

DEALING WITH SECTORAL CORRUPTION IN BANGLADESH: DEVELOPING CITIZEN INVOLVEMENT

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SUMMARY

Bangladesh has had a troubled political history since gaining independence in 1971 and is also beleaguered by poverty and natural environmental disasters. In particular however, corruption is blighting its prospects for economic growth, undermining the rule of law and damaging the legitimacy of the political process. This article adopts a sectoral approach to the study of corruption by examining people's experiences of using health and education services in Bangladesh through a large scale quantitative survey. It also presents case study research which assesses the impact of anti-corruption work by Transparency International Bangladesh (TIB) in the areas of health and education. The article concludes that: the poorest in Bangladesh are most penalised by corruption; there are significant benefits for health and education service users resulting from TIB's interventions and there is a need for committed political leadership if ongoing efforts to tackle corruption are to be effective and sustainable. Copyright © 2009 John Wiley & Sons, Ltd.

KEY WORDS — Bangladesh; corruption; Transparency International; public services

BACKGROUND AND INTRODUCTION

The People's Republic of Bangladesh, formerly East Pakistan, became an independent state after the civil war of 1971. It is a densely populated South Asian country with some 160 m people who commonly experience natural disasters in the form of floods and cyclones in the flat land and delta of rivers on the Bay of Bengal. Poverty is widespread with GDP per head estimated at just \$444 in 2006, or almost half the population living on less than one dollar per day (Oxford Economics, 2008). Since independence, Bangladesh has experienced political turbulence and spent 15 years under military rule until democracy was restored in 1991. Continuing unrest has been a major impediment to economic growth, set alongside the increasing strength of Islamic fundamentalism. Politics have been dominated and polarised by the two largest political parties, long-time rivals the Awami League (AL) and the Bangladesh Nationalist Party (BNP). The October 2001 elections produced a BNP victory in the form of a four-party alliance. The opposition party, AL, refused to accept the result and from 2001 to 2006 their attendance at Parliament was sporadic, claiming discrimination by the BNP speaker. Violence and political strikes/hartals have accompanied the political turmoil. In August 2004, 20 people were killed and more than 100 injured in a grenade attack at an AL political rally. In January 2005, the former finance minister, Shah Kibria, was assassinated along with four colleagues and over 70 injured in an attack at an AL rally in Northern Bangladesh. Since summer 2006 opposition parties, directed by AL claimed that the BNP-led government was seeking to manipulate the electoral infrastructure and announced in January 2007 a boycott of the general election. The parliamentary elections were cancelled.

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On 11 January 2007, the President declared a state of emergency and a reconstituted unelected military-backed caretaker government was put in place. The caretaker Prime Minister, Dr Fakhruddin Ahmed, governs Bangladesh through a number of advisers who, *inter alia*, are carrying out reforms to the electoral system in preparation for a poll to elect a new democratic government in December 2008. This has resulted in some 12 million duplicate, deceased or bogus names being removed from the electoral register. Under the constitution, executive power rests with the caretaker government until a prime minister heading a new administration is sworn in following a parliamentary election. Foreign governments are keen to see emergency rule lifted and the restoration of full constitutional rights amidst reports of human rights abuses and mass arrests. August 2008 witnessed signs of a return to an elected government in the first round of local mayoral elections. Despite the introduction of a range of electoral reforms, the election is expected to be fought between the two largest political parties. The dysfunctional two-party system therefore looks set to continue in Bangladesh. The two major obstacles to economic progress are lawlessness and corruption.

This article will focus on the latter by considering attempts to tackle pervasive corruption at grassroots level through active citizen engagement in two key public services central to the daily lives of Bangladeshis. The article will:

- (a) Analyse people's actual experiences (as opposed to perceptions) of corruption at grassroots level in using key public services in the health and education sectors in Bangladesh.
- (b) Consider how Transparency International Bangladesh (TIB) is trying to tackle abuse in these sectors and the impact of their work on petty corruption in health and education services.
- (c) Draw some conclusions on the sectoral approach to tackling corruption in Bangladesh.

THE LITERATURE

Corruption has been defined as 'behaviour which deviates from the formal duties of a public role, because of private-regarding pecuniary or status gains (personal, family, private clique)' (Nye, 1967, p. 419). This behaviour includes bribery, nepotism and misappropriation of public funds. Other definitions include the misuse of public office for personal gain (Klitgaard *et al.*, 2000) and the abuse of public office for 'private economic gain' (Rose-Ackerman, 1999, p. 75), although all three definitions erroneously suggest that corruption is limited to the public sector. There is a limited literature on the specific problems of petty corruption in Bangladesh despite its pervasiveness. What literature does exist tends to focus on political corruption, the misuse of power by political leaders or within the electoral process (Younis and Mostafa, 2000; Akuter, 2001; Ahmad, 2002; Ahmad *et al.*, 2004; Ahmad, 2005; Kashem, 2005; Khan, 2005; Quah, 2005; Zakiuddin, 2006). The research for this article is located in two areas of the literature. First, Ivanov (2007) is critical of the global anti-corruption agenda and its associated universal diagnosis of the problem and calls for a move away from a global campaign against corruption which is devoid of local context. He argues that 'a more contextualised analysis of corruption as a social construct could inform more successful policies' because corruption is a 'value-ridden concept that should not be treated as though it were essentially the same phenomenon around the world' (Ivanov, 2007, p. 42).

