representative who undertakes an informal monitoring role, was shown discrepancies between the amounts recorded in the supply note sent by the District Reserve Store and the amount received by the sub-centre. In another, the Medical Officer had raised a query about drug supplies when he realised they had received only Tk 62,000 of the Tk 75,000 annual allotment of drugs. How this shortfall generally occurs, and what happens to the leaked drugs in other areas is not known. However, health officials had explained to the Medical Officer in the union in question that the remaining amount had been kept by the district office to cover the costs of payments to audit teams[12].

In a high-performing UHC we were told by two separate sources that one reason drugs ran short was because doctors in that facility were prevented from making extra earnings through private practice or drug sales, and so resisted paying speed money to the District Reserve Stores (DRS). As a result, their drugs supplies frequently come with short expiry dates, and have to be burned, with the result that the facility runs short of drugs, although on paper the UHC has received their allotment of drugs. Although the practice of burning expired drugs in this facility was confirmed by two separate sources, one a facility employee, there was no additional independent confirmation of the matter, and the research had no means of gauging whether or not this was a common practice.

It proved easier to discuss leakages in the primary and secondary school stipends programmes than in the drug supply system. One reason may be that (in contrast to the health sector) corruption and leakage are perceived to have declined in both stipends programmes, which seems to make people feel more free to discuss how corruption has been organised in the immediate past. A second reason is that there are grey areas with respect to corruption in the stipends programmes: practices which constitute misallocation (resources being diverted away from intended uses but still used for the broad purpose intended) are not necessarily 'corrupt' (immoral or negative in impact). People seem more comfortable discussing these practices, which are morally acceptable.

Primary school stipends programme

As with the issue of drug supplies, community members speak openly about their perceptions that corruption occurs in the distribution of stipends. However, these allegations are frequently made on the basis that if a card-holding child has not received the full amount of the stipend this is because there has been corruption [13]. In some cases, this may be true. There are a number of different ways in which corruption and leakage occur at the facility level. One is payments in return for beneficiary cards. The SSPS survey found that one in ten households reported paying for cards, with amounts averaging Tk 46. In one school, we found mothers being charged Tk 30 for the photographs to go on the stipend cards, and in another, where the head teacher also reportedly listed 'ghost' beneficiaries, Tk 50 was being charged to pay for new cards. More than 90% of schools reported receiving the Tk 1,000 with which to cover expenses of disbursement, so it is in fewer than 10% of cases that there was a plausible reason for charging beneficiaries. It is also possible that that money does not cover the costs, as is sometimes claimed. One suggestion was that heads or teachers may treat the Tk 1,000 as their reward for administering the stipend: one teacher complained, 'the head teacher takes the Tk 1,000, even though we do all the work', suggesting that the payment is seen by teachers as a payment for services rather than intended to cover costs incurred. A second form of corruption is when a portion of the stipend payment is taken at the point of disbursement. The SSPS survey found approximately one in six stipend beneficiaries reported making

[12] An RMO from another area also reported that audit teams require substantial bribes.
[13] Cash amounts are disbursed in quarterly instalments; the amount a beneficiary can receive will depend on their record of attendance and performance over previous months.

payments to receive their stipend. The qualitative research only found one such incident, when students reported having had to pay Tk 20 per payment in the past. Such practices have reportedly declined, possibly as a result of closer official supervision and monitoring and greater scrutiny and awareness among beneficiaries.

The third form of corruption (or misallocation) is through diversion to ineligible students. The SSPS survey found that 20% of stipend resources were going to students who were not eligible because they had not met the attendance or examination criteria[14]. The qualitative research confirmed that teachers commonly alter marks and attendance records of stipend-holders to ensure they remain eligible. More importantly, we also found that it is widely, although not universally, considered acceptable behaviour for a teacher to adjust the marks or attendance records of a poor student slightly. There are two caveats here. First, the student must be considered 'meritorious' or worthy of such assistance. Secondly, the adjustments must not be large. So a student who regularly misses school and does poorly in the examinations is unlikely to merit such illicit extra assistance. While the practice of adjusting marks does continue, the old practice of keeping double records is believed to have stopped. The frankness with which this practice was discussed, and even welcomed, suggests that it is generally taken as evidence of compassion and generosity towards poor students, rather than as a form of corruption.

It should be noted that many interviewees, including students, teachers and education officials, reported believing that corruption and leakage had declined in the last two or three years. There is not only believed to be less corruption in terms of informal payments for cards or to receive the stipend itself, it is also believed that there is less manipulation of records at the school level. The main factors associated with this are understood to include the following:

- Provision for supervision and monitoring have improved (monitoring officers at district level; AUEOs cross-check attendance and examination scores).
- The eligibility criteria relating to performance and attendance have been re-affirmed, and adherence tightened up by the authorities.
- Parents have become more aware about the purposes and requirements of the programme.

Beneficiary selection is another grey area. Officially, a list of the poorest 40% of children in the school is drawn up by the SMC with the assistance of teachers. This procedure is generally followed. But the selection of beneficiaries is an important and often conflict-ridden local issue, which local people scrutinise closely. As is the case with other programmes in which targeting is decentralised to the community or its elected representatives, a great deal of lobbying goes on by potential beneficiaries. Teachers almost universally report discomfort with their involvement in the process, although they appreciate the programme aims. Pressure from parents whose children are not selected causes some schools to conceal the fact that selection is made locally, in an effort to deflect criticism.

Despite numerous local sources of pressure for accountability, and efforts from the authorities to tighten up administration, it appears that there remains some bias in the selection process. This is particularly obvious when teachers' relatives, who are not

[14] Stipend recipients need at least 40% marks in annual examinations, and attendance rates of at least 85%. There are also school eligibility criteria, which the SSPS survey found most schools meet.

usually among the poorest 40%, were found to have been among stipend beneficiaries. In one case, the grandchild of the head teacher was reported by the AUEO and by the SMC chair to be a stipend beneficiary, although not a student at the school in question. Evidence from the SSPS survey suggests that the problem is sufficiently large in scale to question the claims to a poverty focus of the stipend programme: the SSPS survey found that 15% of stipend beneficiaries were from the wealthiest 20% of households, compared with 22% from the poorest. However, the entire targeting error cannot be attributed to deliberate or obvious forms of corruption, as the research found there was comparatively little discontent about those who are selected (although there is much unhappiness about those who are left out).

However, the main reason for the large targeting 'error' is that many selected beneficiaries are not poor (see also CAMPE 2005)[15]. How can this be reconciled with the apparently widespread belief that selected beneficiaries are generally appropriate? The explanation appears to lie in the trade-off between poverty and merit involved in selecting beneficiaries. It is widely and clearly understood that the stipends are intended for the poor, but also that the programme is designed to promote good attendance and performance. This is translated into local terminology, therefore, as rewarding poor but 'meritorious' (medhabi) students. Of course, this group is almost by definition not the average poor student. As some people put it frankly when asked for whom the stipend was intended, it is for the 'middle-class poor' (madyhabitta gorib)[16]. The explanation or justification is that these are households that undeniably need help with the costs of education (stationery, private tuition, and clothes are commonly mentioned expenses that the stipend helps to cover), but whose children are also more likely to attend school regularly and to study hard.

Selection committees evidently take the trade-off between merit and poverty into account when selecting beneficiaries. In one case the head teacher admitted pre-excluding the poorest students because they were unlikely to meet attendance and performance criteria. Rather than waiting for them to lose their entitlement, the reasoning was that it is better to give the card to someone who would get the most out of it. In another school, a teacher explained flatly that 'it's a problem: the poor are not meritorious'. A third teacher contrasted merit and poverty as eligibility criteria, pointing out that 'it used to be about merit, but now those who have 40 decimals of land cannot get it'. The merit criterion also easily justifies the award of stipends to particularly clever students from better-off households, in some cases to attract or retain high performers.

One factor that is not widely recognised is that public perceptions of corruption in the stipend programme are very likely to be overstated because schools often have to manage a shortfall of funds when the allocation from Dhaka is less than schools have claimed for[17]. Most schools reported having had this experience. The amount distributed is usually rounded down, and rather than divide the money up proportionately, the stipends of some children are reduced, with the amounts distributed always in round figures (100s, rather than fractions). The negative impacts on the administration and objectives of the programme include that:

[15] It should be remembered that the incentives and eligibility criteria of the stipend programme effectively ensures that the poorest 20–25% of the population are not reached: that group constitutes the hard-to-reach child population who never or sporadically set foot in formal schools where the stipend is offered (BRAC / SCUK 2005). And if they are in formal schools, they are indeed less likely to reach the attendance and enrolment criteria.

[16] This seems to be a clear case of the 'deserving poor' benefiting at the expense of poorer people, and is consistent with the politics of beneficiary selection in other programmes in Bangladesh and elsewhere (see Matin and Hulme 2003; Hossain 2005).

[17] The shortfall per school can be as much as one-third, according to figures cited by head teachers.

- Perverse incentives are set up with respect to attendance and performance, as it is those students who are supposed to receive the full Tk 300 amount whose payments are most likely to be reduced.

- Parents learn to distrust teachers, whom they strongly suspect of 'eating' the stipend money.

- The scope for community-based scrutiny and accountability of schools / upazila level distribution of the stipend is reduced because varying amounts of money are distributed, based on unclear and changing criteria. Where corruption is actually occurring, this becomes hard to detect.

Teachers generally face the most negative effects from the stipend programme, and are particularly vulnerable when funds run short. One teacher complained that: 'the way people abuse chairmen and members, that's how they abuse teachers now', that is, people now assume teachers as well as local politicians are corrupt. As we will see below, their involvement in the stipend programme has contributed to the declining prestige and authority of school teachers.

Secondary school stipends programme

As with the primary stipends programme, there is a strong sense among beneficiaries, parents, teachers and officials interviewed for this research that corruption and leakage have declined, in this case since the tightening up of rules and adherence in response to concerns about 'ghost' students, falsified school records, and informal charges in 2002–2003. According to the SSPS survey, the number of beneficiaries dropped by as much as 60% between 2002 and 2003[18].

The survey findings support the belief that there has been a decline in irregularities in that fewer such problems were found by the SSPS than in earlier studies. However, there are still serious irregularities at the school level. Three main forms of corruption or leakage are reported at the school level in the secondary stipends system. First, that of 'ghost' students: these are female students who are registered in schools on paper only. According to one District Education Officer (DEO), this practice does still occur, and it involves a split of the payment between female students, the SMC, and teachers[19].

Secondly, students are certified as eligible for the stipend although they have not met the criteria. The SSPS survey found some 34% of class 8 students had been certified by their schools as eligible when they had in fact failed to meet either the examination or the attendance criteria. This is the most common form of corruption, and it involves collusion by students. The important issue here appears to be that school authorities are willing and able to falsely certify students' eligibility. While this is a problem in all types of secondary school, it seems to be most common in madrasahs[20].

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[18] There are four major programmes of this kind, but they all provide similar benefits and operate along similar lines at the school level. Secondary school stipends are payments to unmarried female students at secondary level, regardless of socioeconomic status. Similarly to the primary stipends programme, however, beneficiaries must meet attendance (75%) and examination results (45%) criteria, as well as remaining unmarried. Unlike in the primary programme, payments vary depending on which class the student is in. One-off payments for books and SSC exam fees are given to class 9 and 10 students. Schools receive tuition fee payments directly, and the programme has created strong incentives for secondary schools and dakhil madrasahs to attract and retain female students.

[19] The time lag between payment and the period for which the stipend was earned made it difficult to assess ghost students within SSPS.

[20] The SSPS survey findings on school attendance strongly suggest that dakhil madrasahs have the lowest attendance averages of all secondary schools, and are most likely to falsify their attendance registers.

There is additional support for the view that corruption regarding the stipends is particularly problematic in dakhil madrasahs. An important factor appears to be the weakness of supervision at the facility level. UNOs formally head madrasah SMCs, but meetings usually occur in the UNO's office, and visits to madrasahs are rare. In addition, madrasahs are on average more dependent upon the stipends programme than other types of school. Both non-government schools and dakhil madrasahs have seen impressive gains in female student enrolment from the stipends programme, but the impact has been more significant in madrasahs. The SSPS survey found that tuition fees compensation averaged 19% (non-government) and 31% (madrasah) of incomes in these schools (excluding government salary payments; figures for 2003-2004). And for approximately 10% of madrasahs, this dependence was even higher, with tuition fee compensation payments accounting for more than 50% of non-salary income. It is not surprising, then, that the priority in many madrasahs is to retain access to the stipend and the students who receive them, even at the cost of corruption and concealment. Parents in one madrasah explained that if a female student looks as though she may drop out because she is not getting the stipend, the madrasah authorities will arrange for her to receive it in a bid to retain her, even if she is not eligible.

The third main area of corruption or leakage is when payments are taken in return for the stipend. While the SSPS survey found such practices had declined, average payments of Tk 15 were reported by 11% of beneficiaries. There seems to be widespread awareness that this practice constitutes a serious breach of the rules, and most respondents claimed to no longer hear of it happening, even in other schools. Interestingly, the role of the media in preventing this form of corruption was mentioned by a number of Upazila Project Officers (UPOs) or Upazila Secondary Education Officers (USEOs): as one put it, 'no head teacher wants his face in the paper for taking money from students'. We found fragmentary evidence of such payments, but nothing concrete.

More usually, we found 'examination fees' were being deducted from students' stipends. This was routine in non-government schools and madrasahs, but not in government schools. In some cases, a 'session fee' or 'session charge' was also deducted[21]. Some head teachers were quick to point out that students' permission was necessary, but there were schools in which this was not optional. UPOs / USEOs claim that they disallow the practice, but it is evidently common practice. The implications of this include that:

- Respondents may be referring to these cuts when they report informal payments, particularly if this purpose is not explained to parents, or if they do not agree to the deduction.

- Whether students and parents view this as corruption or a legitimate deduction may vary: whether they report this as a form of leakage will therefore depend on how the question is framed; this needs to be taken into account when interpreting findings from surveys of stipend beneficiaries.

- Even where such practices are genuinely innocent, the ambiguities that they introduce into the system increase the scope for concealing corruption and increase the perception of corruption.

We uncovered other odd and unfair practices relating to the stipend. In one madrasah, students reported that teachers occasionally compensate female students who 'might feel bad if they have not received the stipend' by deducting small amounts from those who

[21] When we say deducted, we mean that the female students are required to hand the money over. There is little possibility of deducting the money at source, which most respondents take as proof that corruption of this kind cannot occur.

have received it. As with the issue of students' permission, it seems likely that considerations of social hierarchy and authority will limit the scope for young female students to resist teachers' requests.

The authorities of the different types of school displayed very different attitudes to the stipend: madrasah staff took an almost proprietorial interest in the stipend, whereas government school staff demonstrated detachment and disinterest to the point that they claimed not to know the amounts involved. These differences reflect the importance of the stipend to both the institution and the students themselves. Whereas in madrasahs we saw that not receiving the stipend might lead to female students dropping out, in a government school, the head teacher reported students buying compact disks and clothes on the day of the stipend payments, graphically highlighting the socioeconomic differences between the students attending these institutions.

3.4 PRIVATE SERVICES

Large-scale leakage of services occurs when teachers and doctors provide private services in such a way that the services they provide in their official roles suffer in quality or quantity. Weak regulation of private practice in health feeds beliefs about corruption in the public health service, although, strictly speaking, private practice is corruption only when it occurs during opening hours or on facility premises. In reality, a strict separation of private from public consultations is rare. Under these circumstances, what medical staff may view as a matter of convenience and rule-bending—treating patients at the government facility as private patients—is easily and accurately viewed as corruption and leakage by patients and observers. The CIET surveys found 20% (2000) and 18% (2003) of patients reported making extra payments to doctors in government health facilities (CIET 2004).

