MCH-FP Extension Project (Urban)
Health and Population Extension Division

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Working Paper No. 36

Improving the Effectiveness of the Health Department of Dhaka City Corporation

Summary of the Needs Assessment Studies

Shamsuddin Alamgir
Cristobal Tunon
Abdullah H. Baqui
Mohammed Ali Bhuiyan
Md. Jasim Uddin

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FOR HEALTH AND
POPULATION RESEARCH

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Foreword

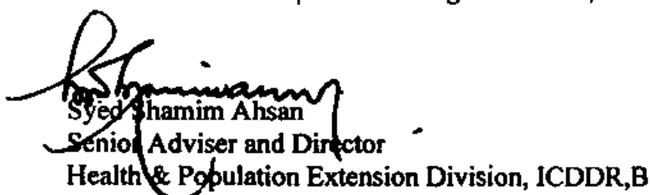
I am pleased to release these reports on urban Maternal and Child Health and Family Planning issues which are based on the operations research activities of the MCH-FP Extension Project (Urban) of the Centre. Over the years, the Centre has acquired a unique expertise on urban development matters that 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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The authors is greatly indebted to Officials of Dhaka City Corporation Chief Health Officer, Zonal Executive officers and Assistant Health Officer. The authors also acknowledge with gratitude Jahanara Begum, Dr. Mahbub Alam Majumder, for their support in the implementation as well as data collection, editing and entry. Last but not the least, authors express thier gratitude and appreciation to our reviewers and all those who have given critical comments and advice at numerous occasions.

GLOSSARY

MOHFW	:	Ministry of Health and Family Welfare
DCC	:	Dhaka City Corporation
UEP	:	Urban MCH-FP Extension Project
MOLGRDC	:	Ministry of Local Government, Rural Development & Cooperatives
LGD	:	Local Government Division
MCHFP	:	Maternal-Child Health and Family Planning
NGO	:	Non-Governmental Organization
ICDDRB	:	International Centre for Diarrhoeal Disease Research, Bangladesh
CWFP	:	Concerned Women For Family Planning
AHO	:	Assistant Health Officer
ZEO	:	Zonal Executive Officer
EPI-HQ	:	Expanded Program on Immunization, Head Quarters
BASICS	:	Basic Support for Institutionalizing Child Survival
GOB	:	Government of Bangladesh
NID	:	National Immunization Day
MNT	:	Measles and Neonatal Tetanus
DHS	:	Directorate of Health Services
DFP	:	Directorate of Family Planning
PHC	:	Primary Health Care

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EXECUTIVE SUMMARY

The MCH-FP Extension Project (Urban) of the International Centre for Diarrhoeal Disease and Research conducted a series of needs assessment studies of the Health Department of Dhaka City Corporation (DCC) to review the current organization, management practices, resources and technical capabilities of the Department. Data for the studies were obtained from members of the DCC and its Zonal offices through participatory workshops, surveys and the review of relevant documents and records.

The problems that has been limiting the effectiveness and performance of staff members of the Health Department of DCC were identified. The findings can be listed as follows:

a. Acute shortage of skilled staff, and many positions are vacant
b. Lack of job descriptions and ambiguities in roles and responsibilities of the staff members
c. Weak supervision and monitoring systems
d. Narrow focus on selected Primary Health Care (PHC) components
e. Inadequate logistic support for zonal level offices

The findings the studies highlighted the need to restructure the Health Department of the DCC to enhance its capacity so that it can effectively ensure the PHC services for the growing population of the city, as well as more effectively cover a larger geographical area. A number of short-and-long term measures are suggested to make the Department more efficient and effective. The suggestions are:

a. Filling up of vacant key managerial positions with qualified and competent persons
b. Regularization of the posts of Assistant Health Officer
c. Review of the functions of Health Department

d. Changing the organizational structure of the Health Department
e. Preparing clear job descriptions
f. Strengthening staff development and training activities
g. Improving systems for performance review, incentives, sanctions and rewards
h. Strengthening communication with other agencies and departments

In absence of any consensus on how the Health Department of DCC can contribute to solve urban PHC problems, it is suggested as a possible approach that the DCC to assume a more active role in monitoring health conditions and promoting greater coordination among service providers. This will mean the broadening of current focus of the Department on the delivery of immunization services and will require additional technical skills and more consistent liaison with providers in government and commercial sectors with the voluntary organizations. Above all, decisions on any enhanced role of the municipality need to be accompanied by clearly defined policies and support from relevant agencies in health, population and in the Local Government sectors.

BACKGROUND

Until recently, Bangladesh was almost entirely rural. In 1961, about 95% of the population lived in rural settlements (Baqui, et al., 1995). At present, about 20% (25 million) of the country's total population of (120 million) people live in urban areas (BBS, 1991). The population growth rate is less than 2% per year, where as the growth of urban population is 6-7 % per year (Islam, 1995). According to a recent report, at the current pace of urbanization, Dhaka is expected to become the ninth Mega city of the world by the year 2015 (UNFPA, 1996). It has also been projected that urban share of Bangladesh's population will rise from 20% of the total population in 1990 to 33% of the total in 2010, i.e. an absolute increase of over 55 million people (Baqui, et al., 1995). Clearly, there is a strong need to plan, implement and monitor health-care services for the growing number of city dwellers as this is a difficult challenge to health authorities.

In urban areas of Bangladesh, the government health service system play a relatively minor role in the delivery of health care (Mazumder et al., 1997). Non-governmental organizations and commercial concerns (e.g. pharmacies and physicians in private practice) are the most common providers (Mookherjee et al., 1996). There is a lack of effective coordination and cross referral among the various facilities and the multiple providers of services. This often results in low utilization of the existing infrastructure, gaps in coverage, duplications in areas of responsibility, and limited access and availability of services to the catchment populations, particularly the urban poor (Arifeen and Mookherjee, 1995).

The need for improved coordination in urban health-service delivery has been recognized by all stakeholders. The government has already assigned public health functions that include urban primary health care activities to municipalities and City Corporations. But the municipalities and City Corporations do not have sufficient resources or experience in these areas. Only 14 out of the 138 municipalities and City Corporations in the country have a physician looking after specific health issues.