Second, Spector (2005), drawing on Kaufmann's work (2003), argued that conventional approaches to fighting corruption (passing laws, creating new institutions and conducting anti-corruption campaigns) have not significantly impacted on corruption or in reducing state capture. Spector (2005) poses the question 'is corruption in government incurable'? He suggests not, and argues there is evidence that anti-corruption reforms which have targeted particular programmes and sectors have made a difference:

One of the best ways to understand the spread of corruption and what can be done to control it, is by analysing its impact sector-by-sector. International experience has demonstrated that broad anti-corruption programmes may have positive, though short-term, effects on the problem while raising public awareness. However,

programmes that are targeted at vulnerable sectors (i.e. the education and health areas) can take hold and be sustained over the longer term (Spector, 2005, p. 6).

In short, he claims that an approach which analyses corruption on a sector-by-sector basis and helps identify concrete initiatives, is more likely to have an impact. As an example of sector-specific corruption in developing countries, Vian (2005) examines corruption in health care provision arguing that it is government's role to promote equitable access to services, sustainable finance for health objectives and the prevention of the spread of disease. In many cases, she contends, government failure is linked to corruption in health care which is particularly vulnerable because of the diversity of services, the scale and expense of procurement and the nature of health care demand. Vian (2005, p. 59) concludes that 'much of the corruption found in the health sector is a reflection of general problems of governance and public sector accountability'.

In a similar vein, Chapman (2005) argues that national education systems across developing countries are particularly vulnerable to pervasive corruption. This is because: its delivery structures down to community level make it attractive to patronage and manipulation; there are a number of significant gatekeepers at each level (district education officers, headmasters/mistress and teachers) and, education funding is spent across multiple sites resulting in weak monitoring and accounting systems. Chapman concludes that 'corruption is not inevitable and is not a life sentence for a country or government' — the key factor influencing the level of corruption is the quality of top leadership. Leaders, he contends, 'who respect the rule of law, emphasise transparency in the operation of the offices they oversee, take actions against subordinates found violating rules and exhibit integrity in their own transactions can make a difference' (Chapman, 2005, p. 71). Azfar (2005, p. 211) arrived at similar conclusions in an economic study of health and education in developing countries where he found that 'corruption does in fact undermine the delivery of health and education services and that increasing accountability reduces corruption'.

Specifically in terms of corruption in education and health services in Bangladesh, Zaman (2005) argued that it is pervasive in the entire public health sector including hospitals attached to medical colleges, regional and sub-regional public hospitals and clinics, offices of the civil surgeon and various population planning delivery outlets. In education, he contended that the service suffered from misallocation of budgets and shortage of funds because of corruption. As a result, school infrastructures are very weak, teachers are badly paid, poorly trained, teaching methods lack innovation, and materials and equipment are inadequate to provide quality education. In short Zaman concludes:

What is striking about Bangladesh is that corruption affects almost everyone and it is hardly ever punished. On the contrary, corruption, especially political corruption is the fastest way to the echelons of power... Corruption is also a key impediment to the realisation of the UN Millennium Development Goals... Corruption deprives children of access to education and prevents access of the poor to basic health services (Zaman, 2005, p. 23).

The remainder of the article will examine people's direct experiences of corruption as users of health and education services, and a grassroots campaign organised through TIB to tackle rent-taking/bribery. In so doing, we will test Spector's assertion (2005) that one of the best ways to address corruption is on a sectoral basis.

EXPERIENCES OF CORRUPTION IN EDUCATION AND HEALTH

Education is seen as a basic right of citizens and an investment in human capital if Bangladesh is to improve its economy and enhance the quality of people's lives. The Constitution of the People's Republic of Bangladesh (article 15) states: It shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing for its citizens: the provision of the basic necessities of life, including food, clothing, shelter, education and medical care. The Government of Bangladesh is therefore tasked to provide education and health care services to all citizens particularly the disadvantaged groups, such as the poor, women and children. But the quality of education and health services is inferior.

The data set used to investigate direct experiences of education and health service users in this article is a 5000 household interview probability survey selected across 52 districts (out of 64) within the six divisions of Bangladesh. A three-stage stratified cluster sampling method was used to select households: primary sampling units or *Mauzas* were randomly selected from each strata; a block of 200 households was randomly selected from each primary sampling unit and 20 households were selected systematically for interview. The survey was conducted in June to July 2007 and probed questions on corruption in the previous 12-month period.

