PUBLIC PRIVATE PARTNERSHIP IN URBAN PRIMARY HEALTH CARE: A STUDY ON DHAKA CITY

THESIS SUBMITTED TO THE UNIVERSITY OF DHAKA FOR THE AWARD OF THE DEGREE OF MASTER OF PHILOSOPHY

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SESSION 2004-2005

DEPARTMENT OF PUBLIC ADMINISTRATION

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CERTIFICATE

It is a pleasure to me to certify that the thesis entitled "Public Private Partnership in Urban Primary Health care: A Study on Dhaka City" submitted by Mst. Shumshunnahar, for the award of the degree of Master of Philosophy, is her original research work. It is done by the candidate under my direct supervision.

I have gone through the work and found it satisfactory for submission to the Department of Public Administration, University of Dhaka, for the partial fulfillment of the requirements for the degree of Master of Philosophy in Public Administration.

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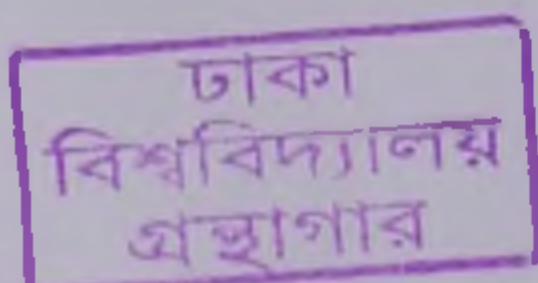

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DECLARATION

I Mst. Shumshunnahar, hereby declare that this thesis work "Public Private Partnership in Urban Primary Health Care: A Study on Dhaka City" has been originally carried out by me and under the guidance and supervision of Dr. Mobasser Monem, Professor, Department of Public Administration, University of Dhaka, Bangladesh. This work has not been submitted either in whole or in part for any degree at any university.

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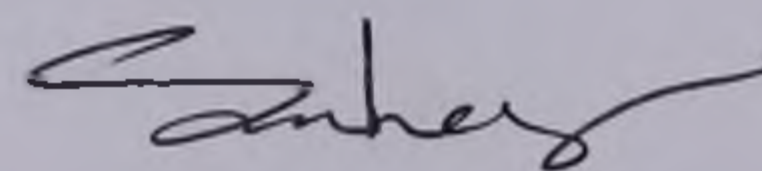

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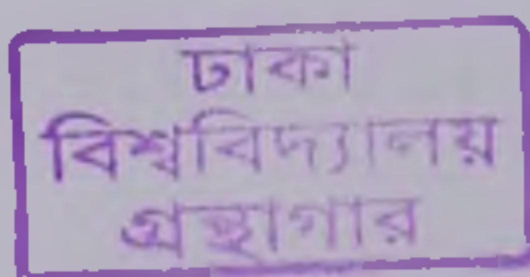
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ACKNOWLEDGEMENT

First and foremost I would like to express my heartiest gratitude to my supervisor, Dr. Mobasser Monem, Professor, Department of Public Administration, University of Dhaka for his tremendous help and encouragement with my study. I am highly indebted to him for his valuable advice and intellectual guidance throughout the period of my study. His comments and suggestions were very stimulating and developed my ideas to accomplish this study.

I would like to extend my gratitude and thanks to my honorable teachers Dr. Mohammad Mohabbat Khan, Professor Mahbubur Rahman, Dr. Ferdous Arfina Osman, Dr. Aka Firowz Ahmad, Dr. Musleh Uddin Ahmed. They all gave me the necessary guidelines and suggestions to carry out the study properly.

I would like to acknowledge the contribution of the respondents of this study who provided valuable information. The study would not have been possible without their support and co-operation

Last but not the least, I would like to thank my family for the constant inspiration that kept me focused and motivated.

Mst. Shumshunnahar

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ABSTRACT

Although, the introduction of PPP in Bangladesh is in experimental stage, its implication in health sector is remarkable. The aim of the government of Bangladesh behind building this partnership with the private sector in health care is to reach the poor and underserved sections of the population. On the other hand, the private sector of Bangladesh which is mostly unregulated has proved its effectiveness and has enormous potential in health care. Being the signatory of MDGs, Government of Bangladesh has made a substantial commitment to provide health care to its people in the best possible way and notable success has been achieved in the delivery of EPI, ORS, and family planning services by which Bangladesh is also received recognition internationally. Evidence indicates that, in many parts of Bangladesh, the private sector provides a large volume of health services but with little or no regulation.

The purpose of the study aimed to examine the current status of public private partnership in urban primary health care; to assess the effectiveness of public private partnership in urban primary health care; and to register the stakeholder's perception on public private partnership in urban primary health care. A comprehensive survey has been conducted over both service seekers and service providers to test the hypothesis. The data analysis approves that coverage area of PPP health centers is satisfactory, satisfaction of the service seekers is very high and responsiveness of the service providers is also good. Therefore, the survey verifies and substantiates the hypothesis about the effectiveness of PPP in urban primary health care. At the same time, survey shows that partnership with the private sector to provide health services to the poor has generated many challenges. These include the motives of the private sector, scope and objectives of partnership, policy and legal frameworks, benefits of such partnerships, technical and managerial capacity of governments and private agencies to manage and monitor such partnerships, incentives for the private sector, stakeholders' perspectives towards partnership, and explicit benefits to the urban poor through such partnerships.

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Public-Private Partnerships (PPPs) is a special feature of governance; it is an organizational innovation that allows for improved provision of public services with limited budget. Government of Bangladesh has achieved a remarkable progress in its health indicators particularly in terms of increased coverage of child immunization, decline of infant mortality rate, maternal mortality rate, total fertility rate and increase of contraceptive prevalence rate with the performance of collaborating of private. But still it has been struggling to achieve universal health coverage, removing the prevailing rural-urban and poor-rich health inequalities. Moreover, maternal and child malnutrition, lack of awareness of the poor urban patients and in sufficient technical and diagnosis problem of providers are the current challenges of the health services centers. This paper has found that the coverage of the PPP health centers in urban health primary health care both in terms of area and types of disease are wider and deeper than the privately and publicly owned health services.

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ACRONYMS

ABCN	Area Based Community Nutrition
ADB	Asian Development Bank
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BCC	Behavior Change Communication
BEES	Bangladesh Extension Education Services
BMDC	Bangladesh Medical and Dental Council
BOO	Build Own Operate
BOT	Build Operate Transfer
BPMPA	Bangladesh Private Medical Practitioners' Association
BRAC	Bangladesh Rural Advancement Committee
BTO	Build Transfer Operate
CARE	Cooperation for American Relief Everywhere
CBD	Community Based Distribution Programs
CBNC	Community Based Nutrition Component
CBNP	Community Based Nutrition Program
CBO	Community Based Organizations
CC	Community Clinics/Coordination Committee
CCMG	Community Clinic Management Group
CDC	Communicable Disease Control
CHF	Community Health Forum
CHS	Community based Health Schemes
CMYP	Comprehensive Multi Year Plan
CNC	Community Nutrition Clinic
CNOs	Community Nutrition Organizers
CNPs	Community Nutrition Programmers
DBFO	Design Build Finance and Operate
DBO	Design Build Operate
DCC	Dhaka City Corporation
DFID	Department for International Development
DGHS	Directorate General of Health Services

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ACRONYMS

DOTS	Directly Observed Treatment Short course
DSF	Demand Side Financing
DSK	Dhaka Shastho Kendro
EPI	Expanded Program on Immunization
ESD	Essential Service Delivery
ESP	Essential Service Package
FGD	Focused Group Discussion
FPSTC	Family Planning Services and Training Centres
FWA	Family Welfare Assistant
FWVs	Family Welfare Visitors
GAVI	Global Alliance for Vaccine and Immunization
GDP	Gross Domestic Product
GMP	Growth Monitoring and Promotion
GoB	Government of Bangladesh
GPs	General Practitioners'
HA	Health Assistant
HEED	Health Education and Economic Development
HNPSP	Health Nutrition and Population Sector Program
HPSP	Health and Population Sector Program
HPSS	Health and Population Sector Strategy
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IEC	Information Education and Communication
IMED	Implementation Monitoring and Evaluation Division
IMR	Infant Mortality Rate
JICA	Japan International Cooperation Agency
LCC	Limited Curative Care
MCH	Maternal and Child Health
MIS	Management Information System
MMR	Maternal Mortality Rate

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ACRONYMS

MOCS	Medical Officer Civil Surgeon
MoHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
NATAB	National Anti Tuberculosis Association of Bangladesh
NGO	Non Governmental Organization
NIDS	National Immunization Days
NIPHP	National Integrated Population and Health Program
NNP	Net National Product
NSDP	NGO Service Delivery Program
ORS	Oral Dehydration Solution
PHC	Primary Health Care
PLW	Pregnant and Lactating Women
PMU	Project Management Unit
PR	Principal Receipts
RDF	Revolving Drug Fund
RDRS	Rangpur Dinajpur Rural Services
RH	Reproductive Health
RTI	Reproductive Tract Infection
SARD	Society for Action Research and Development
SDS	Service Delivery Survey
SF	Supplementary Feeding
SGS	Southern Gonounnayan Somity
SHED	Society for Health Extension and Development
SIDA	Swedish International Development Cooperation Agency
SMC	Social Marketing Committee
STD	Sexually Transmitted Diseases
SWAP	Sector Wide Approach
TB	Tuberculosis Bacillus
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate

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ACRONYMS

TLMB	The Leprosy Mission Bangladesh
TMSS	Thangamara Mohila Shobuj Shongho
TOR	Terms of Reference
U5MR	Under 5 Mortality Rate
UFPO	Upazila Family Planning Officer
UHCs	Upazila Health Complexes
UHFPO	Upazila Health and Family Planning Officer
UHFWCs	Union Health and Family Welfare Centers
UJMS	Uttarayaon Janakallayan Mahila Shamity
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens Fund
UPHCP	Urban Primary Health Care Project
VARD	Voluntary Association for Rural Development
VHSS	Voluntary Health Services and Society
VOSD	Voluntary Organization for Social Development
WASA	Water and Sewerage Authority
WB	World Bank
WDR	World Development Report
WHO	World Health Organization

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Chapter One: Introduction

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1.4 Rationale of the study

1.5 Hypothesis

1.6 Methodology

1.7 Area of the study

1.8 Limitation of the study

1.9 Techniques of Data Analysis

1.10 Literature Review

1.1 Introduction

Government of Bangladesh has made a substantial commitment to provide health care to its people in best possible way. Notable success has been made in the delivery of EPI, ORS, sanitation and family planning services for which Bangladesh is internationally recognized. The national development plans laid out the foundations for comprehensive delivery of a wide variety of Health and Family Planning services through a package in urban and rural areas. However, for a period of time, there was proportionately less than optimum investment in the primary health care services for the urban poor and slum dwellers to meet those priority needs. Moreover, deficiencies in the public sector health system in providing health services to the urban population are well documented.

The inability of the public health sector has forced poor and deprived sections of the population to seek health services from the private sector. Evidence indicates that, in many parts of Bangladesh, the private sector provides a large volume of health services but with little or no

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regulation (Rajasulochana and Dash…). The private sector is not only Bangladesh's most unregulated sector but also its most potent and untapped sector. To address the inefficiency and inequity in the health system, many state governments have undertaken health sector reforms. One of these reforms has been to collaborate with the private sector through Public-Private Partnership (PPP).

State governments in Bangladesh are experimenting with partnerships with the private sector to reach the poor and underserved sections of the population. Collaboration with the private sector to provide health services to the poor has generated many challenges. These include the motives of the private sector, scope and objectives of partnership, policy and legal frameworks, benefits of such partnerships, technical and managerial capacity of governments and private agencies to manage and monitor such partnerships, incentives for the private sector, stakeholders' perspectives towards partnership, and explicit benefits to the poor through such partnerships (Rajasulochana and Dash…).

Public-Private Partnerships (PPPs) is a special feature of governance; it is an organizational innovation that allows for improved provision of public services with limited budget, by tapping the financial, technical and outreach-related strengths of the private sector. Under a PPP, a local authority or a central-government agency enters a long term contractual agreement with a private supplier for the construction of public infrastructure or the delivery of a public service, such that resources, risks and rewards are optimally shared among the partners. PPPs have emerged as a policy option in the health sector in the recent decades, mainly on two grounds, shrinking budgetary support for the health sector, and therefore a search for other sources for funding and dominance of neoliberal ideas, such as NPM in the ongoing health sector reforms.

Several authors have documented PPPs encountered in practice in the health sector and the associated benefits and risks. These works have discussed the practical issues in the implementation of the PPPs and laid down pre-conditions to be met: the presence of adequate legal and judicial frameworks or sufficient capacity to introduce and manage these types of projects (ADBI 2000; Ahmed 2000; Bennett and Muraleedharan 2000; Bhat 2001; Asto, Cummings and McLean 2004; Nikolic and Maikisch 2006). Some authors have discussed economics behind PPPs as it applies to physical infrastructure or to construction sector (Bettingnies& Ross 2004; Iossa & Martimort 2008; Estache, Iimi& Ruzzier 2009). Very few

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papers throw light on how economic concepts and principles can guide objectively the public sector while entering into such partnerships in the health sector taking into accounts its unique features and complexities.

1.2 Background of the study

By 1990s, the pursuit of governance assumed a central position in development discourse whereby the litany of underdevelopment was termed as a crisis of governance. "Governance" has been defined as "the manner in which power is exercised in the management of a country's economic and social resources for development." Governance has also been referred to as "the institutional environment in which citizens interact among themselves and with government agencies or officials" to achieve desired development objectives. Critics have referred to governance conceptualization as a "democratic capitalist regime, presided over by a minimal state" and in view of the strong influences of Western liberal and social democracy, it has been termed as the "focal concern and teleological terminus of much modernization theory" (Rajasulochana and Dash, ...)

Nevertheless, since the 1990s, policy makers and practitioners have been looking for solutions whereby the enigma of development could be unlocked and understood particularly in terms of poverty reduction and improving human development indicators. Since then, concerted efforts to establish linkages between governance and growth, poverty and institutional performance—defined by the analytical tools and instruments of New Institutional Economics—have led to mixed and contested empirical evidence. Cross-country comparisons and 'unbundling' of governance components such as rule of law, voice and accountability, corruption control and state capture, have indicated that a greater focus on external accountability can lead to improved governance (Rajasulochana and Dash, ...). Debates on public services and market-friendly growth strategies have also highlighted the need of an effective state and citizen empowerment. For instance, the 2001 World Development Report (WDR) and World Bank's empowerment framework recognize accountability as an integral component of 'empowerment'.

As part of structural adjustment programs, development assistance in the 1980s shifted from financing investments to promoting policy reform. The change was a result of an increasing awareness that developing countries had been weighed down more by poor policies than by lack

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of finance for investment. After more than 20 years of experience with policy-based or conditional lending, desired development outcomes have not always been achieved. Many studies of adjustment programs conclude that policy-based lending works if countries initiated and owned the reform program (Rajasulochana and Dash.). Studies also suggest that international financing institutions must "do a better job of understanding which environments are promising for reform and which are not" (Dollar and Swenson 1998).

The advent of neo liberalism has similarly fallen short of expectations. In Latin America, for instance, countries that implemented neoliberal development policies and reforms (marked by tighter fiscal and monetary policies, more independent central banks, indiscriminate opening to international trade and investment, and privatization of public enterprises) showed the "worst long-term growth failure in more than a hundred years" (Weisbrot 2007). In contrast, countries which opposed neo liberalism and introduced new economic policies have performed somewhat better. Many developing countries in Asia have been similarly adversely affected by conditional lending programs and neoliberal development policies. Their poor fiscal positions were aggravated by the Asian financial crisis.

However, the Asian crisis of 1997 was to spur a new round of debate on state role, improved regulation and putting governance at the centre of development interventions once again. Concurrently, the governments strived to involve and at the same time regulate the non-state actors in the provision of public services. The liberal governance agenda shifted its focus on the poor again and informed by experiences and lessons from several developing countries, a new emphasis on accountability emerged that was best illustrated by WDR, 2004. The need for strengthening accountability relationships between policy makers, service providers, and clients is at the core of the 2004 WDR approach to "making services work for the poor." In a mutually informing and accountable relationship, the 'governance relationship' of partnership and accountability lies between key actors: citizens and clients; politicians and policymakers; and service providers(Rajasulochana and Dash, ...).

There is a growing belief that fostering a partnership between the public sector and the private sector would improve equity, efficiency, accountability, quality and accessibility of the entire health system. Advocates argue that the public and private sectors can potentially gain from one another in the form of resources, technology, knowledge and skills, management practices, cost

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efficiency and even a make-over of their respective images(ADBI 2000). Although widely used, there is no universally accepted definition for PPPs. Yet as a general term, partnership is often used to describe a range of inter-organizational relationships and collaborations. Two useful definitions of PPPs are: "......means to bring together a set of actors for the common goal of improving the health of a population based on the mutually agreed roles and principles" (WHO 1999). "......refers to a variety of co-operative arrangements between the government and private sector. It is a method of involving the private sector in delivering public goods or services and/or securing the use of assets necessary to deliver public services.

Partnerships also provide a vehicle for coordinating with non-governmental actor to undertake integrated, comprehensive efforts to meet community needs. The structure of the partnership varies to take advantage of the expertise of each partner, so that resources, risks and rewards can be allocated in a way that best meets clearly defined public needs"(Axelsson, Bustreo and Harding 2003). Thus, these definitions highlight three core elements of PPPs: autonomy of each partner, mutual commitment to agreed objectives, and mutual benefit for the stakeholders. Often the PPP concept is misconstrued as an attempt at privatization, especially in the context of increasing private participation in the public health system. Nevertheless, there are significant differences between PPP and privatization. In PPPs, the public and private providers (for profit private entities, not for profit private organizations, community-based organizations, social groups etc) share costs, revenues and responsibilities. Privatization represents the transfer of tasks and responsibilities to the private sector, with both costs and revenues being in private hands. In fact, PPPs describe a range of possible relationships among public and private entities in the continuum between nationalization and privatization, depending upon the objectives they seek to achieve (Rajasulochana and Dash, ...).

PPPs in advanced countries emerged in the 1980s under the Reagan and Thatcher administrations for urban development (Beauregard 1998). The relative success of such approach in delivering urban infrastructure gave way to wider replication in the South based on the market efficiency mantra. Much like the UNDP example cited above, most bilateral and multilateral development agencies consider PPPs as the solution to meet the growing requirements for public services in the rapidly urbanizing cities (World Bank 1997).

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1.3 Objective of the Study

The objectives of the study are the following:

1. To examine the current status of public private partnership in urban primary health care in Dhaka city.
2. To register the stakeholders perception on public private partnership in urban primary health care.
3. To assess the effectiveness of public private partnership in urban primary health care in Dhaka city.

1.4 Rationale of the study

Even though the government is spending Tk 100 crore on an average every year under the Urban Primary Health Care Project, essential healthcare is a far cry for slum and pavement dwellers. Many street dwellers in the capital are deprived of the government's primary health services like taking care of communicable diseases, reproductive health of women, and child care. A study by the International Centre for Diarrhoea Disease Research, Bangladesh (ICDDRB), on 4,000 street dwellers last year, found that nine percent of the child deliveries occurred in their pavement huts. The figure was much higher at 59 percent in 2008 when ICDDRB intervened with its urban health care project. The study showed that slum and street dwellers account for over 30 percent of Dhaka city's more than 10 million populations.

