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DECENTRALIZATION OF HEALTH SERVICES

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Dr Bhojraj Pokharel
WHO Short-term Professional

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1. TERMS OF REFERENCE

(1) To review the status of decentralization of health services to the district level in India, Bangladesh and Nepal with regard to:

– Flow of funds for health (e.g. block-grant with/without earmarking for health)

– Programme planning (full bottom-up or mixed with top-down planning)

– Staff recruitment and payment

– Role of central level (minimal or significant change)

(2) To identify the problems encountered in decentralizing health services to the district level, and suggest steps to overcome it, and

(3) To recommend how best WHO could assist countries in implementing decentralized health services.

2. ACTIVITIES UNDERTAKEN AND EXPECTED OUTPUT

2.1 Activities Undertaken

This assignment is primarily based on a review of available literature, interviews, discussions and field visits. An extensive review of available publications, cross-country experiences, case studies, and relevant websites on the Internet was carried out. Discussions were held with government officials, academicians and scholars from concerned universities and research institutions. Field visits in Bangladesh and Kerala in India were undertaken to observe country experiences in decentralizing health services. In the course of field visits, various interactive meetings on the issues of decentralization in health services were held with health workers, officials, NGOs and development partners involved in health.

A list of selected literature reviewed is given in *Annex* I and persons contacted and institutions visited are listed in *Annex* 2.

2.2 Expected Output

• Preparation of documentation on experiences of target countries in decentralization of health services, and

• Identification of areas where WHOs' involvement to strengthen decentralized health services is desirable.

3. DECENTRALIZATION: CONCEPTS AND APPROACHES

Decentralization is primarily related to devolution of authority. Experts in administration and management attempted to broaden the sphere of decentralization, and consequently transfer administrative and managerial authority to lower units in the hierarchy. Economic liberalization and

free market economy further widened the jurisdiction of decentralization and developed in the form of privatization. In the present day context, the meaning of decentralization is limited not only to the political arena but also to administration, management and economy. To put it more succinctly, decentralization is the transfer or delegation of planning, decision-making or managerial authority from the central government and its agencies to field organizations, subordinate units of government, semi-autonomous public corporations, regional authorities or nongovernmental organizations.

4. DECENTRALIZATION IN HEALTH SERVICES

The Alma-Ata declaration on *"Health For All by 2000"* is a turning point in the process of decentralization in health services. In the South-East Asian Region, vertical and horizontal differentiation of health-related institutions in the form of district, region, hospital boards, community level health units can be considered as a precursor to decentralization of health services. Steps have been taken to delegate administrative and financial authority to these institutions; however, the extent and sufficiency of delegation can be questioned. As mentioned earlier, decentralization demands a holistic approach, and the decentralization of health services cannot be looked into in isolation. As a part of reforms in the health care delivery system, decentralization is currently being promoted in many countries as a means to improve the performance and outcomes of national health care systems. To this effect, since the early nineties, there have also been notable policy shifts among donors towards programmes supporting good governance and decentralization. The recent meeting of health ministers in the South-East Asia Region has also highlighted the need for decentralization of the health sector.

It is often imputed that health ministries in developing countries have a reputation of being the most bureaucratic and least effectively managed institutions. Such centrally managed health care systems, by and large, are poorly structured, badly led and inefficiently organized. Failure of such systems spawned the need for "people centred" health care systems that build on bottom-up approaches in planning, allow wider participation of people in needs assessment, ownership over the resources and facilities and stewardship of the local bodies.

