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## Making reform work: institutions, dispositions, and the improving health of Bangladesh

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**MAKING REFORM WORK  
Institutions, Dispositions and the Improving Health of  
Bangladesh**

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17 March 2008

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# **MAKING REFORM WORK**

## **Institutions, Dispositions and the Improving Health of Bangladesh**

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### **Abstract**

We examine whether local governance can improve social development empirically, using good and bad cases of public health outcomes in Bangladesh. We explore the institutional underpinnings of service provision, digging down beneath the “rules of the game” to analyze the beliefs, understandings and dispositions that drive social behavior. Changes in deep social attitudes led to improvements in social indicators. Regional variation in health outcomes is explained by the presence or absence of a dense web of relationships that enmeshed reformers in local systems of authority and legitimacy, strengthening their actions and making local society more susceptible to change.

*Keywords:* local governance, accountability, decentralization, social development, Bangladesh, Asia

## 1. Introduction

The challenge of improving public services is of central importance to low-income countries, where large swathes of the population suffer high burdens of ignorance, disease, poverty and malnutrition. Many of the benefits of success have been underlined by the recent experiences of Sri Lanka and Kerala, two low-income cases where indicators of social development<sup>1</sup> have raced ahead of economic growth (Alailama and Sanderatne 2000, Krishnan 2000, Véron 2001). Both examples suggest that success resulted from policies that extended primary services throughout the population, leading to gradual – but over time significant – improvements in education, health, mortality, and similar indicators of social development. But beyond these general observations, the question of how to organize and implement public service reforms to achieve such goals has no easy answers (World Bank 2004).

One of the measures most commonly advocated for improving public services is decentralization. By “bringing services closer to the people”, proponents argue, the quality of governance will be improved, and with it the quality of services that the public sector provides (or regulates). The slogan “bringing government closer to the people” can be disaggregated into three distinct advantages that, it is argued, decentralized government has:

- (i) More and/or better information
- (ii) More accountability
- (iii) More voice and participation.

By creating local governments beholden to local citizens, it is argued, public decision-making will benefit from improved information about local needs and place-specific

characteristics (e.g. geography, weather), the performance of public officials will be easier to scrutinize, and citizens will find it easier to participate in public debates and decisions. As a result, public policy will rise in quality, public investments will be better attuned to local priorities and conditions, and infrastructure and services will be more sustainable in the long run, as citizens will feel “ownership” over their production and maintenance (some influential references in this regard include Manor 1999, Putnam 1993, World Bank 1994, and Wallis and Oates 1988).

As we shall discuss in detail below, the reasons for thinking that decentralization will do these things are strong. But empirical evidence in favor, oddly, is mixed and – taken as a whole – weak. This leaves reformers in a quandary. Can local government reforms improve social services and hence increase social development? This paper examines the question empirically with new, detailed evidence on good and bad cases of public service effectiveness. We focus on sub-national variation within a single country, Bangladesh, in order to explore the institutional and social bases of high vs. low levels of social service provision, and hence high vs. low levels of social development. The background to this is Bangladesh’s decentralization program, which began in 1997 with the Local Government Act, followed by the Upazila and Zilla Parishad Acts of 1998 and 2000. These reforms have served, according to the accepted taxonomy, to ‘deconcentrate’ the country’s administration to division, district, sub-district, and union levels, but have stopped short of full devolution to any of them.

But it is useful to first review Bangladesh’s recent development trends. The last 15 years have brought significant progress to the country, which will come as a surprise to the many who still view Bangladesh through the lens of its immediate post-

independence experience. In 1971, Henry Kissinger is said to have characterized Bangladesh as an “international basket case”. Other observers, aid agencies, and even tourist guides largely agreed in spirit, if not tone, describing the country as a site of recurrent natural disasters, and a crowded labor reserve with few prospects for development (Faaland and Parkinson, 1976). But in 1990-91 the country achieved a structural break (i.e. a change in time-series parameters) in its growth and development trends, and moved onto a new path of strong growth averaging 3.2% *per capita* between 1990-2005 (Mahajan and Hussain 2006). Economic growth was accompanied by healthy progress in poverty reduction and other social indicators. Just between 2000 and 2005, for example, the share of the population living in poverty declined from 49% to 40%, and that living in extreme poverty fell from 34% to 25% (Mahajan and Hussain 2006).

Longer-term trends in poverty and broader indicators of social development show even faster progress. Figure 1 details how social indicators have improved, often dramatically, between the years before the structural break, and the years since. Because of these improvements, Bangladesh has already met its Millennium Development Goal (MDG) on gender parity in primary and secondary schooling a decade ahead of time, with current girl:boy ratios of 48:52 in primary schools, and 52:48 in secondary schools. Further evidence shows that among 11-12 year olds, slightly more girls than boys complete the five-year cycle (73% vs. 72%; Chowdhury et al., 2003). Bangladesh is likely to meet its consumption poverty and child mortality goals as well, given realistic growth projections and continuing levels of social expenditure. But other MDGs, such as maternal mortality, primary school enrolment and completion, and child malnutrition, are unlikely to be met (World Bank 2007). Accelerating progress in these areas is an

acknowledged priority of both the government and donor communities. One contribution of this paper is to analyze the place-specific institutional underpinnings of accelerated social development.

FIGURE 1 HERE

Impressive as these changes are, closer examination reveals striking and persistent variation in social indicators across space. Primary enrollment and primary completion rates are respectively 54% and 62% higher in the highest regions of the country than the lowest, for example. Divergent trends occur even within the same city: the ratio of girls to boys in school is 30 points higher in “Other Urban” Dhaka than “Standard Metropolitan Area” Dhaka. Child malnutrition, measles vaccination coverage and infant mortality also vary significantly across Bangladesh’s regions. And even these high levels of variation – essentially amongst different parts of the public service provision system – are trumped by variation between public and non-governmental service providers. For instance, Chaudhury (2006) uses data from 1994-2004 to show that areas of the country served by Gonoshasthaya Kendra (GK), a pioneer NGO in health care, reduced infant mortality consistently to levels of 32 per thousand live births in 2004, while the country as a whole remained well above 50.