Health experts found the government's urban health care system inadequate and faulty. They said there is a lack of proper planning in the Urban Primary Health Care Project (UPHCP), which is run by the Local Government Division. The working hours of the health centers do not suit the slum dwellers. "Most of the slum and street dwellers have limited access to health care because the centres open after they go out to work and close by the time they are back to their huts," observed by one of the Health Systems scientist at ICDDRB. According to Dhaka City Corporation (DCC), about 75 percent of the urban populations in the country are out of the government's primary health care service, as the service mechanism for urban people is still inadequate and neglected. The Local Government Division looks after urban health care, but it can cover only one fourth of the four crore Dhaka city populations for a lack of manpower, money and infrastructure, sources close to UPHCP.

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UPHCP health services are limited to only six city corporations and five municipalities, which have only seven percent of the country's total population, UPHCP Project Director told The Daily Star. UPHCP provides services in reproductive health care, child health care, and communicable diseases control. It provides limited curative care only in Bogra, Comilla, Sirajganj, Madhobdi and Savar municipalities and six city corporations. The remaining 104 municipalities are out of UPHCP service network.

According to Bangladesh Urban Health Survey 2006, childhood malnutrition is high among slum population. Almost 50 percent of slum children are underweight compared to 28 percent outside the slums. It said over 56 percent of the slum children are stunted or suffer from chronic malnutrition.

The health infrastructure of the country was built centering the rural people 30 years back when urbanization was slow. It is now time to focus on health services of urban people as more people are migrating to the cities, experts said. The country's urban population is expected to grow by 3.42 percent between 2010 and 2015, according to the World Urbanization Prospects: 2007 Revision Population Database of the United Nations Population Division. This is higher than what is projected in rural population growth at a rate of 78 percent. By 2050, urban people will account for over 56 percent of the country's total population, up from 30 percent today; experts said quoting the United Nations Population Division.

1.5 Hypothesis

The hypothesis of the study is that "The service provided by the Public-Private Partnership (PPP) in urban primary health care is very effective in Bangladesh".

1.6 Methodology

The study will be based both on primary and secondary sources. Primary data will be gathered through structured questionnaire and Secondary data will be gathered from the published literature. Data and information will also be collected through interviews of both the service seekers and the service providers. Moreover, Focus Group Discussion (FGD) would be conducted with the stakeholders

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1.7 Area of the study

Dhaka city is the study area of this research. There are several NGO,s who are in partnership with the govt. of Bangladesh for delivering health services for the urban people of Dhaka city. Under Dhaka City Corporation (DCC), the NGO partners are Bangladesh Women's Health Coalition (BWHC), Bangladesh Association for Prevention of Septic Abortion (BAPSA), Population Services and Training Centers (PSTC), Shimantik, Narimaitree, Marie Stopes Clinic Society (MSCS), Unity Through Population Services (UTPS), Progoti Samaj Kallayan Protisthan (PSKP). All the Mentioned NGO,s are delivering their health services specific area wise. And the areas are old Dhaka, Mohammadrpur, Lalmatia, Hajaribag, Mouchak, Magbazar, Mirpur, Shayamoli, Kallayanpur, Paikpara.

1.8 Limitation of the study

Social research dealing with the human sciences has some obstacles. This study was conducted to assess the present status, perceptions and effectiveness of PPP in urban primary health care only in Dhaka city. A small sample of 100 (50 service seekers and 50 service providers) respondents have been chosen for the study due to time and resource constraints. Besides, some respondents were hesitant, and some were reluctant to answer some certain issues like income, health facilities and access, problems etc. After persuasion of the discussion and explanation they personated me t o carry out the conversation.

1.9 Techniques of Data Analysis

The purpose of the data analysis is to provide the research questions or the objectives. The results of the study interpreted according to the univariate (single variable). This univariate presentation is consist of simply saying what the data look like, signifying primarily the extent of a particular phenomenon or event.

The collected data of this research are mainly of qualitative. Almost all the collected information organized, analyzed and presented with the use of Statistical Package for Social Scientist (SPSS). By the SPSS Program the raw data has been processed and at the same time it used to analyze data.

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1.10 Literature Review

Public sector management reform is a live issue in many countries, and will continue to be, so long as governments continue to seek ways of modernising their public administration systems, to improve service delivery, respond to domestic external pressures and meet the challenges of globalisation. This search for new methods of producing and delivering public services, among other reasons, has brought about new concepts such as new public management (NPM), which focuses on the use of market-type mechanisms associated with the private sector to bring about changes in the management of public services.

Privatisation, and public-private partnerships (PPP), fall within this NPM framework as alternative service delivery arrangements to traditional public procurement. The term privatisation has become muddied over the years and conjures up different images in different parts of the world and subsequently for different academics. In Europe and the former Soviet Socialist Republics, privatisation refers to the selling of state-owned enterprises. In the USA, the term is more generic, an umbrella term covering all private sector involvement, including outsourcing and PPPs.

Some scholars have differentiated between outsourcing (contracting out); privatisation and PPPs, arguing that contracting out and privatisation are at opposite ends of the spectrum of private versus public involvement, with PPPs somewhere in-between. Arguably, there are significant differences between the three forms of alternative service delivery. A typical contracting out involves a private-sector party providing commercially a service previously provided by the public sector itself. There is little transfer of control or risk to the private sector, and no substantive private sector involvement in decision making. In contrast, to be a PPP, an arrangement would typically be characterised by some devolution of control and authority to the private sector, as well as private sector participation in decision making. In addition the private-sector partner would likely be a provider of capital assets as well as a provider of services.

The difference between full privatisation and a PPP arrangement is that in a PPP the public sector retains a substantial role while in privatisation subsequent government involvement is minimal unless regulation of the post-privatised entity is necessary. According to Savas privatisation is the act of reducing the role of government or increasing the role of other

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institutions of society in producing goods and services and in owning property. What this does is change the portfolio of activities carried out by the government, thus reducing the size of the public sector. The argument is therefore that NPM is about how to improve the management of activities that remain under public ownership by applying private sector practices, and as such, outright privatisation should be left out of PPP discussions.

For the purpose of this review, the term public-private partnership will represent the full spectrum of public and private collaboration; privatisation and contracting out are treated as forms of PPPs. The diagram below illustrates the scale of public-private partnerships considered in the review. Private sector involvement in the delivery of public services is not a new concept; PPPs have been used for over three decades, predating the contracting out initiatives of 1970s in the USA. Initially focussing on economic infrastructure, PPPs have evolved to include the procurement of social infrastructure assets and associated non-core services. PPPs have extended to housing, health, corrective facilities, energy, water, and waste treatment.

PPP policy has also evolved globally as public sectors develop the necessary skill base to procure infrastructure by way of PPP, including the capacity to create and maintain a regulatory framework. The private sector has also become increasingly innovative in several experienced countries, thereby adding significant value to public procurement. The UK has been a modern instigator of this wave of private sector involvement, with the introduction of the Private Finance Initiative (PFI). PFIs have been used to develop and deliver all manner of infrastructure and services and now represent 10 to 13% of all UK investment in public infrastructure; close to 100 PFI projects are initiated or completed per year (Palmer, 2009)

The growing use of PFIs has inspired governments worldwide to adopt PPP arrangements. The Australian government has used PPPs to deliver several social infrastructure projects; Ireland has used them for transport infrastructure; in the Netherlands, social housing and urban regeneration programs have been delivered through PPP arrangements; India is investing heavily in highways through PPPs; Japan has around 20 new PPPs in the pipeline; in Canada, 20% of new infrastructure are designed, built and operated by the private sector; the USA is a pioneer with contracting out and have started experimenting with other forms of PPPs; emerging democracies from central Europe are also following suit. The former Prime Minister of Czech Republic, Jiri Paroublek, explains that "just like any other market economy, we are trying to multiply *our*

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economic potential and implement projects for which the public sector alone has neither the strength nor the resources" (Palmer, 2009)

.In developing countries, contracting out was introduced in the mid 1980s during the first wave of governmental privatisation of state enterprises, under structural adjustment programs. Policies were adopted to address the perceived lack of managerial capacity in government, as well as the need to stop the continued dependence of state enterprises on state subsidies. According to Deloitte, in Africa, between 1990 and 2004, approximately 14% of public sector infrastructure was provided through a PPP, the most common sectors being water, energy and transport (Palmer, 2009). The PPP trend is global, accelerating and encompassing a broad range of infrastructure sectors. Applying PPPs in social infrastructure sectors has to some extent reduced the concentration of PPP projects at the central government level. Increasing number local authorities are engaging in PPP arrangements to procure much needed local infrastructure.

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Chapter Two: Public-Private Partnership: Theories and Dimensions

2.1 Introduction

2.2 Theories and Dimensions of PPP

2.2.1 Service **contracts;**

2.2.2 Management **contracts;**

2.2.3 Concessions;

2.2.4 Build–**operate–transfer (BOT) and similar arrangements;**

2.2.5 Joint **ventures.**

2.2.6 Hybrid Arrangment

2.1 Introduction:

Although the concept of PPP is widely used, no definition is universally accepted for PPPs. But for the sake of better understanding the word partnership is often used to describe a range of inter-organizational relationships and collaborations. Following are the two operational definitions of PPPs:

"......means to bring together a set of actors for the common goal of improving the health of a population based on the mutually agreed roles and principles" (WHO 1999).

"......refers to a variety of co-operative arrangements between the government and private sector. It is a method of involving the private sector in delivering public goods or services and/or securing the use of assets necessary to deliver public services. Partnerships also provide a vehicle for coordinating with non-governmental actor to undertake integrated, comprehensive efforts to meet community needs. The structure of the partnership varies to take advantage of the expertise of each partner, so that resources, risks and rewards can be allocated in a way that best meets clearly defined public needs" (Axelsson, Bustreo and Harding 2003).

These definitions focus on three core elements of PPPs: autonomy of each partner, mutual commitment to agreed objectives, and mutual benefit for the stakeholders. Often the PPP concept is often misconstrued as an attempt at privatization, especially in the context of increasing

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private participation in the public health system. However, there are significant differences between PPP and privatization. In PPPs, the public and private providers (for profit private entities, not for profit private organizations, community-based organizations, social groups etc) share costs, revenues and responsibilities. Privatization represents the transfer of tasks and responsibilities to the private sector, with both costs and revenues being in private hands. In fact, PPPs describe a 'range of possible relationships' among public and private entities 'in the continuum between nationalization and privatization' depending upon the objectives they seek to achieve:

In all the PPP models, 'contract' has been the most common form of partnership all over the world. It could be claimed that the private sector has always been engaged in many parts of the provision of public services, so what is so new about contracting under PPPs? Now any project to create goods and services can be roughly broken down into four "tasks": 1. defining and designing the project, 2. financing the capital costs of the project, 3. building the physical assets, and 4. operating and maintaining the assets in order to deliver the product the product/service. Under the traditional public provision, only the task 3 was contracted out to the private sector. But under PPPs, a larger number of tasks are bundled together and contracted out to the private sector. The private sector provider then has a considerable control over the delivery of the product/service. In fact, Bettignies and Ross (2004) suggest there are three 'main characteristics' of the new wave of PPPs:

1. Contracting –out relationship is the foundation of PPPs
2. PPPs involves "bundling" of responsibilities, or the allocation of two or more tasks to a unique (consortium of) partner(s).
3. PPPs allocate the financing task to the private partner. It would then be pertinent to understand these characteristics of PPPs in the light of relevant theory and experience in the health sector.

With regards to the third characteristics of PPPs i.e., allocation of financing tasks to the private sector, there are two concerns: one, about the use of PPPs by governments to "hide" public debt while continuing to offer desired services. Depending on how the accounting is done, the PPPs may not show up as debt on the government's books. Two, there is a considerable debate whether the public or the private sector can borrow at a cheaper rate. A detailed discussion on private financing and the cost of capital lies beyond the scope of this paper. Nevertheless,

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bundling of financing the project with other tasks entails incentives for high level performance for the private sector. The next two sections discuss in detail the theories underlying the first two characteristics: Contracting- out and bundling of tasks.

Contracting as the foundation of PPPs

Contracting (out and in) as a management tool in health sector reforms is being adopted across all types of public health systems, such as tax-based system of UK and New Zealand, social insurance based system of the Netherlands and Germany, vertically integrated system like Denmark etc. Contracting is the most popular form of PPPs, on account of several benefits- *contracting stimulates quantity, quality and cost of health care, makes service provision competitive and increase operational efficiency, increases consumer choice by expanding the service base, improves resource efficiency by encouraging prioritization of services provided, and improves accountability of providers in their use of public funds* (Aston, Cummings and Mclean 2004).

The above mentioned efficiency gains under contractual agreements can be attributed to three factors (Bettignes and Ross 2004):

Ex-ante competition: A firm that starts with competitive bidding *prior* to contract can become of *ex post* monopoly after the contract. Ex-ante competition for the project can replace competition in the market to force bidders to lower costs, raise quality and be innovative. Any breach/violation of the contractual agreement by the private contractor can lead to termination of contract, law suits for contract breach, damage to reputation, and loss of future business, etc. This does not happen with public sector provision of the service (where each department has monopoly power within its own sphere of influence).

Optimal Risk Allocation and Incentives: Under a contract the private providers are exposed to such risks- technical risk, construction risk, or operating risk- that they can best manage, which gives them a strong incentive to control those risks through careful and high quality execution of the project. Clearly then the private entities display a greater ability to deliver more innovative products more quickly, with more flexibility and at a lower cost (not necessarily at a lower price) due to its access to high powered incentives.

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Scale and/or Learning Economics: Governments typically do not have enough work to generate the volume of business needed to utilize the full capacity of a say, Construction Company, to get unit costs down to their minimum, through scale or learning economics. With reference to the choice governments have to make between in-house and contract out (market) provision of goods and services, the advantage goes to the market when there are significant scale or learning economics that cannot be achieved by the volume of business required by the government. However, there are two important issues involved in the contracting process, namely transaction costs and reimbursement mechanisms.

"Bundling" of tasks as a defining characteristics of PPPs

Another key characteristic of the PPPs is "bundling" i.e. the responsibility of two or more tasks may be given to the same partner. A public authority contracts with a public company to build as well as run a hospital especially in countries with national health services. A popular example is that of UK's Design-Build-Finance and Operate (DBFO) model. In such a model a company — usually in the construction sector — will create a "special purpose vehicle" to bid for a contract with a health authority to build and provide non-clinical services to a hospital. The successful contractor will enter into three types of subcontract: one with banks to finance the project; one with a construction company to build the hospital; and one with a facilities management company to manage it over the lifetime of the contract, typically 30 years. Over the lifetime of the contract, the health care provider undertakes to pay a defined amount from its revenues and the contractor undertakes to maintain the fabric of the hospital in good order and (depending on the agreement) manage facilities. While this arrangement provided a source of much needed new finance, a great deal of this funding is "off balance sheet" financing and does not appear in the government books as new borrowing. This arrangement enables the government to remain within targets set for public sector borrowing. There is still relatively little experience with such models of hospital provision, and governments have yet to undertake rigorous evaluations in terms of cost, quality, flexibility and complexity. Yet the merits of these models (bundling) compared with the traditional model of provision are similar to those associated with contracting –out as follows (Bettignes and Ross 2004):

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Scale and/or learning economics: A number of PPPs involve projects like construction of super specialty care establishments, which are novel for the government, but may be familiar to a large multinational organization that has worked on a similar project in other jurisdictions. Contracting –out will be particularly attractive under two conditions a) when the government will not be able to amortize the expense of "learning" across multiple projects; and b) when the operations activity will benefit from ongoing research and development that cannot be effectively replicated by government.

Ex-ante competition: Another possible advantage from handing a bundle of two or more tasks – of design, finance, construction, operations and maintenance –over to the private sector derives from the greater efficiencies that may be attainable with private sector production, through ex-ante competition, improved incentives and presence of a market for corporate control. Such an advantage of bundling to the private sector flows from complementarities associated with combining design, construction, financing and operations with one firm (or consortium). The idea is that by combining these functions, the consortium will have an incentive to minimize the full lifetime costs associated with it. In the private sector, firms that are underperforming can be sold to other owners who can profit by fixing the problems. This is not possible with public sector provision providing the service. This may involve spending more in construction to reduce maintenance or operation costs later, an effect the consortium can internalize. However, one major concern with regards to contracting –out in general and PPPs in particular, is typically about *the loss of control* associated with giving providers certain contractual rights. The fear is that the perfect contract can never be written and that, even if it could, performance cannot be perfectly monitored. Two negative implications follow:

First, the incompleteness means that when changing circumstances necessitate changes in the behavior of the private firm, this will have to be negotiated without the benefit of competition and this could be costly; and

Second, the imperfect monitoring means that the private partner can cheat on quality or some other contractual element. It is the concern over the quality of services that will be provided by the private sector in hospitals and health service establishments that is the major hurdle PPPs have to overcome to gain public confidence in their ability to meet public needs. More significantly, there are two contracting challenges of PPPs to be faced -important characteristics

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of service quality must be measured and verifiable standards of acceptable performance established. Hart (2003) examines a choice of whether bundle (PPPs) or unbundle (conventional contracting) construction and operation tasks. According to him, relative to PPPs, conventional provision leads to more underinvestment in productive effort building quality, while PPPs lead to over investments in corner-cutting. He concludes that *PPPs may be optimal when building quality cannot be well specified and corner-cutting investments are relatively easy to monitor, because in that case both over investments in corner-cutting and underinvestment in building quality are relatively low.* Another recent research relating to the choice between the conventional contracting and the PPPs is that by Bentz, Grout and Halonen (2002). This paper takes the complete contracting approach where the agency problems between the government and the private provider stem from asymmetric information and non-observability of effort. They conclude that there is a trade-off between conventional delivery and PPPs: compensation to the agent is higher but less frequent in the former than in the latter.

2.2 Theories and Dimensions of Public-Private Partnership (PPP)

The basic PPP contract types are:

2.2.1.Service contracts;

2.2.2.Management contracts;

2.2.3.Concessions

2.2.4.Build–operate–transfer (BOT) and similar arrangements;

2.2.5.Joint ventures.

2.2.6.Hybrid Arrangment

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Each PPP option implies varying levels of responsibility and risk to be assumed by the private operator, together with differences in structures and contract forms as discussed and summarized below: Table 1

	Service Contracts	Management Contracts	Lease Contracts	Concessions	BOT
Scope	Multiple contracts for a variety of support services such as meter reading, billing, etc	Management of entire operation or a major component	Responsibility for management, operations, and specific renewals	Responsibility for all operations and for financing and execution of specific investments	Investment in and operation of a specific major component, such as a treatment plant
Asset Ownership	Public	Public	Public	Public/Private	Public/Private
Duration	1–3 years	2–5 years	10–15 years	25–30 years	Varies
O & M Responsibility	Public	Private	Private	Private	Private
Capital Investment	Public	Public	Public	Private	Private
Commercial Risk	Public	Public	Shared	Private	Private
Overall Level of Risk assumed by private sector	Minimal	Minimal/moderate	Moderate	High	High
Competition	Unit prices	Fixed fee, preferably with performance incentives	Portion of tariff revenues	All or part of tariff revenues	Mostly fixed, part variable related to production parameters
Special Features	Intense and ongoing	One time only, contracts not usually renewed Interim solution during preparation for more intense private participation	Initial contract only, subsequent contracts usually negotiated Improves operational and commercial efficiency. Develops local staff	Initial contract only, subsequent contracts usually negotiated Improves operational and commercial efficiency. Mobilizes investment finance. Develops local staff	One time only, often negotiated without direct competition Mobilizes investment finance. Develops local staff
Problems and Challenges	Requires ability to administer multiple contracts and strong enforcement of contract laws	Management may not have adequate control over key elements, such as budgetary resources, staff policy, etc	Potential conflicts between public body which is responsible for investments and the private operator	How to compensate investments and ensure good maintenance during last 5-10 years of contract	Does not necessarily improve efficiency of ongoing operations. May require guarantees

Source: Heather Skilling and Kathleen Booth. 2007.

