Government of the People's
Republic of Bangladesh

NATIONAL URBAN HEALTH STRATEGY 2011

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Ministry of Local Government, Rural Development and Cooperatives
Local Government Division
in collaboration with
Ministry of Health and Family Welfare

EXECUTIVE SUMMARY

National Urban Health Strategy 2011 has been prepared in response to the policy framework enunciated in the Sixth Five Year Plan (2011-2015) and in the Strategic Plan for Health Population and Nutrition Sector Development Programme (HPNSDP- 2011-2016). Local Government Division (LGD) of the Ministry of Local Government Rural Development and Cooperative (MOLGRDC) prepared this strategy in close collaboration with the Ministry of Health and Family Welfare (MOHFW), the civil society, urban local bodies (ULBs) and the development partners.

The strategy begins with a snapshot of the major issues relevant for it followed up by status of health in urban population. In this part global perspectives are discussed identifying megatrends of 21st century health. These trends are: globalization, demographic shift, climate change and urbanization. The global perspectives also provide a conceptual framework of urban health centering on municipal level determinants, government policies of all level, markets, food, housing, other goods and civil society, community organization, community capacity, social movements. These are structures linked to public health intervention and research and international public health activities. Outcomes in the conceptual framework are categorized as health and non-health outcomes influenced by the needed interventions in light of urban characteristics of population: demographics, socio economic status, ethnicity, employment status, attitude, behaviors. Included in this also are physical environment: housing, climate and density. Social environment, social network, social support and social capital including health and social services, formal and informal are also part of it.

The above are related to Bangladesh context that includes Urban Local Bodies (City Corporations and Municipalities), rapid urbanization, urban poverty and socio economic status. Health status of Bangladesh urban poor are analyzed drawing on the evidence from Bangladesh Urban Health Survey 2006 (BUHS) including several recent policy documents and the strategies described therein. It further draws attention to safe water supply situation and sewerage, housing, environmental safety and availability of health Programme services based on available evidence.

The strategy also provides an evaluative and analytical account of available policies and strategies and lessons learnt. It highlights the facts that in the recent health related policies have been a welcome departure from the past in that for the first time these policies draw pointed attention to improve urban health situation. It further provides an analytical view on public, the private and NGO health facilities. The gaps in urban health care and management in terms of access of the poor to health care, human resource development in health and population and lack of adequate attention for alleviation of urban poverty is explained. It also highlights the complementary role of LGD and NGOs. Statutory responsibility and the overriding need for creating and enabling environment based on strengthening multisectoral collaboration are emphasized. The effectiveness including gaps and weaknesses of partnership between GO-NGO are analyzed for replication drawing on the lessons learnt.

The challenges to urban health are discussed and analyzed highlighting the urgent need for greater focus on PHC and limited curative care by the ULBs and NGOs. A SWOT analysis is presented with identification of strength, weaknesses, opportunities and threats. The challenges are identified based on SWOT analysis. The challenges include protecting the urban poor, resource allocation for urban development, access to and utilization of services, human resource development, increased attention to the persistent and emerging issues in urban health, health education, improving living conditions and environment coordination and capacity and sustainability.

The guiding principles of the strategy are built on themes and objectives of various health, population and nutrition conventions and advocates a right's based approach of the poor. Its vision is to see urban people, specially the poor, healthier, happier and economically productive for attaining middle income status by 2021. The strategy is construed to be a living document. It will need periodic updates in light of which adjustments will have to be made and actions taken. It also sets out some important priority intervention for the government and needs to strengthen service delivery in the non-health sector to strengthen health outcomes. Strategy is presented in the form of a matrix that includes nine specific objectives for which strategies are outlined and provides implementation modalities within a time bound frame.

The objectives include:

- Universal coverage for urban population with a pro-poor focus;
- Strengthen preventive and PHC;
- Urban poverty reduction;
- Achieving National Population Policy goals and targets;
- Achieving national nutrition goals and targets based on available reports;
- Adopting innovative service delivery programmes using modern technology, management policies and practices;
- Improving institutional governance and capacity;
- Financing and resource mobilization; and
- Sustainability.

To attain the objectives, the major emphasis is on coordination across cross-cutting sectors, improved human resource and management of existing urban health delivery infrastructure of all actors, strengthening partnership approach, establishing greater linkages to all existing urban governance related programmes with a more focused attention for accelerated reduction of urban poverty, inter-ministerial, inter agency and coordination, coordination structure at ULB, a separate budget allocation for continuity and expansion of ULB-NGO partnership programme, strengthening monitoring with linkage of data base of LGD to DGHS, capacity building, greater decentralization of authority to ULBs and amendment of the existing allocation of functions of MOHFW and LGD.

Table of Contents

List of Tables, Figures & Boxes

Abbreviations

ADB	Asian Development Bank
ADL	Activities of Daily Life
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ARI	Acute Respiratory Infection
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
BIFF	Bangladesh Infrastructure Financing Fund
BMI	Body Mass Index
BNHA	Bangladesh National Health Account
BOT	Build-Operate-Transfer
BRAC	Bangladesh Rural Advancement Committee
BSTI	Bangladesh Standard and Testing Institute
BUHS	Bangladesh Urban Health Studies
CBR	Crude Birth Rate
CCEA	Cabinet Committee on Economic Affairs
CPR	Contraceptive Prevalence Rate
CSR	Corporate Social Responsibility
CUS	Centre for Urban Studies
DGHS	Director General Health Services
DIC	Drop in Centres
DOE	Directorate of Environment Control
DOTS	Directly Observed Treatment Short Course
EMOC	Emergency Medical Obstetric Care
EOC	Emergency Obstetric Care
EPI	Expanded Programme on Immunization
ESD	Essential Service Delivery
FP	Family Planning
FYP	Five Year Plan

GFR	General Fertility Rates
GO	Government Organization
HNPSP	Health, Nutrition and Population Sector Programme
HPDSP	Health, Population Development Sector Programme
HPNDSP	Health, Population, Nutrition Development Sector Programme
HPNSSP	Health, Population, Nutrition Sector Strategy Programme
HPSP	Health and Population Sector Programme
HRD	Human Resource Development
HIV	Human Immunodeficiency Virus
ICT	Information and Communication Technology
IDCOL	Infrastructure Development Company Limited
IEC	Information, Education and Communication
ITN	Insecticide Treated Net
IUD	Intra Uterine Device
LAPM	Long Acting Permanent Method
LGD	Local Govt. Division
MAB	Municipal Association of Bangladesh
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Centre
MDG	Millennium Development Goal
MIS	Management Information System
MMR	Maternal Mortality Rate
MNCH	Maternal and Neonatal Child Health.
MOE&F	Ministry of Environment & Forest
MOHFW	Ministry of Health and Family Welfare
MOI	Ministry of Information
MOLGRD&C	Ministry of Local Govt. Rural Development & Co-operatives
MR	Menstrual Regulation
MSCS	Marie Stopes Clinic Society
MSI	Marie Stopes International
MSR	Medical and Surgical Requisites
NASP	National AIDS/STD Programme

NGO	Non-Govt. Organization
NIPORT	National Institute of Population Research and Training
NNP	National Nutrition Programme
NRB	Non-resident Bangladeshi
NTCB	National Tuberculosis control Programme
NUHS	National Urban Health Strategy
PHC	Primary Health Care
PMO	Prime Minister's Office
PNC	Post-natal Care
PPP	Public-Private Partnership
RDRS	Rangpur, Dinajpur Rehabilitation Society
SCC	Sylhet City Corporation
SDMO	Sub-divisional Medical Officer
SMC	Social Marketing Company
SSFP	Smiling Sun Franchise Programme
STD	Sexually Transmitted Disease
SVRS	Sample Vital Registration System
TA	Technical Assistant
TB	Tuberculosis Bacillus
TFR	Total Fertility Rates
TOR	Terms of Reference
TT	Tetanus Toxoid
UHS	Urban Health Strategy
ULB	Urban Local Body
UN	United Nations
UNICEF	United Nations International Children Emergency Fund
UPHCP	Urban Primary Health Care Project
USAID	United States Agency for International Development
VAC	Vitamin A Capsule
VCT	Voluntary Counseling and Testing
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

I
Introduction

1.1 Background

1.1.1 The purpose of the study is to prepare National Urban Health Strategy (NUHS).[1] The Local Government Division (LGD) of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) took the initiative to complete the study that began in June and ended in November, 2011. The scope of work included collaboration with the Ministry of Health and Family Welfare (MOHFW), MOLGRDC and the Second Urban Primary Health Care Project (UPHCP II) to develop the NUHS.

1.2 Rationale

1.2.1 The rationale for preparing the Urban Health Strategy lies in the various government policy documents which emphasize preparation of an Urban Health Strategy. They do, however, refer to the need for developing an urban health strategy in collaboration with LGD. The formulation of urban health strategy will enable the government to address urban health issues which are projected to be severe by 2020.

1.3 Snapshot of the strategy

1.3.1 The strategy is built on the premise that rapid urbanization, in particular unplanned urbanization, creates obstacles to achieve a healthy urban environment with all its attendant problems relating not only health care but also family welfare and nutritional security. In such a situation it is imperative to put in the strategy to achieve a healthy urban life. The starting points, among other in this respect are :

- Health care, in particular urban health care should not be narrowly viewed as curative care alone;
- Permanent structure for multisectoral involvement to ensure effective coordination;
- More effective and durable PPP to ensure effective service delivery;
- Financing of urban health, in particular, primary health care (PHC);
- Holistic approach with more emphasis on community participation;
- More focus on the urban poor; and
- Greater effort for population and nutrition programmes.

1.4 Objectives

1.4.1 The major objective of the study will be to assist the Ministry of Health and Family Welfare (MOHFW), LGD and Second Urban Primary Health Care Project to develop the National Urban Health Strategy (NUHS). The terms of reference (TOR) is shown in Annexe-I. The specific objectives will be to:

[1] The study was mounted by the Government of Bangladesh (GOB) with support from the Asian Development Bank (ADB) and other co-financiers under TA 7490 (BAN) of ADB.

- Identify gaps and weaknesses in the existing policies and overall urban health related policies including the previous draft of May 2011; [2]
- Provide further insights from discussions with relevant stakeholders;
- Assess institutional weaknesses of the existing urban health care delivery system and suggest remedial measures; and
- Prepare a strategy for urban health.

1.5 Methodology

1.5.1 The methodology of the study is a combination of primary and secondary sources of information. The primary sources of information are from field level discussions with relevant stakeholders both state and non-state and a national level discussion with policy makers and experts. The field level discussions covered five City Corporations and two Municipalities. The national level workshop was also held with public policy makers and other experts including the development partners. The number of participants in each of these workshops is shown at annex-III. The secondary sources are: Five Year Plan, Draft Urban Sector Policy, health policy, relevant project documents and public statistical data, relevant documents of development partners and non-state actors.

1.6 Limitations

1.6.1 The major limitations of the study are absence of primary data and grass root level perceptions. This limitation may have been compensated to a large extent by field level discussions that include five City Corporations and two Paurashavas. This implies that although 5 out of six City Corporations have been covered, the sample of two out of 17 Paurashavas having population of 100,000 or more indicate about 9 percent of the total. The justifications are mainly two. First, UPHC services are planned to be in selected Paurashavas. Second, the challenges of City Corporation areas are more than those of smaller municipalities. With passage of time and lessons learnt, the coverage can be increased. In this context, it is relevant to mention that the participants were divided into four groups: (i) government and semi-government officials, (ii) civil society/NGOs, (iii) Users' group and (iv) elected officials (commissioners) of ULBs. This made it possible to obtain responses of the relevant stakeholders. In most cases, media personnel, private health service providers also participated to ensure broadest possible participation of all interest groups. A summary of the recommended measures of the workshops is shown at Annexe-IV.

1.7 Time frame of the study

1.7.1 The total days allotted was 61 day starting from the first week of June 2011. Later, considering the volume of work and the fact that the National Workshop was concluded on October 11, further time of 21 days were agreed. The work to be done on intermittent basis finally ending In November, 2011.

[2] The draft refers to the incomplete work earlier done by a consultant. The comments on the same are given at annex-II.

II
Status of health in urban population

2.1 Global trends

2.1.1 Scholars have attempted to sharpen our understanding of urban health by identifying megatrends of the twenty-first century health. These megatrends are often identified as globalization, demographic shifts, climate change and urbanization. [3]

2.2 Globalization

2.2.1 Much is known about globalization with regard to its impact on economic, social and cultural aspects. Not enough is known about how it affects health. The major features of globalization include advances in technology, rapid flow of information, migration of people, goods and services and creation or loss of livelihood opportunities. These elements are all too visible in cities or urban areas with their impact, positive or negative, on urban health. To overcome the negative aspects, the prerequisites are (a) fairness and equity in economic and trade regime and (b) strong national and urban governance. On the whole, it demands an inclusive approach in setting the rules of the game based on fairness and equity backed by commitments to ensure the same. It is said that too often the bad signals are visible: people who are jobless living in slums with little or no access to health services.

2.3 Demographic shifts

2.3.1 This consists of three elements: migration, fertility and mortality. Migration is driven by 'push-pull' factor centering on economic, cultural political or environment. 'Push' factor means and includes less opportunity, social or economic discrimination, political fears and natural disasters. 'Pull' includes increased livelihood opportunities and better living conditions. The movements occur within and between countries. Some may attend their daily duties in cities and back home outside the city. This is facilitated by fast moving transport system. This type of movement on a daily basis has implications for environment and health. Rural-urban migration has been a common pattern. It is said that in 2008, for the first time in history, the majority of the world's population lived in cities. It is also predicted that over the next three decades nearly 60 percent will be urban dwellers. By 2050, it is expected to rise to 75 percent. Further projections include:

- The number of cities with more than 10 million people which stood at five in 1975 will rise to twenty three by 2015 all but four of them in developing world;

[3] David Vlahov (editor) et. al, Urban Health, Global Perspectives, JOSSEY-Bass A Wily Imprint, San Fransisco, 2010,p. 27

- By 2015, an estimated 564 cities around the world will have one million or more residents. These projections underscore the urgency of viewing urban health as a national and global issue.

2.3.2 It is believed that the trend in urban growth will be horizontal expansion in small and medium sized cities. On the face of it, this may appear to be a mitigating factor associated with overcrowding. It is not, however, free from health challenges. It may, for instance, demand long commutes that present sedentary life style and traffic-related health risks. Horizontal growth may lead to loss of crop lands which is a threat to food and nutritional security. It may also raise problems of water supply with implications for sustainability. It follows therefore that creating healthy and sustainable cities represents a complex challenge.

2.3.3 Fertility and mortality are the other two elements of demographic shifts. Urbanization among the more affluent is accompanied by lower birth and lower death rates. Decline in mortality rates is generally associated with urban life due to availability of health care facilities. An offshoot of this phenomenon is the rise in aging population. It is said that by 2025, the global population of people over 60 will be 1.2 million which is double the number in 2000. Although more prominent in developed countries, it will be all too visible in developing countries.

2.4 Climate change

2.4.1 This is the third twenty first century megatrend[4] (Mc Michael, Wooruff and Hale, 2006). In the coming century, emissions of carbon die oxide and greenhouse gases are projected to increase. Cities are said to generate 80 percent of carbon dioxide and other greenhouse gases. Cities become “heat island” resulting from densely built housing and other concrete establishments. Climate change leads to health risks associated with rising heat, air pollution etc. It creates problems of food and water supply. In specific terms it exposes the urban residents to water and food-borne diseases including those caused by vector and rodent. Other threats to health are natural disaster for cities close to coastal areas or rivers.

2.5 Urbanization

2.5.1 The literature on global health in the context of urbanization emphasizes consideration to size, density and complexity through which implications of urban health scenario needs to be assessed.

2.5.2 Large sized cities from the view point of population demand large scale programmes in which quality assurance need to be considered. Density in the sense of overcrowding has its health risks such as poor housing, water supply and sanitation facilities. Quick movement of patients to health care facilities may become difficult due to traffic jams. Conversely, lower density may involve larger expenditure on utilities, longer commutes and social isolation.

[4] Ibid, p.5.

2.5.3 Diversity means mix of population from diverse socio-economic and cultural background. It can lead to cultural clashes. Thus diversity dictates the necessity of tailoring interventions to meet the needs of diverse subpopulation. At the other end, diversity may also mean a variety of specialized services and multiple service options.

2.5.4 Complexity of cities arises from multiple system interaction. Such interaction creates pluralistic political structures with competing demands from diverse groups. Cities are not islands but form part of other socio-political structures: neighborhoods, metropolitan regions and the country's capital. In such a situation resource allocation becomes difficult creating variations in delivery of services.

2.5.5 The four elements of urban life underline the fact that simple and straight jacket interventions are not sufficient. It may well lead to more unintended than intended outcome. The contextual complexity requires similar level of intervention complexity. What is needed is an intersectoral governance approach that integrates the public and non-state service delivery systems. This complexity further demands varying levels of analysis and data management to address the health related issues of urban dwellers and their determinants.

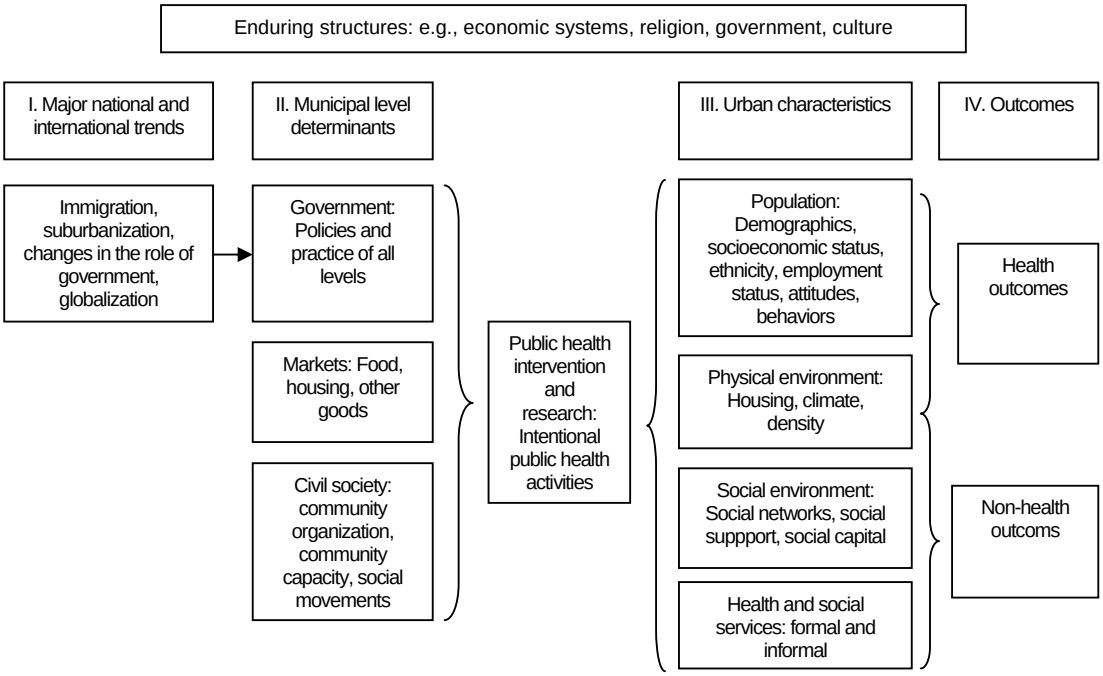
2.6 Health inequalities and inequities in cities

2.6.1 Health inequalities refer to differences or disparities between groups. Health inequity means inequalities that can be corrected but not much effort is made to do the same. This may arise from distorted policies and decision-making arrangements. Addressing the inequities is a must for a right-based approach to health care.

