Working Paper No. 30

# Strengthening Planning and Coordination of Urban Health and Family Planning Services in Bangladesh

## Findings from an Intervention with Government and Non-government Organizations in Dhaka City

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ICDDR,B
CENTRE
FOR HEALTH AND
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# Foreword

I am pleased to release these reports on urban Maternal and Child Health and Family Planning issues which are based on the operations research activities of the MCH-FP Extension Project (Urban) of the Centre. Over the years, the Centre has acquired a unique expertise on urban development matters that ranges from operations research on reproductive health, child survival and environmental issues to providing technical assistance for capacity building to service delivery organizations working in urban areas.

This work has produced important findings on the health conditions and needs of city dwellers, particularly the poor and those living in slums. The research has also identified service delivery areas in which improvements need to be made to enhance effectiveness. Together, these research findings have been translated into interventions currently being applied in government and non-government settings.

In order to carry out this innovative work, the Centre has established a partnership effort known as the Urban MCH-FP Initiative, with different ministries and agencies of the Government of Bangladesh and national non-government organizations, notably Concerned Women for Family Planning, a national NGO with wide experience in the delivery of MCH-FP services. The partnership receives financial and technical support from the United States Agency for International Development (USAID).

The overall goal of the partnership is to contribute to the reduction of mortality and fertility in urban areas. In practice, this joint work has already resulted in the development and design of interventions to improve access, coordination and sustainability of quality basic health services to urban dwellers with emphasis on the needs of the poor and those living in slum areas.

The Centre looks forward to continuing this collaboration and to assist in the wider dissemination and application of sustainable service delivery strategies in collaboration with providers in government, the NGOs and the private sector.

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# Contents

## Executive Summary

This report describes the preliminary findings of an intervention to improve planning of urban health and family planning services and institutionalize coordination among basic health and family planning service providers in Dhaka City Corporation (DCC) Area. The intervention has been implemented by the **Urban MCH-FP Initiative** which is a partnership of government and non-government organizations (NGOs) and the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) for improving the urban health and family planning service delivery system.

The main objective of the intervention was to assess the feasibility and implications of establishing a local level planning process to improve the overall planning and coordination of health and family planning service providers in urban areas, such as DCC, Directorate of Family Planning (DFP), Directorate of Health Services (DHS), NGOs and commercial sector.

The key feature of this intervention was the **establishment of a structure for coordination** at the zonal and ward levels. The project facilitated formation of health and family planning coordination committees at the zonal and ward levels.

The coordination committees at the zonal level were found to be more effective as a coordinating forum for service providers and quickly became a ready-made forum to discuss and resolve common issues and problems. The government has already issued directives for nationwide implementation of the coordination process. Nevertheless, activities at the zonal level require the support from the city and even from the national level in terms of mandate , resources and feedback. Advocacy activities to ensure the involvement of NGOs at the zonal level must be carried out locally and also at the central level through donor organizations and bodies coordinating NGO activities.

Activities of the ward committees were also found to be effective specially in generation of local resources for solving local health issues. The ward committees have established linkages with the formal and informal community leaders and service providers for better planning and implementation of national and local health issues, e.g. implementation of National Immunization Days, providing space for satellite clinics and local initiatives in garbage cleaning.

The Ward Commissioners have commitment to their constituency, and take interest at the ward-level activities which may be considered the key to the success of the ward committees. However, continuous follow up and technical assistance by the facilitating organizations are a pre-requisite to organizing activities at the ward level.

According to the charter, the Health Department of DCC has a mandate to provide continuous support and guidance to the zonal and ward committees in planning and implementation of public health activities. A routine monitoring system at the DCC level must be developed and installed to monitor the zonal/ward-level activities.

# I. Introduction

This report contains the preliminary findings of an intervention to assess the feasibility and implications of establishing a mechanism to improve planning and coordination of basic health and family planning services in Dhaka city. The intervention is part of the **Urban MCH-FP Initiative.** The Initiative is a partnership among the service providers, involving government and non-government organizations that work toward the reduction of fertility and mortality in urban areas through the improvement of the urban health and family planning service delivery system. The Government of Bangladesh (GOB) partners of the initiative are the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) and the Ministry of Health and Family Welfare (MOHFW), including the Directorate of Family Planning (DFP), Directorate of Health Services (DHS) and Dhaka City Corporation (DCC). Whereas the primary non-government partners are Concerned Women for Family Planning, BASICS, Bangladesh and AVSC, Bangladesh. As a key partner of the Initiative, the Urban MCH-FP Extension Project (UEP) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) assisted the partners through applied research and technical assistance in the design and implementation of the elements and the dissemination of lessons learned from the Initiative and in the formulation of appropriate urban health policies.

# II. Background

The rapid urbanization experienced by developing countries in recent years is challenging the capacity of these countries to provide basic services to their growing urban population.

Until recently, Bangladesh was almost entirely rural. In 1961, about 95 % of the population lived in the rural areas (Arifeen and Mookherji, An

Assessment of Program Needs in Zone 3 of Dhaka city, UEP, 1995). At the time of the country's Independence in 1971, only 8% of the population were urban (World Bank , World Development Report, 1994). The last census (1991) shows that, 23% of the country's population live in the urban areas (UEP, 1995).

The growth of the urban population seems to be primarily a result of rural to urban migration. Cities are growing at a rate of 6-7% per annum which is three times as fast as the national growth of about 2% per year (UEP '95). It has been projected that by the year 2010 one-third (over 55 million) of the population of the country will be living in cities ( UEP, 1995). The problems associated with this rapid, unplanned urban growth seem to be greater in Dhaka, the capital of the country, and are likely to get worse unless corrective actions are taken. The most obvious outcome of this urban growth has been the dramatic increase in the number of people living in unhealthy settlements without any basic services. The figure available from Dhaka city indicates that about 19.8% of the urban population live in slums (UPRP-CUS survey, 1996).

Conditions in cities often appear to be better than in the rest of the country. It is evident that the immunization rates and family planning acceptance, for instance, are better in urban areas than in the rest of Bangladesh. Results of research carried out by ICDDR,B over the years on health and sociodemographic conditions in several areas of Dhaka city, have consistently shown that there are significant differences in health conditions, awareness of available services, health knowledge, and use of services between the slum and non-slum city dwellers (USS, 1991, Baqui, 1993, Thwin et al,1996, Laston et al, 1992, Quaiyum et al, 1996, Arifeen and Mookherji, 1995).

