LOCAL GOVERNMENT INSTITUTIONAL ASSESSMENT

A. Overview

1. The government is mandated to provide basic health services as per constitution. Article 15 of the Constitution stipulates it as a fundamental responsibility of the state to provide basic necessities of life, including food, clothing, shelter, education, and medical care. The state's primary duties, under Article 18 of the Constitution, include raising the nutrition level of its population and improve public health.

2. Four key players define the structure and functions of Bangladesh's pluralistic health system: government, private sector, nongovernment organizations (NGOs), and development partners. The government is responsible not only for setting policy and regulation but also for providing comprehensive health care services, including provisioning of resources, fund, and functionaries. The government regulates public, private, and NGO service providers through various acts and legislation. The institutional arrangements for urban primary health care (PHC) of the Government of Bangladesh lie primarily with the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC), Ministry of Health and Family Welfare (MOHFW), and urban local bodies (ULBs) comprising the city corporations and municipalities (*pourashavas*).

3. Bangladesh's aim of becoming middle-income country by 2021 demands substantial improvement and investments in health service delivery. Health has a direct impact on economic growth and countries with weak health indexes find it harder to achieve sustained economic growth. Universal health coverage is among the potential Sustainable Development Goals in a post Millennium Development Goals agenda.

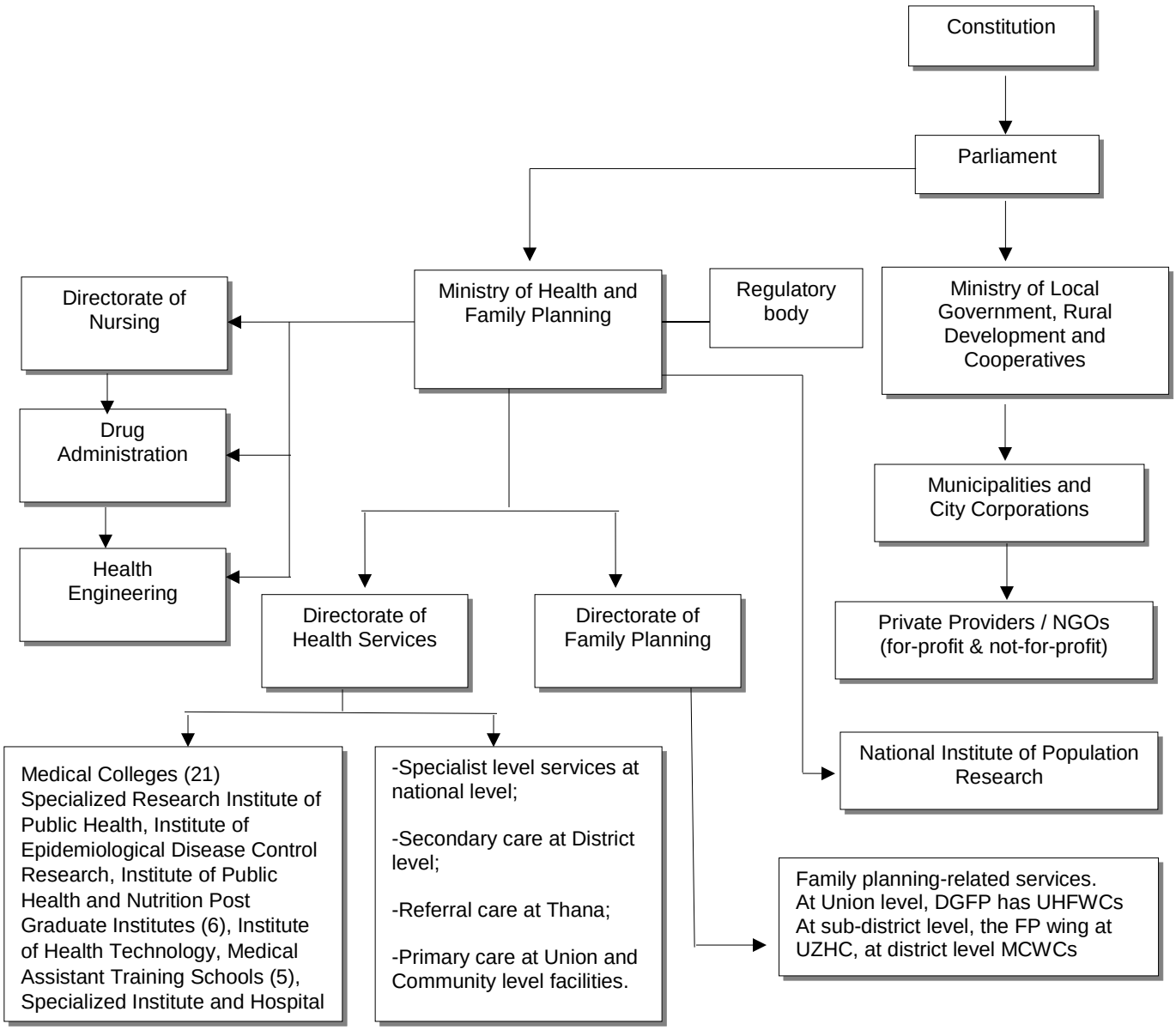
4. Vision 2021 of the government identified empowerment of local government as key requirement to achieve envisaged goal, wherein local government institutions play an important role in governance as well as in development programs. The government emphasizes on institutionalizing the local government to make the public services more accessible to the people and ensure local people's priorities are reflected in the planning process. The Seventh Five-Year Plan committed to undertake a comprehensive set of actions, including (i) building the capacities of local governments through the assignment of appropriate officials, technical assistance, and training programs; (ii) developing planning and budgeting capacities at the local level to help design and implement local-level programs; and (iii) fostering initiatives to provide technical assistance to link local level plan to the national medium- to long-term planning.