5. OVERVIEW OF THE EXISTING SITUATION

5.1 Existing Scenario

Of the target countries, India has a federal system of governance, whereas the rest are unitary. Decentralization has been well recognized at least in principle by the countries (Bangladesh, India and Nepal) under review. Bangladesh and Nepal are relatively newly emerging democratic countries. Whatever be their position, the countries are divided into political and administrative sub-units with varying degrees of authority. The constitution of these countries almost unanimously have provision for decentralization. Likewise, the regulatory framework for decentralization in Nepal and Kerala in India is relatively better. The policy framework, either national or sectoral, emphasizes the need for decentralization. The target countries under review demonstrated that effective implementation of decentralization is limited by a weak institutional base. Unwillingness on the part of the central actors to delegate authority at the local level is seen to be a major obstacle to decentralization. Likewise, strong resistance from health-related human resources is one of the hindrances for decentralization. Dearth of trained manpower or the capability of local level institutions is always treated skeptically by the centre. The problem is further compounded by confusion on the concepts and practices of

decentralization because of the lack of clearly defined new roles for all levels including those who get the benefits of decentralization.

It is interesting to note that willingness on the part of decision-makers to decentralize the health system is there, but it has not happened yet. The policy documents of the target countries on health almost unanimously have given high priority for decentralization. In Nepal, the New Health Policy (1991), Long-term Health Plan (1997), and the Ninth five-year plan (1997-2002) have formulated policies, strategies, and programmes concerning primary health care based on decentralized concepts and approaches. The recently enacted Local Governance Act in Nepal is intended for total decentralization. Likewise, Health and Population Sector Strategy in Bangladesh has given priority for decentralization. The 73rd and 74th Amendment to the Indian Constitution recognized the existence of Panchayati Raj, which, in effect, is the acceptance of the existence of local bodies. Every state is authorized to enact laws on decentralization. According to the Indian Constitution, health is a subject within the purview of the state government. However, major vertical programmes in India are handled by the Central Government. In all the three countries, community participation is solicited in all health-related activities at the local level.

5.2 Planning Process

In principle, it is agreed that the planning process for the health sector will be bottom-up. However, to a great extent, such plans are prepared at the central level. Generally in Bangladesh and Nepal, health ministries prepare the planning guidelines for the local units, and local units prepare their annual plans based on the guidelines dictated by the Centre. The plans prepared by the local units are submitted to the higher level for approval. In the majority of the instances, they are overlooked by the Centre. It can be said from the study that planning at the local level is incremental rather than need-based.

In Nepal, village development committees get five hundred thousand rupees, and out of which five percent has to be set aside for the health sector. The local bodies are free to plan this budget according to their local needs. If they generate the local resources, they are free to develop and finalize the plan for this self-generated fund. Hospital boards are authorized to generate their own funds, and if they do so they are free to plan within their resources, which is not seen in other countries.

In Kerala, 35 to 40 percent of the total budget of the state government is allocated to the local bodies (Gram, Block and District Panchayat). Out of this 40 percent, 30 percent of the budget has to be allocated for planning activities related to social sectors. Plans for such resources are entirely based on locally identified needs. While vertical planning is done by the Centre, the identified target and budget have to be implemented by the local units. The Ninth Five-year Plan in Kerala is considered as the best model for empowering local self-governments. A movement popularly known as "People's Campaign for Decentralized Planning" was launched, whose main focus was to create pressure from below to bring about necessary institutional reforms corresponding to devolution.

In Bangladesh, the line directors prepare their sectoral planning. However, operational planning is done at the local level. It is often cited that there is bottom-up planning but in practice it is top-down approach.

Again, as far as planning for vertical projects/programmes is concerned, local units have a minimal role or almost no say in all the target countries.

5.3   Flow of Funds

As mentioned in the planning process, the target countries, especially India and Nepal, get some central funds, which are block grants. The rest of the activities are tied up in programmes. Major procurement in all the countries is done at the ministry level. In Nepal, hospital boards can carry out procurement by themselves. In India and Bangladesh, emergency procurement is given to the local level health institutions. Procurement authority for the budgeted amount is entrusted to district procurement committee in Bangladesh, whereas in Nepal, it varies according to the will of the centre. Fees levied by semi-autonomous bodies such as hospital boards in Nepal can utilize it by themselves. Whereas in India and Bangladesh, collection of users' fees is not common and all the resources generated by the health institutions goes to the treasury. In all the target countries, up to the district level, the funds are disbursed directly from the ministry.