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It should be noted that different PPP forms are more readily adapted to particular sectors or project types and have been used more extensively in these contexts. Decision makers should note the prior depth of experience in using a particular type of PPP in a particular sector.

2.2.1. Service Contract

Under a service contract, the government (public authority) hires a private company or entity to carry out one or more specified tasks or services for a period, typically 1–3 years. The public authority remains the primary provider of the infrastructure service and contracts out only portions of its operation to the private partner. The private partner must perform the service at the agreed cost and must typically meet performance standards set by the public sector. Governments generally use competitive bidding procedures to award service contracts, which tend to work well given the limited period and narrowly defined nature of these contracts. Under a service contract, the government pays the private partner a predetermined fee for the service, which may be based on a one-time fee, unit cost, or other basis. Therefore, the contractor's profit increases if it can reduce its operating costs, while meeting required service standards. One financing option involves a cost-plus-fee formula, where costs such as labor are fixed, and the private partner participates in a profit-sharing system. The private partner typically does not interact with the consumers. The government is responsible for funding any capital investments required to expand or improve the system. Box 3 shows Malaysia's experience with service contracts for water leak reduction (Skilling and Booth, 2007).

Potential strengths

Service contracts are usually most suitable where the service can be clearly defined in the contract, the level of demand is reasonably certain, and performance can be monitored easily. Service contracts provide a relatively low-risk option for expanding the role of the private sector. Service contracts can have a quick and substantial impact on system operation and efficiency, and provide a vehicle for technology transfer and development of managerial capacity. Service contracts are often short term, allowing for repeated competition in the sector. The barriers to entry are also low given that only a discrete service is up for bid. The repeated bidding maintains pressure on contractors to maintain low costs, while the low barriers to entry encourage participation in the competition (Skilling and Booth 2007).

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Potential weaknesses

Service contracts are unsuitable if the main objective is to attract capital investment. The contracts may improve efficiency and thus release some revenue for other purposes, but the contractor is not under an obligation to provide financing. The effectiveness of the contractor may, in fact, be compromised if other sources of financing (from government or donors, for instance) do not materialize. The fact that the contractor's activities are discrete and segregated from the broader operations of the company may mean that there is no broader or deeper impact on the system operations, only discrete and limited improvements. The public sector remains in charge of tariff setting and assets, both of which are politically vulnerable and critical to sustain the system (Skilling and Booth 2007).

2.2.2 Management Contracts

A management contract expands the services to be contracted out to include some or all of the management and operation of the public service (i.e., utility, hospital, port authority, etc.). Although ultimate obligation for service provision remains in the public sector, daily management control and authority is assigned to the private partner or contractor. In most cases, the private partner provides working capital but no financing for investment. the following Figure illustrates the typical structure of a management contract.

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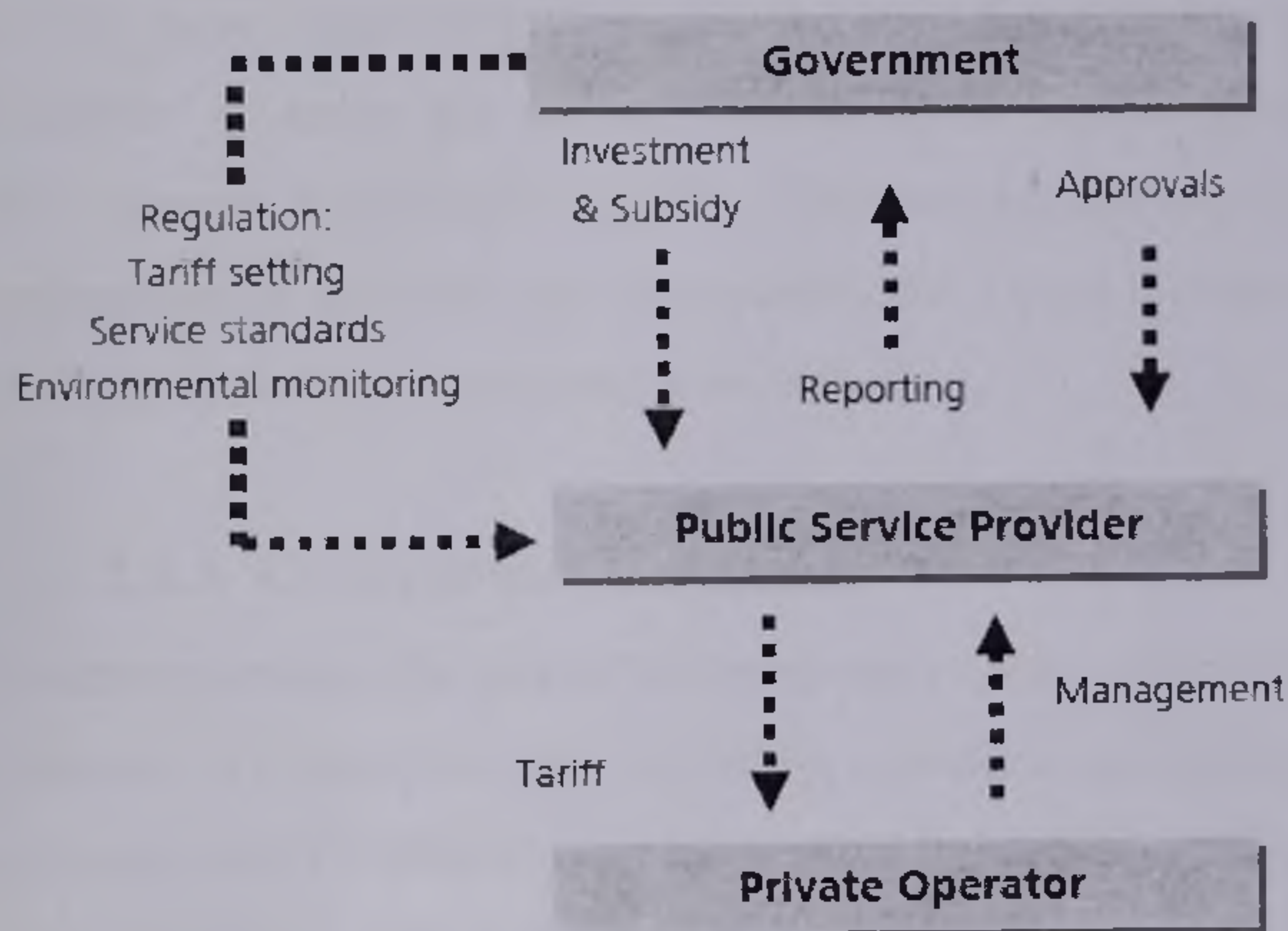
Figure 1 : Structure of Management Contract



Source: Heather Skilling and Kathleen Booth. 2007.

The private contractor is paid a predetermined rate for labor and other anticipated operating costs. To provide an incentive for performance improvement, the contractor is paid an additional amount for achieving previously specified targets. On the other hand, the management contractor can be paid a share of profits. The public sector retains the obligation for major capital investment, particularly those related to expand or substantially improve the system. The contract can specify discrete activities to be funded by the private sector. The private partner interacts with the customers, and the public sector is responsible for setting tariffs. A management contract typically, however, will upgrade the financial and management systems of a company and decisions concerning service levels and priorities may be made on a more commercial basis (Skilling and Booth, 2007).

Potential strengths

Under lease contracts, the private partner's profits depend on the utility's sales and costs. The key advantage of this option is that it provides incentives for the operator to achieve higher levels of efficiency and higher sales. The principal drawback is the risk of management reducing the level of maintenance on long-lived assets, particularly in the later years of the contract, in order to increase profits. Further, the private partner provides a fee to cover the cost of using the assets although the private partner does not provide investment capital.

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Potential weaknesses

The key issue in moving from service and management contracts to a lease is that the contractors' revenues are derived from customer payments and, hence, the question of tariff levels becomes increasingly sensitive. This may require structuring and revising complex tariff arrangements. In addition, the responsibility for capital investment remains with the government and no private investment capital is mobilized.

2.2.3 Concessions

A concession makes the private sector operator (concessionaire) responsible for the full delivery of services in a specified area, including operation, maintenance, collection, management, and construction and rehabilitation of the system. Importantly, the operator is now responsible for all capital investment. Although, the private sector operator is responsible for providing the assets such assets are publicly owned even during the concession period. The public sector is responsible for establishing performance standards and ensuring that the concessionaire meets them. In essence, the public sector's role shifts from being the service provider to regulating the price and quality of service (Skilling and Booth, 2007).

The concessionaire collects the tariff directly from the system users. The tariff is typically established by the concession contract, which also includes provisions on how it may be changed over time. In rare cases, the government may choose to provide financing support to help the concessionaire fund its capital expenditures. The concessionaire is responsible for any capital investments required to build, upgrade, or expand the system, and for financing those investments out of its resources and from the tariffs paid by the system users. The concessionaire is also responsible for working capital. A concession contract is typically valid for 25–30 years so that the operator has sufficient time to recover the capital invested and earn an appropriate return over the life of the concession. The public authority may contribute to the capital investment cost if necessary. This can be an investment "subsidy" (viability gap financing) to achieve commercial viability of the concession. Alternatively, the government can be compensated for its contribution by receiving a commensurate part of the tariff collected. A concession contract's typical structure is shown in the following figure.

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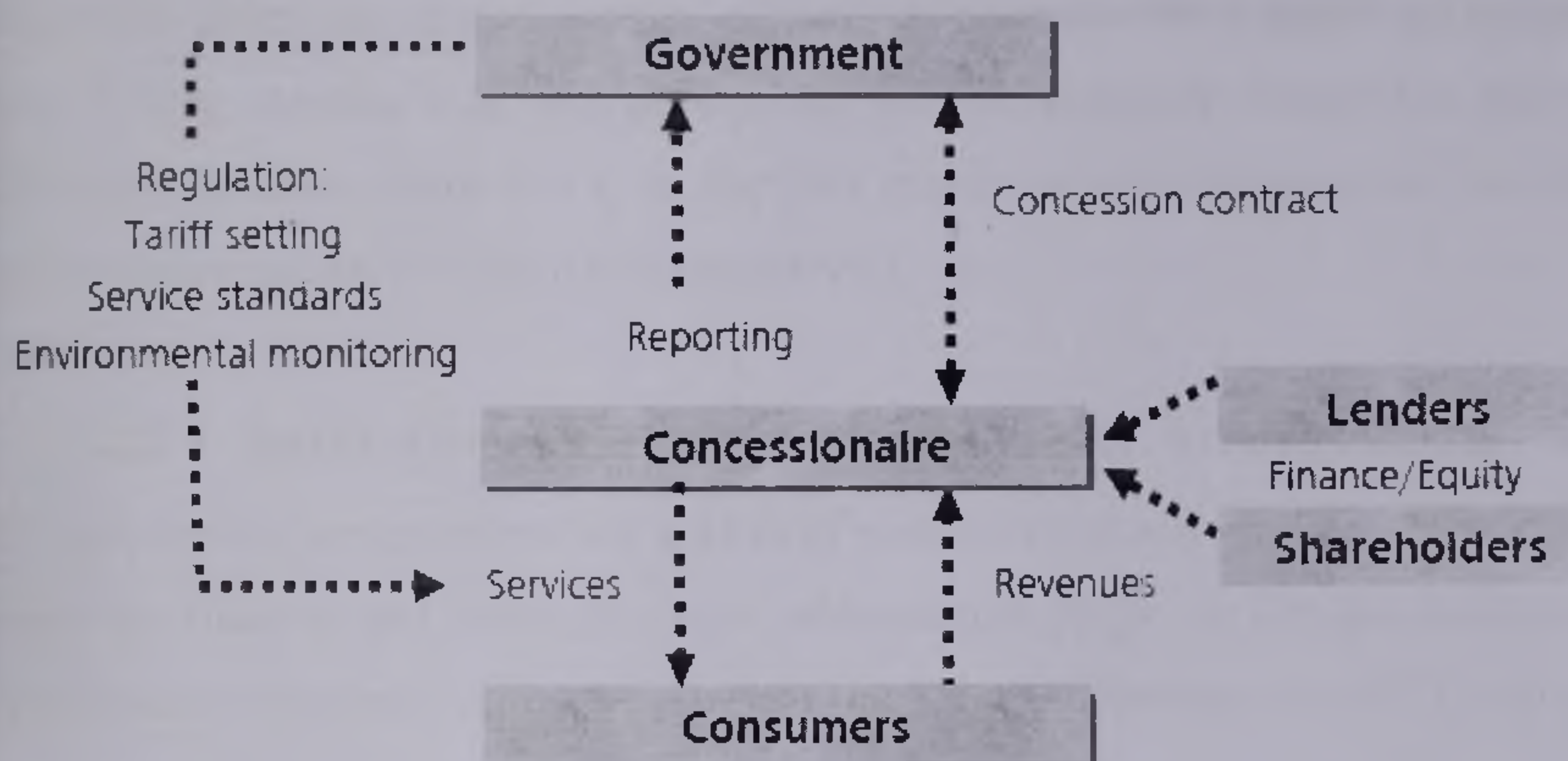
Figure 2: Structure of Concession Contract



Source: Heather Skilling and Kathleen Booth. 2007.

Potential strengths

Concessions are an effective way to attract private finance required to fund new construction or rehabilitate existing facilities. A key advantage of the concession arrangement is that it provides incentives to the operator to achieve improved levels of efficiency and effectiveness since gains in efficiency translate into increased profits and return to the concessionaire. The transfer of the full package of operating and financing responsibilities enables the concessionaire to prioritize and innovate as it deems most effective.

Potential weaknesses

Key drawbacks include the complexity of the contract required to define the operator's activities. Governments also need to upgrade their regulatory capacity in relation to tariffs and performance monitoring. Further, the long term of the contracts (necessary to recover the substantial investment costs) complicates the bidding process and contract design, given the difficulty in anticipating events over a 25-year period. This drawback may be countered by allowing a periodic review of certain contract terms in the context of the evolving environment. There is additional risk that the operator will only invest in new assets where it expects payback within the remaining period of the contract unless provisions for these events are set out in the contract. Because of the long-term, comprehensive nature of the contracts, they can be politically

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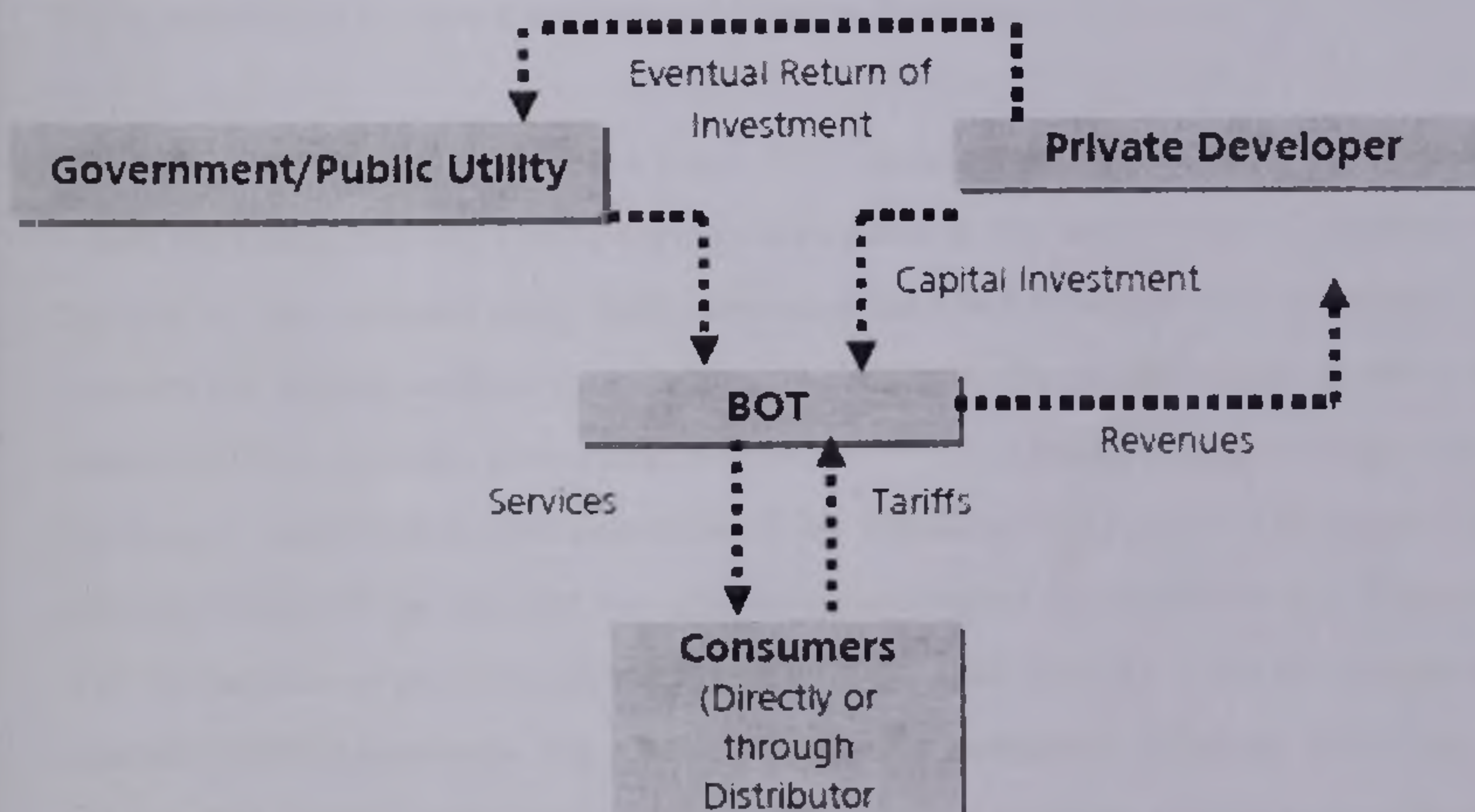
controversial and difficult to organize. It is argued that concessions provide only limited competition given the limited number of qualified operators for a major infrastructure network. There is also concern that concessions not set out monopoly terms but provide room for additional operators where this is in the best interest of certain groups of consumers and the concessionaire cannot provide equivalent service.

2.2.4 Build–Operate–Transfer and Similar Arrangements

BOT and similar arrangements are a kind of specialized concession in which a private firm or consortium finances and develops a new infrastructure project or a major component according to performance standards set by the government. Figure 8 illustrates the BOT contract structure.

Figure 3: Structure of a Build–Operation–Transfer (BOT) Contract



Source: Heather Skilling and Kathleen Booth. 2007.

Several of these are discussed in this section. Under BOTs, the private partner provides the capital required to build the new facility. Importantly, the private operator now owns the assets for a period set by contract—sufficient to allow the developer time to recover investment costs through user charges. The public sector agrees to purchase a minimum level of output produced by the facility, sufficient to allow the operator to recover its costs during operation. A difficulty

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emerges if the public sector has overestimated demand and finds itself purchasing output under such an agreement ("take–or–pay") when the demand does not exist. Alternatively, the distribution utility might pay a capacity charge and a consumption charge, thus sharing the demand risk between the public and private partners. BOTs generally require complicated financing packages to achieve the large financing amounts and long repayment periods required. At the end of the contract, the public sector assumes ownership but can opt to assume operating responsibility, contract the operation responsibility to the developer, or award a new contract to a new partner. The distinction between a BOT-type arrangement and a concession—as the term is used here—is that a concession generally involves extensions to and operation of existing systems, whereas a BOT generally involves large "greenfield" investments requiring substantial outside finance, for both equity and debt. However, in practice, a concession contract may include the development of major new components as well as extensions to existing systems, and BOTs sometimes involve expansion of existing facilities.