5. The National Urban Health Strategy, 2014 outlines 10 key actions: (i) universal pro-poor health coverage for urban population; (ii) strengthening preventive and PHC management system; (iii) ensuring urban poverty reduction; (iv) achieving National Population Policy targets; (v) fulfilling national nutrition targets; (vi) adopting innovative service delivery using modern technology, management policy and practices; (vii) improving institutional governance and capacity development; (viii) strengthen health service program of the ULBs; (ix) financing and resource mobilization; and (x) attaining sustainability.

6. Focus on institutional strengthening, improvement in service delivery, and establishment of effective project management systems constitute the major building blocks for the additional financing of the Urban Primary Health Care Services Delivery Project. The government envisions that the implementation arrangements for additional financing of the project will strengthen the capacity of ULBs to deliver PHC services. The Local Government Division (LGD) will be the executing agency and responsible for stewardship and agents setting in capacity development of

local governments (including in fulfilling local bodies' mandates in public and primary health) and ULBs will be implementing agencies. MOHFW is responsible for health stewardship, health technical guidance, etc. The project steering committee will comprise LGD, MOHFW, and representative of mayors.

B. Institutional Arrangement for Urban Health



DGFP = Directorate General of Family Planning, FP = family planning, MCWC = mother and child welfare center, NGO = nongovernment organization, UHFWC = union health and family welfare center, UZHC = upazila health complex.
Source: Asia Pacific Observatory on Health Systems and Policies.

7. **Local Government Division and Ministry of Local Government, Rural Development and Cooperatives.** MOLGRDC is mandated to provide PHC in urban areas. All ULBs work under LGD of MOLGRDC. All the rules and regulations, acts, ordinances, and government orders regarding the functioning of ULBs are prepared and issued by LGD. LGD/MOLGRDC is also

mandated to identify relevant legal frameworks that defines the role and responsibilities of the ULB's Health Department to establish organizational structure and delivery of PHC services. The ministry has published two important acts, e.g., Local Government (City Corporation) Act, 2009 and Local Government (*Pourashava*) Act, 2009. Both acts are almost identical and provide necessary guidelines regarding urban health management. Successful implementation of these acts, in the near feature, will significantly contribute towards improving urban health sector performance.

8. The institutional arrangement of the Urban Primary Health Care Services Delivery Project at national and ULB levels are as below:

1. Institutional Set-Up at National Level

a. National Urban Health Coordination Council

9. At the national level, the Urban Health Coordination Committee (UHCC) co-chaired by secretaries of MOHFW and LGD, was formed on 22 March 2015. A technical working group for urban health headed by the additional secretary, LGD and represented by city corporations, MOHFW, development partners, NGOs, etc. has been formed to develop guidelines for delivering urban primary health services. It is also expected to address gaps in service delivery Urban Primary Health Care Services Coordination Committee has also been constituted under the chairmanship of secretary, LGD to ensure policy and working level coordination between MOHFW and LGD. However, to institutionalize the process in the regular functioning of these two agencies might require some period.

b. Urban Development Wing, Local Government Division

10. In November 2012, the LGD established the Urban Development Wing (UDW), with four permanent cadre posts and 21 contractual posts. The UDW is responsible for the following: (i) implementing the National Urban Health Strategy and its operational plan in coordination with MOHFW and under the guidance of the UDW/LGD; (ii) functioning as the administrative authority for urban primary health in Bangladesh and facilitate the functions and responsibilities of ULB health departments and project implementation units (PIUs); (iii) coordinating urban health service-related activities of government and nongovernment agencies, development partners, international organizations/agencies like the World Health Organization, United Nations Children's Fund (UNICEF), United Nations Population Fund, etc., urban PHC projects such as Urban Primary Health Care Services Delivery Project, Government of the United Kingdom's Urban Health Program, European Union support to urban health and nutrition in Bangladesh, etc.; (iv) mobilizing resources for ULBs' health departments; (v) monitoring activities and performance of ULBs' health departments, urban health facilities, and projects/programs on urban primary health; (vi) organizing recruitment, deputation, training, career planning, and deployment of ULBs' health personnel; (vii) providing overall personnel functions for ULBs and urban health facilities; (viii) setting and enforcing clinical, ethical, and management quality standards for urban health facilities both in public and private/NGO sector, with the Directorate General of Health Services (DGHS); (ix) maintaining a database for all urban PHC facilities and authorities with DGHS; (x) performing evaluation and monitoring functions over ULBs' health departments and the urban health facilities at the field level; (xi) promoting advocacy and behavior change communication activities; (xii) maintaining constructive liaison with ministries and other government agencies, development partners, and private sector/NGOs.