Notwithstanding the process of budget allocation, local units get some funds from the Centre for the implementation of programmes. Funds are disbursed from the Centre on a periodic basis. All the funds are not transferred to the local treasury at once. Local units are mandated to submit physical and financial progress reports periodically. They are also given the authority to expend the allocated funds within the same budget line.

In Nepal and Bangladesh, the flow of funds takes a rather lengthy route. The Ministry of Finance releases the budgeted funds to the Ministry of Health, which in turn disburses the funds to the local units. Local governments do not have control over these funds. It can be said that local bodies have a very minimal role in handling the budget. In India, vertical projects are directly administered by the central governments by mobilizing the government machinery. Local bodies have a limited role in the utilization of such resources and implementation of activities.

5.4   Human Resources Management

Recruitment at the senior level is the function of the Public Service Commission (PSC) in all the countries under review. In Nepal, recruitment at all levels is done by the PSC, however appointments could vary according to the positions. The Ministry appoints the medical doctors, whereas paramedical and other support staff are appointed by the Department, region and the districts. In India and Nepal, the total administration of doctors is done by the ministry, whereas in Bangladesh, Divisions are empowered to transfer within their division. Hospital boards can create posts and appoint employees without recommendations from any higher level authority in Nepal.

In India, the District Medical Officer is authorized to appoint the paramedical and support staff upon the recommendation of the District Appointment Committee. Local Panchayats can also hire staff on contract basis, if any vacancy exists in their health institutions. They are also authorized to exercise minor disciplinary actions against health workers.

In Bangladesh, Divisions and Districts are authorized to appoint paramedical as well as other support staff on the recommendations of the selection committees.

Almost all the staff get their salary from the central treasury. If the hospital boards create positions and have the resources, they can compensate the staff. These boards can provide incentives based on their own decisions.

Bangladesh is seriously thinking of giving greater autonomy to the hospitals. Once such autonomy is given, hospitals can charge users' fee and they will be able to utilize 30% of such resources for incentives. However, the proposal is yet to be approved by the Ministry of Finance.

It has been noticed in all the countries that health workers are not happy and willing to work under the local institutions.

5.5   Participation of Nongovernmental Sectors

Governments have realized the importance of private sectors in providing medical services and have adopted a policy of encouraging private sectors for profit and not-for-profit. Partnering of activities with the nongovernmental sector is growing in Bangladesh.

The principles of mutual respect, trust, recognition of mutual expertise are the basis of GO-NGO collaboration. Private health care institutions are growing rapidly in urban areas. In all the three countries, private physicians and pharmacists are providing a large proportion of curative medical services. Likewise, the private sector has come forward in areas such as establishment and management of hospitals and nursing homes, diagnostic centres and pharmacies. The governments are promoting the private sector through different fiscal policies.

Though private sector participation is highly encouraging in the health sector, they are not well-regulated. Competition has started to crop up; however due to lack of regulatory framework, oftentimes competition is not so healthy. In Nepal, the private sector is benefiting from the government in the form of customs rebate on the import of equipment, and in return, they are mandated to provide a certain percentage of their services free of cost to the poor. However, they do not seem to be interested in providing such free service to the poor patients. As a result, private hospitals and the other units have turned out to be accessible only to those who can pay for it.

5.6   Changing Scenario

The countries under study indicate that decentralization is a relatively new phenomenon. The decentralization process demands considerable changes in the regulatory framework, institutional bases, policy postulates, programme orientation, attitudes, values and norms. Change processes involve uncertainties, where confusion may lead one to believe in status-quo-ante. Naturally, even in the largest democratic country, like in India, resistance from political, bureaucratic and medical professional groups is common. This is manifested in the form of low level of participation of medical officers in the planning process in Kerala. Decentralization process is further hindered by low capacity of the local units to identify and prioritize the local needs.