2.6.2 Despite the general perception that urban dwellers live a healthy life, the reality is disaggregated data reveal stark inequities in health care system. In most developing countries, a large part of the urban population lives in slums that are subject to eviction from time to time. This is because they have no legally recognized right and title to the land in which they live. In the result, different segments of city dwellers and the substantive health challenges of the urban poor including people in the lower income bracket are overlooked.

2.6.3 The interplay of four megatrends creates a complex environment which needs to be understood and appreciated to address urban health issues. The conceptual framework developed by Galea, Frendenberg and Valhor (2006) is shown in Figure- 2.1.

Figure- 2.1: Conceptual Framework for Urban Health



Source: Urban Health: Global Perspectives, Ibid, p.8.

2.6.4 The above framework rests on three pillars: urban physical environment, social environment and health and social services. It shows that for achieving desirable urban health outcome, there is need for interplay of various factors such as urban characteristics, municipal level determinants, government policies and practices of all levels, food, housing and other goods and civil society and community organizations. This underscores the need for macro and micro level linkages. From this perspective, urban health is not limited to curative care. As will be seen later, the above perspective holds good for Bangladesh also.

2.7 Bangladesh context

2.7.1 Urban areas

2.7.2 Bangladesh Census (2001) defines urban areas as developed areas around (i) an identifiable central place where (ii) amenities like metalled roads, communication facilities, electricity, gas, water supply, sewerage, sanitation etc usually exist, (iii) which are densely populated and majority of population are non-agricultural and (iv) where community sense is well developed.[5]

2.7.3 For the purpose of local government administration, urban local bodies are categorised into (a) City Corporation and (b) Municipalities locally called Paurashava. Paurashavas are further divided into three categories A, B and C depending on size, population and income. The government, from time to time, notifies in the gazette constitution of urban local bodies (ULBs).

[5] Population Census 2001, Bangladesh Bureau of Statistics (BBS), Ministry of Planning (Planning Division), pp 8-9. The provisional report was published in July 2003.

2.7.4 Apart from City Corporations and Municipalities there is another urban local government unit. This is called Cantonment Boards responsible for civic facilities within the limits of cantonments. This lies outside the functional domain of LGD. As regards healthcare, there are Combined Military Hospitals and such other facilities under the control of Armed Forces cater to the needs of the member of the armed forces. However, civilian populations also live within the limits of the Cantonment Boards. In recent times, lots of private facilities have emerged. Nevertheless, it may be necessary to collect more information relating to the poorest section of civilians.

2.8 Population

2.8.1 Excluding the city states of Hongkong and Singapore, Bangladesh is the most densely populated country in the world. It has a population of about 150 million people with a density of 920 persons per square kilometer (BDHS 2007).[6] Relatively young age structure of the population indicates rapid population growth during the second half of the twentieth century. There is wide discrepancy in population estimates between the government and the development partner (BDHS, 2007).[7]

2.8.2 Provisional estimates of the National Census, 2011 show that the population is little over 140 million. This has led to controversy. The government agency, responsible for carrying out census, believes that the figure would go up to 160 million in the final count.

2.9 Population profile of City Corporations

2.9.1 The population of the six City Corporations is shown in Table-2.1.

Table-2.1: Population Sizes of the City Corporations

City Corporation	2001 Population*	Estimated 2005 Population**	Estimated 2005 slum population***	Percentage****
Dhaka***	6,550,209	9,136,182	3,420,521	37%
Chittagong	3,021,618	4,133,014	1,465,028	35%
Khulna	732,720	966,837	188,442	19%
Rajshahi	367,314	489,514	156,793	32%
Sylhet	265,372	356,440	97,676	27%
Barisal	273,384	365,059	109,705	30%

* Source: BBS, 2003, Population Census 2001.

** Source: Estimates from Centre for Urban Studies 2005 Census and Mapping of Slums Team (CUS 2006).

*** Dhaka Metropolitan Authority area.

**** Calculated by the author.

[6] National Institute of Population Research and Training (NIPORT), Bangladesh Demographic and Health Survey (2007), published in March 2009, p 2.

[7] Ibid, BDHS.

2.10 Population of Paurashavas

2.10.1 Available information indicates that there are now 310 paurashavas. In the census (2001), 17 paurashavas have been identified to have more than 100,000 populations. Population growth varied across paurashavas.[8] The highest decadal growth occurred in Sylhet (172.8 percent). The reasons include high rate of remittance from abroad, declaration of Sylhet as a separate division and creation of Sylhet City Corporation (SCC). More or less similar reasons explain the growth in Barisal.

2.11 Rapid urbanization

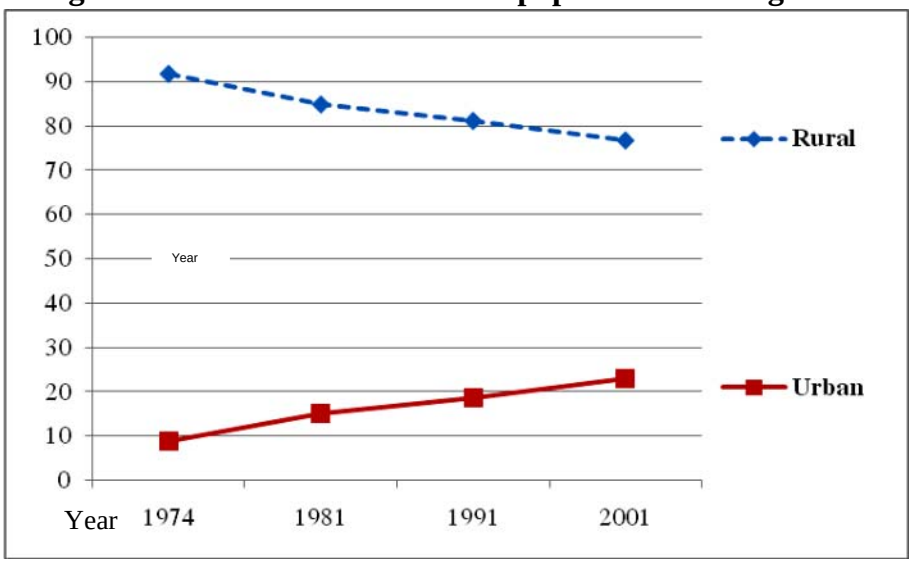
2.11.1 Bangladesh is experiencing a high rate of urbanization. In 1974 people living in urban areas were only 8.8% of the population (Table- 2.2). By 2001 urban population were 23.1% of total populations. The continuous rise in urban population and decline in rural population is clearly visible in figure- 2.2 below. It is estimated that currently 25% of the total population are living in urban areas. [9] This is expected to be 50% by next 20 to 30 years.

Table-2.2: Growth of urban population in Bangladesh

Year	1974		1981		1991		2001	
	Number	%	Number	%	Number	%	Number	%
Urban	6273603	8.78	13535963	15.05	20872204	18.73	28605200	23.1
Rural	70124397	91.79	76376037	84.95	90582981	81.27	101424549	76.9
Total	76398000	100	89912000	100	111455185	100	130029749	100

Source: Sixth Five Year Plan, (2011-2015, Part-2) p. 199.

Figure 2.2: Growth rate of urban population in Bangladesh



Source: Sixth Five Year Plan, (2011-2015, Part-2) p. 199.

[8] For details see Bangladesh Census (2001), Ibid., p. 32, Table-5.3.
[9] Planning Commission, Ministry of Planning, Sixth Five Year Plan SFY 2011-2015, (Part-2) p. 199.

2.12 Urban poverty

2.12.1 The Sixth Five Year Plan (2011-2015) admits that despite the general perception that poverty is more in rural rather than in urban area, the manifestation of urban poverty is more appalling than in rural areas. The Household Income and Expenditure Survey, 2010(BBS 2010), forms the basis of incidence of national, urban and rural poverty. The national poverty rate is estimated at 31.5 percent, 21.3 percent for urban and 35.2 percent for rural respectively. On the face of it, the poverty rate is more in rural than in urban areas. However, it does not reflect the scenario with respect to the socio-economic status of the slum dwellers and the variations across slums, non-slums and City Corporation area and District Municipalities. Most of the urban poor live in slums and squatter settlements. Besides, there is a large number of floating populations with no housing facilities.

2.12.2 Based on a 2005 study by the Centre for Urban Study (CUS), the plan provides the number of slums in different City Corporations. This is shown in Table- 2.3.

Table- 2.3: Number of slums with population

Name of Division	Number of slums	Population in million
Dhaka	4300	2.8
Chittagong	1814	1.8
Khulna	470	0.17
Rajshahi	539	0.148
Total :	**7123**	**4.918**

Source: CUS Bulletin 48, 2005
Note: It does not include Barisal and Sylhet City Corporations.

2.13 Explanation of urban poverty

2.13.1 The rising number of the urban poor can be explained by the 'Push' factor and partly by 'Pull' factor. Under the 'Push' factor the ultra poor and transitional poor move to cities in search of jobs. In this former category are those who are without any hearth or home. They depend on other doing odd jobs to earn a living but at some point of time move to cities to work in the informal sector. They live in slums or squatter settlements. There are two categories of transitional poor. First, the section of people living around river banks. Most of the big rivers are subject to erosion every year. The agricultural lands owned and operated by small and marginal farmers lose their lands including their dwelling houses as a result of recurring river erosion. They are forced to move to urban areas in search of jobs. Second, there are also those having their small commercial establishments which are devoured by river erosion thus depriving them of their sources of livelihood. Higher fertility rates in urban slums are also considered to be an important factor of growing urban number of urban poor.

2.14 Socio-economic status

2.14.1 There are marked variations in socio-economic status across slums and non-slums and District Municipalities[10]. This is shown in Table- 2.4.

Table- 2.4: Socio-economic Status

Percent distribution of household by wealth quintile, according to survey domain, BUHS, 2006.

Household Wealth Quintile	Dhaka Metropolitan Area: Large Slum	Dhaka Metropolitan Area: Medium/ Slum	Dhaka Metropolitan Area: Non-Slum	Chittagong City Corporation : Slum	Chittagong City Corporation : Non-Slum	Other City Corporation: Slum	Other City Corporation: Non-Slum	District Municipality	Total
Poorest	35.1	34.2	3.3	47.6	10.7	46.5	13.4	24.9	20.0
2	30.6	31.0	12.4	25.3	19.3	25.1	13.6	21.4	20.0
3	21.2	20.7	19.2	14.8	20.1	19.6	17.9	22.0	20.0
4	9.4	10.7	26.1	10.3	24.7	7.6	23.8	20.0	20.0
Richest	3.8	3.5	38.9	2.0	25.1	1.2	31.3	11.6	20.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of households	947	986	3,194	776	1,566	297	950	3,353	12,069

Source: BUHS (2006), P. 39

2.15 Situation in urban health

2.15.1 The situation depicted by recent policy and other surveys presents a dismal scenario. The study draws principally on the Bangladesh Urban Health Survey- BUHS 2006.[11] The survey covers slum and non-slum areas. Due to environmental pollution, bronchial asthma and other respiratory troubles are on the increase. Communicable diseases like gastroenteritis, skin diseases, and respiratory tract infection are also spreading at an alarming rate. Others include dengue, water borne diseases like diarrhea, cholera and hepatitis. Non-communicable diseases include hypertension, ischemic heart diseases, stroke, diabetes and cancer. In addition, mental health has also been identified to be a critical area for intervention. Social health issues include violence against women, smoking and drug abuse. Across the country, road accidents leading to deaths and disabilities are a major public health issue. Recent surveys have led to the finding that the rate of infant and under-5 mortality is much higher in slums than in of non-slums. The child illness and mortality are worse in urban poor than in rural poor. Same is the case with acute respiratory infection and severe stunting. The major reasons are identified to be weak environmental health services, poor sanitation, and poor nutrition, overcrowded living conditions, poverty and lack of affordable primary health care services.[12]

[10] National Institute of Population Research and Training (NIPORT), Bangladesh Urban Health Survey (2006), published in 2008. p 39.
[11] BUHS 2006, Ibid.
[12] Sixth FYP, Ibid, p. 42.

2.15.2 Across slums, non-slum areas and District municipalities, the recent survey provides useful insights on the state of health, population and nutrition (BUHS 2006).[13] The major findings are discussed here:

2.16 Health Status of the urban poor

2.16.1 It has several features. First, slum dwellers have functional limitations in Activities of Daily Life (ADL) (temporary health related limitations) and their percentage is 21 to 26 compared to 13 to 19 percent of non-slum dwellers and 15 to 16 percent dwellers in District municipalities. Women suffer more on this count than men in specific activities of daily life. More women (15 to 21 percent) than men (13 to 19 percent) experienced greatest limited functionality in the ADLs of strength and mobility compared to limitation of personal care as 11 to 14 percent in women than 4 to 8 percent in men. This covers all three survey domains; slum, non-slum and municipalities.

2.16.2 Second, an extremely low proportion of men (7 to 9 percent) and women (5 to 6 percent) suffered from serious injury in the year preceding the survey. Three survey domains were no different in this respect. Across domains, serious injury to women resulted from domestic violence for women (57 to 65 percent) and for men from road accidents (40 to 45 percent). In all domains, rates of domestic injuries are similar.

2.16.3 Third, under nutrition measured by body mass index (BMI<18.5) was more common among women (27 percent) and men (35 percent) in slums than among women (13 percent) and men (19 percent) in non-slums. The scenario is opposite for obesity or over weight with more residents in non-slums (35 percent of women and 18 percent for men) than in slums (15 percent of women and 7 percent for men).

2.16.4 Fourth, prevalence of hypertension was higher among men in non-slums-age 35 and older (38 percent of women and 25 percent of men)- than slum population (25 percent of women and 18 percent of men). More or less the same trend is visible in respect of prevalence of diabetes among both women and men age 35 year or more (17 and 14 percent respectively) than among their counterparts in the slums (6 percent for women and 8 percent for men).

2.17 Smoking, alcohol and drug abuse

2.17.1 Men in slums were more predominant in smoking (60 percent) followed by District Municipalities (50.6 percent). In non-slums, it was 46 percent. The habit starts at an early age and increases with age in slums. Early age (15 to 19 years) smoking is 35 percent in men of City Corporation slums and 20 percent in City Corporation and Municipality non-slum areas. The poor men and those without education were given to this habit. Rates of use of drug or alcohol were identical across slums and non-slums.

[13] BUHS 2006, Ibid.

2.18 Violence against women

2.18.1 The most common forms include wife beating (physical) and life-time sexual violence was the highest in slums and higher in District municipalities compared to non-slums. A very high proportion of women reported injury as a result of violence. The highest rates were reported in slums (42 percent) followed by non-slums (35 percent). In District Municipalities it was 31 percent.

2.19 Fertility and family planning

2.19.1 BUHS provides comprehensive analytical data relating to fertility rates, its trends, adolescent pregnancy and motherhood, use of contraception, sources of supply, infant and child motility, ante-natal case (ANC), post-natal case (PNC), experience of complications around delivery, use of maternal health care, micronutrient intake, infant feeding and child nutritional status. It is not necessary to repeat the analytical data as these are voluminous. Only the highlights are presented below.

2.20 Fertility

2.20.1 Conceptually, BUHS categorizes fertility into Total Fertility Rates (TFR) and General Fertility Rates (GFR). The weighted sum of the age-specific fertility rates are known as TFR. GFR represents the annual number of live births in a population per 1000 women aged 15-44. The Crude Birth Rate (CBR) is the annual number of births per 1000 member of population. The findings are presented in Table-2.5.

Table-2.5: Total fertility rates (women age 15-49)

Domain	Total Fertility Rate*	Mean number of children ever born to women age 40-49
Dhaka Metropolitan Area: Large Slum	2.4	4.6
Dhaka Metropolitan Area: Medium/Small Slum	2.5	4.6
Dhaka Metropolitan Area: Non-Slum	1.8	3.7
Chittagong City Corporation: Slum	2.4	4.8
Chittagong City Corporation: Non-Slum	1.9	3.9
Other City Corporation: Slum	2.5	4.6
Other City Corporation: Non-Slum	1.7	3.4
District Municipality	2.1	4.0

*Women aged 15-49 years.
Source: BUHS 2006, p 315.

2.20.2 The trend shows lower rates of Dhaka City non-slums, Chittagong City non-slums and other corporation non-slums. The scope of intervention therefore, lies more in slums and in district municipal areas. In respect of child bearing trends, it began earlier in the urban slums than in the non-slum areas and district municipalities.

The scenario for teen age pregnancy and motherhood is shown in Table- 2.6.

Table- 2.6: Teen age Pregnancy and Motherhood

Domain	Percentage who are:		Percentage who have begun childbearing	Number of women
	Mothers	Pregnant with first child		
Dhaka Metropolitan Area: Large Slum	16.5	3.2	19.7	470
Dhaka Metropolitan Area: Medium/Small Slum	19.1	5.9	25.1	462
Dhaka Metropolitan Area: Non-Slum	7.9	3.3	11.2	346
Chittagong City Corporation: Slum	13.5	3.7	17.2	596
Chittagong City Corporation: Non-Slum	6.7	0.7	7.4	493
Other City Corporation: Slum	24.6	6.4	31.0	374
Other City Corporation: Non-Slum	12.5	1.7	14.2	412
District Municipality	13.1	2.4	15.6	361

Source: BUHS, p 226.

2.21 Current use and trend of contraceptives

2.21.1 The finding of BUHS is that use varied across the survey domains. It is highest (66 percent) in non-slum areas of Chittagong City women but lowest (55 percent) among women of medium and small slum areas of Dhaka City. The pill is the most popular among modern method of contraceptives irrespective of background characteristics.

2.22 Sources of supply

2.22.1 Private medical sector dominated the sources of supply (50 percent in slums, 63 percent in non-slums and 41 percent in district municipalities). The overall share of NGOs as a source of supply varied between 13 to 22 percent and was the highest in slums. Pharmacies remain the major source of supply for the pill and condoms. NGO facilities rank the principal source of injectibles in all three domains.

2.23 Infant and Child Mortality

2.23.1 The overall finding is that the Infant and Child Mortality have declined.[14] Between the periods 10 to 14, 5 to 9 and 0 to 4 years preceding the survey, the decline, in non-slum areas is by 22 to 42 percent. In urban slums, this was high at 31 percent. The rate of decline did not continue for slum areas as it did for non-slums and district municipalities. These areas experienced a decline from the period of 5 to 9 years to o to 4 years preceding the survey at the rate of 11 percent. The decline is attributable to recent improvements in the health of urban infants although it is uneven. The disparity between slums and non-slums and district municipality is substantial. This calls for more coordinated action in areas where the decline is low.

2.23.2 Most common diseases for Infant and Child Mortality are Acute Respiratory Infection (ARI) and Diarrhea.

[14] BUHS, Ibid, p 339.