What explains such stark differences? Following North (1990), Olson (2000), Williamson (1995), and other institutional theorists, the analysis in this paper is predicated on the notion that differences in social indicators are explained by the wide variation in levels of primary service provision (e.g. education, health care) across Bangladesh. Variations in service provision are largely explained by the differing patterns of accountability and objective incentives that local officials face. And

following Bourdieu (1986), incentives and accountability are, in turn, largely explained by the underlying understandings and dispositions that individuals must share if formal and informal institutions are to work effectively. The causal pathway looks like this:



Hence to understand success and failure in public service delivery, we must go beyond the organizations that produce them, beyond the institutions in which they are enmeshed, and beyond even the informal rules and conventions that govern incentives. We must go down to the underlying beliefs, understandings and dispositions that drive social behavior, and so help determine whether a given set of organizations and their policies can successfully meet the needs of citizens, or not. By focusing our analysis at this level we can better understand the incentives faced by both the producers and users of public services, and hence the degree of accountability that public servants face. And when we understand incentives and accountability, institutional theorists tell us, we are a long way towards understanding public sector effectiveness.

This paper analyzes the operation of such a pathway in Bangladesh via a close examination of the social and institutional underpinnings of service provision in two *upazilas* (sub-districts). Upazilas are the third of four levels of sub-national administration in Bangladesh, with an average population of 250,000, and are roughly similar to municipalities elsewhere.<sup>2</sup> Going from higher to lower, Bangladesh has six Divisions, 64 Districts, 460 Upazilas, and 4,401 Union Parishads. Union Parishads typically comprise 15-20 villages, encompassing some 25,000 people. There are over 70,000 villages in Bangladesh (Library of Congress 2008).

Our two cases were chosen purposively from the extremes of high and low-performing upazilas in terms of social development outcomes, focusing especially on maternal and child mortality. We do not pretend that these – or indeed any – two cases constitute a “sample”, or are in any sense representative of Bangladesh. Rather, we chose extremes of performance in the hope of gaining analytical richness and insight into the object of our research: the causes of good and bad social development outcomes. For the sake of focus and brevity, we dwell mostly on the health sector. Saturia is the high-performing upazila, and Rajnagar is the low-performer.

Our evidence is based on extensive qualitative and quantitative fieldwork by a team from the Bangladesh Institute of Development Studies (see methodology annex for more details). It indicates that two factors are responsible: (1) Health care provision is systematically better in Saturia, with services more suited to the needs and characteristics of the local population made available to more villages more frequently than in Rajnagar; and (2) services are in much higher demand in Saturia, with greater knowledge of the benefits of health care, greater acceptance of modern clinical methods, and fewer barriers to access due to traditional customs and beliefs. We explain this two-fold difference as a function of the deeper institutional and social context in which services are provided, and demanded, in each upazila.

The rest of the paper is organized as follows. Section 2 reviews the literature on decentralization and local governance, focusing on the question of effective service provision and the positive outcomes this can generate. Section 3 provides descriptive statistics of social development “outputs” in Saturia and Rajnagar, and connects these to differences in primary service provision “inputs”. Section 4 explains differences in

service provision as a function of local institutional settings that differ critically in the incentives and accountability that obtain in each. Section 5 concludes.

## **2. Literature Review: Institutions, Accountability and Social Development**

The importance of accountability to “good governance” has become a development nostrum in recent years (UNDP 1993, World Bank 1994). It is thus important to realize that the notion of accountability, much more than a policy fad, is rooted in strong theoretical arguments about the roles of incentives and information in democratic governance. Theory predicts that the incentives and accountability that obtain in democratic politics will tend to promote good social development outcomes (Dahl 1989). Democratic theorists posit this as a principal positive argument in favor of democracy over other systems of government, alongside strong negative arguments about avoiding the risks and costs of autocracy and dictatorship.

But the extension of such arguments to sub-national units, and hence to the question of decentralization, is a relatively recent phenomenon. Indeed, the concept of decentralization was essentially absent from political theory during the two millennia that separate Plato’s *Republic* from Rousseau’s *Social Contract*. Summarizing heroically, this is because the democratic ideal of ancient, medieval and renaissance times featured assemblies of free men who represented themselves directly. Democracy was appropriate for city-states with limited populations. Large nations with large populations required monarchical rule (Rousseau 1968 [1762]). Decentralizing political authority was unnecessary in a city-state, and nonsensical in a monarchy, and hence the question did not arise.

The advent of representative democracy changed this. The new form came about in two ways: (i) in some countries (e.g. Britain), constitutional monarchy was gradually transformed by the accretion of economic and social reforms into democracy, and (ii) in others (France, US) democratic republics were created by revolution. In the new democratic ideal, the many are represented in the legislature by the few, allowing democracy to flourish in much larger populations and territories. The great theorists of the new American Republic, Madison, Hamilton and Jay, treated the question directly. They explored what powers states should have, and which should be reserved for the center, and carefully explored the implications of different balances of authority between higher and lower levels of government. In today's terms, their ideal was a highly decentralized federation of states, albeit with a stronger center than under the doomed Articles of Confederation. Five decades later, Tocqueville (1967 [1835, 1840]) described in admiring terms an American system of government more decentralized than any in Europe. He admired this decentralization as consistent with democracy, and decried European centralization as consistent with tyranny.

The theoretical basis of such a position is easy to understand, as it is simply an application of the previous arguments about democracy to the question of geographic scale. If the participation and accountability that obtain via democratic processes are good for the quality of government and its responsiveness to citizens' needs, then disaggregating decision-making from the national to regional and local levels – i.e. decentralization – should improve quality and responsiveness further. This view posits that there exists a class of public services where economies of scale are low, and heterogeneity of demand/need is high across space. For such services, if spillovers<sup>3</sup> are

low, local provision can bring about efficiency gains by tailoring supply in terms of individual communities' demand/need, costs, and other technical parameters.

