URBAN PRIMARY HEALTH CARE SERVICES THROUGH PUBLIC - PRIVATE PARTNERSHIP

- A PERFORMANCE EVALUATION APPROACH IN DCC AREA.

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DHAKA, BANGLADESH.

APRIL, 2010

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by

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Thesis submitted in partial fulfilment of the requirements for the degree of
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It is hereby declared that this thesis or any part of it has not been submitted elsewhere for the award of any degree or diploma.

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Dedicated to my beloved parents and family

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Abstract

Primary Health Care (PHC) as the strategy to achieve constitutional goals of Bangladesh Government "Health for All". Bangladesh has made important gains in providing primary health care since the Alma Ata Declaration in 1978. All health indicators show steady gains and the health status of the population has improved. Infant, maternal and under-five mortality rates have all decreased over the last decades, with a marked increase in life expectancy at birth.

Dhaka City Corporation (DCC) is a public organization working under Ministry of Local Government, Rural Development & Co-operatives (MoLGRD&C), has provided curative and preventive health services to the citizens by the constitutional mandate of "the Local Government (City Corporation) Act, 2009". On the other hand, the Urban Primary Health Care Project (UPHCP) has been directly executed by the Ministry of LGRD&C through public-private partnership with NGOs as well as DCC act as coordinating organization of the project.

The purpose of UPHCP was to improve the health status of the urban poor because the scope of quality health services in Dhaka city is very limited particularly for the poor and grass root community.

Dhaka City Corporation is the biggest City Corporation in Bangladesh and Dhaka has the highest number of health partnership with NGOs. That's why; Dhaka has been selected as study purpose. The research methodology has been designed based on the theoretical framework in connection to the study aim and objectives. From both the cases, a good number of health centre (HC) have been selected for data/information collection. The research was designed towards understanding the nature of primary health care services provided by DCC and UPHCP through public-private partnership. The study was also tried to examining a performance evaluation both DCC and UPHC HC. To understanding the level of satisfaction, the research explores application level of satisfaction index, widely used to examine satisfaction level from individual perspectives as well as used t-test to examine the significant different on accessible facilities, income level, waiting time, nature of health service receives by DCC and UPHC HC from respondents point of views.

Keywords: Primary Health Care, Public-Private Partnership, Satisfaction, Grass Root Community.

Abbreviations

ADB	Asian Development Bank
CPR	Contraceptive Prevalence Rate
CSP	Child Survival Programme
DCC HC	Dhaka City Corporation Health Centre
FDG	Focus Group Discussion
EPI	Expanded Programme on Immunization
EOC	Emergency Obstetric Care
ESP	Essential Services Package
GOB	Government of Bangladesh
GAVI	Global Alliance for Vaccine Initiative
HFA	Health For All
IDD	Iodine Deficiency Disorders
MoLGRD&C	Ministry of Local Government, Rural Development and Co-operatives
MSU	Michigan State University
MBO	Management by Objectives
NGO	Non Government Organizations
OPEC	Organization of Petroleum Exporting Countries
PRSP	The Poverty Reduction Strategy Paper
PEPFAR	President's Emergency Plan for AIDS Relief
PAPR	Partnership Agreement on Poverty Reduction
PPP	Public Private Partnership
SIGN	Safe Injections Global Network
RBM	Roll Back Malaria
LGED	Local Government Engineering Department
UNDP	United Nation Development Programme
UPHC HC	Urban Primary Health Care Health Centre
WHC	Ward Health Committees

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CHAPTER – ONE

INTRODUCTION

1.1 Background Information

Bangladesh is one of the most populous countries in the world with a population of over 145 million. With an annual population growth rate of about 1.5, around two million people are annually added to the country's populations. Bangladesh is one of the developing countries in the world, with a per capita income of $695 (Barket, 2009). There is highly inequity in income distribution. Around 40% of the population lives below poverty lines. Although Bangladesh has improved in several health indicators, includes increase in life expectancy. However, neonatal mortality and maternal mortality rates are still unacceptably high (ADB, 2005). There has been a considerable slowing down in the rate of increase in the contraceptive prevalence rate (CPR) over the last decade, resulting in a near stagnation in fertility decline. Malnutrition remains a major area of concern, especially among young children, adolescents and pregnant mothers.

In Bangladesh, contraceptive use among currently married couples increased from 8% in the mid 1970's to 56% in 2007 (USAID, 2009). This resulted in a significant decline in fertility from 6.3 to 2.7 children per woman over the same period. However, Bangladesh Demographic and Health Survey 2007 show that contraceptive use rate has not improved in the past three years. Bangladesh's goal to reach a fertility level of two children per woman or below will require contraceptive use to increase substantially over the current use rate.