Interestingly, while the SSPS survey found that only 3% of patients leaving facilities reported paying during that visit, 25% of community members reported 'usually' making payments to the UHC. It is possible that, as the SSPS health report notes, the presence of the SSPS survey team may have temporarily stopped private activities. But the figures may also reflect the fact that approximately 25% of users will at some point make payments at their local UHC, although on any given day, only a small proportion of patients will do so, if at all. A final possibility is that a parallel paying outpatient department was operating, so that SSPS teams were surveying the non-paying outpatients, sampled on the basis of the tickets they receive on arrival, rather than those who sought private services (who do not receive such tickets).

It seems likely that some of what could be interpreted as corruption is the more complex matter of private and public services being mixed (see also Lindelow *et al.* 2005). An important issue here is the norms around service provision: everyone involved expects public services to be low-quality, brief consultations for very common complaints. Both patients and doctors are, as a result, accustomed to expecting payments to be made for anything more complicated than common complaints—diarrhoea, routine acute respiratory infection (ARI) or nutrition-related. So although private practice is known to be illegal on government time or property, doctors easily justify payments received on UHC / union facility premises or during opening hours. One justification is that patients in a 'serious' condition sometimes offer payment to queue-jump or be given more attention than the average outpatient. When more 'serious' patients visit the outpatient department, the doctor's choices are as follows:

- Treat that patient as any other patient (i.e. give them less time than clinically necessary).

- Advise the patient to return after hours to his / her private practice.
- Refer the patient elsewhere.
- Treat the patient as they would a private patient on the premises, and charge them accordingly.

Of course, these decisions will often be arrived at on the basis of the patients' ability to pay. On at least one occasion, we heard the final choice being justified as reducing the time and travel costs to the patient. There may well be some convenience to patients, but the logic of this entails that patients must be aware that private services can be obtained on the facility premises and during opening hours. The disadvantages of doctors making their private services available on facility premises and during opening hours are clear: it enhances the profession's reputation for corruption and venality, while also reducing the time for non-paying consultations.

Private practice also leads to leakage in the form of services diverted from public to private, and the leakage is mainly of time. The SSPS found that consultation times averaged approximately four or five minutes per patient. If, as our team noted, this usually involves a consultation in a room full of other patients, the time dedicated to an individual patient may be even less. Doctors themselves admit that one reason patients come to them in their private practices is longer consultations. Some of the reasons for short consultations seem to be as follows:

- Effective opening hours in the outpatient department are short, with an unofficial 'norm' of core opening hours between 10.00 am and 1.30 pm[22].
- There are few doctors, and rarely more than two available to see outpatients within those three hours. As long as at least one doctor is seeing outpatients, service is considered to be provided.
- The norm is that all patients, as far as possible, are seen. With many people expecting to be seen within this brief time and by few doctors, consultation times are short.
- For many patients as well as doctors, the consultation is the token required to access free medicines. It is not about sharing information, discussing or understanding the problem or getting prescriptions (except for private patients). Physical examination is not routine, and the patient need not always be present[23].

3.5 ABUSE OF INFLUENCE

One final form of corruption involves the use of government facilities and offices to achieve political influence, usually through the placement of politically-connected people in positions within facilities that are practically or symbolically valuable. This issue is dealt with in detail in the different sections of the present report, and is flagged here to

[22] The qualitative team found that across upazila facilities there was an unofficial norm of core opening hours between 10.00 am and 1.30 pm. This is even shorter than the four to six hours of opening widely reported by communities in the SSPS study, and very likely reflects the lower profile of the qualitative research team: the researchers appear to have had somewhat less impact on health facilities than the highly formal, 'audit' approach of the SSPS survey. The team witnessed numerous forms of private practice and other bad practices, with little effort made to hide it from the researchers.

[23] For familiar complaints, women will often go to the outpatient department reporting their husband's symptoms, so that the husband does not have to waste a day's work travelling and waiting at the UHC. This may be one reason for the slightly higher proportion of women attending UHCs.

underline the point that corruption does not necessarily involve financial transactions. The abuse of influence takes numerous forms, and implicates citizens and political representatives as well as government officials. As was noted above, DPEOs interviewed for the qualitative research frequently complained of political pressures on them to appoint unworthy but well-connected candidates. Another way this reportedly occurs is through local political figures attempting to influence the appointment of medical officers in efforts to ensure favourable medical certificates. When asked whether there were regional differences in how well different upazila health complexes performed, a UHFPO recounted the following story:

> 'In some places the security is not very good. There are local political pressures over the UHC. The politicians ask for false injury certificates. One incident like this occurred here. A medical officer was forced to issue a false injury certificate for a patient who was admitted in the UHC. Later the court seized the admission register and the note in the admission register, which was written by the same doctor, was different from the injury certificate. The court convicted the doctor for issuing false injury certificate and asked the CS office to take divisional action against him. Now, he is going to lose his job. But no one will consider under which circumstances and pressure the doctor issued such false certificate.'

UHFPOs and other medical officers widely reported feeling pressure from locally powerful groups to exaggerate or falsify medical reports for police cases. With respect to schools, Section 5 describes how attempts are made to capture SMCs for political purposes. In secondary schools this often becomes part of partisan competition, with school staff and students sometimes seen as political resources. In primary school SMCs, by contrast, the value of SMC membership seems to be more about building political capital at the local level through the demonstration of respected social status and commitment to the community. Obtaining influence in education or health facilities of course may also enable access to the forms of corruption or leakage listed above.

Without undertaking longer-term research across a wider range of health and education facilities, it is difficult to assess precisely how political and other forms of influence are abused within individual facilities. However, some findings from the SSPS survey highlight some of the practices through which influence may be exerted on a significant scale. For example, as Table 3.2 shows, 46% of government secondary school head teachers expressed the view that procedures for direct appointment to the position of head teacher are unfair compared to 36% of non government secondary school head teachers. However, far fewer government school head teachers believed that the unfair means included informal payments than was the case for non government school head teachers (15% compared to 34%). If informal payments are not the unfair means in question, this strongly suggests that the use of influence may be one means by which head teacher appointments are being made in government secondary schools.

4 Human resources: motivations to perform

This section explores material and non-material incentives that influence the performance of doctors, teachers and officials who are frontline service-providers or supervisors of facilities[24]. It is worth briefly reiterating some of the consequences of poor motivation to perform, as found in the SSPS surveys[25].

- At both secondary and primary level, teacher absenteeism was a problem, but there were few illegitimate absences.
- At primary level, most teacher absences were legitimate, and training-related. Only 1.5% of government and 1.9% of non-government school teachers expected to be working were unofficially absent at the time of the survey.
- However, 32% of government and 29% of non-government teachers arrived more than 15 minutes late for school, with teachers living further away more likely to be late.
- At secondary level, approximately 10% of teachers were absent, but only approximately 5% of those teacher absences were definitely unauthorised.
- Some 64% of secondary school teachers have additional work and sources of income. Second and even third sources of income are particularly common among non-government and dakhil madrasah teachers.
- Attracting and retaining doctors in rural health facilities is a problem: 68% of union health facilities lack a doctor, while UHCs have just over 50% of the doctors they are supposed to.
- Time given to public service provision by doctors is also low, compounding the problem: communities reported to the SSPS that outpatient opening hours were typically between four and six hours per day. The qualitative research suggests the lower estimate may be closer, given the unofficial 'norm' of 10.00 am to 1.30 pm opening.

4.1 MATERIAL INCENTIVES

Pay and benefits

How remuneration of frontline staff affects performance will depend not only on the level of remuneration, but also on what they compare this with, and how reliably they receive their pay and benefits. In terms of what their salaries can purchase, and in comparison with other educated and professional groups, teachers are poorly-paid, a fact which recurrently erupts into political struggle[26]. A recent cross-country study of teacher

[24] Other research team members are preparing papers containing more detailed discussions of the career and personal profiles of nurses and head teachers (in Bangla) and of doctors (in English).
[25] This list does not cover all aspects of performance. As was discussed in Section 2, the research was not able to address issues relating to the technical aspects of service delivery, including pedagogy and diagnosis.
[26] In July 2006, the issue of teachers' pay emerged as a political issue as primary school teachers struck for better pay and status, while non-government primary school teachers mounted a heated national campaign involving strikes, threatened fasts-to-death and confrontation with the authorities. Non-government secondary school teachers also joined the fray. While there are evidently partisan agendas here, media reports suggest there is a wider sympathy and political support for teachers' demands, notably among the educated middle classes, the media and civil society.

incentives found that the average official remuneration of Bangladeshi teachers entailed living below the poverty line. Based on the amount teachers are paid, Bangladesh ranks among the bottom 50% of low income countries: Mauritania, Burkina Faso and India pay their teachers better (Bennell, 2004: 34–35).

In primary education there are large gaps in the remuneration levels of government compared with non-government teachers (100% of whose basic salaries are from 2006 to be paid by government; see Table 4.1). The biggest gap is in allowances, which non-government teachers either do not receive or receive at a lower rate. Government school teachers can also expect yearly increments and other forms of raises over time, but these are not available to non-government school teachers. Inevitably, these differences are presumed to underlie the generally better performance of government as compared with non-government schools. They have also been a point of contention among non-government school teachers, who, quite reasonably, measure their own remuneration levels and professional status with reference to counterparts in government schools.

Although they do the same jobs, as some teachers pointed out, they are not all equally well-qualified or well-trained. Government school teachers are generally trained to a higher level, and more likely to have professional qualifications than their non-government and madrasah colleagues. They also generally performed better on tests undertaken as part of SSPS to measure teachers' basic literacy, numeracy and reasoning skills. At secondary level, government teachers performed better than non-government teachers, who in turn scored higher than madrasah teachers. This ranking mirrors levels of training and qualifications among these three teacher types. It may also reflect the degree of competition involved in recruitment.

There are also gender differences among teachers. At primary level, the SSPS found more than 50% of government school teachers were female, compared with only 30% in non-government schools. While only 10% of government schools had no women teachers, nearly 33% of non-government schools were in that situation. Head teachers are overwhelmingly male, particularly in non-government schools. The SSPS surveys showed that men teachers tend to be better qualified than women teachers, as well as to have served longer in the school. These factors might help to explain why women typically earn less than male government school colleagues. While the overall picture is that male teachers tend to be better qualified than their female counterparts, women teachers in *government* schools both earn more and are usually better qualified than their male *non-government* school equivalents. What this suggests is that differences in qualifications and remuneration levels in the two systems, more than systemic gender-based discrimination in respect of pay, can explain gender differences in pay.

Table 4.1 Teachers' pay (mean monthly, Tk)

	Primary	
	GPS	RNGPS
Head	6,430	2,063
Assistant	5,685	1,982

Source: SSPS primary report.

Given the great prestige and high social status of doctors in Bangladesh, it comes as a surprise that salaries in health facilities are compressed to the extent that doctors in upazila and union facilities are paid at best less than twice that of other staff (see Table 4.2). In fact, the mean salary of doctors in union facilities is slightly lower than that of

medical assistants who usually receive three years of training in addition to having their higher secondary certificate (HSC) qualifications. However, doctors interviewed for the qualitative research did not compare their pay and allowances with that of other staff within facilities. One reason may be that the gulf in social and professional status and education makes such a comparison with lower status colleagues unlikely. This may be clearer when we see that doctors compared their own salaries against:

- Doctors in other (developed) countries.
- Doctors in the private sector in Bangladesh; in one case, disgruntled newly-recruited UHC medical officers contrasted their Tk 9,000 starting salary with the Tk 25,000 being drawn by their classmates at the Apollo Hospital in Dhaka.
- Specialists / doctors with postgraduate qualifications.

There are a number of possible career paths for doctors, making it difficult to arrive at a single definitive position on how they view their material incentives. A young doctor in a union or upazila facility, for example, will typically have a small salary and no private practice. This doubly disadvantageous position is likely to last the full two year upazila / union posting required of new recruits to government service. Many young doctors treat those two years as a sentence being served in preparation for further training, rather than as a posting to settle into or to develop professionally. Those two years will, very likely, be spent studying for the FCPS examination or other postgraduate study opportunities, rather than building up a private practice or, even less likely, a good relationship with the local user-community. Their performance at the upazila or union level has no impact on their likelihood of gaining access to training or other opportunities. Civil Surgeons, UHFPOs and RMOs interviewed for this research explained that the imperative of completing postgraduate training was a key factor behind doctor absenteeism. Other factors included concerns about security, problems with accommodation, and good political connections, which in some cases enable staff to avoid pressure to attend. One Civil Surgeon explained the main reasons behind doctor absenteeism as follows:

> 'Doctors want to stay in Dhaka for higher studies. Some junior doctors are home sick and remain absent frequently.'

The expectation appears to be that many young doctors in these positions will make no better than token appearances at the facility to which they are posted. One recently posted Medical Officer, fresh from postgraduate training commented of her junior colleagues:

> 'Some MOs remain absent every now and then … Everyone is concerned about their career, so they remain absent and study.'

The extent to which postgraduate study is vital to doctors' professional careers was highlighted by a Medical Officer who had passed the age at which postgraduate training is given, and who spoke bitterly about his failure to become a specialist:

> 'As I have received EOC training, so I have to stay in the UHC for at least two years according to the agreement. Moreover, my age has exceeded the entry limit in post graduation programmes … I am not satisfied with my job. I am working for about 20 years as a Medical Officer without any promotions. People working in other sectors do not have to do further education for promotions. Like those who are working in secretariat, do they have to study more for promotions?'

Overall, junior doctors' incentives are strongly skewed towards postgraduate study.[27] Those who succeed in gaining specialist training can expect to be promoted faster and, further, to earn higher salaries, and to have a more lucrative private practice. Specialist doctors earn well through private practice in the larger cities and are unlikely to be attracted to rural postings. The vast majority of specialist posts in upazila facilities are unfilled; doctors on site are usually non-specialist MOs, RMOs and UHFPOs. Those specialists who are posted to UHCs have stronger incentives than non-specialists or the RMO and UHFPO to be absent. The professional superiority of this class of doctor also makes it difficult for facility managers (RMOs and UHFPOs) to discipline them.

RMOs and UHFPOs are typically doctors who chose to follow the administrative career route, aiming for the Civil Surgeon's office or higher within the government health service. Doctors who do not choose or succeed in postgraduate training are likely to become RMOs or UHFPOs, or to remain in upazila or union health facilities. There are advantages here, too, however. The career path of an RMO or a UHFPO is generally to attempt to get a posting in or near their home area. It is possible that this helps in building up what are often lucrative private practices. The career patterns of this group suggest that the private practice attractions may be so great that it is even worth their while to seek return transfers after a brief nominal posting elsewhere[28]. That these are unattractive rural postings in the eyes of other, more ambitious doctors, suggests that the assumption that all doctors prefer to be near Dhaka does not hold. Interestingly, the prospect of lucrative private practice makes (some) rural postings attractive, showing how incentives to be present in the facility can be aligned with private material incentives.

Good quality accommodation appears to be an important incentive for doctors to stay in an upazila facility, but other positive aspects of government service cited include:

- Higher status as a government doctor; doctors often admit that patients prefer to see a government doctor in their private practice, because their training and experience levels are assumed to be better. Government employment thus certifies the skills and qualifications of providers in the private health sector.
- Job security.
- Regular pay and benefits, including pension.

Table 4.2 Doctors' pay compared with other facility staff (mean monthly, Tk)

Facility	Category of staff	Low	Mean	High
Upazila Health Complexes	Doctors	7,405	10,012	13,150
	Nurses	5,814	7,884	10,935
	Medical Assistants	6,885	9,849	10,835
Union facilities	Doctors	7,405	9,551	13,150
	Medical Assistants	6,885	9,773	10,737
	Health Assistants	4,014	5,410	6,153

Source: SSPS health report.