Dhaka City Corporation:

The Dhaka City Corporation, is the largest City Corporation of the country with a population of about 5 million (estimated from the Census 1991). It began with an area of 6.15 sq. mile as a municipality. It was awarded the status of a corporation in 1978, renaming it as the Dhaka City Corporation in 1990. The executive power of the Corporation is vested in and exercised by the Mayor. The Corporation constitutes eight standing committees to monitor and guide its diversified activities. DCC business is divided into ten administrative zones. Each zone is headed by a zonal executive officer (Figure 1) who is primarily responsible for implementation of development projects and maintenance work of the zone. The zones are further divided into a number of wards; ward is the lowest administrative unit of the Corporation. The average number of wards per zone is 9 and the average size of population per ward is 50,000 (range 40,000 - 60,000).Health Department is one of the 17 departments of Dhaka City Corporation.. The central health department is being reinforced at the zonal level by zonal health department. They work in close coordination (Figure 1). The responsibilities of the City Corporation in the area of public health have been delineated in the Dhaka Municipal Corporation Ordinance issued in 1983. These responsibilities range from refuse removal to the provision of public latrines with power to prosecute landlords and households without sanitary latrines. The DCC was also responsible for the registration of all births and deaths in the its area. The City Corporation was also given more specific health-related functions which include the following:

- Prevention and control of infectious diseases
- Establishment and maintenance of health and maternity centres
- Support for the training of dais
- Promotion of family planning and the health and welfare of women and children
- Promotion of public health including health education
- Establishment and maintenance of hospitals and dispensaries as required by the government
- Provision and maintenance of first aid centres and mobile medical aid units

- Promotion of societies for the provision of medical aid
- Promotion of medical education
- Payment of grants to institutions for medical relief and .
- Medical inspection of school children

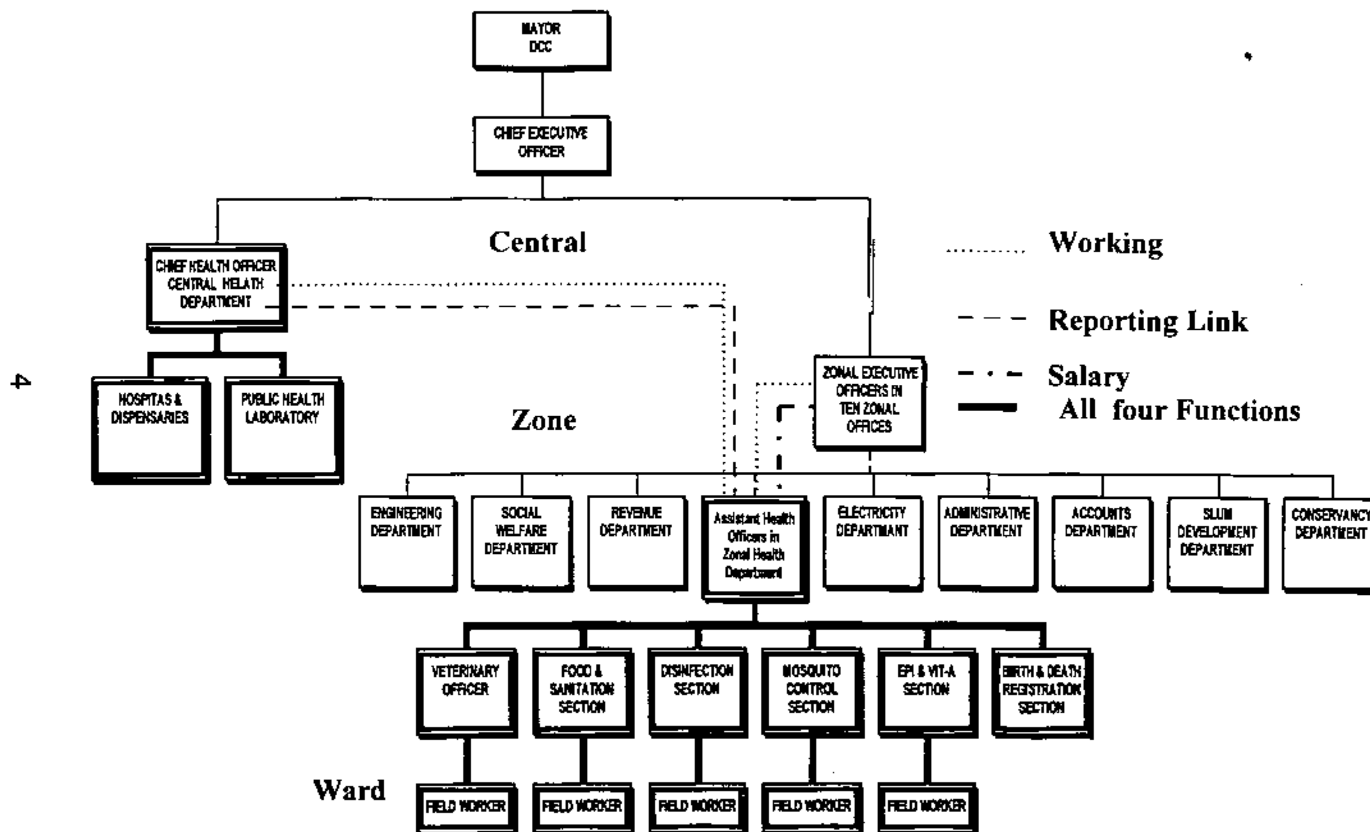
These functions are the same for all "paurashabhas" or municipalities in the country, regardless of size. Although these functions are outlined in the Ordinance, the current capacity do not permit the Corporation to implement them.

Rationale:

In August 1994, the International Centre for Diarrhoeal Disease and Research (ICDDR,B) began to collaborate with the Government of Bangladesh and a national NGO, Concerned Women for Family Planning. This partnership is known as the "Urban MCH-FP Initiative". The overall goal of the Initiative was to contribute to the national commitment to reduce current high levels of fertility and mortality in urban Bangladesh. The MCH-FP Extension Project (Urban) of ICDDR,B was established to support the Initiative's attempts to improve the effectiveness and efficiency of urban service providers by conducting operations research and disseminating findings, and providing technical assistance to the partners on issues related to building sustainable organizations and efficient support systems for service delivery. The Project also provides technical assistance to the government agencies responsible for the formulation of urban health policy.