Modern theorists have developed these ideas in a number of ways. Tiebout (1956) posits a world in which individuals with heterogeneous tastes move costlessly between localities offering different combinations of public goods and taxes (to finance the goods). Given perfect information about the full range of options, a competitive equilibrium in locational choices will ensue, producing an efficient allocation. Although this paper is usually viewed as the foundation of the economics of decentralization, it is fair to say that it has fallen out of favor recently. This is because its assumptions of a highly mobile population and fixed governments are unrealistic,<sup>4</sup> and because it offers no political analysis of a question now viewed as fundamentally concerned with political economy.

Oates (1972) builds on Tiebout in order to examine heterogeneity of tastes and spillovers more carefully. Although this is another foundation stone of the economics of decentralization, still there is no political mechanism, no democratic participation, and no accountability. Besley and Coate (1999) provide politics, in a model of central policy-making in which elected representatives bargain over public goods provision in multiple districts. For heterogeneous districts, they find that decentralization is welfare superior in the absence of spillovers, and higher heterogeneity reduces the relative performance of centralization for any level of spillover. Hence under plausible assumptions, decentralized government can be expected to provide public goods better suited to the needs of heterogeneous populations, leading to higher levels of social development and improving welfare.

For a literature that addresses the question of accountability, government effectiveness, and development outcomes more directly, we must look to political economy work, such as Evans, Faguet, Tandler and Ostrom et al. Questions surrounding the state's capacity and willingness to drive forward broader developmental changes in society are central to the work of Evans, Tandler, and Ostrom, who deal with different aspects of such themes in many of their works. Unfortunately there is only space to review a small portion of their considerable scholarship here. Evans (1995) develops the highly influential idea of 'embedded autonomy'. This holds that bureaucratic 'embeddedness' in the real economic conditions and needs of a country, but with significant 'autonomy' from interest groups and distributional coalitions, are the two essential characteristics that have allowed certain economies and societies to develop rapidly. Evans (1996) extends the idea further, arguing that synergy between state and society can extend each others' developmental efforts, and that such synergies are most likely in countries characterized by egalitarian social structures and robust, coherent bureaucracies. In his view, such synergies are constructible, even where initial conditions are not promising, a point which we echo below.

Tandler (1997) argues that in order to create accountable sub-national governments likely to drive forward development, decentralization should paradoxically be twinned with a strong central state, or other committed national institution, such as a political party or NGO. Faguet (2007) attempts to explain high variation in local government performance in Bolivian municipalities after the 1994 decentralization. He models local government as occurring at the confluence of two quasi-markets – one for votes and the other for political influence – and one organizational dynamic between government and

elements of civil society. Good government results when these three elements, political, economic and civil, are in rough balance, and actors in one cannot distort the others. Specific types of imbalance – a dominant economic interest, for example, or a weak government-society nexus – map into specific forms of government failure.

And in the name of analyzing infrastructure policies, Ostrom et al. (1993) develop the notion of polycentrism. Appealing to ideas of democratic representation and accountability, they argue for the theoretical benefits of decentralization. They then analyze how a system of asymmetric, overlapping jurisdictions centered at different points, and designed to best suit the economic and technical characteristics of a variety of public services – roads, ports, watershed management, schools and hospitals, for example – can raise efficiency and promote long-term sustainability.

With literally hundreds of studies over the past 40 years, the empirical literature is much larger than the theoretical literature. But as Faguet (2004) and others have noted, empirical evidence on issues such as responsiveness to local needs and effects on social development, are mixed. Taken as a whole, it is difficult to draw clear empirical lessons about decentralization's potential for increasing social development. Proponents, such as Olowu and Wunsch (1990), Shah (1988) and Wallis and Oates (1988) find evidence that decentralization makes government more responsive to local needs by “tailoring levels of consumption to the preferences of smaller, more homogeneous groups” (Wallis and Oates 1988, 5). Manor (1999) finds evidence that decentralized governments increased public sector responsiveness in Côte d’Ivoire, the Philippines, and India.

Using data from a sample of 80 countries, Huther and Shah (1998) provide evidence that devolving power and resources to local governments increases social

development, political participation, and an overall quality of government index. Parry (1997) find that greater local government power over educational services improved educational outcomes. Rowland (2001) and Blair (2000) find that decentralization improved the quality of democratic governance achieved in both large cities and small towns. Eskeland and Filmer (2002) find econometric evidence that decentralization did lead to improvements in Argentine educational achievement scores. And in a study of Bangladesh, Galasso and Ravallion (2000) use careful econometrics to show that pro-poor program benefits increased with decentralization in Bangladesh.

On the other hand, opponents such as Crook and Sverrisson (1999), Smith (1985) and Solnick (1996), counter that local government's lack of human, financial and technical resources, and greater propensity to corruption and elite capture, will prevent it from providing effective public services under decentralization, regardless of whether they are "tailored" or not. In a series of three studies of local government in Africa, Ellis, Kutengule and Nyasulu (2003), Ellis and Mdoe (2003) and Ellis and Bahiigwa (2003), find that decentralization will likely depress growth and rural livelihoods by increasing business regulations and taxes that stifle private firms (Malawi), and propagate rent-seeking behavior down to the district and lower levels, so helping to entrench rural poverty, instead of solve it (Tanzania and Uganda).

Similarly, Véron et al. (2006) use evidence from India to show that when upward ties of accountability (e.g. to a political party) are weak, horizontal accountability structures can degenerate into networks of corruption manipulated by "community" actors. Francis and James (2003) and Bahiigwa, Rigby and Woodhouse (2005) argue that decentralized governments in Uganda, often captured by local elites, are not independent

or accountable to voters, and so are not useful tools for poverty reduction. Samoff (1990) asserts that decentralization reforms around the world have mostly failed, and finds the evidence on responsiveness strongly negative. Slater (1989) supports this position with an example from Tanzania, where decentralization did not serve the interests of the poor, but rather allowed a militarized autocracy to penetrate deeper into the countryside. Akin, Hutchinson and Strumpf (2005) find that decentralization in Uganda led local governments to invest less in public goods, and more in publicly financed private goods. And Asthana (2003) finds that decentralization of water provision decreased efficiency, raising costs and lowering asset utilization.