There are many variations on the basic BOT structure including build–transfer–operate (BTO) where the transfer to the public owner takes place at the conclusion of construction rather than the end of the contract and build–own–operate (BOO) where the developer constructs and operates the facility without transferring ownership to the public sector. Under a design– build–operate (DBO) contract, ownership is never in private hands. Instead, a single contract is let out for design, construction, and operation of the infrastructure project. The questions of ownership and the timing of the transfer are generally determined by local law and financing conditions, and the number of possible permutations is large. (See Box 8). With the design–build–finance–operate (DBFO) approach, the responsibilities for designing, building, financing, and operating are bundled together and transferred to private sector partners. DBFO arrangements vary greatly in terms of the degree of financial responsibility that is transferred to the private partner.

Potential strengths

BOTs have been widely used to attract private financing to the construction or renovation of infrastructure. BOT agreements tend to reduce commercial risk for the private partner because there is often only one customer, the government. The private partner must be confident however that the purchase agreement will be honored. An advantage to DBFO projects is that they are

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financed partly or completely by debt, which leverages revenue streams dedicated to the project. Direct user fees (like tolls) are the most common revenue source. However, other sources of finance in the road sector, for instance, might include lease payments, shadow tolls, and vehicle registration fees.

Potential weaknesses

BOTs have a project-specific application so they are potentially a good vehicle for a specific investment, but with less impact on overall system performance. It can be difficult to link the increases in production brought about by a BOT with commensurate improvements on the demand side. While initial capital construction costs may be reduced through the private sector's experience, private debt may be an expensive substitute for public financing where a take–or–pay agreement is in place. The benefit of competition is limited to the initial bidding process and these contracts are often renegotiated during their life. The tender documents and processes require careful design and adequate time.

2.2.5 Joint Venture

Joint ventures are alternatives to full privatization in which the infrastructure is co-owned and operated by the public sector and private operators. Under a joint venture, the public and private sector partners can either form a new company or assume joint ownership of an existing company through a sale of shares to one or several private investors. The company may also be listed on the stock exchange. A key requirement of this structure is good corporate governance, in particular the ability of the company to maintain independence from the government. This is important because the government is both part owner and regulator, and officials may be tempted to meddle in the company's business to achieve political goals. From its position as shareholder, however, the government has an interest in the profitability and sustainability of the company and can work to smooth political hurdles. The private partner assumes the operational role and a board of directors generally reflects the shareholding composition or expert representation. Box highlights joint venture arrangements in the PRC.

The joint venture structure is often accompanied by additional contracts (concessions or performance agreements) that specify the expectations of the company. Joint ventures also take some time to develop and allow the public and private partners considerable opportunity for

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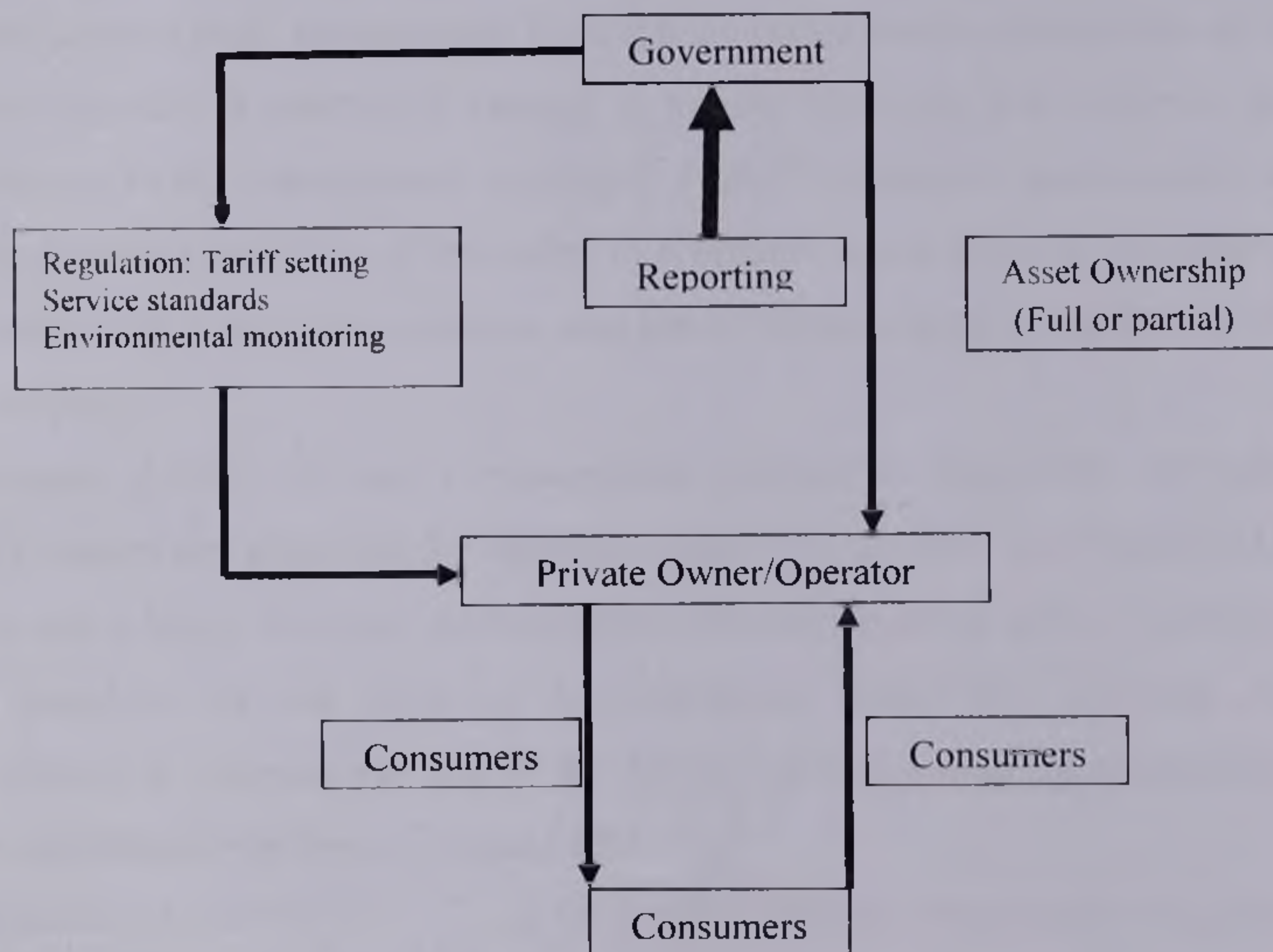
dialogue and cooperation before the project is implemented. Under the joint venture structure, both public and private partners have to be willing to invest in the company and share certain risks.

The following figure is the typical joint venture contract's structure.

Figure:4 Structure of Joint Venture Contract



Source: Heather Skilling Kathleen Booth, 2007

Potential strengths

Joint ventures are real partnerships of the public and private sectors that match the advantages of the private sector with the social concerns and local knowledge of the public sector. Under a joint venture, all partners have invested in the company and have an interest in the success of the company and incentives for efficiency.

Potential weaknesses

Government's dual roles as owner and regulator can lead to conflict of interest. Joint ventures also have a tendency to be directly negotiated or to follow a less formal procurement path, which can lead to concern for corruption.

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2.2.6 Hybrid Arrangements

Contract arrangements that incorporate different characteristics of a range of contract types can also be developed. Called "hybrid arrangements", these bring together the attributes most suitable to a particular project's requirements and the operating conditions. Hybrid arrangements provide a tailored solution in terms of scope, risk sharing, and/or scope that is most directly suitable to the project at hand. Obviously, the variations are endless, but examples include:

1. A "management contract plus" arrangement, in which the performance-related element of the management contract is substantial enough to transfer real risk. For instance, the payment of bonuses to the management contractor might be linked to achievement to increases in the operating cash flow of the utility by a predetermined amount. To achieve the bonus (if sufficiently large), the contractor may put additional inputs at risk to achieve the cash flow outputs.
2. A private contractor, LEMA, through a management contract, is responsible for water distribution and wastewater collection in Amman, Jordan. The contract provided LEMA with a fixed-fee and a bonus based on the improved performance of the utility. Similarly, LEMA faced penalties for not achieving improvements. Under this structure, the management contract in Amman was one of the first to adopt risk-sharing mechanisms more typically associated with deeper forms of PPP.
3. In Gabon, a concession contract was offered for a vertically and horizontally integrated national utility, providing both water and electricity. The Government decided to keep water and electricity services together in the scope to permit continued cross-subsidies from electricity to water. This contract design yielded several benefits, including cost reductions through the sharing of human, financial, and technical resources and creation of a platform for investment planning that is more integrated.
4. An "affermage-lease plus" arrangement has the ability to share responsibility for investments. Under a standard affermage/lease, the contracting authority retains full responsibility for undertaking and financing new investment even though the operator may be in a better position to manage new construction and some other investment obligations. In some cases, the operator is given a limited investment responsibility, such as extension of network service coverage in certain areas. Alternatively, the operator and contracting authority may reach an agreement to co-finance investments.

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Chapter Three: Primary and Urban Primary Health Care in Bangladesh

3.1 Introduction and Background

3.2 Population and Demography

3.3 Health Status

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3.5 Urban Health Service

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3.6.1 HPSP (1998–2003)

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3.1 Introduction and Background

Bangladesh, a country with a huge population (140 million) living in a small area (144,000 sq. km.), low per capita income (US$ 460) and low literacy (52.8 per cent), has achieved remarkable improvement in its health status. Bangladesh's health system is the outcome of many policy shifts and changes. At the time of independence, Bangladesh had an urban-based, elite-

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biased and curative health system which was extremely limited in terms of medical facilities and services. With the passage of time, Bangladesh's health system has been refined to a large extent by shifting the policy focus from urban to rural and curative to preventive care. Such a policy shift has produced many tangible outputs which are considered by many as a lesson for other developing countries. There is perhaps no country in the world that has made more progress in achieving health for all with fewer resources during the past three decades than Bangladesh (Perry 2002). Bangladesh's Infant Mortality Rate (IMR) and Total Fertility Rate (TFR) have dropped significantly while life expectancy and immunization coverage have increased considerably. A combination of efforts of external donors and the Government of Bangladesh (GoB) has helped the country achieve this impressive level of success (Osman, 2008).

Despite the achievements, there remain many challenges. Making health services (both basic primary and curative care) accessible to the poor is still a challenge. On the other hand, high rates of maternal mortality and child malnutrition indicate that issues of quality have not been properly dealt with. Based on secondary literature (policy, plan and program documents, review reports and research reports), this article attempts to analyze the existing health system and the policy changes contributing to these achievements and the challenges. It also endeavors to put forward some policy options to address the challenges.

3.2 Population and Demography

Bangladesh is now Asia's fifth and world's seventh populous country with an estimated population of about 146 million. Density of population is around 979 per square kilometer, the highest in the world. Rural population comprises about 74% while urban constitutes about 26%. There has been rapid urbanization during the last three decades. Adult literacy rate is 54% (2006). Census of 2001 reveals that 43 per cent of the population is below 15 years of age. This young age structure constitutes built-in population momentum. Urban population is increasing faster. Though Bangladesh has made progress in reducing poverty and per capita income has been creeping up, a substantial number of population are poor. Progress made in improving Bangladesh's Human Development Index (HDI) has placed her among the medium-ranking HDI countries. Strong policy interventions led to continuous reduction in the annual growth rate of population from the level of 2.33 % in 1981 to 1.54 in 2001 and further to 1.48 (2007). The Total

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Fertility Rate (TFR) also went down from 3.4 (1993-94) to 2.7 (2007). The CPR (any method) increased from 44.6% in 1993-94 to 58.1% in 2004, but again fell down to 56.8% in 2007. Life expectancy at birth has continuously been rising, and is now 66 years (2008) from the level of 58 (1994). Reversing past trends, women now live longer than men. The country, however, is being over burdened with about two million new faces every year creating extra pressure on food, shelter, education, health, employment, etc., and thus making the anticipated economic growth difficult.

3.3 Health Status

Since independence, Bangladesh has made significant progress in health outcomes. Infant and Child mortality rates have been markedly reduced. The under five mortality rate in Bangladesh declined from 151 deaths per thousand live births in 1991 to 65 deaths/1000 live births in 2007 and during the same period infant mortality rate reduced from 94 deaths per 1000 live births to 52. EPI coverage extended its reach from 54% in 1991 to 87.2% in 2006.The MMR reduced from 574/100,000 live births in 1991 to 290 in 2007. Deliveries attended by skilled birth attendants increased from only 5% in 1990 to 20% in 2006. The prevalence of malaria dropped from 42 cases /100,000 in 2001 to 34 in 2005. Bangladesh has also achieved significant success in halting and reversing the spread of tuberculosis (TB). Detection of TB by the Directly Observed Treatment Short-course (DOTS) has more than doubled between 2002 and 2007, from 34 to 92%. The successful treatment of tuberculosis was 91% in 2007. Polio and Leprosy are virtually eliminated. HIV prevalence is still very low. Development of countrywide network of health care infrastructure in public sector is remarkable. However, availability of drugs at the health facilities, deployment of adequate health professionals along with maintenance of the health care facilities remain as critical issues, impacting on optimum utilization of public health facilities

3.4 Nutrition Status

There has been considerable progress in reducing malnutrition and micro-nutrient deficiencies in Bangladesh. According to BDHS, percentage of U5 underweight (6-59 months) has reduced to 46.3 (2007) from 67 (1990) and that of U5 stunted (24-59 months) from 54.6 (1996) to 36.2

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(2007). Percentage of children 1-5 years receiving vitamin-A supplements has increased from 73.3 (1999-00) to 88.3 (2007). The rate of night blindness has reduced to 0.04 per 1000 people (IPHN, HKI 2006). However, in spite of efforts taken by the government, high rates of malnutrition and micronutrient deficiencies along with gender discrimination remain common in Bangladesh.

3.5 Urban Health Service

The urban areas provide a contrasting picture of availability of different facilities and services. While the secondary and tertiary level health care facilities are almost all located in the urban areas, primary health care facilities and services for the urban population at large and the urban poor in particular are significantly inadequate. Rapid influx of migrants from rural areas and the population growth has resulted in the phenomenal rise in the number of people living in urban slums in large cities. These are creating continuous pressure on urban health care services delivery. Since the launching of two urban primary health care projects by Local Govt. Division, Ministry of Local Government, Rural Development and Cooperatives, the primary health care services have been delivered by the city corporations and municipalities through contracted NGOs in the project' area. Rest of the urban areas and services are being covered by MoHFW's facilities and their affiliated NGOs.

3.6 Health Policy of Bangladesh

The National Health Policy of Bangladesh was formally approved by Parliament in 2000. Prior to this, the healthcare system had been running under the guidance of the long-term Five Year Plans. Two population policies were adopted in 1976 and 2004 (Osman, 2008). In addition to these policy documents there have been two sector strategies: Health and Population Sector Program (HPSP) and Health Nutrition and Population Sector Program (HNPSP). Broadly, the goals of all these policy documents are to reduce population growth, ensure access to primary healthcare services and provide maternal and child healthcare services to the poor and disadvantaged sections of the population.

The health sector started its operation with an underlying emphasis on population control. Along with reducing population growth, the goal of the health sector was to provide 'minimum'

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healthcare to the entire population with particular emphasis on the poor and disadvantaged. With this objective, the First Five Year Plan (1973–78) adopted the strategy of establishing the health infrastructure along with capacity building of health professionals. Accordingly, the construction of health centers at the union level and health complexes (31 bedded hospitals) at the *thana* (sub-district) level began. In the meantime, the first population policy was adopted in 1976 and the successive Five Year Plans were closely influenced by this policy (Osman, 2008).

The key strategy of the population policy was to provide comprehensive health and family planning services mainly through clinics and female field workers, with a strong emphasis on doorstep services to rural women (Bangladesh Health Watch 2006). The policy also encouraged private sector and non-governmental organization (NGO) participation in the program. In 1977 the government felt the need for private sector participation in health service delivery which was reflected in the interim Two Year Plan (1978–80) and in the Second Five Year Plan (1980–85). The Plan encouraged the private sector and NGOs to share some responsibilities for providing healthcare services to the bulk of the population. As a result, private healthcare facilities started increasing rapidly after 1982 when government restrictions on private laboratories, clinics and hospitals were relaxed (Khan 1996) and some vertical programs started to be implemented through public-private-NGO partnership(Osman, 2008).

The Fifth Five Year Plan (1997–2002) added certain new strategic issues under the influence of the Health and Population Sector Strategy (HPSS) adopted in 1997. HPSS gave the health sector a new direction towards efficiency and cost-effectiveness by advocating certain institutional and governance reforms. HPSS fed into the Fifth Five Year Plan (1997–2002) and the National Health Policy approved on 14 August 2000. As a result, these three documents are very similar in their strategies. In 1998 the operational plan of HPSS, called the Health and Population Sector Program (HPSP), was launched.

3.6.1 HPSP (1998–2003) emerged as a major reform program, which gave four big boosts to the health sector:

1. A transition from a projectised bifurcated approach to sector-wide approach (SWAP) of management through which all the sectoral projects were planned and managed in an integrated manner instead of running vertical projects.

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2. Unification of the health and family planning wings of the Ministry of Health and Family Welfare (MoHFW) to avoid duplication and overlapping of MCH services and to provide health and family planning services in a package to ensure efficiency gains.
3. To achieve the greatest health and impact per Taka spent and to serve the most vulnerable groups like women, children and poor, an Essential Service Package (ESP) containing five basic maternal, child and public health services was introduced which was delivered from one single service point, called 'one stop shopping'.

The National Health Policy approved in 2000, having been closely infl uenced by the HPSS, pronounced the same strategies as those mentioned above to achieve the following goals:
1. To reach basic health services to the people at all levels, particularly to the poor.
2. To ensure the availability of primary healthcare services at the union and *Upazila* levels.
3. To improve maternal and child health and reproductive health services.
4. To strengthen family planning services.

Implementation of HPSP started before the National Health Policy was enunciated. Thus, HPSS is one of the most influential health policy documents in Bangladesh. HPSP ended in June 2003, producing little improvement in Bangladesh's health indicators. Although the program had some successes in introducing certain fundamental changes in planning, management and the pattern of service delivery, the outcome and impact of the program was not up to expectation.

Despite good initiatives, HPSP failed to improve health indicators as desired due to a lack of good governance and political commitment. Studies show that the partial unification of health and family planning wings (only at the upazila level and below), withdrawal of domiciliary

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Table: 2 Improvement of Health Status in Bangladesh Over Nearly Four Decades of Independence

Indicators	1970s (1978–80)	1980s (1990)	1990s (1996–97)	2000s (2003)	2007
Population growth rate (in %)	2.7A	2.10B	1.74C	1.54K	NA
Infant Mortality Rate (per 1,000 live births)	150A	110B	77C	66K	52H
Under-5 Mortality Rate (per 1,000 live births)	229A	110B	116C	94K	65H
Maternal Mortality Rate (per 1,000 live births)	10.00A	5.7C	4.1C	3K	NA
Life expectancy at birth (in years)	47A	53B	58C	60K	65.4J
Total Fertility Rate (per woman aged 15–49 years)	5.04A	4.3B	3.3C	3.3F	2.7H
Delivery care by trained personnel (in %)	2A	5B	8C	12K	18H
Fully immunized children (12–23 months) (in %)	2A	75B	66C	73G	82 H
Under-5 Underweight (in %)	NA	NA	56D	48E	46H

Note: NA: Not available.