Thus, a major area of UEP's activity for the involves the strengthening of institutional capacity of the Dhaka City Corporation for effective planning, coordination, implementation and monitoring of health activities in the municipalities. To provide technical assistance, one needs to identify areas that would require support from the project. During 1995 and 1996, the Project conducted a series of needs assessment studies of the Corporation's Health Department to identify obstacles affecting the performance of the Department.

Fig. 1: Organogram Of Health and other realted Depatment of Dhaka City Corporation at different level



OBJECTIVES

The study was carried out:

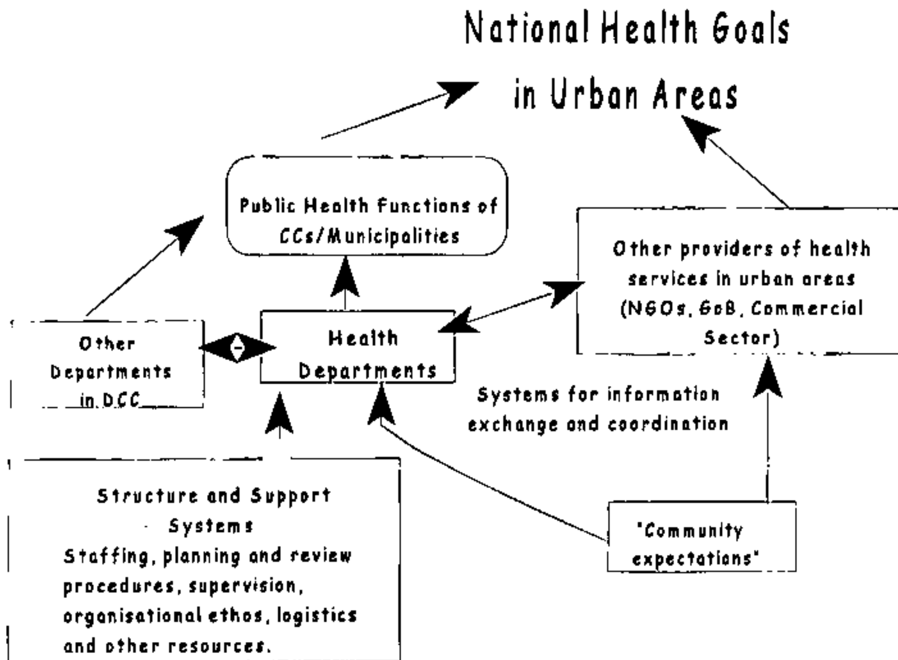
a. to assess the capacity of the Health Department of the DCC to plan, monitor, implement and coordinate urban primary health-care activities and to make appropriate recommendations, and

b. to identify training needs and requirements for technical assistance from external agencies.

FRAMEWORK

In this study, the effectiveness of the Health Department was assessed in terms of its current capacity, and potential contribution to the achievement of the public health functions of the Corporation. In the DCC Ordinance 1983, some functions have been designated as public health functions. Other departments within the DCC, such as Conservancy, Engineering or Social Welfare, have been contributing directly or indirectly to the achievement of these functions. On the other hand, concurrent contributions of other urban providers, such as NGOs, GOB and commercial sector, have to be combined with the activities of the Corporation toward achieving the national health goals in urban areas. Apart from large scale organizational restructuring or administrative reform, a limited options are a available for the managers to influence performance in large established organizations, particularly in the public sector. The scope of the needs assessment studies was limited to areas amenable to management interventions without major budgetary or manpower increases.

Figure 2: Frame Work of the Study



The framework used to design the needs assessment studies (Figure 2) perceived the effectiveness of the Department as a function of a variety of factors, which include the achievement of its mission, i.e. the actual execution of the functions that the Department is responsible for. Given the urban environment and the existence of multiple service providers, other important elements included in the model were the relations of the Department to outside agencies with overlapping objectives. The leading assumption on the mission of the Department was that it had to acquire a predominant role of coordinating and monitoring rather than increasing its activities as a service-delivery organization.

The framework also assumed that the work of the Department is shaped by "community expectations" and political pressures that determine functions which are considered priorities for action. Finally, other critical factors included in this model were the resources and systems available to staff members in the Department for the attainment of the mission which includes the organizational structure and management procedures in place to organize and guide the work of the Department. On the basis of this model, the study included the following areas:

- Functions of the Health Department and job descriptions of the staff members at different levels
- Human resources
- Formal planning process for health activities
- Mechanisms for communication with other service providers
- Information systems
- Essential logistics
- Staff perception of strengths and weaknesses of the Department

METHODOLOGY

The study used data from various sources. Special surveys on facilities of the DCC were carried out. Staff strength was assessed at the zonal level through specific questionnaires. Workshops, involving various categories of staff members, were conducted, and field observations were made during meetings of City Corporations officials with representatives from other service -delivery agencies. Official records, reports, ordinances, and relevant literature were also reviewed.

Appendix B contains the instruments used for data collection in this study. The first stage of data collection involved the review of records on staff positions at the central and zonal levels (from August 1995 to March 1996) to assess the present staff strength. A meeting of the chief officers of the Health Departments of all major cities of the country was held to identify the major urban health issues. The issues identified were presented at the plenary session chaired by the Secretary, Local govt division.

The second stage of data collection was conducted through brain storming sessions in the workshops with various categories of health staff members of the DCC. The workshops were jointly organized by the Urban Extension Project and the Dhaka City Corporation. Thirty EPI supervisors and Sanitary Inspectors from 10 zones of the DCC participated in the first workshop, which was held in May 1996. The participants from the second workshop, held in June 1996, included the Chief Executive Officer (CEO), the Chief Health Officer (CHO), 6 Assistant Health Officers (AHO) and 7 Zonal Executive Officers (ZEO) of the DCC.