If this short review makes for frustrating reading, so too do the longer ones. A broad international survey of local government reforms carried out in 1983 (Rondinelli et al.) finds that decentralization has seldom, if ever, lived up to expectations, at least partly because most countries implementing reform experienced serious problems of implementation. Twenty-one years later, Shah, Thompson and Zou (2004) review the empirical studies and find that decentralization has in some cases improved service delivery, corruption and growth, but in other cases worsened them. Our lack of progress in understanding decentralization is striking.

What most of these studies have in common is that they are national-level studies of one or more countries. Few take municipalities or localities as their unit of analysis, and fewer still attempt to unlock the black box of local government decision-making in order to understand why some local governments perform well and others badly. One exception is Faguet (2007), who examines local government effectiveness in two extremes of municipal performance. Our paper most resembles his, only deeper. Faguet

explains municipal performance in terms of economic and civic actors operating within a political structure. Our analysis takes account of these factors, but then goes deeper – to the social and cultural factors operating beneath the level of formal structure. But before we can enter into this analysis, we must introduce Saturia and Rajnagar.

### **3. Divergent Development: Saturia vs. Rajnagar**

Saturia upazila is located in Manikganj district west of Dhaka, while Rajnagar upazila is located in Moulvibazar district on Bangladesh's eastern border with India. Despite its greater distance from the capital, it is Rajnagar that is wealthier, with an average household income of Tk.7,081/month compared to Saturia's Tk.5,831/month, and more livestock assets per family.<sup>5</sup> Average landholdings are higher in Rajnagar, at 182 decimals<sup>6</sup> per household vs. 137 in Saturia. And Rajnagar's literacy rate of 64% is also higher than Saturia's 58%. This is at least partly explained by the high levels of remittances families in Rajnagar receive from a large diaspora in the UK. Indeed, the nearby airport in Sylhet boasts direct flights to London. But Rajnagar is also more unequal, with more households in both the extreme poor and rich categories, while 86% of Saturia's population is concentrated in the intervening two categories.

But paradoxically, Saturia has systematically superior health indicators than Rajnagar. Under-five mortality in 2005 was 13 per thousand in Saturia, compared to 40 per thousand in Rajnagar; the prevalence of illness in Saturia is 25%, compared to 36% in Rajnagar; and the notional maternal mortality rate over the previous 5 years<sup>7</sup> was 0 in Saturia, compared to 791 per hundred thousand live births in Rajnagar. The statistics on complications during childbirth tell the same story: mothers in Rajnagar suffered more from long labor, excessive bleeding, high fever and convulsions than mothers in Saturia.

In light of this, it is not surprising that Saturia has had considerably more success in reducing its maternal and child mortality rates<sup>8</sup> over the past few years than Rajnagar.

FIGURE 2 HERE

It is also not surprising that much of this is due to superior provision of health services and better infrastructure in Saturia. Pregnant mothers receive more antenatal care in Saturia (91%), for example, than Rajnagar (73%). More mothers are informed about the signs of pregnancy complications in Saturia (83%), and where to go when they occur (87%), than Rajnagar (63% and 73%). Access to sanitary toilets is higher in Saturia (90%) than Rajnagar (69%). More mothers receive vaccinations and nutritional supplements during pregnancy in Saturia, and more have a post-partum check-up, and more quickly, than Rajnagar. Figure 3 summarizes additional data on child health interventions and outcomes in the two upazilas.

FIGURE 3 HERE

If economic variables do not explain such divergent health outcomes, what does? The answer cannot relate to the structure of local government or the health sector, nor to the quantity nor design of the physical infrastructure available, as these are common to both upazilas. Both Saturia and Rajnagar benefit from the same upazila administrative apparatus, with similar levels of staffing and finance. And both are served by the Ministry of Health and Family Planning, which in Bangladesh employs a particularly standardized, homogeneous model of health provision that deploys assets uniformly, allocates resources mechanically, and is as a result insensitive to local characteristics or variations in local demand (Pearson 1999).

It is important to note that this does not imply stasis in Bangladesh's health sector. Indeed, both sub-districts benefited from health reforms during the past two decades. The fourth five-year plan (1990/91-1994/95) re-oriented health policy towards combating maternal and infant mortality through major immunization drives, family planning, and attention to respiratory and diarrhoeal diseases in children. This was followed in the fifth five-year plan with the introduction of the Essential Services Package (ESP) for the health sector, which seeks to provide a common core of basic services related to children's health, communicable diseases, reproductive health, and some curative care (Pearson 1999). Key elements in both five-year plans included fomenting community participation in the production of health services, and more intensive service delivery (Ensor et al. 2002; Ministry of Health and Family Welfare 2008). Public health experts generally agree that these reforms have contributed significantly to Bangladesh's improving health indicators (Ensor et al. 2002; World Health Organization 2008). But their impact in Saturia and Rajnagar has not differed. Hence variations in performance must be due to something else.

If the answer is not local health "hardware", is there something in the health system's "software" that might explain differences in performance? A visit to each upazila is telling in this regard. There are numerous, obvious differences in the maintenance and operation of the health facilities at hand. Field visits to each Upazila Health Complex (UHC) found Saturia's was well-maintained and clean, with more bathrooms available, all clean and in working order, the operating room in good repair and used regularly, and staff absenteeism of 1%. In Rajnagar, by contrast, most of the rooms, wards, windows and doors were damaged, its toilets were so dirty they had

become unusable, the operating room was unused and abandoned, and staff absenteeism was 10%. Unfortunately for the residents of Rajnagar, health workers made far fewer community visits than in Saturia, leaving them more reliant on this degraded infrastructure. Detailed interviews revealed that patients in Saturia were quite happy about the quality of services they received, while in Rajnagar opinions were decidedly mixed.