Sources: A Second Five Year Plan (1980–85); B Fourth Five Year Plan (1990–95); C Fifth Five Year Plan (1997–2002); D Mitra et al. 1997; E NIPORT et al. 2001; F NIPORT et al. 2003; G NIPORT et al. 2005; H NIPORT et al. 2007; J BBS 2006; K IMED 2003.

3.6.2 HNPSP (2003 –2012):

With the expiry of HPSP, GoB has undertaken another gigantic program called the Health, Nutrition and Population Sector Program (HNPSP) for the period 2003–2010. HNPSP is basically a continuation of HPSP with some modifications and additions in its concepts and

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components. For instance, it has incorporated nutrition in its program activities and proposed to continue with the earlier sector wide approach, the Essential Services Package (ESP) and the client-centered focus on a service delivery system with some modifications (MoHFW 2003, 2005). Major reforms under HNPSP include:

1. Strengthening public health sector management through pro-poor targeting measures and sector-wide approach.
2. Health sector diversification implying a shift from the government's role as a 'provider' of services towards a 'purchaser' of services, thus establishing formal collaborations between the public and private sectors called Public Private Partnership (PPP).
3. Stimulating informed demand for essential services by poor households through demand-side financing options (DSF). DSF aims to increase utilization of health services by the poor by subsidising the cost of drugs, tests and transport to the health facility, since utilisation is greatly discouraged due to high out of pocket spending for these purposes. It includes introduction of voucher schemes enabling poor pregnant women to access private for-profi t facilities for institutional deliveries.
4. The significant modifications have been a U-turn to the previous system of bifurcated health and family planning wings of the Ministry and restoration of domiciliary services.

3.7 Urban government and Public Health

Formally, urban local government is the sole authority managing urban public health services under the guidance of the above-mentioned policies and legislation. Two types of urban local bodies, known as city corporations and pourashavas, have massive public, environmental and primary health care mandates. In urban centres with no local government, urban services are provided by field administration of the central Government. Centrally, the Ministry of Local Government and Rural Development is the supporting authority of the directly elected urban local bodies. Along with the Ministry of Local Government and Rural Development, the Ministry of Housing and Works and the Ministry of Health and Family Welfare also share responsibility for developing and providing urban infrastructure and water and sanitation services. In this regard, it is worth mentioning the roles of the Local Government and Engineering Department and the Water and Sewerage Authority (WASA) under the Ministry of Local Government and Rural Development and the Department of Public Health and

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Engineering under the Ministry of Health and Family Welfare. In all urban areas except the two big cities of Dhaka and Chittagong, water supply and sanitation services are provided by the local bodies.

In urban areas, publicly provided primary health care facilities operate under the control of local government institutions. Almost all pourashavas have urban-based upazila health complexes and some pourashavas have district hospitals in their areas. Usually, these two facilities coordinate with each other as a single unit if they are in the same pourashava. In addition to these facilities, some pourashavas have specialized hospitals, such as tuberculosis and diabetic hospitals. In pourashavas, other than the government facilities, there are, on average, 2-15 private clinics, 1-4 NGO clinics and 2-20 diagnostic centres. In addition, there are 35 urban dispensaries across the country that provides primary health services, mainly to the urban poor. Many private for-profit and not-for-profit hospitals also provide health services in urban areas. Private hospitals are mostly located in big pourashavas or city corporations. Despite the existence of all of these institutional arrangements and relevant policies and legislation, the urban poor are grossly deprived of adequate access to services.

3.8 Health System in Bangladesh

Table 3: Major Policy and Programmatic Developments in Bangladesh since Independence which are shown below:

Year	Policy/Program	Major Actions or Innovations	Changes in the Health System
1973–78	First Five Year Plan (1973–78)	1. Priority to population control 2. Provision of 'minimum healthcare' to the entire Population iii) Develop and expand training facilities	1. A separate administrative structure for family planning (1975), health and family planning bifurcated 2. The strategy of establishing health infrastructure in all rural *thanas* by establishing a Thana Health Complex (presently known as *upazila* health complex)

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			with 31 beds in all rural *thanas/upazilas* Establishment of Medical Colleges and hospitals, training institutes
1976	The Population Policy	i) Targeted towards population control for achieving the demographic goal of slowing population growth	Various social and legal measures and system of incentives and disincentives were undertaken to reduce population growth
		ii) Comprehensive health and family planning services through clinics and domiciliary workers	A new cadre of female field workers was created to provide domiciliary services, which increased easy access to free-of-cost health, and family planning services
		iii) Encouraged private sector and NGO participation in family planning program	Public-private-NGO partnership developed in health and family planning services
1980–85	Second Five Year Plan (1980–85)s	i) 'Health for all by the year 2000' through Primary Healthcare approach.	Target was fixed to construct THCs in each rural thana and Union Health and Family Welfare Centres (UHFWCs) in each union by 1985
		i) Public-private partnership for health and family planning services emphasized	Private health facilities started to grow rapidly and NGOs became active partners in many health program
1985–90	Third Five Year Plan (1985–90)	Maternal and child health was emphasized as a strategy to provide PHC and population control services Intensification of EPI, control of diarrhoeal disease.	Vitamin 'A' distribution UHCs and UHFWCs were to deliver both family planning and MCH services
1990–95	Fourth Five Year Plan (1990–95)	MCH and PHC services were emphasized	Comprehensive health and family planning service delivery was focused on
19	The Health and	i) Priority in the allocation of	Introduction of ESP to make

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August 1997	Population Sector Strategy (HPSS), a policy document	resources to an Essential Service Package of public health, reproductive health and limited curative care	health services cost effective
1997–2002	Fifth Five Year Plan	ii) Unifi cation of health and family planning wings of the Ministry of Health	Partial unifi cation of health and family planning wings at the *thana* level and below instead of top to bottom unifi cation
28 June 1998	Health and Population Sector Programme (HPSP) (1998–2003)	(The operational plan of HPSS) iii) Provision of a one-stop service delivery	All the basic services under ESP are being delivered through one-stop service centres at the *Upazila* (UHCs), Union (UHFWC) and partially at the village (Community Clinics) level
14 August 2000	Health Policy	iv) Transition from a project driven approach to a sector-wide approach	In planning, the newly introduced SWAP enfolded all the relevant programs as a single entity rather than having separate plans for individual projects. This led to a drastic reduction in the number of line directors from 126 to only 29 In implementation, all sources of funding including GoB, donors and households was considered as sectoral resources as a whole
2003	Health, Nutrition and Population Sector Program (HNPSP) (2003–2010)	i) Voucher scheme being implemented with provisions for antenatal and birthing care at home and in public or private sector facilities Outsourcing of management of Union Health Centres and Community Clinics to NGOs is at an early stage	i) Health sector diversification, through the development of new delivery channels for publicly and non-publicly financed services (PPP)

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		ii) Stimulating informed demand for essential services through demand side financing (DSF) iii) Continue sector-wide approaches iv) In addition to the previous fi ve components the ESP has added nutritional aspect and control of emerging communicable diseases such as dengue, arsenic	1.DSF has been implemented in the form of a maternal health voucher scheme that provides for transport and maternity care in 33 poorest *upazilas* 2.SWAp continued 3.Scope of ESP has been broadened
		v) Back to the previous system of bifurcated health and family planning wings of the Ministry of Health	Health and family planning wings have again been Bifurcated
		vi) Continuation of doorstep delivery of services	Domiciliary services have been reinstated

Source: (Osman, 2008)

3.8.1 Finance

A donor consortium led by the World Bank provides financial and technical assistance to the health sector of Bangladesh. Of all the members of the consortium, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Health Organisation (WHO), Asian Development Bank (ADB) and the United States Agency for International Development (USAID) assist Bangladesh's health sector on a continuous basis. UNICEF supports child health, immunisation and nutrition programmes, USAID and UNFPA support family planning service delivery and population education, WHO is the main international source of technical assistance in the field of health supporting primary healthcare and maternal and health services and ADB provides support for health planning capacities (Osman 2004).

In 2007–08, the GoB spending on health was 7 per cent of the national budget (MTR 2008), which was 3.4 per cent of Gross Domestic Product (GDP) (NIPORT et al. 2005). By

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comparison, India spends 4.8 per cent (WHO 2005) and Sri Lanka 3.5 per cent (WHO 2007) of their respective GDPs on health. Private and social insurance systems are almost non-existent as the necessary economic and administrative conditions are yet to be put in place. To make health services accessible to the poor, the government provides free services at the upazila level and below. Due to the policy emphasis on primary care, the health expenditure pattern had a preventive bias for a long time. This has now changed its track. During the 1980s and 1990s about half of the total expenditure was being spent on primary level care (MoHFW 1995). This increased slightly during the HPSP period due to greater emphasis on the funding of particular services rather than primary care more generally (Ensor et al. 2002).

Studies suggest that the ESP approach was successful in diverting more resources (between 60 and 70 per cent of public spending) into primary levels of care, in focusing attention on resource flows into vital essential services such as maternal care and in shifting attention from hospitals to primary services most used by the lower income groups (MoHFW 2001). The reverse has been happening in the HNPSP period: MTR (2008) notes a declining share of budget for ESD services and for rural facilities (upazila level and below) as expenditure for tertiary hospitals has increased.

3.8.2 Payment

In health service, payment refers to the ways in which money is paid out. This could be in the form of fees, capitation (the unit of payment is defined on a per-person basis) or budgets (Roberts et al. 2004). These methods create incentives, which influence how providers behave in determining the quantity and quality of services. In Bangladesh, public expenditure accounts for 31 per cent while private out-of-pocket expenditure accounts for 69 per cent of total expenditure on health (WHO 2006). The government uses tax revenues to subsidies the cost of healthcare provided in public facilities.

Another widely used method of payment is salaries. Healthcare providers like doctors, nurses and health workers are mostly employed by the government, which closely influences the pattern of their services. They tend to be less responsive to the patients as the quality of their services does not affect their income. Although public facilities are supposed to provide most services

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free of charge, in reality they are not free for patients. Often the patients are forced to purchase drugs and supplies. Moreover, various kinds of unofficial and informal payments are widely practiced. A study conducted by the Ministry of Health found that informal fees are common at all levels of the health system and they can amount to more than ten times the official charges (Killingsworth et al. 1999). In the tertiary level hospitals, patients pay user-fees at a nominal rate which is far from sufficient to pay for the needed care leading to low quality services. Again, about 75 per cent of the government doctors are engaged in private practice, wherein they are paid by the patient from out-of-pocket. In private practice, doctors typically charge high fees, which lower income people cannot afford. Moreover, this creates profound differences in access even to public services because public doctors give favorable treatment to their private patients.

3.8.3 Organisation

This refers both to the overall structure of the health system, and to the individual institutions that provide healthcare services. In Bangladesh, health services are provided by a mix of public-private institutions and NGOs. The public sector provides all types of care (both curative and preventive), the private sector mainly provides curative care and NGOs provide mainly preventive and basic care. GoB has contracted some of its services to NGOs which include immunization, nutrition and tuberculosis (TB) control. Despite these multiple providers, public sector services are considered as the key source of care for a majority of the population. Government health services are provided through a four-tier system of government-owned and staffed facilities. They are:

1. Union Health and Family Welfare Centers (UHFWC) at the union level covering a population of about 30,000 each. There are 4,400 UHFWCs which provide mainly Primary Healthcare (PHC) services including maternal and child health services, family planning services, EPI, Behavior Change Communications (BCC) and limited curative care. At the ward level, there are community clinics to serve 6,000 people.
2. At the upazila level, there are 417 Upazila Health Complexes (UHCs) with 31–50 beds providing both in-patient and out-patient care, PHC, family planning services and some referral services.
3. At the district level, there are 59 District Hospitals with bed capacities ranging from 50 to 250 providing both primary and tertiary care and both in-patient and out-patient care.

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4. Medical College Hospitals at the regional level providing tertiary care accompanied by specialized laboratory facilities for the treatment of complicated cases usually (but not always) referred to them by the lower level facilities. There are 14 public Medical College Hospitals with bed capacities of 250 to 1,400 and with a total bed capacity of 8,000 (Rahman 2006).

In addition to these four levels of facilities, at the national level there are six postgraduate institutions providing both in-patient and out-patient specialized care. Of the above-mentioned facilities, UHFWCs and the UHCs are the key facilities to provide services in rural areas. In addition to these facilities, at the ward levels, there are government run satellite clinics for providing immunization and family planning services. Other than these government facilities, NGOs, private practitioners including medical doctors as well as traditional healers also provide health services in rural areas. In urban areas, private medical doctors are the main source of care for the rich while the poor go to the public facilities. Private hospitals and clinics outnumber public facilities in urban areas although in the rural areas public facilities are the main sources of modern care. Table 3 gives a description of the organization of the health system in Bangladesh. It shows that the public sector is much stronger than the private sector in terms of physical infrastructure across the country, although private hospitals outnumber public hospitals in urban areas.

3.8.4 Regulation

This refers to the use of coercion by the state to alter the behavior of actors in the health system including providers, insurance companies and patients. In Bangladesh, the Ministry of Health regulates the activities of all the providers by framing policies, rules and regulations. In addition to this, the Bangladesh Medical and Dental Council (BMDC) regulates the medical profession by issuing licenses to medical personnel for practicing medicine. The regulatory function of BMDC is limited only to the issuance of licenses rather than monitoring the performance of doctors or punishing their misdeeds. Due to the lack of a strong regulatory mechanism, private practice is unregulated and many criminal activities take place in the private sector. On the other hand, private clinics and hospitals are regulated by being registered with the Directorate General of Health Services (DGHS) only. There is no system to monitor the quality of private care, competence of providers and for ensuring the safety of patients.

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Table 4: Organisation of Health Facilities in Bangladesh

Levels	*Types of Facilities*	*Public*	*Private*	*NGO*	*Total*
Union (4,498)	Union Health and Family Welfare Centres	4,400	–	NA	4,498
Upazila (489)	*Upazila* Health Complexes	417	–	–	417
District (64)	District Hospitals	59	–	–	59
Regional (6 Divisions)	Medical Colleges in cities and towns	14	20	–	34
	Other hospitals	676	1005	2	1,683
National	Post-graduate institutions	6	–	–	6

Source: BBS 2011

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Chapter Four: Current Status of Urban primary Health Care in Bangladesh

4.1 Introduction

4.1.1 Partnership in Expanded Program on Immunization (EPI)

4.1.2 Partnership for Essential Service Package (ESP)

4.1.3 Partnership in family Planning (FP)

4.1.4 Partnership in Nutrition

4.1.5 Partnership in Tuberculosis Bacillus (TB)

4.1 Introduction

Bangladesh is a signatory of Alma Ata declaration of 'Health For All' in 1978. So far, the country has achieved a remarkable progress in its health indicators particularly in terms of increased coverage of child immunization, decline of infant mortality rate, maternal mortality rate, total fertility rate and increase of contraceptive prevalence rate. But still it has been struggling to achieve universal health coverage, removing the prevailing rural-urban and poor-rich health inequalities and to create provisions for essential health services for the majority of rural poor. Moreover, poverty related infectious diseases, maternal and child malnutrition, delivery by unqualified providers are the current challenges of the health sector.

On the other hand, there exists a huge resource gap (availability of US$ 5 against the need of $35) for primary health care. Moreover, due to systemic faults, people who can afford to pay are consuming free services. People pay for unofficial fees and cost of drugs, poor have to pay more than others do, and 80% of the "out of pocket" expenditures being on drugs due to profit driven unregulated medicine market (Ali, 2004). In Bangladesh due to resource limitation and other issues the public sector could not be very effective and due to the lack of self-regulation and proper policies the private sector remains disordered. Therefore, optimum utilization of the available resources in an orderly manner through partnership is an urgent need of the present

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time. Recognizing the urgency to mobilize all available resources from public, private and community towards creating cohesive Essential Service Package (ESP) delivery mechanism for all in the community, Public Private Partnership (PPP) for essential health services was developed in 1999. It was also a policy response to the national health policy of Bangladesh and the Health and Population Sector Program (1998-2003), which have pronounced the desires for integrating ordinary people and local government institutions with health services, providing client centered services, building community ownership and providers accountability.

There are several partnership programs in national health care running in Bangladesh. Among those partnership programs, five are the major areas in health care:

4.1.1 Partnership in Expanded Program on Immunization (EPI)
4.1.2 Partnership in Essential Service Package (EPS)
4.1.3 Partnership in Family Planning (FP)
4.1.4 Partnership in Nutrition
4.1.5 Partnership in Tuberculosis Bacillus (TB)

4.1.1 Partnership in Expanded Program on Immunization (EPI)

Neo-natal death, infant mortality and morbidity of children under five years are high in Bangladesh. It is estimated that one-fourth of under-5 mortality can be prevented through immunization. Immunization is one of the greatest public health achievements of the government of Bangladesh. The Expanded Programme of Immunization (EPI) including vaccination against six diseases: neonatal tetanus, polio, diphtheria, measles and tuberculosis was globally launched in 1974 and was adopted by different countries later. In Bangladesh, the EPI was formally launched on April 7, 1979 in order to reduce morbidity, disability and mortality associated with these six vaccine preventable diseases. The program could make a little headway until 1985 when it got a new direction. In 1985, Government of the Peoples' Republic of Bangladesh committed to the Global Universal Child Immunization Initiative (UCI), and began a phase-wise process of EPI intensification from 1985-1990 through partnership with NGOs. The intensified immunization programme was expanded in the country in phases, and near universal coverage was achieved by the end of 1989 (Talukdar, et.al. 1991).

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Operation of EPI Programme

Since the intensification of EPI programme in 1985, special emphasis was given on increasing childhood immunization coverage and the provision of tetanus toxoid immunizations to pregnant woman. EPI 'intensification' began in a small number of pilot thanas and gradually expanded to the entire country over the subsequent five years. The intensified immunization programme started with only 8 upazilas and 10 municipalities in 1985 and by 1989 all 460 upazilas and 88 municipalities were included in the programme. The phasewise intensification of EPI is shown in the following Table:

Table 5: Phase-wise intensification of EPI

Year	Phase	Thanas	Municipalities
1985-86	1st	8	0
1986-87	2nd	62	10
1987-88	3rd	120	20
1888-89	4th	270	34+4 city corporations
1989-90	-	-	20
	Total	460	88

Source: MOHFW (2006), Comprehensive Multiyear Plan (CMYP) for 2008-2015

The table shows that EPI intensification started with rural areas and in 1987, special focus was given to the municipalities in order to support urban immunization activities. EPI intensification consisted of:

- Establishing the cold chain from EPI Headquarter to District and Upazila level;
- Procuring and managing logistics needs for around 134,000 EPI outreach sites;
- Providing basic EPI training for thousands of mid-level managers, supervisors and field workers in public and private sectors;
- Conducting advocacy and planning meetings nation-wide;
- Coopting the private sector in developing a communication strategy

Thus partnership in EPI was started with the intensification in 1985. Since 1995, as part of the global polio eradication effort, the EPI sponsors two National Immunization Days (NIDs) annually for children under five years of age. During NIDs, oral polio vaccine and vitamin A capsules are given to the children. Vigorous facility-based and community-based surveillance are

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now being established to detect suspected cases of polio. At present, there are 134,684 EPI(EPI Headquarter, Mohakhali, Dhaka) fixed and outreach sites throughout Bangladesh staffed by two government field workers: Health and Family Welfare Assistant (FWA) and Health Assistant (HA). Almost all sites are within 15-20 minutes walking distance and field workers are instructed to conduct home visits to register newborns (in the EPI Registration Book) and invite parents to bring their target children to come to vaccination sessions prior to the actual session.
In rural areas, at each level of administration there is an EPI Coordination Committee (CC). At the district level, Civil Surgeon assigns the Medical Officer Civil Surgeon (MOCS) to coordinate the EPI activities in the district. At the upazila level Upazila Health and Family Planning Officer (UHFPO) is the head of CC, at the union level, the UP Chairman and at the ward level, the respective member heads the CC. In the upazila, the UHFPO, Medical Officer-EPI (MO-EPI), Upazila Family Planning Officer (UFPO), MO-Maternal and Child Health (MO-MCH), EPI Technician and Health and Sanitary Inspectors (HI and SI) are responsible for upazila level planning, programming, co-ordinating, training and supervision of EPI service delivery. At the union level, the Assistant Health Inspector (AHI) and Family Planning Inspector (FPI) are responsible for overseeing that the Health Assistants (HAs) and Family Welfare Assistants (FWAs) are carrying out community level activities. At the ward level, immunization is organized, and managed by the FWAs and HAs who select the vaccination centers at convenient places like schools or private houses. Every month, 24 vaccination centers are organized per union. In urban areas, City Corporation and the municipalities implement the EPI programme.