During these workshops, special questionnaires were administered to all the participants. The questionnaire contained questions on issues, like coordination, planning, job description, training, information systems, and logistics. Open- ended questions were manually tabulated and close-ended questions were entered into computer for analysis. In addition to the questionnaires, Visualization for Participatory Planning (VIPP) methodology was used for identifying and prioritizing problems, analyzing causes and exploring solutions.

FINDINGS

The findings presented below are organized according to the areas considered in the study.

Charter of Duties and Job Descriptions (Health Department of DCC)

The Health Department of DCC had 1242 sanctioned posts in August 1996. At the central level, there were a Chief Health Officer and 55 staff positions. Most of the Department's workforce was deployed at the zonal level under the direction of Assistant Health Officers (AHO). The AHO worked under the command of the Zonal Executive Officer (ZEO) as part of the administrative line management. However the AHOs are supported by the Chief Health Officer (CHO) who provides them technical assistance (Fig 1). The Chief Health Officer, in consultation with the ZEOs or independently, communicates with the AHOs in matters related to health program. In addition, the CHO maintains the ACR of the AHOs. In recent years, there have been two administrative reorganizations of the

Department: the general restructuring that took place in 1986, commonly known as the Enam Commission, and the decentralization of local government of 1990 (Table 1). According to the DMC Ordinance the Department has as many as 17 public health functions, which can be grouped into broad areas based on the current activities of the Department. They are: (1) preventive health (2) Curative health (3) Vector control (4) Veterinary services, (5) Environmental control (Appendix A). Of the 17 major responsibilities seven are routinely implemented, six are occasionally implemented, and four are not implemented (Appendix A). Although the Department had 22 dispensaries (Allopathic and Homeo), two hospitals, and one maternity centre, the bulk of the family health-related work revolved around the provision of immunization to children and pregnant women.

Table 1: Number of posts sanctioned in different sections of the Health Department (DCC)

Section	Changes introduced by Enam Commission(1986)	Changes by Local Government Ministry (1990)
Field staff	614	701
Dispensaries	16	23
Central Office	70	55
Veterinary Staff	Not part of Health Dept.	144
Hospitals	Not part of Health Dept.	319
Total	700	1242

Source:Enam Commission report 1986, Annual report 1990, LGRD

Some of the public health functions of the DCC, e.g. refuse collection and aspects related to sanitation, were the responsibility of the Conservancy Department. Previously, the Conservancy Department was under the Health Department. With increasing area and expanding volume of responsibilities as well as political priority, it was separated from the Health Department. But most public health functions were assumed to be the responsibility of the Health Department.

The findings of the study suggest that the functions of the Department seem to have evolved through local needs and administrative

orders rather than on a purposefully designed set of specifications or clearly articulated terms of reference (Table 2). At the level of individual staff members, all the zonal officials interviewed informed that they had never received any form of written job descriptions. However, all the respondents opined that defined job descriptions would help them discharge their duties efficiently and outline their areas of responsibility.

Nevertheless, there was some evidence that job descriptions were a felt need: a ZEO prepared a set of draft job descriptions for staff at the zonal level, but the proposal remained a personal initiative with apparently little official support.

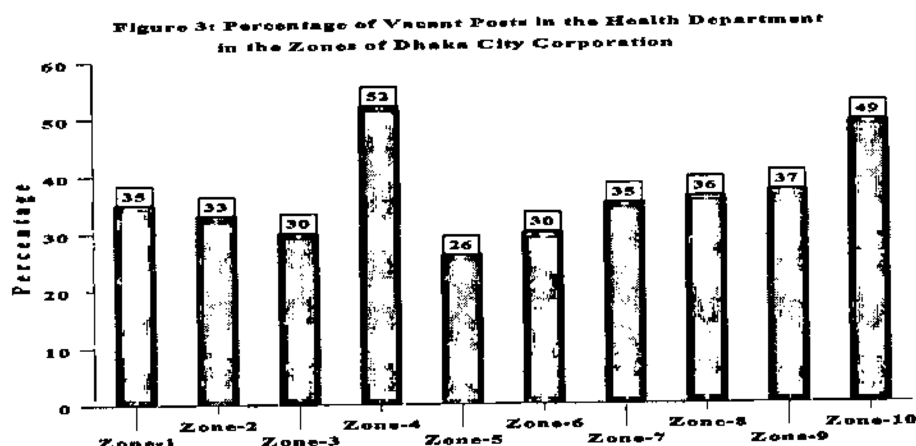
Table 2: Current responsibilities reported by different groups of staff DCC

Staff category	Reported responsibilities
Zonal Executive Officers	Management and supervision of conservancy activities, administration and personnel management, coordination of construction activities, National Immunization Days, involvement in disaster response.
Assistant Health Officers	Manage EPI programme, food and sanitation activities, mosquito control, birth and death registration, National Immunization Days and Vitamin A distribution.
Hospital Consultants	Curative treatment both indoor and outdoor, administrative and personnel management.
EPI Supervisors	Supervision, monitoring and reporting of immunization activities as well as vaccine collection, storage, supply and cold chain maintenance.
Vaccinators	Vaccination activities at ward level

Source: Workshops held on May and June 1996

Human Resources

The survey of Health Department staff conducted in August 1995 revealed that the number of vacancies at zonal level ranged from 25 to 50%. Sanctioned positions in the zones ranged from 63 to 121 depending on



Source: Central and Zonal Office record of DCC

the area of the administrative unit. The categories of vacancies ranged from health managers to helper. Based on the current activities, it is necessary to minimize the vacancies of certain key positions. For example, at the managerial level, four out of the ten zones did not have a zonal-level officer in-charge of health matters. This is regarded as one of the important barriers to management of health activities at the zonal level due to increased workload on them. Although vaccination was the main primary health care related activity of the

Department, there was also a shortage of vaccinators. In some cases, vaccinators had to operate two or three centres. Supervisors reported that the vaccinators had received little training. Vaccinators\ recruited in 1960s and 1970s are expected to retire soon, and are not physically capable to operate at several centres and to undertake the extensive travel involved. All the respondents in the both the workshops underscored the need for

immediate actions to fill up the key positions required to carry out the current health programs.