The key findings from the survey were:

- Overall 66.7 per cent of households experienced corruption in their interactions with different public service providers. An overwhelming 96.6 per cent of households that interacted with law enforcement agencies experienced corruption. Land administration (52.7%) and judiciary (47.7%) are the next most corrupt sectors. Nearly two-fifths of those households which interacted with education and health experienced corruption.
- Corruption is pervasive in Bangladesh and remains unabated with no significant difference between 2006 and 2007. In some sectors corruption in the form of bribery has increased but decreased in others. The incidence of bribery, for example, has increased in education, health, land administration, local government and the NGO sectors. The sectors where bribery has decreased: law enforcement, judiciary, electricity, banking and tax, may have been as a result of the focussed anti-corruption drive by the caretaker government from January 2007.
- Households paid bribes (42.1%) for receiving services from different sectors, an average of Taka 4134 per household or Taka 861 *per capita* (about 60 and 12.5\$, respectively). The average amount of bribe paid by a household is the highest for those receiving services from banking, followed by judiciary, land administration and law enforcement. In urban areas, higher bribe amounts are paid for interaction with education, health, land administration, law enforcement and banking sectors. In rural areas, higher bribe payments are made through interaction with electricity and local government.
- Bribery represents 3.84 per cent *per capita* income of an average Bangladeshi citizen (Transparency International Bangladesh, 2008a).

We consider people's experiences of education and health services more specifically.

EDUCATION

Data from the survey revealed that 72.6 per cent of respondents ($n = 3629$) had used education services in the previous 12 months. This level of service usage represented the highest interaction with services examined in the survey which included: education, electricity, health, NGOs, banking, tax, land administration, local government, law enforcement and the judiciary. In terms of the experiences of service users, 34.7 per cent of them had encountered corruption in education under various guises: bribery, negligence of duties, nepotism, embezzlement or deception. The breakdown of these figures is shown in Figure 1.

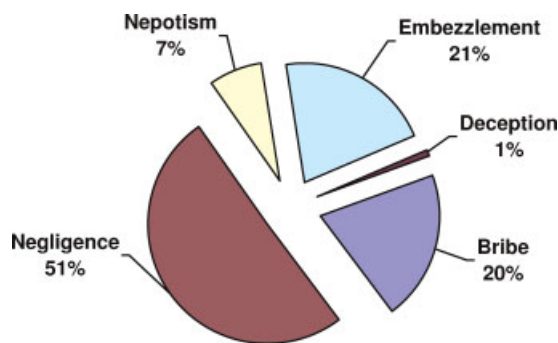


Figure 1. Corruption in education ($n = 1260$). This figure is available in colour online at www.interscience.wiley.com/journal/pad

The largest form of corruption in the experience of users was negligence of duties by teachers involving such things as: poor time keeping, irregular classes (absenteeism), delays in releasing exam results and lack of interest and motivation by teachers in their jobs.

To further understand which factors influence/predict corruption in the education sector in Bangladesh, we conducted logistic regressions. We were interested in finding out which variables predict the likelihood of education service users paying bribes (as one element of corruption). In this case, we selected the categorical dependent variable and predictor variables as follows:

Survey question: did you pay a 'donation' or bribe for admission to education services?

Categorical dependent variable

Paybribe: Did you pay a donation or bribe for admission?

Predictor variables

Tincome: total household income per month.

Locate: area/location of respondents.

Sex: gender of the respondent.

Type: type of institution (government/non-government and private).

Time: regularity and timeliness of teachers.

Tutor: respondent's children attend their teachers as a private tutor.

Addben: additional benefits gained (prior sight of exam papers and additional marks).

The results are shown in Appendix 1.

The omnibus tests of model coefficients show a significant value ($p < .05$) and the Hosmer and Lemeshow test supports the conclusion that the model is a good fit (χ^2 value of 4.654 and $p > .05$). The model summary statistics indicate that between 27.7 and 42.6 per cent of the variability in the dependent variable is explained by this set of predictor variables. The Wald test shows that three variables contribute significantly to the predictive ability of the model (significance $< .05$): whether children employ their teachers as private tutors; the total household income of the family and the gender of the victim of corruption. The results suggest that those who paid a bribe at admission are: less likely to employ private tutors; are from lower income groups and males (probably as the head of household). We now turn to people's experiences of health care in Bangladesh.

HEALTH

The survey data showed that 44.7 per cent of respondents ($n = 2234$) had used health services in the previous 12 months. In terms of their experiences as service users, 41.8 per cent of them had encountered corruption in health under various guises: bribery, negligence of duties, nepotism, embezzlement or deception. The breakdown of these figures is shown in Figure 2 where bribery and negligence are the highest forms of corruption experienced by health service users. These will take the form of: doctors charging for writing prescriptions; referring patients to their private clinics and having to pay extra fees for pathological tests in government health facilities.

To further understand which factors influence/predict corruption in the health sector in Bangladesh, we conducted logistic regressions. We were interested in finding out which variables predict the likelihood of health service users paying bribes (as one element of corruption). In this case, we selected the categorical dependent variable and predictor variables as follows:

Survey question: did you pay any extra money (excluding fees) for hospital treatment?

Categorical dependent variable

Paybribe: Did you pay any extra money for hospital treatment?

