Change Management and the Health Sector of Bangladesh: A Review of Key Policy Issues

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ABSTRACT

Managing change or change management is an inevitable part of any organization. Health sector, like any other organization, also faces continuous changes, which take place in the form of policy change and health sector reforms. Since independence Bangladesh health sector has undergone various changes mainly due to changes in its objectives. However, these changes could not bring expected or targeted results mainly due to inefficiency in managing change. Effective management of change is essential for the sector, and ignoring this aspect is making objectives unfulfilled and resources unutilized. This paper is an attempt to aid the health managers to better manage the health sector so that they take out the desired results as planned.

Keywords: *Change management, HPSP, HNPSP, Sector wise management approach*

INTRODUCTION

Managing change or change management is an inevitable part of any organization. The change in management becomes inevitable when new policies, new technologies, new ideas, and new strategies are adopted. If management is not changed with the changing events, the ultimate objectives of the organization may not be achieved. Like any other organization health sector also faces continuous changes. Changes in the health sector take place in the form of policy change and health sector reforms, which necessitates a wide range of changes in management of the health sector itself. Health sector reform often brings change in the form of rearrangement of health human resources, decentralization, change in service delivery system, change in financing mechanism and so on. Capacity to manage these changes should, therefore, be present within the reform itself.

Since independence, a number of changes have taken place in the health sector of Bangladesh. Successful implementation of these changes require political, analytical, and communication skills. However, due to lack of skill to manage these changes in the health sector, the objectives and targeted output of the sector could not be achieved in several occasions. In this context, the paper aims to compare and contrast the Health and Population Sector Program (HPSP) and Health Nutrition and Population Sector Program (HNPSP) in order to find out the major changes that have taken place in the areas of

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management structure, service delivery and resource utilization, and to assess the effects of lack of skill in managing change in the health sector of Bangladesh.

This paper attempts to delineate the issue of change management, change management in the health sector, change in the health sector of Bangladesh, resultant effects of lack of managing change in the health sector of Bangladesh, and finally to propose some recommendations in the consecutive sections.

KEY ISSUES INVOLVED IN MANAGING CHANGE

Change management is a systematic approach to dealing with changes, both from the perspective of organization and individual. Change management has at least three different aspects: adapting to change, controlling change, and effecting change. All three aspects are at the heart of any change. For an organization, change management means defining and implementing procedures and/or technologies to deal with changes in the business environment and to profit from changing opportunities (www. SearchTechTarget.com). According to Nickols (2004), in order for many companies, organizations, or institutions to stay competitive in their fields, they must prepare themselves for change and the effects of that change as well.

Process of Change Management

According to John Kotter (1998) the management of change is at the heart of the manger's job. It is essential for the manager to create a feeling that change is needed. Manager should involve as many people as possible in the process of change. He should ensure that people understand the reasons for change and importance of it. A vision needs to be created which is easy to communicate. The manager should be positive and optimistic in his language. He should communicate the vision rigorously and try to ensure that the massage is not misunderstood. It is essential to remove obstacles through involving those who might oppose the change. The manager should build a critical mass involving all cadres of staff in discussing and developing change. Hence, the sufficient numbers become committed to the change.

It is necessary to plan systematically for easy wins early one though the change may take a long time. Working in small incremental steps and celebrating small successes early encourage the staff.

There are six steps in the change process (Kramlinger, 1998) :

Step 1 The strategy. Executives or a design team decide a new strategy.

Step 2 The message. The strategy is announced and employees are asked for support.

Step 3 Enrollments. People enroll, or not; that is they either accept or reject the change.

Step 4 Training. People learn how to perform the required new skills and behaviors.

Step 5 Reinforcing. Managers and systems act to support new behaviors.

Step 6 Monitoring. Feedback is monitored; adjustments are made.