The dispensaries managed by the DCC were staffed either by a part-time medical officer or by a Compounder, Pharmacist Homeopath. They are trained to dispense drugs but not to treat patients. AHOs and ZEOs felt that these service-delivery locations should have full-time medical officers to ensure the availability of quality services. Staff position assessment also revealed that personnel were on deputation from other departments. For example, spray-men were deputed from the mosquito control department at the LGD. The common outcome of this situation was a sense of ambiguity in authority and accountability. Moreover, the ZEOs of the DCC were deputed from various departments of the government and are subject to transfer. This result break of continuity of chain of command as well as impedance in the management at the zonal level.

However, organization of human resources requirement for the Department in the future context can and should be based on the long-term goal of urban health and expected role of the DCC as a stakeholder.

Financial Resources

In the financial year 1997-98 the DCC has budgeted an amount of the Tk 402 crore. This budget comprises areas like management and maintenance (99.5), development (263), revenue earning (188). The distribution of the budget for the health sector is as follows:

Area	Budget Spent (1997-98) (Crore)
Management and Maintenance	
1. Medicines for dispensaries	.11
2. Chemicals and bleaching powder	.10
3. EPI (Primary health care)	.08
4. Hospitals	.29
5. Supplies	2.25
6. Mosquito control activity	4.00
7. Staff salary	1.20

Development:

1. Equipment for mosquito control	2.15
2. Lab instruments and other miscellaneous for public health laboratory	0.20
3. Construction and development of Slaughter house	1.00
4. Construction of maternity centre	0.50
6. Extension of hospitals (along with all accessories)	1.00

Revenue earning:

1. Marriage, birth and death	.01

While reviewing the total budget of the health Department, it appeared that the health Department spend 7.3% of management and maintenance head, 1.02 % of development head and negligible amount direct revenue earner. As a whole share of the Health Department stands at 2.49% of the total DCC budget. Review of records also revealed that for many years it never exceeded 3%. The majority amount of the budget (70-75 %) goes to the Engineering Department. With current budgetary allocation in PHC sector, it is unlikely that the DCC will be able to ensure urban primary health care. However, such allocation should be decided based on the long-term goal of the DCC in the field of urban primary health care.

Planning and Coordination

Around a third of the AHOs and ZEOs who attended the Workshop reported that they routinely prepare monthly work-plans, and another third indicated that they planned their work on a quarterly basis. The rest said they had no work-plans. On the other hand, 20 of the 30 supervisors of vaccination services (EPI supervisors) interviewed, reported that they had monthly work-plans.

During data collection, field observation of the DCC's Health Department activities, no firm evidence was found that support the existence

of any work-plans in the Department. The workshop participants claimed that they had only targets for immunization activities, Vitamin A administration, and mosquito control. At the same time, only 20% of the participants claimed to be able to achieve the assigned targets.

The study revealed that review of performance was not at all carried out at any level. Besides there was no system for providing feedback on performance. The only exception perhaps was the practice of conducting reviews of National Immunization Days activities at the zonal level.

During the workshops, managers and supervisors at the zonal level reported that they maintained regular contacts with the EPI Headquarters, NGOs, ICDDR,B, and BASICS for urban immunization program and national immunization campaigns. The participants largely referred to the existing zonal health and family planning coordination committees as the main mode of coordinating with other agencies. The formation of the committees was facilitated by the UEP. The urban health facility survey, conducted by the Project in 1995, identified the following DCC infrastructure in use by the DCC itself and agencies for health and family planning service-delivery purpose. It was observed that considerable amount of DCC properties are being used for urban health and family planning purpose. This indicates the potential of DCC structures to be used for health and family planning services in urban areas by the stakeholders.

Table 3: Distribution of health and family planning service-delivery sites located at DCC properties (Commissioner Officer, Community Centres)

Zone	Total no. of community centre (n=28)	No of facilities located (n=15)	Total no of Commissioner Offices (n=107)	No of facilities located (n=24)	% of DCC properties with H&FP (n=31)
1	04	3	15	6	47
2	06	4	14	2	30
3	08	4	11	1	26
4	04	3	18	3	27
5	01	0	10	1	9
6	02	1	11	2	23
7	00	0	09	5	55
8	03	0	10	0	-
9	00	0	07	3	42
10	00	0	02	1	50

Source: Health facility survey, ICDDR,B, 1995.

Information Systems on Local Health Conditions and Services

The DCC managers and supervisors agreed on the need to collect more information on health conditions and the activities of service providers in their respective localities. The AHOs and EPI supervisors stated that they received regular monthly reports on vaccination activities from NGOs and also sent monthly immunization reports to the national EPI HQs. But apart from records on immunization outputs, the Zonal Offices did not have any information on local organizations providing health and family planning services. Some offices also had gross population figures about their areas of work, and reports on vitamin A administration. A few zonal offices had lists, often out of date, of local educational establishments.

Sometimes the zonal offices were asked to report on mosquito control activities, birth and death registration and special events such as vaccination campaigns. The Zonal Offices did not receive any reports from DCC dispensaries or hospitals. There was no requirement for the Zone Offices to report on any family planning activities.

In a few areas, the Zonal Officers maintained records on display boards about organogram and mosquito control activities, and about projects involving construction of roads and buildings.

The issue of collection, compilation and analysis of EPI surveillance data is currently getting ground. Current orientation and capacity of the DCC staff members being not adequate to develop and maintain a routine surveillance system, an external facilitating agency is assisting to develop the surveillance system.

Nevertheless, in general, reports and information received at any level were not analyzed, and no feedback was given to the concerned staff members. Even when the information was readily available, as in the case of EPI performance, the zonal offices did not displays program information.

Logistics

Most zonal offices did not have sufficient space to accommodate health staff members and materials. For example, there was no sitting space for the AHOs in zone 9 and 10, and the space allocated in zone 3, 4, 7 and 8 is very small. As a result, the health staff had to be located in different sites, resulting in communication problems.