11. Since establishment, the UDW has had issues with assignment of responsible staff and assumption of effective authority over urban health. To ensure effective functioning, UDW should be strengthened with adequate personnel and resources. A dedicated joint secretary level officer, with requisite support staff and other resources, should be assigned to the wing to monitor urban health services. At present, UDW is headed by an additional secretary assisted by two deputy secretaries, four senior assistant secretaries, and various support staff. One of the assistant secretaries is entrusted to look after health issues.

c. Project management unit

12. A project management unit (PMU), headed by a full-time project director, has been functioning in LGD to provide the required technical, administrative, and logistical support for project implementation. The project director is at least a deputy secretary level officer, preferably at the joint secretary level, and has project management experience, preferably related to the health sector.

2. Institutional Set-Up at Urban Local Body Level

a. Urban local government bodies

13. ULBs are responsible for PHC services provision and delivery in its jurisdiction. The mayor is officially entrusted with all powers. Councilors are the members of the council (*Parisad*) and responsible for the tasks of different standing committees. The Local Government (City Corporation) Act of 2009 and Local Government (*Pourashava*) Act of 2009 stipulate the various health functions to be performed by ULBs (Appendix 1).

14. The urban health function is one of the core functions of ULBs in line with the phrase ‘citizen health and environment and protection’ of the acts. However, institutional arrangements towards ensuring universal health coverage to urban residents should involve regular coordination, monitoring, and application of regulations for both public and private service providers alike.

b. Urban Local Body Health Department

15. Each ULB has a health department called a city corporation or municipal health department, which provides public health services. The ULB health departments have institutional problems which contribute to the non-attainment of needed program results. Due to vacancies of medical officers and limited staff strength across many ULBs, the strengthening of the ULBs is yet to reach the desired level. Moreover, absence of a career path for the medical officers of the health unit of the corporations and municipalities compared to their health ministry counterpart also act as a deterrent to undertake leadership in resolving medical and service delivery issues. Additional technical posts need to be sanctioned for PHC as existing PIU staffing are insufficient to oversee service providers. PIUs undertake monitoring visits to the clinics but providing regular guidance to the service providers is a challenge considering its current staff strength. Lack of resources and technical capacity severely limits the ULBs from taking an effective role in monitoring service delivery.

c. Project implementation unit

16. While PMU is the central managing agency, the PIUs are the main drivers for implementation of project activities at the city/town level. PIU is formed with city corporation or

municipality officials and project-appointed staff. To ensure smooth and effective relations between public–private contracting parties, PIUs have established partnership committees in their respective localities with adequate representation from local officials and private sector representatives. Further delegation of procurement and service contract administration-related responsibilities to PIUs are proposed under the additional financing of Urban Primary Health Care Services Delivery Project. However, this will require streamlining of project financial management and procurement systems across all layers of project implementation, as well as strengthening PIUs' monitoring and oversight role.

3. Urban Health Coordination Committees at Urban Local Body and Ward Levels

17. In each city corporation and municipal level, UHCCs have been established. City corporation/municipality UHCCs are chaired by the chief executive officers, and is comprised of the district civil surgeon, chief health officers, partnership area NGOs (PANGOs), and other stakeholders. At the ward level, a ward UHCC has been established. The ward UHCC is chaired by a ward councilor, and co-chaired by zonal health officers, and comprise representation from NGO workers and local stakeholders (including representatives from poor communities and informal settlements, at least 40% representation must be female). The ward UHCC serves as a mechanism for grievance redress of any resettlement-related issues and coordinates user forums to discuss communities' feedback on NGO health services provision. Though one primary health care center (PHCC) serve multiple wards, the other ward councilors are not part of this Ward Primary Health Care Coordination Committee. This results lack of interest and ownership among these councilors.

a. Ministry of Health and Family Welfare

18. The statutory responsibility for the health sector is vested in MOHFW headed by a minister. The ministry is responsible for policy formulation, decision-making, maintaining liaison with donors and other line ministries, and the activities of directorates and departments under its jurisdiction. The MOHFW comprises of nine executing authorities (directorates of director generals), of which the DGHS and the Directorate General of Family Planning are directly involved with provision of health and family planning services. The director generals are responsible for health programs and projects under their respective directorates. Below the director general, the civil surgeon is the team leader and chief of health services at the district level and the upazila health and family planning officer (UHFPO) is responsible for technical and administrative supervision of health and family planning activities at the upazila level. The UHFPO is the last tier in state health administration. The civil surgeon and UHFPO are supported by the deputy director of Family Planning and upazila family planning officer in the district and upazila levels, respectively. At the local level, administration of health matters is fully controlled by the MOHFW.