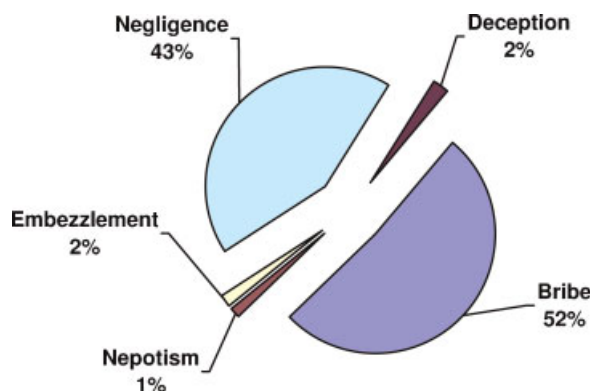


Figure 2. Corruption in health ($n = 934$). This figure is available in colour online at www.interscience.wiley.com/journal/pad

Predictor variables

Toincome: total household income per month.

Locate: area location of respondents.

Sex: gender of the respondent.

Private: advised to go to private clinic.

Diagnose: doctors press you to go to a certain diagnostic centre.

Prescrip: paid money for prescription.

The results are shown in Appendix 2.

The omnibus tests of model coefficients show a significant value ($p < .0005$) and the Hosmer and Lemeshow test supports the conclusion that the model is a good fit (χ^2 value of 7.852 and $p > .05$). The model summary statistics indicate that between 10 and 16 per cent of the variability in the dependent variable is explained by this set of predictor variables (this is a lower level of explanation than the education model above). The Wald test shows that two variables contribute significantly to the predictive ability of the model (significance $< .05$): whether the patient pays the doctor for writing a prescription; and if the doctors press service users to go to a specific diagnostic centre. The results suggest that patients who have to pay extra money for hospital treatment are: more likely to be those for whom the doctor must write a prescription; and those who are pressed by doctors to go to a certain diagnostic centre. Comparing both education and health provision the data indicate that while negligence by professionals in these services is a major problem (51% in education and 43% in health), there is much greater prevalence of bribery in the health sector (20% in education and 52% in health). We now consider how TIB, as a major anti-corruption agency, is tackling petty corruption in these core services.

TACKLING PETTY CORRUPTION IN EDUCATION AND HEALTH

TIB is an accredited national chapter of Berlin-based Transparency International, a global civil society organisation leading the fight against corruption. TIB began its activities as a trust in 1996, and in 1998 the Government of Bangladesh approved its registration as an independent, non-partisan, not-for-profit, non-governmental organisation. TIB's vision for Bangladesh is a country in which government, politics, business, civil society and the daily lives of its citizens are free from corruption. To secure this vision, its mission statement is:

To catalyse and strengthen a participatory social movement to promote and develop institutions, laws and practices for combating corruption in Bangladesh, and to establish an efficient and transparent system of governance, politics and business (Transparency International Bangladesh, 2007, p. 8).

The 'social movement' operationalises its mission statement through the TIB *Making Waves* project (2003–2008). TIB works against corruption, not against the government of the day, nor any particular public sector

department. As a social movement TIB's task is to create a demand for effective policy reform and institutional change conducive to the reduction in corruption. It has no mandate or capacity to investigate or take action against individual cases or allegations of corruption, whether large or small. TIB is a co-stakeholder and a source of support to initiatives for reducing corruption and establishing transparent and accountable governance in Bangladesh including those by Government. As the public sector is at the heart of corruption and there is a lack of political will at the highest level to tackle this insidious problem, local people as victims have a key role to play in exerting pressure for change. TIB has been growing a social movement which empowers people to take responsibility for tackling the worst excesses of corruption by channelling bottom-up efforts into a positive force for change in Bangladesh.

The key mechanisms through which *Making Waves* impacts on reducing corruption and generating accountability in education and health at local level are: committees of concerned citizens (CCCs); volunteer youth groups (youth engagement and support, YES); advice and information desks (AI desks); report cards and people's theatre which we consider in more detail.

CCCs are local level watchdogs and a key pillar in TIB's social movement against corruption. There are a number of steps involved in their formation as follows:

1. TIB undertakes the primary selection of possible areas in a geographical cluster within which a CCC could be formed (with the ultimate aim of covering the whole of Bangladesh).
2. A long list is prepared of potential CCC members with all the relevant information.
3. The Committee is formed and a memorandum of understanding between the CCC and TIB is signed along with the adoption of the CCC operational manual.
4. Implementation of CCC programmes begin.

The long term objective of the CCC movement is to create accountable governance in Bangladesh at local levels through greater transparency in public, semi-public, non-profit and private sector transactions, leading to gender sensitive and sustainable poverty reduction. The immediate objective of CCCs is to function as community watchdog forums for creating anti-corruption awareness and mobilising citizens for participation in various anti-corruption initiatives (Transparency International Bangladesh, 2007). The CCCs are groups of citizens selected on the basis of: (i) high degree of moral and social standing and credibility within their own communities; (ii) commitment to the values, mission and code of ethics of TIB and (iii) ability to influence and mobilise local government officials, service providers and the public to curb corruption.¹ CCC members, at least 25 per cent of whom must be females, are drawn largely from professional groups such as teachers, lawyers, journalists,

¹Essential criteria for membership of CCCs

S/he should be:

- a person of high integrity and honesty;
- a transparent person having no known 'skeletons in the cupboard';
- widely respected, locally influential and acceptable to all;
- active and interested to work voluntarily;
- a person who shares the vision, mission, values and objectives of TIB and is committed to TIB Code of Ethics;
- a permanent citizen of Bangladesh and resident of the CCC area;
- involved in bona fide legal activities;
- income tax payer (with TIN if applicable) with legal income from a known source and
- conscious, enlightened, tolerant, proactive, patriotic and optimistic.