Those who are in charge of the change must understand all that the change will involve and all that the change will affect. Managing change occurs in four broad stages. The first

stage is the planning stage. An organization determines a need for change, creates a change management team, and develops a plan of action. The second stage is "the implementing, managing, and maintaining stage when the change plan needs to be executed and phased rollout [is] identified." The third stage involves developing tracking and monitoring instruments to assess the successes or failures of the change so that necessary adjustments can be made. Wilbur (1999) stated that, the last stage "consists solely of continuous tracking and monitoring until the organization has institutionalized the change" (Quoted in Nickols, 2004).

Factors Important for Successful Change Management

There is increasing emphasis on the need to adapt to change management strategies to the particular characteristics of the organization and its environment and to address all aspects of the organization. Following basic considerations should be addressed carefully and effectively to ensure success-

i) Leadership

Executive sponsorship and participation are critical to the success of change initiatives. Numerous studies have identified leadership and participation of top management as the single greatest contributor to success in change management programs (Kanter 1983; Kanter et al. 1992; Goodstein and Burke 1995; Mohrman and Mohrman, 1993). Change leadership must be diffused throughout the organization and an effective leadership network established to overcome resistance and inertia within the organization (Lawler et al., 1998). Leaders are needed to provide vision, inspiration and conviction, and to demonstrate integrity, provide meaning, generate trust, and communicate values.

ii) Recognition of and Attention to the Personal Aspects of Change

Managing the social psychology of the workplace and creating a critical mass in favour of change are critical for successful organizational change. Times of change, communication and employee engagement are more important than usual, and can substantially affect the cost and outcome of change efforts.

iii) In-Depth Understanding of the Existing Organization

Better understanding of the key elements of the organization's performance should be assessed before change takes place. The organizational assessment needs to take into consideration where the organization is in the growth and evolution/development (lifecycle) process so that the change process can work "with the flow of the tide rather than against it" (Greiner 1998:8).

Skills and Strategies required for managing change

Among other things, political and analytical skills are crucial to manage changes.

Political Skills

Organizations are first and foremost social systems and therefore are intensely political. Without people there can be no organization. Political skill is essential for a successful management of change.

Analytical Skills

Analytical change is the second most important skills required. There are two sets of skills that are very important: (1) systems analysis, and (2) financial analysis. Change agents must learn to take apart and reassemble operations and systems in appropriate ways, and then determine the financial and political impacts of what they have done. Conversely, they must be able to start with some financial measure or indicator or goal, and make their way quickly to those operations and systems that, if reconfigured a certain way, would have the desired financial impact.

People Skills

The skills most needed in this area are those that typically fall under the heading of communication or interpersonal skills. To be effective, we must be able to listen and listen actively, to restate, to reflect, to clarify without interrogating, to draw out the speaker, to lead or channel a discussion, to plant ideas, and to develop them. All these and more are needed. Part of the job of a change agent is to reconcile and resolve the conflict between and among disparate (and sometimes desperate) points of view ((Nickols, 2004).

Reasons for failure

Although the change management literature generally recognizes the need for change initiatives, the potential for failure is great.

-       Companies resist new truths with a great deal of emotion (Martin 1998:114). Inability to change the basic ways of thinking within the organization may cause failure.

-       Lack of leadership, poses serious problem. Even when an organization can figure out what to do, it still has to figure out how to make goals and methods transparent enough that employees are willing to take some calculated risks (Martin 1998:137).

-       Change needs to be implemented over the long term, with careful attention to the disruptive aspects of change management.

-       Plan of change should be made very carefully and take long period. Critical mistakes in any of the phases can have a devastating impact, slowing momentum and negating previous gains (Kotter 1998:2)(Quoted in Branch, 2002).

MANAGING CHANGE IN HEALTH SECTOR: MAJOR AREAS

Health sector also faces continuous changes in the form of policy change and health sector reforms. The need for change in the health service is now widely recognized--by public, by professions and by government (Iles & Sutherland, 2001). All countries, whether developed, developing, or least developed, are in various stages of health sector reforms. Health sector reforms are "sustained processes of fundamental change in the policy and institutional arrangements in the health sector". The respective governments usually guide these processes on a technical and political basis. They are designed to improve the functioning and performance of the health sector and, ultimately, the health

status of the population (Johnson, 2000). In developing countries, numerous organizations and projects are supporting national health sector efforts, among them national governments and other national organizations; international health organizations, banks and donors are the main.