19. MOHFW in 2012 adopted a health care financing strategy, Expanding Social Protection for Health: Towards Universal Coverage Health Care Financing Strategy, 2012–2032. The strategy is being implemented in three phases, short-, medium-, and long-term. The short-term was coterminous with the Health, Population and Nutrition Sector Development Program, i.e. 2016. The medium-term phase is now up to 2021. The long-term phase, which ends in 2032, will build upon the achievements of the short and medium-terms of sequenced implementation of the planned strategic interventions, moving Bangladesh towards achieving universal health coverage.

b. Non-project health service providers

20. Non-project urban areas are covered by the United States Agency for International Development and Department for International Development-funded NGO Health Services Delivery Project, a network of contracted NGOs providing services in over 4,000 urban service locations. Marie Stopes Clinics Society provides services in 120 service locations while urban health networks for the poor are organized by Manoshi (Bangladesh Rural Advancement Committee). Other NGOs and private providers, outpatient department facilities of MOHFW, secondary and tertiary hospitals, and outdoor dispensaries complete the urban health providers' landscape. NGOs provide essential and special services. However, the various urban PHC services are largely inadequate in view of the needs of the fast-growing urban population.

c. Private health service providers

21. Private sector health service providers can be grouped into two main categories—the organized and the informal. The organized private sector (both for-profit and nonprofit), serving mostly urban areas, includes qualified practitioners of modern systems of medicine. The informal sectors, which primarily serve rural areas, consist of providers without formal qualifications such as untrained allopaths, homeopaths, *kobiraj*, etc., known as alternative private providers.

22. Urban PHC services, often in the form of formal and informal, non-public or private health work force have been dominating Bangladesh. The quality and extent of current health services provided by public and private sectors in the country needs improvement. High fees and excessive diagnostic testing are the main reasons for expensive treatment in the private sector. The National Health Policy, 2011 states that quality control is necessary for private health care facilities, which requires strengthening of government regulatory system. The 16th strategy of National Health Policy, 2011 spells out the measures to be taken to develop and apply necessary rules and regulations to ensure availability of proper and quality medical care for the patients in the private sector.

23. In Bangladesh, most transactions (64% of total health expenditure) are made directly from patients to providers as out-of-pocket payments (OOPs). Direct payment for the purchase of pharmaceuticals and medical goods is the predominant contributor to OOP, either through self-purchase or on the advice of a formal or informal health-care provider (WHO 2015, Bangladesh Health System Review) (fund flow diagram in Appendix 2). Hence, the government may face bigger challenges in this regard, where household health expenditure as share of total spending tends to be higher among poorer income groups. High rates of OOP can create a barrier for the sustainability of urban PHC.

C. Intuitional Challenges in Urban Primary Health Care

24. The independent midterm review in November 2015 observed that LGD has been effectively providing leadership through the ongoing Urban Primary Health Care Services Delivery Project to the country's efforts in identifying scalable models for PHC delivery through ULBs and merits continuation and expansion to meet the growing demands in the short term. This will also contribute significantly to continue providing leadership to support the country's plans to deliver sustainable urban PHC.

25. However, despite its successes, improvement in institutional strengthening under the ongoing project remains a challenge. Many of the urban health departments are understaffed, with several posts remaining vacant. In addition, many of the positions are not permanent and staff are employed through master roll or short-term contracts. Most of them are not clinicians.

26. It is virtually impossible for a ULB to become sustainable in the absence of autonomy and delegation of authority. Of the 11 city corporations and 324 municipalities in the country, most are dependent on the grants and block allocations from the central government. The sources of ULB's income are from holding taxes, fees, and charges they levy as well as rents and profits accruing from properties of the local body and fees received through its different services. The local revenue resources are insufficient for the ULBs to meet the expenditure needs of the growing urban population.

27. The discourse of municipal finance in Bangladesh has been largely through these perspectives: (i) local resource mobilization, (ii) national government's grant, and (iii) transfers through project and project financing. ULBs get government grants, but it is difficult to determine how much of it is for health activities. All ULBs do not get funds from the government equally due to the absence of a well-structured fund transfer mechanism.

28. Human resources constraints are one of the major issues hindering the efficacy of ULBs. Provision of technical positions like doctors, paramedics/clinicians, etc. of health departments in the present organogram of ULBs are inadequate to meet the manpower requirements for urban PHC services (to illustrate, organogram of 'A Class' *Pourashava* in Appendix 3), and in addition, there are usually many vacancies for technical positions in ULBs. ULBs are not fully autonomous in hiring their staff. First and second-class officials get appointed by the MOLGRDC, while only third and fourth-class employees get appointed by the ULBs.

29. Approval of a new organogram for a ULB is complicated. Approval must be obtained from the line ministry, Ministry of Public Administration, Ministry of Finance, Ministry of Law, and the secretariat committee, though ULBs are fully responsible for paying salaries and all other allowances from their own sources.