**Service delivery system in urban areas**

In terms of primary health-care services, the main provider of western health care and modern family planning services in rural areas of Bangladesh are the agencies of the Ministry of Health and Family Welfare. Over the years, these agencies have established a well-defined **rural system** for service delivery that functions through visits of specialized government field workers to households; through outreach sites for immunization, and satellite clinics for MCH-FP service delivery; and through static service-delivery centres, such as Health and Family Welfare Centres located in almost each and every union of the country. A few number of Rural Dispensaries located at the union level also function as community -level facilities. In rural areas, community-level facilities link up to government hospitals at the thana level and district level for specialized curative care. There are clear definitions of responsibilities: for family planning, each field worker is employed in her own area of residence and provides services to 5000 - 6000 population in a defined geographical unit. At the same time, each union (population 15,000-20,000) is served by a certain number of satellite clinics and has a government Health and Family Welfare Centre with one male and one female paramedics. The Directorate of Health Services has Health Assistants administering services like vaccination, vitamin A supplementation, health education etc at the union level; and they function as a referral chain to Thana Health Complexes and District Hospitals. The situation in urban areas is different. Although urban health matters are the responsibility of municipal authorities, a variety of government and non-government voluntary organizations (NGOs) and commercial sector provide services in urban areas. The organizations include: Municipal Health Department, two wings of MOHFW, such as Directorate of Health services (DHS) and Directorate of Family Planning, NGOs, and the commercial sector. The government sector, including Municipal Health Department and NGOs, concentrates on curative, preventive and promotive health care, while the commercial sector

concentrates mainly on curative health care. Sometimes, the commercial sector provides other essential services, such as pregnancy care and family planning supplies ( Mazumder and Tunon et al , 1996). The commercial sector comprises western and non-western sources of care: traditional healers, TBAs, pharmacies, private doctors, clinics, nursing homes and hospitals. The government and NGOs are financed either by the government or by national and international donations and need to be regarded as a "subsidized sector" in which services are provided either free of charge or at nominal charges.

The existence of multiple sources of western care offers the element of choice to those who can afford it. But in the subsidized sector, this multiplicity of providers - without appropriate **coordination** can also result in differential levels of quality of care, limited referrals among the providers, gaps and overlaps in coverage, as well as wastage of resources. Since the poor are likely to be more dependent on the subsidized sector, the lack of coordination could have greater consequences on the capacity of the poor to access essential clinical services.

Results of the needs assessment studies, conducted in Zone 3 of Dhaka city, show that there are 52 health and family planning facilities in Zone 3 alone. Most of them are clustered working in the same area often providing the same services with different service charges with very little coordination and referral among them. The lack of coordination and limited referral among the service providers results in gaps and overlaps in coverage, as well as under use of available resources. The study showed that (map, annex -2) in Ward 65, there is a Community Centre, where there is a dispensary and a EPI centre run by DCC and there is a MCH-FP Centre run by DFP. Although these providers work in the same premises, they don't know each other. In Ward 60, there are three MCH-FP Centres in an area run by three different organizations. All these centres are located within half a mile which creates overlapping. In Ward 58 there are two MCH-FP Centres run by two different organizations in the same premises.

In contrast, there is no MCH-FP service-delivery facilities in Ward 59, 61 and 64. Clients are not even aware of the services available at these facilities. A review of clients visiting facilities that provide both FP and EPI revealed that:

About 25% of the clients visiting for non -FP reasons were unaware that FP services were available in those facilities;

About 20% of the clients who brought their children for non-EPI reasons were unaware that EPI was available in that facility;

The above situation referred to the lack of coordination and limited referral among the service providers which results in gaps and overlaps in coverage as well as under utilization of available resources. This situation underscored the need for establishing functional coordination among the service providers at the direct care level, ie, at the zonal and ward levels.

**Dhaka City Corporation**

The Dhaka City Corporation, the largest city corporation in the country has a population of 5.15 million (estimated from 1991 census), and comprises approximately 20% of the urban population of the country (25 million), with an estimated slum population of 20% living below the poverty line. About 38% of the city population living in both the slum and non-slum areas have been projected as the poor population. The Corporation has 17 departments, including a Health Department headed by a Chief Health Officer who is responsible for ensuring as many as 18 public health services to the city dwellers. However, the current focus of Health Department on public health services is as follows:

Public health responsibilities of the Dhaka City Corporation and current focus

| Assigned function | Routine | Occasional | No emphasis |
|---|---|---|---|
| Preventive health | 1. EPI<br>2. Sanitation<br>3. Food safety<br>4. Birth and death registration | 1. Control of insanitary buildings<br>2. Prevention and control of infectious diseases | 1. Ensuring family planning and child welfare services<br>2. Medical inspection of school children<br>3. Health education |
| Curative health | 1. Establish and maintain hospitals and dispensaries | 1. Provide medical relief services | 1. Payment of grant to institutions for medical relief |
| Vector control | 1. Control vector and destroy breeding sources | | |
| Veterinary services | 1. Ensure safe meat | 1. Stop unauthorized slaughtering of animals<br>2. Control of street dogs and stray animals<br>3. Control of unauthorized farming | |
| Environment control | | 1. Prevention and control of dangerous and offensive articles and trades, etc. | |

DCC consists of 90 Wards, divided into 10 administrative zones. Each zone is headed by a Zonal Executive Officer (ZEO), who is primarily responsible for the implementation of development and maintenance works of the zone. There is a health section in each zone headed by a medical doctor, designated as Assistant Health Officer (AHO), who is

responsible for planning, implementing and monitoring public health activities at the zonal level.

## III. Objective of the Intervention

The objective of the intervention was to assess the feasibility and implications of establishing a local- level planning process to improve overall planning and coordination of health and family planning service providers in urban areas.

## IV. Methodology

This was a time series type of operations research study. There was no comparison area. Post - intervention observations and experiences have been documented and compared with pre- intervention information. The study used data from various sources. The first stage of data collection pre-intervention information included an inventory of zonal health offices, official files and records. The second stage of data collection post-intervention information included review of meeting minutes, organization of workshops for committee members and DCC health staff members and survey on members of zonal committees and observation by the UEP staff members through participation in meetings and regular activities of the DCC health offices.

## V. Description of the Intervention

Based on the findings of the needs assessment study conducted by the Project in 1994, the Project designed the intervention " Planning and Coordination of Services" with a view to develop mechanisms for local-level planning and for effective coordination among the health and family planning service providers (Directorate of FP, Directorate of Health Services, DCC, NGOs and commercial sector organizations) at the zonal and ward levels.

The key feature of the intervention was the establishment of Health and FP Coordination Committees at the zonal and ward levels. The zonal committees were designed to meet every alternative month and coordinate activities of different service providers at the zonal level. The zonal committees were also responsible for developing and regularly reviewing an annual work plan of the zonal activities. The zonal committees would support implementation of the ward-level activities through the ward committees.

The ward committees were also designed to meet every alternative month and were to be responsible for local-level planning of health and family planning activities at the ward level. The ward committees were also supposed to be responsible for generating and mobilizing local resources for health and family planning activities. The zonal committees were seen as a forum for service providers, while the ward committees were the forum for community leaders and service providers.