Partnership Strategy: Sharing of Tasks and Responsibilities

The government made a strong commitment to improving its national EPI programme with the technical and financial assistance of international donors (Perry, 2005). The international partners include the World Health Organization (WHO), UNICEF, USAID, the Japan International Cooperation Agency (JICA), Rotary International, the Swedish International Development Agency and GAVI (Global Alliance for Vaccine and Immunization). These organizations have program offices at the national level and coordinators at the field level. At present, 42 percent of the National EPI programme expenses are paid for by the Government, and the remainder is provided by the external donors (Perry, 2005). Donors mainly fund for special campaigns for neonatal tetanus, measles, oral polio vaccines but the routine vaccination

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is fully funded by the government. Amongst the donors, UNICEF is the largest donor (contributes nearly about 57% of the programme expenses).

Government implemented the EPI with many allies who have contributed significantly to the success of the program. The Scouts through inaugurating immunization badge and Gils' Guide letting their premises used as immunization site, NATAB (National Anti Tuberculosis Association of Bangladesh) through putting *moni (* a logo saying " Get your child immunized") tin plates on the back of rickshaws all over the country, stickers and posters on ferries, buses and trains and distributing slides on immunization to many cinema halls assisted the program tremendously (Huque, 1991). Voluntary Health Services Society (VHSS), the umbrella organization for health NGOs assisted the program, through distributing stickers/ posters on immunization and publishing official newsletter on immunization. VHSS played an important role in publishing Tika-Dak, the official newsletter of the program, and tika barta, the statistical bulletin (Huq, 1991).

In addition to these allies, the EPI programme operates throughout the country in collaboration with numerous (20-25) NGOs. During the mid-1980s government sought cooperation from NGOs including BRAC, CARE (Cooperation for American Relief Everywhere), Proshika, Rangpur Dinajpur Rural Services (RDRS), Concern Bangladesh, Dhaka Sustha Kendra (DSK), ICDDR,B, Rotary International and many smaller NGOs as well. These NGOs have strengthened the immunization program throughout the country through providing training for vaccinators, managers and communicators, provision of immunization services in areas where government services cannot easily reach, providing many of the communication materials and activities which have supported program expansion, and mobilizing local talent and resources for the program.

EPI is possibly the most effective model of partnership between government and NGOs of the country. Without large scale NGO involvement, the EPI would not have been such a success (Chowdhury et.al 1999). Shortage of government manpower to provide immunization services led to the GO-NGO collaboration in EPI. "To deliver EPI services, nearly about 600,000 staff is needed while GOB has only 60,000-70,000," disclosed a government official during interview. Bangladesh government purchases EPI vaccines with its own currency and supply EPI vaccines and other logistics e.g. AD syringes, safety boxes, refrigerators, record report forms to all concerned NGOs free of cost. In 2004, a Terms of Reference (TOR) of GO-NGO Collaboration

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for strengthening routine EPI was approved, which clarifies the patterns of such partnership(EPI Headquarters DGHS, Mohakhali, Dhaka). The main aspects of the TOR are the following:

- NGOs who are willing to provide immunization services, should be registered locally (to ensure accountability). NGOs having at least three years experience working in EPI will be enlisted at local GOB authority (Upazila Health and Family Planning Officer/ Civil Surgeon), which will be sent to EPI Headquarter for finalization and future reference. Upon receiving the recommendations from local authority, the EPI HQ will finalize the list of NGOs for providing EPI services.
- NGOs will be assigned after considering the experiences, strength of manpower and capability to provide immunization services.
- One NGO would be allowed to work on EPI in specific geographical area, the local health authority will distribute the work to ensure better coverage, to minimize wastage of resources (human, vaccines & logistics) and to avoid the duplication in service delivery.
- In rural static clinics, the number of vaccination days in a week should be consistent with the existing norms of EPI service delivery system i.e. twice in a week and date/day be fixed up in consultation with local health authority. In the urban areas, the number of vaccination days will be need based to minimize wastage of resources.
- Registration, record keeping, EPI session conduction, storage of vaccines and cold chain maintenance should be according to government instructions and guidelines.
- EPI resources from GOB must be used only for EPI services, and EPI vaccines should not be charged for. A banner or signboard should be hanged/displayed in front of the service center containing the message "Here EPI vaccines are provided free of cost".
- For EPI activity/performance, NGOs will be accountable to local GOB authority. On the other hand, local GOB authority and a Working Team in urban and rural area including the development partners will be responsible for monitoring and supervising the EPI activities of NGOs in their assigned areas.
- NGOs should contribute and provide support, assistance, help for EPI service where GO is considered weak on some set of criteria: hard-to reach areas (char, haor, chit mahals and hilly areas where normal transport system does not allow timely arrival of vaccines at sites.), and high risk areas (where there are inadequate numbers of vaccinators, reported

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case of high rate of neonatal tetanus and neonatal death, low vaccination coverage, people are disinterested to vaccinate and silent areas), low performing areas, post of GOB vaccinator lying vacant and where other limitation/constraint exists. In such cases, NGOs should be given priority to render EPI services considering their capability in terms of the availability of trained manpower on EPI and organizational strength.

- Reporting of EPI activities/performance should be through government local health authority (UHFPO/CS). NGOs will submit monthly EPI performance report early in the first week of every month to local health authority for compilation of reports of that area and onward transmission to appropriate authority.

4.1.2 Partnership for Essential Service Package (ESP)

The public private partnership for Essential Service Package (ESP) was an experimental program within the Health and Population Sector Program (HPSP) of the Ministry of Health and Family Welfare (MOHFW), of the Government of Bangladesh. The ultimate objective of the program was to improve community access to good quality Essential Health Services including: Maternal and Child Health (MCH), Reproductive Health (RH), Communicable Disease Control (CDC), Limited curative Care (LCC), Behaviour Change Communication (BCC) in a package called Essential Service Package (ESP) through development of partnership among the public and private providers and the community. PPP vision encompasses "empowering people to take care of their own health...making better use of existing all public, private and community resource"(PPP Reference Document 2000).

Partnership Strategy: Sharing of Tasks and Responsibilities

The programme was funded by DFID, co-managed by MOHFW and NICARE and facilitated by six NGOs. NICARE provided technical assistance to the programme. Although the Technical Assistance of this programme has formally ended in 2004 the approach continued with active community and NGO participation as unique example of resource pooling and participation. In PPP there had been many combinations of support: the PPP project itself, the GOB, the community (through volunteered time and user fee revenue). The resources that community members are already spending were to be pooled together with the public resources from central

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government and local government institutions and used effectively. The key operational strategies of PPP included: reaching the poor, women and children; establishing community ESP outlets; utilizing the decentralization process; stakeholder (including community) participation; introduction and local use of user fees; introduction of community financing; and enhancement of social development process. The implementation of these operational strategies can be explained through its elements and approaches.

Elements of PPP

PPP aimed to combine healthcare provided through community-based schemes with the resources available from the public health sector and the traditional and modern private health sector to create an integrated health scheme. This partnership was developed between the community, government and health care providers. There were three elements of PPP vision: the Community-based Health Scheme, the Funding and Commissioning Partnership, and the Healthcare Provider Partnership.

i) The Community-based Health schemes (CHS)

Creating Community-based Health Schemes (CHS) were the programmatic and administrative foundation of PPP health service delivery. A CHS was run by the members of the scheme to provide health care for a community population of about 6,000. CHS was a large representative health committee developed as formal community based organization, ran with a constitution, general and executive committees and management responsibilities. An executive committee was elected to manage the daily affairs of the CHS. The executive committees tended to equate participation with community contributions to the CHS in the form of land for building Community Clinics, money, and in-kind donations by community. All members agreed to pay for services and protect the limited public sector resources only for the poor (Ali, 2003). This developed a sense of ownership among the community. In addition to this there were resource pooling from the community through a financing mechanism such as weekly or monthly contributions, subscription, and donation from rich and middle class.

For 6000 to 8000 catchments population one Community Essential Service Delivery (ESD) outlet was established run by the community members. 41 community-based ESD outlets or Community Based Health Schemes (CHS) were established with GO-NGO-Community partnership using GOB facilities and local resources. These included 22 CHS in Brahmanpara

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upazila of Comilla, 10 in Sariakandi in Bogra, 5 in Hatiya of Noakhali and 4 in Kalai of Joypurhat district. Almost all CHS were functioning through the already established Community Clinics (CCs). Where CCs were not available, other facilities like cyclone centers at Hatiya or UP rooms etc. were used as ESD outlets.

ii) The Funding and Commissioning Partnership

It was a tripartite contract among the government, private sector including the community and NGOs. The CHS made a partnership agreement with the MOHFW and /or local government to pool all possible funding or resources. According to the agreement, it was required that the CHS covered the whole community including very poor members who are exempted from charges, provided the MOHFW Essential Service Package (ESP) as a minimum. Three or more CHSs also involved a graduate physician as 'Community Physician' at union level (for about 20-25,00 population) who accepted referrals from less qualified providers, supervised clinical practices and served the public health needs of the communities in the scheme.

Primary stakeholders, including the poor, women, and children were invited, along with other local stakeholders, to participate in the development process for the PPP models. This approach linked to existing community development, is also a feature of the Funding and commissioning partnerships.

NGOs (local, national and regional) were also a channel for the MOHFW funding received from HPSP donors and this funding was recognized in Funding and Commissioning Partnership Agreement. Five NGO partners were facilitating the formation and management of CHS. They were: BRAC, PAPAN Foundation (Poverty Alleviation, Peoples Awareness and Nutrition), a local NGO in Brahmanpara, TMSS (Thengamara Mohila Sabuj Sangha), a regional NGO in Bogra, DUS (a local NGO) worked at the Hatia island, JAKAS (a local NGO) at kalai upazila. In one union in Brahmanpara, the UP took an active role in the process.

iii) The Healthcare Provider Partnership

A network of existing modern qualified and traditional healthcare providers created from the public (physician, health workers), NGO (health workers) and non-organized private segments (medical assistants, community health volunteers, traditional birth attendants) of the local health sector provided services under the funding and commissioning partnership. A community

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physician based at union offered services to 3-4 CHSs on fixed days. The community physician not only provided services but also provided training to other providers. These public and private providers were working to prescribing protocol, referral as a safety net mechanism, submitting training and quality assurance requirements and were bound by prescribing /dispensing requirements. All kinds of ESP providers were provided with training on ESP delivery. Bulk purchase of medicine was another feature of the scheme. Each CHS was provided with a Revolving Drug Fund (RDF), which was used for procuring quality drugs from pharmaceutical companies.

Three different approaches were adopted to set up CHSs and development of partnership arrangements. They were:

i) Direct approach

Setting up CHSs by the Upazila Health and Family Planning Officer (UHFPO) with technical assistance from NICARE. One of the program objectives was to build MOHFW capacity to manage public private partnerships to deliver health services. Initially there was no effective capacity of the MOHFW for this experimental program, which led to heavy reliance on technical assistance from international agency, NICARE.

ii) Local Government Approach

Setting up CHSs using the Union Parishad. In this approach union parishads were trained using technical assistance from the Bangladesh Academy for Rural Development (BARD).

The establishment of CHSs had been conducted through direct approach and local government (union) approach facilitated by BARD.

iii) The NGO approach

Both national and local NGOs who valued partnership approach were engaged to facilitate the development of CHSs. Under this approach NGOs were invited to submit a proposal for the facilitation of setting up CHSs and partnership arrangements in specified unions. Memorandum of Understanding (MOU) was signed between NGOs and the local authorities though they were controlled centrally. In this regard, local (PAPAN), regional (TMSS) and national (BRAC) NGOs having a well-established local network were involved.

In establishing the CHS as well as Community Based Organizations (CBO) the NGOs played facilitating, coordinating and supportive roles to mobilize the community towards CHS, identify

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the local resources, coordination with GOB officials, ensure the participation of local leaders, identify the poor and hard core, assess training needs for ESP delivery, create CHS fund/mobilization of local resources. NGOs facilitated capacity building of the Community Clinic Management Group (CCMG), Community Health Schemes (CHS) and Community Health Forum (CHF). They helped the CCMG, CHS and CHF to set their own agenda, including day-to-day clinic activities, generate resources, manage revolving fund, monitor field staff, and recommend the project authority for staff remuneration, maintain books and accounts for clinic operation, stock of medicine, logistics and security and safety of clinic and staff.

In providing Community Clinic services, NGOs provided staff, co-financed the program, ensured minimum components of the ESP and managed and supervised CCs. They facilitated training for service providers including community physicians, private medical assistants, health workers, CHS management operations, laboratory technician basic training, training on STD/RTI management, BCC, EOC and refreshers, and on-the-job training. NGOs developed community nurses in hard-to-reach areas. NGOs provided support in monitoring and supervision. There was a provision of joint monitoring and joint GO/NGO services in extreme hard-to-reach areas.
The specialty of NGO approach was that NGO facilitation style was more concentrated towards community participation, sustainability of CHS and enabling the poor to access health care services.

Now, to clarify the partnership strategy further, let us specify the key service components of ESP delivery:

1. Provision of policy and guidelines
2a. Financing
2b. Co-financing
3. Provision of ESP services
4. Training
5. Referral
6. Quality Assurance
7. Drug Supply/Revolving Drug Fund
8. Health Education

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9. Staff/Human Resources
10. Monitoring and Supervision
11. Facilities
12. Land for ESD Outlets
13. Coordination
14. Community mobilization
15. Identification of local resources
16. Reporting
17. Feedback

4.1.3 Partnership in family Planning (FP)

Bangladesh family planning programme is a unique model of public-private-NGO partnership. National family planning programme in Bangladesh has undergone many changes since its inception. Starting from 1950s to 1970s, the preconditions for take-off of the family planning program were created, during the 1980s the programme has substantially taken off and in the 1990s the program has achieved self-sustained growth and in the present decade it is driving towards maturity.

Organized family planning efforts in Bangladesh began its journey in 1953 with the creation of Family Planning Association, which was a non-profit national voluntary service delivery organization. (Zaman, et.al.1996). In this initial phase, family planning effort was a voluntary one and it was a stage when people began to be aware of the problem. From 1960 to 1965 efforts were undertaken for the creation of basic institutional infrastructure for family planning services. All government clinics and hospitals at the thana level were provided with conventional contraceptives. From 1965 to 1971 there was a shift in the direction of service provision from clinic-based to field-based delivery.

After independence in 1973, a separate family planning wing was created in the Ministry of Health in a bid to strengthen family planning programme. Oral pills were introduced in the country for the first time and Maternal and Child Health (MCH) services were integrated to family planning services in a limited scale. In 1976, government created a new female work force for family planning called Family Welfare Assistant (FWA). One FWA (for each ward)

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was appointed to serve a population of about 5000 to 6000. FWAs were to make house-to-house visits to inform couples about family planning and to distribute supplies. In addition, country's national population policy was announced in 1976 focusing on MCH-based family planning, provision of fieldworkers, promoting community participation in planning and implementing family planning programme and encouraging NGOs and private sector participation in the program and donor support.

In the beginning of 1980s, NGOs became active participant of the program. In 1986, as an attempt at intensifying NGO participation, NGO coordination committee was established. In 1987, cafeteria approach (broadening of method choice) was introduced and in 1988 satellite clinics (merged with immunization program) were set-up. This stage is called the "take -off stage" of the programme (MOHFW, 1999). During the mid 1980s CPR was 25.3 (MOHFW, 1999). Since 1990s the programme has achieved self sustained progress by giving emphasis on institutional improvement of combined FP-MCH services, launching of nutrition programmes for mothers and children, involving more women in income generating activities, and mobilize greater community support through different projects. By mid 1990s, CPR increased to 49 (MOHFW, 1999)

There is a Health and Family Welfare Centre (UHFWC) in every union, which is supposed to provide services for a population of approximately 20,000. There are 3613 operating UHFWCs in 4484 unions headed by Medical Assistants (usually a paramedic) or doctors. These provide antenatal care, safe deliveries, health education, child care and family planning.

At the thana, there is a 31 bedded Thana Health Complex (THC), which provides both indoor and outdoor services for antenatal, post-natal, family planning and curative services. THCs serve a population of about 200,000.

In addition to these, there are 93 Maternal and Child Welfare Centres (MCWCs), 64 district hospitals and 19 medical college hospitals which provide maternal and child health services.

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Table 6 Government Infrastructure for Family Planning Service Delivery

Level	Service and Training Institution	Total Number
Central	Maternal & Child Health Training Institute (MCHTI), Azimpur, Dhaka Mohammadpur Fertility Services Training Centre (MFSTC), Dhaka Family Welfare Visitor Training Centre	01 01 01
District	Maternal Child and Family Planning Clinic at District hospital Maternal and Child Welfare Centre	59 98
Upazila	Maternal and Child Health Service Clinic at Upazila Health Complex	417
Union	Union Health and Family Welfare Centre	3613
Ward	Satellite Clinics	30,000
Unit	Family Welfare Assistants	23,500

Source: Family Planning Program in Bangladesh, IEM Unit, Directorate of Family Planning, Dhaka.

There are also more than 500 NGO clinics throughout the country providing a variety of services, most of which focus on family planning and provide only limited clinical services (IUD and Norplant but not usually sterilization). Of them USAID funded NSDP alone has 318 NGO clinics. Apart from the NGOs, for profit private sector including Social Marketing Company (SMC), hospitals, clinics and pharmacies are also involved in family planning program in Bangladesh.

Partnership Strategy: Sharing of Tasks and Responsibilities

In Bangladesh, family planning program runs through a partnership among public sector, private sector and NGOs. In this partnership, GOB is the major provider, then private sector and then NGOs. "At present, government funding is about 60% of the public spending on family planning programs and the rest is funded by the development partners," informed an official of the Directorate of Family Planning. Government delivers family planning services through its well-established infrastructure across the country as mentioned above by its huge number of staff. The Family Planning Directorate has 53,022 sanctioned posts for medical and non-medical staff. Currently, there are 4,684 FWVs and 35,500 fieldworkers (23,500 government and 12,000 NGO) in the Bangladesh family planning program (Zaman, et.al. 1996).