Decentralization in Kerala and Nepal is supported by regulatory framework. In Nepal, the Local Governance Act, 1999, has mandated the local bodies including health-related administrative units to be actively involved in the operation and management of hospitals, formulation and implementation of plans and programmes, supply of medicines and so on.

In Bangladesh, the government is trying to improve services in the hospitals by providing them greater autonomy in management, and ensuring local level accountability. The governments have started doing some institutional reforms such as formulation of local level committees/boards with the participation of local governments and NGOs. Bangladesh has selected 12 Upazillas to implement decentralized planning process, however its implementation is still awaited. Five hospitals are

selected for pilot activities. However because of strong resistance from the medical community and other people working in the hospitals, it has not been implemented. In Nepal, the local units are authorized to retain and utilize the fees accrued from their services. In India and Bangladesh, it goes to the treasury, but they are in a process to mandate local units to utilize such resources.

Government policy, in principle, is committed to decentralized health services. The policy is limited by the lack of uniform technical competence at the local level, resistance from the Centre to delegate authority and lack of interagency coordination. Factors such as difficulty in changing values and attitudes and lack of commitment for decentralization also limit the success. It appears that there is willingness to decentralization, but the needed commitment is yet to be ensured.

6. DISCUSSION AND CONCLUSIONS

To achieve the unfinished agenda of HFA 2000, countries in the Region are continuously involved in the process of health sector reform. The major concern is to provide better and affordable health services, irrespective of who provides it. In the past, most of the health ministries in this Region have limited their role only as implementers of government activities rather than acting as policy innovators, coordinators, facilitators, problem-shooters and good stewards in the total sector. One of the major shifts in the recent past is that health ministries are focusing more on national health issues. With the advent of "liberalism in governance" and "market economy", countries are redefining the role of government from a sole service provider towards a "good manager and facilitator".

Decentralization of health services is regarded as the most important force in improving efficiency as well as equity and responding to local health conditions and demands. However, decentralization of health services is one of the trickiest problems. While discussing decentralization, questions such as, 'which task is to be decentralized?' 'who is to decentralize?' and at 'what level to decentralize?' are to be taken into account. The success and failure of the decentralized system depends on how these issues are categorically addressed by the national and local authorities. A full understanding of the problems and possibilities of decentralization requires a thorough analysis of the political, economic and social contexts that condition the policies of the individual country. Again, decentralization of health services cannot be seen in isolation, but should be viewed in totality in the context of overall development perspective of the countries. Most of the countries in the Region including Bangladesh, India and Nepal have embarked upon decentralized health sector reform. These countries are at various stages in the process of decentralization. Some have enacted legislation to empower the local bodies, whereas others are in the process of preparing enabling mechanisms. In spite of the limited success achieved in this direction, much more needs to be done to realize the objectives of the grass-root level decentralization programme. On the basis of country experiences, a desired level of decentralization has not been achieved. The following problems are considered to be the critical factors to this end:

- *Half-hearted tendency* to translate the provision of the act/policy of decentralization into practice;

- *Capacity issue:* Central authorities claim that local bodies do not possess the required capacity to carry out new responsibilities to be shifted from the Centre through decentralization;

- *Lack of strategic planning* for the implementation of policies on decentralization;

- *Limited resources for implementing the programmes on decentralization*;

- *Mismatch between authority and responsibility* to manage the health services where financial and human resources do not support responsibilities;

- *Over-dependency* of local bodies on the Centre, even if they are empowered with authority and responsibility for local health services;

- *Clarity of new roles:* Different actors at various levels (Centre, region and districts) are confused with their new roles and responsibilities vis-à-vis decentralization;

- *Political instability resulting in inconsistent policy***;**

- *Unregulated and unmanaged NGOs and private sectors;*

- *Minimal involvement of research institutions:* Some countries in the Region do not have professional research institutions to follow up and update the developments in the decentralization practices in the health sector;

- *Overt role of the ministries:* The central health ministries should limit their roles to designing long-term vision and policy, setting standards and monitoring the programmes, providing sound technical guidance, managing resources and acting as strong regulations. They should hand over the activities to appropriate agencies, whether they are lower level political units or technical units or the nongovernment or private sectors on the basis of their capacity.