2.24 Acute Respiratory Infection (ARI)

2.24.1 The major findings are (a) ARI prevalence among under 5 children two weeks prior to the survey in urban slums, urban non-slums and district municipalities were 14, 12 and 13 percent respectively. The treatment accorded to children with ARI was 41 percent in case of urban slums and district municipalities as against 73 percent in non-slums. Treatment was given by GO/NGO/ private health provider, community clinic, NGO satellite clinic as well as medically qualified doctors. [15]

2.25 Diarrhea

2.25.1 The data shows that there are variations in the prevalence of diarrhea across survey domains. This is shown in Table- 2.7.

Table- 2.7: Prevalence of diarrhea

Domain	Percentage of Children with Diarrhea	Number of Children
Dhaka Metropolitan Area: Large Slum	6.76	721
Dhaka Metropolitan Area: Medium/Small Slum	8.24	664
Dhaka Metropolitan Area: Non-Slum	4.28	546
Chittagong City Corporation: Slum	8.83	733
Chittagong City Corporation: Non-Slum	7.29	676
Other City Corporation: Slum	5.82	723
Other City Corporation: Non-Slum	2.74	618
District Municipality	5.97	598

Source: BUHS, Table-10.43 p. 350.

2.25.2 The prevalence of diarrhea ranges from 8.24 percent in Dhaka Metropolitan medium and small slums to 2.74 percent in other city corporation non-slums. The percentage in district municipalities is 5.97. It can be said that generally in non-slum areas it is lower than in slum areas.

2.26 Infant feeding and child nutritional status

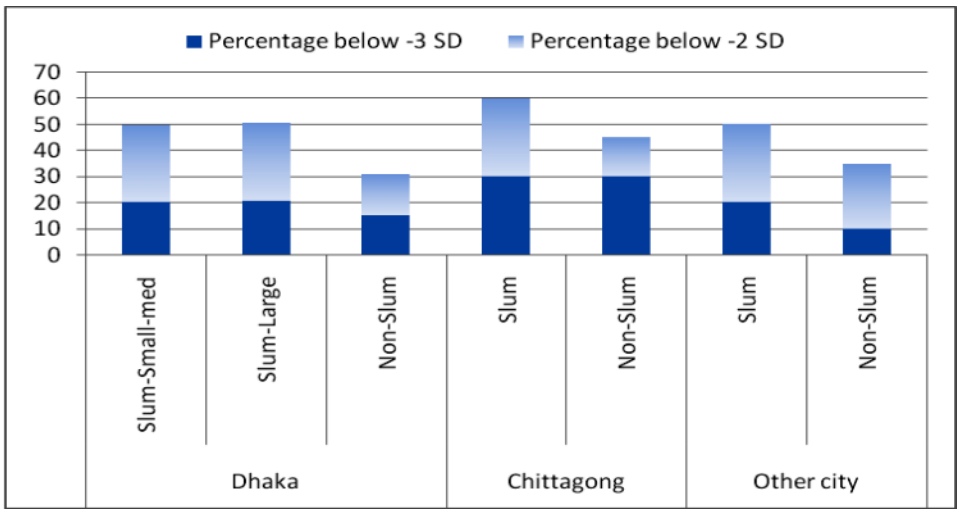
2.26.1 The findings of BUHS in these aspects, on overall basis, indicate positive and negative conclusions. First, there has been very little progress in improving child and infant feeding practices and nutritional status in urban Bangladesh. Second, on the positive side, breast feeding of children at any time is still almost universal. There are no differences in rates between slums of City Corporations, urban non-slum areas and district municipalities. However, this was higher at 43 percent than 36 percent national rate observed in 2004. The situation shows signs of improvement. The figure 43 percent is from Bangladesh Health and Demographic Statistics (BDHS, 2007).

[15] For details see Tables-10.3.A and 10.3a, pp 344-345 of BUHS 2006.

2.27 Nutritional status

2.27.1 Nutritional status is measured by stunting (height-for-age), wasting (weight-for-height) and under weight (weight for age). This is shown in Figure- 2.3. Stunting in slums were higher (56%) in comparison to non-slums (36%). Severely stunted under 5 children is also higher in slums (28%) than non-slums (16%). The figure- 2.3 summarizes the prevalence of stunting in slums and non-slums of Dhaka, Chittagong and other City Corporations. The higher percentage in slums compared to non-slum are widen. In Dhaka, the large slums had more stunting than small or medium sized slums.

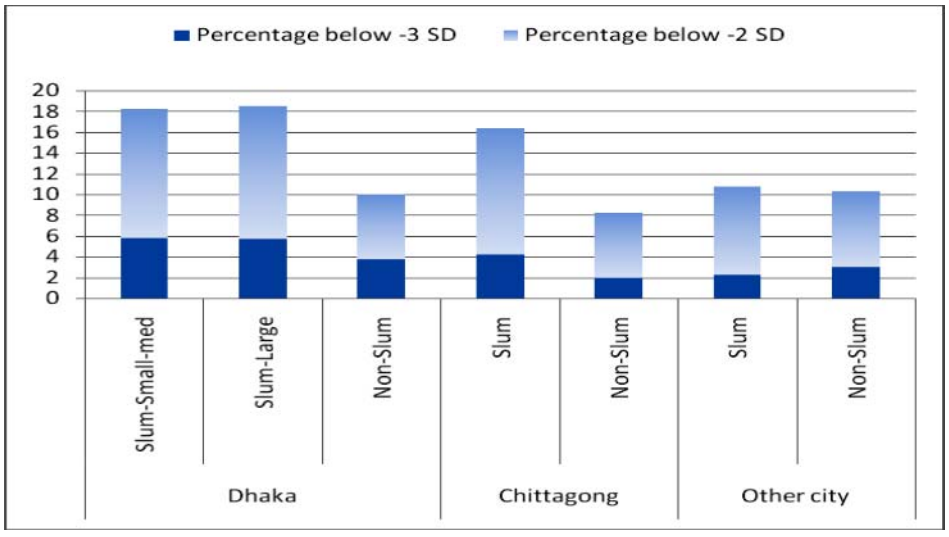
Figure- 2.3: Stunting (Height for Age) in City Corporations.



Source: BUHS, p. 412.

2.27.2 Wasting (weight for height) of children is higher in slums (17%) compared to non-slum (10%). Percentage of children under five years classified as wasted in different City Corporation areas are shown in figure- 2.4.

Figure- 2.4: Wasting of under five years children in different City Corporation.



Source: BUHS, Table-11.12.A. p. 394.

2.27.3 The survey further notes that maternal height and body mass index (BMI) are strong indicators of childhood stunting and wasting. This highlights the importance of investing in the nutritional status of women and children. There is a close relationship between maternal education and household wealth with child nutritional status. Their relationship of stunting with maternal education and household wealth is inverse. The pattern of wasting in slum area is difficult to explain, the report says.

2.28 Overall situation

2.28.1 BUHS (2006) flags the following highlights.

- The decline in under 5 mortality rate has been uneven resulting in iniquities across survey domains. The decline has been slowest in urban slums;
- Slum areas and municipalities are lagging behind the non-slum areas in the reduction of neonatal mortality. Slums are also lagging behind the other areas for post-neonatal mortality. Females are shown to have higher mortality rates (1-4 years) than males and the difference is higher in slum areas;
- Safe delivery practices and treatment of ARI are important for reduction of neonatal mortality. In this aspect slum population suffer a greater burden of unsafe delivery practices and inappropriate treatment of ARI;
- Access to and utilization of effective health care services for infectious diseases is important determinants of positive outcome in respect of post-neonatal mortality.
- ARI related morbidity during 6-11 months is highest in non-slums while diarrheal morbidity rates are relatively more in slum areas. Only forty percent of children in slum areas are taken to a health care provider where as in case of non-slums, it is seventy five percent. This tends to imply that higher incidence of post-neonatal mortality rates in slums may be due to inappropriate treatment of infectious diseases, specially ARI;
- Under 5 mortality is high in slums and district municipalities;
- Infectious diseases and under nutrition are likely to be the major causes of death of children aged 1-4 years.

2.28.2 BUHS concludes that data on causes of death and health care will help in understanding factors responsible for the differences in mortality rates across urban areas and enable policy makers and others to design appropriate intervention to improve the situation.

2.29 Findings from the field

2.29.1 The findings from the various workshops in and out of Dhaka generally confirm the situational analysis as mentioned earlier. The relevant issues raised in the workshops are attached as annex-IV. The participants in the workshops stressed the

need for expanding (a) the inadequate health infrastructure at primary, secondary and tertiary level of both government and those of ULBs. (b) meeting the shortage of physicians including skilled health workers including flexible working hour to meet the needs of clients, in particular the urban poor, (c) improving supply chain, (d) increased attention to governance issues including empowerment of urban local bodies in the field of health care, (e) more effective coordination between and among different actors in the field of health care (f) delineating the public private participation for effective management of health care system. (g) developing a functional referral system, (h) increased attention to the urban poor, (i) strengthening preventive health care by ensuring safe water supply, effective solid and medical waste disposal, improving sanitation facilities, (j) provision of urban family planning workers including social safety net to ensure nutrition for the poor, (k) putting in place a reliable urban data base and its linkage to national data base and (l) more effective regulatory enforcement to prevent adulteration of food, (m) awareness building for health, population and nutrition, (n) attention to ensure regular fund flow from the budget, (o) effective steps to prevent pollution of all types. (p) flexibility in sanctioning manpower by LGD, (q) special attention for rehabilitation of slum adolescent drug addicts, and health and rehabilitative care for the aged.

2.29.2 Some of the Mayors and other participants highlighted the need for attention to (i) mental health for the poor and (ii) violence against women including effective measures for prevention and rehabilitation of drug addicts in slums.

2.29.3 In addition to the above, all the Mayors and some participants highlighted the need for ensuring effective coordination at all levels. For ULBs, they suggested constitution of a central coordination committee under Mayor's leadership and similar committees at ward level. For upfront action, a draft is shown at annex-V.

2.30 Human development indicator

2.30.1 Health and economic status provide only a partial picture of overall human development. Other major indicators include education, access to safe water, sanitation facilities, housing and environmental protection all of which contribute a healthy urban life. Not discussed earlier in the socio-economic status scenario is level of access to and utilization of health related facilities and quality of the health care services. These are now discussed below.

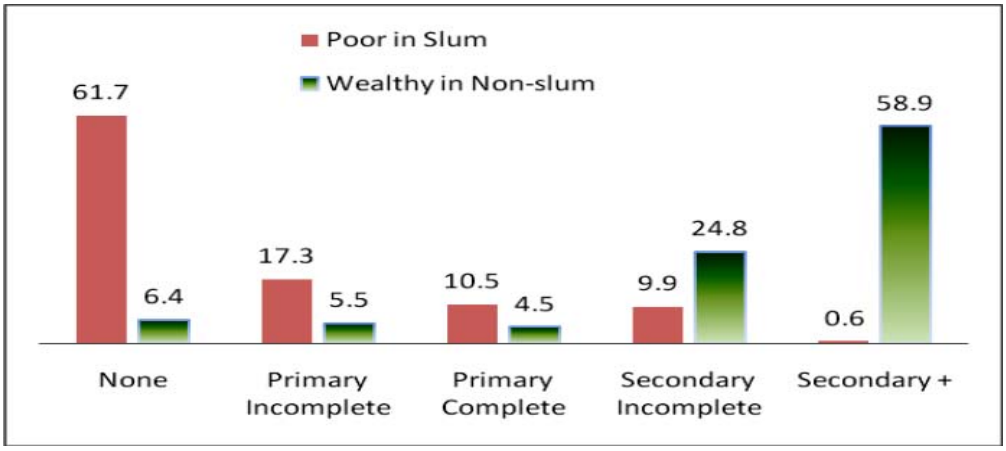
2.31 Education

2.31.1 A comparison of educational attainment of women in slums and wealthiest in non-slums present a scenario of extremes of life. The gap between the two is immense indicative of deprivation of the poorest in slums. This is shown in Table- 2.8 and in Figure- 2.5.

Table- 2.8: Educational attainment by women: Poorest in slum and wealthiest in non-slum

	None	Primary incomplete	Primary complete	Higher Secondary incomplete	Higher Secondary and above
Richest in Non-slum	6.4	5.5	4.5	24.8	58.9
Poorest in Slum	61.7	17.3	10.5	9.9	0.6

Figure- 2.5: Educational attainments by background characteristics of women



Source: BUHS 2006, P. 103

2.32 Safe water supply and sanitation

2.32.1 Access to safe water is an important determinant of health. Most urban households obtain their water from a piped source or tube-well although there are variations in accesses between slum and non-slum areas. Around 8 out of 10 residents of District Municipalities get the supply from tube-wells.[16] Supply of water is, however, severely handicapped by irregular or acute shortage to meet the rising demand of the urban population, in particular, in City Corporations. Quality of water or safety is another issue. There are plenty of reports regularly published by the media about supply of polluted water for domestic use. Even the rivers in Dhaka city have become highly polluted by unsafe sewerage system as shown in Box- 1.

Box- 1: Shut sewerage, waste lines to the Buriganga

- The High Court yesterday directed the government to seal off all the sewerage outlets into the Buriganga River within next year.
- In response to a writ petition, the HC also directed the authorities concerned to stop dumping waste into the river and declared their inaction in preventing water pollution illegal. The authorities are also to clean up the river and move all the source of pollution from there.

Source: The Daily Star, June 2, 2011, P.1.

[16] BUHS, Op.cit., P. 58.

2.32.2 Shortage of supply and safety concerns are there in District Municipalities is shown in Box- 2.

Box-2: Water crisis in most areas of Moulavibazar town

- 60 percent locality has no supply line while tube wells are inoperative
- Many residents of the area applied for water connection 10 to 12 years ago, but they are yet to get it.
- The Asian Development Bank has approved the project for purification and supply of surface water in Moulavibazar town.

Source: The Daily Star, June 2, 2011, P.8.

2.33 Housing

2.33.1 Generally, slum population do not own any land but live in cramped conditions mostly on makeshift houses on government land without any security of tenure and with constant fear of being evicted. This, however, do not adequately reflect other types of accommodations which are equally crowded with little space between two houses. Same is more or less true of non-slum areas of some City Corporations like Dhaka. The rising demand for accommodation led to high rise building with very little space between two buildings. Added to this is the inadequate number of open spaces and parks which are essential for healthy living.

2.34 Disaster Management

2.34.1 Urban areas are prone to various disaster situations. The most common are fire accidents that affect both high rise buildings as well as slum areas. Unauthorised installations of factories and go-downs in residential areas which use inflammable materials besides short circuiting of electric connections are the main causes of fire. A newly emerging threat is from earth quakes including old and dilapidated buildings.

2.35 Environmental safety

2.35.1 This is one of the weakest areas and remains a major threat to health. Specific features include (a) safe disposal of solid and medical waste and (b) noise and air pollution. The media perception in regard to disposal of waste is shown in Box- 3.

Box- 3: Uncollected waste: a health risk

Sylhet, May 28: More than half of the 700 tons of waste generated in the Sylhet city per day are not collected mainly due to shortage of manpower posing a threat to public health.

Beside this, the survey also shows that clinical wastes of all the public and private hospitals, clinics, diagnostic centres, and blood banks are dumped at open space without being processed.

About 0.48 kg solid waste is produced per capita per day while about 3kg clinical waste is produced per bed at the hospital.

Different fatal diseases such as cancer and tuberculosis are spread because of waste, especially clinical ones which are not collected by the corporation for months.

Meanwhile, a dishonest section of people is marketing used disposable syringes and saline bags collected from the wastes, resulting in spreading to serious diseases including hepatitis B and environmental pollution.

Source: The Independent, May 29, 2011, p.6.

2.35.2 Sources of noise and air pollution are from vehicles through unnecessary horning and emission of black smoke. The Directorate of Environment Control (DOE) is not fully able to control these forms of pollution.

2.36 Availability of health programmes and service facilities

2.36.1 BUHS-2006 provides from evidence in this regard.[17] It shows that overall availability of health services is higher in non-slum (64 percent) than slum areas (51 percent). It is however highest in District Municipalities (86 percent). This is explained by the continued emphasis on rural health care facilities and the fact that in the cities the concentration of secondary and tertiary facilities of the public sector. MOHFW traditionally place less emphasis on primary health services in urban areas. A beginning has since been made by LGD which launched Urban Primary Health Care Project in 1998. BUHS data also show low MOHFW investment in services and programmes in slums (11 percent) and non-slum (13 percent). It is relevant to mention that in terms of access, private health care facilities remain beyond the capacity of the slum population. An important feature of access to health care is the universal presence of pharmacies which are widely available and accessible. These outlets provide a wide variety and number of effective low cost drugs. As prescriptions are not required, many people self medicate, and thus avoid doctor's fees in seeking treatments. [18]

2.36.2 The presence of NGOs provides an additional outlet for access to health care. Their presence however remains limited but has recently increased with the advent of UPHCP.

2.37 Perceptions about urban health

2.37.1 Admittedly, more than decade-old development of such facilities in City Corporation and District Municipal areas have provided increasing access to health care in urban areas and relieved, to some extent, the unbearable burden on facilities run by the public sector. At the same time, the development of increasing participation by private actor including NGOs could not fully meet the needs of people in slums and pavements, beside railway tracks or those living in railway station after nightfall. The highlights of a media report in this respect are shown in box-4.

Box-4: Urban health unwell

- Essential medicare far away from people in slums, on pavements.
- Urban health facilities remain unknown to the poor in slums and pavements.
- Health facilities are expensive for them.
- Many street dwellers are deprived of the government's health service like treatment of communicable diseases, reproductive and child care.
- Nine percent of the child deliveries of 4000 street dweller occur in pavements.
- Urban health care system inadequate and faulty.
- Working hour of centres does not suit urban slum dwellers because these open after they go to work.
- Seventy five percent of urban populations in the country are out of government's primary health care because it is inadequate and neglected.

Source: The Daily Star, May 19, 2011, pp.19-20.

[17] BUHS 2006, Table- 5.4.8, p 213.
[18] Ibid, pp. 213-214.

III
Current efforts on urban health: lessons learnt

3.1 Policies and strategies

3.1.1 Since its birth in 1971, the system of formulating development polices and strategies centered on a document called Five Year Plan (FYP). In FYPs, besides the sectoral policies, macro-economic policies used to be articulated and investment priorities set. This is also the practice in most South Asian countries like India, Pakistan and Nepal. This was departed first in 1991 and then in 2001. In 1991, the system of Three-Year Rolling Plan (TYRP) emerged which basically replaced the Annual Development Programme (ADP). ADPs used to be based on FYPs. In 2001, came Poverty Reduction Strategy Paper (PRSP). Till 2008, there were three PRSPs. The present government in 2009 decided to restore the system of FYP. The sixth FYP (2011-2016) is now the guiding document. It contains, as before, sectoral policies and strategies including Health, Population and Nutrition (HPN).[19] The HPN is basically a sector-wide policy approach. This approach meant a departure from past traditions of looking at only health and population. Nutrition now is included as part of the overall health sector. It also involved a transition from sector-based approach to sector-wide programme approach. Currently, the Strategic Plan for Health, Population and Nutrition Sector Development Programme (HPNSDP, 2011-2016) is the guiding document for HPN activities.[20] There are also some Ministry-based sectoral policies in addition to the above policies. Thus, MOHFW has a Health Policy. This development came during the eighties. As to the consistency of the three major documents, it may be said that the sixth FYP does refer to the Strategic Plan and affirms the same.