The EPI supervisors did not have transport. Only two AHOs had motor·cycles provided by the DCC. The lack of transport facilities was a major obstacle to their work as supervisors, since public transport was not suitable and the system of reimbursement for traveling expenses involved complex and lengthy procedures. The Zonal-level officers from the Health Department also said that they had no secretarial support or sufficient office equipment and materials.

A common complaint of the zonal officials was the lack of funds allocated to the promotion of coordination of health and family planning activities. In practice, it was difficult for them to convene a meeting, because they had no funds for basic support, such as mailing invitation letters, reproducing materials, or providing refreshments.

Staff Development

The AHOs, ZEOs, and EPI supervisors, there was no mechanism for identifying training needs of personnel of the Health Department. In-service training activities were organized by external agencies, such as NGOs and projects of the Directorate of Health Services. Three quarters of the AHOs had not received health-related training in the previous two years. All managers and supervisors agreed that the health staff members need additional training to assume the responsibilities of managing urban health. They perceived the need to establish a mechanism to provide regular refresher courses to the staff members. On the whole, they felt that basic training in the following areas is required:

- ❑ Immunization
- ❑ PHC and MCH-FP concepts
- ❑ Food, sanitation and environment

- Mosquito control measures
- Animal-borne diseases of public health concern
- Modern slaughter house management
- Program planning, implementation and monitoring at the local level

Appendix A provides a detailed breakdown of areas of training needs advocated by the various categories of the health staff members.

Staff perception of strengths and weaknesses of the Health Department at DCC

The participants in the workshops brain stormed to come up with a list of strengths and weaknesses given in the table as follows:

Areas mentioned by AHOs		Areas mentioned by EPI Supervisors	
Strength	**Weakness**	**Strength**	**Weakness**
Urban EPI Zonal coordination Committees Mosquito control Good staff relations	Limited focus on PHC Vacancies and staff shortages Part-time staff in dispensaries Untrained staff Unclear chain of command Lack of charters of duties and job descriptions Limited capacity for local planning	Urban EPI Zonal Coordination Committees Mosquito control Birth and death registration	No focus on MCH-FP activities Lack of trained staff Lack of training facilities Lack of MIS Inadequate logistic supply Less attention to health activities

The weaknesses mentioned by zonal officials were also endorsed by Chief Health Officers from the main cities of the country. The Chief Health Officers identified the following problems as the major issues concerning urban health.

- Lack of coordination and proper administration
- Inadequate resources in the Health Departments of municipalities and city corporations
- Lack of water and sanitation facilities, specially in slums
- Need to strengthen information, education and communication activities for PHC
- Special needs of slum populations
- Lack of quality services
- Weak programme information flow on PHC

DISCUSSION AND POLICY IMPLICATIONS

The growth of cities and urban slums in Bangladesh, combined with increasing awareness of intra-urban inequities in health, particularly among women and children, calls for better coordinated and more cost-effective services with a leading role of the city corporations and municipalities in urban health. The perception that municipalities should have an expanded role beyond providing services to safeguard food, sanitary conditions, and the environment has gained momentum. This has led to initiatives to build greater capacity at the level of municipalities so that they can play a more active role in the coordination of urban health services. This concern on the role of local institutions is not altogether new. The statutory public health functions of municipalities and corporations are expressed in such general terms that they can fit a variety of measures and services and remain relevant in the face of changing priorities and emergencies.

In recent years, the broad mandate given to a municipality, in relation of public health, has made it relatively easier for a municipality to increase its participation in urban health activities. The DCC manages hospitals, dispensaries, and maternity centre in addition to its other public health functions. The municipal authorities have played a pivotal role in service delivery for immunization and have begun to assume the responsibility of bearing some of the cost involved. Also, in some parts of the city, DCC facilities are used by family planning workers of the government or NGO sector as the service delivery points.

The role of the private sector with regard to provision of preventive health services may require testing of few innovative approaches. One such approach could be encouraging the private sector providers to institute preventive services of defined quality either through self investment or reimbursement from the DCC. Prices of such services delivered can be regulated by the DCC.

The consumers can be made aware of their rights and entitlement through specific IEC activities, and their feedback on the quality of service delivery can be used for improving the services provided by GOB and NGOs.

Nevertheless, the problems impeding the ability of municipalities to effectively perform the mandatory health related activities are both internal to the DCC and outside which involve relations with other service providers.

The first obstacle is that the Health Department of the DCC is not equipped at the central or local level-with resources to enable it to play a significant role in areas beyond immunization, curative care, food and veterinary services, and sanitation. Even in these areas, as the needs assessments studies indicated that there were serious shortage of trained staff members in the Health Department, both in management and at the service-delivery level. This obstacle is relatively easier to remove. Of far greater significance is the fact that the responsibility of the DCC in urban primary health care is not clearly defined. There is no shared vision or consensus among agencies and organizations concerned with health matters on the role of the Health Department of the DCC in this field.

Given the multiplicity of service providers in Dhaka city, what should be the future role of the Health Department? The availability of providers from other government departments, NGOs and commercial sector organizations suggests that the DCC needs not expand the current its current service-delivery function. A more relevant role for DCC should include more responsibilities for monitoring health conditions and establishing partnerships with other service-delivery providers to reduce

health inequities. For example, the DCC can collaborate with other partners for reorganization of health facilities and can allow other agencies to use more of its many properties throughout the city for service delivery. This means that the Health Department will be required to involved more in fostering coordination amongst the service providers and promoting healthy life-styles in the community than in the actual provision of services. Equally, the Corporation should increase the Department's capacity the for enforcing provisions of public health legislation.

Policy Implications

Before deciding on a wider role of the DCC in PHC, it is important to define the clearer role the Health Department should play within the Corporation. The current distribution of health-related functions within the different departments of DCC needs to be assessed. The immediate need is to reach a consensus within the Corporation and between the Corporation and other agencies on the expected role of the municipalities in urban primary health care. This involves the development of a systematic exercise to identify the city's health priorities, the formal distribution of responsibilities for action on those priorities, and the strengthening of mechanisms for coordination. The importance of reviewing the responsibilities of the Health Department needs to be stressed. Over time, other issues, beyond the narrowly defined health services, will come to the forefront as basic needs. For example, environmental pollution, solid waste disposal, growth of slums, and food safety are likely to be increasingly more important problems affecting the city dwellers and will demand additional resources from the DCC.