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Apart from the commercial providers, NGOs are another provider with an active role in family planning. NGOs have played a critical role in the family planning arena through developing and testing novel approaches to problems in research, advocacy and service delivery in settings where the government and for profit private sectors are particularly weak. It is mentioned before that it was at the beginning of 1980s NGOs became active participant of the FP program. At present more than 200 national and international NGOs are involved in FP program (BDHS, 2004). USAID/Dhaka with its assistance through five Cooperating Agencies (CAs), namely AVSC International, Pathfinder International, Family Planning Association of Bangladesh (FPAB), Family Planning Services and Training Centres (FPSTC) and The Asia Foundation (TAF) supports 109 of these NGOs working in 332 sites (rural, urban, peri-urban) in Bangladesh (Barakat et.al. (1995) (Barakat, et.al 1995). These Cooperating Agencies of USAID provide fund and technical assistance to their affiliated NGOs. The USAID supported NGOs excepting AVSC International, employ about 6,000 field workers to carry out community based distribution programs (CBD) in the areas where government does not have any field workers. Many of the NGOs have mini clinics to run the CBD program.

GO-NGO partnership in family planning takes place in two ways: affiliation through a formal bilateral contract and affiliation through open bidding. Bidding takes place for a few numbers of cases in the provision of clinical services. NGOs concerned with the provision of family planning services can be affiliated to the government program through fulfilling certain conditions. These conditions clarify the partnership arrangement between government and NGOs. According to the government regulations, the main conditions for affiliation of NGOs are the following (DGFP, 2007):

- The applying organization should be registered with the Directorate of Social Welfare/NGO Affairs Bureau/Registrar, Joint Stock Company
- To run the program, the organization should submit the commitment of the donor agencies for fund, quantum of fund and the period of assistance. In case of the non availability of donor fund, the organization should mention the alternative source of fund with all proofs and details of expenditure to run the organization. The government /the Family Planning Directorate will have no financial responsibility to run the affiliated organization.

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- Along with the application, the organization should submit in advance a two-year service delivery plan in consistent with the government regulations for Method-mix family planning services and an estimate of the method wise monthly requirement of contraceptives.
- For Community Based Distribution (CBD) services, an organization would be allocated an area through the recommendations of Upazila Family Planning Officer (UFPO) and the approval of Concerned Deputy Director Family Planning. The authority should ensure that in the allocated area, not more than one NGO is operational. While allocating an area, eligible couples under the FWA and the number of couples under the NGO fieldworker would be examined. The applying organization should also submit a commitment letter for providing domiciliary services along with the application.
- In City Corporations/ Municipalities/Unions, affiliation of NGOs with the Family Planning Directorate would be subjected to the recommendations of various committees headed by the Upazila Nirbahi Officer (in case of the provision of CBD and Clinical services in Municipalities/unions at the upazila level) and by the Deputy Director Family Planning (in case of the provision of CBD and Clinical services in pourasavas at the City Corpoartion and Sadar Zilas).
- The affiliated organization would submit a monthly report on its activities on a prescribed form of Management Information System (MIS) to the respective Upazila Family Planning Office.
- Every after two years the affiliated organization will have to renew the affiliation.

4.1.4 Partnership in Nutrition

Nutrition programme of the Government of Bangladesh needs to be discussed in two phases: BINP (1995-2002) and NNP (2002-2010) as these two major programmes had been operational in this area so far. Project sites of BINP include a total of 61 thanas. Of them 6 thanas were undertaken during the first two years of project operations, expanding to 17 additional thanas in the third year, another 17 additional thanas in the fourth year and 20 additional thanas during the last two years. The programme had three components: 1) national nutrition activities (US$ 20.6 million) including institutional development, IEC, and monitoring and evaluation; 2)

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Community-based nutrition (US$39.1 million); and (3) intersectoral nutrition programme development (US$ 7.6 million), supporting schemes such as home gardening and poultry rearing. The Community-based Nutrition Component (CBNC) was the core component of the project. The main activities in the CBNC include the following:

- Monthly growth monitoring and promotion (GMP) for children under two years of age and pregnant and lactating women (PLW)
- Supplementary feeding (SF) of malnourished PLW and malnourished and growth-faltered children under 2 years of age
- Nutrition education for pregnant women, mothers of children under two, and adolescent girls.

BINP ceased its activities in 2002. Based on the experiences of BINP National Nutrition Project (2000-2004) was evolved. National Nutrition Programme (NNP) is the continuation of National Nutrition Project. NNP officially commenced its field activities in September 2004.

The NNP has two components: i) service delivery and ii) program designing and support.

i) Service delivery component is again divided into two subdivisions: a) Area Based Community Nutrition (ABCN) service delivery and b) Nutrition services at the National level.

   a. ABCN includes the services provided at the field level, which include the services like: BCC activities, training, birth weight recording and registration, growth monitoring and promotion (GMP) activities, food supplementation to the selected malnourished (severe cases and growth faltered) children, pregnant and lactating women, micro-nutrient supplementation (Vit.A & Iron-Folate), adolescent forum & services etc.

   b. Nutrition services at the national level includes promoting, extending and sustaining breast feeding habit, micronutrient programmes.

ii) Programme designing and support services includes programme management and necessary institutional development, monitoring, evaluation and operational research and IEC/BCC.

Besides, to ensure household food security for the poor and vulnerable, inter-sectoral approach involving Ministry of Agriculture, Ministry of Fisheries and Livestock and Ministry of Women

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and Children Affairs is being implemented through the establishment of village nurseries and homestead nutrition gardens, poultry rearing for nutrition, food assistance, development support and nutrition services through vulnerable group development program. Thus the components of NNP have remained the same as BINP. Only the CBNP has been renamed as Area Based Community Nutrition programme (ABCN). The main focus of the programme is ABCN. Like BINP, the ABCN activities are performed by NGOs. Ten partner NGOs were working with NNP till August 2006 to deliver ABCN services. BRAC, the largest and one of ten NGOs has withdrawn it in August 2006 and 53 upazilas where BRAC was working, are redistributed among other nine NGOs.

Partnership Strategy: Sharing of Tasks and Responsibilities

Public private partnership plays important role in NNP implementation. Planning, financing and logistics are mainly the responsibilities of GOB. The main sources of financial or technical support for the NNP are the Government of Bangladesh (GOB), the World Bank, Canadian CIDA and Netherlands Government, (MOHFW, 2005). Amongst the international donors, the World Bank provides loan while the remaining two provide grants. UNICEF is one of the largest sources of technical support for the program. Government has established an institutional set-up for the program in the form of Nutrition Management Committee at each of the administrative levels starting from the district down to the community level. Government has realized that behavioral/attitudinal factors play an important role in improving the level of nutrition. As a result, community mobilization and their involvement in the program would be an important part of it. In case of program implementation particularly at the field level, government as well as the external donors have felt that NGOs are better equipped to take the programme to the community. Accordingly, NGOs are made responsible for program implementation mainly at the field level. Thus in recognition of the government's capacity limitations and role for community-level service delivery, BINP was implemented largely through the NGOs (World Bank, 2005). As under BINP, NGOs are the major partners with the government in NNP implementation. The nine NGOs partnering the NNP include national and local NGOs. They are: Thengramara Mahila Sabuj Sangha (TMSS), Society for Health Extension and Development (SHED), Society for Action Research and Development (SARD), Voluntary Association for Rural Development (VARD), Health Education and Economic Development Bangladesh

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(HEED, Bangladesh), Voluntary Organization for Social Development (VOSD), Bangladesh Extension Education Services (BEES), Southern Gono Unnayan Samity (SGS), Uttarayan Janakalyan Mahila Samity (UJMS). The monitoring report of NNP in August 2006 shows that BRAC implemented the programme in 53 NGOs, TMSS in 9 upazilas, SHED in 8 upazilas, SARD in 6 upazilas, VARD in 5 upazilas, HEED in 4 upazilas, VOSD in 9 upazilas, BEES in 6 upazilas, SGS in 2 upazilas, UJMS in 3 upazilas. NGOs recruit only the Upazila Nutrition Manager (Head of the nutrition programme) and field Supervisors whose salary is paid by the government. A chain has been established between the CNCs and these implementing NGOs. Although a protocolized referral system is yet to be developed, a significant number of pregnant and lactating women are referred from CNCs to nearby Government and NGO health facilities for growth faltering, severe malnutrition and severe illness. Data shows a very subtle difference in the utilization of Government and NGO facilities.

So the specific key service components of nutrition are:

1. Provision of policy and guidelines
2. Financing
3. Provision of Area-Based Community Nutrition ABCN
4. Space for CNC/facility
5. Logistics and supply
6. Nutrition Management Committee
7. Human Resources
8. Training and Behaviour Change Communication (BCC)
9. Monitoring, evaluation and operations research
10. Reporting
11. Coordination
12. Community mobilization
13. Referral
14. Advocacy
15. Quality Assurance

4.1.5 Partnership in Tuberculosis Bacillus (TB)

The programme is mainly donor funded. Funding for TB control can be divided into three categories: grant, loan and purely government fund. Grants include the funding from Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), USAID, and WHO. A total of US$ 88.44 million has been committed for the period of 2004 to 2011. This fund is disbursed through

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two principal recipients (PR): Government of Bangladesh and BRAC (GFATM 2006). Forty percent of GFATM fund is spent for medicine. Government bears recurrent and maintenance expenditure.

Partnership in TB control stretches from the central level down towards grassroots level. Government provides TB care from tertiary hospitals, Chest hospitals at the central level, Chest Disease Clinics (CDCs) at the district level, Upazila Health Complexes (UHCs) at the upazila level and Union health centres at the union level. In addition to these government facilities, 11 NGOs are providing TB care under the NTP umbrella. A recent study shows that in Bangladesh up to 70 per cent of poor TB patients consult traditional healers, homeopathic providers or allopathic doctors before seeking out DOTS services. NTP assumes that just over half of patients seek care from private chest specialists, health centres and NGO clinics. Table 7 presents a picture of care-seeking pattern for TB case.

Table 7: Care-Seeking Pattern for TB Case Management (NTP Assumptions)

Sources of Care	% of patients
Health Centres, NGO clinics	34
Chest Specialists (private)	20
General Practitioners (private)	16
Other Public Outlets	16
Village Doctors	14

Source: NTP, 2011, Presentation to Canadian International Development Agency

In such a context of medical pluralism, it is highly difficult to keep a track record of the TB patients. Moreover, as case finding is passive, those who seek care often remain undiagnosed and untreated due to the limited availability of micro-scopic examination of sputum smears, lack of trained laboratory and health personnel, and the absence of an effective referral system (UNICEF, 1999, Hussain, 2001, WHO, 2003). Moreover, long distance to health facilities, low quality services at the health centres contribute to poor access to TB care. These wide-ranging

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deficiencies recommended a large-scale, coordinated effort to ensure the smooth implementation of prevention and care programs for TB at all levels.

Furthermore, where private practitioners constitute a large proportion of the service delivery infrastructure and where they are the first points of contacts for almost half of the population, it is important that they are an integral component of the delivery of TB services under the umbrella of NTP. From this realization PPP in TB control commenced in 1994 through involving NGOs first and gradually, in course of time, private practitioners of different categories have been involved in the programme.

It is recognized by the policy makers that in order to enhance the quality and access of health care provision, involvement of all types of health care providers through PPP is a prerequisite. Reliance on private practitioners leads to inequitable access to quality services, constrains government capacity to monitor the course of the epidemic, and raises concerns about the potential of increasing resistance to first-line TB drugs (Open Society Institute, 2006). Due to this, private practitioners have also been incorporated as a partner in TB control. The main categories of partners in public-private partnership for TB control are the government, NGOs, private practitioners and the community. PPP for TB control in Bangladesh takes the following forms:

i) Public-Public Partnership: It refers to the collaboration between the NTP (DGHS under the MOHFW) and Defence, Police health services, between DGHS and DGFP. In such partnership, NTP opens DOTS corner in military hospitals and train their doctors on DOTS. Again the Directorate General of Health Services may take help from the field workers of DGFP. In these cases, Family Welfare Assistants and Family Welfare Visitors report the doubtful cases.

ii) Public-Private Partnership: The TB management practices in the private sector are not standardized and the precise number of TB cases detected and treated in the private sector is not known. For this reason, partnership with private sector was initiated in 2003 through involving 63 chest physicians and general practitioners (GPs). Committees of Resource Persons were formed from the National Chest and Heart Association, Bangladesh Private Medical Practitioners' Association (BPMPA), College of General practitioners and NTP. The Committee prepared the guidelines,

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cards and reports, one special PP referral/ transfer form and brochure for the patients. The project was piloted in 4 urban areas of Dhaka to effectively involve private practitioners in TB service delivery. At present huge number of private practitioners in different cities as well as at the district levels are working under the project who are given a one day orientation training. As an attempt at involving private practitioners, NTP has established collaboration with all medical colleges and teaching institutes, which accepted the DOTS strategy as the best way to combat TB. All private medical colleges have DOTS centres. Under this category, partnership also takes place between government and village doctors or quacks. It is a unique feature of this partnership. This project was piloted in collaboration with the Damien Foundation. A majority of TB patients in rural area seeking treatment turn first to the village doctors. They are more acceptable to the villagers due to accessibility, availability and low cost. As a result, this program drew a linkage between the quacks and government in lieu of which they get some incentives. After providing them necessary training, they are allowed to use a 'signboard' for their publicity. Village doctors are trained on DOTS. They are given one-day orientation on TB, the importance of the disease, community awareness, signs and symptoms, diagnosis and treatment. So far, 10,000 village doctors have been trained on DOTS. The treatment success rate has been around 90% (MOHFW, 2006a).

iii) GO-NGO Partnership: The NTP has established formal partnerships with NGOs immediately after the introduction of DOTS. Specific areas are assigned to NGOs for programme implementation. On July 7, 2004 BRAC signed an agreement with the GFATM as the principal recipient to control TB in Bangladesh in collaboration with the Ministry of Health and Family Welfare. Subsequently, BRAC signed agreements with 10 NTP partner NGOs (Damien foundation, The Leprosy Mission Bangladesh (TLMB), Health Education and Economic Development (HEED) Bangladesh, National Anti-TB Association of Bangladesh (NATAB), and ICDDR,B, LEPRA, Bangladseh, RDRS, LAMB, UPHCP, NSDP) to expand financial support for strengthening DOTS services. BRAC leads the implementation of the TB control program by the NGOs in collaboration with NTP. In urban areas particularly in Dhaka, TB programme is implemented under the umbrella of two programmes:

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Urban Primary Health Care Project (UPHCP) and NSDP (NGO Service Delivery Programme). UPHCP has 8 partner NGOs and NSDP has 10 partner NGOs. The urban programmes are operational in four divisions: Dhaka, Chittagong, Rajshahi, Khulna. In Barisal and Sylhet it is not yet fully operational.

Partnership Strategy: Sharing of Tasks and Responsibilities

To discuss partnership, at the outset, it is essential to determine the key service components in TB control program to be provided by the partnership. Based on the existing literature (Zafarullah, 2004) the service components can be identified as:

1. Provision of policy and guidelines
2. Provision of quality diagnostic services
3. Provision of laboratory facilities
4. A referral mechanism
5. Provision of DOT
6. Late patient tracing (defaulter tracing)
7. Decisions on levels of fees for services
8. Provision of supplies and logistics
9. Recording and reporting of treatment outcomes
10. Monitoring and supervision of service activities
11. Coordination
12. Training and orientation
13. Health education
14. Community mobilization
15. Quality Assessment of Diagnosis
16. Feedback

These functions are shared by the above mentioned partners: government, NGOs, private sector and the community. Table 8 shows how these service components are shared by different partners.

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Table 8 Sharing of tasks among the partners

Government	NGO	Private practitioners	Community
Policy guidelines for treatment (1) Laboratory services (3), Provision of DOTS (5) Training of program coordinators supervisors and laboratory staff (12), procurement and distribution of drug and laboratory supplies (8), monitoring and evaluation (10). Coordination (11) Quality Assessment (15)	Provision of DOTS (5) Health education (13) Training and orientation (12), Community mobilization(14) Late patient tracing through its community-based networks (6) Quality Assessment (15)	Provision of quality diagnostic services (2) Provision of laboratory facilities (3) Referral (4) Provision of DOTS (5) Feedback (16)	Late patient tracing (6) Health education (13) Community mobilization (14)

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Chapter Five: Effectiveness of Urban Primary Health Care

5.1 Data Analysis, Result and Discussion: Service Seekers

Part A

5.1.1 Age Distribution of the Respondents

Following is the table showing the frequency of the age distribution of the respondents:

Age group	Frequency	%
<20	0	0%
20-30	31	62%
31-40	19	38%
41-50	0	0%
50+	0	0%
Total	50	100%

Table : 9

Out of 50 respondents most of them belong to the 20-30 age limits. It indicates that men and women between this age limits are the service recipients. Indeed, they are the target population because of the reason that this group more vulnerable to most of the diseases. The age limits between 31 and 40 is the second most age that people take the services from the health centers.

5.1.2 Sex Distribution

The survey has incorporated 25 female and 25 male stakeholders.

Sex	Frequency	%
Male	25	50%
Female	25	50%
Total	50	100%

Table :10

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5.1.3 Duration of staying at urban areas:

The survey also includes the information regarding the duration of the respondents in terms of year in seeing services from the health centers. Out of 47 respondents, 40 of them have been availing the service for zero to five years.

Time duration of the respondents (Year)	Frequency
0-5	40
6-10	6
11-15	1
15+	-
Total	47

Table: 11

5.1.4 Respondent profession distribution

The survey shows that people with low income seek the service from the health centers. Among the respondents, housewives are the highest service seekers. Among the other respondents, garment workers and student and drivers are mentionable.

Respondent profession	Frequency	%
Business	3	6%
Service	1	2%
Driver	6	12%
Student	6	12%
Garments worker	10	20%
House wife	21	42%
Sales man	1	2%
Night guard	1	2%
Other	1	2%
Total	50	100%

Table : 12

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5.1.5 Income distribution

The survey demonstrates strongly that the people with the monthly income below less than 5000are the main stakeholders.

Respondent income level	Frequency	%
0-5000	37	74%
5001-10000	3	6%
10001-15000	8	16%
15001+	2	4%
Total	50	100%

Table : 13

Part B:

5.1.6 Type of service received from PPP.

The service received from the service centers are divers and highly concentrated to particular diseases. But notable are the family planning and TB service.

Type of service	Frequency
Family planning	18
ESP	10
EPI	5
Nutrition	3
TB	18
Total	54

Table : 14

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5.1.7 Quality of service from the Health centers'

Out of 50 respondents, 34 have said that the service is good and 10 respondents said it was very good whereas 6 said that it was not good.

Quality of service	Frequency	%
Not good	6	12%
Good	34	68%
Very good	10	20%
Total	50	100%

Table : 15

The respondents have answered differently when they were asked why they thought it was not good. Most of them said the quality of the service is not good.

5.1.8 The service recipients who said that the service was good explained in the following way:

Why good	Frequency
Free service	8
Less pay	8
Quick service	5
Well behavior	2
Better service	8
Easy to access	2
Total	33

Table : 16

The table shows that 8 people said that it was good as it was free service. Another group of same numbers mentioned about the less pay. Whereas five of them stated about the quick service and 2 respondents pointed out the good behavior. "Better service" as a reason mentioned by 8 people and 2 people have said that it was easy to access.

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5.1.9 The service recipients who said that the service is better. Why better - they explained in the following way:

Why better	Frequency
Free service	1
Less pay	1
Better service	5
Responsive	1

Table : 17

5.1.10. Received service with money

Respondents when asked whether they paid for the service or not; 48% admitted paying money to the centers for the service whereas 52% answered negatively.