The goal of health sector reform is to improve the equity, effectiveness, efficiency and sustainability of the health sector, and the organizations and institutions that comprise it (Johnson, 2000). The World Health Report (2000) identified the following five goals of health sector reforms that serve to orient discussions about the purposes of reforms, and the measurement of its outcomes: Efficiency; Quality; Equity; Client Responsiveness; and Sustainability.

The track record of health sector reform's impact on these goals is mixed, in part reflecting the complexity of the reform process and agenda. In some settings, the failures of reforms have become a cause for conflict and disruptive public debate about the undertaking of new reform efforts. In other settings, reforms have resulted in positive outcomes and work continues towards a fuller attainment of the five goals. In all countries the constraints on health system functions are unrelenting, and governments are compelled to continually adapt and reform the functions of their health sectors (WHO, 2004). Health sector reform therefore implies changes, changes which affect people who work at all levels in the health system. Institutions and people must be prepared for change, and managers, leaders and HR professionals must be capable of managing change. These changes may include re-profiling jobs or new organizational structures in which people are thrust into new decision-making and supervisory roles. They may involve new work teams or cutting or limiting hiring of public sector employees. People contracted through traditional public sector system mechanisms may find themselves working along side people who are contracted differently. Work processes, norms and procedures may change requiring people to learn a new way of doing things. Such change may view as threatening. Employees may or may not be in agreement about the need for and direction of change. The changes may result at least temporarily in worry, fear and insecurity among the workforce, breakdown in employee morale and a dip in productivity. Tensions may arise among public sector leaders, employees and unions with unions and employees concerned that their jobs may be eliminated or out-sourced (Johnson, 2000). Lack of management capacity to manage change, at the central and regional levels may grind its momentum to a halt.

Human resource is the main driving force of the health system. The efficient and effective management of human resources is an essential component of a high performing health system and can influence the success or failure of health sector reforms and different organizations or institutions. Therefore, change human resource management plays a vital role.

However, planning for human resource needs in the health sector and training do not ensure that these human resources will be strategically identified, recruited and positioned by health organizations, and will work effectively and efficiently in institutions that hire them. It does not ensure employees working in the system will receive support and motivation to perform at the highest level and will be treated fairly. It

also does not ensure that employees will achieve results in the workplace and successfully adapt to and participate in change as it occurs. Health sector reform must be concerned not only with the planning of the workforce but also with the continual management and development of this workforce within the health system (Martinez and Martineau, 1998). The strategic management of human resources in each institution and the day-to-day support, encouragement, direction, performance monitoring and supervision that they receive are critical (Quoted in Johnson, 2000).

There are many drivers of change and many targets for the change. Change can take place in several areas of the health sector. The major focal points of change in the health sector are,

Objectives: The mission, vision, goals, objectives and key performance indicators need to be changed under successive health plans.

Health Professional: The skills, competencies, knowledge and behavior of the health workforce need to be changed to make better use of human capital and to run the health sector in the most effective manner.

Service offered: Change takes place to provide new range of services and to enhance the service coverage.

Process: There arise compelling reasons to undertake the change in the health sector service delivery mechanism to increase the availability and utilization of user-centered, efficient, affordable and accessible quality services.

Culture: The beliefs, attitudes and behavior of the leadership and workforce may be changed to operate more efficiently.

Structure: Organizational structures divisions, departments, roles, responsibilities and jobs descriptions also change over time.

Technology: With new innovations and increasing demand for modern health care technology, change in the areas of drugs, equipment and machinery take place. Management information system also changes for facilitating referral system and managing patient records.

Regulation: Change can take place in the public sector regulations for better management of the health sector, along with the changing roles of the NGOs, and private providers.

Procurement: The terms, process and technology of the procurement of drugs, equipment and vehicles can also be the focus of change.

Health Care Facilities: Locations, premises, equipment infrastructure, service providers, support and maintenance may need to be changed within a facility.