3.1.2 Until 2011, there was not adequate attention to urban health. The earlier FYPs including Health and Population Sector Development Programme (HPSDP) continued more investment in and attention to the strengthening of rural health service delivery programmes. It resulted in accelerated construction of health infrastructure initially centering on administrative units called Upazila (Sub-district) and further down to local government units called Unions and below.

3.1.3 The major justification of more investment in rural health to improve service delivery was justified on several grounds such as more incidence of overall poverty, economic and social. This perception was further strengthened by the belief that in Districts and Sub-divisional units of administration, there were public hospitals. The rural areas had access only to some dispensaries run mostly by District Councils. The rural residents were thus deprived of modern medical care. One of the major features of the strategy also was to pay attention to prevention of diseases for which besides Civil Surgeon, there was also a functionary called Chief Medical Officer. He was

[19] SFY 2011-2015, Ibid.
[20] Planning Wing, Ministry of Health and Family Welfare, HPNSDP (2011-2016), April 2011.

responsible for prevention aspect of health. This position was later abolished by merger of preventive and curative health care in the person of the Civil Surgeon.

3.1.4 The development is post 2009 period marks a major shift in the policies and strategies with emphasis on urban health. The sixth FYP and the Strategic Plan recognizes the need for improving urban health delivery system.

3.2 Government efforts in urban health

3.2.1 Currently 59 district hospitals and MCWC are reported to provide Comprehensive Emergency Obstetric Care (EMOC). These are categorized as postgraduate institute hospitals (9), medical college hospital (14), specialized hospitals (3), children hospitals (5), general hospitals (13), district hospitals (52) Tb hospitals (11), leprosy hospital (3), MCHTI, MFSTC & 100 bed hospital (1) and MCWCs (71). From the above, it is clear that health care services in urban areas, specially for the urban poor, is inadequate. In particular the focus more on curative and less on primary health care. Apart from less focus on primary health care, the current strategy also is deficient in capturing the potential of non health outcomes involving social network and community participation. Additionally it lacks focus on food, housing and other goods and services. It also is deficient in addressing physical environment and the growing needs of the people in road transport sector for example, it is now acknowledged that road safety is a public health concern.

3.3 Efforts by ULBs

3.3.1 Health facilities rendered by City Corporations are shown in the Table- 3.1.

Table- 3.1: Health facilities of City Corporations

Name of City Corporation	Name of Hospitals	Number of beds	No. of Dispensary
Dhaka City Corporation	Dhaka Mahanagar General Hospital Dhaka Mahanagar Shishu Hospital Nazira bazar Maternity	50 100 31	8
Khulna City Corporation	Lal Hospital Taltola Hospital	Only outdoor services	nil
Rajshahi City Corporation	City Hospital	20	nil
Chittagong City Corporation[21]	Memon-1 Memon-2 Bandor Tila Maternity South Bakolia Maternity East Bakolia Maternity	100 45 32 18 30	20
Sylhet City Corporation	-	-	1

Source: City Corporations.

[21] Each dispensary in Chittagong has 1 Medical Officer and 1 Paramedic and provides outdoor services along with full free medicine from the dispensaries. Three Maternity Centres in Chittagong having indoor facilities are not operating. Sylhet also provides outdoor services along with full free medicine in Binodini Charitable Dispensary. The account of above facilities does not include those of Sylhet and Barisal.

3.4 Statutory responsibility

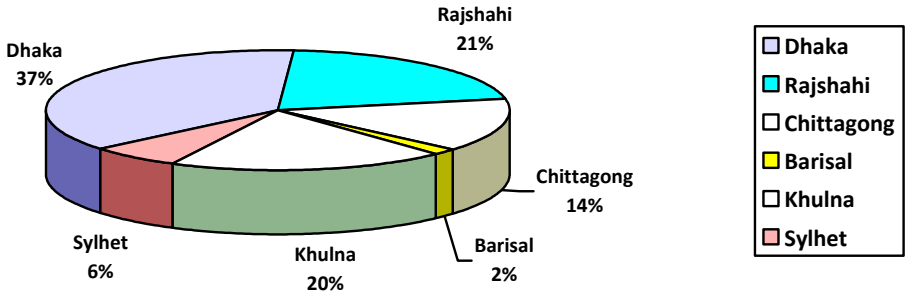
3.4.1 Primarily, two ministries such as Ministry of Health and Family Welfare (MOHFW) and Local Government Division (LGD) of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) are responsible for urban health care. MOHFW is responsible for the administration of as many as 37 health related laws, LGD is responsible for oversight functions of ULBs apart from overall local government bodies. The City Corporation Act, 2009 and the Pourashava Act, 2009 clearly assign the provision of preventive health and of limited curative care as a responsibility of ULBs. Due to their limited resources and manpower, they have not been able to effectively discharge their statutory responsibility. In point of fact, such responsibility found place in the relevant legislations of earlier days.

3.4.2 An equally important reason of the above relates to somewhat unclear allocation of functions for the MOHFW and LGD in the existing government document called 'Allocation of Functions' under the 'Rules of Business'.[22] The allocation of functions of two ministries are shown in Annexe- VI & VII.

3.5 Private facilities

3.5.1 Private health facilities consist of hospitals, clinics, pathology laboratories and diagnostic centres. The hospitals number 1972 with 35338 beds compared to 20590 beds in public category. The number of registered private hospitals/clinics with bed facilities varies across the six administrative divisions. The situation is shown in figure-3.1.

Figure-3.1: Registered private hospitals/clinics across division



3.5.2 Figure-3.1 reflects highly unbalanced growth of private health facilities in the six administrative divisions of the country. The future strategy should be to design necessary policy instruments to pave the way for a more balanced development. As for the needs of the urban poor in the deficit divisions, policy instruments are also needed to encourage the growth of non-profit private foundations to be set up in such areas. In this context, it may be useful to recall the Prime Minister's recent call to the business community to exempt taxes on capital investment in these social sectors. The deficit areas should enjoy this facility in the first phase. [23]

[22] For details see 'Rules of Business' and 'Allocation of Functions, 1996' as amended from time to time.
[23] This was widely reported in the media.

3.6 Governance issues

3.6.1 There are complaints of substandard services by some of the private diagnostic centres and the fees charged are much higher than those laid down in the relevant law. An effective oversight mechanism needs to be developed including regulatory reforms and enforcement of legally prescribed facilities for opening a clinic either in public or private sector. Equal attention also needs to be paid to similar problems in public hospitals.

3.7 Alternative health care provider

3.7.1 In urban slums, alternate health care providers constitute a major source of services. This stream of health care consists of allopathic, homeopathic and ayurvedic practitioners even ordinary pharmacies or retail drug outlets. Apart from providing treatment to infants and children, they were detected by BRAC to give oxytocics which is hazardous for mother and newborns. [24] BRAC has trained about 3318 alternate health care provider in Dhaka slums. In Chittagong, Khulna and Rajshahi, the number of alternate health care provider trained by BRAC respectively are 969, 394 and 292. This is an important lesson well-worth emulation by all health care providers. Impact needs to be assessed.

3.8 Gaps in urban health care and management

3.8.1 DGHS has a functional Management Information System (MIS) limited to public health facilities. Private sector and the NGOs are not mentioned. This is a serious gap which needs to be addressed. To this may be added the limited number of small hospitals of ULBs. Other weaknesses need to be mentioned in case of the public sector. First, the total deaths in public hospitals in 2007 was reported to be 116, 610 as against the admitted patients numbering 5, 319, 743. According to DGHS, the death rate is 2.2 percent. However, it is also admitted that it is of dubious validity. [25]

3.8.2 For the medical facilities run in the field of primary health care and limited curative facilities, there is no system in place now to link the data base to national data base of DGHS.

3.8.3 Second, the dichotomy in public sector financing and its consequent problems. Of the total number of 20590 beds, 18551 are financed from the revenue budget and the remaining 2039 under development budget. The financing under the latter mode is fraught with uncertainties resulting in irregular and insufficient flow of funds.

3.8.4 Third, as a corollary to the second, irrespective of the modes of financing, flow of funds remain unstable creating difficulties for public hospitals to provide the needed medical services to the larger number of patients than their facilities can bear.

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[24] BRAC, Annual Report (2008-2009), Manoshi, p.18.

[25] Directorate General of Health Services (DGHS), Management Information System (MIS), Ministry of Health and Family Welfare, Health Bulletin 2008, p. 22.

3.8.5 Fourth, total requirement of funds remain tied to the fixed number of beds so that for those lying on the floors, the expenditure needed is not generally provided. It is widely known that, from time to time, the media publish harrowing accounts of numerous patients lying on the floor.

3.8.6 Fifth, since 1972 onwards, human resource development in health and population sector centred on recruitment of medical graduates to the exclusion of nurses and trained medical assistants. Only recently, the government have started to give some attention to fill up the gaps in respect of nurse and trained medical assistants.

3.8.7 Recent international research has provided new perspectives in respect of strengthening heath outcomes.[26] Based on large scale examination of the reasons why people fall into poverty and how they escape it in diverse contexts, it has been concluded:

'Several other factors are also associated with falling into poverty, but in terms of frequency and magnitude, the effects of ill-health and health care expenses predominate in every region examined. Ill-health— when high treatment costs go together with loss of earning power—imposes a double burden on households and it has the biggest influence on becoming poor (and remaining in poverty). Researchers who have examined these trends have concluded that a medical poverty trap is operating across multiple countries.

Thousands of families are living only one illness away from poverty, and thousands more have become deeply indebted on account of burdensome health care costs. Investing in more affordable and effective heath care interventions is essential for reducing people's vulnerability to descents into poverty.' [27]

This underscores the need for effective poverty alleviation Programme for the urban poor including those in the lower and middle income category.

3.9 Morbidity or disease profile

3.9.1 The only source of country-wide data in this respect is available in the various annual Health Bulletins of DGHS. The Bulletin of 2010 lists 10 diseases gathered from public facilities only with a word of caution that not all cases are reported to public facilities or to similar type of institutions. The Bulletin (2007) says about 80 percent of the people seek health care from the private facilities. [28] It does not, therefore, reflect the correct situation. Finally, no disaggregated data for urban areas exist. Nevertheless, the available country-wide data shows some of the top ranking diseases.

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[26] Anirudh Krisha, One Illness Away-why people become poor and how they escape poverty, Oxford University Press, 2011 [paper back edition].

[27] Ibid, p. 73.

[28] Health Bulletin, Ibid, p. 28.

3.9.2 Disaggregated urban data base from all types of facilities, public, private and NGOs, may provide a useful and rational basis for health care planning and strategies which will need to be adjusted on a periodic basis. Further, since 80 percent of the patients seek health care from private facilities, there is a strong ground for the assumption that the remaining 20 percent cannot afford to avail private facilities for high costs or other barriers. This is a simple and incomplete assessment and does not adequately address the overriding issue of fall into and escape from poverty because of the high cost involved in health care.

3.9.3 The existing approach to analytical view of disease profile does not also give much attention to the emerging concern for rehabilitative care of those affected by autism besides mental care. In respect of autism it is felt that it is an important public health concern. It has received in recent time's attention of the policy makers at the global as well as at the national level. Additionally, attention to autism is perceived to be important for drug addicts and for mental health care. Systematic data on the current facilities in public and private sectors are hard to come by. As this is a highly specialized area of health care, there is need for forging public-NGO partnership to address this issue with support from the MOHFW.

3.10 Complementary role of LGD

3.10.1 The above description of the existing situation reflects the need for a partnership arrangement between the two ministries. LGD can clearly play a complementary role to fill up the inadequacies of urban health care that is all too visible by now. Further, it will also require collaborative efforts of LGD with other ministries which directly or indirectly influence desirable public health outcomes to create and enabling environment for achieving such outcomes. An illustrative example is shown in Table- 3.2.

Table- 3.2: Ministry and Agencies responsible for enabling environment

Ministry/ Division	Multiple health related agencies	Management of total Health, Family Welfare and Nutrition
1. MOHFW	-	
2. LGD	(i) WASA (ii) ULBs	Safe water supply and sewerage (i) Public health (ii) Sanitation (iii) Open spaces and Parks (iv) Food safety (v) Solid and medical waste disposal
3. Public Works Housing and Urban Development	(i) Rajuk (ii) Directorate of urban development and housing	(i) Urban development and housing (ii) Housing and settlement
4. Environment and Forests	Directorate of Environment Control	Environment control including all types of pollution
5. (i) Ministry of Communication (ii) Ministry of Home Affairs	(i) BRTA (ii) Police	(i) Registration of vehicles and licensing (ii) Management of vehicular traffic

3.10.2 Efficiency of each of the above Ministry and their affiliated agencies contribute to healthy urban life. There is no specific Ministry or agency responsible for urban poverty alleviation as poverty alleviation is viewed to be the outcome of collective efforts by the government as a whole.

3.11 Partnership between GO-NGO

3.11.1 A related development in the policies and strategies occurred with the emergence of non-government organizations (NGOs) immediately following the emergence of Bangladesh. Both national and international NGOs are now more involved in the health system both in rural and urban areas. The current government policies and strategies also recognize the efficacy of partnership. Alongside this development came also the participation of the private sector. Private entrepreneurs made investments since the nineties, in setting up medical colleges with hospitals. In urban areas there has been phenomenal growth in the health facilities known as private clinics and diagnostic centres. This has also raised the issues of access and affordability of those in need of health care particularly the urban poor and those in the lower income group. The policy framework as articulated in the sixth FYP is somewhat ambivalent in respect of strategy of partnership with NGOs in Primary Health Care (PHC). It affirms that the existing system of PHC through contracted NGOs for the City Corporations and selected Municipalities under the Local Government Division (LGD) will continue to be pursued. At the same time, it states that MOHFW will continue to provide PHC services in urban areas not covered by the current Urban Primary Health Care Project (UPHCP). [29] The Strategic Plan also adopts the same approach in respect of PHC. [30]

3.11.2 It further notes that 35 dispensaries under the Director General of Health Services (DGHS) are providing outdoor patients service through EPI and maternal and child health (MCH) to the urban population. The effectiveness of such services remains somewhat unclear. As a way out the Strategic Plan recommends, among other, commissioning a study to determine how the two Ministries can jointly assess map, coordinate, plan and work together to provide quality HPN services for the urban population. That being so, necessary decision needs to be taken on completion of the study. DGHS also has 4000 satellite centres to reach the urban poor besides EPI services. Further, various NGOs provide essential service and some specialized services through 52 HIV/ AIDs clinics and 158 PHC centres, 34 comprehensive centres, Direct Observed Treatment Short (DOTs) centres and 47 Voluntary Counseling and Testing (VCT) centres.

[29] SFYP (Part-2), Ibid, p. 341.
[30] Planning Wing, Ministry of Health and Family Welfare, Strategic Plan for Health, Population & Nutrition Sector Development Program (HPNSDP) 2011-2016, p. 29.

3.12 Services and delivery by NGOs

3.12.1 The relevant policy and other documents of both the government and the development partners acknowledge the complimentary and useful role of the NGOs as part of the non-state actor in health care in both rural and urban areas. Bangladesh National Health Accounts (BNHA-III), however, points out gaps and inadequacies as to the reliable data base relating to the number and the extent of health care expenditure. [31] The effectiveness of health care and the ability to reach those who are in need of health care are, however, acknowledged, in particular, their focus on child and reproductive health and family planning by the government and private think tanks.

3.13 Smiling Sun Franchise Programme (SSFP)

3.13.1 Claimed to be the largest, it adopts an innovative model which has been operating through a health care clinic network of 27 NGOs for 30 years with funding support from the United States Agency for International Development (USAID). [32] Cost recovery principle was initially 100 percent but soon had to adjust to 50 percent. MOHFW's support includes family planning commodities and Essential Service Delivery (ESD) free of charge and clients of SSFP also do not have to pay for such services. Its services include (a) child, maternal and reproductive health care, (b) clinical and non-clinical family planning services, (c) communicable disease control, (d) TB treatment, (e) safe delivery, (f) post-abortion care and (g) limited curative care. Other successful 'competitors' include Marie Stopes International (MSI), The Family Planning Association of Bangladesh, and Bangladesh Rural Advancement Committee (BRAC). SSFP has collaborative relationship with these NGOs in the form of monthly NGO meetings. The Social Marketing Company (SMC) runs a clinical social franchise known as Blue Star.

3.13.2 In 2007, the move towards sustainability was initiated by the promoters of this model for leading SSFP through a three-phase project, based on build-own-transfer (BOT) concept. It is said that SSFP currently is at transfer stage. The strategy is to achieve sustainability through creation of an independent, privately managed health franchise system. With the current target of 50 percent cost recovery, it remains to be seen from which source the remaining 50 percent will come. This calls for further probe.

3.14 Challenges

3.14.1 Despite clinging on to the principle of full cost recovery and the claims that it has significantly improved, the management is faced with the fact that USAID's role in the near future will decrease but is still unclear as to how the donor relationship will evolve.[33] One thus has to wait and see. At the same time, the case studies on SSFP identify the opportunity of the government establishing SSFP as the provider of choice to run clinics that were outsourced from the government. It is too early to say if the government will positively respond to the proposal submitted in this regard by SSFP.

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[31] For details see BNHA-III, 2010 MOHFW, Health Economics Unit (HEU), pp 12-13 and 68-69.
[32] Global Health Group/Chemonics International, Clinical Social Franchising Case Study Series, April, 2011.
[33] Clinical Social Franchising Case Studies, Smiling Sun Franchise Program Bangladesh, The Global Health Group, April 2011, p.37.

3.15 BRAC's Manoshi Programme

3.15.1 The Bengali phrase Manoshi means 'Conceived in the mind'. In the field of maternal, neonatal and child health, it is BRAC's flagship programme that entirely focuses on urban slums of six City Corporations, a hundred percent urban coverage though not of entire slum population. Funded by Melinda and Gates Foundation, the project was started in 2007, and duration is of five years. It operates on the principle of 'Community Health Solutions'. Thus its emphasis is on capacity development of community health workers and birth attendants to provide health services to pregnant and lactating women, neonates and under five children. Included in its approach are timely referral to quality health facilities, community empowerment through development of women's groups and linkage with local ULBs and other non-government organisations. Its principal objective is to achieve a knowledge-based society among the urban poor. It is thus contributing substantively to the achievement of MDGs 4 and 5 in Bangladesh as the annual reports show.[34]

3.16 Challenges

3.16.1 BRAC's Annual Report (2008-2009) identifies as many as eleven challenges arising out of complex environment of urban slums. It also provides information on how BRAC is trying to mitigate the challenges. [35] On the major issue of the challenge of sustainability, it has suggested some interventions. These need in-depth scrutiny and necessary adoption. At the heart of the issue is institutionalization of community based health solutions for adaptation by a permanent structure of UPHCP in partnership with the NGOs. This needs sustainable flow of fund.

3. 17 Marie Stopes Clinic Society (MSCS)

3.17.1 Marie Stopes Clinic Society (MSCS) is a partner of Marie Stopes International, London. Established in 1988, MSCS is a Bangladeshi NGO. MSCS has 24 clinics and 44 mini clinics throughout the country mainly in urban areas. Although it is dedicated to ensure comprehensive reproductive health and other healthcare services, it is also engaged in providing services in family planning, EPI, limited general health and supportive pathology. Its other initiatives include opportunity card scheme for the poorest, voucher scheme for safe delivery, roving team for voluntary contraception (VSC) and intra uterine device (IUD), advocacy and capacity development. The other features of its services include health care service for the homeless through a mobile van in 10 locations of Dhaka and Chittagong, drop in centres (DIC) in partnership with 25 NGOs and adolescent health care. Finally, it has health care programme for factory workers in 74 factories using health card which partially fills a long felt gap in urban health care delivery.