The Health Department needs a new structure to integrate PHC elements and establish monitoring and health promotion cells. Both at the central and the zonal level, a focus on monitoring primary health conditions would require better trained staff and a clear definition of their duties and responsibilities. The DCC must ensure the provision of basic, as well as refreshers training. This is an area in which much stronger coordination is needed between the municipalities and the Directorates of Health and Family Planning.

To play a greater role in coordinating with other service providers and the community, the Health Department will require a larger degree of autonomy at the zonal level and for the establishment of a mechanism that allows groups in the community to express their own needs and assessments of the overall performance of health services. Basic resources, such as space, transport, minimal discretionary funds, and clerical support, will also be needed if the zonal officials are asked to play this role. This devolution of authority needs to be accompanied by better technical supervision and guidance from the central Health Department officers. To carry out these functions, the central department must be equipped to design and help implement improved systems for work scheduling and performance review and for the allocation of incentives, sanctions and rewards based on performance.

The results of the needs assessments studies conducted by the Project also indicate that there is need to look closer into organization, distribution, output, and cost of the curative services provided by the Health Department.

The problems identified by the needs assessments studies are not unique to the DCC. The solutions outlined in this document are based on the analyses of the results of the needs assessments studies and the suggestions of staff members of the health Department. These solutions need to be subjected to a further analysis in terms of their cost and feasibility. Such enterprise was beyond the scope of this paper. Nevertheless, the issues and solutions identified in the course of the needs assessments and the work with staff from the Health Department can be the basis for designing solutions which, with appropriate adaptations, can indeed help improve the performance of Health Departments of other large municipalities.

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11. Ordinance of Dhaka City Corporation-1983

APPENDIX A

Functions of Dhaka City Corporation

Assigned function	*Routine*	*Occasional*	*No emphasis*
Preventive health	1. EPI 2. Sanitation 3. Food safety 4. Birth and death registration	1. Control of Insanitary buildings 2. Prevention and control of infectious diseases	1. Ensuring family planning and child welfare services 2. Medical inspection of school children 3. Health education
Curative health	5. Establish and maintain hospitals and dispensaries as required	3. Providing medical relief services	4. Payment of grants to institutions for medical relief
Vector control	6. Control vector and destroy vector breeding sources		
Veterinary services	7. Ensure safe meat	4. Stop unauthorized slaughtering of animals 5. Control street dogs /stray animals	
Environment control		6. Prevention and control of dangerous and offensive articles and trades, etc.	

IDENTIFICATION OF TRAINING NEEDS OF ZONAL HEALTH PERSONNEL

Sanitary Inspector

- Basic training on food and sanitation.
- Orientation on relevant rules, regulations, ordinances, and mobile court procedures.
- Refreshers course on birth and death registration system.
- Basic training on relevant industrial health requirements.

Supervisors (Mosquito control)

- Extensive refreshers technical training on mosquito control measures and related issues which include: (i) Vector life cycle, (ii) Chemical and environmental control, (iii) Modern equipments, (iv) Spray techniques, and (v) Environmental hazards of insecticides

EPI Supervisors

- Basic and refreshers technical training on EPI.
- Basic training on urban MCH-FP programme.
- Refreshers training on social mobilization and motivation techniques.
- Refresher training on supervision and monitoring of EPI programme.
- Basic training on coordination mechanism with GO/NGO and public representatives on health programme implementation.

Veterinary Inspector

- Basic training on common animal borne diseases of public health importance.
- Refresher training on relevant legal procedures.
- Basic training on managing modern slaughter houses.
- Refresher training on supervision and monitoring of meat and fish business.

■ ***Assistant Health Officer***

- Basic training on MCH-FP programme.
- Foundation training at PACT on office and personnel management.
- Refreshers training on technical issues of EPI, disease eradication and reduction goals.
- Basic training water, sanitation and environmental issues, including food safety measures.
- Refreshers training on mosquito control measures and related programme management.
- Refreshers training on birth and death registration management.
- Basic training on veterinary public health, like cattle health, slaughter houses management.
- Basic training on maintaining coordination with GO/NGO and public representatives.
- Basic training on prevention and home management of infectious diseases (ARI, diarrhoeal diseases)

■ ***Vaccinator***

- Training MCH-FP motivation and counseling and referral techniques.
- Immunization related training (Registration, injection technique, sterilization, reporting, and side-effect management).
- Vitamin-A distribution and night blindness, related training.
- Basic health education and motivation techniques.
- Disease surveillance.
- Training on prevention and home management of common infectious diseases (Diarrhoea, ARI, viral hepatitis, STDs).
- Food and nutrition education.

APPENDIX B

MCH-FP Extension Project, ICDDR,B
INVENTORY FORM for URBAN CLINICS
(self-administered) ___/___/___

1. Name (exact):______________________________________ |__|__|__|

2. Location/address:______________________________________

____

3. Management: (✓)

Directorate of FP	
Directorate of Health Services	
City Corporation/ Municipality	
NGO ______________	
Private ______________	
Other ______________	

7. Services currently provided at the clinic and in the community: (✓)

Services		Clinic (✓)	Com (✓)	Day #
Family Planning:	Non-clinical			
	Inj			
	IUD			
	Norp			
	Tubect			
	Vasect			
	MR/Abort			
Antenatal Care				
Postnatal Care				
EPI				
Motivation/Counseling				
Delivery:	Normal			
	Caesarian			
General Treatment:	Male			
	Female			
	Children			

4.Fixed/Outreach Centre: ______________

5.Working area:______________

Population served: ______________

Eligible couple No. ______________

Under 5 Children No. ______________

Under1 Children No. ______________

6. ___ working days per ________

8. Staffing:

Doctor:	Female	
	Male	
Nurse		
FWV/Paramedic	Female	
	Male	
Medical Assistant	Female	
	Male	
Field Worker	Female	
	Male	
Vaccinator	Female	
	Male	
Other		