S/he should not be:

- a person with any record of involvement in corruption;
- an un-discharged insolvent;
- convicted of a criminal offence involving moral turpitude, declared by a competent court to be of unsound mind;
- a public servant enjoying any special status granted by law enabling participation in the conduct of and management of a legal entity;
- actively involved in party politics;
- guilty of any default of any public dues determined by a court of law;
- less than 30 years nor more than 70 years of age and
- immediate family member of the executive director of TIB and any other full-time member of the TIB staff.

physicians, business people, social workers, NGO workers and women activists. Members are volunteers and non-partisan. Volunteer youth groups of local students/young people (usually aged between 15 and 30 years and unlimited in numbers) are mobilised and attached to the CCCs. They involve themselves in awareness raising activities. By undertaking various tailor-made programmes, these young people learn the core values of volunteerism and prepare themselves as future leaders of the anti-corruption social movement. They also develop the commitment and leadership qualities needed to expand and strengthen the anti-corruption constituency. The activities of these groups entitled YES include debating competitions, publications, anti-corruption campaigns, cycle rallies, human chains against corruption and cartoon exhibitions.

Once the committees are formed, they must work on at least one school, one hospital and one local government body, but are otherwise free to draw up their own independent programme priorities and annual plan of work. TIB provides the technical and financial support in implementing the programmes and acts as a catalyst for CCCs in advocating changes generated by their local successes at the national level. Six CCCs were formed in the greater Mymensingh area in 2000. Based on their success, another 30 committees were formed in July 2006—in total 36 CCCs are working in 34 districts across all six divisions in Bangladesh. CCCs have been established in clusters with the aim of ‘shadowing’ the local government Upazila and District structures. There are plans to increase the number of CCCs by a further nine (from 36 to 45) to improve geographical coverage nationwide by the end of 2009 (Transparency International Bangladesh, 2008a). TIB will establish CCCs in the Chittagong Hill Tracts and extreme north-west areas of Bangladesh which are populated by vulnerable, marginalised and hard core poor people (including Char dwellers). Because grassroots activists are seen as fundamental to the success of the social movement against corruption, TIB invests in training and capacity building of CCC members, associated volunteer youth groups and theatre activists, which is financed by donor partners.² Approximately, 2.5 per cent of the (proposed) budget (£9.8 m) for 2009–2013 has been allocated to capacity building at the local level. Typically, this includes training in areas such as: social mobilisation, tackling corruption, good governance, networking, marketing and communication, gender awareness and training, financial sustainability, local level advocacy and campaigning.

Apart from various anti-corruption awareness activities, the focus of the CCCs’ watchdog functions is normally on improving key public services. The primary instrument used to achieve concrete changes in public service delivery is the use of report card surveys and their follow-up. Report card surveys are conducted by the CCCs in consultation with local people to examine issues which most directly affect their daily lives, typical of which are: health, education, land administration and local government. The surveys make an assessment of the content and quality of public services provided to local people and highlight the nature, process and implications of corruption at local levels. Reports are then used to advocate and demand public accountability from service providers (see Table 1). People’s theatre is one of the major advocacy tools of TIB which is used at the local level to build awareness against corruption, particularly amongst the most vulnerable and illiterate. AI desks provide access to information which is key to creating awareness and helping people to resist and become victims of corruption. TIB has set up AI desks attached to the CCCs and in satellite format. Members of the public are provided access to basic information and advice on key public services. The annual work plans of CCCs provide the mechanism against which they report on their outputs, share their activities across the wider social movement and use lessons learned in developing the work of new CCCs. This sharing of practical knowledge is facilitated formally through regular newsletters and an annual convention of the CCCs.

IMPACT ON PETTY CORRUPTION

To assess the impact of TIB’s work on education and health services for the period 2003–2008, we adopted a mixed methods approach involving: secondary data analysis; interviews with key stakeholders; field work visits to, and case studies of, CCCs and focus group work with education and health service users and victims of corruption at

²At present Transparency International Bangladesh has the following donor partners: Department for International Development UK (DFID); Swedish International Development Agency (SIDA); Danish International Development Agency (DANIDA); Embassy of Norway and UNDP.