Money paid for service	Frequency	%
Yes	24	48%
No	26	52%
Total	50	100%

Table : 18

5.1.11. Reasons for selection this health centre

Out of 50 respondent 23 have ensured that the reason of selecting of the health center is the lowest distance than the other health centers and second highest is for the reason of free service and after that well behavior is also the mentionable reason.

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Reasons for selecting ppp health centers	Frequency	%
Good assistant	1	2%
Well behavior	6	12%
Nearest home	23	46%
Free service	7	14%
Better service	3	6%
Quick service	2	4%
Less pay	1	2%
Easy to access	4	8%
Other	3	6%
Total	50	100%

Table : 19

Part C:

5.1.12. PPP Health service centers distance from residence

39 respondents out of 50 answered that because of the closeness of the centers they visit the health centers.

Distance of HSC	Frequency	%
Closer	39	78%
Far	1	2%
Not so far not so closer	8	16%
Equally close to all the service receivers	2	4%
Total	50	100%

Table : 20

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5.1.13.Time (month) distribution of frequently visited PPP

The frequency of Time duration of visited PPP health service (month) is between 0-5.

Time duration of visited PPP health service(month)	Frequency
0-5	44
6-10	2
11-15	2
15+	-
Total	48

Table : 21

5.1.14 PPP health service better than any other health service (Government and NGO)

42 out of 50 respondents have said that PPP health centers are better that government and NGO health centers.

Better PPP health service	Frequency	%
Yes	42	84%
No	8	16%
Total	50	100%

Table : 22

When they have been asked why it is better they responded mentioned different reasons. 17 respondents have said that it was because of better service and 13 respondents identified good behavior as the reasons whereas other people have mentioned diverse reasons.

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5.1.15 PPP health service better than any other health service (Government and NGO)

Why better – The respondents explain that better service and well behavior is the reason for coming to the PPP health service centers.

Why better	Frequency
Well behavior	13
Better service	17
Free service	2
Less pay	3
Better environment	2
Time and money saving	1
Near to home	1
Attendance availability	2
Total	41

Table : 23

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Chapter Six: Perception of Stakeholders

6.1Data Analysis, Result and Discussion: Service Providers

Part A :

6.1.1 Name of the service provider organization and frequency distribution

It can be observed for the data presented in the table that no single health center is dominant. People have the tendency to go all type of PPP health centers. There are 10 PPP health centers so far mentioned by the respondents.

Sl. No.	**Organization**	**frequency**	%
1	UTPS	9	18%
2	BWHC	6	12%
3	DCC	4	8%
4	PSKP	5	10%
4	BAPSA	6	12%
6	MSCS	5	10%
7	PSTC	5	10%
8	NARIMAITREE	5	10%
9	SHIMANTIK	5	10%
	TOTAL	50	100%

Table : 24

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6.1.2 Respondent age distribution

Following is the table showing the frequency of the age distribution of the respondents:

Age group	Frequency	%
<20	-	-
20-30	20	40%
31-40	22	44%
41-50	8	16%
50+	-	-
Total	50	100%

Table : 25

Out of 50 respondents most of them belong to the 31-40 age limits. It indicates that men and women between this age limits are the service providers. The age limits between 20 to 30 is the second highest age that provides the services from the health centers.

6.1.3 Respondent sex distribution

Sex	Frequency	%
Male	14	28%
Female	36	72%
Total	50	100%

Table : 26

The survey has incorporated 14 female and 36 male which is 28% and 72% subsequently.

6.1.4 Length of service frequency distribution

The significance of the comments and opinions of the service providers lies with the fact that how long they are involved in this service. Noticeably, 44% of the respondents have five to ten years of experience attached with the health centers whereas 50% of them have five or less than five years of experience and only 6% have 11 to 15 years of experience.

Group of service year	Frequency	%
<5	25	50%
6-10	22	44%
11-15	3	6%
16-20	-	-
Total	50	100%

Table : 27

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6.1.5 Respondent professions

The respondents of PPP health centers who been surveyed are very much representative and they are from diverse profession.

Profession	Frequency	%
Counseling	6	12%
Administration	4	8%
EPI	12	24%
ESP	4	8%
Monitoring	4	8%
Family planning	8	16%
Nutrition	3	6%
Paramedical	7	14%
TB	2	4%
Total	50	100%

Table : 28

6.1.6 Reason for chosen this service as a Profession

When asked, "what is the reason to choose the profession in PPP health centre?", they replied in the following way:

Although the reasons are obviously different, 26% have mentioned "help the poor" as the reason to choose the service. It is the most dominant reason.

Reasons for choosing	**Frequency**	**%**
Help the poor people	13	26%
Public dealing/relationship	4	8%
Service/employment	7	14%
Better status	5	10%
Go-NGO service provider	4	8%
Experience of paramedical	3	6%
Others	14	28%
Total	50	100%

Table : 29

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Part B:

6.1.7 Type of services provide by the centre.

The survey shows that five types of service are provided by the different PPP health centers. Among those family planning and ESP are the most common service provided by the PPP health centers.

Service type	Frequency
Family Planning	48
ESP	45
EPI	33
Nutrition	27
TB	19
Total	172

Table : 30

6.1.8 Respondent responses on service quality.

All the respondents have claimed the service provided by the PPP health centers as better.

Better service provided by the centre	Frequency	%
Yes	50	100%
No	0	0%
Total	50	100%

Table : 31

6.1.9 Why better

When the respondents have been asked why they think that the service provided by the PPP health centers are better they replied with the following reasons:

Majority of the respondents have identified "Quick and timely service" and "Easy access" as the reasons for claiming the service to be better. Among the other reasons they have pointed out Qualitative treatment, no corruption, participative, money saving, coverage better and accountable.

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Reasons	Frequency	%
Qualitative treatment	5	10%
Easy access	8	16%
No corruption	2	4%
Quick and timely service	18	36%
Participative	1	2%
Money saving	5	10%
Coverage better	1	2%
Accountable	4	8%
Other	5	14%
No answer	1	2%
Total	50	100%

Table : 32

6.1.10. Respondent response about better service provider by the private health centre.

When the respondents were asked whether the PPP health services provide better service than the private health service 90% of them answered that it is better than the private health centers. On the other hand, only 10% of the respondents did not agree.

Response	Frequency	%
Yes	45	90%
No	5	10%
Total	50	100%

Table : 33

6.1.11 Why against Yes reply:

Survey also investigates why they consider the PPP health services are better than the private service, the frequent answers were "Less pay" and "Free service". Among the reasons that the respondents mentioned are easy access, strong rules and regulations, door-stop service and time and money saving.

Reasons	**Frequency**	%
Easy access	7	14%
Less pay	16	32%
Free Service	14	28%
Strong rules & regulation	3	6%
Door stop service	6	12%
Time & money saving	3	6%
No answer	1	2%
Total	50	

Table : 34

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Part C:

6.1.12 Effective service, than others are provided:

90% respondents have reported that the service provided by the PPP health centers is effective and 10% have said that it is not the case.

Effective service	Frequency	%
Yes	45	90%
No	5	10%
Total	50	100%

Table : 35

6.1.13 Reasons for why it is effective than others

The survey demonstrates that the majority of the people believe that the service as better than any other type of service is because it is poor people oriented and the service is provided at the door-stop.

Reasons	Frequency	%
Poor people oriented	15	30%
Better condition	2	4%
Joint venture	1	2%
Easy access	2	4%
Strong rules & regulation	4	8%
Door stop service	14	28%
High responsibility	2	4%
Higher coverage	5	10%
No answer	5	10%
Total	50	100%

Table : 36

6.1.14 PPP health Service Centers Distance:

The survey also attempted to show the effectiveness in terms of distance of the PPP health centers from the recipients' residence. Only 6% of the respondents have said that the location is far and other have disagreement about the distance but more or less close.

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Distance	Frequency	%
Close	22	44%
Far	3	6%
Not so	13	26%
Equally close to all	12	26%
Total	50	

Table : 37

6.1.15 Coverage area of PPP health service:

Most of the respondents have mentioned that the coverage of the PPP health centers is 70% to 80%.

Coverage area	Frequency	%
40-50%	2	4%
50-60%	3	6%
60-70%	13	26%
70-80%	32	64%
Total	50	100

Table : 38

6.1.16 Service Recipient percentage

Most of the respondent 23 out 50 respondents have said that around 31-40 people are receiving services daily where the second highest is 21-30. Here the table shows that only 7 respondents have ensured that 40 or more than 40 people are receiving the services provided by the PPP health service centers.

Coverage area	Frequency	%
40-50%	3	6%
50-60%	15	30%
60-70%	18	36%
70-80%	14	28%
Total	50	100%

Table : 39

6.1.17 No. of recipient in daily.

23 out 50 respondents have said that around 31-40 people are receiving services daily where the second highest is 21-30. Here the table shows that only 7 respondents have ensured that 40 or more than 40 people are receiving the services provided by the PPP health service centers.

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Coverage of Stakeholder	Frequency	%
0-10	-	-
11-20	3	6%
21-30	17	34%
31-40	23	46%
40+	7	14%
Total	50	100%

Table : 40

6.1.18 How is The primary Health indicators in PPP health centers

Out of 50 respondents most of them (64%) agreed that the health indicators like infant mortality rate , maternal mortality rate is low than the other areas. Whether 24% view is as same as the other areas.

Health care indicator opinion	Frequency	%
Yes	32	64%
No	-	-
Same	12	24%
Worse	-	-
No reply	6	12%
Total	50	100%

Table : 41

6.1.19 Type of Problem:

When the respondents were asked about the type of problem they face they mentioned the following:

a) Lack of technical support
b) Lack of administrative support
c) Poor salary
d) Rule and regulations
e) Lack of real data
f) Lack of resources
g) Lack of good working environment
h) Tough to manage illiterate patient

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Chapter Seven: Test of Hypothesis, Recommendation and Conclusion

7.1 Test of Hypothesis

7.2 Recommendations

7.3 Conclusion:

7.1 Test of Hypothesis:

In the hypothesis, it has to be proved that whether the service provided by the Public-Private Partnership (PPP) in urban primary health care is really effective. The study will make inference on the hypothesis considering the findings of different statements.

The data analysis demonstrates that coverage area of PPP health centers is satisfactory, satisfaction of the service seekers is very high and responsiveness of the service providers is also good. Therefore, the survey verifies and substantiates the hypothesis about the effectiveness of PPP in urban primary health care.

7.2 Recommendations:

The public-private partnership model shaped in Bangladesh for Urban Primary Health care project involving municipal corporations, NGOs and other government structures together, with some refinements, can be a good model for other countries. But it has its shortcomings as well. When the public sector comes in, it wants to establish control in these projects and that's a problem.

The following recommendations can be made based on the above mentioned analysis:

1. Focus should be given on providing a package of essential primary health services with an emphasis on preventive intervention, giving priority to maternal and child health
2. Expanding the role of the private sector including NGOs in the provision of health, nutrition and population services
3. To be more farsighted in this mission, gender, equity, poverty and developmental issues are to be addressed in designing and provision of services,

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4. The service can be improved by providing categorical service and some of the fees can be increased to expand cost recovery and improve efficiency of resource utilization.
5. Involve beneficiaries in the management of health care to enhance its effectiveness.
6. The issue of malnutrition is to be addressed as proactive approach.
7. To make the endeavor more successful comprehensive approach should be taken. The issue of sustainability and environmental should also be emphasized.
8. Endeavor to provide one stop shopping for health and population services.
9. It has to ensure civil society participation, particularly participation of elected representatives, community leaders at different levels like service delivery point level and local level committees headed by local representatives.
10. Close monitoring and supports are necessary to ensure the accountability of the service. It shall enable the effectiveness.
11. Salary of the personnel working in the PPP health centers should be standardized as the poor salary has a bad impact over the salary.
12. The health service centers run by PPP are providing free service only for 30% patients so if it can be raised to 50% will be better.
13. The health centers should provide the minimum diagnosis for the patients.
14. There is insufficiency of medicine, the health centers are providing medicines but not enough for all the patients so the health centers should preserve sufficient medicine for the patients.
15. The survey conducted on the service providers show that there is a certain degree of lack of coordination between the public and the private entity and also between the healths centers, that should be minimize.
16. The respondent among the service providers reported limited number of personnel which is not sufficient to deal with the coverage area.
17. The survey also found that the health centers need the technical support in terms of equipments and machines.

7.3 Conclusion:

Government of Bangladesh has made a substantial commitment to provide health care to its people in best possible way. Notable success has been made in the delivery of EPI, ORS,

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sanitation and family planning services for which Bangladesh is internationally recognized. The national development plans laid out the foundations for comprehensive delivery of a wide variety of Health and Family Planning services through a package in urban areas. However, for a period of time, there was proportionately less than optimum investment in the primary health care services for the urban poor and slum dwellers to meet those priority needs. Strengthening the health system through better management and organization and effective use of resources can improve health conditions and enhance the quality of health care delivery in Bangladesh. Furthermore, more research is needed on health system. Apart from policy issue mentioned above, there should be good governance in health administration, both in the private and the public sector, for which political commitment should be transparent and all allocations should be demand based and balanced ones. There could be arrangements where civil society organisations and human right agencies can interact to ensure accountability and transparency in procurement, so that well functioning services can be provided through access of quality medical products and technologies. A strong health financing structure is also important, which can ensure population's protection from health related financial crises. In addition to these aspects, a well functioning information system is also vital, which would disseminate information timely on critical health outcomes. There should be also participation of health watch groups with regular inflow of information. Existing human resource development (HRD) plans need to be reconstructed to have long-term objective to improve the quality of healthcare services (clinical and managerial skills), and to address emerging health problems of Bangladesh. Funding on training is very much crucial for informal health providers, as well as funding for community systems that mobilize demand for services. In addition to that tailor made programmes need to be provided in line with local needs, so as delivering services to hard to reach, at–risk and vulnerable populations. There should be strategies for community engagement to increase awareness of, access to, and utilization of health services, and provision of appropriate services at the community level. Moreover, strong leadership (political, donor, and government) support & public accountability are essential to strengthen a sense of commitment & accountability of Bangladesh health care systems, especially in times when the government is exploring means of reform.

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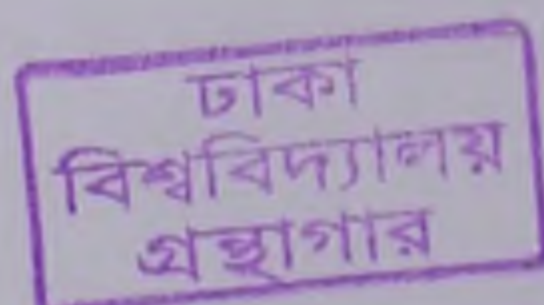

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APPENDIX - 1

Department of Public Administration

Dhaka University, Dhaka

Title of the research: Public Private Partnership in Urban Primary Health Care: A Study on Dhaka City

QUESTIONNAIRE SURVEY ON SERVICE PROVIDERS

[This survey shall help to identify the status, problems and effectiveness of Public Private Partnership in Urban Primary Health Care in Dhaka city. The data and information collected from this survey will be used only for research purposes. Mentioning name of the respondent is optional.]

Part: A: Respondents' Profile

The following statements ask about respondents' profile.

1. Name of the Service Provider:
2. Name of the Organization:
3. Age: .... years.
4. Sex: a. Male b. Female
5. Length of the services...................... years.
6. What do you do?..............................
7. Why have you chosen this service?

....

Part B: Current Status of the services

8. Types of services provide by you and your centre?

    a. Family Planning b. ESP c. Immunization & Vaccination (EPI) d. Nutrition e. TB

9. Do you think this service is better than the services provided by the public health centers?

    a. Yes b. No

10. If the answer is yes, then why?..

11. Do you think this service is better than the services provided by the private health centers?

    a. Yes b. No

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12. If the answer is yes, then why?..

Part C: Effectiveness of the services

13 Do you think that the service you have given is more effective than others?

a. Yes b. No

14 If the answer is yes, then why?..

15 Are the PPP health service centers are at reachable distance of the community around?

a. Close b. Far c. Not so far not so close d. Equally Close to all the service-receivers

16. What is the coverage area of PPP health services centers in terms of approximate percentage?

a. 40%-50% b. 50%-60% c. 60%-70% d. 70%-80%

17. Approximately what percentages of people of your coverage area do receive the service?

a. 40%-50% b. 50%-60% c. 60%-70% d. 70%-80%

18. On an average, How many people receive the services daily?..........................

19. Are the primary health indicators (maternal death rate, infant mortality rate etc.) better in the areas in which PPP provide services than the other areas?

a. Yes b. No c. Same d. Worse

20. What type of problems you are facing about delivering services?..

Thank you for your co-operation.

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APPENDIX - 2

Department of Public Administration

Dhaka University, Dhaka

Title of the research: Public Private Partnership in Urban Primary Health Care: A Study on Dhaka City

QUESTIONNAIRE SURVEY ON SERVICE SEEKERS

[This survey shall help to identify the status, problems and effectiveness of Public Private Partnership in Urban Primary Health Care in Dhaka city. The data and information collected from this survey will be used only for research purposes. Mentioning name of the respondent is optional.]

Part: A: Respondents' Profile

The following statements ask about respondents' profile.

1. Name of the respondent: ....
2. Age: .... years.
3. Sex: a. Male b. Female
4. Duration of staying in Urban areas....................................years.
5. What do you do/ profession?..
6. What is your average Income (monthly)

   a. 0-5000 b. 5001-10000 c. 10,001-15000 d. 15001-Above

Part B: Status of the services

7. Which type of service did you take from the health centre run under PPP?

   a. Family planning b. ESP c. Immunization & Vaccination (EPI)

   d. Nutrition e.TB

8. What do you think about the quality of services taken from the Health centers?
   a. Not Good b. Good c. Very Good

9. If the answer of the q. no 8 is Not good, then why?..
   ....

10. If the answer of the q no. 8 is Good, then why?..

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....

11. If the answer of the q no. 8 is Very Good, then why?..

12. Did you have to pay money other than fees for receiving services?

a.Yes b. No

13.Why do you select this health centre?...

Part C: Effectiveness of the services

14. Are the PPP health services centers are at reachable distance from your residence?

a. Close b. Far c. Not so far not so close d. Equally Close to all the service-receivers

15.How frequently you visit the PPP health services?..

16.Do you think PPP health services are better than any government owned or NGO owned health service?

a. Yes b. No

17.If the answer is yes, why?...

....

Thank you for your co-operation.

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APPENDIX 3

List and Addresses of UPHCC in Dhaka City Corporation

DCC PA – 01 – PSTC – Project management office, City Maternity (3rd floor), Dhalpur, Golapbag, Dhaka - 1203

DCC PA – 02 KMSS – 25/1. Agasadak Road, Dhaka

DCC PA – 03 BAPSA – Hazaribag Park, Near commissioners office, ward no 58, Hazaribag, Dhaka 1205

DCC PA – 04 PSTC – 104, Siddeswari Circular Road, Dhaka - 1217

DCC PA – 05 SHIMANTIK, 308/3, Block – A, Tilpapara, Khilgoan, Dhaka - 1216

DCC PA – 06, Narimaitree, 312, Bara Baghbazar, dhaka

DCC PA – 07 MSS – 65-V, Noorjahan Road, Mohammadpur, Dhaka - 1207

DCC PA – 08 UTPS, Project Management Office, Naki Barir Tak, 2nd Colony, Harirampur Road, Mirpur – 1, Dhaka - 1216

DCC PA – 09 PSKP – J-2/A, Pallabi Extension, Mirpur, Dhaka

DCC PA – 10 UTPS, Project Office, House no – 3(2nd floor), Road no – 11, Sector – 11, Uttara Model Town, Dhaka 1230

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