[27] That this point applies more generally across the health service received further confirmation from discussions with young postgraduate student doctors in Dhaka.
[28] We found a number of RMOs and UHFPOs were on their second posting to the UHC.

Private practice

A second reason doctors do not compare their earnings with that of their facility colleagues seems to be the absence of any expectation that doctors will subsist on their government salaries. Private practice is widespread, although some doctors prefer not to discuss it, suggesting there is discomfort about the practice. Primary and, in particular, secondary school teachers also offer their services privately, but this provides teachers with a less significant proportion of their income than it does doctors. Gruen *et al.* (2002) found that 75% of doctors double their government salaries through private practice, while 20% quadruple it. The SSPS survey produced similar findings, with mean additional earnings by doctors in upazila and union facilities at more than Tk 11,000 per month.

The earnings from private tuition are less substantial, and it is less widespread among teachers. Only between 13% and 14% of primary school teachers admitted offering private tuition (see Table 4.3). For government teachers who do offer such services, private tuition earnings represent 21% of the income from their salary; the equivalent figure for non-government teachers is 27%, although in absolute amounts, government school teachers earn far more (see Table 4.1). This reflects the strong demand for government school teachers in some subjects as private tutors in both primary and secondary: as with doctors, government employee status certifies quality. The SSPS estimates that at secondary, school teachers in general earn approximately 37% on top of their salary from private tuition, with government secondary school teachers earning considerably more than other teachers.

Table 4.3 Primary school teachers' extra incomes (mean annual, Tk)

Income source	GPS	Teachers (%)	RNGPS	Teachers (%)
Private tuition	13,520	13	5,983	14
Agriculture	15,103	18	15,574	49
Running a business	17,167*	2	29,524*	9
Other waged employment	8,477*	1	3,477*	5
Total				
Overall	15,659	30	17,946	63
Male	17,835	50	19,561	79
Female	6,406*	11	5,171	24

Source: SSPS data from sampled primary teachers.

* Denotes estimate generated using fewer than 30 observations.
Note: Mean annual earnings are calculated only for those teachers who have this source of additional income.

With some restrictions, private practice and private tuition are legal practices for doctors and teachers. However, there are numerous types and forms of private practice / tuition, and many shades of illegality involved in the way these are actually practised. In upazila health complexes and union facilities, private practice is permitted after hours (after 2.30 pm, when outpatient services are supposed to end), and off the premises. There does appear to be some ambiguity regarding whether or not doctors are permitted to see patients in their accommodation which is attached to the facility. Strict observation of the rule that 'no business activities' are allowed on government premises should entail that doctors offer private consultations elsewhere. However, in practice, doctors in rural locations are very likely to use the accommodation attached to the upazila health complex to conduct their private practice. (In busier towns and cities, doctors are more likely to

conduct their private practice from a pharmacy, possibly in a market or town centre.) Advantages for the doctor are likely to include that:

- Patients know where the doctor is to be found at any time.
- There is confirmation that the doctor is a government doctor.
- A doctor on emergency duty can still conduct private practice. The main disadvantage of this practice is that it blurs the distinction between public and private services. There are also indications that combining private and public leads to a heavy workload.

Private practice[29] takes a number of different forms. The degree of regulation in facilities varies. In health, we see the most rigid separation of private and public services at one extreme, and total mixing of these services at the other (Figure 4.1). The most usual arrangement is that private services are offered alongside, but are still to some degree separable, from public services. Not surprisingly, the facility with the most complete mixing of private and public services also features other poor management practices (UHC 5); by contrast, the facility where public and private are clearly separated also experiences the greatest involvement and pressures for accountability from the local community (UHC 1).

[29] By which we mean consultations for which patients pay. This would exclude the practice, believed by some to occur, by which doctors receive a commission from pharmacies for patient referrals or prescriptions that direct them to that pharmacy (i.e. are not paid directly by patients, but patients still pay). We found no evidence of such relationships. However, we did find 'medical representatives', as pharmaceutical company sales representatives are euphemistically known, influencing prescriptions in the most poorly-managed of the UHCs (UHC5). We can assume that staff receive a commission when they prescribe the brand being marketed.

Figure 4.1 Regulation of private practice in five UHCs

Strict separation of private and public services ⟷ No separation of private and public services

	UHC1	UHC2	UHC3	UHC4	UHC5
Private practice permitted in the hospital?	No	No	Yes	Yes	Yes
Regime	Doctors offer private services from their homes, not on UHC premises	Doctors offer private services from their quarters after 1.00 pm	Private services offered after 1.00 or 1.30 pm	Some private service during opening hours	Private services routinely offered during opening hours
Other notable features	Strong community involvement and oversight	Full prescriptions are written for outdoor patients	Doctors behave well with patients in order to build up large private practice	UHC has links with the local Member of Parliament (MP)	Pharmaceutical company representatives involved in prescribing, patient care
	Follow-up of outdoor patients takes place			Three new MOs recently recruited, bringing strength up to five	Tk 2 charged for outdoor tickets

Source: SSPQS.

The theory that private practice creates incentives for doctors to under-perform so as to generate demand for private services is not easily assessed[30]. One argument against the view that private services are detrimental to wider access to medical services was made by patients, who commented that an advantage of the government health system was that it gave them access to good quality, qualified government doctors. Another argument against the view that private service provision reduces provision for the poor is that markets for the services of government doctors are typically segmented: those who access their public services are not, according to the doctors interviewed for the present research, also usually able to pay to see them privately.

Whether or not the poor can pay, government services are both services for the poor and poor services, particularly because of the brief consultation times. Short opening hours and the unavailability of doctors are clearly related to the short consultation times offered in public facilities. To that extent, private practice does reduce services, but not necessarily because this creates demand for private services. To some extent, short opening hours are simply institutionalised bad practice. Facility managers justify short

[30] World Bank (2003) summarises the evidence on the incentives and disincentives with respect to private medical practice.

opening hours on the grounds that outpatients do not arrive before 10.00 am: in turn patients do not arrive earlier, because they expect to have to wait longer if they arrived when the facility officially opens.

An interesting and under-explored issue is whether doctors' private practice creates incentives to be present in rural upazila / union postings and to give good public service in order to develop a good local reputation. As we saw above, there are categories of doctors whom private practice attracts to such postings, usually non-specialist doctors, often with local origins. The picture is complicated because not all rural postings are equally attractive: some private practices flourish in rural areas, but not where the population is very poor or uneducated. At the same time, an upazila or union close to a large city is also unlikely to be a good base for private practice. The ideal conditions are where competition is low but demand is high. It is not clear that incentives for gaining a good local reputation can influence doctors' behaviour towards patients in government health facilities if, as doctors generally believe, those patients cannot themselves afford private services. However, the view that these incentives are so present was voiced in a number of contexts by both medical staff and patients, and it does appear to influence providers' behaviour. The belief that a good reputation impacts positively on private practice may well be sufficient to influence doctors' behaviour, regardless of its truth.

The different forms of private tuition offered by primary school teachers include group-based and individual coaching, off and on the school premises. An important issue here is that private tuition at primary level is widely viewed positively— almost as an additional responsibility of teachers, and not as an important income source. It is often framed as 'coaching' by school authorities, who encourage teachers to give extra classes to special scholarship classes. These are treated as extra classes, but teachers are paid directly by their tutees. These practices are generally encouraged by school authorities and education officials in the interests of improving academic outcomes, and SSPS found these often cited as a reason for improvements in academic quality, along with extra 'model' tests. At primary level, it is worth noting that many teachers commented that private tuition had increased as a result of the stipends programme. Many, including students and parents, appear to believe that this is in fact a purpose of the scheme.

At secondary level, while there is also school-based coaching (see CAMPE, 2006), private tuition is more plainly commercial and lucrative. Unlike at the primary level, private tuition is mainly a subject-specialised service, with demand overwhelmingly for sciences, mathematics and English. This means that some teachers corner the major share of the private tuition market. The belief in urban and metropolitan areas, at least, is that this is a highly lucrative market. A teacher in one big city government school told us that he had himself previously provided private tuition, with the earnings from which he had bought himself a Tk 75 lakh apartment in Dhaka. He used to earn an additional Tk 5,000–7,000 from each student he taught, which came to an annual additional income of between Tk 50,000 and Tk 70,000. This teacher stated that to achieve transfers to schools like the one in which he taught with prospects for lucrative private tuition, it was usual to pay between Tk 2 and 4 lakh, as well as to use the influence of senior officials and politicians; the head teacher of the same government school also claimed having used politically influential individuals to achieve influence and overcome obstacles to career progression.

Box 3 Forms of private tuition found in secondary schools

Domestic	Batches (between 6 and 10 students)	Individual	Coaching centres
Free or subsidised tuition from a student-lodger, sibling or other relative	GSS Tk 200-250 per month Tk 1,200-1,500 (metropolitan) Location: teacher's home Subjects studied: English, Mathematics, Sciences: Biology, Chemistry, Physics	Tk 300-1,000 (urban NGSS) Tk 500–1,200 (GSS)	Coaching centre tutors are not usually schoolteachers
	NGSS Tk 100-150 (rural) Tk 200-250 (urban) Location: sometimes school premises after hours; also teacher's home Subjects studied: English, Mathematics, Science, Arabic	Tk 1,800-2,000 (metropolitan GSS) Student's home, usually better-off households	

Source: SSPQS.

Again, the question arises as to whether private tuition creates incentives to withhold teaching in the classroom, or indeed to perform better. It is clearly the case that it is insufficient teaching time in the classroom that is the main motivation on the part of students for taking private classes. In a number of discussions with class nine students, the point was raised that a 45 minute session is too short to cover a subject, in particular with large class-sizes. One group calculated that at best they could each get no more than 45 seconds of the teacher's attention in a single period. The main point of private tuition is to get more individual attention and cover the curriculum more thoroughly; in effect to extend the length of the teaching-learning day. The research found no evidence that teachers deliberately withhold lessons or shorten the teaching day to generate demand for their private services: class sizes are so large, and individual class periods and the entire school day are so short that teaching time is necessarily limited.

Again, we see that government school teachers are preferred private providers, but there is also a strong demand for clever students from colleges and universities, many of whom provide services in coaching centres. The major markets for these and other commercial arrangements for private tuition are predominantly urban, middle class and male. As the SSPS survey found, government school students are most likely, and dakhil madrasah students least likely, to pay for private tuition, in a close reflection of the socioeconomic status differentials of students attending each kind of school (see Table 4.4). Urban households on average spend three times more than rural households on private tuition, and a little more than half of private tuition spending on male students is spent on female students.

Table 4.4 Spending on private tuition at secondary level, 2004

	GSS	NGSS	DM
Percent of households spending on private tuition	90	63	51
Mean annual private expenditure per student (Tk)	7,635	1,459	515

Source: SSPS secondary report.

Other income-earning activities

The major economic activity of public social sector workers other than private practice / tuition is agriculture, by which we mean owning land and overseeing work on it. Land-ownership and some income activities from agriculture are found in all three sectors, as would be expected of this social and economic class. Perhaps most surprising, SSPS found that almost 20% of doctors with additional income said this came from sales of agricultural produce; some also earn income from land rentals. Agricultural activity seems to be most prominent among school teachers, particularly in non-government schools.

A direct impact of this is likely to be the time and attention diverted from the official job, as well as seasonal absences. In one region it had become such a problem that a DPEO was lobbying for permission to move a school holiday in one upazila: there was a month each year, he explained, when everyone— children, adults, students and teachers—was harvesting onions rather than at school. Some groups, non-government school teachers in particular, are also involved in small business activities, although these seem to have a less direct impact. Managing agriculture is a particularly important preoccupation for non-government school teachers, for whom, we will see below, land ownership is an important element of local elite status. It is also this status that makes non-government school teachers seem more affluent than their government counterparts: government primary school teachers are less likely to be from the traditional elite families in the local communities they serve, and more likely to be from urbanised and educated families.

4.2 NON-MATERIAL INFLUENCES

Additional public activities and roles

Table 4.5 outlines the additional public roles of teachers and doctors as found in our sample facilities. All undertake a number of additional public roles; some are mandatory. Primary school teachers have a particularly large public role at the village, collecting information and statistics for government. Some of these activities are paid: teachers were remunerated some Tk 50 per form for completing voter list registrations in 2001, and some still expect payment for the most recent round.

Teachers are kept busy with these additional activities and roles, which some teachers reported, clash with their professional roles, particularly in terms of the extra burden of time. However, the most time-consuming task that reduces academic teaching time is school-related: the administration of the stipends programmes. Overall, it is surprising that the additional tasks assigned to teachers are not unwelcome, but many appear to appreciate the social standing that comes with ‘doing government work’. In addition to tasks for central government, teachers play important roles in local-level governance: dispute resolution; sanitation surveys for local government; and helping people with official paperwork and advice, including about medical issues. These roles are fully in line with the customary activities of the local elite, which it seems still includes teachers.

Table 4.5 Additional public roles of key workers

	Primary teachers		Secondary teachers			Doctors
	GPS	RNGPS	GSS	NGSS	DM	
Community						
Bichar / shalish	Yes	Yes	No	Sometimes	Yes	No
Help local people with official paperwork	Yes	Yes	No	Yes	Yes	No
Religious duties	no	no	no	no	Yes	No
Medical advice	Yes	Yes	Yes	Yes	Yes	Yes
Guiding visitors	Yes	Yes	no	no	no	Yes
Government						
Immunisation campaigns	Yes	Yes	No	Yes	Yes	Yes
Health education	No	No	No	No	No	Yes
Voter list preparation	Yes	Yes	Yes	Yes	Yes	No
Shishu jorip (child survey)	Yes	Yes	No	No	No	No
Census	Yes	Yes	Yes	Yes	Yes	No
Sanitation survey	Yes	Yes	No	No	No	?
Work with police	No	No	No	No	No	Yes
Polling officer	Yes	Yes	no	no	no	
Political						
Canvassing	Yes	Yes	no	no	no	No
Union activities	Yes	Yes	no	no	no	No

Source: SSPQS.

Compared with teachers, whose time is regularly taken up by additional work for government, doctors undertake few additional public roles. They also generally play a smaller role in the community, and any extra activities they mention are linked to their professional role (mainly health education). However, there are some doctors, those with links of origin or other ties to the community they serve, who come to be seen not as government officials on a posting but as the educated, affluent leaders of local society. These doctors may provide low cost or free private services to local poor people, for instance, use personal resources or connections to improve facilities at the UHC or work to bring public resources or projects to the area.

Social status and social relations

Teachers have traditionally been important people at the village level, enjoying high levels of respect and trust. Their opinions have been sought on major community decisions as well as on vital private domestic concerns, such as marriage. This high approval rating seems to have reflected their own comparatively high social and educational status within rural society as much as their professional capabilities or roles. One consequence of this high approval rating may well have been to convince uneducated rural people of the social

value of schooling their children. Arguably, however, another has been to insulate teachers against pressures to perform or to be accountable for their performance.

In discussions with all the main stakeholders, we found effective consensus that there has been a relative decline in teachers' status within communities, but teachers' status remains high. Box 4 outlines the main arguments about the changing nature of teacher status. It was clear from interviews with parents, students and community members that while teachers no longer have the unique position they once held in rural society, they remain generally popular and respected. The teachers interviewed seemed least confident of this, feeling keenly the impact of perceived corruption in the stipends programmes, particularly at primary level.

Box 4 Views on how teachers' status is changing

Teachers' status has declined relatively because:	Teachers' status is still high because:
People are generally richer and better educated than before	Islamic teachings emphasise respect for teachers
There are many more teachers than before	Teachers are still comparatively well-educated
Teachers are involved with corruption in the stipends	They do lots of work for government
Teachers beat students less than they used to, so students fear / awe them less	They help people in the community
Teachers are becoming more involved with politics	People are becoming more aware of the need for education
People respect those with power and money more than those with education	Nowadays teachers come on time, and teach properly
Teachers are now recruited through corruption more than merit so their quality has declined	

Source: SSPQS.