As part of the capacity-building effort of DCC at the zonal and ward levels the Project organized a series of workshops, seminars and training programs for the DCC staff members. The first workshop was conducted for ZEOs and AHOs to orient them with the Project, as well as to identify their appropriate role as overseer in the planning and coordination process at the zonal and ward levels. A second workshop was conducted to identify the needs of the Health Department at DCC and zonal level that requires technical assistance to improve its capacity. The third workshops were conducted at the zonal level, one in each zone to develop annual zonal work plans of health and family planning activities. The UEP staff members routinely visited offices at the zonal and ward levels and provided continuous technical assistance in implementing the activities of the work plan. Two-day training was conducted for the supervisory staff members (EPI Supervisors) on how to gather information on health and family planning conditions at the zonal level and how to maintain and display these information. In addition, the UEP staff members visited the

zonal and ward offices and provided continuous assistance to prepare invitation lists, invitation letters, agenda for meetings, and writing minutes of meetings.

Parallel process of coordination was started at the policy and field levels. The Project envisioned the need for local-level coordination, but also realized that for the development of effective mechanisms and replication, an appropriate policy support would be needed. Keeping this in mind, the Project started policy dialogue with the top-level officials of both MOHFW and MOLGRDC and formed the Interministerial Urban PHC/EPI/FP Coordination Committee (IMC) in February 1995. The UEP presented the key findings of needs assessment studies in the IMC meeting held on February 22, 1995 and made a recommendation to formulate appropriate policy guidelines and provide support for establishing appropriate coordination at the DCC, zonal and ward levels. BASICS, Bangladesh also presented their experiences of implementing the urban EPI program and made similar recommendations. In this meeting, the IMC provided the structure and guidelines for Health and Family Planning Coordination Committees to be formed at the DCC, zonal and ward levels.

According to the Terms of Reference (TOR) provided by the IMC, these committees were responsible for coordinating the activities of different service providers, including GOB, NGOs and the commercial sectors in their assigned areas. Furthermore, the responsibilities included monitoring and providing guidance and technical assistance to the lower-level committees in issues related to local health and family planning. These committees were also responsible for establishing the planning process at the local level and also for generating resources. The UEP facilitated coordination among the service providers at the zonal level while with technical assistance from the UEP, major service providers of the ward facilitated coordination among the service providers and community leaders at the ward level.

The DCC Health and Family Planning Coordination Committee in a meeting held on April 17, 1995, instructed the ZEOs to form Health and Family Planning Coordination Committees at the zonal level by June 1995. The DCC committee requested the UEP to facilitate the formation of committees at the zonal level.

The first zonal committee was formed in Zone 3 on June 11, 1995. During the formation of the zonal committee in Zone 3, it became evident that it is not possible to form zonal coordination committees without detailed inventories of health and family planning service providers, including the services available in that zone. Because, all service providers of the zone have to be represented in the zonal committees to establish coordination among them. Based on the observation, the Project conducted an inventory of health and family planning facilities in all zones of DCC from July to September 1995 and simultaneously formed zonal committees in all zones.

Key indicators for monitoring and evaluating the intervention were:

1. Committees at the zonal and ward levels were established
2. TOR for these committees were formalized
3. 70% of the routine meetings of these committees were held as per schedule
4. 70% of the committee members participated in routine meetings as per schedule
5. 50% of the meetings included discussion on MCH-FP service delivery
6. 50% of the meeting decisions were implemented
7. 70% of the zonal and ward committees had their own work plans
8. 50% of the committee members were aware of the key issues of the work plan of their own committee.

According to these indicators, the results of the intervention so far achieved are furnished below:

| Indicator | Ward | | Zone | |
|---|---|---|---|---|
| | Target | Achievement | Target | Achievement |
| 1. Committees established | 20 | 35 | 10 | 10 |
| 2. TOR formalized | 20 | 35 | 10 | 10 |
| 3. Routine meetings held | 174 | 71 | 70 | 70 |
| 4. Committee members attended routine meetings | 70% | 90% | 70% | 62% |
| 5. Meetings had pre-set agenda and ended with some decisions | 50% | 100% | 50% | 100% |
| 6. Decisions of meetings implemented | 50% | 44% | 50% | 57% |
| 7. Committees have their work plans | 70% | - | 70% | 100% |
| 8. Committee members knew about the key issues of the work plans | *NA | *NA | 50% | 55% |

*NA: Not applicable, since no survey was done.

## VI. Intervention at the Zonal Level

During July-September 1995, the DCC established health and family planning coordination committees in other nine zones. During this period, the ZEOs invited all the service providers to a special meeting to discuss about the creation of a mechanism for coordination among the DCC, GOB, NGO, and private sector organizations delivering basic health and family planning services in the zone. DCC had no records of local organizations working in health care provision. The invitation list was prepared on the basis of an inventory of health and family planning facilities conducted by the UEP in Dhaka city. The UEP staff members assisted the ZEO in preparing the agenda, invitation lists and invitation letters. In addition, before the meeting, the UEP staff members had visited the major GOB and NGO service providers of the zone and briefed them on the objectives of the zonal committee and how the zonal committees will benefit the service providers. The UEP staff members also organized a half-day workshop to orient the DCC zonal officers on their expected role. The general intention was for DCC to act as a supportive coordinating body rather than as an overseer of service providers.

The local DCC officers accepted this role and their attitude, to some extent was reflected in the invitation letter issued by the local authority ( Annex 3).

The response of all service providers was enthusiastic, and the zonal committees were formed smoothly. The composition of the committee is shown in Box 1. Membership was open to representatives from government, NGOs and the commercial sector, as well as the community leaders. The committees are headed by the ZEOs, and the AHOs are the member secretaries. All local providers from NGOs and government agencies are members. In all ten zones, about 61 NGOs were included in the zonal committees. At the beginning, the local elected representatives, the ward commissioners, were listed as members of the

committees. The ward commissioners did not, however, accept the role very well. They thought that they were undermined. Consequently, their position in the committee was elevated as the advisor. The experience of Zone 3 in Dhaka City showed that since these are mechanisms for coordination among service providers, the best role for the ward commissioners is to act as advisors to the committees. This modality was later implemented in all zones.

**Box 1**

**COMPOSITION OF THE ZONAL COORDINATION COMMITTEES**

1. Chairperson — Zonal Executive Officer (ZEO)
2. Advisors — Local Ward Commissioners
3. Member-Secretary — Assistant Health Officer (AHO)
4. Members
   - Thana Family Planning Officer
   - Representative from the Civil Surgeon's office
   - Representative of local NGOs
   - Physicians from govt. dispensaries
   - Private sector representative
   - Local social activists
   - Representative from municipal health facilities

The Zonal Health and Family Planning Coordination Committees in all 10 zones have been formed to acknowledge that the coverage and effectiveness of existing resources, especially those delivering health and family planning services, can be enhanced by greater coordination among service providers.

Keeping this in mind all 10 zones held their first coordination committee meetings during October-November 1995. The zonal committees meet every two months.

During the first round of meetings, the committees agreed on their own TOR. Staff members of the UEP of ICDDR,B attended these initial meetings and facilitated a process to identify key areas of responsibility to be undertaken by the committee. These TOR were drawn with the understanding that they could be amended in the future. In general, the committees agreed on the TOR listed in Box 2.