3.17.2 Besides its two current projects funded by Marie Stopes International, it works with UPHCP-II, PLAN Urban Health Project, HIV/AIDS prevention projects. In all it claims to serve about two million clients. It has a total staff of 1566.

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[34] For a more detailed analytical and evidence-based assessment, see BRAC's Annual Report (2008-2009), relating to Manoshi.

[35] To gain further insights, see Manoshi, Ibid, pp. 40-43 and Manoshi: Community Health Solutions in Urban Bangladesh, Report 2007-2010.

3. 18 UPHCP

3.18.1 UPHCP under Local Government Division (LGD) is perceived to be another good example of PPP. It is funded by ADB. The project is nearing the end of a second phase. A third phase is in the offing based on the experiences gained and lessons learnt. Its services encompass various aspects of HPN with a focus on the urban poor. Between the periods from July 2005 to December 2010, it has served 7.27 million clients of which 76.44 percent are female and 23.56 percent male. On the whole, it draws on the earlier experiences of partnership arrangements in service delivery in Urban Local Bodies (ULBs). The extent of closer involvement of ULBs remains to be assessed. The major weaknesses perceived by some ULBs include lack of a structure for coordination at local level. A related issue is the gap in the capacity of ULBs to build up reliable data on urban health care and its linkage to the national level data via LGD.

3.18.2 Despite some limitations in its initial phase, an independent evaluation of UPHCP has identified key massages from it. [36]

Key Massages

- The UPHCP-II has increased access to the Essential Service Package by the urban poor in Bangladesh.
- Service outreach and the Red Card system implemented entitlement by the poor.
- Improved access by the poor to Emergency Obstetric Care and MR will contribute to achievement of MDG 5 (reduction of maternal mortality) and MDG 4 (reduction of neo-natal and infant mortality).
- The project responds to the urban dynamics in Bangladesh in terms of the projected growth in urban population, the legal framework which mandates local government to provide primary health care in urban areas and the service needs of poor, disproportionately youthful and reproductively active population.
- UPHCP-II uses an innovative model of service delivery, Public Private Partnership or PPP which offers valuable lessons for MOHFW in contracting out. The Bangladesh PPP experience in contracting NGOs for primary health care is also relevant across South Asia.
- The UPHCP-II model merits continuation in the context of rapid urbanisation, delivering on the legal mandate for local government to provide primary care in urban areas, achieving the MDGs, especially MDG 5, through significantly extending service coverage to the poor and the PPP modality of contracting NGOs providing an important exemplar for MOHFW in the context of the HNPSP Sector Investment Programme (SIP).
- Sustaining increased provision of urban health services to the poor through the UPHCP-II is complex and has many dimensions (continued relevance, contribution to implementation of national policy, institutional, financial, managerial, etc.) for which strengthened technical support for the project is required.
- Despite its achievements, the UPHCP-II programme could do better. Currently, there are a number of technical and operational challenges that need to addressed.

Source: Mid-term review by DFID.

3.19 Some constraints of NGOs

3.19.1 The sixth FYP, in respect of urban health, draws up the boundaries of MOHFW and LGD for PHC services. MOHFW, it said, will continue to provide PHC service in

[36] Report of the Mid-term Review: Independent Consultant Team, Second Urban Primary Health Care Project, April 2009

urban areas not covered by UPHCP. It stops short of mentioning the constraints of NGOs in their partnership programme with the public sector entities. [37]

3.19.2 Discussions with some partner NGOs have led to the identification of the following constraints:

- Duplications and overlaps of areas covered by NGOs;
- Difficulties in stable flow of funds, in particular, funds locked up as performance guarantee which impedes expansion of services and operative capacity;
- The conflicts arising from two different sets of services, (a) one free and other paid and (b) under utilization of safe delivery through institutions and use of skilled birth attendants at the same place; and
- Centralized procurement system.

3.19.3 Duplications and overlaps of services in the same area is essentially an issue of site selection. In the absence of an effective coordination structure at ULBs, this is bound to happen. It is necessary to map out areas for the partner NGOs.

3.19.4 The second constraint relates to locking up of funds for performance guarantee. The way out is to use a diminishing scale by release of part of the performance guarantee money proportionate to satisfactory services rendered each year till the figure is zero at the end of the project. LGD needs to work it out in consultation with the partner NGOs. Be it noted that the Strategic Plan (2011-2016) recommends, among others, commissioning a study to determine how the two Ministries can jointly assess, map, coordinate, plan and work together to provide quality HPN services for the urban population. At the other end, the sixth FYP, referring to the recent renewed commitment of strengthening local government administration and institutions, lay emphasis on devolution of health programmes and fund utilization through such local bodies. It goes on to add that adaption of such approach will enable need based allocation of resources and close supervision through locally elected council. It is felt that the study referred to should also provide a road map to translate this policy into reality within a time-bound action plan based on the partnership with the NGOs having a proven track record in quality HPN services. The issue of capacity building of NGOs should also receive due attention.

3.19.5 Finally, the issue of free service visa vis charging of user fee. The resolution of this contentious issue lies in the introduction of health insurance for the poor and the vulnerable at costs to the state. This also needs to be worked out by policy makers.

3.20 Typologies of existing PPP

3.20.1 It appears that at present PPPs are broadly of three major types. First, NGOs in stand-alone programmes in partnership with the public-private health facilities

[37] For more details see sixth FYP (Draft), PP. 40-41.

through referral system. Second, NGOs combining stand alone programmes and utilizing other partner NGOs for delivery of services. Third, ULBs through UPHCP, engaged in service delivery in partnership with NGOs but having linkage with public-private hospitals through referral system. The third one is in fact GO-ULB-NGO partnership. All these have limited participation with private facilities probably because of high costs. There is thus a big gap in purely public-private partnership except through grant in aid by MOHFW and the Ministry of Social Welfare to non-profit private health facilities involved in secondary and in some cases specialised health care.

3.20.2 It is also relevant to note that the government, acting through the Prime Minister's Office (PMO) has in August 2010 issued the Policy and Strategy for Public-Private Partnership (PPP) with three guidelines outlining modalities for partnership in investment programmes. Under the policy, only rural health services and hospital qualify for funding. [38] There is scope for NGOs and ULBs acting through LGD and MOHFW, to take up the issue of inclusion of urban health services and hospital in policy and seek funds for investment.

3.21 Access to PPP policy funds

3.21.1 Under the policy, projects eligible for funding are categorized into big, medium and small. The level of funding is discussed below.

3.22 Large project

3.22.1 A project, which is estimated to have a total investment above BDT 2.5 billion (as identified in the pre-feasibility report), excluding on-going capital for expansion, shall be classified as a Large project.

3.23 Medium projcet

3.23.1 A project, which is estimated to have total investment above BDT 500 million and 2.5 billion (as identified in the pre-feasibility report), excluding on-going capital for expansion, shall be classified as a Medium project.

3.24 Small project

3.24.1 A project, which is estimated to have total investment above BDT 500 million (as identified in the pre-feasibility report), excluding on-going capital for expansion, shall be classified as a Small project.

3.25 Viability gap financing

3.25.1 Viability Gap financing (VGF) is meant for projects where financial viability is not ensured but their economic and social viability is high. VGF could be in the form of capital grant or annuity payment or in both forms. VGF in the form of capital grant shall be disbursed only after the private sector company has subscribed and expended

[38] Bangladesh Gazette (Additional issue) August 2, 2010, p.7970.

the equity contribution required for the project. The VGF is to be managed by the Finance Division and is for disbursement to the PPP Project Company, upon request by the line Ministry/ implementing agency, as per the terms of the concession contract.

3.26 Infrastructure financing

3.26.1 The infrastructure financing is an arrangement for extending financing facilities for the PPP projects in the form of debt or equity through specialized financial institutions such as Bangladesh Infrastructure Finance Fund (BIFF) and Infrastructure Development Company Limited (IDCOL). The government may participate in such financing arrangements through necessary budget provision.

3.27 Incentives to private investor

3.27.1 The Government is keen to provide various fiscal and non-fiscal incentives to the private investors for launching PPP projects in priority sectors. All incentives in PPP, including fiscal and monetary incentives are to be considered and granted by the government, through the appropriate agencies of the government. The incentives may be in the areas of reduction of cost and protection of return to the private sector.

3.28 Fiscal incentives

3.28.1 All PPP projects will receive the applicable incentives, provided by the government from time to time which may, inter alia, include:

- Reduced import tax on capital items under PPP projects; and
- Tax exemption or reduced tax on profit from operating/ managing for a specific time period.

3.29 Special incentives

3.29.1 Any specific project may get special unique incentives with the approval of the Cabinet Committee on Economic Affairs (CCEA). Special incentives may be extended to PPP projects targeted for rural or and underprivileged population. Special incentives may be given to non-resident Bangladesh (NRBs) to invest in PPP projects.

3.30 Lessons learnt

3.30.1 Several lessons are learnt from the foregoing account. First, the inadequacy of MOHFW's services in the urban areas in respect of urban poor for primary health care. Although the gap is partially filled by the involvement of NGOs either in the form of standalone project or in the form of partnership with LGD. Much remains to be done. Second, whatever the form of intervention, there is strong ground for more investment in this area focusing on slum population. Third, both the NGOs and LGD in partnership with NGOs can play complementary role in filling up the gap which now exist thus relieving MOHFW of much of the burden and allowing it to concentrate more on government and stewardship role. Fourth, LGD requires putting in place an effective collaborative structure with the Ministries of Housing and Urban Development, Environment, Communication and Home Affairs.

3.30.2 Each of the four programmes/institutions has some innovative features which are worth emulation. Replicability on a sustainable basis remains a key issue. The franchising concept is novel but it remains to be assessed if it is replicable and sustainable. The strength of the Manoshi Programme lies in its community health solutions entirely focused on urban areas centering on capacity development of community health workers, services delivery for targeted population, timely referral to quality health facilities and community empowerment with linkage among the government, ULBs and NGOs. The most innovative feature of Manoshi appears, among others, to be the establishment and use of Expectant Mother's Group and Spouse Forum.

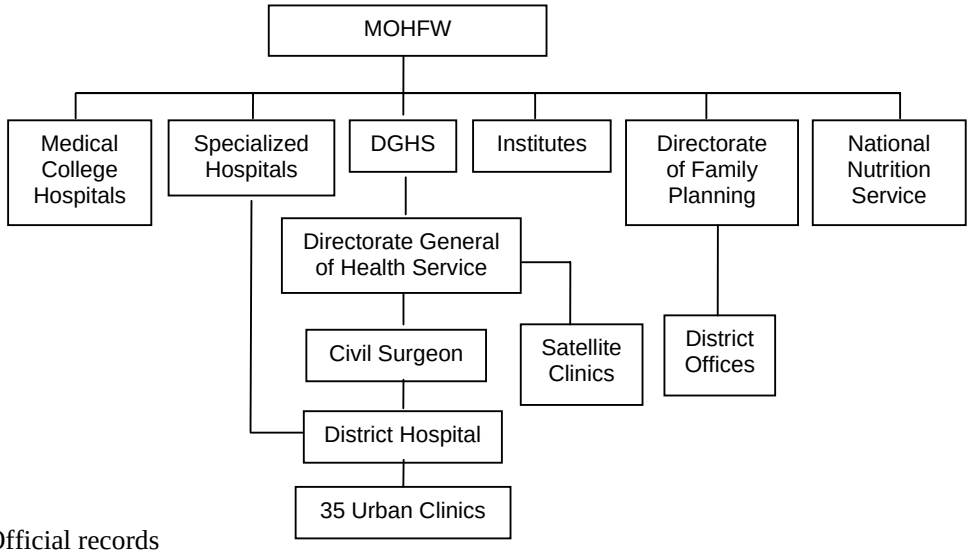
3.30.3 In respect of MSCS, two of its services are innovative and need-based. Firstly, health card scheme covering 74 factories. Secondly, the programme for the homeless in 10 spots. The average number of clients is said to be 1500 per month. The constraint is continuity of the service. There are several common features also. The missing link is the development of a common approach if feasible and desirable.

IV

Challenges to urban health

4.1 The widespread public perception is that there is lack of balance in MOHFW's current health care programme. This perception is premised on the ground that it has more focus on curative and less focus on PHC. Besides, although it carries out an immunization programme, its ability to reach the urban, in particular the urban poor is limited. Its partnership with the private sector is yet to be developed while the focus of its partnership with NGOs is the rural areas. As part of the previous policies and strategies, it has concentrated all its efforts to the rural areas which are still visible. Its presence in the urban areas in terms of infrastructure and service delivery is limited to secondary and tertiary care. It has only 35 urban dispensaries. Existing urban health delivery structure/ organizations is shown at Figure- 4.1.

Figure 4.1: Structure and organization of health delivery by MOHFW



Source : Official records

Notes : Rural facilities are not shown. National Nutrition Service works through NGOs.

4.1.1 Distribution of public health care services and facilities follows similar pattern of administrative tiers, viz. national (mostly capital-based in Dhaka), regional (in divisions), district, upazila, union and ward. The country has 6 divisions, 64 districts, 482 upazilas and 4,498 unions. As the Ministry of Health and Family Welfare deploys health workforce according to the older ward system, which divides each union into 3 wards. Therefore, number of MOHFW wards is 13,494.

4.1.2 Primary health care (PHC), which includes family planning services in the urban area (city corporations and municipalities), is provided by Ministry of Local Government; and in rest of the country by Ministry of Health and Family Welfare (MOHFW) provides health care services. Provision of secondary and tertiary care, in both urban divisional directorate with necessary staff, and rural areas, is the sole responsibility of MOHFW. The MOHFW delivers its services through two separate executing authorities, viz. Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). The names explain their functions.

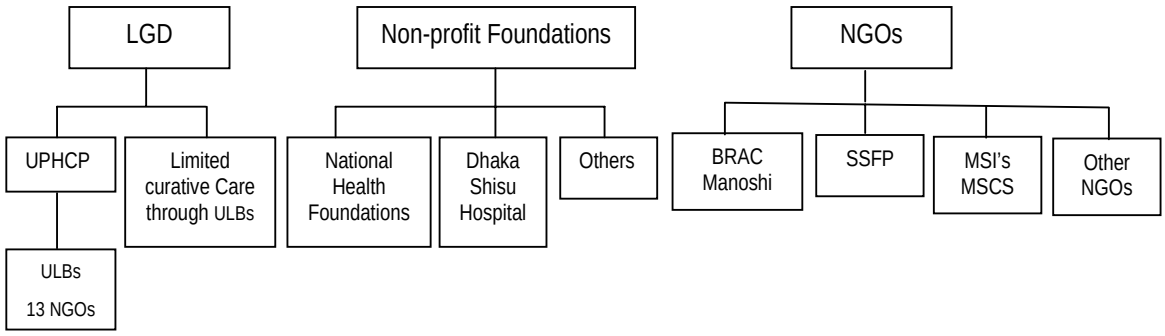
4.1.3 PHC services of both DGHS and DGFP begin at the ward level through a set of community health staffs, at least one in each ward (Table). To supervise these field staffs, there is one assistant health inspector (for DGHS) and one family planning inspector (for DGFP) at union level. There are several hundred non-bed community facilities to provide outpatient services (1466 for DGHS and 3500 for DGFP). Besides DGFP also operates centres (MCWCs) (union: 23; upazila: 12; district: 62), 471 MCH-FP clinics (upazila: 407; district: 64), 177 NGO clinics (upazila: 68; district: 104; national: 05), 08 model clinics (national: 02; regional: 06) and organizes 30,000 make-shift satellite clinics per month.

4.1.4 The public sector hospital care in Bangladesh is mainly provided by DGHS. [39]

4.1.5 Key weakness of MOHFW's service delivery programme in the area of family planning is its inability to reach the urban poor. It has not the required personnel or organization in urban areas although the TFR in urban slums exceeds that of the national average.

4.1.6 Existing urban health facilities apart from what is shown in Figure- 4.1, is shown in Figure- 4.2.

Figure- 4.2: Other health delivery structures and programmes



Source: Officials records and NGOs.

4.1.7 It is not necessary to give more details of UPHCP and NGOs. About Non-profit foundations, be it mentioned they are partially financed by MOHFW through annual grants in aid. There are procedural complexities in obtaining such funds from the Ministry of Finance. There are private hospitals, clinics and diagnostic centres. Weak governance is a feature. Besides, these are not pro-poor.

4.1.8 The Sixth Five Year Plan (2011-2015) provides information on institutional framework for urban governance and management. There are a large number of disparate entities, across several ministries including LGD. Desirable health outcomes can be achieved from cohesion and consistency in the functioning of these bodies. This is shown in Table- 4.1.

[39] DGHS, Health Bulletin 2009, P.9. Para 4.1.1 to para 4.1.4 are reproduced from the Bulletin.

Table- 4.1: Institution framework for urban governance and management

Ministry	Agency	Major Responsibilities
1. Ministry of Housing and Public Works	i) Urban Development Directorate. ii) National Housing Authority. iii) Rajdhani Unnayan Kartipakkha (RAJUK).	• Urban Development. • Urban Housing. • Residential plot allotment and approval of building plan in Dhaka city. • Local urban planning, infrastructure development for housing, residential commercial and industrial use.
2. LGD	i) Dhaka and Chittagong Water Supply Authorities.	• Safe water supply for city residents. • Overall urban governance including primary health and limited secondary care.
3. Ministry of Environment and Forest	i) Directorate of Environment.	• Environmental protection across the country.

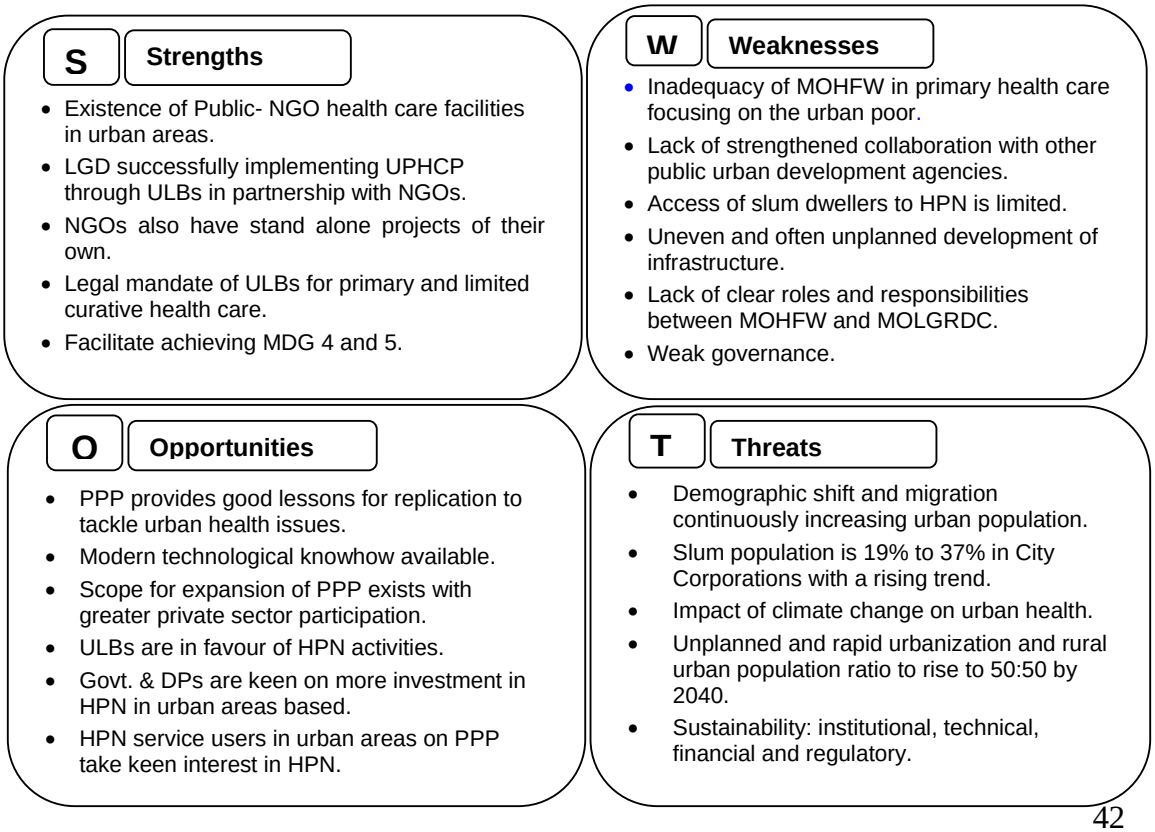
Source: Based on Sixth FYP, pp 207-209.