These differences grow sharper at the union level.<sup>9</sup> The Union Health and Family Welfare Center (UHFWC) visited in Rajnagar was badly understaffed, with no doctor in charge. This forced it to close when staff attended at Satellite Clinics (SCs) in the villages, leaving it open only three days a week. The UHFWC in Saturia, by contrast, was fully staffed and open 5 days a week. Facilities were well maintained and clean in Saturia, but badly maintained and dirty in Rajnagar, with the toilets once again unusable. Both have electricity, but almost no lights or fans worked in Rajnagar, rendering the operating room inoperable. In Saturia all of the above did work, and the operating room was in regular use. The tubewell did not function in Rajnagar, and the water supply lines were damaged, while Saturia's water infrastructure was in good repair. In Saturia medicines and family planning supplies were well stocked and regularly replenished, whereas Rajnagar received family planning supplies but no medicines from the Ministry.

As we might expect, the combination of superior facilities and happier patients led to greater popularity amongst the population – the Saturia facility treated 8,000 patients in 2005, while the Rajnagar facility managed only 4,400, despite a larger overall population. These differences were reflected at the village level, where the Saturia SC was better endowed with health and sanitary equipment, including a toilet, which the

Rajnagar SC did not have. On the day each was visited, 85 patients were treated at the Saturaia SC compared to just 24 at the Rajnagar SC. The dysfunctionality of Rajnagar's UHFWC, of course, contributed to heavier use of its upazila health complex, despite the problems identified at the latter. Because a UHC is a higher-cost installation than a UHFWC, the upwards deflection of patients in Rajnagar led to higher overall costs for a given number of treatments. Thus in Saturaia, better functioning of the health services pyramid not only extended services to more patients, but effectively reduced unit costs.

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

In summary, the structure of the public health system, and the quantity and design of its assets, were quite similar across both upazilas. But these assets were maintained and exploited in quite different ways, leading to significant differences in the quality and quantity of services provided in the two upazilas. These differences led to important differences in real health outcomes, and explain why people in Saturaia suffered from fewer diseases, and had healthier mothers and children, than those in Rajnagar. The link

between better health services and improved outcomes is further supported by a detailed econometric analysis of the two areas (Ali and Rahman, 2006).

#### **4. Institutional Determinants of Divergent Development**

So far we have good proximate causes of the variation in health outcomes. But to find the deeper determinants, we must go further. Why were infrastructure and equipment deployed differently in the two districts? Why were they cleaned and maintained in one but not the other? To answer these questions we must follow the examples of Evans, Tandler and Ostrom and dig deeper into the local institutional context in which the health sector operated, identifying the underlying incentives and behaviors at work. And to explain variations in this institutional context, we must go deeper still, and consider how the districts' histories and geographies impacted upon people's beliefs and social relations.

Consider first the question of monitoring. Focus group discussions revealed important differences in the way that public services were monitored in the two upazilas. Health authorities in Saturia reported extensive monitoring by their superiors at the district level, with frequent visits to the area, whereas their similars in Rajnagar reported no such monitoring. This establishes upwards accountability for Saturia's health system, but not for Rajnagar's. Accountability also works in the downward direction in Saturia, with the active involvement of union parishad<sup>10</sup> (UP) officials in health delivery issues. Focus groups testified that the UP chairman takes steps to facilitate the proper implementation of Saturia's health program, and union officials regularly monitor the quality of services provided in town and villages.

Our research team corroborated this when we found the chairman observing immunizations in different areas of his union on National Immunization Day. When asked why he did so, he responded, “As the local people’s elected representatives, it’s our responsibility to monitor whether they’re getting the services they’re supposed to receive. We keep tabs on whether health authorities are providing proper services to the people or not, and visiting villages in a timely fashion or not.” We found no evidence of any of this in Rajnagar, whose health officials were left operating in an institutional vacuum, disconnected from both their superiors and from the elected representatives of their target population. In such a context, it is not surprising that their performance was indifferent and unresponsive. These findings echo Chaudhury (2006), who finds that Gonoshasthaya Kendra’s remarkable success in improving basic health care indicators in its target population is largely due to the upwards and downwards accountability that it is able to generate.

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

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

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

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

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

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

In this way, attitudes conducive to better health, and the information on which they are based, are reinforced in the population. New ideas circulate, and new standards of health care are adopted by the group, which can then mobilize its efforts in aid of a needy members, further reinforcing the importance of medical care. As Bourdieu, Brett (Forthcoming) and others have pointed out, institutions do not operate in a psychological vacuum, but rather rely on attitudes and dispositions compatible with their core ideas. In Sauria, health-compatible attitudes are reinforced by a dense web of social and institutional relationships. In a similar vein, Chaudhury (2006) attributes GK's success to the way it anchors its health programs in the local community, relying on village workers and natural authorities, and so exploiting the local knowledge and credibility/authority that they enjoy. It is significant that BRAC, another large NGO with notable success in the health sector, uses a similar model (BRAC 2005).

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

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

Even in the home, special foods and nutritional supplements are spurned in Rajnagar, as families choose instead to rely on their normal daily diets. Visits to health centers and medical staff are avoided by villagers who shun pre-birth medical tests.

Hence pregnant women requiring interventions tend to arrive at the UHC in a near-critical state. Thus another respondent:

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

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

So the attitudes, and the personal and institutional relationships, that characterize each district are significantly and systematically different. What explains such differences? In our view, these differences are largely a product of the districts' history and geography. First, consider geography. Saturia is some 50 km west of Dhaka, and well connected to it by good-quality transport, telecommunication and media links, as well as dense networks of personal and professional contacts. The last is the most important. Saturians can easily commute to work in Dhaka, while officials, academics, and NGO professionals from Dhaka can – and often do – take day trips to Saturia, often in search of a more “typical” (i.e. ex-Dhaka) Bangladeshi context for studies, fact-finding missions, pilot projects, etc. Hence the presence of Dhakan ideas, attitudes, and dispositions is quite apparent in Saturia.

None of this is true of Rajnagar, which lies some 300 km northeast of Dhaka. Access to Dhaka is typically by long road trip, or air plus road travel via Sylhet. Regular

contacts with Dhaka are accordingly fewer and less intense. Rajnagar is located where the Bangladeshi plain meets the northeastern foothills, producing a terrain quite different from the rest of the country. Residents report feeling “isolated” from the capital, and “special” within Bangladesh. Such feelings inform both their identity and behavior.