**Box 2**

**TOR of the Zonal Committee**

1. Establish coordination among government, NGOs and private sector providers of health and family planning services within the zone.
2. Regularly review the content, distribution and use of existing primary health care services to determine areas of low coverage, gaps and overlapping wards and take appropriate steps to solve the problems.
3. Review existing zonal primary health-care resources to assess technical assistance needs.
4. Prepare a zonal work plan and review the progress twice a year.
5. Promote the establishment of ward-level coordination committees to foster community participation and local health promotion activities.
6. Establish information systems on local primary health services and needs.
7. Increase health education activities and institute mechanisms to address consumer queries on MCH-FP services.
8. The committee can co-opt members and include issues in the TOR based on the local requirements.

After the formation of the zonal committees, the Project introduced the concept of zonal work plans to make the zonal committees effective

and enable them to systematically tackle the local problems, as well as to establish a self-monitoring mechanism of their activities.

During November-December 1995, all the 10 zonal committees organized a half-day workshop to orient the zonal committee members on their expected role and to develop zonal work plans for the January- June 1996 period. The workshops were structured into briefing and working sessions. In the briefing session, the participants were briefed on the role and responsibilities of the zonal committees according to the TOR. They were also briefed on the process of work plan development and its importance as a tool for self-monitoring of activities. In the working session, the participants were divided into groups. Each group comprising 5-6 members and were asked to prepare a list of activities to be done by the zonal committee during the next one year. Later, they were provided with a format to write down the activities along with the time line and name of the member organization responsible for implementing the activities. The UEP staff members assisted the zonal committees in organizing and conducting these workshops. Assistance included the preparation of schedule, agenda, format for work plans and conduct the plenary and working sessions. In June 1996, the zonal committees reviewed implementation of their work plans and prepared subsequent work plans for the July 1996-June 1997 period.

**Box 3**

**Role of Committee Members**
(as defined by the participants at the Workshop for Action Plan Development)

1. Regularly attend and actively participate in the committee meetings.
2. Identify resources and expertise of individual organizations and share that with each other.
3. Identify local health-related problems and solve them through the zonal Health & FP coordination committee.
4. Submit copy of activities report of individual organization to the zonal committee (by first week of every month).
5. Each and every member organization should be treated equally. There should not be any differential treatment for big or small organizations.
6. Give importance to others work and opinions.

In the work plans, the committees distributed responsibilities for implementing activities of the work plans among the member organizations. The main activities included in the work plans prepared by the committees were to :

1. Hold regular coordination meetings every two months.

2. Organize promotional events locally, especifically:
   National Population Day
   National Immunization Days
   World Women's Day
   World Health Day

3. Establish zonal-level MIS for regular exchange of service statistics and information on health activities in the zone.

4. Maintain up to date information displays on zonal health and family planning conditions.

5. Promote the establishment of health and family planning coordination committees at the ward level.

6. Reorganize service-delivery outlets to increase access to services in slum and poor communities.

## VI. 1 Findings from monitoring and evaluation of zonal committees

Meetings and decisions of the committees

During October 1995-December 1996, each zonal health and family planning coordination committees met 10 times (seven routine bi-monthly meetings and three special meeting for NID) resulting in a total of 100 meetings at the zonal level. It may be mentioned here that, the UEP staff members contacted the ZEO and AHO ( chairperson and member-secretary of zonal committee) before each of these meetings and provided assistance for organizing these meetings. On an average 62% of the committee members attended these meetings. The table below categorically shows the attendance of major stake holders of urban health service delivery.

**Attendance of committee members in zonal committee meeting**

| Category | Total number of member | Average number of member attended routine meeting |
|---|---|---|
| DCC | 53 | 42 (79%) |
| NGO | 99 | 74 (74%) |
| GOB | 29 | 9 (31%) |
| Ward Commsioner (male and female) | 108 | 8 (7%) |

The data show that, among the stake holders, DCC and NGOs played a very significant role in the whole coordination process. The attendance of members from DCC and NGOs in the zonal committee meetings was 79% and 74% respectively while the attendance of GOB (DHS and DFP) officials was 31%. The experiences suggested that the increased attendance of GOB officials will require directives and follow up their respective department. The attendance of commercial sector was very negligible since it requires lot of extra efforts to ensure their attendance in the coordination meeting. It may require support from their professional association such as Bangladesh Medical Association (BMA), Bangladesh Private Clinic Owners Association etc. Future efforts to improve coordination must include the active involvement of commercial sector providers. There might be point for DCC to have high percentage of attendance, since most meetings were held at the DCC premises. But the attendance of NGOs shows their interest of participating in the coordination process. Since the attendance of NGO members was high in the zonal committee meetings, their awareness about the composition and purpose of zonal committee formation was also high (Jasim et.el, Perceptions and involvement of members of Zonal Health and Family Planning Coordination Committees in Dhaka). Ward commissioners were

found to be very regular in attending the ward committee meetings than those of the zonal committee. Because, ward is their immediate constituency and first place of interest.

All meetings of the zonal committees had a set agenda, and ended with some decisions on health and family planning activities at the zonal level. The study revealed that 57% of the decisions of the zonal committees were fully implemented, while 29% of the decisions were partially implemented.

**Implementation status of decisions of zonal committees**

| Fully implemented in all zones | Partially implemented in some zones | Not implemented as yet |
|---|---|---|
| 1. Organize routine meeting of the committee (two monthly) | 1. Reorganize service-delivery points ( done in two zones) | 1. Introduce referral system among service providers |
| 2. Review and accept the TOR | 2. Establish regular exchange of service statistics and information on health and family planning activities at the zonal level | 2. Update slum list of zones and focus health family planning activities for poor and slum dwellers |
| 3. Develop work plan for the committee | 3. Form ward committees ( done in 34 wards) | |
| 4. Participate in Measles and Neonatal Tetanus campaign | 4. Install incinerator for clinical waste disposal at zonal level (done in two zones) | |
| 5. Plan and implement National Immunization Days (NID) at the local level | | |
| 6. Strengthen promotional activities (Observance of National and International days) | | |
| 7. Train DCC staff on Health and FP MIS | | |
| 8. Display health and family planning information at zone offices | | |

Work plan

It was mentioned earlier that the concept of zonal work plans was introduced at the zonal level to establish some sort of self-monitoring of the zonal activities. After one year of introducing the work plans, the Project conducted a study to measure the level of involvement of the zonal committee members in the zonal-level activities. Result of the study showed that 55% of the committee members were found to be aware of the major activities included in the zonal work plans, and 58% of the committee members knew about the time line of the work plans. As of June 1996, 54% of the activities of the work plans have been implemented by the zonal committees (Jasim et.el. Perceptions and Involvement of members of Zonal Health and Family Planning Coordination Committees in Dhaka).

Resources at the zonal level

While working at the zonal level, it was observed that the Health Department of DCC has been lacking basic human and financial resources at the zonal level to carry out their assigned functions. There were serious shortage of manpower, since about 40% of the positions of health staff at the zonal level were vacant. The position of AHO, the key health person at the zonal level was vacant in four of the ten zones in the city. Physical working environment and space at offices of AHOs were poor in most zones of the city. Some AHOs did not have office space or any clerical support staff assigned to them. Only two AHOs had motorcycles. EPI Supervisors did not have secretarial support at the zonal level or transport to monitor the EPI activities and to communicate with the GOB/NGO service providers.