Table 1. Committees of Concerned Citizens in operation

Inputs	Process	Outputs	Outcomes
<ul style="list-style-type: none"> • CCCs are formed as community watchdog groups to promote transparency and accountability at the local level • CCCs are encouraged to deal with local issues related to service delivery by public, private and non-governmental sectors 	<ul style="list-style-type: none"> • Identify corruption points • Conduct workshop/meeting with service providers • Issue report card on nature and extent of corruption • Report card findings disseminated to the community, press and public authority • Make recipients aware of corruption issues through fact sheets, meetings and advice and information desks • Raise awareness through cultural/theatre shows, local campaigns and community meetings 	<ul style="list-style-type: none"> • Corruption in schools and hospitals decreased • Transparency and accountability of schools and hospitals increased • Community and potential service recipients are aware of their rights and secure better access to education and health services 	<ul style="list-style-type: none"> • Better quality of education and health services • Increased access to health and education for poor people • Demand for public education and health services increase

case study locations. Impact assessments are undertaken to estimate whether or not interventions produce their intended effects. In strict methodological terms, determining impact requires comparing, with as much rigour as is practicable, the conditions of targets/recipients that have experienced an intervention with those of equivalent targets/recipients who have not, using quantitative designs such as randomised experiments, quasi-experiments, before and after studies and so on. Due to the complex and often hidden nature of corruption, quantitative methods were ruled out and we relied on narrative accounts from providers and users of education and health service in case study locations.

The selection of the CCC case study locations was a particularly important choice and we used the following criteria to inform the process: length of time CCCs had been established; CCCs perceived by TIB to be 'successful' through to 'less successful'; gender diversity within CCCs and an area without a CCC to act as a counterfactual for comparison in assessing impact.

The case study areas selected to gather evidence of impact were:

- (1) Natore: Natore Sadar Hospital; Moshironnessa Government Primary School and Laksmipur Union Parishad.
- (2) Chapai Nawabgonj: Chapai Nawabgonj Sadar Hospital; Bidirpur Government Primary School and Chapai Nawabgonj Municipality.
- (3) Rajshahi: Rajshahi Municipality, Education Board and School Management Committee.
- (4) Gazipur: Gazipur Municipality.
- (5) Naogaon: local hospital, primary school and NGO group (control area).

By its nature, a case study approach has inherent methodological weaknesses. The trade-off in securing depth and richness of qualitative information in five-case study areas is lack of generalisability. That said, the selection of our case study areas was judicious and we used secondary data on CCCs which we did not visit to validate our findings. In addition, researchers must be careful attributing changes/impacts to an intervention (before and after studies) without the benefit of an experimental design approach.

Through the case studies, we met with CCC and YES members in all areas (except the control area), and a mix of groups ranging across: teachers, school management committees and mothers of students, victims of corruption, hospital users and health watch groups. We also held meetings directly with health providers, nurses, doctors, civil surgeons, school principals and elected representatives in each of the case study areas. The field work for the research was conducted during March/April 2008. We summarise the findings from the qualitative data gathered through interviews, focus groups and non-participant observation in education and health services.

The education sector

The CCCs actively engaged with primary schools in the case study areas, a key improvement being the significant number of eligible students now enrolled. Student attendance had not been satisfactory and CCCs intervened to address this and other issues. They met with school management committees and guardians, organised workshops and promotional campaigns along with awards aimed at incentivising attendance. As a result, student enrolments have increased and text books are available for free distribution to students. The scholarship pass rate has also improved. Teachers, the school management committees and guardians are now jointly engaged in providing better education for the children in an accountable and transparent way. Teacher attendance and performance in their jobs are being closely monitored by CCCs. A key element in maintaining pressure for change is 'mothers gatherings' where mothers/guardians meet with school management committees and call them to account for the behaviour of teachers. As recipients of education services they are best placed to provide CCCs with information to monitor and enforce change. TIB uses local transparency and accountability as a way of 'naming and shaming' schools which are underperforming by directly confronting teachers, principals and management committees with the implicit 'threat' of exposure in the press/media.

The health sector

CCC members and the YES group have worked consistently with hospitals in the case study areas to improve health services. They have met with the authorities and identified gaps in their provision. They prepared information booklets

Table 2. Pre- and post-intervention in health and education

Services before CCC intervention	Current status—CCC intervention	Impacts
Pre- and post-intervention in health		
<ul style="list-style-type: none"> • High level of dissatisfaction over services of public hospitals/health complex • Corruption by doctors in terms of time spent outside hospitals on private work, irregular office hours, referring patients to his/her own private practice or specialised diagnostic centres • Money charged for free services and extra money taken for different health services by doctors, nurses and ancillary ward staff • Inadequate medical facilities such as beds, operating theatres, trolleys and ambulances • Bribes demanded to issue medical certificates • Medical representatives in doctors' offices during clinic hours • Lack of cleanliness and hygienic environment • Inadequate supply of medicines 	<ul style="list-style-type: none"> • Doctors are coming to hospitals on time • The availability of doctors has increased • Information on ticket fees, service charges, fees for diagnostic tests, etc. are published on notice boards • Published notices that patients should not pay extras for free services • Extra money from fees for tickets is either deposited to welfare fund or returned to patients (for example Rangpur and Kurigram) • Cleanliness improved • Health officials (surgeons and doctors) are now more helpful both in terms of information transparency and gradual improvements in health facilities • Updated list of medicines, and doctors and nurses rota is now on display 	<ul style="list-style-type: none"> • There has been a general degree of co-operation following the release of the report card and ongoing engagement with the CCC • Key health personnel such as the Civil Surgeon, superintendent, senior medical staff and ancillary staff participated in the report card press release and answered questions from journalists • The report card findings received extensive publicity in the media • Volunteers of the CCC regularly visit hospitals to monitor services and ensure patients receive the necessary support
Pre- and post-intervention in education		
<ul style="list-style-type: none"> • Extra money collected under the guise of various fees • Lack of transparency in collecting money • Anomalies in distributing stipends among poor students • Teachers reluctant to take classes on time and to teach allocated class times • School Management Committee inactive • Absence of (or inactive) parents teachers associations 	<ul style="list-style-type: none"> • Education authorities are aware of the anomalies which exist and have sought to address these • Teachers' performance has improved including their time-keeping and maintaining class discipline 	<ul style="list-style-type: none"> • School management committees are more active and willing to work with CCC to improve the quality of education services. In some areas (such as Sunamganj) they did not even know each other • Through events like mothers' gatherings and satellite AI-desks, people have become more aware of their rights