4.1.9 The above multiple agencies across Ministries multiply problems of coordination and consistency on urban governance and management. In the result, securing gains for building up healthy cities by improved coordination and collaboration remains a remote possibility. This is believed to have contributed to unplanned urbanization with its adverse consequences for urban health and environment. It is imperative that LGD takes increasing initiative to ensure more effective collaboration with these bodies.

4.2 SWOT analysis

4.2.1 The strengths, weaknesses, opportunities and threats of urban health system are shown in Figure- 4.3.

Figure- 4.3: SWOT analysis



4.3 Challenges

4.3.1 Keeping in view the evaluative analysis in preceding sections and the areas mentioned in the SWOT analysis of the foregoing pages, the challenges to urban health are identified below.

4.4 Protecting the urban poor

4.4.1 The Sixth FYP (2010-2015) points out that "poverty has increasingly been urbanized by way transfer of the rural poor to urban areas. But manifestation of urban poverty is more appalling than the rural poverty. Urban poverty is invariably associated with poor quality housing."[40] Recent data from national survey on poverty rates provide alarming signals about urban poverty.[41] The data show that in Barisal division, urban poverty is more than the rural. Same is the case with Khulna. This is shown in table- 4.2.

Table- 4.2: Poverty head count ratio by divisions, 2005-2010.

Division	2005			2010		
	Total	Urban	Rural	Total	Urban	Rural
National	40.0	28.4	43.8	31.5	21.3	35.2
Barisal	52.0	40.4	54.1	39.4	39.9	39.2
Chittagong	34.0	27.8	36.0	26.2	11.8	31.0
Dhaka	32.0	20.2	39.0	30.5	18.0	38.8
Khulna	45.7	43.2	46.5	32.1	35.8	31.0
Rajshahi	51.2	45.2	52.3	35.7	30.7	36.6
Sylhet	33.8	18.6	36.1	28.1	15.0	30.5

Source: Bangladesh Bureau of Statistics, HIES 2005 and HIES 2010

4.4.2 Given the poor state of urban poor, it is imperative to implement broad-based measures to improve their quality of life. It goes beyond health care facilities and includes such areas as improved living conditions consisting of housing facilities, cleaner environment for the slums and access to education. All these will need additional investment, more importantly, a collaborative structure of cooperation and coordination at Ministry level. In this context it is learnt that recently an initiative has taken jointly by LGD and the Ministry of Public Works and Housing to put in place an urban forum with participation from the civil society.[42] Additionally, protection of the urban poor should also be in such areas as urban safety net Programmes and services both cash and kind. During the past few years, the government has increased investment in safety net both food and cash. However, such Programmes are more in the rural than in urban areas.

[40] Sixth FYP (2010-2015), p 205.
[41] Ibid, p 205, Table- 5.3. This is based on Household Income and Expenditure Survey (HIES), 2010.
[42] Discussion with Secretary, LGD and the Centre for Urban Studies (CUS).

4.4.3 Health care system in a broader sense transcends clinical care. It has a close relationship with reasonably good system of preventive care. Apart from immunization and other medically dependent services, it will include access to safe drinking water facilities, solid and medical waste disposal, prevention of pollution and access to safe food and housing facilities in urban areas. Overall for such areas, the responsibility allocation lies with parastatals/departments across more than one Ministry. Health sector is part of human development that has cross-cutting themes. Approach to deal with health poverty is necessarily multi-sectoral in nature. This demands greater and more effective collaborative and coordinative structure to address the cross-cutting issues.

4.4.4 In its assessment of urban health services, the Strategic Plan of HPN admits the inadequacy of PHC services. [43] It further underlines: "The emphasis on urban health is a new (and very different) element compared to HPSP or HNPSP. It will involve MOHFW working in new ways with its partners, notably MOLGRDC, NGOs and others."[44] As priority interventions it calls for, among others, (a) commissioning a study to determine how the two Ministries can jointly assess, map, coordinate, plan and work together to provide quality HPN services for the urban population and (b) establishing a permanent institutional arrangement and governance mechanism incorporating, agencies and institutions with responsibility to urban health.

4.4.5 Financial protection of this segment of the urban population is imperative to carry forward the overriding goals of universal coverage and health equity. Several interventions are called for in this regard. First, separate budgetary allocation for ULBs in respect of PHC, investment of infrastructure, expansion of the existing secondary health facilities of ULBs. Second, health insurance for the poor. Third, guiding the ULBs for greater mobilization of resources and the corporate bodies to support health programmes for the urban poor as part of their corporate social responsibility (CSR). Exploring other sources of finance. Fourth, introducing and further expanding the safety net for the urban poor both cash and food.

4.4.6 Available information in financial protection indicates the weakness in respect of all the three elements mentioned above. Thus, the allocation to MOHFW for HPN is spent mostly on rural health service. There is no separate allocation for urban health to expand and strengthen PHC services. Similarly, the allocation to LGD is not specifically for urban health but the overall budget for ULBs in which health receives insignificant allocation for urban health. Bulks of the allocated funds are spent on roads and their maintenance.

4.4.7 Health insurance on the lines indicated earlier is virtually non-existent. Worse still, there is but insignificant coverage of health care for the urban poor in the formal sector such as factories. Similar is the case with other sections of the urban poor such as self-employed or in the informal sector. In this category, there is a large presence of poor urban children.

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[43] op.cit., P.29.
[44] Ibid, P.29.

4.4.8 ULBs lack the ability or willingness to mobilize their own resources. There is a model taxation schedule approved by the government which is not used to their advantage. All ULBs have not gone for an upward revision of taxes on urban properties for decades. Some corporate bodies, limited though their number is, do support health care facilities but more efforts are needed to tap this source.

4.4.9 Some recent studies have shown that "it can cost less to prevent people falling into poverty than helping them escape. The message is stark and clear: sickness and accidents are the most common and most preventable cause of new poverty." [45] This lesson for policy makers imply that much of the resources being allocated for health care can be saved if the poor can be protected.

4.5 Resource allocation

4.5.1 More allocation of resources is necessary but not sufficient to address the multiple issues of urban health. Economy and efficiency in resource use is essential for success in this and related areas. An essential element in this regard is effective service delivery to the clients, in particular, the urban poor. Wider use of PPP model is relevant in this context for several reasons: comparative advantage of the NGOs in reaching the poor, operative style and administrative norms are more flexible than the government systems that enable quick decisions, possibility of associated savings for the ULBs and therefore, the government.

4.6 Resource allocation for urban development

4.6.1 During the last two decades, government has adopted specific polices on periodic basis. The National Housing Policy- 1993 aimed for 'Housing for All' and recognized the importance of planned development of human settlements. The Urban Management Policy Statement- 1994 envisions sustainable and equitable urban development through decentralization, public awareness and sector participation. This was updated in 1999. The National Urban Sector Policy drafted in 2006 envisioned a decentralized and participatory process of urban development in which the national and local government, private sector and civil society play complementary roles. This draft National Urban Sector Policy is now being finalized by LGD for approval by the cabinet.

4.6.2 On the recent draft Urban Sector Policy, comments have been invited by LGD. There are weaknesses in the draft with regard to emphasis to health and other cross cutting things which appear to have weak linkages. The specific interventions that need stronger foundations include land use zoning, housing for the poor and slum improvement, unclear relationship among agency level coordination bodies with city corporations and urban research training and information.[46]

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[45] op. cit., a reviewer's comment on Anirudh Krishna's Landmark Book: One Illness Away: why people become poor and how they escape poverty, Oxford University Press, 2010.

[46] Comments were sent by the Urban Health Expert to LGD which has been acknowledged and assurances given for consideration.

4.6.3 With regard to past investment source, key initiatives include small town infrastructure development Programme I and II, municipal support Programme and the on-going urban governance infrastructure improvement Programme (UGIIP, phase I). Besides, Bangladesh Municipal Development Fund (BMDF), BMDF is claimed to have been successful in linking performance of municipalities in achieving action based governance improvement to access infrastructure funding in phases. Nevertheless, the Sixth FYP has listed some areas for further refinement.[47] Although achievements have been claimed during the 4th FYP (1990-1995), it lacks a pro-poor focus in that only 1000 squatter families have been settled through a housing scheme. Lot remains to be done in this area with participation from NGOs or under PPP framework which should be explored. In this context, the strategy for urbanization under 6th FYP underscores the need for facilitating NGO involvement in housing and refers to replicable model for housing for the poor.

4.7 Access to and utilization of services

4.7.1 This essentially implies management of both supply and demand side. Efficiency in supply chain management is essential for meeting demand which is need-based and location specific. A glaring example relates to wider prevalence of unsafe delivery practices. PPP models are designed to ensure community-based service delivery, follow-up and referral linkage related services. Advocacy and community solution approach by Manoshi, which is also emulated by other NGOs makes access to and utilization of services easier for the urban community, specially the poor.

4.7.2 In respect of supply chain management procedural complexities in procurement of essential drugs and related materials need to be avoided. Supply shocks in such areas are likely to depress the demand for and utilization of services.

4.7.3 Demand side management by the introduction of demand voucher for safe delivery is an innovative practice of meeting unmet demand. This is part of the partnership model and needs to be scaled up.

4.8 Human resource

4.8.1 Availability of skilled personnel at all levels in the chain of service delivery system is a necessary condition for effective access to and utilization of services. Lack of availability and use of balanced and skilled manpower in public health delivery facilities remains a big challenge for the government. For long and even now, this is all too visible. The positive side is that only recently MOHFW has taken initiative to address this issue by recruiting more doctors, nurses and health assistants. More time is needed for their training for skill-building. The highlights on lack of human resources and related weaknesses are shown in box- 5.

[47] Sixth FYP, 2011-2015, p 210.

Box-5: Highlights[48]

- In recent times, at least 10 patients became victims of maltreatment and some of them even died because of doctors' negligence in private clinics.
- A large number of unregistered health service providers are also doing business.
- Public hospitals are struggling to provide quality healthcare services because of acute manpower shortage, lack of medical equipment and beds.

Source: The Independent October 23, 2011, p 1.

4.8.2 The above highlights reflect weak governance which is also a challenge. In contrast, the PPP model specially, that of Manoshi, has adopted community based solutions to urban health issues involving use of community health workers for improving maternal and neonatal child health (MNCH).[49] Despite the above, NGOs still face problems of retaining skilled staff.

4.8.3 ULBs too are faced with this shortage of skilled manpower more or less for same reasons. This is further exacerbated by long delays in obtaining approval from LGD in filling up posts of doctors. [50] On the whole availability and continuity of the services of skilled personnel constitutes a challenge for urban health. A way out for the ULBs (including PPP) will be to utilize the services of private practitioners on contract basis. LGD will need to empower the ULBs to implement this step.

4.9 Persistent and emerging issues

4.9.1 Emerging challenges are on several fronts such as climate change, road and food safety, domestic violence, high incidence of drug addiction in slums and to a degree in non-slums. The impact of climate change is not particularly limited to curative health care. Others are social health challenges leading to higher degree or rural urban migration, accentuation of poverty and pressure on civic services.

4.9.2 The impact of climate change has engaged priority attention of the government including global attention. The challenge will primarily be in the area of adaptation in health sector. The major impact of global warming and climate change will be an increase in vector borne diseases e.g. malaria and dengue fever. The current incidence of diarrhea is on the increase which is partly attributable to increased flooding and drainage congestion. This will also increase with climate change.[51] Global warming will increase temperature in summer season, increasing the incidence of heat strokes which would be further aggravated by shortage of drinking water. Possible other diseases-related impact is yet to be assessed. The suggested course is to upgrade monitoring and research to develop adaptation strategies. Be it noted that the above actions relate to whole of Bangladesh. The challenge now is to link the same to possible impact on urban health and social dimensions.

[48] The front-paged news was captioned Boom time for clinics meaning private clinics.
[49] For details see BRAC, Manoshi: Community Health Solutions in Urban Bangladesh, Report 2007-2010.
[50] Based on discussions with Mayor of ULBs.
[51] Bangladesh Climate Change Strategy and Action Plan 2009, GOB, P. 38.

4.10 Domestic violence

4.10.1 BUHS (2006) has highlighted this issue as an emerging threat to urban health issue. Much of such acts of violence remain invisible specially in respect of those in the slums. Occasional incidents are reported by the media in respect of such incidents in more affluent urban families. On the whole, there are unreported incidents due to social and cultural barriers. The way out is to upscale advocacy campaigns against domestic violence together with regular counseling of couples through community based health workers and social leaders and where appropriate punitive action.

4.11 Drug addiction

4.11.1 Increasing incidence of drug addiction in slums and in non-slums is an emerging urban health challenge. Mayor of Dhaka City Corporation drew pointed attention for more focus on slums. In his view, the poor in slums need more rehabilitative care. Those who are affluent can either go abroad or avail of costly care within Bangladesh.[52]

4.12 Communicable and Non-communicable disease (NCD)

4.12.1 According to data of DGHS, incidence of tuberculosis is very high. Besides curative care, a more effective mechanism needs to be put in place for effective prevention through advocacy and health education programme. NCDs are perceived to be a major threat to urban health. The rising incidence of NCDs is believed to be caused by urban life style, environmental pollution, lack of food safety etc. Besides, high level of tension associated with urban life also remains one of the major factors having impact on both physical and mental health.

4.13 Human Immunodeficiency Virus (HIV)

4.13.1 It is not an immediate challenge except for close surveillance and monitoring. This is being done on a country-wide basis by DGHS. Available data show that currently the prevalence of HIV/AIDS is less than 0.1 percent.[53] Injectable drug addicts in slums who prove to be HIV positive are 10%. HPNSSP speaks of The HPNSSP strategy is to strengthen the capacity of the national AIDS/STD programme (NASP) in both management and technical aspects. The challenge is to ensure linkage with urban health.

4.14 Avian Flu

4.14.1 There have been periodic outbreaks of Avian Flu. Such outbreaks hit part of the poultry industry which is almost entirely privately owned and managed. It is also seen as a public health issue. Transmission of the disease to human has been less than significant. In 2008, only one child living in a slum area was reported to be affected. No death has been reported so far. Actions are taken by the ULBs to prevent inflow of affected poultry from entering city markets. This preventive action needs to be supported by increasing advocacy, surveillance and ULBs capacity.

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[52] Dhaka Mayor's comment in workshop at Dhaka City Corporation.
[53] HPNSSP, Third Draft, September, 2010, MOHFW.

4.15 Human Anthrax

4.15.1 Human anthrax was not reported earlier in the country except report of 19 cases of coetaneous anthrax in a study among 624 tannery workers of Dhaka city in 1997. In 2009, three outbreaks of human anthrax were reported from northern part of Bangladesh with 55 infections. [54]

4.16 Road safety

4.16.1 Road safety has become an emerging threat to public health as more than 12000 persons on average die every year. The current approach is to strengthen public sector trauma or orthopedic facilities. Much cost in investment can be saved if greeter attention to licensing the driver and related road safety measures are given.

4.16.2 In contrast, civil society and the media support the above latter line of action for which they organized civil protest.[55] This emerging challenge to urban public health as both public and private facilities are all located in the urban areas. Much scope lies for the public sector in addressing this social challenge by partnering with the civil society in further reforms in relevant regulations.

4.17 Food safety

4.17.1 Food safety is increasingly becoming an urban health issue. Despite periodic enforcement of relevant laws, lack of food safety is a public health concern. At issue here are unclear responsibilities across MOHFW and LGD. The law called pure Food Ordinance dates back to 1959. It vests the ULBs the authority to enforce the law and the LGD is to discharge its oversight functions as such laws are allotted to it by virtue of the Allocation of Functions under the Rules of Business.[56] At the other end, MOHFW, under the same instrument is to deal with all matters relating to adulteration of foods stuffs and other goods relating to health. Bangladesh Standards and Testing Institution (BSTI) under the Ministry of Industries (MOI) are responsible to ensure safe food through testing. At issue here is to put in place a governance structure involving all relevant Ministries. The Minister level committee earlier formed and located in MOLGRDC was transferred to MOHFW in 2008. It is said to be dysfunctional.[57]

4.17.2 The concern for food safety was raised in the national parliament. The parliament decided that MOI should come up with proposals to the relevant parliamentary committee. As explained in the above, this is not the sole responsibility of MOI. MOHFW is the focal point while the LGD through the ULBs has statutory responsibility.[58]

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[54] Health Bulletin (2010), DGHS, P 79.
[55] The Independent, October 23, 2011, p 3 of the Metro section. A civil society forum called Nirapad Sarak Chai which in English means: We demand Safer Roads organized a fast unto death movement which they stopped after the Minister for Communications expressed solidarity with them and assured to work with them closely to ensure road safety.
[56] Allocation of Business (Schedule of Rules of Business as revised up to August 2000), pp. 49 and 74.
[57] Based on the consultant's experience as Adviser MOHFW, 2008.
[58] For details see The Daily Star, an English daily of October 25, 2010, p 20, column 1.

4.18 Losses due to traffic jams have been calculated by a government agency. The highlights are as follows:

Box- 6: Losses due to long commuting hour

- 8.15 million work hours of commuters wasted. 40 percent of it is business hours.
- Tk 20 billion lost due to 3.2 million business hours wasted.
- Tk 200 billion worth of business hours lost a year.
- Environmental damage worth Tk 22 billion.
- Motor vehicle speed 12 kph against the capacity of 40 kph. Cost of the speed loss is Tk 12 billion a year.
- Public transport operations and freight industry lose Tk 20 billion each in lost trips.
- Tk 5.75 billion excess fuel burned.

Source: Study by Roads and Highways Directorate (RHD) published in the Daily Star on October 24, 2011 as part of the public awareness campaign jointly organized by the daily and Grammen Phone.

4.18.1 Adequate planning and management of urban transport system could have led to huge associated savings which could be used for strengthening urban health and associated services. The current situation points out weaknesses in planning for urban development which needs to addressed.