There was no fund for the zonal-level coordination activities. Based on the experiences of the Zonal Health and Family Planning Coordination Committees, DCC has agreed to put more resources and allocated a

special budget of Tk 60,000 (Tk 6,000/zone) for the zonal health offices for the financial year 1995-1996. These special funds have been added to facilitate the organization of coordination activities at the zonal level.

The city and zonal health offices do not have information on health and family planning needs and resources in the zone. Very little information is shared on MCH-FP conditions and resources at the zonal or city level.

## VII. Intervention at the Ward Level

Unlike the zonal health department the ward commissioner's office do not have any direct linkage with GOB and NGO health and family planning services. Traditionally, ward commissioners are routinely engaged in various development activities, like construction of roads, drainages, bazaars and community centres, street lighting, mosquito control, ensuring garbage disposal , management of local tribunals and other socio-cultural activities. Local health and family planning activities are not a priority to them. At the very beginning, the Project tried to orient ward commissioners with the importance of health and family planning activities at the community level and explain the benefit of their participation in the activities. Although the ward commissioners were made advisors to the zonal committees, their participation in the zonal-level activities was not found to be encouraging. But they were found to be comfortable in organizing activities at the ward level and can play a better role in his/her ward.

The Project initially concentrated on the coordination process at the zonal level and tried to gain reasonable experiences before proceeding to the ward level. The original intention was to establish a mechanism for the regular exchange of information among the service providers and to constitute the ward committees as an opportunity for local service

providers to meet and receive support from the community representatives. It was anticipated that defining the composition and functions of committees at the ward level would be much more complex than at the zonal level and that it had to be handled more cautiously. The elected representatives of the community, for example often belong to political parties and would have to be oriented very carefully to help them focus on health activities only.

Secondly, the ward commissioners are not accountable to the zonal authority. If the ward committees are headed by the ward commissioners, a question of the relation between the ward and zonal committee becomes a potential controversial issue.

Thirdly, there were doubts about the capacity of UEP to help establish and, later, continue facilitating and monitoring the intervention at the ward level by looking at the work of committees in ***all 90*** wards of the DCC area.

Nevertheless, all ward commissioners, who took part in the zonal meetings, expressed their interest to form the Health and Family Planning Coordination Committee in their wards and the major providers of the ward voluntarily agreed to form and facilitate the activities of the ward committees.

Considering the above factors, the zonal committees have included the formation of Ward Health and Family Planning Coordination Committees in their annual work plans for the July 1996-June 1997 period. The major service providers of the ward were assigned to communicate with the ward commissioner and other service providers of the ward and form the ward committees. The Ward Commissioners convened the meetings and invited all service providers and community leader social workers to attend. The UEP staff members assisted the assigned providers/facilitating organizations to organize the first meeting of the

ward. The assistance included briefing the Ward Commissioner, sharing and explaining the Local Government Division's circular, preparing the list of service providers, drafting the invitation letter, setting agenda, and drafting the minutes of the meeting.

Accordingly, the ward committees have been formed in 34 wards from July to August 1996 with a view to introduce a local-level planning process at the grassroots level and ensure participation of community leaders in the planning process for improving health and family planning conditions at the ward level. The expectation was that these committees will plan generation and use of local resources.

**Number of Ward Committees formed by zone**

| Zone | Number of wards | Number of wards formed committees | Assigned facilitating organization |
|---|---|---|---|
| 1 | 15 | 4 | Concerned Women for Family Planning (CWFP) |
| 2 | 11 | 7 | CWFP |
| 3 | 9 | 9 | CWFP-7, World Vision-1, Jatyo Torun Shangha-1 |
| 4 | 14 | 6 | Nari Moitree-2, FPAB-3, CHCP-1 |
| 5 | 9 | 2 | Manobik Shahajjo sangstha-1, Eskaton Modern Health Care-1 |
| 6 | 8 | - | |
| 7 | 8 | - | |
| 8 | 8 | 1 | Gono Shahajjo Sangstha |
| 9 | 7 | 5 | Unity Through Population Services (UTPS) |
| 10 | 1 | - | |
| Total | 90 | 34 | |

The composition and the TOR for the Ward Health and Family Planning Coordination Committee suggested by the Local Govt. Division of MOLGRDC are included in Box 4.

**Box 4**

**Composition of Ward H&FP Coordination Committee:**

| | | |
|---|---|---|
| 1. | Ward Commissioner | Chairman |
| 2. | Concerned Female Ward Commissioner | Member |
| 3. | Representative from local NGOs | " |
| 4. | Interested social worker | " |
| 5. | Representative from H&FP private sector | " |
| 6. | EPI Supervisor/ Vaccinator of CC/Municipalities | " |
| 7. | FPI/ FWA/ FWV/ HA/ AHI | " |
| 8. | Ward Secretary/ FBI/ FWV/ AHI/ NGO representative / EPI Supervisor/ Member-Secretary | |

**TOR for the Ward H&FP Coordination Committee:**

1. Coordinate H&FP activities at the ward level.
2. Plan MCH-FP program activities at the ward level, set monthly/annual target based on the available data, monitor, implement and evaluate program performance monthly/quarterly/annually.
3. Evaluate performance of field workers and praise/reward them for good work, and assist them to improve performance based on the need.
4. Plan and implement IEC activities to encourage people to participate in MCH-FP program activities. Organize health education session in local schools, clinics, and satellite clinics.
5. Take care of any side-effects or complication cases at the ward level through field workers. Refer the complicated cases to higher level immidialtely.
6. Maintain record of all births, deaths, in-and out-migration at the ward level through field workers.
7. Meet once a month on a fixed date. Prepare annual schedule of monthly meeting and follow that.
8. The committee can co-opt members and include issues in the TOR based on the local requirements.

The total number of members in a ward committee varies from 7 to 36. However, the average number of members per committee is 17. It is revealed from the review that about 65% of the ward committee members are social workers/community leaders, including 20% female members which reflects the wide enrollment of community representatives in the ward committees.

Generally, the ward committee meetings are held in the morning , members of the ward committees, especially the community leaders, expressed their opinion to organize meetings in the evening. Because, in the morning they remain busy with their occupational business. Meeting time in the evening does not match with the working hour of service providers. They need to adjust their time with the community needs.