One point regarding the change in teachers' status that did not emerge through direct questioning is the impact of the rising proportion of women teachers. It seems likely that the feminisation of the profession will affect its positive public perception. We came across several instances of women teachers being compared unfavourably with men. One set of perceptions is the basic prejudice that women are generally less capable than men. In one of the better performing primary schools, this prejudice was voiced openly by community members, and taken as a challenge by the all-women teaching staff, who proceeded to improve student performance dramatically over a two-year period. This improved the community's perceptions of women teachers, but it is clear that the local lack of faith in their professional abilities was at times demoralising. A second set of biases against women teachers is that their qualifications and training are of a lower standard than that of men. A third prejudice reported by parents, students and male teachers is that women teachers are more likely to be absent or late because of domestic pressures, which we will examine further below.

Although we did not take a similar approach to researching the status of doctors, we did explore how they communicated and interacted with user communities. It is clear that there is a large gap between most doctors and almost all other people around them within

the upazila and union facilities, including other staff. It is only in the larger district towns that they find other people with their level of education, social background and urban orientation. However, the common perception that doctors are typically superior and distant from patients, and unable to communicate with them because of the social distance between them was not borne out, either in interviews with patients or from observation. One UHFPO told us that new or young medical officers sometimes get frustrated when dealing with poor rural patients, and need to be encouraged and shown how to behave well with them.

However, while they are not universally rude, user surveys clearly show that few upazila and union facility doctors do a good job of explaining things to their patients[31]. When as part of the present research, doctors were asked if they ever found it difficult to communicate with poor rural patients, some doctors referred to dialect: surprisingly few recognised that differences of class or education could impede communication. This gap between patients and doctors is bridged in a number of ways: first, there are the field workers in health, from whom doctors admit they learn about the disease burden and health profile of the area. Secondly, those least able to communicate with doctors (poor rural women, elderly people, and so on) may be accompanied by a person with a higher level of education or social standing, both to explain and understand the treatment, and to ensure they receive a service. The third, as we will see next, is that a section of doctors is more closely linked to the communities they serve, and may play something of a mediating role.

Staff in schools and health facilities do not all have the same relationships to the communities they serve: their own personal characteristics make a difference, and create different motivations to perform. This became clear when personal interactions with teachers led the primary qualitative research team to view non-government school teachers as in general wealthier than their government school counterparts. In part this includes understanding recruitment processes, which for non-government schools favour the educated offspring of wealthy local families[32]. In fact, the SSPS primary survey clearly documents that government school teachers report considerably higher income levels. It seemed that the qualitative research teams were picking up on social dynamics that had not been uncovered by the larger survey. For both education and health, we found there were social status differentials among key workers that created different sets of incentives and different types of relationship with the local user community. In general, doctors and teachers were drawn from two middle-class groups: first, the educated and comparatively urbanised sections of the middle class, often with other family members also in government service, and secondly, the newly educated sections of the traditional rural elite, with all the social authority and responsibility that this entails. The differences in their incentives include that while the first group is more likely to have a family living in the nearest town (for teachers) or the nearest large city / Dhaka (for doctors), the second is more likely to have their family with them and to live close to the facility (mostly teachers). The second group is also more likely to have close personal and traditional relationships with and responsibilities towards the user communities than the first. It may well prove harder for user communities to hold members of their own local elite to account, but the alternative side of this is that there is greater familiarity with and proximity to people from known local families.

[31] The CIET surveys found that patients were three to four times more likely to report having received a full explanation for the remedy or treatment for their illness from private practitioners than from government health facilities (CIET 2004; pp. 38).

[32] This also applies to secondary: the SSPS found that as many as 72% of non-government secondary school head teachers had been born in the upazila, compared with only 36% in government schools.

Domestic and personal aspirations and ambitions

An important non-material incentive for doctors to be absent from or not posted to upazila and union facilities is that they and / or their families live elsewhere. A major factor is children's education: for people this highly educated, only large cities can offer the quality of education they aspire to for their children, particularly as they grow older. If doctors are not joined by their families in the facility, they are likely to spend no more than two or three days per week in the facility. A roster is prepared by the medical officers to ensure constant coverage by at least one doctor. A doctor who lives away from the facility may meet his obligations by undertaking two 24-hour stints in a row, and then be absent for the next four days. The preference for large cities also takes into account other urban amenities and advantages, including higher quality health care.

The pressure to earn well for families, translated into private practice, is also widely assumed to keep doctors away from the facilities and in cities. It is true that the doctor population is particularly dense in large cities, particularly Dhaka, but the reverse of this is that there is considerable competition for patients. Specialists are often in high demand, but even then it can take time to build up a reputation. As a result, general practitioners may more successfully establish a private practice in rural and small town postings than in urban areas (see also Chaudhury and Hammer, 2003).

We saw above that one bias against women teachers is the perception that they are more likely to be late or absent, because domestic responsibilities fall more heavily on them. There may be some basis to this perception, as middle-class women are evidently expected to perform their domestic roles in addition to their professional roles. They also do so with less help from extended family and domestic servants than their class of woman would have had a generation previously. In the women-staffed school mentioned above, the head teacher brought her four-month old infant with her, and breast-fed her on the premises. In a UHC we conducted a group discussion with nurses which included three of their children, who had come to work with their mothers because it was a school holiday. Inevitably, workers are not performing at their best when accompanied by small children, but these women seem to lack reasonable alternatives. In their survey, Chaudhury and Hammer (2003) find that women doctors are very slightly more prone to absenteeism than men, which they link to the fact that they are also less likely to live in the area in which the posting facility is located. We saw above that women teachers are also more likely to devote efforts to obtaining a posting in a favourable location (close to home, with good transport links).

For teachers, the pressures to diversify income sources are great, as private tuition and salaries rarely amount to a living wage. Teachers also tend to invest heavily in their children's education. For some, particularly government school teachers, their family are likely to have been educated for generations, and their own parents and siblings may also be teachers or professionals. Such investments may be less likely among non-government teachers, who one education official noted, 'tend to have many children'. This is a polite way of summarising their traditional outlook compared with the more modern perspectives and contained family sizes of government officials.

We saw above that there are a number of potential career paths to which doctors can aspire within government service. Within the non-governmental organisation (NGO) and

for-profit private sectors there are a wide range of opportunities for doctors, and these also draw a number of doctors out of the government service every year[33].

For teachers, the prospects of promotion are less good. In all schools, there are two levels of positions: assistant teacher and head teacher. An assistant head teacher role is also usually assigned, but this does not attract additional remuneration unless the role involves acting as head teacher, when some allowances are given. While in government schools there may be the prospect of transferring to more desirable locations, non-government school teachers have no such options.

To sum up the findings with respect to the motivations of teachers and doctors to perform, remuneration for public services is widely seen as inadequate. It is both expected and accepted that teachers and doctors will supplement their official incomes, either through private services or through additional economic activities. It is reasonable to expect, and other research indicates that such practices are likely to affect the quality and/or quantity of services they provide in their official capacities, mainly by reducing the amount of time they are willing or able to give in their official role (see also CIET, 2004). On the other hand, the demands of private practice may also create some positive incentives to perform, as was argued above.

An important finding of the research is that the high social status of doctors and to a lesser extent, teachers, does not insulate them against the needs of the communities they are supposed to serve. Instead, despite their high education and social status, many teachers and doctors have roots and connections in the communities, which give them greater scope for responsiveness. At the same time, the social distance between ordinary members of the community and educated government service-providers appears to be lessening, mainly the result of education becoming more widespread. The research found that domestic and personal constraints can represent significant obstacles to regular attendance and improved performance by public sector workers: these factors highlight the need to incorporate a more thorough gender and social analysis into the assessment of constraints to social sector performance.

[33] One UHFPO explained that a Dr S had been 'unofficially absent' for about three years. Many letters had been issued, and after a final circular in the newspapers asking him to attend, he would finally lose his job. As the UHFPO put it, 'it takes a long time to terminate a government employee'. It happened that the name was familiar to the interviewer, who shares his office with a trained doctor of that name in his research organisation. Back in Dhaka, his colleague confirmed that he was indeed Dr S, but also that he had effectively resigned from the service years previously. However, his name remained on the books while official procedures were followed. Meanwhile, his officially non-vacant post could not be filled by another doctor.

5 Exploring quality

5.1 PERCEPTIONS AND MODELS OF QUALITY

The review of the literature on education in Bangladesh revealed differences in how different stakeholders perceive and value education[34]. These differences in the models of quality being used matter: efforts to improve performance may suffer from a mismatch between the preferences and expectations of users, providers and policy makers. One aim of the research was thus to explore the meanings and models of 'quality' in service provision.

The findings were that while perceptions of quality often reflect merely how different groups are situated, there were some issues of wider interest (see Annex Figures 1–3).

Primary education

UEOs and AUEOs were found to focus on teaching-learning processes and school management, while DPEOs focused on visible factors such as school tidiness and uniforms, as well as on the correctness of official paperwork. One DPEO asked:

> 'Is the standard of reading and writing high? Is there a flower garden? Are the school grounds clean and tidy? These sorts of issues influence the quality of the school … In a good school, teachers will be aware, school grounds will be improved, students will be seated appropriately. For example, the small ones should be seated at the front and the big ones at the back.'

DPEOs often relied on official primary grading criteria to define quality, reflecting their greater detachment from schools compared with upazila officials.

Primary school students focused on teacher–student relations and school facilities. 'Good' schools were those in which teachers were kind and friendly, did not beat students, explained things well and made learning enjoyable; where there were playing fields, adequate buildings and furniture, clean toilets and drinkable water. Many schoolchildren seemed to have absorbed official imagery of 'model' schools: Shaheed Minar (martyrs' memorial), flower garden, boundary walls. Like students, primary school teachers focused on their material environment, but also felt that the catchment area mattered. Head teachers emphasised academic supervision and extra coaching and other teachers cited the correct administration of the primary school stipend, a matter which causes them much trouble.

Parents had the least well-defined understanding of what a 'good' primary school might mean. For most, the best feature of their local school and the reason for having chosen it was its proximity to their home. Beyond that, parents demonstrated a preference for 'good' reading and writing standards, but showed no signs of understanding of how those might be defined or assessed. One issue which united everyone in primary education was the importance of teachers and students attending on time and regularly. A 'bad' school was widely defined as one in which attendance was haphazard, and in which, even when in attendance, teachers did not necessarily take classes at the correct time.

[34] Nath *et al.* 2004; ESTEEM 2004; Ullah 1992.

Secondary education

Secondary education officials focused on external factors more than their primary level counterparts did, particularly on the intrusion of politics into secondary schools. This partly reflects their different professional concerns and their different relationships to schools: there are fewer secondary education officials, and they often seem more distanced from, and have less direct responsibility within, schools than their primary level counterparts. This situation is likely to change with the transformation of the Upazila Stipends Projects Officer post to that of a Upazila Secondary Education Officer[35].

The most striking finding with respect to the models of quality in secondary education was how these were graduated depending on the type of school. Teachers, parents and students of government secondary schools, for example, held especially lofty ideals: a 'good' secondary school was one with an SSC pass rate of 80% and A+ grades achieved annually. A selective admission test was considered vital and winning national sporting and cultural prizes desirable. Staff and users in non-government secondary schools were less ambitious: less than 50% pass rate was considered 'bad' in one, while in another, a 'good' school was one which competed at district level. Even further down the range of expectations, students and teachers of dakhil madrasahs focused on achieving basic buildings and furniture. In contrast to the highly competitive government secondary schools, 'bad' madrasahs were likely to suffer from having too few students. As at primary level, most groups felt that regular and timely teacher and student attendance was important. Another unifying factor at secondary level was the view that in a good school, teachers should be trained in their subject.

Health

With respect to health facilities, there was some common ground to be found among staff, community and users: all felt that staff attendance and the availability of medicines were important features of high-performing facilities. But other features of good facilities according to the users of union facilities which were not considered vital by staff included being able to access appropriate medicine and services free of charge; and receiving services without excessively long waiting times.

In UHCs, doctors commonly stressed the importance of basic and sometimes more sophisticated equipment (which they usually lacked), and of the physical environment of the facilities. Many doctors noted that patient knowledge, behaviour and attitudes towards medical care, including their general levels of education, were important to how effectively they were able to make use of the services available. Patients and community members, by contrast, placed greatly more emphasis on the availability of staff and drugs, and on effective arrangements for accessing medical services, particularly during emergencies.

[35] We found that, to date, this change was mainly in name only.

5.2 COMPARING HIGH-AND POOR-PERFORMING FACILITIES: FACILITY MANAGEMENT AND ACCOUNTABILITY

The research was designed to compare high- and poor-performing facilities sampled on the basis of the SSPS survey findings and to explore the determinants of performance. Annex Tables A2–A4 outline selected issues of interest in each of the facilities that contributed to the comparative analysis. The focus here is on comparing high- and poor performers in terms of their management and governance practices. While attention is given to the relationship between users and providers, the qualitative research does not focus on the technical aspects of service delivery – classroom instruction or diagnosis, for example. The SSPS survey reports do explore these issues, however. Comparative analysis of this kind is necessarily cautious, but having both types of data enabled us to develop a fuller picture of the facilities. This was helped by the need to understand apparent paradoxes in the findings. Once they had completed their research activities, the qualitative researchers often disagreed with how facilities had been ranked in the sample, mainly, analysis ultimately showed, because many facilities had experienced change between the SSPS survey in 2004–2005 and the qualitative SSPQS in 2006. A second factor was that the qualitative methodology combined with the quantitative data helped highlight how the quality of management and governance influenced performance.

An important background consideration is that, in general, the direction of change in all three sectors is positive. At the secondary level, 58% of institutions reported a trend towards improving SSC or dakhil madrasah examination results over the previous five years. The qualitative evidence on the primary schools also shows that most had made gains in the year since the SSPS survey. In UHCs, there were signs that doctor recruitment was increasing and expansion of Emergency Obstetric Care (EOC) capacity and to 50-bed facilities meant noticeable improvements.

Facility management

Differences in the management of facilities provided the most striking contrasts between the better and worse facilities. This is not entirely surprising given that government-owned facilities are otherwise very similar in structure, human and material resource endowments, and in how they implement policy from the centre. The management dimensions that were examined in the research included:

- Managers' personal qualities and relationships with staff, including the extent to which they set a good example for other staff and students.
- Strategic direction: whether or not the facility has a set of targets and a plan or vision for implementing change that is shared among staff.
- Control: the extent to which rules and regulations are adhered to and discipline maintained.
- Systems for collecting information that enable problems to be diagnosed and progress to be monitored[36].

[36] Questions for exploring these issues were developed on the basis of work done by Philippa Wood in support of the SSPS design (Wood 2004).

Health

Comparing across the facility types, even in the best-managed health facility, managers had less impact than head teachers. The most serious management failure in health is the regulation of private practice. This is least regulated in the worst UHC, M, and banned on the premises of A (the best UHC). This reflects the degree of managerial control exercised in UHC A compared with UHC M. There is also some impact of local conditions and context that make such control possible. This qualitative evidence supports the SSPS analysis of health facility efficiency, which showed that community reports of payment for services were associated with less efficient facilities.

Questions about how they attempt to motivate doctors to be in attendance and to perform revealed the weakness of their strategies: most reported trying friendly persuasion and encouragement. The UHFPO of the poor-performing UHC, B, said that he always set a good example by arriving on time and staying late, but this was unconvincing as he had himself arrived at 11.00 am, claiming earlier official business.

Although improvements were being made in a number of the UHCs, there was no evidence of plans for development being shared with other staff. Instead, these were the result of central policy – expansion to 50-bed facilities; recruitment of extra doctors in the 24th Bangladesh Civil Service examinations; scaling up of EOC facilities, or of *ad hoc* requests for staff or equipment.