Partners, funding and ownership: Change can also happen regarding collaborative ventures with development partners, NGOs and other funding sources, methods and terms of funding for service provision, and the stakeholders relationship with government.

Research and development: The focus of change can be the activities to develop leading edge inputs, services and methods of operation.

CHANGES IN THE HEALTH SECTOR OF BANGLADESH

Since 1975, an international consortium of government development agencies in coordination with the World Bank have provided financial and technical assistance to the Government of Bangladesh for the implementation of successive projects, each five to six years in length. The initial project, called the First Population Project (1975-80), provided support for re-establishing a physical infrastructure for family planning service delivery, which had been greatly damaged during the liberation war of 1971. The Second Population and Family Health Project (1980-86) provided funds for the further development of the national family planning program. The Third Population and Family Welfare Project (1986-91) began to provide some support for the reduction of infant mortality along with support for family planning services. The Fourth Population and Health Project (1992-98) provided further support for MCH and disease control activities along with family planning services (Perry, 1999).

A review of the Fourth Population and Health Project led to concerns about the lack of progress in reducing maternal mortality and morbidity, the low utilization of Government health services, and their cost-effectiveness, sustainability and quality and led to the formulation of the Health and Population Sector Program (1998-2003) (Perry, 1999). The HPSP came to an end on 30th June 2003. In order to encompass all the activities of the health sector, the GOB has revised the HPSP and formulated the new Health Nutrition and Population Sector Program (HNPSP) (2003-2006), which was being initiated in 2004, including nutrition as a sub-sector. The purpose is to increase the availability and utilization of user-centered, effective, efficient, equitable, affordable and accessible quality services for a defined Essential Services Package (ESP) plus other selected services. HNPSP will continue to focus on areas of reproductive health and population such as safe motherhood, reduction in total fertility and advocacy for vulnerable groups (WHO, 2005).

Though the broad aim of both HPSP and HNPSP is to improve the health status of the population, particularly the vulnerable groups, a number of changes have been taken place in the health sector over the last ten years mainly in the areas of management structure, service delivery mechanism and utilization of public sector resources. This section, therefore, explores the major changes those have been initiated by HPSP and HNPSP.

Three managerial reforms had undergone major changes throughout these policy changes (MOHFW, 1998): the way services are delivered (more integration between health and FP); decentralization to lower level; and Sector wide management.

Decentralized local communities became involved in the management of Government hospitals in their respective area under HPSP. A National Steering Committee for Community and Stakeholder Participation in the HPSP evolved. This committee consists of clients, legal experts, academics, and representatives from community-based

organizations, women's organizations, and professional associations along with representatives from the MOHFW (MOHFW, 1998). This National Steering Committee facilitate the development of local-level structures for involving local Government and NGO leaders in policy and strategy development, planning, monitoring, regulatory activities, and client advocacy.

HPSP developed centralized procurement system, which created delays in creating supplies and logistics. HNPSP delegated the authority of procurement of goods and equipments to the Line Directors and institutions (MOHFW, 2004). The guidelines for procurement of supplies and services, particularly through the pool, have been criticized as cumbersome and time consuming (HEU and MAU, 2001). Ensor et al, (2001) mentioned that the new procurement methods delayed much procurement and meant that over the first two years actual expenditure was around 12% below the planned budget.

To improve the performance of the health sector and enhance the efficiency with which resources for health are used the Sector Wide Management Approach (SWM) was initiated under HPSP. In terms of policy and strategy, SWM looks at the sector as a whole, whether the Government or the private sector, NGOs or other agencies such as community groups run the services. Equally, it considers all sources of funding, including individuals' payments and those by employers as well as Government and international agencies. And it covers the range of services, including FP as well health in an integrated way.

SWM were supposed to contribute to this improvement in performance in two main ways: a) by improving Government's capacity to set policy and strategy which are then translated into plans and implemented and b) by improving the efficiency with which limited resources are used. Through these mechanisms, SWM contributed to the strategic objectives of enhancing service effectiveness and improving service coverage. The new Sector Wide Management Approach created another base for change in management of the health sector (MOHFW, 1998).