D. Lessons Learned from Ongoing Urban Primary Health Care Services Delivery Project

30. ULBs under MOLGRDC have delivered PHC services in project areas since 1998 through contracted NGOs under the three phases of urban PHC projects (Urban Primary Health Care Project [1998–2005], Second Urban Primary Health Care Project [2005–2012], and Urban Primary Health Care Services Delivery Project [2012–present]). The project is operated on a public–private partnership, performance-based contracting model with pro-poor targeting as well as gender-responsiveness which aims to provide 30% free services to the poor populace in the project areas. The Urban Primary Health Care Project was designed to provide a role model of how the government could change from being a direct provider of services into a contracting agency and, by doing so, provide an effective way to finance and organize the ULBs' PHC delivery, while also providing possible directions for further diversification of health care services in Bangladesh. The Urban Primary Health Care Services Delivery Project runs clinics known as comprehensive reproductive health care centers and PHCCs, under the brand name of *Nagar Sastho Kendro*, that has been effective in improving the health of the urban poor and reduce preventable mortality and morbidity, especially among women and children.

31. The ongoing Urban Primary Health Care Services Delivery Project is intended to sustain improvements in PHC by building capacities of ULBs to manage, finance, plan, evaluate, and coordinate urban health services. This was expected to be achieved through organizational restructuring of the ULB's health departments. However, there has been little progress until date in this respect.

32. The project has facilitated formation of several key institutional structures at national level, such as the UHCC, technical working group under UDW. The outputs from these committees are yet to reach a significant level. The UDW, which was to play a key leadership role in institutional dialogue and towards moving from stand-alone project approaches to a programmatic role in urban health, is yet to fully assume its mantle delaying achievement of intended outcomes.

33. ULBs are yet to receive block allocation earmarked specifically for urban PHC from the government resulting in fund shortages and consequent inadequate support to PHC services and facilities in their jurisdictions.

34. Many of the ULBs are considered best performers in providing PHC services as per PANGOs' ranking. However, it is observed that ULBs' health service is mostly focused on immunization, conservancy, slaughter house, birth and death registration, etc. activities, and PHC services is still not part of ULB's mainstream focus mainly due to their full functional dependency on NGOs for the same. The project has provided a strong focus in the ULBs as they are functional PIUs in PHC services, but there is still little interest due to sustainability concerns. In most cases, ULB/PIU are not allocating the recommended 1% annual revenue budget contribution to the Urban Primary Health Care Sustainability Fund. Even PANGOs are not adhering nor fully aware about the timing and basis of contribution for 80% of excess income generation.

E. The Way Forward

35. During the additional five-year implementation period, the government envisages sufficient strengthening of urban health service administration, including at ULB level, to sustain health services through the establishment of a functional, fully-staffed, permanent institutional body with a dedicated revenue budget head for urban PHC under MOLGRDC from which government budget allocations will supplement ULBs' health financing. ULBs would also ensure financing and functionaries, and institutional arrangements will be sustained accordingly. It is expected that contracting out of health services will predominantly continue even after project completion, and where the capacity exists, selected ULBs may deliver services themselves.

36. Sustainability of urban PHC should be ensured through (i) strengthening of UDW to take a leadership position in delivery of urban PHC services in health policy, planning, coordination, monitoring, and program guidance for urban health; and (ii) establishing a revenue budget line for ULBs' PHC service from government revenue allocations support technical, logistics, and human resources requirement for health services in ULBs and deputation of medical officers from MOHFW. This allocation could also be used to supplement ULB-financing of urban PHC as a means for sustainable financing when development partner-financing support ends.

37. ULBs have two budget heads they can utilize to support health efforts. First, the revenue raised through tax collection on which ULBs have sole authority. Thus, they can determine the extent of budgetary allocation from this head that can be used to support health interventions. Secondly,[1] revenue budget from LGD as well as a development budget they may receive from

[1] By creating a provision of revenue budget head for PHC service in the LGD.

the line ministry and provided by international donors. These funds are usually earmarked for specific activities. ULBs usually receive some funding support for water and sanitation efforts from this budget head.

38. The health departments of ULBs also require strengthening with sufficient manpower resources. Health department staffing should include sufficient medical officer/s and other health professionals, and auxiliary staffs reflecting its population and health requirements. Capacities of such staff should be built with in-service orientation and training for ULB-centered health responsibilities.

39. ULBs must be made to consider PHC as a priority subject and take a proactive role in ensuring PHC delivery to all urban dwellers. ULBs must earmark a sizable part of their budget for health care and establish health investment accounts. The government should also assist the ULBs with adequate budgetary support for the purpose, including targeted block grants for public and primary health.

40. The Urban Primary Health Care Services Delivery Project should also address differential health needs of women and men and ensure service delivery is non-discriminatory and inclusive. Since women mostly bear the burden of household chores, it is important that the mindset of men and family members are made more gender-sensitive through behavior change communication. It is also to be recognized that climate change, distortion of water, and sanitation facilities affect women the hardest. So, in the next phase of the project, these issues must be addressed for sustaining the effects of the present project.

41. It is necessary to develop urban health management information system as an online platform creating online accounting system to capture and transmit service transactions electronically, thereby strengthening internal controls as well as improving data quality and timeliness of reporting.