Health facility managers may not plan improvements because the average length of tenure does not encourage long-term plans. A second deterrent is that the day-to-day challenges of running a UHC with few doctors leaves little space for such visions:

> 'There is no use of having goals and ambitions. I have tried to make this UHC an ideal one. But we don't have the minimum required manpower, resources or equipment. At this moment we just have one sweeper. There has been no supply of X-ray film for more than six months. I indent this every month, but there is no supply' (UHFPO of 'medium' UHC SB).

A third factor is the centralised control of resources and equipment. Even minor, but vital, repairs to UHC buildings must go through the Central Medical Maintenance Unit (CMMU), which is notoriously slow and unresponsive. In some cases, repairs were funded out of the pockets of staff.

An important managerial role in both health and education is to attract resources, whether through official channels or community involvement (in education). The physical facilities of UHCs are homogenous, but in varying states of repair. The worst infrastructure was in the UHC ranked third out of four places: the roof leaked and doctors shared a consultation room. It was only with the help of the local MP, a relative of the UHFPO, that they had been able to make vital repairs after the floods. All UHCs in the sample were deficient in some piece of vital equipment: X-ray machines, ambulances, or electricity / generators were commonly cited. Interestingly, one of the best-endowed facilities was identified as the worst-performer overall. Three of the five reported either planned or ongoing expansion to 50-bed facilities. In one facility it was pointed out that expansion was unlikely, as the local MP was from an opposition party and in no position to arrange for such a development.

A striking finding was that the poorest performer (UHC M) was also that with the best endowment of doctors, while the best facility (UHC A) had the fewest in post. This unexpected finding appears to reflect:

- the remote location of UHC A: doctors are unwilling to be posted there, but at the same time, local people rely on the facility, as they have few alternatives; and

- the good political connections of the managers of UHC M, who are able to attract material and human resources to the facilities, but who appear, at the same time, to feel comparatively insulated against pressures to improve performance.

By contrast, the quality of union sub-centres was positively related to the presence of a doctor and / or medical assistant: the best had both present for most of the week, and the worst had none. In between, the better-performing USCs had some doctor presence and a regular medical assistant in attendance, while poorer-performing USCs at least had a medical assistant present most of the week.

Apart from the use of political connections to attract resources, there were limited signs of managerial innovation in health. In the best facility, the RMO had established a protocol for assessing nurses' (but not doctors') performance. Health facility managers believe they have good information systems for assessing and monitoring the health of their user population, and it is true that immunisation and other public health targets are closely monitored. This success, however, throws into sharp relief the general failure to engage users or monitor patient satisfaction as a source of information about performance, as we will see below. Nowhere did we see any evidence of doctors' attendance or performance being subjected to any scrutiny or monitoring.

Education

At both primary and secondary level, rapid changes had come about in the wake of changes in management. We will see below how academic performance has been affected by changes in the SMC membership in some schools. Even more direct has been the impact of new head teacher appointments, re-affirming the vital role of the head teacher in school management identified by other studies. In the best primary school, the head teacher held a weekly staff meeting and monitored and discussed classroom performance daily with the teachers. The relationship between the teachers was mutually cooperative, and there was a clear, shared vision of how the school would improve. It emerged that they felt driven to perform as a team in part by community criticisms about the all-women teaching staff. Impressive gains had been made in terms of scholarship examination performance, and the head teacher made a point of crediting her colleagues with these achievements. The head teacher of another high-performing primary school also demonstrated innovations and performance-oriented management practices; particularly common among the more effective head teachers was the use of extra testing.

Management style in the worse primary and secondary schools was marked by the poor examples set by head teachers. In the poorest performing primary school in the sample, students reported regularly seeing their head teacher asleep at his house on their way to and from school. Also in the poorer performing schools, records were found to be kept meticulously, but were often falsified. This common practice in poor-performing schools makes the task of identifying quality particularly difficult. Staff morale was often lower in the worse schools, and suspicion about teacher corruption in the distribution of stipends tended to be higher. The head of one of the worse schools reported having plans for school improvement, but it was clear that these were not shared or discussed with other staff.

On paper, at least, the human resource endowments of all six primary schools are similar. In none were posts vacant, and in most cases, teachers were recorded as present more than 95% of the time. However, in the worse schools, staff were reportedly busy with

other activities. Teachers in non-government schools are most likely to be occupied with other income-earning work, particularly during agricultural high seasons. While teachers commonly report that the head teacher checks on their classroom performance, this was more meaningful and methodical in the better schools. In one high-performing school, teachers discuss classroom performance daily between shifts. In another, the head teacher observed teachers and then re-deployed them so that better teachers taught the lower grades instead of the higher ones, as is more usual. His reasoning was that it is more important to build a good educational foundation at the earlier stages.

In poor-performing primary schools, it is common to hear complaints about irregular teacher attendance, although this rarely shows up in records. Teachers may also send students on errands or in other ways waste class contact time. In one poor-performing school, teachers all live far away and are regularly late. High-performing schools, by contrast, emphasise promptness: in two, head teachers arrive at a fixed time before school starts, specifically to monitor teacher (and student) promptness. Early coaching sessions for the special scholarship student class also meant that other teachers were present early. School timetables were closely adhered to in these better schools.

At secondary level, the best non-government school had seen recent improvements in facilities: new furniture, fans and computers. These were all the result of efforts by the newly-installed SMC, working with the community, particularly the local bazaar committee. The worst of the three had basic but functional facilities, but its physical context plainly prevents better supervision by education officials: access is 8 km of dirt track, more easily but less safely reached by boat during the rainy season. The facilities of all three madrasahs were poor enough to significantly impede learning. However, there were signs of recent support from community members, local and national political actors, and the government to improve these facilities.

In some, but not all, of the better secondary schools, efforts to monitor and regulate teacher attendance were found. In the best of the madrasahs, the founder and *de facto* SMC head personally monitors teacher attendance, to good effect. In the worst government school, teachers were often absent, and in the average and worst non-government schools, teachers were reportedly occupied with other income-earning activities, particularly during high seasons for agricultural activity. In the worst non-government secondary school, the new head teacher lived far from the school, and lacked a personal relationship with the other teachers.

The information used to monitor progress in schools was, in most cases, narrowly focused on performance in particular examinations. Most schools seem to pay more attention to attendance than in the past, probably as a result of the incentives set up by the stipends programmes. In some of the worse cases, however, this seems to encourage falsification of records. Less managerial attention is devoted to wider issues of efficiency, such as drop-out or repetition. Even the head teacher of the best primary school was unclear about (or reluctant to discuss) progress on these issues.

Accountability

Part of the research design drew on the analytical framework for the *World Development Report 2004*, and focused on unearthing accountability mechanisms linking users, providers and policy makers (World Bank, 2004). We attempted to uncover the informal practices and relationships that create pressures for provision or improved quality among parents, students, teachers, officials and politicians. The facility-based nature of the research meant a naturally closer focus on the relationships most evident at that level. This section compares the relationships for accountability in better- and poorer-

performing schools and health facilities, focusing on the relationships at the facility level between users and providers, or the 'short route to accountability'[37]. It looks at both formal provision for user-participation in school management and at informal pressures to perform.

Schools and madrasahs

As other research has shown, Parent–Teacher Associations (PTAs) exist mainly on paper, and play little role in the management or governance of schools. We found no active PTAs and limited awareness of formal provision for such a body. In the best primary school, there was known to be a PTA committee, but parents were unclear about its role (see also CAMPE, 2005). But while PTAs are rarely formally constituted and rarely meet as a PTA, events to which parents are invited are often identified by school authorities as PTA meetings. It seems likely that they are also recorded as such. Schools to which parents are regularly invited for various purposes do gain at least some of the benefits of a formal PTA, which may help to explain why the SSPS picked up a positive relationship between PTAs and performance.

Information flows were mainly from the school to parents: instructions, invitations, requests for fees, etc. No signs were found of parent group action on school issues, although in a poor-performing school, a local demonstration against the corrupt head teacher had recently been held. A common response to questions about the PTA was that 'there isn't one here, but it would be a good thing.' Several groups of mothers commented that the focus group discussion session that we were holding with them as part of the research was the first time the PTA had ever met, and participants valued the opportunity to reflect on the quality of the school[38]. There is evidently parental interest in a greater role, but this is not well-served by provision for a PTA.

Why is parental participation so limited? One explanation is that there is already a reasonable flow of information between schools and parents, through formal and informal channels, including the ma shomabesh (mothers' meetings) and utthan boitok (courtyard discussions) that are still used by schools to reach women. It is also acceptable and expected that parents will occasionally visit the school to ask after their child's progress, although it seemed less common in some urban secondary schools and the madrasahs for mothers to do so. The SSPS found that parents of government primary students visited an average of five times per year, and those of non-government primary students three times.

On the other hand, we saw above that parents do not have clear ideas about quality or high expectations of their children's schools. This may be the result of lack of information or of a basis for comparison with 'good' schools. Closely supporting the qualitative findings, at secondary level, the SSPS found 'closeness' most often identified by parents of non-government school students as the main reason for selecting a particular school (45%), followed by 'quality' (37%). By contrast, a striking 84% of parents of government school students stated 'quality' as the main factor, while 45% of parents of students in dakhil madrasahs cited 'religion', a factor which was negligible for other types of school.

The strong positive response to our focus group discussions with mothers also suggests that parents may lack opportunities to reflect and become critically aware of the role they might play in schools, opportunities which they appear to value. There is certainly a social

[37] This draws on the analytical framework used in the *2004 World Development Report 'Making Services Work for Poor People'* (World Bank 2004).
[38] The ESTEEM action research (ESTEEM 2004) produced similar findings.

and educational gap between poorer parents who have had little schooling themselves, and their children who have. We found secondary school students who discouraged their parents from visiting; one girl indicated that she was embarrassed by the prospect of her unschooled mother talking to her teachers, although there may be other reasons behind this. An interesting related finding was that while no example of collective action by parents could be found, there were examples of students taking action (see Box 5).

A third explanation for why parents do not actively engage is that formal provision for a PTA does not take into account three social hierarchies poor parents, particularly women, would have to challenge or work through:

- Gender: all stakeholders readily admitted that women merit more representation at the school level because of their closer involvement with children's schooling. But in the secondary schools and madrasahs, it was felt that women's purdah and their innate 'shyness' at talking to strange men probably made any formal role impractical.

- Class and social difference between parents and teachers: while there has been a relative decline in teacher status, mainly because there are more educated and wealthier people in villages than before, teachers are still highly respected and authoritative people at the community level. This makes it difficult for parents, particularly uneducated poor women, to challenge their behaviour or performance. This issue is examined further below.

- Class, social and power differences between SMCs and parents. We turn to this next.

SMCs were designed to manage schools at a time when there were few educated villagers and authority was concentrated in the hands of the traditional landed elite. The SMC headship was a matter of respect, one of the honorary functions of traditional village elites. We can assume that elections for the SMC positions rarely occurred. The situation has changed, and education officials note that SMCs are not what they used to be: there are vastly more schools needing to be managed than before, which has created many more openings for SMC heads and members. Women still play virtually no role in SMCs, despite formal provision for at least one woman member. And these roles still go to those with authority and power, but this is increasingly the domain of local politics— the Union Parishad chairman, members or their supporters. SMC headship is prized as a rich source of political capital: those lobbying for SMC headship might be thinking of reviving or establishing a political career. There is also scope for corruption, although the richest pickings are in the non-government schools and madrasahs.

The growing role of local political competition in SMCs has advantages and disadvantages in terms of school performance. One disadvantage is that if it deteriorates from competition to conflict it can divert attention from school management[39]. All three non-government secondary schools and one madrasah experienced recent SMC-related competition, in some cases erupting into conflict. The non-government secondary school identified as the best had a strong SMC of recent vintage. The local bazaar committee chair, also a local Bangladesh Nationalist Party (BNP) leader, had become the leader of the SMC in 2004, through the unusual process of election. This had brought to an end a long battle for control of the school between his group and that of the local Awami League leader, who for 15 years had taken the lead role. Whether or not this ongoing conflict affected the school's quality in the past is not clear. What is clear is that its resolution had yielded rapid improvements in terms of material resources, monitoring of teacher

[39] Government secondary schools are treated as not having SMCs, although on paper, this should be composed of the DC and various other district officials and representatives. The more accessible government secondary schools do have visits from these officials, but neither the average nor the bad schools in this sample reported regular visits.

attendance, and academic performance. Morale seemed high in this school, the view being that things were getting better. It is not unrelated that the change in the SMC leadership was towards the ruling party: there are widely felt to be benefits available to well-connected SMC heads. In this particular case, the pressures on the SMC head to perform are a combination of electoral and parental: SMC members' own children attend the school. In fact, the SMC members with whom we spoke— all fathers of children in the school— felt that the strength of their presence meant there was no need for a PTA.

The average non-government school had unresolved SMC competition issues: the SMC head lived elsewhere, and disagreement had erupted over SMC efforts to appoint a less-qualified but well-connected teacher. The poor-performing non-government school SMC featured a local businessman whom informants reported as being on more than 20 SMCs; as we will see below, teacher recruitment in non-government schools is a major source of corruption. The madrasah classified as the worst featured both major political parties, in a friendly but ineffective SMC.

The best government primary school also experienced SMC competition, driven by a number of factors. The long-standing SMC head was abroad. Once his term had ended, overtures were made by the ex-chairman, whose land adjoins the school, for his relative to be selected for SMC headship. The objective appeared to be two-fold: to pave the relative's path into local politics, and because the ex-chairman had designs on the school's land, which suffered from insecure tenure as 'Enemy Property' land. Intimating that she was unhappy with this candidate, the head teacher took the unusual step of encouraging the father of a student to stand in as acting SMC head. He was reluctant, believing himself to be neither sufficiently educated nor wealthy enough to perform the customary functions of an SMC head. However, he was highly attentive to the problems of the school and a was daily visitor. During the period of his office, performance improved dramatically; this success had encouraged him to consider being a candidate for selection onto the SMC, despite his misgivings about his comparatively low status.

While intense competition can have both good and bad effects, at the other end of the scale the lack of competition over the SMC has also had negative effects. The management of a poor-performing non-government primary school had deteriorated to the extent that local people brought out a 'missil' (a procession) to protest corruption and other bad behaviour by the head teacher. The situation had deteriorated in large part because the SMC leader had been jailed for murder, rendering the SMC leaderless. In the worst primary school, the absence of any potential for competition was highlighted by the fact that SMC members and the head teacher were from the founding family - a clear illustration of how non-government schools are sometimes little more than extensions of the business portfolios of wealthy families. In the best madrasah, the SMC was ruled by the founder, a man with strong personal ambitions for the institution who lived close by, and who spent his time monitoring and lobbying for improvements. These efforts were paying off.

Box 5 Student collective action to improve school quality

In school S, the poorest performing of the non-government secondary schools in the sample, female students from several classes had gone together *en masse* to ask the head teacher to improve the mud floors of the classroom. They did not like the fact that their feet and clothes were always getting dirty. They said that if he did not respond to their request, they would make a formal application in writing. Within days a concrete floor had been laid. This success encouraged them to lobby for fans. In the best madrasah (A), students had collectively asked for class timetables to be adjusted, and lobbied successfully for a computer class. In the best government secondary school (RB), students had pressurised successfully for three new toilets. Also in that school, students report to the head teacher if their teachers are late or absent.

While there were no similar organised group actions found at the primary level, students are involved in the general maintenance and development of their school grounds. Some primary school students also reported monitoring their teachers' attendance.

Source: SSPQS.

Accountability relations are strongest at primary level between providers and policy makers. AUEOs, UEOs, DPEOs and stipend project officer, who are responsible for implementing policy, all play a role in monitoring school performance. The qualitative evidence suggests that the more inaccessible schools are likely to have less frequent supervision and to be of lower quality. However, this relationship is not perfect, as two of the poor-performing primary schools (GPS G and RNGPS MD in the comparative table) receive at least the average number of official visits.