HPSP, in contrast to previous plans, with the objective to improve performance and efficiency of the overall health and population sector, included family planning activities along with health activities in an integrated way. This change in policy led to change in staff management and budget management. The separate structure in the two directorates have been responsible for the establishment of separate cadres of staff all the way down to the field level which have eventually led to inefficiencies as a result of duplication of efforts and internal conflicts and to fragmentation of services. As a result, HPSP proposed to eliminate the duplicative organizational structures, which have arisen separately in the Directorate of Health Services and the Directorate of Family Planning and which at present are considered to be a major cause of "waste and inefficiency" (MOHFW, 1998). The health and family planning services included in the ESP were designed to deliver in integrated way through unified management system. In order to ensure this integrated service delivery the manpower of MOHFW at Thana level and below have been restructured and reorganized.

MOHFW planned to unify the health and family planning activities at the Thana level and below during the first phase of the HPSP. During the second phase, the activities at

the district level and above were unified (Perry, 1999). This change in the form of unification of two Directorates namely, Directorate of Health Services and the Directorate of Family Planning, surely necessitates change in the management structure i.e., change management becomes inevitable. But while formulating HNPSP, it was felt that the unification of DGFP and DGHS caused subordination of family planning staff, usually at lower numbers (about half) than their health counterparts. This led to insufficient service delivery. So the directorates are again deunified (MOHFW, 2004). All designation, job descriptions and job allocations of the existing Health Assistants and Family Welfare Assistants were replaced by a single comprehensive job designation and description under HPSP. And again restructured under HNPSP.

The change of unification under HPSP, called for another change in the form of decentralized service delivery system, which gave Thana level, more authority. The development of client-centered services required that local people, including representatives of the local communities, have authority for decision-making, including authority for local financing and financial decision-making. Government hospitals were given greater autonomy and more opportunities to retain the fees generated by their services and had a drug revolving fund. But the inherent bureaucratic procedure and lack of administration impeded devolution of authority especially at lower levels.

Health and Population Sector Program (HPSP) was formulated with a wider range of reproductive health services, provided as a part of an 'essential services package' (ESP), to expand access to and improve the quality of family planning and other basic health services. A number of cost-reduction and/or revenue generation measures to attain financial sustainability as well were pursued. This new service delivery model discontinued door-to-door contraceptive distribution and at the same time increased or introduced some user fees. Therefore, ESP was designed as client-oriented service from the one-stop service centers. This allowed the clients to receive the necessary services from one fixed site. The reorganized service delivery strategy expected the client to attend fixed center and seek for the essential services of their necessity. The important aspect is that the clients should not wait for services at their homes; rather they should attend the health center to seek services. Doorstep delivery of pills and condoms were gradually discontinued (MOHFW, 1998).

However, while formulating HNPSP it was felt that discontinuation of door-to-door service caused discontinuation of door-step services for follow-up, supplies and motivation, making the family planning field workers largely dysfunctional and consequently led to loss of momentum in family planning services. It is felt that, this caused the fertility rate and maternal mortality rates stall at the same rate for about 10 years and HNPSP is designed so as to provide the door-to-door services again (MOHFW, 2004). Chawla et al(2003) found that, discontinuation and dropout rate for family planning method was 48% in 2000 at the time of HPSP, which was very high, whereas HNPSP targets to reduce this to 15%.

Under HPSP, satellite Clinics and Expanded Program of Immunization (EPI) outreached sites were merged. To ensure geographic equity it has been planned to establish one community clinic for more or less 6,000 populations with the exception of metropolitan

and municipal areas, which required the construction of 13,000 new clinics by the MOHFW. Up to June 2001, 25% of the planned CCs were completed and functional (SPI, 2002). It was also designed that no community clinic would be established near to Mother and Child Welfare Center (MCWC), Upazila Health Complex (UHC) and Union Health and Family Welfare Center (UHFWC). The distance of community clinic from these centers must be at least half-hour walking distance (MOHFW, 2000). Community Clinics were developed to replace satellite clinics. All fixed sites at the union level were designated as Union Health and Family Welfare Centers and provided the entire scope of Essential Service Package (ESP) services rather than the emphasis on health or family planning services. HNPSP designer found that the CCs are non-functional and decided not to construct CCs under the new program.