42. Sound institutions and good governance go together. To improve institutional governance for urban health management in ULB level, the project should focus on three pillars in its capacity building efforts: (i) leadership, (ii) staff development, and (iii) enhancing process and systems to meet international standards and country's best practices. In support of this, more specific tangible actions are needed at both national (LGD) and local (ULB) levels:

(i) At LGD level:

a. strengthen UDW with permanent dedicated staff and support;
b. designate one district surgeon for primary health and one for public and environmental health;
c. conduct regular UHCC meeting at the secretarial level;
d. reactivate Urban Health Working Group at the sub-secretariat (working group/staff) level with regular meetings and report preparation;
e. MOHFW deputes chief health officer/medical officer and other staff to serve in ULBs;
f. appoint technical staff for UDW/PMU to strengthen ULBs' capacity;
g. establish a revenue budget head in LGD specifically for PHC;
h. LGD develops a strategy for retention and career progression of ULBs' medical officers; and
i. redefine Urban Primary Health Care Sustainability Fund mechanism for its best utilization to cover an increasing share of ULB health costs.

(ii) At ULB level:

a. Mayors and councilors (ULB leadership) foster motivation, vision, and assumption of responsibility on health issues;
b. strengthen health departments with required manpower and capacity development;
c. allocate sufficient budget for health departments;
d. engage in capacity development on human resource recruitment, financial management, procurement, monitoring and evaluation, information and communication technology, health service quality assurance, etc.; and
e. hold regular Health Coordination Committee meetings under the mayor with participation of the chief health officer/medical officer, civil surgeon, deputy director of Family Planning, private hospitals, NGOs, and private sector.

HEALTH FUNCTIONS[1] OF MUNICIPALITIES AND CITY CORPORATIONS

1. **Responsibility for health systems**. A city corporation/municipality shall be responsible for the health of its people and for this purpose it may cause such measures to be taken as are required by or under this ordinance.

2. **Insanitary buildings.**

(i) A city corporation/municipality may, by notice, require the owner or occupier of any building or land which is in an insanitary or unwholesome state:
   a. to clean or otherwise put it in a proper state;
   b. not to keep it unhealthy;
   c. to lime wash the building and to make such essential repairs as may be specified in the notice; and
   d. to take such other steps to such building or land as may be specified.

(ii) If any requirement of a notice issued under sub-section (1) is not complied with within such period as may be specified in the notice, the city corporation/municipality may cause necessary steps to be taken to rectify the same, and the cost so incurred thereunder by the city corporation/municipality shall be deemed to be a tax levied on the owner or occupier under this ordinance.

3. **Waste removal, collection, and management**

(i) A city corporation/municipality shall make adequate arrangements for the removal of refuse from all public streets, public latrines, urinals, drains, and all buildings and land within its jurisdiction and for the collection and proper disposal of such refuse.

(ii) The occupiers of all other buildings and lands within city corporation/municipality limits shall be responsible for the removal of refuse from such buildings and lands subject to the general control and supervision of the city corporation/municipality.

(iii) The city corporation/municipality may cause public dustbins or other suitable receptacles to be provided at suitable places and in proper and convenient situations in streets or other public places, and where such dustbins or receptacles are provided, the city corporation/municipality may, by public notice, require that all refuse accumulating in any premises or land shall be deposited by the owner or occupier of such premises or land in such dustbins or receptacles.

(iv) All refuse removed and collected by the staff of the city corporation/municipality or under its control and supervision and all refuse deposited in the dustbins and other receptacles provided by the city corporation/municipality shall be the property of the city corporation/municipality.

4. **Public toilet**

(i) A city corporation/municipality shall provide and maintain, in sufficient number and in proper condition, public latrines and urinals for the separate use of each sex and shall cause the same to be kept in proper order, and to be properly cleaned.

(ii) The occupier of any premises to which any latrine or urinal pertains shall keep such latrine or urinal in a proper state to the satisfaction of the city

[1] The functions of municipality and city corporation in the acts are typically similar. The Local Government (Municipality) Act, 2009 – 2nd Schedule: Detail Functions of the Municipality – Public Health outlines the broad responsibilities for public health by a municipality. The similar functions have been outlined in the Local Government (City Corporation) Act, 2009 – 3rd Schedule" Detail Functions as responsibility for Health Systems.

corporation/municipality and shall employ such staff or resources for the purpose as may be necessary or as may be specified by the city corporation/municipality.

(iii) Where any premises are without privy or urinal accommodation, or without adequate privy or urinal accommodation, or the privy or urinal is on any ground objectionable, the city corporation/municipality may, by notice, require the owner of such premises (a) to make such structural or other alterations in the existing privy or urinal accommodation as may be so specified; (b) to remove the privy or urinal; and (c) where there is an underground sewerage system, to substitute connected-privy or connected-urinal accommodation for any service-privy or service-urinal accommodation.

5. **Births, deaths, and marriage registration**

(i) A city corporation/municipality shall register all births, deaths, and marriages within the limits of the city corporation/municipality and information of such births, deaths, and marriages shall be given by such persons or authorities, and shall be registered in such manner, as the by-laws may provide.