The character of supervision clearly matters. Education officials interviewed for this research maintained that official record-keeping and keeping paperwork up to date were important features of good school management. This was treated as an important goal in itself, even in schools in which actual academic performance was below par and corruption rife. GPS G is an example of a school in which the head teacher was praised for good paperwork despite poor overall management. Some forms of supervision have clearly had a positive impact, however. Centrally-set policy goals, particularly those to do with raising the rate of class V scholarship examination participation and pass rates, appear to be highly effective as targets against which all stakeholders can and are beginning to monitor change. We found many schools and upazilas in which rapid gains had been made, and this early success seems to have energised additional action. Head teachers generally report receiving advice from UEOs and AUEOs on academic issues and on tactics for achieving these targets, typically extra coaching sessions and a separate 'scholarship class'. Such efforts are, it should be noted, at the expense of the schooling of the less academically-able children and of the poor, who are less likely to be able to afford extra coaching. DPEOs and UEOs were using figures on improving scholarship participation and pass rates to encourage competition among schools and area, as well as to monitor change.

Formally, DPEOs, UEOs and AUEOs help ensure financial accountability, primarily through monitoring teacher attendance (the single largest recurrent expenditure in a school being salary costs). AUEOs also monitor the records of students receiving the stipend. As we will see below, while procedures have been tightened up and leakage is likely to have declined in the stipend programme, it is evident that records are regularly 'adjusted', even if only slightly, to avoid penalising otherwise worthy beneficiaries. While the worst cases of outright corruption are found among the worse-performing schools, 'adjustments' to the records of stipend-holders and other forms of leakage also occur in high-performing schools. We found that education officials were making considerable efforts to cross-check

and to tackle these practices in schools, which were making it increasingly difficult for schools to cheat.

At secondary level, accountability pressures on teachers and head teachers are directly to the central Directorate in government schools. In non-government secondary schools, the main official source of pressure on head teachers and teachers is the Divisional Directorate, which formally agrees the MPO, releasing the government-portion of teacher salaries. The government official charged with overseeing secondary education at the district level is the District Education Officer (DEO). These officials typically share a building or compound with the DPEO, and the contrasts between them are striking. Whereas DPEOs are often busy individuals with considerable firsthand knowledge of the district's schools, DEOs are more often office-bound, frustrated by their lack of authority and power to act. Many are former secondary school head teachers. In terms of civil service status they are lower in rank and standing than secondary school head teachers, over whom they are nominally in a supervisory position. In practice, at both primary and secondary level, the authority of officials to withhold or delay teacher salary payments seems to curb the most flagrant neglect of duties, but does not seem to have much effect on quality beyond that. Teachers frequently report that the need to keep their jobs was a motivation in turning up regularly. Given that school records are falsifiable, however, this is not always a powerful incentive.

Many school authorities, in both high- and poor-performing schools, try to develop relationships with local and national politicians as a means of accessing charitable or official resources, official permission, and for the symbolic status. We have already seen that SMC membership is believed to bring valuable local political capital. The three madrasahs reported recent successes in attracting resources through politicians, while one non-government secondary school successfully manoeuvred to get the Pourashava to build a brick road by the school in return for taxes on its substantial lands. In two high-performing primary schools, local politicians regularly 'ask after' the school, playing a casual monitoring role without providing any material resources. At secondary level, party politics is in greater evidence, with MPs appearing in a number of supportive roles, often where they can link themselves to visible physical resources. Union Parishad members and chairmen are expected to take some interest in their local schools, but MPs are busy people with many more claims on their attention, so any support they give for local schools is lauded.

While there are positive elements to the role of politicians in school governance, there is a less savoury side, too. As we see below, the use of political connections is widely regarded by teachers and officials interviewed for this research as an important factor behind corruption in recruitment. Officials complain bitterly of this apparently unavoidable form of interference in their duties. Political influence is also used to gain student admissions in popular schools. In what had once been a high-performing school, the highly competitive admission procedure had reportedly been compromised when well-connected people began to use their political clout to gain admission.

Health

There is almost no effective formal provision for patient or community participation in the management or governance of health facilities. In one of the medium UHCs, the Local Level Plan was being followed in the form of a meeting to which some patient representatives were invited. In all other UHCs, the Upazila Health Services Improvement Committee was cited as the relevant group. This is officially chaired by the local MP, and is rarely more than ornamental. Meetings of this committee are usually recorded as occurring several times per year, but even casual questioning reveals that it is rare for

there to be more than one a year, and it is as often a formal function to honour the visit by the MP as it is a working group meeting.

Across the board, doctors and other service-providers rejected the view that systematic patient participation, even to provide feedback, was desirable or necessary. Reasons included that:

- Patients are mainly poor uneducated people who do not really understand medical issues.
- Nurses assert they already bear the brunt of patient complaints.
- The main complaint is that medicines fall short; facility staff can not address this.
- Facility staff are well-informed about patients' and the community's health needs through their own interactions and through health workers in the field.
- There are already adequate means of hearing patients' views: they can complain directly to doctors, nurses or to the RMO or UHFPO (patients also felt that they could, if necessary, complain directly to the boro daktar (the 'big doctor').
- Local elites (chairman, members) represent community views on the Health Services Improvement Committee; direct participation is not necessary.

Few doctors had considered the possibility of a formal structure to represent patients. In a rare case, an RMO drew the following unflattering comparison with SMCs:

> Yes, patients can contribute to some extent if they are involved. But there are also hazards in involving local people in management. For example, School Managing Committees (SMCs) were formed through this concept. But now the SMC is the most corrupt organ of the system. The members of the SMC are making money, taking up to Tk 50,000 for employing teachers. Similarly, if local people are engaged in the management of the UHC, they will ask for many undue advantages. Don't you know the character of our politicians?

These attitudes were surprising given that health policy reform debates have raised the issue of user complaints about doctor behaviour with the Medical Association (e.g. CIET, 2004; also Chaudhury and Hammer, 2003). Many considered the existence of a complaint box for receiving written complaints to be adequate, although one suggested the addition of a literate person to write the complaints, neatly underlining the gross inadequacy of such a procedure in this context.

These attitudes partly reflect the social distance between doctors and their patients. It may be difficult for doctors' prestige to accept that poor, rural patients might have the right, and indeed the formal means, to complain about their performance. Certainly, nurses reported finding this difficult to stomach, and their status is distinctly less elevated. But this distance is not insurmountable: once initial minor difficulties of communication, usually seen as differences in dialect, are overcome, patients and doctors seem able to communicate reasonably well.

This attitude also relates to how doctors view public services: those in rural posts widely believe that UHC outpatients are predominantly people for whom poverty, physical grind and malnutrition, rather than health service access, are the major determinants of health. They expect, and are provided with, a short free or subsidised consultation about common minor ailments, and free or subsidised medicines or vitamins. Of course, UHCs are equipped to do far more than this. But poor people (are assumed to) expect only this, and

that is, therefore, mainly what they receive. Within this reasoning, what, apart from medicine shortages, is there to complain about?

There are additional pressures on medical staff. Union Parishad representatives were found playing a positive role in some union facilities, but the overall low standard of service in these facilities does not indicate major success. In the best UHC, accountability pressures were being reasonably effectively exerted through: involvement and informal monitoring by the local elite family who had donated the land for the UHC; and a local youth club close to the facility, which had taken it upon itself to act as *de facto* complaints centre and to help poor patients get access to services. No NGOs were found working to represent patients' views.

Although MPs have a designated role in the management of upazila health services, their presence was only slightly more noticeable than in schools. The facility with the greatest MP involvement was that designated the worst performer. The current MP had close links with the UHC historically and reportedly helped transfer the UHFPO, a local man, back to the facility (he had been posted here previously). It is not clear whether this MP's role is positive or negative in terms of impact on quality, but he had helped the facility gain access to equipment and resources. MP backing also seems to give facility managers a sense of security, however, without which they may have felt pressures to perform more strongly. The second-worst facility also enjoys comparatively strong MP support: the UHFPO is related to the MP, who has even raised the UHC's problems in Parliament. The MP represents a minor opposition party, and has rarely been able to achieve much in the way of securing equipment from the Ministry. Nevertheless, his position seems to have contributed to the UHFPO's capacity to resist pressures from the police and other powerful locals. The best UHC, by contrast, had little MP involvement.

Knowing that formal mechanisms were likely to be weak or absent, we looked closely at the informal pressures to perform. We found that while doctors reject the notion of formal patient representation, they are in fact routinely subject to unregulated informal pressures, which sometimes expose them to risk. One is the routine, public grumbling of dissatisfied patients. The mass mode of consultation commonly practiced in UHCs provides dissatisfied patients with an audience and the potential to embarrass the service-provider into better performance. This can be observed quite readily, and our team collected a number of examples of such complaints. However, this was not always seen as 'complaining'. One patient (who had grumbled) asked, how could someone like her complain about people like that (government doctors, of high status)? This dissonance suggests that these informal complaints are tolerable because they do not directly challenge doctors' status or authority, even if they might occasionally yield a more attentive consultation.

The second pressure is the fear of violent attack. It does not seem to be well known that doctors believe such attacks to be reasonably common[40]. In the two worst facilities and in one of the better ones, attacks had happened in recent memory, in response to perceived medical negligence. In the worst facility, these were believed to be reasonably regular. In the best, there had in the past been protests against informal payments for services, but this was no longer an issue.

Threats are also present in the form of politically influential people, who exert strong pressures on UHFPOs and other UHC staff for favourable treatment and false injury certificates with which to sue opponents. One RMO noted that:

[40] In their study, Gruen *et al* (2002) also report doctors' fears about physical security in rural postings and of pressures from organised criminal networks.

> 'In some areas the political and the law and order situation is not very good. In those areas politicians and the local leaders ask for injury certificate. It is very difficult to work in such areas. Eventually the quality of service in those areas is not good.'

When asked about the advantages and disadvantages of local or national politicians becoming involved in facility, a Civil Surgeon noted that:

> 'There are some advantage and some disadvantages. The advantages are people listen to what they say, so they can make people understand many issues. The disadvantage is sometimes they create trouble for the service. Often they create chaos. They also ask for false injury certificate.'

A UHFPO in an area noted for its insecurity and crime explained that:

> 'In some areas local politicians try to dominate the UHC. Those UHCs can not perform well. We all know that political activity and terrorism are more in this part of the country. So we are also facing this. But it depends upon the UHFPO as well. The previous UHFPO used to allow the local politicians to come here. Who ever was a bit influential used to use his toilet, even. I strictly stopped these practices. Certainly everyone is allowed in my room, but for work, not for chatting or gossiping.'

Because they often lack knowledge of the community, doctors are not always aware when a patient they are treating is locally influential or not, and this reduces their worst behaviour. Whether or not doctors have had personal experience of such attacks, regular press reports of mob violence or attacks on private and public health facilities that result from medical negligence appear to have had an impact on reducing at least the worst excesses of neglect. It is a pressure that doctors themselves identify as influencing their behaviour for the better.

Relationships of accountability are weak throughout the health system, not least because of official provisions for upazila or district level officials (UHFPOs and Civil Surgeons) to discipline doctors are limited. This weakness was illustrated by the response by health facility managers to questions about how they motivate doctors: one explained, 'I ask and request everyone to work well', another said that he showed appreciation for their hard work. Formal procedures for disciplining bad behaviour are virtually non-existent.

6 Discussion and conclusions

A number of issues of relevance for policy and future research emerge from the qualitative research, particularly with respect to the definition and measurement of performance and quality in service-providing facilities, and the role of governance and management in the performance of social service delivery. We discuss these below.

There is little coherence about what constitutes quality and performance in schools and health facilities. Different stakeholders have different models of what constitutes quality, and therefore different priorities about what needs to change in order to bring about quality improvements in schools and health facilities. In part this reflects simple differences in how different actors interact with and are affected by the facilities. But in part it also demonstrates a lack of clarity or consensus about what a good performing school or health facility would look like, reflecting the lack of a shared sense of where the problems lie. While differences are likely to persist on these issues, some agreement among the key actors over the core priorities for action to improve performance and quality is likely to be necessary for bringing about any effective change. This is an area in which further research may be able to support the development of a more defined agenda on quality and performance in social service delivery.

Communities and service-users have expectations of education and health facilities—but these are low. An important broader implication of the findings of the qualitative research is that despite their low quality, the health and education facilities being studied here all provide services of varying degrees of value to user-communities. People use them, discuss them, rely to an extent on them, and have developed their own ways of registering complaint when they fall below locally acceptable minimum standards. In only one case, that of a union sub-centre, did we hear that the facility was so useless that it would be preferable to close it[41]. But while the facilities all provide services that people value, they all operate at a low level: all could raise the quality, and most the volume, of services provided. One implication of this is that local standards of relevance to local conditions and needs do appear to exist, but these are based on users' experiences of what the services it is realistic to expect. As such, the standards that are relevant for local users are probably lower than may be necessary to set targets for significant improvements in the quality and performance of facilities.

The quality and performance of facilities can change rapidly. In many of the facilities studied, changes had occurred in the one to two years since the SSPS surveys had taken place. Some of these changes showed up in commonly used performance indicators (for example, school performance in national examinations), while many others affected inputs or processes that can be expected to contribute to performance within the Heneveld-Craig framework. There were also policy shifts at the national level, such as the introduction of new recruitment and supervisory practices by government and new physical facilities and equipment. Much of the change was positive—more children passing more examinations, more equipment, beds and doctors, reported declines in some forms of corruption.

In many cases, this change was intentional, directed by facility managers, and oriented towards improvements in various dimensions of quality and performance. This included school-level arrangements for more teaching contact time, usually through stricter monitoring of teacher attendance or additional coaching sessions for prospective scholarship examinees. In other cases, change had come about because of personnel

[41] A local man said that the centre was a source of marital strife: women seek medical help and when they return without having received any, they take it out on their husbands.

changes, usually head teachers or new health facility managers. In some cases, changes in the governance of the facilities were having an impact on how effectively they were being run.

Although it is appropriate to highlight the extent of positive change because this was common in many of the facilities in the sample, the evidence for this change is qualitative and based on case-studies: as such, these changes should not be treated as evidence of a general trend towards improvement. One reason to avoid assuming a general trend towards improvement is that investments in physical facilities and increased recruitment of doctors and teachers in the last two years may reflect the timing of the research with respect to the electoral cycle: an election was due less than a year from the starting date of the field research. Another reason is that in some cases, change suggests vulnerability and sensitivity to changing inputs and circumstances, rather than general improvement.

Quality and performance are difficult to define and measure. The three findings about quality and performance discussed above contribute to a fourth: that quality and performance are difficult to define and to measure, even with good quality and varied data. Defining quality and performance is difficult partly because the need to take into account multiple stakeholders' views conflicts with the need for clarity about the core issues. A vital question is how to take into account parents' and patients' models of schools and health facilities when the expectations of both of these groups are so low that they could not serve as targets for facility improvement. And rapid change in inputs and processes associated with facility performance and quality make it difficult to compare the performance of facilities against each other and to specify the range of performance.

Other obstacles to the measurement of quality and performance include that commonly-used performance indicators focus on quality at the expense of volume (primary scholarship examination indicators) or on volume at the expense of quality (Upazila Health Complex outpatient figures). A further factor is that some institutions have strong incentives to falsify records, such as those used to assess student eligibility for stipends, and pharmacy records of the drugs distributed in health facilities.

One indicator that should be of use and should be taken into account in the assessment of quality is evidence that the facility has a strategy for its development and a plan for its implementation; this would signal that the facility possesses the drive and managerial capacity for performance improvements, as well as helping to capture the dynamic elements of performance.