## VII.1 Findings from the monitoring and evaluation of ward committees

Meetings and decisions of ward committees

During August 1996-February 1997, 34 ward committees organized 71 meetings (174 planned ). Organization of routine meetings at the ward level was found to be difficult than at the zonal level. About 90% of the committee members attended these meetings. The Ward Commissioners being the formal leader of the community as well as the chair of the ward committee have lot of unscheduled commitment, resulting in repeated rescheduling of the meetings at the ward level. It may be mentioned here that the major service provider of the ward who is also the member-secretary of the ward committees organized these meetings with the help of ward commissioners which might be reason for high turn-over of ward committee members in the routine meeting. All these meetings had pre-set agenda and had some discussion and decisions on the local health and family planning issues. These 34 committees in its 71 meetings have taken as many as 79 decisions, and as of February 1997, of which 39 decisions (44%) have been implemented. The major decisions implemented are:

- Ward Commissioner provided refrigerator for CWFP clinic in Ward 81;
- Ward Commissioner of Ward 65 provided fund to build a house for satellite clinic;
- CWFP established a satellite clinic at DCC hospital in Ward 64;
- Local garbage collection system through rickshaw vans introduced in Ward 48;
- Circulated leaflets to local hotels and restaurants to ensue pure drinking water to the consumers in Ward 48;
- Tanneries were requested not to dump waste water to surface drains in Ward 48;
- Reorganized working area of GOB and NGO field workers in Ward 65 to avoid duplication;
- Arranged miking for NID, and also used mike of local mosque for NID in Ward 67, 68, 70, 73, 74, 79, 80, 81, 82, and 83 ;
- Printed leaflet for NID and provided lunch to volunteers working for NID in Ward 67, 68, 70, 73, 74, 79, 80, 81, 82, and 83 ;
- Publicity of NID done by local video channels in Ward 65

Implementation of these decisions reflects the mobilization of community and generation and use of local resources by the ward committees for solving the local health issues. Resource generation at the ward level is easier than the zonal level, since it has no bureaucratic complications.

It may be mentioned here that the concept of work plan preparation has not yet been implemented at the ward level.

Prominent role

NGOs played a key role in the ward committees, because most NGOs which are the members of the zonal committees, are the member-secretary of the ward committees. It can be summarized from the above

discussion that NGOs and DCC representatives played the most significant role in the zonal and ward committees, since NGOs needed coordination and collaboration with other organizations for making their services more accessible to the people, while DCC has the mandate to ensure health and family planning services to its city dwellers.

The service providers can not influence the decision-making process of the ward committees since 65% of the committee members are community leaders/ social workers who influence the decision-making process by bringing in the local issues, like water, sanitation, and environment, as a priority issue for the ward committee, although these are the less-priority to the facilitating organizations those who only deal with health and family planning issues. This is indeed a good sign, since this indicates that involvement of community representatives in the planning process always focuses on their real need.

Monitoring of ward committee activities

Committees at the ward level may not be monitored by the zonal committees, since the ward commissioners are not accountable to the zonal authority. This is a problem particularly to Dhaka city, because only Dhaka city has zone systems. This should not be a problem for other cities. However, the zonal committees can review reports and minutes of the ward committees and provide technical guidance and logistic support to the ward committees in planning and implementing its health activities. Activities of the ward committees may be monitored by the DCC Health and Family Planning Coordination Committee headed by the honorable Mayor. But the committee has not yet been formed.

## VIII. Discussion

Coordination is a process by which multiple organizations share their experiences and responsibilities and work together with a set of guidelines to achieve common objectives. The experience says that the process has to be started paralelly from the top and bottom level. At the beginning, the Interministerial Committee of MOHFW and Local Government Division of MOLGRDC reached a consensus to form a Health and Family Planning Coordination Committee at the DCC/Municipal, zonal and ward levels headed by DCC/Municipal representatives. But the MOHFW and Local Government Division needed comments and suggestions from the lower level for issuing directives and guidelines for committee formation. So, some of the zonal committees were formed on a trial basis before the directives were issued and provided feedback to the national level for issuing the directives and guidelines. In this respect, UEP facilitated the formation of committees and feedback process. So, the role of an external facilitating agency was found to be critical. However, in the process of forming zonal and ward committees, it was necessary in some cases, to show the minutes of the Interministerial Committee meeting or the circular issued by Local Government Division to convince the zonal and ward-level people to form committees at respective levels. However, the directives from the top always require clearer definition of responsibilities, role and functions of administrators, providers, and policy makers at various levels of collaborating agencies.

Although there were both human and financial resource constraints, the zonal committees were found to be very effective to help improve planning and coordination at the zonal level. The zonal committees become a ready-made forum to plan and implement national and local health activities. All 10 zonal committees successfully planned and implemented NIDs and Measles and Neonatal Tetanus Campaign at the zonal level. Zone 7 and 8 installed low-cost incinerator to dispose clinical waste. Zone 3 and 8 reorganized health and family planning service

facilities to make them more accessible for urban poor and slum dwellers. The zonal committees developed annual zonal work plans and established a self-monitoring system of zonal activities. These committees also established a mechanism for the regular exchange of service statistics and information on health and family planning activities at the zonal level.

The coordination among service providers at the zonal level was found to be the issue of mutual interest. The interest of DCC is to ensure services for its city dwellers without investing own resources, while the interest of provider groups is to make their services more accessible through using the DCC infrastructure. Mutual interest of different stake holders (service providers) was the key instrument behind the success of the zonal committees. However, continuous follow up and technical assistance of the UEP staff members has also contributed to the success of the zonal committees.

Both the zonal and ward committees have contributed to establish linkages among all stake holders of the urban health service-delivery system. The zonal committees have become the forum for service providers, while the ward committees have become a forum for service providers and community leaders. The ward committees have established linkages among the formal and informal community leaders and service providers for better planning and implementation of the national and local health issues. Also, ward-level committees were found to be very effective in local resource generation for solving the local health issues. For example, the ward committees successfully mobilized local resources for volunteer mobilization for NID, offering space for satellite clinic and providing equipment (refrigerator) for clinical health activities.

It was observed from the accomplishment of zonal and ward committees that the zonal committees concentrated mostly on health and family planning issues, while the ward committees concentrated more on public health issues related to water, sanitation, and environment. Before

the formation of ward committees, the main agenda for the zonal committees were health and family planning activities. The ward committees were also started with the same agenda. But soon after the first meeting, the ward committees brought the new agenda, e.g. water, sanitation, and environment, in the ward committee meeting since these are the prime health problems at that level. Gradually, these agenda have been expanded and came into the discussion at the zonal meetings. Actually, the concept of urban health should not be limited only to health and family planning. It must include other issues, like environment, water and sanitation.

The Project team has provided inputs to government officers and NGO providers at the zonal and ward level. At the zonal and ward levels, the Project team has facilitated coordination among agencies, provided research findings, and trained local staff primarily on the roles and functions regarding program planning and coordination.

Experiences from working with the ward committees show that some times the elected community representatives may have different understanding and expectations from the Project. Whenever the health issue was discussed with them, they often came up with requests to establish a hospital/dispensary in their constituency which may not be the prime objective of the zonal/ward committees. So, the gradual move to the community need to minimize the risk of generating expectations beyond resources is important, and it is also important to have a clear understanding of the representativeness of the elected leaders and to find a realistic role for them in the committee. The other factors, like relation between the elected representatives and government officials, should also be considered. A balance must be maintained in this relationship.