(ii) A city corporation/municipality shall record marriages and death registration and shall discharge any other duty per the ordinance.

6. **Infectious diseases**

(i) A city corporation/municipality shall adopt such measures to prevent spread of infectious diseases and to restrain infection within the municipality as the rules and by-laws may provide.

(ii) A city corporation/municipality may, and if so required by the government shall establish and maintain one or more hospitals for the reception and treatment of persons suffering from infectious diseases.

(iii) A city corporation/municipality may, in the prescribed manner, frame and implement schemes for the prevention and control of infectious diseases.

7. **Promotion of public health.** Subject to the provisions of this ordinance and the rules, a city corporation/municipality may, and if the government so directs shall, take such measures for promoting public health, including education in health, as it considers necessary or the government directs.

8. **Hospitals and dispensaries**

(i) A city corporation/municipality may, and if so required by the government shall, establish and maintain such number of hospitals and dispensaries as may be necessary for the medical relief of the inhabitants of the city corporation/ municipality and the people visiting it.

(ii) Every hospital and dispensary maintained by a city corporation/municipality shall be managed and administered in such manner as may be prescribed.

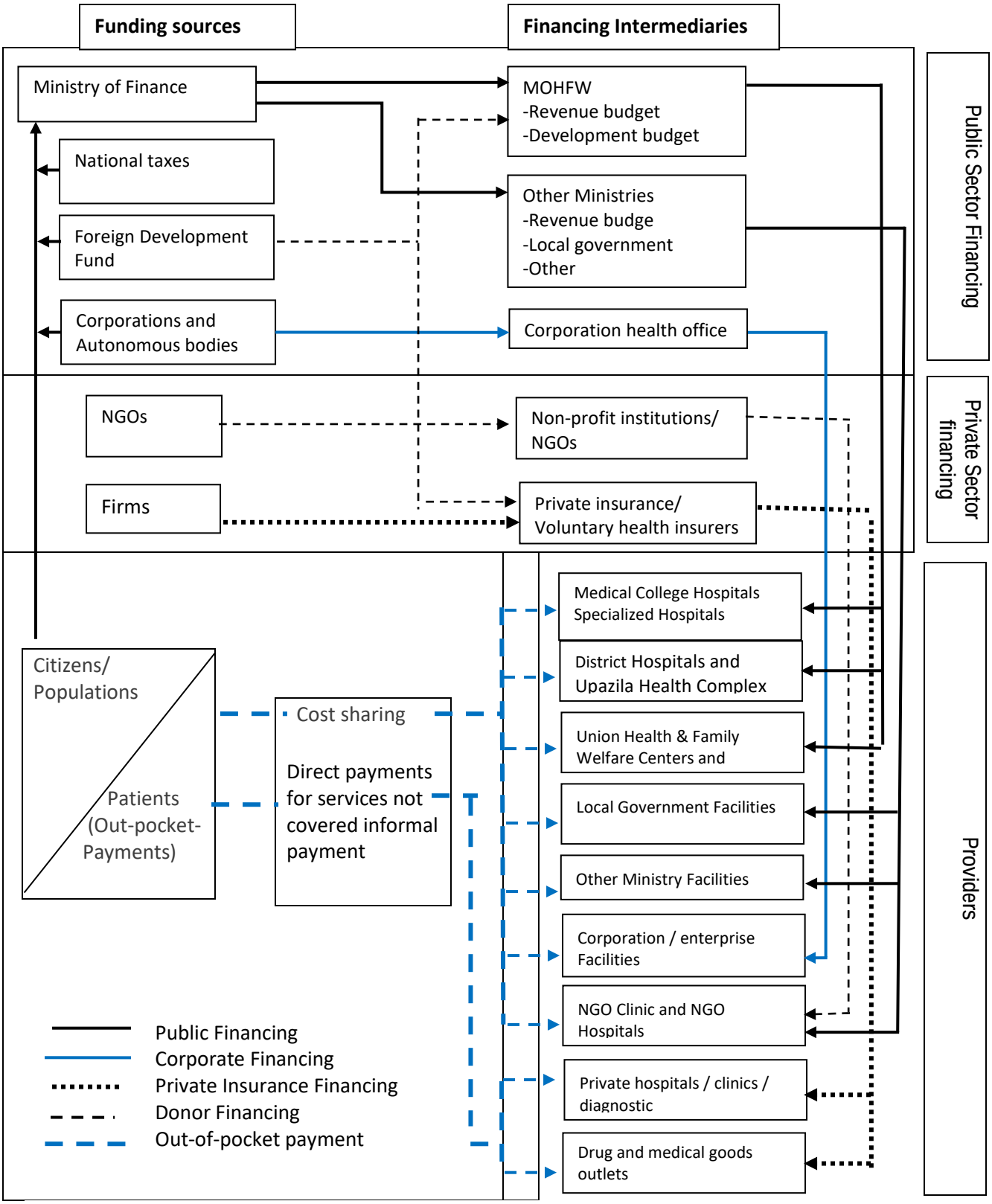
(iii) Subject to any directions that may be given in this behalf by the prescribed authority, every hospital and dispensary maintained by a city corporation/ municipality shall be provided with such drugs, medicines, instruments, apparatuses, appliances, equipment and furniture in accordance with such scale and standards as may be prescribed.