about the nature and types of health care services available which they distributed through satellite AI desks. In addition, the YES group members have organised public theatre shows and exchanged views with people from the hospitals' catchment areas. As a result, there have been some significant developments in health provision such as an improvement in the ticketing system. Previously, the price of a ticket for services in the out-patients department was 4.40 Taka, but patients paid 5.00 Taka due to 'lack of change' being available. Now a fund has been created, in collaboration with hospital authorities, for patients in poverty with the extra 60 paisa received from each ticket.

Medicine supplies were also very low. Following the intervention by CCC and YES members, supplies have increased and the list of medicines available is on public display. The behaviour of doctors, nurses and ancillary staff towards patients has also improved. An ambulance service is available for which patients do not make additional payments, patients tests are carried out in the pathology departments of the hospitals (as opposed to a private clinic) and toilet facilities have been significantly improved. Finally, the issue of cleanliness is a higher priority although has still some way to go. Interesting though, the control hospital visited was displaying information on prices and medicine in response to a Ministry of Health circular requesting this in all hospitals. We summarise the case study education and health services before CCC intervention, following intervention and the nature of the impacts in Table 2.

To institutionalise change beyond the confines of the local school and hospital, TIB has begun a process of creating 'islands of integrity', a concept developed by Transparency International. An island of integrity is where an individual school or hospital makes a public commitment to continue its work without engaging in bribery or to disclose their actions if they do resort to bribes. Following such a public commitment, CCCs and YES groups monitor their adherence to these principles of transparency, accountability and integrity, implied by their declaration. For example, in the case of a school, it would become an island of integrity if the school management committee held regular meetings, operated transparent accounts where students did not pay additional 'fees', ensured good levels of attendance by pupils and teachers alike and delivered academic results. Similarly, in hospitals, the public would have open access to necessary information about health services and the range of medicines which were available. No additional charges would be levied for standard health checks and tests.

TIB will, in turn, promote 'integrity pacts' with public bodies as a means of maximising accountability, transparency and integrity in the wider public sector (see Figure 3). The 'integrity pact' is a tool developed by Transparency International to help stakeholders—governments, businesses and citizens—fight corruption in specific sectors and institutions of public interest. The pact is an agreement between stakeholders under which all parties have rights and obligations that neither side will: (a) abuse entrusted power for private gain; (b) pay, offer, demand or accept bribes for services rendered or public contracts made or while carrying out and (c) collude with each other including competitors to obtain a contract. Any violations will entail sanctions. In practical terms, the 'integrity pact' institutionalises the commitment of 'islands of integrity' where the whole is greater than the sum of the parts. For instance, the Chair and members of a Union Parishad will formally sign an integrity pact to be accountable and transparent to all service users for the range of functions which they provide. TIB will advocate for district education officers, civic surgeons, mayors or municipality chairs in each CCC to sign an 'integrity pact' demonstrating their public commitment to public accountability, transparency and integrity.



Figure 3. Promoting change in health and education. This figure is available in colour online at www.interscience.wiley.com/journal/pad

CONCLUSIONS

There are a number of conclusions which can be drawn from this two-part study comprising a quantitative analysis of people's direct experiences of corruption in education and health services, and a qualitative assessment of the work of TIB in selected case study areas.

First, the empirical results from the survey highlight the prevalence of petty corruption in the delivery of health and education services in Bangladesh—42 and 35 per cent, respectively. The incidence of public services corruption in rank order in Bangladesh is: law enforcement, local government, land administration, the judiciary, followed by health and education (Transparency International Bangladesh, 2008b, p. 14). In health care those users who are most vulnerable to corruption are patients needing a prescription from the doctor and those requiring further medical tests who are coerced to attend a private diagnostic centre of the doctor's choice. In education, lower income groups and males are more likely to have to pay bribes at admission and, as a consequence, are less likely to need to employ private tutors. These findings broadly reflect the empirical results from the Transparency International's Global Corruption Barometer (2007) which interviewed 63,199 people in 60 countries (Bangladesh is not included). The barometer study concluded that the poor are most penalised by corruption. Reported bribery across regions varied considerably and in the Asia-Pacific group of countries 22 per cent of respondents had paid a bribe in the past year.³ This is significantly lower than petty bribery in health and education services in Bangladesh. The barometer report concludes that 'the poorest in all societies are the ones hit hardest by bribery. However, as they face the most demands for bribes, they are more likely to pay. This, in turn, means that corruption acts as a regressive tax that increases income inequality' (Transparency International, 2007, p. 13).