The question of proximity to Dhaka is important because the capital is the political, economic, and intellectual nerve-center of the country. The Bangladeshi state is highly centralized, with power, resources and authority concentrated in the center. Not only are most policy decisions of importance made there, but most private sector firms and NGOs are either based there or controlled from there. The city boasts the best educational institutions and the most modern health facilities – indeed, the highest quality of public and private services in the country generally. It is also by far the place best connected to the outside world. It is richer, more knowledgeable, and more sophisticated than the rest of the country. Thus we can expect districts that are close and well-connected to Dhaka to more easily mirror the attitudes and behaviors first adopted there, compared to districts that are farther removed.

Second, Rajnagar is more religiously conservative and observant than Satoria, and this is largely due to its history. In 1303 a messianic Muslim saint from Mecca, Hazrat Shah Jalal, arrived in the Sylhet region, of which Rajnagar is a part, where he helped defeat the local ruler. With the aid of 360 companions, including several others who would be sainted, he spread Islam throughout the region before dying in Sylhet around 1350. Sylhet became a center of Islam in Bengal. Shah Jalal’s shrine in the main mosque complex, which houses his swords and robes, is highly revered, and a holy destination for pilgrims from across Bangladesh and South Asia.

Attempting to locate the cause of modern social phenomena in the mists of time is, in the best of circumstances, a tricky enterprise. But it is reasonable to infer that the example of conservative, militant Islam championed by a local saint, and the everyday presence of his shrine as a place of veneration and pilgrimage, reinforce a conservative religious orthodoxy in Rajnagar (and Sylhet more broadly), in a way that simply has no parallel in Sauria. That is to say, Rajnagar's streak of religious orthodoxy may or may not have begun with Shah Jalal. But however initiated, the history and architecture of sainthood that he established in Sylhet, which thrive to this day, serve to reinforce orthodoxy, and all the ideas and behaviors associated with it (Ahamed and Nazneen 1990). Hence Rajnagar's women are not allowed to venture out of doors unaccompanied, modern medicine is suspect, and women have much less power to make important decisions about their lives than in Sauria. Such ideas and behaviors – as we have seen above – help to drive Rajnagar's inferior social development outcomes.

The third important factor is a combination of geography and history: Sauria has a much higher intensity of NGO interventions than Rajnagar, and this has been sustained over several decades. Since the 1970s, NGOs have played a significant role in raising awareness amongst women and the rural poor in Bangladesh, changing attitudes towards education and health care, and fomenting participation and economic empowerment. As a result, Saurian women are informed about, seek, and even participate in the provision of education, maternal and child health care, and birth control, to name three key services. A large share of Saurian men have benefited from economic empowerment, and household income earning activities – such as pottery-making, weaving, and the preservation and transformation of foods for market – are commonplace. None of this is

true of Rajnagar. The greater presence of NGOs in Sauria is probably due, once again, to its proximity to Dhaka. But it is the persistence of this NGO intensity over decades that has permitted their interventions to transcend the building of facilities and skills, and reach the deeper beliefs and behaviors of the population.

In summary, we have two upazilas with similar local government administrations, similar health service administrations, similar infrastructure and equipment, and similarly qualified staff employed by a common central ministry. But these assets and personnel were deployed in very different ways, resulting in high variation of service, and significantly different social outcomes. Why? The answer lies in the deep changes in understandings and dispositions amongst Saurians towards the value of health care (and other primary services). These are a product of the rising education levels documented in section 1, plus the promotion by public authorities of a primary health care model implemented at the district, upazila, and union parishad levels. These elements combined to make Saurians seek out modern health care, and take a greater interest in its effective provision. Which, in turn, imposed greater constraints of accountability on public health officials. There is considerable evidence that similar dynamics, not documented here, have taken place in the education and water sectors, and with respect to local government more generally.

But improvements in education, and the roll-out of a primary health care model, are national phenomena in Bangladesh. Why did they combine to promote change in Sauria but not Rajnagar? Because in Sauria such advances were like seeds planted in an institutional soil that nourished them and allowed them to take root. This “soil” consists of a dense web of relationships between citizens, their natural and legal authorities, and

service providers, that enmeshed these advances – and the reformers who drove advances forward – in local systems of authority and legitimacy. This strengthened both reforms and reformers, and made society more susceptible to change. Saturaia’s institutional soil was prepared and made fertile by its proximity to the capital, its history of sustained NGO involvement, and a relatively open, tolerant religious tradition. In Rajnagar, by contrast, similar institutional underpinnings were missing. Citizens felt less empowered, and less connected to their authorities. The seeds of change fell on soil made barren by history and geography, and social development stalled.

## **5. Conclusions**

It is tempting to attribute differences in behavior, and hence outcomes, between Saturaia and Rajnagar to simple exogenous cultural – especially religious – factors. To be sure, Rajnagar is more religiously traditional and conservative than Saturaia, and this contributes importantly to how women are treated there. But our reading of the evidence is that much more of the micro-level variation between the two upazilas can be explained via an analysis that enmeshes Saturaia’s service delivery model in a web of local relationships and interactions that impose binding upwards and downwards accountability on her health providers.

If services are to respond to a population’s particular – and changing – needs, and be credible in the eyes of the population, then the elected representatives of that population should be involved in their production. They should have a degree of voice, or other leverage, over the way those services are provided, including the application of positive and negative incentives to directly responsible staff. Of course, such representatives must themselves be the product of elections that are free, fair and

transparent if they are to have credibility and act with moral weight. They use their moral weight to communicate community problems and expectations upwards to service providers and their superiors, as well as the substance of policy reforms *and their motivations* downwards to the grass-roots. In this way, not only are specific policies made credible in the eyes of the people, but the changes in social behavior that underpin progress can begin to occur.

Perhaps the more important point is that history and geography are given, but questions surrounding the institutional basis of service provision are patently susceptible to reform, as the case of Saturia shows, and hence are the proper object of policy. And so when confronting the failures of health care in Bangladesh, we do well to ask ourselves not how conservative are her Muslims, but rather what are the institutional foundations of success in Saturia, and how can they be replicated not only in Rajnagar but throughout the country. This is because a number of the behavioral traits we think of as “cultural”, and hence exogenous to policy analysis, are in fact sustained by particular institutions, and can thus be transformed by institutional reform.