The original design of the committees gave prominent role to community representatives/ elected representatives at the zonal level. Various meetings were held with them in this respect. But the experience

suggests that the involvement of elected representatives must be focused at the level in which their interest and influence is more relevant, i.e. among their immediate constituency. In practice, this means that they have a minor "advisory role" at the zonal level and a future more active involvement at the ward level once they get a better understanding of the initiative and its impact. The Ward Commissioners have commitment to their constituency, and have interest at the ward-level which may be considered the key to the success of the ward committees. However, continuous follow up and technical assistance by the facilitating organizations are a pre-requisite to organize activities at the ward level.

The needs assessment study of the Health Department of DCC conducted by the UEP shows that the Health Department does not have the required structure, manpower, resources and expertise to ensure health services to the city dwellers. At best DCC can take responsibility for ensuring coordination among the health and family planning service providers in the DCC area. It could be argued that DCC is in the best position to facilitate coordination among the urban service providers on account of their mandate to ensure health and family planning services to the urban population and because only this agency has a network of administrative resources throughout the city. In addition, the recent experience of urban immunization services managed by city corporations and municipalities created a precedent for improving the coordination of other primary health-care services through local government agencies. The local government network includes elected representatives.

At this stage of the intervention, the important question is what support is needed to make these committees sustainable? The experience suggest that the Health Department of DCC has to provide continuous support and guidance to these zonal and ward committees in planning and implementation of public health activities as per the charter. There must have been routine monitoring of zonal coordination activities by the DCC Health Department. The Health Department has to review the reports and

minutes submitted by the zonal committees and provide feedback and required support accordingly. The Health Department of DCC will need to provide financial support to zonal authorities to continue coordination activities at the zonal level. Committees at both level may need major service providers of the zone/ward to facilitate activities at the zonal/ ward levels for a certain period. But over the period , DCC has to take over the responsibility of planning and coordination activities.

## IX. Lessons Learned

1. The Zonal committees were found to be effective as a coordinating forum for service providers, while the ward committees were found to be effective as a forum of grassroots level service providers and community leaders for local-level planning and local resource mobilization. However, committees at both level require major service providers of the zone/ward to facilitate organization of zonal/ward committee meetings on a regular basis and to provide technical assistance in preparing agenda, schedule and minutes of these meetings, as well as follow up of zonal/ward level activities. But the ultimate objective is that the CC/Municipalities will take over and continue the coordination process.

2. An inventory of health facilities of the zone/ward has to be done before the formation of zonal/ward committees. Because, local inventories of resources for health and family planning are a precondition to any intervention for strengthening local planning and coordination. These studies of the supply of services need to be complemented with assessments on patterns of service use by different groups of clients in slums and non-slum areas. The zonal and ward committees can improve and rationalize the use of scarce health resources at the zonal and ward level.

3. It is essential to organize an orientation session for the members of the DCC staff on their role as overseer and supporter in the coordination process prior to the formation of zonal/ward committees.

4. At the DCC and zonal level more human and financial resources are needed to support and monitor the activities of the committees properly .

5. The involvement of NGOs at the local level requires local mobilization plus advocacy at higher levels with parent organization and bodies coordinating NGO activities.

6. Participation of Ward Commissioners should be focused at the ward level. Their participation at the zonal level is not encouraging. This may be due to the fact that they are elected by ward and their interests and constituencies are at that level.

7. Experiences of CWFP, UTPS, FPAB and Nari Moitri which have facilitated activities of ward committees suggest that the formation of ward committees is indeed a positive move toward establishing coordination among the community leaders and service providers. But repeated persuasion to the ward commissioners is needed to organize meetings and activities at the ward level. Because, traditionally, the ward commissioners are routinely engaged with various development activities, like construction of roads, drainages, culverts, bazaar and community centres, street lighting, ensuring garbage disposal, management of local tribunals, and other socio-cultural activities.

8. Usually the ward committee members prefer evening hours as the suitable time for ward committee meetings which does not match with the working hours of service providers. Service providers need to adjust their time according to community need.

## X. Policy Impact

- The coordination committees at the zonal level are perceived as a positive initiative by most providers and decision makers. The committees have quickly become a ready-made forum to discuss and resolve common issues and problems at the zonal level. Following the success of the coordination process in the DCC area, the InterMinisterial Committee (IMC) requested Local Government Division to establish such process in all CC/Municipalities. Accordingly, the Local Government Division instructed all CC/Municipalities to form Health and Family Planning Coordination Committees. Coordination committees have already been formed in 60 Municipalities of the country. The Local Government Division is now monitoring activities of these committees.

- Of the 132 Municipalities of the country, only 8 Municipalities had their own Medical Officers (MO) or Health Officers (HO). As recommended by the IMC, the Local Government Division has already looked into the issue and encouraged Municipalities to put more resources for health activities and recruit MOs/HOs using their own fund. As of now, the Local Government Division has recruited 34 MOs for 34 Municipalities. In addition, as requested by the Local Government Division, MOHFW deputed six MOs to six Municipalities.

- The existing structure, technical capacity, staff, job descriptions and resources do not support the tasks assigned to the DCC Health Department according to charter of duties. DCC has already realized the fact and took initiative in this respect. A draft proposal for restructuring the health department and redefining job descriptions for health personnel based on the current needs and priorities has already been prepared which could be potentially adopted in other

cities of the country. The UEP provided technical assistance in preparing the proposal.

## XI Further Policy Implications

- Clearer directives from the policy level explaining the role and responsibilities of each and every individual stake holders of the urban health service-delivery system are required to minimize confusion in respect of coordination.

- For establishing the planning and coordination structure at different levels of CC/ Municipalities, a catalytic agent may be required. The CC/Municipalities can play such a catalytic role. But to perform such a catalytic role, CC/ Municipalities have to invest more financial and human resources for health activities and continue to guide the lower-level committees to emphasize on health activities by using their own resources.

- Municipal health staff have a variety of responsibilities that go beyond health family planning activities. So, only restructuring may not improve their knowledge and expertise to plan and coordinate health and family planning activities. They rather urgently require training on health and family planning activities. Training facilities of MOHFW could be used for such training.

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7. Arifeen and Mookherji, An Assessment of Program Needs in Zone 3 of Dhaka City Corporation, 1995. Urban MCH-FP Extension Project, ICDDR,B.

8. Jasim.et.el, Perceptions and Involvement of members of Zonal Health and Family Planning Coordination Committees in Dhaka.