Another factor to take into account in the definition and measurement of quality may be that 'quality' may depend to some extent on intangible factors such as levels of trust or good communication or established systems (including informal; see below) for accountability between service-users and –providers. These are not always obvious.

Formal accountability systems are weak. None of the formal accountability systems function as intended, and many do not function at all. In part this is because these systems typically depend on membership of formal committees; social hierarchies of class and gender deter poor parents or patients from seeking positions on such committees, or from complaining or making demands on higher status service providers through them. In practice, it seems to be primarily through the mediating role of community leaders or elected representatives that the interests of community members are represented in the formal committees that are supposed to ensure accountability. Where community leaders and elected representatives do not play this role effectively, there is little evidence of any regular effort to hold managers or head teachers to account for the performance of their facility. A number of incidents were documented in which extreme accountability failures within facilities had led to violent conflict.

Informal pressures were found help to ensure minimum levels of service provision, but it is not clear how effective or widespread these are. The research documented that in practice a variety of informal pressures are exerted on teachers, doctors and managers which encourage them to be more responsive to the needs of those they are supposed to serve. From what the research was able to detect, some of these pressures are exerted by service-users at the point of service delivery—students in class, patients in the consultation room. There is also evidence that community leaders and elected representatives may exert some effective pressures through channels that are not formalised, for example, when Union Parishad representatives unofficially monitor the presence of doctors in union health facilities.

One finding of the research was that communication between service-users and –providers was reasonably regular. One reason that communication between these groups is possible is that teachers and even doctors are not uniformly insulated or separate from the communities they serve, and many have personal social roots in those societies. It seems likely that these factors help to ensure at least a minimum degree of responsiveness to community needs.

Of all these informal pressures, the one that merits closest attention is the growing influence of local and national politics on facility performance. This appears to have had ambiguous impacts. What is clear is that the management and governance of health and education facilities have become matters of local political interest. Again, this finding may partly reflect the timing of the research: fieldwork took place less than one year before national and local elections. Some of the political interest in facility management is for the rents that may be gained, or in order to gain advantages against political rivals, through the sale of jobs in schools and the use of government doctors to issue false medical certificates against political rivals.

The unsavoury aspects of political interest in schools and hospitals are, however, mixed up with a somewhat healthier form of political competition. This is because there is substantial political capital to be had in being seen to support the development of a school or a health facility. Many of the facilities studied for the research have experienced some recent form of support or intervention from political actors. In most cases, this meant efforts to improve physical resources. In some cases, it meant that elected representatives have exerted pressures on service providers to be present or to perform. In other words, there are cases in which elected representatives have helped make local service-providers more accountable to service-users. Whether or not this is a significant aspect of facility performance given the weakness of formal accountability systems is not known, however.

Current policy discourse advocates the total exclusion of political actors from the governance of facilities, specifically in schools. Such an agenda may not be realistic, as formal exclusion is merely likely to lead to concealed forms of political influence. Given the findings of this study, the exclusion of political representatives may also reduce the scope for the informal accountability pressures that are currently exerted on teachers and doctors. Much is assumed about the role of politics in the governance of the social sectors, but the findings of the present research suggest this issue deserves to be looked at in more detail through more focused research.

Dominant perspectives on social sector human resource management are not likely to reflect the full range of the incentives of key workers. While it is widely assumed that private practice diminishes public service quality, the findings of this research were that the incentives to build private practice may create positive incentives for doctors to be present in rural facilities and to treat patients well. The research also found that high

social status of doctors and teachers was not a major factor in insulating them against the needs of the communities they serve, in large part because many have roots and connections in those communities. There are also signs of change in the social status of doctors and in particular teachers, as service-users clearly consider the social gap between them to be narrowing. A particularly important issue, given the growing number of women professionals in the social sector, is the significance of domestic and personal constraints on attendance and performance. Policies to address performance will need to take into account the gender dimensions of human resource management.

Successful action has been taken to tackle some forms of corruption and leakage in the social sectors. The weak governance of financial and human resources in the social sectors contributes to corruption, leakage and the abuse of influence, which in turn limit performance at the facility level. Informal charges or 'speed payments' tend to reduce incentives for officers to undertake field-level supervision, and corruption in recruitment is understood to have negative implications for the quality of teacher recruits, particularly in non government schools. However, there have also been attempts to tackle corruption and undue influence in public sector teacher recruitment, with some reported success. There also appears to have been significant successes in reducing leakage and corruption in the stipends programmes, although practices of falsifying records to ensure students who fail to meet programme criteria continue to receive the stipend still occur.

A second area where more information and analysis may be useful is in relation to the loss of public service time. This form of leakage has the most direct negative impact on service quality, because the amount of time spent by teachers and doctors on providing public services is a direct determinant of their performance.

A positive finding from the research was that higher authorities and to some extent communities have attempted to address aspects of corruption and leakage that affect service provision. Some actions documented in the report are little more than increased local scrutiny, perhaps the result of greater awareness of the extent of the problem, influenced by media coverage of these issues. As might be expected, facilities with stronger accountability mechanisms and more effective managers also tended to be those that had taken action to reduce corruption or leakage. But the most significant actions on corruption and leakage in both primary and secondary stipends programmes had been through the introduction of new programme regulations and practices. These had reportedly led to significant declines in corruption in these programmes. It is interesting to note that the research team could find no documentation of these efforts to tackle corruption in the social sectors. Successful actions at local or national level to address corruption deserve to be documented and widely disseminated for the benefit of other sectors and facilities.

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Annex

Figure A1 User and provider views on the features of good primary schools (including staff and students of ebtedayee sections of dakhil madrasahs studied)

Features of a good primary school		DPEOs	UEOs	AUEOs	Teachers	Students
Academic	High scholarship examination pass rates	■	■	■	■	
	Students study well / get high marks					■
	Many scholarships	■	■	■		■
	Use of teaching aids	■	■	■		
	Follow / complete curriculum	■	■	■		
	Teach love of country	■				
	Teach respect for parents					■
	Regular class tests	■	■	■		
	Homework is given					■
	Extra coaching for scholarship examination				■	■
	Help for weak students (educational and financial)	■	■	■		
Teacher characteristics	Teacher quality is good	■	■	■		■
	Teachers are well educated					■
	Teachers explain things well / follow up / make learning fun					■
Environment and facilities	Enough classrooms				■	■
	Fans				■	■
	Boundary wall / gate and guard				■	■
	Clean environment, garden and trees, Shaheed Minar	■	■			■
	Playground					■
	Clean, working toilets					
	Enough benches / tables and chairs in good repair					
	Tube-wells with good water (iron- and arsenic-free)					
	First aid available	■	■	■		
Management and supervision	Administration / paperwork is maintained properly	■				
	Teachers come on time / regularly		■	■	■	■
	Children come on time / regularly		■	■	■	■
	Good head teacher / leadership qualities		■	■		

Features of a good primary school		DPEOs	UEOs	AUEOs	Teachers	Students
Area characteristics	Close academic supervision		■	■	■	
	Planning, monitoring and feedback take place	■	■	■		
	Good examples set by head teacher	■	■			
	No vacant posts	■	■			
	Own income sources	■	■	■		
	Active SMC	■	■	■	■	
	Community involvement	■	■			
	Plenty of wealthy and educated people			■	■	
	School close to students' homes				■	■
	Communications / good roads	■	■	■	■	■
Other	Has a good reputation locally					
	Many students					
	Students receive the primary stipend*					
	Stipend selection criteria followed					
	Stipend payments made properly					

Source: SSPQS.
*Mentioned in ebtedayee sections of dakhil madrasahs where students are not eligible.

Figure A2 User and provider views on the features of good secondary schools

Features of a good secondary school		DEOs	Head teachers	Assistant teachers	Students
Academic	High pass rates / SSC / dakhil examination results	■	■	■	
	Good SSC results	■	■		■
	Get scholarships				
	Selective admission procedures / tests		■		
	Can study up to Alim level (madrasahs)				■
	Coaching for class and scholarship examinations				
Teacher characteristics	Active / honest and experienced head teacher	■	■	■	
	Teachers are trained in their subject	■	■		
	Teachers are graduates				
	Teachers are serious and focused / good teachers	■		■	
	Teachers explain things well				■
	Good teacher–student relations				■

Features of a good secondary school		DEOs	Head teachers	Assistant teachers	Students
	Women teachers available (to deal with female students' problems)	■			■
	Enough teachers for all classes				■
Student characteristics	Students focus on their studies				■
	Children finish homework at school	■			
	Many students		■		
Extra-curricular	Committed to teaching extra-curricular activities		■		
	Regular physical training (PT)				■
	Participate in national competitions		■		
	Fieldtrips / picnics				■
Management	Head teacher is a good manager	■		■	
	Teachers attend regularly and take classes on time	■			
	Students attend on time	■			
	Good relations between SMC and head teacher		■		
	Strict rules and regulations				
	SMC members should be educated			■	
	Active SMC			■	
Environment and facilities	Adequate furniture		■		
	Enough classrooms / to have sections		■		
	Library / with books		■		■
	Separate female students' and male students' common rooms		■		■
	Computer and computer room				■
	Nice classrooms				■
	Boundary wall				■
	Science laboratory				■
	Playing field and equipment				■
	Electricity and fans				■
	Separate toilet for female students				■
	Separate, partitioned seating for female and male students*		■		
	Tube-well with arsenic-free water				■
	Clean environment with a garden				■
	Newspapers are provided				■

Features of a good secondary school		DEOs	Head teachers	Assistant teachers	Students
Parental involvement	Parents take interest in children's progress	■			
	Good coordination / relations between parents / teachers	■			
Other	Accessible location, easy access			■	■
	Good reputation			■	
	Politics-free environment	■			
	Mandatory school uniform				■

Source: SSPQS.
* Mentioned in a madrasah.

Figure A3 User and provider views on the features of good union health facilities

Union sub-centres		Doctors	Medical Assistants	Community	Patients
Administration	Staff attend regularly	■	■	■	■
	Always open during office hours / patients can always get service	■		■	■
	Medicine does not get misused (healthy people do not take medicine claiming to be sick)	■		■	
	Sufficient medicine is available	■	■	■	
	Those responsible for providing services do so attentively and sincerely		■	■	
	There is supervision from the managing authorities			■	
Service quality	There are many patients	■	■	■	■
	Patients are treated well by from all hospital staff including doctors	■	■	■	■
	Doctors can motivate patients properly	■		■	
	Patients are given medicines properly	■		■	■
	Small operations can be performed	■		■	
	Information and health education about disease prevention is available		■	■	
	Get appropriate service and medicine is dispensed accordingly		■		
	Free medicine is given			■	■
	No money is given for treatment			■	■
	Quality of medicine is good				■
	First aid is given to urgent cases				■
	Can speak freely with doctors				■

Union sub-centres		Doctors	Medical Assistants	Community	Patients
	All staff come according to the office time				
	Treatment is available quickly				
Building and environment	Space for the doctors to sit				
	The building is in good condition				
	The facility is clean				
	There should be a signboard with the facility name				
	The surrounding area, trees, etc., should be kept nice				
	It should be easy for everyone to come, situated in a convenient location				
	Electricity, fans, water, etc., should be provided				
	Space for patients to sit				
	Arrangements for living quarters for doctors				
	Good toilets				
Other	Local youth leaders do not exert illegal or bad influence				
	A pharmacy close to the facility				
	Doctors are available 24 hours				
	Service is given without thinking about whether people are poor or wealthy				

Source: SSPQS.

Figure A4 User and provider views on the features of good upazila health complexes

Upazila Health Complexes		Doctors	Nurses	Community	Patients
Administration	All posts are filled				
	Those responsible for providing services do so attentively and sincerely				
	RMO, UHFPO take responsibility				
	Targets for programmes like IMCI and EPI are met				
	Emergency service always available				
	There are forms for the admission and discharge of (indoor) patients				
	There are enough official registers, stationery and other supplies				
	Doctors and other staff stay until the correct time				

Upazila Health Complexes		**Doctors**	**Nurses**	**Community**	**Patients**
Service quality	Doctors and nurses give free services sincerely	■	■	■	
	The number of indoor and outdoor patients should be proportionate to the population	■			■
	Doctors should give correct and proper service	■			
	Clean, many beds	■	■	■	■
	Many caesarean patients, people are aware	■			
	Genuine patients should get good treatment	■			
	Staff and workers behave well with patients	■	■	■	■
	Ambulance for patients		■	■	■
	Doctors and staff always available for emergency care		■	■	■
	Pathology equipment is available and working and services given free		■	■	■
	To explain things to new patients, a staff member is available at the gate		■		
	Good food is given to indoor patients		■	■	
	Medicine is given properly from the hospital to patients		■	■	
	A male and a female doctor are always available		■		
	Doctors and nurses are available as necessary		■		
	Orthopaedics, gynaecology, dental, tuberculosis (TB) / leprosy and ear nose and throat (ENT) departments		■	■	■
	Doctors and medicines are free			■	■
	All the medicines that a patient needs are given			■	■
	When a patient comes, service is given quickly, not delayed				■
	All kinds of operations are available			■	■
	Blood bank			■	
	Specialist doctors are available			■	
	Oxygen is available			■	
Building and environment	Good living quarters for doctors	■		■	■
	Electricity, water, fans, rubbish disposal	■		■	■
	Indoor and outdoor facilities kept clean	■	■	■	■
	Sufficient beds for patients	■			
	The ticket counter should be at the front instead of at the back	■			
	Good toilets for patients to use, because they need them		■	■	

Upazila Health Complexes		Doctors	Nurses	Community	Patients
	Big signboard with the name of the hospital on it				
	Seating for patients				
	Separate wards for children and other patients				
	Good seating for doctors				
	Natural environment should be well-maintained				
Other	Hospital bed linen should be clean				
	Doctors do not conduct private practice during opening hours				
	Separate ticket lines for men and women				
	There should be no separate arrangements for giving services and medicines to wealthy and poor				
	Doctors should always be available in the hospital's residence				
	Good communications for coming and going				
	Arrangements for health education for patients				
	Pharmaceutical company representatives do not interfere when patients are receiving treatment				

Source: SSPQS.

Table A1: Performance indicators for sampled facilities

Primary school sample	Attendance rate 1-5 2005 (%)	Combined SSPS test score Class 5 (%)	Repetition rate 2005 (%)	Performance ranking 1	Performance ranking 2
Government school 1	62	45	9	poor	8/67
Government school 2	82	49	10	average	43/67
Government school 3	91	65	4	high	64/67
SSPS average for all government schools	**76**	**52**	**11**	**-**	**-**
Registered non-government school 1	76	48	16	Poor	11/58
Registered non-government school 2	89	50	15	Average	39/58
Registered non-government school 3	88	56	1	High	57/58
SSPS average for all non-government schools	**77**	**46**	**10**	-	-
Ebtadayee section of dakhil madrasah 1	36	60	0	-	55/75
Ebtadayee section of dakhil madrasah 2	47	53	0	-	46/75
Ebtadayee section of dakhil madrasah 3	38	47	0	-	36/75
SSPS average for all secondary sections of dakhil madrasahs	**55**	**50**	**4**	-	-

Secondary school sample	Attendance rate 6-10 2004 %	Combined SSPS test score Class 9 %	Total 6-10 rep rate 2004 %	SSC pass rate 2004	Performance ranking 1	Performance ranking 2
Government school 1	51	82	13	64	poor	21/68
Government school 2	69	75	10	80	average	36/68
Government school 3	78	79	2	77	High	53/68
SSPS average for all government schools	**64**	**74**	**6**	**68**	-	-
Registered non-government school 1	60	52	9	29	poor	13/70
Registered non-government school 2	59	51	3	33	average	33/70
Registered non-government school 3	79	66	0	38	High	67/70
SSPS average for all non-government schools	**57**	**56**	**6**	**43**	-	-
Secondary section of dakhil madrasah 1	46	49	0	61	poor	9/33
Secondary section of dakhil madrasah 2	66	46	0	61	average	17/33
Secondary section of dakhil madrasah 3	61	83	0	83	high	30/33
SSPS average for all secondary sections of dakhil madrasahs	**63**	**54**	**2**	**52**	-	-

Primary health care sample	monthly outpatient figures per 1000 population	measles immunisation per 1000 U5 population	under 5 ARI contacts (absolute and per	Percentage of drug and regimen details appropriat e for	Performance ranking 1	Performance ranking 2

			capita)	sampled patients		
Upazila health complex 1	31	17	2	13	poor	4/61
Upazila health complex 2	33	18	2	25	poor	10/61
Upazila health complex 3	33	20	1	13	average	15/61
Upazila health complex 4	42	15	8	25	average	23/61
Upazila health complex 5	49	26	9	17	high	53/61
Upazila health complex 6	87	25	16	0	high	56/61
SSPS averages for all Upazila Health Complexes	**39**	**18**	**16**	**29**	-	-
Union facility 1	72	-	3	14	-	24/62
Union facility 2	64	-	20	38	-	54/62
Union facility 3	33	-	-	15	-	6/62
Union facility 4	75	-	7	67	-	55/62
Union facility 5	121	-	0	14	-	22/62
Union facility 6	55	-	63	6	-	39/62
SSPS average for all Union facilities with health services	**53**	**-**	**15**	**32**	-	-

Source: SSPQS.