Consider how the two upazilas treat their pregnant women. Rajnagar’s are kept indoors and discouraged from visiting health workers, regardless of the sickness, suffering, and death this causes. But Saturia’s are free to leave the house unaccompanied, and encouraged to seek medical attention by family and friends far more knowledgeable about the health consequences of their actions than their similars in Rajnagar. Is this difference a cultural one? A religious one? Without doubt Rajnagar’s social mores are affected by its religious orthodoxy, which is itself deeply embedded in

the region's history and identity. But history is not destiny. As for any municipality anywhere, Rajnagar's history determines its initial conditions, not its trajectory.

Indeed, until recently, such initial conditions were largely shared by Saturia. "It was not like this ten years ago," a resident of Saturia reminds us, but then things changed. Change came through an 'Evans-esque' synergy of NGOs' educational and empowerment programs, the efforts of public health and education workers, and continuous exposure to the attitudes and practices of the capital. Success took the form of the production of an institutional framework that enmeshed reformers and their efforts in a dense web of relationships that both strengthened their actions and made local society more susceptible to their message. Exogenous factors such as history and geography contributed much to the production of this institutional framework. But so did the directed efforts of reformers such as NGO workers, public sector professionals, and local leaders, who set out to change things. And change they did – Saturia's "cultural" behaviors changed, its people became healthier, and its women more free.

Our "tale of two upazilas" provides another, broad lesson about the importance of strong micro foundations for the study of local government. It is notable that a common legal and administrative framework produced such disparate outcomes in Saturia and Rajnagar. This implies that their success and failure have little to do with the laws, policies, and other national characteristics of Bangladesh, and much to do with the local incentives and patterns of interaction that foment involvement by, and accountability to, the public, or not. This suggests that studies that attempt national-level evaluations of decentralization start out with the wrong question. Decentralization is not a policy prescription that produces discrete national results to be measured and parameterized, as

much of the existing literature seems to assume. It is, rather, a process of letting go by the center that loses as many independent, idiosyncratic dynamics as there are local governments in a country. Decentralization does not produce a limited number of good or bad outcomes; it produces a large number of good outcomes, and a large number of bad outcomes. The simplest question that can be asked is: How do the good and the bad compare? The more interesting questions are: What makes the good good? And how do we make the bad good? This requires that we study local government reforms as local, and not national, phenomena, and focus analytically on the institutions, actors, and dynamics that comprise the local political economy. Only by resisting the temptation to aggregate can we hope to understand how decentralization works, and how to make it work better.

## **Methodological Annex**

Quantitative and qualitative research methods have been applied to collect data from a variety of respondents. The categories of respondents include: (i) government health facilities at upazila, union and community levels; (ii) health service providers (i.e., doctors and other medically trained persons) of upazila, union and community level health facilities; (iii) patients of upazila, union and community level health facilities, including in-patients of upazila health facilities; (iv) selected households of selected villages; (v) selected male and female members of the villages; and (vi) selected individuals (knowledgeable and articulate) from in and around the selected villages. The instruments used for data collection include structured questionnaires for both patients of health facilities and households, semi-structured interview schedules for health providers

and others, checklists for focus group discussions, and observation checklists for the health facilities. Structured questionnaires include the socio-economic and demographic background of patients and the households, health status and health seeking behavior, and service delivery issues, among others. Interview schedules focused on service delivery issues, the attitudes and behaviors of health providers, and the knowledge, attitude, culture and practices of people living in the area. Focus group checklists also included issues related to health care practices and service delivery issues. Observation checklists included physical facilities, utilities, hygiene condition, staff, quality of services, etc.

### **Case Selection**

Two upazilas were selected purposively based on their performances in reducing maternal and infant mortality over the past years – one being the over-achiever in reducing maternal and child mortality, and the other being the under-achiever. Before selecting the upazilas, two districts were selected to ease the selection of the upazilas. The selection of the districts was made based on Sen and Ali (2005), where some of the districts emerged either as over-achievers or under-achievers with respect to Bangladesh's MDGs. On this basis, Manikganj was selected as the overachiever with respect to maternal and child mortality, and Moulvibazar was selected as the underachiever. Data were then collected from district civil surgeon and family planning offices about certain reproductive and child health indicators for all the upazilas of both the selected districts. Based on that information, the upazilas of each district were ranked according to performance. Selection of upazilas was then based on extremes of performance within each district, leading us to Sauria upazila in Manikganj district, and Rajnagar upazila in Moulvibazar district.

With respect to government health facilities, three health facilities were selected for investigation from each of the upazilas. They are: the Upazila Health Complex (UHC); one Union Health and Family Welfare Center (UHFWC); and one Satellite Clinic (SC). Selection of the UHC was straightforward, as each of the upazilas has one such health complex. Selection of the UHFWC was random from amongst those centers that are at least eight kilometers away from the UHC and similar facilities. Satellite Clinics were selected from within the catchment areas of the UHFWC. Selection at this stage was again random, but from within those Clinics that are at least five kilometers away from the UHFWC.