Yet another change took place in the form of consolidation of 105 semi-independent projects (most of which were funded with external donor support) into 15 programs that received funding from Revenue Budget of the MOHFW along with funds from external donors. Under the SWAp, there has been a shift from the separate projects to a more integrated single programme. One of the objectives of the reform was to improve the efficiency of resource utilisation. The "project approach" used in the past (whereby externally funded projects operated outside of other activities funded from the Revenue Budget) encouraged the use of donor funds in a more clearly focused and more readily accountable fashion. However, the approach led to the creation of separate management structures for these activities and, as a result, it isolated the project's activities from the mainstream management of MOHFW activities and created duplication of efforts. Further, the recurrent expenditures incurred by these projects have rarely been absorbed into the Government's Revenue Budget, and the project personnel supported by the Development Budget have not enjoyed the security and benefits of regular MOHFW employees. As a result, tensions and conflicts have developed in the MOHFW (Perry, 1999). However, the studies show that people are still unfamiliar with the procedures for operating a programme rather than different projects (Rahman *et al*, 2000).

RESULTANT EFFECTS OF LACK OF SKILL FOR MANAGING CHANGE IN THE HEALTH SECTOR OF BANGLADESH

The HPSP was one of the world's first examples of a Sector Wide Approach (SWAp) in which a number of development partners contributed in a 'pool' fund and coordinated technical support within an overall sectoral programme and implementation plan (White, 2007). However, frequent change in the policy focus, and lack of skill in managing change affected the development activities of the health sector to a great extent.

There remained general and continuing lack of understanding of the MOHFW personnel about the SWAp process, managing pool fund and procurement procedures. Lack of knowledge of the SWAp process delayed preparation and approval of Operational Plan for every financial year. Some were not approved until the first quarter of the year. The disbursement of development budget was also delayed. Moreover, due to shortage of trained procurement experts, there remained lack of understanding about the procedures of procurement under the reform programme, specially, the time lags required for

approval for international procurement. The guidelines for procurement of supplies and services, particularly through the pool, have been criticized as cumbersome and time consuming (HEU and MAU, 2001). The new procurement methods delayed much procurement and meant that over the first two years actual expenditure was around 12% below the planned budget (Ensor et al, 2001). All these resulted in under spending of the development budget in almost every year (Table 1). During the early stages of health sector reform, about 23% to 34% money was unspent. The main short fall was in the Reimbursable Programme Aid (RPA), which was provided through the donor pool (HEU and MAU, 2001). Family planning supplies which continued to be financed largely through bilateral donor and direct government sources have largely been untouched. Spending on maternal care was only 40% of what was planned in the initial HPSP planning documents (Ensor *et al*, 2001).

Table 1: Development budget of the MOHFW (nominal in Million Taka)

Year	Approved Budget	Revised Budget	Development Expenditure			Expenditure as % of Revised budget
			DPs share	GOB share	Total	
1995/96	9,454	8,970	5,004 (61.6%)	3,115 (38.4%)	8,119	90
1996/97	N/A	9,530	6,171 (61.1%)	3,933 (39.5%)	10,104	106
1997/98	N/A	11,310	6,889 (61.9%)	4,231 (38.1%)	11,120	98
1998/99	N/A	12,720	6,292 (64.1%)	3,518 (35.9%)	9,810	77
1999/00	14,690	13,730	7,905 (76.6%)	2,410 (23.4%)	10,315	75
2000/01	15,770	15,280	5,766 (56.9%)	4,364 (43.1%)	10,130	66
2001/02	16,210	13,630	8,017 (68.7%)	3,654 (31.3%)	11,671	85
2002/03	17,020	14,630	7,029 (64.3%)	3,910 (35.7%)	10,939	75
2003/04	15,120	19,480	7,874 (58.8%)	5,509 (41.2%)	13,383	69
2004/05	20,800	13,720	7,177 (60.0%)	4,779 (40.0%)	11,956	87
2005/06	21,770	20,470	8,517 (47.6%)	9,365(53.4%)	17,882	87
2006/07	23,750	13,730	N/A	N/A	N/A	N/A
2007/08	26,060	23,630	N/A	N/A	N/A	N/A
2008/09	24,390	N/A	N/A	N/A	N/A	N/A