4.19 Other emerging issues

4.19.1 Other issues that need attention are: care for the aged, mental health, care for the disabled both young, socially excluded population and urban eye care.

4.19.2 In recent times, the loagurity has increased. This means that over the next decade or more, the demographic profile in urban areas will change with more aged people. Added to this is the fact as more young people go abroad for a living, the aged are left uncared for in many cases in urgent need of rehabilitative care. This calls for strengthening existing, through limited, number of such centres most of which are privately managed.[59]

4.19.3 Mental health care in urban areas also need more attention. Although these centres are largely in the public sector, there is need for a more broad-based partnership with non-state actor.

4.19.4 There is now an increasing campaign for taking adequate care of the disabled, specially the children and the adolescent. There are some private initiatives under which training and education are imparted to the disabled children. More attention and support are needed to strengthen coverage and quality of rehabilitative care.

4.19.5 Urban eye care also merits attention. The current national policy on eye care is nation-wide. Only during 2011, MOHFW has launched Dhaka Urban Eye Care Project. It is a good initiative to achieve the stated policy goal of prevention of

[59] The media, specially the electronic, periodically broadcast news on the helpless of the aged population in urban areas. Besides, in some of the workshop in course of this study, suggested interventions for the aged.

blindness. There is scope here for DCC and the ULBs to establish linkages with this project. It is felt that with increasing air pollution in Dhaka and other urban areas impacting adversely also on eye, LGD may explore possibilities of establishing linkages not only with this project but also these run by charitable clubs like the lions and the Rotary Clubs. [60]

4.19.6 Finally, the socially excluded class of various groups. In recent times, the case of the hermaphrodites locally called Hijra has received attention of the government. Initiatives have been launched for their training and rehabilitation.[61] The other socially excluded group has various names that also need attention and health care.[62]

4.20 Health Education

4.20.1 Besides attention to the above, health education service delivery will need to be strengthened in urban areas focusing on the poor. In this regard, a fuller assessment of the work now being done by DGHS needs to be made to design service delivery in health education in urban areas.

4.21 Improved living conditions and environment

4.21.1 Nationally and globally it is increasingly recognized that intended urban health outcomes depend largely on healthy living conditions, access to safe water and environmental safety. Ensuring environmental safety in urban areas is of utmost importance to strengthen health outcomes. The specific areas include soil, water, air and food. The present status of all or most of the areas as highlighted by the media has earlier been mentioned. There is a symbiotic or mutually reinforcing relationship between urban health and the latter elements. This relationship need to be exploited to create healthy living. The poor in slums live in crowded conditions without adequate access to safe drinking water and other civic facilities. Many live in footpaths or in and around the railway tracks. Those who live in slums with makeshift houses live in crowded conditions. Those who have housing facilities in slums are in constant fear of eviction as they do not enjoy security of tenure. Overall they become victims of diseases.

4.21.2 Health Minister, in his speech in the National Workshop highlighted this fact adding that unless living conditions and environment are improved, healthy urban life cannot be ensured. He cited the incidence of diarrhea in cities for which unsafe water is largely responsible. These services lie outside his domain yet for such incidence he is held responsible. This calls for increasing partnership with LGD. Water and Sewerage Authority including urban housing is under its functional domain.

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[60] Orbis, a development partner suggested inclusion of a more strengthened urban eye care system.

[61] The media has highlighted this initiative as part of the welfare drive to rehabilitate this socially excluded population.

[62] Mayor of Bogra Municipality cited the case of Harijans and requested for necessary intervention.

4.22 Improving coordination and capacity

4.22.1 There is no denying the fact that overall governance of health sector, in particular urban primary health effective and quality service delivery is severely handicapped by both weak coordination and even more so by lack of capacity of existing institutions. In some cases, no such mechanism exists as in the case coordination between LGD and MOHFW. It has also been found that even in cases such as food safety for which a Minister level committee is in place, the mechanism is not functional. More or less same is the case with the Road Safety Council located in the Ministry of Communications which came under heavy public criticism in recent times. The extent to which LGD is able to influence decisions of other public agencies across different ministries responsible for urban development and identify in the Sixth FYP (2011-2015) remains anybody's guess.[63]

4.22.2 In respect of ULBs, the plan identifies key constraints that impede city governance. It also suggests measures to improve the same.[64] The measures are as follows:

- institutional reforms and decentralization of responsibilities and resources to local authorities;
- participation of civil society including women in the design, implementation and monitoring of local priorities;
- building capacity of all actors (institutions, groups and individuals) to contribute fully to decision-making and urban development processes; and
- facilitating networking at all levels.

4.23 Sustainability

4.23.1 Sustainability of urban health and related services can be grouped into (a) institutions, (b) technical and (c) financial. Attention to all three aspects is essential for overall sustainability of urban health.

4.23.2 As has been emphasized by the Strategic Plan of HPNSDP (2011-2016), for achieving desirable outcomes in urban health, new ways of working will be required. The key element in the new plan will be to:

- put in place a functional coordinative structure involving MOHFW and LGD and other related ministries;
- Strengthening existing coordination mechanism;
- greater decentralization of authority and
- building up more effective alliances with the NGOs, private sector, business academia and other relevant non-state actors.

[63] Sixth FYP (2011-2015), Part II, pp 207-209. In this part a good number of urban governance bodies have been mentioned.
[64] Ibid., pp 215-216.

4.23.3 Technical capacity of MOHFW, LGD and ULBs including partner NGOs will have to be increased both for PHC and secondary care supported by a functionally effective referral system. In particular, increasing use of ICT will need to be further strengthened for all involved institutions.

4.23.4 Stable flow of funds as earlier stated is an essential prerequisite for sustainability. It should be for total health care and not limited to curative care only. Preventive and PHC should receive attention along with other areas of non-health outcomes.

V
Urban health strategy

5.1 This is the core part of the report read with the matrix of strategies. In this part are included mandate and scope of health strategy, guiding principles, vision, mission and objectives and other responsibility of organizations, and time frame.

5.2 Mandate

5.2.1 The mandate is derived from the policies such as the 6th FYP (HPN sector), Health Policy 2011 and the Strategic Plan 2011-2016. There is thus a strong linkage with the relevant policies.

5.3 Guiding principles

5.3.1 The principles draws on the themes and objectives of various health, population and nutrition related international conventions and conferences subscribed by the government. Major among these include Alam Ata, Millennium Development Goals, International Convention on Population Development and Nutrition. It also advocates a right-based approach for the poor.

5.4 Vision

5.4.1 The Vision is to see urban people, specially the poor, healthier, happier and economically productive for attaining middle income status by 2021.

5.5 Mission

5.5.1 The Mission is to create an environment whereby the urban people in particular the poor have equitable access to and utilization of health, population and nutrition services rendered by multiple service providers.

5.6 Objective

5.6.1 The development objective is to improve equitable access to and utilization of essential health, population and nutrition services particularly by the poor.

5.7 Way forward and implementation plan

5.7.1 The strategy to be construed as a living document. It will need periodic updates in light of which adjustments in strategies will have to be made and actions taken. The strategies and implementation plan are shown at appendix- A.

5.8 Priority interventions from the government

5.8.1 A number of priority interventions by the government, the development partners and ULBs are required for successful implementation of the areas mentioned

in the matrix (Appendix-A). These are:

- Full commitment of the government through public announcement preferably by the Prime Minister;
- More investment in urban poverty, housing, safe water supply, sanitation, drainage and urban environment;
- Consultative framework for urban governance and management;
- Increasing advocacy for increased and separate budget for ULBs;
- Capacity building of LGD and ULBs for overall urban governance;
- Putting in place an effective referral system;
- Development and prudent utilization of urban HPN data preservation for more effective management of urban HPN services in partnership with non-state actors;
- For a more durable PPP, (a) create and activate NGO-Private Sector Unit (NPSU) in MOHFW with mechanism for linkage to LGD's relevant wing and formulate framework of relationship through PPP and through diversification of HPN service delivery package jointly with LGD;
- Initiate reforms in legal and regulatory framework that lie within the functional domain of LGD and linkage to MOHFW;
- Constitute a Joint Task Force to provide policy guidelines and to oversee NGO and PPP related activities under joint leadership of MOHFW and LGD;
- Formulate proposal for necessary amendments of Allocation of Functions to remove confusion of respective jurisdictions of MOHFW and LGD to provide greater clarity than at present;
- ULBs to play a more proactive role for local level planning and delivery of HPN services to the poor with emphasis on community participation; and
- Initiate further technical assistance (TA) for implementation of the strategies.

Strategy Matrix

Lead Responsibility : Public: MOHFW/LGD, DGHS, DGFP & NNS and ULBs, Private sector: NGOs.

Associate Responsibility : ULBs for Primary/Limited Secondary Levels, Ministry of Environment and Forest, Ministry of Communication, Ministry of Commerce, Ministry of Industries, Ministry of Home Affairs, Ministry of Social Welfare, Ministry of Housing and Urban Development, and District Administration.

Objective	Strategy	Implementation modalities	Time-frame
1. Universal coverage for urban population with a pro-poor focus.	– Full free health card for the poor (slum population). – Partially free health card for the transitional poor. – Mandatory insurance for employees in the formal sector. – Voluntary for others.	• Review the current status and identify replicable model. • ULBs in partnership with NGOs for the slum population for both poor and transitional. • All formal sector employees organizations, public, private and NGOs. • Public and private insurance companies.	Continuous
2. Strengthen preventive and PHC.	– Coordination across cross-cutting sectors: urban safe water supply, road and food safety, housing and environmental health. – Expand and strengthen elements of PHC and attention to emerging issues. – Better organization and management of existing urban health delivery infrastructure i.e. LGD, MOHFW, ULBs, private and NGO facilities. – Improve human resources for primary health and ESD including steps removal of weaknesses in urban family planning services, doctor-nurse-paramedics and strengthening community health solution approach. – Adopting a more inclusive approach. – Containing high incidence of NCDs in urban areas.	• LGD acting through ULBs in urban areas for PHC and limited curative health care solid and medical waste (solid + liquid) for which a separate management mechanism needs to be established. • MOHFW for secondary and tertiary levels and ESD including maternal and child health services, eye care and other social health risks: drug addiction, violence against women in areas not covered by ULB & NGOs and areas outside UPHCP and other NGO initiatives. • Drawing up of a 20 year plan for HRD of ULBs with periodic updates. • Similar plan for public and private sector. • Local resource mobilization by ULBs and other service providers including funding from corporate bodies and philanthropists. • MOHFW in collaboration with ULBs, private sector and NGOs to develop an effective referral system drawing on the lessons from successful non-state actor. • Community involvement to be strengthened by ULBs and by the involved NGOs to be more closely monitored at ULB and LGD levels. • Enlist support of ULBs, civil society and NGOs to adopt a more inclusive approach e.g. socially excluded classes including the aged people, autistic children and adolescent and others. • Strengthening health education for appropriate life style management dietary intake for all age groups in particular for the aged including attention to mental health.	2012 and continuous where appropriate.

Objective	Strategy	Implementation modalities	Time-frame
	– Ensuring flexible working hours at all service delivery centres of PHC centres to suit the needs of the clients.	• PHC and related service delivery centres both NGO run facilities and ULB-NGO partnership to work out flexible working hours to meet the needs of the clients, in particular the urban poor.	
3. Urban poverty reduction.	– Ensure reduction of urban poverty. – Implementation of the concept of escape from poverty rather than into poverty by strengthening measures to achieve non-health outcomes, introduce and strengthen urban safety net programmes. – Strengthen overall urban sector development linkages as part of the policy under consideration by LGD by capturing the synergies of preventive primary health care with a holistic approach with greater focus on mother and child care including care for the adolescent and old age groups. – Establish greater linkages to all existing urban governance related programmes and projects with a more focussed attention to accelerated reduction or urban poverty.	• LGD to establish greater linkages to existing urban governance related programmes and projects with a more focused attention to accelerated reduction of urban poverty such as the on-going Urban Governance Infrastructure Improvement Project (UGIIP), sanitation and sewerage etc. • Similar actions by LGD to establish linkages with on-going and future programmes/ projects of other ministries having a bearing on urban poverty. • Review the draft urban sector development policy and realign it to achieve urban poverty outcomes. • LGD to review the recent urban poverty analysis by the sixth FYP (2011-2015) and take corrective measures in cities where the incidence of poverty is high. • Take stock of all public agencies across different Ministries involved in urban development programmes and ensure coherence and consistency for gains in urban health outcomes.	Continuous
4. Achieving National Population Policy goals and targets.	– Greater attention to remove the mismatch of supply of needed materials in those urban areas where the rate of population growth is high. – Special and more focused efforts to strengthen service delivery in partnership with NGOs.	• DGHS and DGFW to take special care in supply and demand side management. • More attention to underserved urban areas based on available studies. • Increasing coverage of FP services with more emphasis in urban slum. • Intensify FP services in urban area by establishing a strong monitoring mechanism. • Intensify supply of FP materials at ward level through community workers in partnership with NGOs. • Establishing a good referral system. • Mapping of urban slum. • Service centers with service provider in each slum for LAPM service. • Duplication of service should be avoided in each slum.	2016 and Continuous

Objective	Strategy	Implementation modalities	Time-frame
5. Achieving national nutrition goals and targets based on available reports.	– GO-NGO-ULB partnership.	• Health care for those affected by severe malnutrition. • Promote good and functional nutritional practices. • Strengthen & ensure food safety. • Focus on the needs of the urban poor. • Increasing collaboration between the upcoming UPHCP-III and capacity building of ULBs private sector and NGOs. • NNP to cover urban areas, in particular, slums. • Intensify nutritional education using both traditional and modern methods with emphasis on food-based nutrition. • Ensure and expand social safety for the urban poor. • Strengthen monitoring and evaluations including surveillance.	2016 and Continuous
6. Adopting innovative service delivery programmes using modern technology, management policies and practices.	– LGD acting through ULBs and partner NGOs to take immediate steps as part of Digital Vision 2021 to focus on urban HPN service delivery programmes. – ULBs with more proactive support. – Adopting the flexible management practices of NGOs and their operative style.	• LGD to broaden the scope of Digital Vision 2021 instrumented by A 2 I programme by bringing urban PHC services delivery programmes under it. Referral system and computer services at PHC centres. • LGD to review the recruitment rules of ULBs to empower them to meet personnel shortages in their health and related units. • Simplify operative procedures supported by decentralization.	2021 and continuous
7. Improving institutional governance and capacity.	– LGD to establish and strengthen its cooperative alliances with all relevant Ministries/ agencies such as Ministry of Environment and Forest, Communications, Urban Development and Housing and Home affairs for more effective interaction to achieve desirable outcomes of urban health. – More effective ULB level coordination.	• LGD to review its interface with disparate bodies such as central government agencies (e.g. Urban Development Directorate, National Housing Authority, Public Work Directorate under Ministry of Works etc.) Special Purpose Authorities such as those responsible for water supply and sewerage (e.g. DWASA and CWASA), Dhaka Transport Coordination Board (DTCB) under Ministry of Communications and Development Authority such as Rajdhani Unayyan Kortipokkho (RAJUK), Chittagong Development Authority (CDA), Khulna Development Authority (KDA) and Rajshahi Development Authority (RDA) as these bodies are responsible for urban development in order to ensure growth of healthy cities. • The existing level of coordination by ULBs of the above agencies/ bodies be reviewed for more strengthening to obtain gains of urban health.	2016 and Continuous

Objective	Strategy	Implementation modalities	Time-frame
8. Financing and resource mobilization.	– Ensure separate budget allocation for continuity and expansion of ULB-NGO partnership. – Reorient the ULBs for more resource mobilization linking performance to local mobilization of resources. – Tap resources from private corporate bodies as part of fulfillment of their social responsibility. – Exploit opportunities for more support from development partners in short to medium term. – Transparency and accountability. – Monitoring, Evaluation and Supervision. – Strengthening PPP framework. – Availing opportunities for more investment in urban health by both NGOs and ULBs. – Examine feasibility to use funds from Municipal Development Board.	• LGD to take upfront action for separate budget to carry out HPN activities from FY 2012-2013 preferably from revenue part of the budget by making it a well-argued case for consideration and approval by the Ministry of Finance and/ or Planning Commission. • LGD to obtain more funds for investment in all relevant areas supportive of urban health. • LGD acting through ULBs to develop procedures and guidelines to ensure transparency and financial probity in the use of funds without limiting the flexibility of operations of ULBs and partner NGOs. • LGD to set up a separate wing for monitoring, evaluation and supervision of all urban development related activities that have a bearing on achieving positive outcome for urban health. • Similar action to strengthen monitoring, evaluation and supervision by ULBs. • Establish and strengthen urban health related management information system (HMIS) with linkage to HMIS of DGHS. • LGD to review the existing PPP framework, identify its strength, weakness, opportunities and threats to fully exploit the achievable gains for urban health. • LGD to establish linkages with the NGO-Private Sector Unit (NPSU) proposed to be established by MOHFW through its own separate wing for HMIS. • LGD to take initiatives for obtaining funds under the current framework of policy and Strategy publicly gazetted by Prime Minister's Office in 2010. • Review and update proposals from interested NGOs/ ULBs for approval by MOF for PPP funding support. • Hold discussions with Municipal Development Board for obtaining funds based on their existing framework and procedures.	2012 and continuous
9. Sustainability	– Ensuring sustainability of urban health programme based on PPP and other programmes.	• Apart from stable flow of funds necessary for sustainability, LGD to establish a permanent consultative structure that ensures bi-annual consultations with partner NGOs, private sector and health governance think tanks to capture further opportunities for sustained delivery of quality services in all areas connected with urban health to be reinforced by relevant non-health sources. • Put in place a functional coordinative structure involving MOHFW and LGD and other related ministries. • Consolidating coordinative mechanism across Ministries dealing with cross-cutting themes. • Greater decentralization of authority. • Building up more effective alliances with the NGOs, private sector, business academia and other relevant non-state actors. • Capacity building at LGD, NGO, private sector and ULB levels.	2016 and Continuous

Annexe-I

TERMS OF REFERENCE

Project: TA – 7490 (BAN): Second Urban Primary Health Care Project

Expertise: Urban Health Strategy Expert (National)

Period of Engagement: 60 days (intermittent) June 6, 2011 – September 7, 2011

Objective/ Scope of Work: The consultant will assist the Ministry of Health and Family Welfare (MOHFW) and Ministry of Local Government and Rural Development (MOLGRD), Local Government Division (LGD) and the Second Urban Primary Health Care Project (UPHCPII) to develop the National Urban Health Strategy.