7. RECOMMENDATIONS

7.1 General

(1) An enabling environment for smooth transition from centralization to decentralization should be created.

(2) Strategic plans for the phased implementation of decentralization should be developed and capacity building at centre and district levels appraised to match the changing roles.

(3) New roles and responsibilities of different actors should be defined and they should be provided with necessary orientation and training.

(4) The regulatory mechanisms and capacity-building should be strengthened by developing legal basis, standards, norms, protocols and performance indicators.

(5) Civil society and champions of change should be involved through various policy interventions.

(6) There should be a balance between responsibility and adequate administrative and financial authority.

(7) Research institutions should be encouraged and supported to update, monitor and analyze practical aspects of decentralization of health services.

7.2 Specific Recommendations for the Countries

Bangladesh

(1) Confusion regarding the new roles at different levels needs to be clarified to strengthen the process of decentralization.

(2) Capacity at the local level should be enhanced through appropriate training and orientation.

(3)   Local bodies should be provided greater authority in relation to finance, administration and planning.

(4)   Local bodies and health institutions should be provided authority to utilize resources generated locally for development and maintenance along with proper guidance.

(5)   The legal framework for decentralization must be strengthened.

(6)   Strong and sustained bureaucratic, technical and political commitment should be extended to the decentralized process.

(7)   Immediate implementation of pilot programmes in district and hospitals as envisaged in the plan is necessary to replicate their success experiences in other areas.

(8)   Research institutions should be motivated to constantly update, analyze and study the development in sector reform, including decentralized process.

India (Kerala)

(1)   Planning for vertical programmes should be based on local level planning (Top-down planning to be converted into bottom-up approach) to strengthen the ongoing decentralized process. Accordingly, resources of such plans need to be channelized through local bodies.

(2)   The new roles of actors at different levels to avoid confusion and they must be oriented and trained accordingly.

(3)   The capacity of the Ministry and Directorate of Health at the state level for strategic planning and project development should be strengthened.

(4)   Research institutions should be involved for study, analysis and advice on the outcomes of the decentralized process for further improvement.

(5)   Development of the capacity at different levels to institutionalize the best practices of decentralization for replication within the country and in the Region is advisable.

Nepal

(1)   Strong and sustained political commitment is needed to delegate authority and stop encroachment the delegated authority.

(2)   A few model districts should be identified and intensive health decentralization be implemented on pilot basis. All resources should be provided in block-grants and the health institutions along with human resources should be transferred to local bodies of these districts.

(3)   The capacity of model districts should be appraised and appropriate programmes for capacity building developed.

(4)   The new roles of Ministry, Department, Regions, Districts and other sub-units should be clearly defined and restructured accordingly. Unambiguous job descriptions, and training/orientation package should be prepared and administered.

(5)   Appropriate strategic plans indicating the date from which the law, in totality, will be in operation, including the health sector should be developed.

(6)   The Central monitoring and Supervision Committee headed by the Prime Minister should be supported to make the transition process smoother.

(7)   Parallel planning process in the district should be stopped.

(8)   Research institutions should be involved for study, analysis and advice on the outcomes of the decentralized process for further improvement.

7.3   Role of WHO

(1)   Member Countries should be assisted to strengthen process development, including development of *strategies, standards, norms and performance indicators.*

(2)   WHO should provide technical and financial support to define "new roles", develop appropriate job descriptions and provide training and advocacy in the changed context.

(3)   WHO should assist in developing strategic plans for phased devolution and defining the areas for capacity building on a phase-wise basis.

(4)   Based on the decision of the government, WHO may provide technical support to decentralized units to *develop documents and processes*. WHO should also provide technical support for developing negotiating skills of decentralized bodies to enter into agreement with development partners.