9. **Medical, aid, medical education, etc.** A city corporation/municipality may, and if so required by the government shall, take such measures as may be necessary or as may be specified by the government for the:

(i) provision and maintenance of first aid centers;

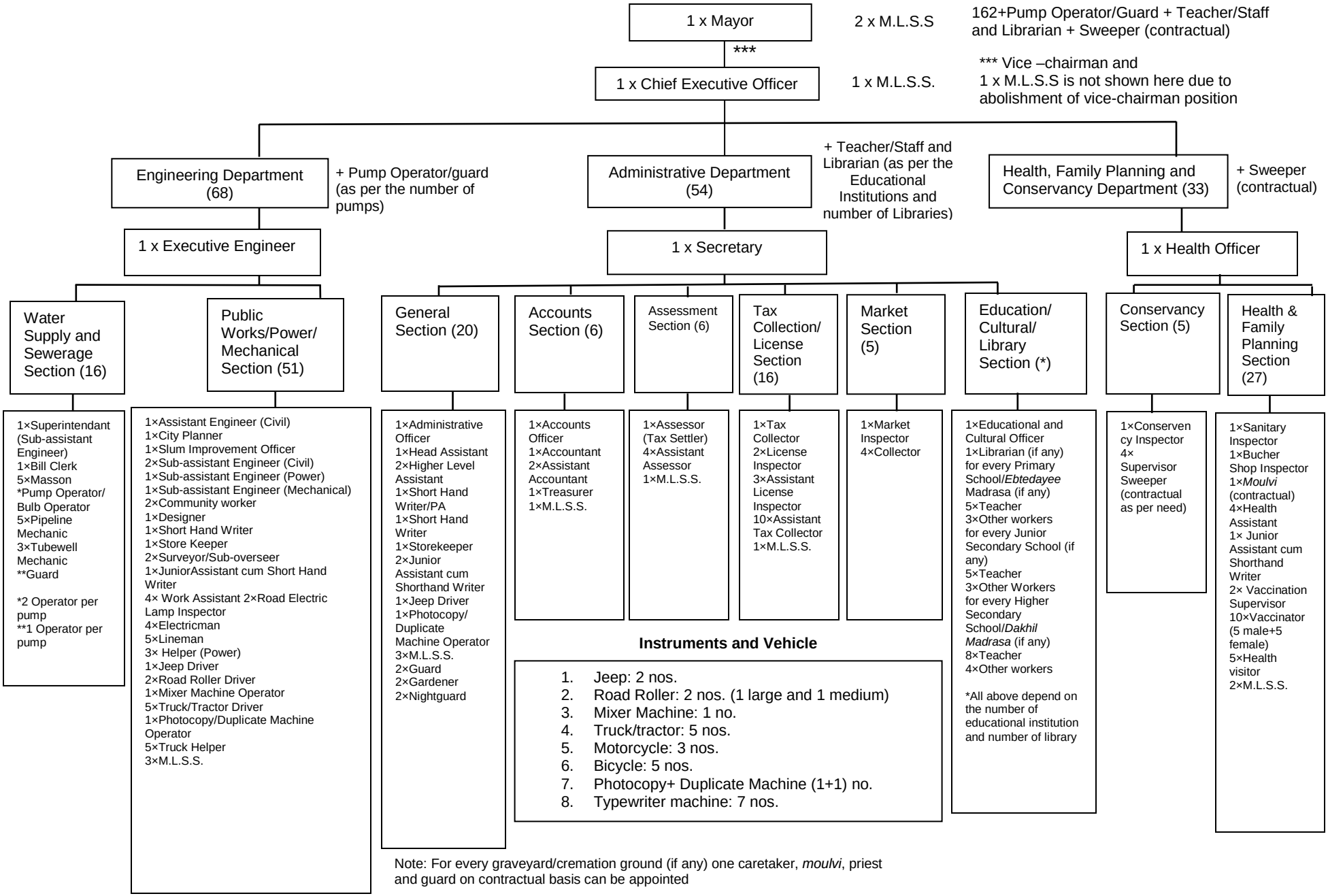
(ii) provision and maintenance of mobile medical aid units;
(iii) promotion and encouragement of societies for the provision of medical aid;
(iv) promotion of medical education;
(v) payment of grants to institutions for medical relief; and
(vi) medical inspection of school children.

FINANCING FLOW IN THE BANGLADESH HEALTH SYSTEM



Source: WHO. 2015. Bangladesh Health System Review. Asia Pacific Observatory on Health Systems and Policies. Geneva.

CLASS-A *POURASHAVA*: ORGANOGRAM



Note: For every graveyard/cremation ground (if any) one caretaker, *moulvi*, priest and guard on contractual basis can be appointed