**Annex 1**

**List of Special studies:**

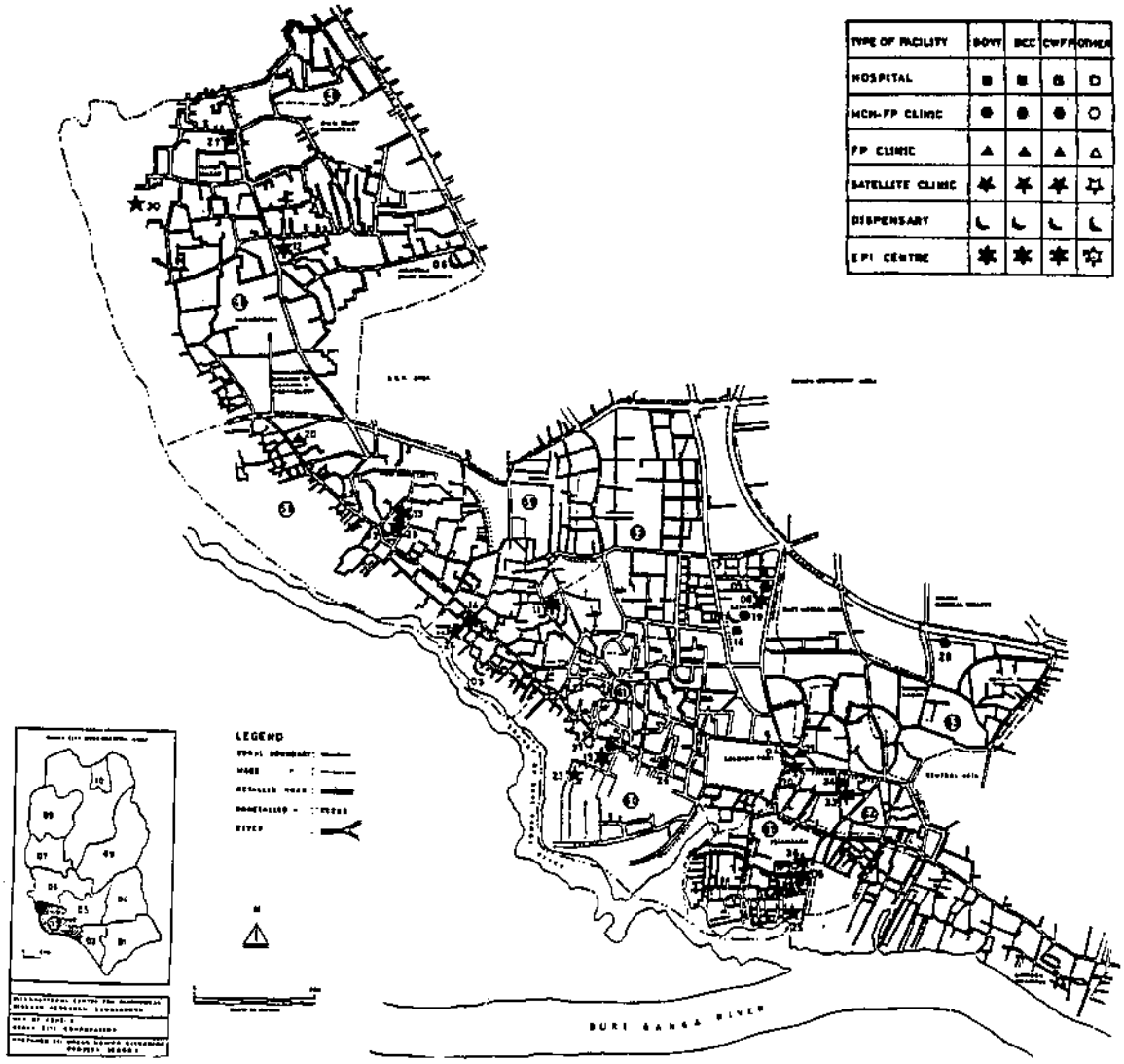
1. Jahanara Khatun et el. Inventory of staff position and resources of health department of DCC at the zonal level.

2. M. A Quayum et el. Survey of EPI coverage in urban Dhaka.

3. S. U. Alamgir et el. Situation analysis of DCC health department.
4. M.A Majumder et el. An inventory of health and family facilities in Dhaka City.

Annex 2

# Intervention Area
# Zone 3 of Dhaka City Corporation
Distribution of Government and NGO Health Facilities



## Annex 3

**Invitation letter of ZEOs for forming the zonal H &FP coordination committees:**

DHAKA CITY CORPORATION
ZONAL OFFICE
ZONE-3

Ref: Date:

To
_____
_____
_____

Sub: Coordination and review meeting on Health and FP activities of DCC zone-3

Dear sir,

You have been providing Health and FP services in the Dhaka City Corporation area since long time. I appreciate your sincere efforts and congratulate you/your organization on behalf of Zone 3 of DCC. I would like to let you know that DCC has taken initiatives to provide continued support to the Health and FP activities in the DCC area.

As a first step toward this initiative, a coordination and review meeting on Health and FP activities in this zone will be held on June 11, Sunday at 10 A.M. in the office of the undersigned.

You or your representative are requested to attend the meeting.

Sincerely,

(_____)
Zonal Executive Officer
Zone - x
Dhaka City Corporation

CC:_____

## MCH-FP Extension Work at the Centre

An important lesson learned from the Matlab MCH-FP project is that a high CPR is attainable in a poor socioeconomic setting. The MCH-FP Extension Project (Rural) began in 1982 in two rural areas with funding from USAID to examine how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first years, the Extension Project set out to replicate workplans, record-keeping and supervision, within the resource constraints of the government programme.

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of governmental Family Welfare Assistants. Other successful programme strategies scaled up or in the process of being scaled up to the national programme include doorstep delivery of injectable contraceptives, management action to improve quality of care, a management information system, and developing strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, this project started family planning initiatives in Chittagong, the lowest performing division in the country.

In 1994, the Centre began an MCH-FP Extension Project (Urban) in Dhaka (based on its decade long experience in urban health) to provide a coordinated, cost-effective and replicable system of delivering MCH-FP services for Dhaka urban population. This important event marked an expansion of the Centre's capacity to test interventions in both urban and rural settings. The urban and rural extension projects have both generated a wealth of research data and published papers.

The Centre and USAID, in consultation with the government through the project's National Steering Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-97. Salient features include:

- To improve management, quality of care and sustainability of the MCH-FP programmes
- Field sites to use as "policy laboratories"
- Close collaboration with central and field level government officers
- Intensive data collection and analysis to assess the impact
- Technical assistance to GoB and NGO partners in the application of research findings to strengthen MCH-FP services.

## The Division

The reconstituted Health and Population Extension Division (HPED) has the primary mandate to conduct operations research to scale up the research findings, provide technical assistance to NGOs and GoB to strengthen the national health and family planning programme.

The Division has a long history of accomplishments in applied research which focuses on the application of simple, effective, appropriate and accessible health and family planning technologies to improve the health and well-being of the underserved and population-in-need. There are several projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures which cuts across several Divisions and disciplines in the Centre. The MCH-FP Extension Project (Rural), of course, is the Centre's established operations research project but the recent addition of its urban counterpart - MCH-FP Extension Project (Urban), as well as Environmental Health and Epidemic Control Programmes have enriched the Division with a strong group of diverse expertise and disciplines to enlarge and consolidate its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. First, the public health research activities of these Projects focus on improving programme performances which has policy implications at the national level and lessons for international audience. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructures; dissemination of research findings to the highest levels of policy makers as well as recipients of the services at the community level; application of research findings to improve programme performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national programme at Thana, Ward, District and Zonal levels both in the urban and rural settings.

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CENTRE
FOR HEALTH AND POPULATION RESEARCH

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