(5)   *WHO should collaborate with research institution* and assist them to consistently watch, monitor and analyze developments and trends in decentralization for further strengthening of the reform process.

(6)   WHO should *concentrate its limited resources on a few pilot districts* to strengthen integrated primary health approach instead of scattering it over a large number of districts.

Regional Level

(1)   *Decentralization* should be included *as one of the subjects of discussion* during the forthcoming annual meeting of Health Ministers and Secretaries. SEARO could convene a series of *consultation meetings* as a preparatory work for this higher-level meeting.

(2)   WHO should prepare *country profile* in the area of sector reform, including decentralization as an ongoing process and update them.

(3)   Share the experiences within and outside the region through publication, meetings, exchange of visits and interaction and coordination of the, professional research institutes for decentralization.

(4)   WHO should *coordinate with other development partners* for enhancing the capacity at national and local level.

(5)   As a development partner, WHO should expand its role to be facilitator and informer; policy designer and advocator; resource (technical, human and fiscal) mobilizer, and innovator.

8.   ACKNOWLEDGEMENT

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Annex 2

PEOPLE CONTACTED AND INSTITUTIONS VISITED

Bangladesh

Mr. Mir Shahabuddin Mohammad
Joint Secretary (Planning)
Ministry of Health and Family Welfare.

Prof. Prof. A B M Ahsanullah
Director-General
DGHS

Dr A S M Moshiur Rahman
ADG, DGHS

Dr Md. Abdur Rahman Khan
Line Director, Administration
DGHS

Dr Mazeda Begum
Line director, Finance
DGHS

Dr S M Asib Nasim
Deputy Team leader, PCC

Dr Enamul Karim
Consultant
Management Change Unit

Dr M A Motin Bhuyan
Divisional Director
Chittagong Division.

Manager
Hathazari Upazilla Health Complex and
  Union Health complex chief

Thana Nirbahi Officer
Hathazari Upazilla

Mr Prava Shankar Chakma
Deputy Manager
BRDB, Chittagong

Dr.Salehuddin Ahmed
Deputy Executive Director, BRAC

MrJamil H Chaudhary
General Manager
Grameen Trust

Mr Fazlul Hoque Khan
General Manager
Grameen Trust

Dr. W Hardjotanojo
WHO Representative
Bangladesh.

India
New Delhi

Prof Ghanashyam Shah
Jawaharlal Nehru University

Prof D N Rao
Jawaharlal Nehru University

Dr G V N Ramana
Word Bank

Dr P Mathew
Director
Institute for Social Studies (ISS)

Dr Chandan Datta
Society for Participatory Research in Asia (PRIA)

Dr R J Kim-Farley
WHO Representative, India

Kerala

Mr Rajeev Sadanandan
Special Secretary
Ministry of Health and Family welfare
Kerala

Dr Aysha Beegom
Director Health Services

Dr C R Soman
Chairman
Health Action by People
Thiruvananthapuram

Mr Maitreya
Foundation for Integrated Research in
  Mental Health (FIRM)
Thiruvananthapuram

Dr Najeeb Sali
Primary Health Centre (PHC)
Mangalapuram

Mr P M Dev
Researcher, SAHAYI
Thiruvananthapuram

Mr T M Thomas Isaac
Member, State Planning Commission

Dr B Ekwal, Vice-Chancellor
University of Kerala and Member
State Planning Commission

Dr Rajbabu Alinkan
Chief
Reproductive and Child Health project
Calicut Corporation

Dr Kutti
Medical Officer
Narikuri Community health Centre

Ms Raji
Junior Public Health Nurse

Madavoor Sub-Centre
Narikuri

Dr R Babu
District Medical Officer
Calicut

Ms Nalini
President
District Parishad
Calicut

Mr P Mohanan Master
Ex. President

District Panchayat
Calicut

Mr Jose Mathew
Junior Superindentent
District Panchayat
Calicut

Dr K P Sreenivasan
District Medical Officer, Indigenous Medicine
Calicut