URBAN MCH-FP INITIATIVE
QUESTIONNAIRE FOR SITUATION ANALYSIS

Name of the respondent________________________ID No. |___|___|___|

Designation___________________________|___|___|

Name of interviewer____________________________________|___|___|

Date of intervew____/____/____

Coordination

1. With which agencies do you coordinate most on a regular basis?

	Yes	No	Never
a. GoB health dept.	1	2	3
b. GoB FP dept.	1	2	3
c. EPI office	1	2	3
d. ICDDR,B	1	2	3
e. NGOs	1	2	3
f. Private sector	1	2	3
g. BASICS	1	2	3
h. Others ___________ 1	2	3	

2. What is the main mechanism of coordination? |___|

1-Coordination committee
2-Meeting
3-Personal communication
4-Official communication
7-Other, __________________

3. What agencies do you need to coordinate more ?

a. ______________________________ |__|__|

b. ______________________________ |__|__|

c. ______________________________ |__|__|

4. What are the main responsibilities of the Dhaka City Corporation in primary health care?

	....	Yes	No
a.	Ensure FP	1	2
b.	Ensure immunization	1	2
c.	Ensure maternal care .	1	2
d.	Ensure safe water	1	2
e.	Ensure sanitation ...	1	2
f.	Nutrition education ..	1	2
g.	Ensure essential drugs 1	2	
h.	Health education	1	2
i.	Coordination among service providers	1	2
j.	VAC distribution	1	2
k.	Other ________________	1	2

Assignment

5. Have you got a copy of your role and responsibilities (Charter of duties)? |__|

1-Yes
2-No

6. What are your main routine activities?

a.____________________ |__|

b____________________ |__|

c.____________________ |__|

7. What additional activities are assigned to you from time to time?

a.____________________ |__|

b.____________________ |__|

c.____________________ |__|

Planning

8. Do you have any work plan of your activities? |__|

1-No work plan	2-Yes, monthly
3-Yes, quarterly	4-Yes, half-yearly
5-Yes, yearly	9-Don't know

9. Do you have any targets or objectives that you need to achieve?
[code: 1-Yes 2-No 8-NA 9-Don't know]

a. Primary health care |__|
b. Family planning |__|
c. EPI |__|
d. Vitamin A capsule |__|
e. Health education |__|
f. Water |__|
g. Sanitation |__|
h. Disinfection |__|
i. Mosquito control |__|
j. Veterinary |__|
k. Slaughtering |__|
l. Medical services (H) |__|
m. Medical services (A) |__|
n. Birth, death registration |__|

10. How frequently are they reviewed? |__|

1-Reviewed sometimes	2-Not reviewed at all
3-Monthly	4-Quaterly
5-Half-yearly	6-Yearly
8-NA	

11. Can you always achieve your target? |__|

1-Yes, Skip to Q13
2-No
3-Some times
8-NA, Skip to Q13

12. Reason(s) for not achieving the target.

a. ______________________________ |__|

b. ______________________________ |__|

c. ______________________________ |__|

13. Do you attend any weekly/monthly staff meeting to review your activities?

		1-Yes	2-No
a)	DCC		
b)	Zone		
c)	Ward		

<u>Training</u>

14. Did you receive any training in the last 2 years? |__|

1-Yes 2-No

15. If yes, please mention the name of organizer, place and year of training.

Area	Organization	Place	Year
a.________	________	________	______
b.________	________	________	______

16. In what areas would you like additional training?

a. ______________________________ |__|

b. ______________________________ |__|

17 Do your staff need training? |__|

1-Yes
2-No, Skip to Q 23

18. In what areas your staff need training?

a. ________________________ |__|

b. ________________________ |__|

MIS

19. What report do you prepare/sign and submit to your supervisor regularly?

	Name of the report	periodicity	topic	destination
a)	____________	________	________	________
b)	____________	________	________	________
c)	____________	________	________	________

20. What report do you receive regularly?

	Name of the report	periodicity	topic	source
a)	____________	________	________	______
b)	____________	________	________	______
c)	____________	________	________	______

21 Do you have any information on the following of your catchment area?

		Yes	No
a.	Total population	1	2
b.	ELCO	1	2
c.	FP acceptors	1	2
d.	EPI coverage	1	2
d.	Vitamin A coverage	1	2
e.	Child death	1	2
f.	Maternal death	1	2
g.	No. of community groups	1	2
h.	School	1	2
I.	Health facilities	1	2
j.	>5 chidren	1	2
k.	>1 children	1	2

Logistic support

22. What logistic support do you need to strengthen activities of your department? |__|

Resources available	Resources needed
Office space	Office space
Secretarial support	Secretarial support
Typewriter	Typewriter
Transprot	Transprot

Programme capabilities

23. What are the strong points of your health programme?

a. ______________________ |__|

b. ______________________ |__|

c. ______________________ |__|

24. What are the weak points of your health programme?

a. ______________________ |__|

b. ______________________ |__|

c. ______________________ |__|

25. What are the reasons behind this weakness?

a. ______________________ |__|

b. ______________________ |__|

c. ______________________ |__|

DCC Health Department Staff Position

Designation	Sanctioned Post	Staff in Position	Vacant Post
Assistant Health Officer			
PHC Workers			
EPI Supervisor			
EPI Technician/ Supervisor			
Vaccinator			
Health Inspector			
Sample Collector			
Spray-man/ Disinfection labour			
Spray-man (Mosquito)			
Veterinary Inspector			
Slaughter Inspector			
Junior Assistant/Munshi			
Mollah			
Seal Man			
Cleaner			
Security Guard (Slaughter)			
Part-time Medical Officer (Dispensary)			
Pharmacist/Compounder			
Female Attendant/ Nurse			
S. Guard/ Medicine Porter			
Homeo Doctor			
Homeo Compounder			
Security Guard (Homeo)			
Registration Assistant			
Lower Divisioin Clerk			
Peon/ MLSS			
Assistant Mechanic			
Insect Control Inspector			
Insect Control Supervisor			
Assistant Veterinary Doctor			
Total			

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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