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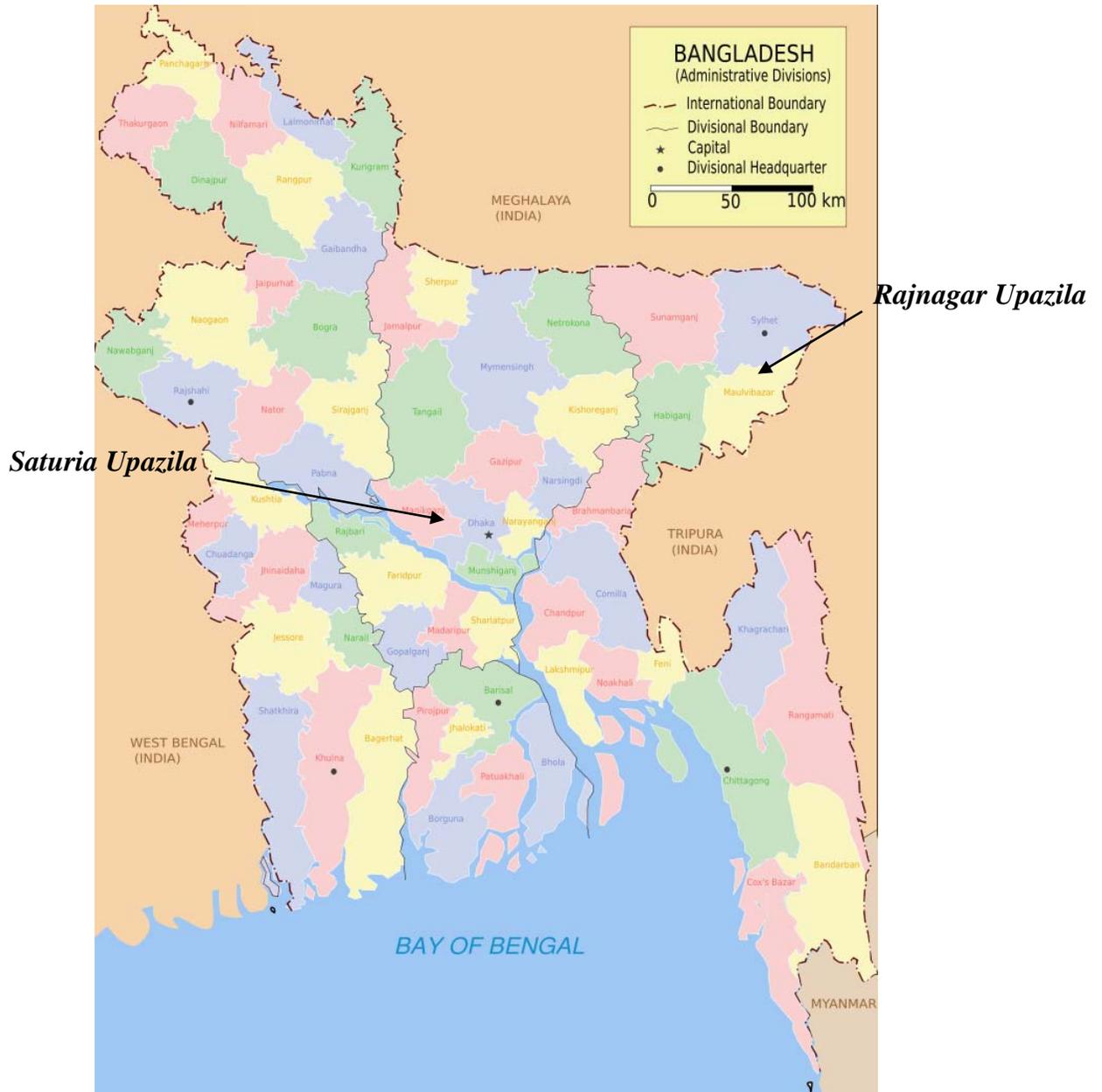
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**Figure 1: Improvement in Social Development Indicators**

<b>Indicator</b>	<b>Pre-Break (Year)</b>	<b>Current (Year)</b>	<b>% Change</b>
Enrollment, primary school (% net)	71 (1990)	84 (2004)	18%
Enrollment, secondary school (% net)	19 (1990)	44 (2005)	132%
Ratio of girls:boys in secondary education	26:74 (1977)	52:48 (2002)	200% (girls)
Immunization, DPT (% of children 12-23 months)	1 (1980)	93 (2004)	9200%
Immunization, measles (% of children 12-23 months)	1 (1982)	76 (2004)	7600%
Life expectancy at birth (years)	45 (1972)	62 (2003)	38%
Malnutrition prevalence, weight for age (% of children under 5)	68 (1983)	47 (2005)	-31%
Infant mortality rate (per 1,000 live births)	145 (1970)	65 (2004)	-55%
Under-5 mortality rate (per 1,000 live births)	239 (1970)	88 (2005)	-63%
Improved sanitation facilities (% of population with access)	23 (1990)	64 (2005)	178%
Fertility Rate	7.0 (1972)	3.0 (2004)	-57%

Source: World Bank (2007); Library of Congress (2007)

**Figure 2: Map of Bangladesh – Saturia and Rajnagar**



Map courtesy of Armanaziz and Wikipedia, under a GNU free documentation license.

**Figure 3: Selected Child Health Indicators by Upazila**

<b>Indicator (all %)</b>	<b>Saturia</b>	<b>Rajnagar</b>
Newborns fed colostrum immediately after birth	90.9	84.7
Vitamin A given to child	82.9	72.7
Measles Immunization Rate	93.0	85.6
Diarrhoea incidence, previous 2 weeks	25.4	42.5
Chest problems incidence, previous 2 weeks	12.9	24.2
Breathing difficulty incidence, previous 2 weeks	18.2	28.4
Coughing incidence, previous 2 weeks	35.1	59.3

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<sup>1</sup> This paper uses the term ‘social development’ loosely to refer to non-economic aspects of human development, such as advances in education, health, and access to water and sanitation.

<sup>2</sup> See Rahman (2006) for a detailed discussion.

<sup>3</sup> Spillovers refers to benefits from an investment or service that accrue to external populations. For example, if a health clinic benefits the populations of neighboring villages, then those villages receive positive spillovers.

<sup>4</sup> In most, if not all, countries it is the other way around. See Bardhan (2001).

<sup>5</sup> All of the statistics in this section come from original fieldwork, as detailed in the methodological annex.

<sup>6</sup> One decimal equals 1/100<sup>th</sup> acre.

<sup>7</sup> This is notional because such a low-frequency phenomenon as maternal mortality requires a larger sample or longer time frame for accurate calculation.

<sup>8</sup> Two important indicators in their own right that are sometimes used as proxies for broader social development. See for example Boone and Faguet (1998).

<sup>9</sup> Unions visited were Munshibazar in Rajnagar and Dhankora in Saturia.

<sup>10</sup> A union parishad usually covers several villages.