Table A2 Comparing high- and poor-performing primary schools

SSPQS assessment (2006)	SSPS sample ranking (2005 data)	School	Academic performance	Management and supervision	Physical facilities	Teachers and teaching	Governance and accountability	Context / facility culture
High-performing	High-performing GPS	MS	High examination performance and attendance Low repetition rate	Above average visits from officials (10 km from UEO) Close academic supervision by head teacher Weekly staff meetings	Facilities poor but not noisy	Diverse teaching strategies Extra coaching for scholarship All-women staff	SMC head abroad SMC acting head active and attentive Local competition over SMC headship related to school land ownership	Students and teachers arrive early Community prefer men teachers The bamboo fence around the school garden was stolen
High-performing	Poor-performing RNGPS	MB	Average examination performance and attendance High repetition rate	Below average visits from officials (20 km from UEO)	Facilities poor but not noisy	Teaching aids used but conventional teaching methods Some use of homework to monitor progress	Monthly meetings with mothers SMC head active and attentive UP chairman slightly attentive	School located in village centre from which school is constantly monitored by community Students clean classrooms daily Community help with building materials, monitoring teachers Member uses grounds for shalish / bichar

SSPQS assessment (2006)	**SSPS sample ranking (2005 data)**	**School**	**Academic performance**	**Management and supervision**	**Physical facilities**	**Teachers and teaching**	**Governance and accountability**	**Context / facility culture**
High-performing	Average GPS	D	Above average official examination performance (rising since new head teacher), average in SSPS test Above average attendance and repetition	Above average visits from officials (13 km from UEO) Head teacher since 1999, plans class routines and teaching schedules with help of other teachers	Facilities poor but not noisy	Conventional teaching methods, but some use of homework to monitor progress Male teachers beat students regularly, particularly 'mastaan' students Stronger teachers in lower classes	UP chairman comes to discuss school issues regularly, but no financial help Fathers never visit school (outside the village) Mothers come for stipend SMC head and members are attentive, sometimes visiting before school opens to check on teachers' attendance	Students undertake school care, plant trees, buy items Very poor area

SSPQS assessment (2006)	**SSPS sample ranking (2005 data)**	**School**	**Academic performance**	**Management and supervision**	**Physical facilities**	**Teachers and teaching**	**Governance and accountability**	**Context / facility culture**
Poor-performing	Poor-performing GPS	G	Well below average examination performance Below average attendance Below average repetition	Above average visits from officials (5 km from UEO) Some academic supervision by head teacher	Toilets inadequate Classrooms in poor repair, noisy	Teaching aids used Some use of original methods Teachers not local; travel far Physical punishment rare	Parents informally monitor teacher attendance SMC head is attentive but employed elsewhere	Gets some help with teaching aids etc from local NGO
Poor-performing	Average RNGPS	MD	Average examination performance Above average attendance Above average repetition	No academic supervision by head teacher Average visits from officials (9 km from UEO)	Toilets inadequate Not noisy but classrooms in poor repair	Some use of homework to monitor progress, but teaching methods unimaginative	SMC head is in jail for murder Payments taken for school fund but no accounts available Local people brought out a 'missil' to protest head teacher corruption	Students planted a garden, but livestock spoiled it Particularly lawless area

SSPQS assessment (2006)	**SSPS sample ranking (2005 data)**	**School**	**Academic performance**	**Management and supervision**	**Physical facilities**	**Teachers and teaching**	**Governance and accountability**	**Context / facility culture**
Poor-performing	High-performing RNGPS	A	Average examination performance Above average attendance Low reported repetition	No academic supervision by head teacher Below average visits from officials (15 km from UEO) Head teacher busy with land, sets bad example (smokes biris, sleeps during school hours) Head teacher takes paperwork seriously	Not noisy and enough desks, but classrooms in poor repair One dirty broken toilet for students' use	Some teachers irregular, beat the children and solicit snacks	SMC head is head teacher's brother Founder family members employed as teachers in the school Informal payments previously charged for stipend	Previously help from community to buy trees, UP chairman for furniture MP helped with registration Less help from community now

Source: SSPQS.

Table A3a Comparing high-, poor-performing and average secondary schools: GSS

SSPQS assessment (2006)	Sample ranking (SSPS 2004)	School	Management and supervision	Academic performance	Physical facilities	Governance and accountability	Teachers and teaching	Other
High-performing	Average	RB	New well-connected head teacher since 2005 New, stricter rules and regulations	Above average academic Above average repetition rate Results and attendance improved over last 2 years	Well above average facilities New female students' hostel with MP support 2005 3 new laboratories over last 2 years	Reported payments for stipend MP is attentive	Teacher absenteeism low High reported levels of private tuition with schoolteachers	Municipal area Official use of school grounds but not by local people
Average	High-performing	RP	New head teacher (after 2004) Supervision by DD – focus on accounts / financial	Above average attendance and examination results Declined over last 2 years	Above average facilities	Official SMC members do not visit Links with pourashava chairman	Above average teacher vacancy rate High reported physical punishment	Municipal area Parents uninvolved, but students raise funds School grounds used for political and religious meetings
Poor-performing	Poor-performing	T	New head teacher since 2005	Below average examination and attendance rates (except SSPS test) High repetition rate (no data for 2006)	Basic facilities	Political interference blamed for decline in admission standards c. end 1990s	Below average in-service training Low teacher vacancy rate Teacher attendance erratic Students report	Metropolitan No extra-curricular activities Little parental involvement

SSPQS assessment (2006)	Sample ranking (SSPS 2004)	School	Management and supervision	Academic performance	Physical facilities	Governance and accountability	Teachers and teaching	Other
							universal private tuition (not with own teachers)	

Source: SSPQS.

Table A3b Comparing high-, poor-performing and average secondary schools: NGSS

SSPQS assessment (2006)	Sample ranking (SSPS 2004)	School	Management and supervision	Academic performance	Physical facilities	Governance and accountability	Teachers and teaching	other
High-performing	Poor-performing	M	Ex-student head teacher, in school for 38 years Tighter rules and regulations introduced through new SMC Occasional official visits	SSC pass rate gone from below to above average (2004–2005) Slightly high repetition	Average facilities Improving in last two years: new computers, tubewell, benches, fans	New SMC elected after 15 years Ex-student BNP union leader heads SMC Political affiliation changed from opposition to ruling party SMC members' children attend school Informal payments for stipend MP visited for pre-election support, not since	Written reports on student progress given Low reported levels of private tuition	Rural Accessible bazaar area Recent local donations of furniture, building materials

SSPQS assessment (2006)	Sample ranking (SSPS 2004)	School	Management and supervision	Academic performance	Physical facilities	Governance and accountability	Teachers and teaching	other
Average	Average	D	Head teacher for 11 years, in school 20 years Officials visit when complaints are made about teachers or SMC 42 km from district No SMC currently Head teacher lacks authority / SMC support to enforce teacher attendance	Below average academic and attendance SSC pass rate declining over three-year period	Below average facilities	Ex-SMC chair based in Dhaka Ongoing conflict between ex-SMC members, teachers SMC nepotism over teacher recruitment UNO intervened over teacher recruitment conflict Some assistance from MP	Above average teacher absenteeism Teachers busy with other income-earning activities High levels of private tuition from school teachers	Rural Only local secondary school MP arranged 10 tonnes of wheat (2004) UP chair arranged Tk 11,000 worth of repairs (2004) Various NGO interventions Parents uninvolved School grounds used for political meetings

SSPQS assessment (2006)	Sample ranking (SSPS 2004)	School	Management and supervision	Academic performance	Physical facilities	Governance and accountability	Teachers and teaching	other
Poor-performing	High-performing	S	2005 new head teacher lives far from school, not involved in community District officials last visited in 2000 (very remote)	Above average attendance and SSPS test scores Low and declining SSC pass rate	Average but basic facilities, not noisy	Local conflict involving head teacher – new head installed UP chair attentive, gave Tk 5,000 for building repairs UP member arranged tubewell repair SMC focused on collecting funds SMC head reportedly chairs more than 20 other SMCs, makes money on teacher appointments Reported payments for stipend	Low reported private tuition Teachers busy with other income-earning activities	Rural, 7–8 km kacha road MP arranged Tk 75,000 10 years ago Buildings used for flood shelter, for election purposes Local people used to help in-kind, but not since MPO registration Students make collective demands

Source: SSPQS.

Table A3c Comparing good, poor-performing and average secondary schools: Dakhil Madrasahs

SSPQS assessment (2006)	Sample ranking (SSPS 2004)	Madrasah	Management and supervision	Academic performance	Physical facilities	Governance and accountability	Teachers and teaching	Context / facility culture
High-performing	High-performing	A	District officials visit regularly (10 km from district) Daily supervision from founder (*de facto* SMC chair) AUEO visits occasionally (son is a student)	No science or commerce stream Above average SSPS and SSC scores (but declined in 2005)	Below average, noisy, but improving Two new computers since 2004	Effective SMC Personally run by founder *de facto* SMC chair who is on site daily	High reported private tuition with schoolteachers Teacher attendance highly regular English teacher is renowned in district	Rural but good connections Tk 50,000 raised from Govt fund for repairs, additional Tk 10,000 from coaching for Dakhil examinations Assistance given for poor students MP arranged 2 trucks of earth for playing field Parents uninvolved, very poor community

SSPQS assessment (2006)	Sample ranking (SSPS 2004)	Madrasah	Management and supervision	Academic performance	Physical facilities	Governance and accountability	Teachers and teaching	Context / facility culture
Average	Average	T	Occasional visits by district officials (11 km from district) Head teacher's father was SMC *de facto* chair	No science or commerce stream Above average SSC pass rates, rising to high (2005)[42] Below average SSPS test scores	Below average, noisy Toilets inadequate	SMC ineffective MP attentive when in area Teachers are members of the Jamayatul al-Mudasiyah organisation	Low reported private tuition	MP arranged for 2 tonnes of wheat to be sold for furniture, plans to provide stationery books, materials for repair Community help with cash, materials for repair, labour, lobbying officials Shop established by community to provide madrasah with regular income Local BNP leader helped with cash and kind Grounds used by locals for janaza

[42] The 2005 SSC pass rate was an impressive 91%, but this reflected the small number of candidates.

SSPQS assessment (2006)	Sample ranking (SSPS 2004)	Madrasah	Management and supervision	Academic performance	Physical facilities	Governance and accountability	Teachers and teaching	Context / facility culture
Poor-performing	Poor-performing	J	No visits from district officials (7 km from district) UNO visits rarely SMC monitors teacher attendance	No science or commerce stream Below average attendance but improved 2004–2005 SSC pass rates declined from average to poor (2004 to 2005)	Poor facilities, noisy	SMC of 2 years' standing SMC meetings usually take place in UNO's office SMC working to improve facilities, raise funds UP chairman is attentive, helped with repairs Previous 2 UP chairmen are SMC members SMC members are of different parties (AL) MP cannot do much, helps a little	High reported tuition	Rural Madrasah grounds used for political meetings, sports Community donate cash and skins of Eid sacrifices

Source: SSPQS.

Table A4 Comparing High- and poor-performing upazila health complexes

SSPQS assessment (2006)	Sample ranking (SSPS 2005 data)	UHC name	Performance* (SSPS 2005)	Management and supervision	Facilities and staff	Governance context and facility culture
Best	Average	A	Above average outpatient numbers Below average measles immunisation Below average appropriate regimen	Private practice not allowed on the premises RMO personally solicits contributions / assistance Format for monitoring nurses' performance	High doctor vacancy rates Good dental section Written prescriptions given X-ray, ambulance, emergency obstetric care (EOC), generator available	Remote area, security concerns Monitoring and support from local elite and community Donations received from abroad / local Area is otherwise badly-served for health care *De facto* complaint centre at local youth club
Medium	Poor-performing	SB	Low outpatient numbers Average measles immunisation Low appropriate regimen	Private practice allowed on premises before 9.00 am and after 1.00 pm; then only in doctors' quarters Political / police pressures on managers RMO is local	Expanded to 50-bed in 2002 Written prescriptions given Above average equipment / plant Four out of nine doctors' posts vacant Doctors longer than average duration in post	Meetings of the Local Level Plan for feedback from patients take place 'Courtyard meetings' held for communicating with people informally Chairman / members involved through Upazila Coordination Committee Comparatively remote area Security concerns Local MP is a minister, attentive and helpful when accessed

SSPQS assessment (2006)	Sample ranking (SSPS 2005 data)	UHC name	Performance* (SSPS 2005)	Management and supervision	Facilities and staff	Governance context and facility culture
						Recent episodes of violence when a child patient died
Medium	High-performing	SL	Average outpatient numbers High measles immunisation Low appropriate regimen	Busy private practice but offered after unofficial closing hours (1.00–1.30 pm)	Only four doctors in UHC; 5th deputised from union facility Doctors live in district town Electricity problems Expansion to 50-bed in progress Operating theatre, EOC facilities, anaesthetist available, X-ray and nebuliser are not	Easy access road Security concerns
Poor-performing	Average	B	Above average outpatient numbers Average measles immunisation Low appropriate regimen	Some private practice on premises UHFPO is from local elite; police / political pressure muted	Buildings in poor repair, roof leaks Junior doctors share a consultation room High vacancy rate till 2006: two new general doctors and one obstetrics and gynaecology doctor (2006) Ambulance, X-ray machine not working	UHFPO related to the MP MP attentive but lacks power. Helped arrange post-flood repairs Conflict between UHC staff and local political leader resulted in police case Episode of violence in last 2 years when a teacher patient died

SSPQS assessment (2006)	Sample ranking (SSPS 2005 data)	UHC name	Performance* (SSPS 2005)	Management and supervision	Facilities and staff	Governance context and facility culture
Very poor-performing	Poor-performing	M	Low outpatient numbers Average measles immunisation Average appropriate regimen	Private practice common at all times on premises	Low doctor vacancies 24 hour emergency services Above average equipment / plant EOC in place for 3 years Ambulance available Exansion to 50-bed in process	Community protests a regular feature in the past MP attentive, influences postings Pharmaceutical company representative operate on premises, advise on prescription Reputation for bhangchur Outpatients report payments for service, medicines not given Tk 2 charged for outpatient tickets

Source: SSPQS.
*Indicators used were:
Monthly outpatient per 1,000 population.
Measles immunisation per 1,000 under-5 population.
Percentage of drug and regimen details appropriate for sampled patients