Source: Various issues of ADP, Planning Commission, Various copies of Public Expenditure Review, HEU, MOHFW, MOF official website (www.mof.gov.bd).

N/A: these data are not available.

Although the changes initiated under the health sector reforms programmes were carefully planned, the objectives could not be achieved as expected. Since the

introduction, the ESP has not been able to spend the entire budget channeled to the programme (HEU and MAU, 2001). This reflects that resources are not being translated into service output. Despite having a well organized network of health facilities all over the country utilisation of public health facilities is very low and poor still find it difficult to access high quality essential services in Bangladesh (MOHFW, 2002; Ensor et al, 2001). In 2003, 60% of service users chose unqualified practitioners, 27% used private qualified practitioners, and only 13% used government services during illness (Cockcroft et al, 2004). The levels of maternal and neonatal mortality are still very high in Bangladesh. The maternal mortality rate (3.8 per 1000 live births) is one of the highest in South Asia and in the world outside Sub Saharan Africa (WHO, 2007).

It has been stated earlier that three elements are crucial for the success of managing change: effective leadership and participation of top management, creating a critical mass in favour of change, and in-depth understanding of the organization. However, some of these were lacking in the health sector of Bangladesh while initiating reform in 1998. Though a SWAp was initiated in the health sector for enhanced donor co-ordination, the decision making process was still criticised for World Bank dominance and lack of local ownership. Though the shift to a single programme approach brought the donors closer, dominance of the World Bank still persisted within the donor consortium (White, 2002). The APR (2006) also reports that though the SWAp has brought the donors closer, the current state of information sharing between development partners and the MOHFW is insufficient, which is increasing a sense of mistrust among the partners.

Absence of political motivation and commitment and absence of in-depth understanding of the existing organization are also major constraints in achieving the objectives of health sector reforms in Bangladesh. Though change in the government also causes change of plans in Bangladesh, health managers are unable to motivate people to adapt to changes. Another cause is that, plans are changed frequently. Changes are not communicated properly to the lower levels of staffs.

CONCLUDING REMARKS AND RECOMMENDATION

Since independence, a number of changes have been taken place in the health sector of Bangladesh, particularly in the areas of management structure, service delivery mechanism and utilization of public sector resources. A change in health sector brought about by change in policies requires some managerial efforts. However, the underlying reasons of inability to manage change and achieve the set objectives of the health sector over time are the absence of political motivation and commitment and also absence of in-depth understanding of the existing organizational set-up. With frequently changing policies, changes are not communicated properly to the lower levels of staffs, and to other stakeholders. To manage changes in health sector in a best way, it is therefore recommended that-

- Communication is the main function of the change agent. "Under communication is one of the principal reasons that change management fails"(Kramlinger, 1998). The stakeholders, providers and consumers of health sector should all be well aware of the change before it takes place.

- Separate effective management unit should be developing.

- Continuous and effective training of medical officers, nurse and other related personnel. All level Staff Training, Management and leadership development training, external Pre-Service Training should be arranged.

- The professional can also invite upper management to "a training activity and have them restate the message to kick off the session"(Kramlinger, 1998).

- On-the job training for the staff should be encouraged to make them familiar   with the procurement procedures. Strategically identify, recruit and position by health organizations of health human resources and ensure that they work effectively and efficiently.

- Give continuous support and motivation to health professional so that they perform at their highest level and successfully adapt to and participate in change as it occurs.

- Day-to-day support, encouragement, direction, performance monitoring and supervision should be there.

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