Second, the case study evidence on the work of TIB demonstrates both the tangible impact their work at grassroots level is having and its potential as a social movement for expansion. The mobilisation of concerned citizens and young people who act as a watchdog over education and health providers has increased local accountability and produced a level of financial savings either for reinvestment in public services or a reduction in petty corruption for users. TIB intends to scale-up these activities beyond individual schools and hospitals in the next phase of its development (Transparency International Bangladesh, 2008a). They will do this by institutionalising 'integrity pacts' with public bodies as a means of maximising accountability, transparency and integrity in the wider public sector. These grassroots activities operate alongside work by TIB at the national level which includes: monitoring and holding to account the key pillars of the National Integrity System; diagnostic studies on institutions where the level of corruption is perceived to be high; supporting the work of the anti-corruption commission (set up under the caretaker government in February 2007) and, major advocacy campaigns to raise awareness of people's entitlements to public services.

Finally, an examination of the Bangladesh case attests to key messages from the anti-corruption literature. This country study lends support to Spector's thesis (2005) that fighting corruption on a sectoral basis is more likely to yield positive results. However, it does so in a specific context where the decentralised approach adopted by TIB has facilitated local accountability of service providers. Quah's (2006) argument that the control of corruption will only be effective if supported by strong political leadership is particularly relevant in Bangladesh where its key politicians (Khaleda Zia (BNP) and Sheikh Hasina (AL)) had been jailed on corruption charges, although the latter is in exile in America following release on medical parole, while the former was subsequently released on bail. Despite the launch of an anti-corruption drive by the caretaker government, progress has been initially slow and mired in legal disputes, and at the time of writing has become a hostage to political expediency in a situation where the top priority is holding elections which ensure participation of all major parties. This has led to the release of most of the high-profile corruption suspects who were earlier refused bail. As a result, the future anti-corruption drive in general and the fate of the anti-corruption cases have become uncertain. Even with the implementation of electoral reforms, the return of the old guard, eager to access public funds after nearly 2 years in the political wilderness, looks inevitable. So, entrenched is corruption within the two main parties that the work spearheaded by

³The Transparency International Global Corruption Barometer (2007) Asia-Pacific countries included: Cambodia, Hong Kong, India, Indonesia, Japan, South Korea, Malaysia, Pakistan, Philippines, Singapore, Thailand and Vietnam.

TIB and the anti-corruption commission may well falter. Bracking's (2007, p. 23) review of anti-corruption campaigns ends with 'a call for more contextual understandings of the politics and political economy of different countries and areas'. In the politics of Bangladesh, greater democratisation and the return of an elected government may ironically reinforce or exacerbate problems of corruption.

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APPENDIX 1: CORRUPTION IN EDUCATION

Did you pay a 'donation' or bribe for admission to education services?

Variables in the equation

	B	S.E.	Wald	df	Sig.
SEX	2.267	1.229	4.403	1	.045
TYPE	.400	.893	.200	1	.654
TIME	.871	.930	.879	1	.349
TUTOR	−2.382	1.062	5.029	1	.025
LOCATE	.622	1.057	.347	1	.556
TOINCOME	.000	.000	4.435	1	.042
ADDBEN	−1.079	1.671	.417	1	.519
Constant	−1.237	2.493	.246	1	.620

Omnibus tests of model coefficients

		χ^2	df	Sig.
Step 1	Step	17.807	7	.013
	Block	17.807	7	.013
	Model	17.807	7	.013

Hosmer and Lemeshow test

Step	χ^2	df	Sig.
1	4.654	7	.702

Model summary

Step	−2 log likelihood	Cox and Snell <i>R</i> square	Nagelkerke <i>R</i> square
1	39.898(a)	.277	.426

APPENDIX 2: CORRUPTION IN HEALTH

Did you pay any extra money (excluding fees) for hospital treatment?

Variables in the equation

	B	S.E.	Wald	df	Sig.
PRESCRIP	1.758	.398	19.561	1	.000
DIAGNOSE	.666	.396	4.826	1	.043
PRIVATE	.218	.384	.323	1	.570
TOINCOME	.000	.000	.171	1	.679
LOCATE	−.161	.391	.169	1	.681
SEX	.385	.451	.730	1	.393
Constant	−2.180	.550	15.725	1	.000

Omnibus tests of model coefficients

		χ^2	df	Sig.
Step 1	Step	26.342	6	.000
	Block	26.342	6	.000
	Model	26.342	6	.000

Hosmer and Lemeshow test

Step 1	χ^2 7.852	df 8	Sig. .448
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Model summary

Step 1	-2 log likelihood 218.639(a)	Cox and Snell <i>R</i> square .100	Nagelkerke <i>R</i> square .160
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