Detailed Tasks:

1. Develop **final draft of the National Urban Health Strategy** based on the following:
   (i) Preliminary draft of the Urban Health Strategy prepared by previous national expert, taking into account subsequent comments on the draft by LGD and development partners.
   (ii) Literature review of key relevant documents to inform key issues/ approaches to urban health, including (i) key national documents (e.g. PRSP, Strategic document for HPNSDP, relevant ordinances of MOLGRD and HPSP); (ii) UPHCP-II reviews/ reports/ studies, (iii) reviews/ reports of other major urban health Programmes (e.g. Smiling Sun Franchise Programme, Manoshi, Concern Worldwide), as well as global examples/ strategies; and (iv) relevant national surveys.
   (iii) Consultative meetings with stakeholders, including (i) key government officials from the MOHFW and MOLGRD; (ii) UPHCP co-financing partners; and (iii) other relevant Development Partners including the health consortium chair.
   (iv) Stakeholder feedback/ inputs on the draft strategy from series of sub-national consultation workshops to be arranged in 6 city corporations (including Dhaka) and selected municipalities.
2. The Consultant shall have the following responsibilities with regard to the conduct of the **sub-national consultations** (to be conducted during early June 2011 at latest):
   (i) The Consultant will assist PMU of UPHCP-II to design and organize the workshop session.
   (ii) The Consultant will take note or major responses of participants in the workshop. The detail recording or noting will be done by reporters/ facilitator to be engaged by the PMU/ UPHCP-II.
   (iii) Based on the above, the consultant will summarize the key issues for incorporation in the strategy.
   (iv) Prepare a discussion paper for a national level meeting involving senior government functionaries, primary health experts for finalization of the strategy paper based on their key responses.
3. **Finalize the National Urban Health Strategy**: Prepare a **high-level national meeting** involving senior Government officials to endorse the major recommendations of the draft Strategy. The document may be finalized after incorporating the comments of the finalization workshop.

   Output/ Reporting Requirements: Within 1 week of mobilization, the Consultant will submit a workflow plan/ Gantt Chart of key activities, time-bound to complete the above tasks. Within 6 weeks of mobilization, the Consultant will have prepared a well-consulted draft final document of the Strategy for high-level endorsement at a national level. The Consultant will also be required for provide periodic updates to UPHCPII co-financing partners throughout the assignment period.

An appraisal of preliminary draft of national urban health strategy

The draft was prepared in May 2011. By all accounts, it is a sketchy paper that could not adequately analyze the range of issues involved. It is structured into several parts such as

- Introduction
- Situation, responsibility and existing service delivery in urban areas
- Challenges
- Vision, mission, goals and objectives
- Urban health strategies
- Review and updating the strategy
- Multi-sectoral collaboration
- Way forward and
- Conclusion

In the introductory part, urbanization process in global context has not been analysed. The need for an urban health strategy in not analyzed. The analysis on the responsibility of urban health is weak and insufficient. In the section relating to existing service delivery provision Urban Primary Health Care Project, its background, objectives and lessons learnt are not analysed. The number of contracted and other programmes funded by development partners (DPs) which are country-wide is not analysed in the context of urban health care. The policy-framework of the government as articulated in previous and current five year plans are absent. Thus the absence of National Urban Health Strategy is noted in the part related to challenges but lacks depth of analytical framework. The lack of clear role between the MOHFW and Local Government Division ends with just one sentence. This tendency runs through other sections such as institutional, social and contextual. These are more in the nature of constraints and/ or gaps than challenges.

The section dealing with vision, mission, goals and objectives are conched in standard jargons without focusing on relevant policy articulated in various key documents of the government and the development partners.

Contd.

Next comes the core part of the strategy. It begins with the need for developing urban health strategy through a consultative process with all relevant stakeholders. This in fact is the primary responsibility of the framers of such a strategy document. It speaks of the need for a national level steering committee without mentioning if there is already one such committee. It also suggests forming of health committees in each urban area without details. Further, whether the existing standing committees of Urban Local Bodies (ULB) on public health would be helpful is not mentioned.

It recommends entrusting the ULB, with the roles and responsibilities of urban health delivery although these are already mandated with the task. The whole section on the strategy suffers from lack of clarity and focus on the need and nature of health care among disparate classes of urban population. Key strategic interventions and policy framework are not mentioned.

The section relating to review and updating the strategy is too sketchy and lacks focus. In the section relating to multi sectoral collaboration, nothing is said about the existing state of things, the gaps and inadequacies and how to achieve greater and more strengthened collaboration.

Finally in the section titled way forward, the author of the previous strategy paper admits that short and succinct strategies have been proposed many of which would require unpacking into details to develop plan of action. It is also admitted that due to time constraints and busy schedule of relevant stakeholders, it has been prepared based on document review and consultation with a minimum number of stakeholders. It emphasized further reality check and ownership. The need for a revised strategy document was also emphasized by the previous author.

It is possible to say that had the previous author taken pains to study the past and exiting national level key documents, much of the gaps could be filled up. For instance, the past five year plans, the existing PRSP and the draft sixth five year plan, Bangladesh Urban Health Survey (2006) and other relevant project documents. The list of limited number of documents is not mentioned at all institutions/persons consulted do not form part of the report.

Available documents suggest that a meeting of co-financing agencies of UPCHP-II was held on March 22, 2011 to make an assessment of the work. Minutes of the meeting show that “everyone present expressed unhappiness with the draft submitted by the previous expert”. They were of the view that the previous expert did not dedicate necessary time and effort compared to his earlier works or deliberations on March 8 meeting. The next step was to find a new expert for preparing the draft.

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Subsequent comments by development partners and LGD

Development partners

The appraisal made by development partners appears to be negative. Many gaps and inadequacies were pointed out. These are as follows:

- The flavour of strategy is missing in the document.
- Strategy should be time bound. So duration should be mentioned.
- In the current situation of urban health should include: an overview of urban population with client segmentation, current health situation of each segment based on specific health issues such as maternal & neonatal health, water and sanitation, child health, HIV etc. Throughout the whole document there is nothing mentioned about RH, maternal & neonatal health.
- Gaps should be identified in different segments/ target groups and priority areas to be addressed.
- Rationale/ justification of developing the UHS are important.
- Constraints and challenges based on the consultation workshop findings should be included in addition to literature review.
- Proposed goal: To ensure quality and equitable health care for all urban citizens particularly urban poor in Bangladesh by improving access to and utilization of health, population and nutrition information and services.
- Proposed strategies: should be based on different issues/headlines for different target group focusing on the need and gaps identified in the situation analysis. Heading can be; BCC strategies, Strategies for capacity building, strategies for coordination and partnership, effective referral, strategies for urban poor/ slum population etc.
- Strategies for safety net for the urban poor.
- Strategies to ensure access in terms of physical, financial and availability of PHC.
- Different strategies for different target group are needed.
- A chapter on M&E framework needs to be included.

The above comments of United Nations Population Fund (UNFPA) Dhaka office clearly point out the major inadequacies of the previous draft.

Annex-III

WORKSHOP ON URBAN HEALTH STRATEGY

Participants' List

Sl. No.	Name of City Corporations/ Municipality	Date of Workshop	Venue	No. of Partici-pants
1.	Rajhshahi City Corporation	19.6.2011	RCC Conference Hall	56
2.	Chittagong City Corporation	22.6.2011	Theatre Institute, Chittagong	64
3.	Khulna City Corporation	14.7.2011	Shahid Altaf Auditorium, Nagar Bhaban, Khulna.	70
4.	Sylhet City Corporation	19.7.2011	City Corporation Meeting Room, Sylhet.	86
5.	Dhaka City Corporation	14.09.2011	City Corporation Conference Room, Dhaka.	81
6.	Mymensing Municipality *	31.7.2011	Zilla Parishad Auditorium (VIP), Mymensing.	57
7.	Rangpur Municipality **	21.8.2011	Begum Rokeya Auditorium, RDRS, Rangpur.	64
8.	National Workshop	11.10.2011	Bollroom of Hotel Rupashi Bangla, Dhaka	151
			Total:	**629**

* Municipality being considered to be one of the future City Corporation.

** Municipality selected to be upgraded to City Corporation.

Note: The participants were divided into 4 groups namely 1. User group, 2. Elected officials (Councilors), 3. Doctors, Govt. & Private officials and 4. Civil Society for group discussion in the City Corporations and Municipalities. The groups made their recommendations which were taken into consideration. In the National Workshop participants included top level government policy makers, development partners and health experts. All present at the National Workshop expressed their views.

Summary of the recommended measures emerging from workshops of ULBs

A. Service provisions

1. Supply chain management for HPN to be improved.
2. More structured and effective referral system to be put in place.
3. Working hours for centres should be increased and flexible to meet the needs of clients, in particular the urban poor.
4. Strengthening of nutrition programme is necessary.
5. School health service to be introduced.
6. Free health service for all to be ensured.
7. Address health issues arising out of occupational hazards.
8. Intensify publicity drives for information on health services.
9. Undertake and intensify HPN awareness programmes.
10. Health insurance for the all to be introduced.
11. Voucher scheme for expecting mother to be introduced.
12. Effective awareness-building for environment to be mounted.
13. Social awareness for HIV/AIDS, STD is needed.
14. Preventive health care to be emphasized.
15. Ensure availability of health care for road accidents, snakebite and drowning.
16. Social safety net programme to be introduced.
17. Urban health survey is needed.
18. Citizen’s charter for health to be introduced.
19. Introduce voluntary service by trained private practitioners and motivate.
20. Combat effect of drug abuse.
21. Assurance of quality health service to be ensured.
22. Ensure effective participation of civil society to prevent environment pollution.
23. Continue and further expand partnership arrangement for HPN service delivery in ULBs.

Contd.

24. Introduce nutrition programmes in pre-school and school stages.
25. Ensure service delivery for the handicapped.
26. Prevent noise pollution.
27. Ensure proper planning of HPN services based on reliable field level data.
28. Address adolescent health issues.
29. Intensify campaign for reduction of early marriage for community areas.
30. Health and rehabilitative care for the aged.

B. Cross-cutting issues

1. Supply of safe drinking water to be ensured.
2. Strengthening of sewerage system is needed.
3. Sanitation facilities to be improved.
4. Set up central waste management centre in ULBs.
5. Protect water bodies in and around ULBs.
6. Ensure effective medical waste management.
7. Increase the number of parks, playgrounds and gardens in ULBs.
8. Protect foot paths and make them user-friendly.

C. Institutional issues

1. LGD to implement urban health care with technical support from MOHFW.
2. More effective coordination for HPN.
3. Need for more effective programme coordination of NGOs by ULBs.
4. Coordinative role for the Chief Health Officer of ULBs for ULB doctor to be established.
5. Reduce and eradicate use of quacks.
6. Effective coordination between MOHFW and MOLGRDC to be established.
7. Separate policy for urban areas needed.
8. PHC service to be fully under LGD.
9. Set up a health wing in LGD.

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10. Define more clearly the respective rules of MOHFW and LGD for urban health.
11. Periodic interaction with ward commissioners.
12. Holding periodic meetings with users.
13. Coordination of health service providers at City Corporations/Municipalities under the leadership of the Mayor including ward level coordination.
14. Better coordination among health professional personnel needed.

D. Human resource development

1. PHC centres to be adequately equipped with requisite number of personnel.
2. Training facilities to be improved.
3. Recruit and use volunteers with limited honorarium.
4. Effective and responsible manpower management be introduced in all ULBs.

E. Pro-poor service delivery

1. Pro-poor service to continue.
2. More focus on the poor to be ensured.

F. Finance

1. Create protected fund for urban health care.
2. Financial package of incentives for service providers to be improved.

G. Infrastructure

1. Increase the infrastructure facilities for PHC.
2. Ensure adequacy of ambulance service.
3. Establish in urban areas more general hospitals modeled on Upazila Health Complex.
4. Expand secondary level hospital with 50-bed in ULBs.

Draft Notification for constitution of Apex HPN sector management by Urban Local Bodies

The government is pleased to constitute an Urban Health Population and Nutrition Management Committee as follows:

Mayor (City Corporations and Paurashavas) in their respective jurisdiction Chairman.

2. Members

1. Chairperson, Standing Committee for Health/Environment
2. Civil Surgeon
3. Chief Health Officer (in case of Paurashavas if available).
4. DY Director Family Planning or his representative in case of Paurashavas outside main district town.
5. Two representatives of NGO operating in the area of Health.
6. Two NGO representatives of Family Welfare operating in the area.
7. Two leading tax payers to be nominated by the Mayor or tax payers' association if available.
8. Chief Revenue Officer (In case Paurashavas, Revenue Officer).
9. Two representatives from user group to be nominated by the Mayor (This would be on rotation basis).

The Committee shall have the power to co opt members as necessary.

3. Terms of reference (TOR)

a. Review the progress of work of HPN activities by different service providers public, private and NGOs;

b. Provide necessary guidance and directions to all service provides whenever necessary;

c. Take prompt action to remove difficulties of service delivery;

4. The Committee will meet once in three months or more frequently if required.

Allocations of functions to the
Ministry of Health and Family Welfare

1. Policy regarding Health and Family Planning.
2. International aspects of medical facilities and public health, international sanitary regulations, port health, health and medical facilities abroad.
3. Education, Training and Research on Medical nursing, dental, pharmaceutical, Para-medical and allied subjects.
4. Standardisation and manufacture of biological and pharmaceutical products.
5. Standards for production, import and export of drugs.
6. Control and management of abandoned pharmaceutical concern.
7. Medical and health services including promotional, preventive, curative and rehabilitative aspects.
8. National/International Associations/bodies in medical and allied fields such as Red Crescent, TB. Association, Diabetic Association, BMRC, SMF, BNC, BCPS, BMDC, Pharmacy Council, Nutrition Council, Dhaka Shishu Hospital, National Medical Institute Hospital, BNSB and such other bodies receiving Government grants in aids.
9. Matters relating to:
    a) Public Health.
    b) Registration of births and deaths.
    c) Adulteration of foodstuffs and other goods relating to health.
    d) Control of epidemics and prevention of infectious and contagious diseases and quarantine isolation.
    e) Health insurance.
    f) Standardisation and quality control of food, water and other health related commodities.
    g) Prevention of smoke nuisances.
    h) Nutrition research, educational and nutritional deficiency diseases.

Contd.

10. Matters relating to:

a) Hospitals and dispensaries.

b) Lunacy and mental deficiency including place for reception or treatment of lunatics and mental deficient.

c) Regulations for medical professions and standard.

d) Administration of medical institutions and coordination and determination of standards in institutions for higher medical education or research.

11. Control of drugs.

12. Control of milk food.

13. Port quarantine (sea and air), seamens and marine hospital and hospital with post-quarantine facilities.

14. Port and airport health organisations.

15. Medical examination of seamen.

16. National Malaria Eradication Programme.

17. Malaria Control.

18. Sanitation of hospitals and dispensaries.

19. Scientific societies and associations pertaining to subjects dealt with in this Ministry.

20. Homoeopathy and indigenous systems of medicine.

21. Objectionable advertisements relating to drugs, medicines, milk food and tobacco.

22. Resettlement of demobilised medical and auxiliary medical personnel.

23. Expanded programme on Immunization.

24. Concession of medical attendance and treatment for Government servants other than (a) those in railway service, (b) those paid from defence services estimates and (c) officers governed by Medical Attendance Rules.

25. Medical examination and medical boards for civil services and those paid from Defence estimates excepting civilian services.

26. Sports and health resorts.

27. Countersigning of medical bills of the persons holding non profitable offices.

28. Reimbursement of customs duty on gifts of non-consumable medical stores received from abroad.

29. Preparation of schemes relating to family planning and their submission to the prime Minister or the Cabinet through Planning Commission.

30. Co-ordination and evaluation of all executive functions relating to projects and programmes.

Contd.

31. Motivation:

a) Preparation and development of publicity media to motivate people in family planning;

b) Organisation of publicity work at national and social levels;

c) Educational campaign in those matters.

32. Supply of aids:

a) Procurement, preservation and distribution of birth control materials;

b) Enlightening the people on the use of birth control materials;

c) Organisations for providing assistance in the matters of family planning through hospitals, health centres, maternity and child welfare centres.

33. Preparation and co-ordinations of activities relating to family planning through other Ministries/Divisions and offices.

34. Training in clinical and non-clinical matters on family planning.

35. Arrangement for research in family planning and utilisation of its results.

36. Survey, monitoring evalution and compilation of statistics of field activities in matters relating to family planning.

37. Activities relating to maternity and child health centres.

38. Administration of B.C.S (Health).

39. Administration of B.C.S (Family Planning).

40. Post mortem examination of dead bodies.

41. All matters relating to administration of morgues.

42. Secretariat administration including financial matters.

43. Administration and control of subordinate offices and organisations under this Ministry.

44. Liaison with International Organisations and matters relating to treaties and agreements with other countries and world bodies relating to subjects allotted to this Ministry.

45. All laws on subjects allotted to this Ministry.

46. Inquiries and statistics on any of the subjects allotted to this Ministry.

47. Fees in respect of any of the subjects allotted to this Ministry except fees taken in courts.

Allocation of functions to the
Ministry of Local Government, Rural Development and Cooperatives

A. Local Government Division:

1. Local Government.
2. Financing, regulation and inspection of authorities established for Local Government and Village Administration.
3. Rural police.
4. Burial and burial grounds; cremation and cremation grounds.
5. Pond and the prevention of cattle trespass.
6. Public Health Engineering.
7. Rural water supply, water and sewerage development.
8. All matters in respect of management of tank fisheries and other closed fisheries up to the area of 20 acres by the Upazila Parishads and other Local Bodies.
9. Inns and inn-keepers.
10. Public parks and arboriculture except in the areas which are under development authorities.
11. Works Programme.
12. Administration of B.C.S (Public Health Engineering.)
13. Secretariat administration including financial matters.
14. Administration and control of subordinate offices and organisations under this Division.
15. Liaison with International Organisations and matters relating to treaties and agreements with other countries and world bodies relating to subjects allotted to this Division.
16. All laws on subjects allotted to this Division.
17. Inquiries and statistics on any of the subjects allotted to this Division.
18. Fees in respect of any of the subjects allotted to this Division except fees taken in courts.

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B. Rural Development and Cooperatives Division:

1. Preparation of schemes and implementation of policies in the following sectors.
   a) Rural Development.
   b) Cooperative societies.
   c) Agricultural credit and cooperative banking.
   d) Cooperative marketing.
   e) Cooperative farming.
   f) Small-scale industries including cottage industries on cooperative basis.
   g) Debt settlement.
   h) Relief of indebtedness.
   i) Integrated Rural Development Programme.
   j) Production and employment Prograamme to the rural poor and launder on Cooperatives and Rural Development.
2. Training and education.
3. International Cooperative Union and alliances.
4. Administration of B.C.S (Cooperative).
5. Secretariat administration including financial matters.
6. Administration and control of subordinate offices and organisations under this Division.
7. Liaison with International Organisations and matters relating to treaties and agreements with other countries and world bodies relating to subjects allotted to this Division.
8. All laws on subjects allotted to this Division.
9. Inquiries and statistics on any of the subjects allotted to this Division.
10. Fees in respect of any of the subjects allotted to this Division except fees taken in courts.

Organizations and persons consulted

Organizations

1. Municipal Association of Bangladesh (MAB).
2. Asian Development Bank (ADB).
   United Nations Population Fund (UNFPA)
   Swedish International Development Agency (SIDA)
   Department for International Development (DFID)
   Orbis
3. BRAC, Manoshi
4. Marie Stopes International.
5. UPHCP personnel.
6. Institute of Health Economics, Dhaka University.
7. Directorate General of Health Services (DGHS).
8. Directorate General of Family Planning (DGFP).
9. Centre for Urban Studies (CUS).

Ministries/ Agencies

1. Secretary, Ministry of Health and Family Welfare (MOHFW).
2. Secretary, Local Government Division (LGD).
3. Joint Chief, MOHFW.
4. Consultant, MOHFW.
5. Commissioner, Rangpur Division.
6. Deputy Commissioners, Rajshahi, Chittagong, Sylhet, Khulna, Mymensing and Rangpur.
7. Project Director, NNP (now National Nutrition Service).

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