Map-1.1: Location of Dhaka in Context of Bangladesh

Source:http://wwwn.cdc.gov/travel/destinations/bangladesh.aspx

There has been an increase in use of antenatal care among pregnant women, from 49% in 2004 to 52% 2007. Despite the rise in antenatal care, only one in five women receives the recommended four or more antenatal visits during her pregnancy; less than one in five deliveries are assisted by a trained birth attendant.

Over the last three decades, mortality rates of children under the age of five have declined significantly. Their risk of dying has fallen from 250 to 65 deaths per 1000 live births during these periods (USAID, 2009). Similar sharp decline has occurred in infant deaths due to the success of a number of child health programs like increasing vaccination coverage and improving management and treatment of diarrhoea and acute respiratory infections. Most deaths among children under five years of age, occurs now in the first month of life. Reducing neonatal mortality has become an emerging challenge for Bangladesh.

Socio-economic development for all citizens is the cornerstone of Bangladesh's constitution. According to the articles 15, 16, 17 and 18 of the constitution, the state has the responsibility to ensure to its citizens certain basic needs such as health, education, food and security (GoB, 2004). In order to translate these constitutional goals into reality, the Government of Bangladesh (GoB) is committed to improving the health status particularly the poor and grass root community because these groups are the most disadvantage groups of our society but the overall performance of health sectors mostly depends on the performance of these groups.

The population and health policy (GoB, 2001) is to incorporate population and family planning program as the integral components of overall national development as well as improving health and living status of people. The health police emphasize improving the quality and efficiency of and access to public health services to all of its citizens. As mentioned earlier, Bangladesh has achieved remarkable progress in health sector in the last two decades; although it is still below from the standard in comparison to develop countries (ADB, 2005).

So, to achieve the universal health goals (MDGs), the government need to spread health service all over the country and trying to strengthening health institution and incorporated private sector as public-private partnership.

1.2 Rational of the Study

The urban population has been growing rapidly, mostly because of rural-urban migration by the poor and the vulnerable. The absolute number of poor urban households is increasing. The recent ADB study has shown (ADB, 2009) that the health indicators of the urban poor are worse than those of the rural poor because of poorer living conditions, and limited primary health care (PHC). Failure to provide urban PHC can have serious negative consequences beyond urban areas because infectious diseases can spread from urban to rural areas.

Rapid growing of urban slums in Dhaka city without adequate primary health care is lead to epidemics and communicable diseases (ADB, 2005). In fact, the access of quality health service in Dhaka City particularly in the poor and grass root community is very limited. That's why; the Urban Primary Health Care Project (UPHCP) was initiated by the GoB to improving the health of the urban poor. On the other hand, primary health care has been chosen by GoB as the strategy to achieve the goals "health for all" as well as to achieve the MDG in 2015.

Bangladesh as developing country is very difficult for the government to ensure health for all due to available resources and lack of health infrastructure. That's why; public-private partnership can play an important role regarding this situation because many developed and developing countries were improved their health sectors in collaboration with private sector as public-private partnership.

Dhaka City Corporation (DCC) is a public organization working under Ministry of Local Government, Rural Development and Co-operatives (MoLGRD&C), has provided health services to the citizens by the constitutional mandate of "the Local Government (City Corporation) Act, 2009" (GoB, 2009). The UPHC project has been directly executed by the MoLGRD&C through public-private partnership

with NGO. Under the project, The Government's role became primarily stewardship and regulation as well as DCC's health department role as coordinating agency of the project.

As Dhaka City Corporation is the biggest City Corporation in Bangladesh and Dhaka has the highest number of health partnership with NGOs. Moreover, the present health services of DCC being considered as useful guideline to compare significant performance both natures of health services. That's why; Dhaka has been selected as study area.

1.3 Objectives of the Study

The objectives of the study are-

i. To identify the nature of urban primary health care services provided by Government on its own and public-private partnership programme.

ii. To determine satisfaction index of urban primary health care service users.

iii. To compare the performances of public and private operators in UPHC service.

1.4 Scope and Limitation

The health department of Dhaka City Corporation has provided primary and specialized health services (preventive and curative) through different health centres but UPHCP is being provided only primary health services through public-private partnership. The study only focuses on the urban primary health services rather than other major or specialized health services.

Two different environmental and baseline condition exists between DCC health centres and UPHCP health centres. But a quality health service is a common goal for both the services. This study did not prepare a comparative study between health services rather than tried to prepare a significant performance evaluation between two natures of services. Because, limited number of respondents were

found that they have taken health service both the centres. So, performance statement was like to draw based on the individual statement of the respondents.

Most of the health service users were illiterate. The illiteracy became one of the causes to come poor information, which was trying to solve during interviewed. Moreover for child, respective guardians were interviewed.

The overall health policy, health structure and legal framework were very important for health sector development both public and private point of view. Donors were sometimes taking important role particularly in the developing country for health sector development. Moreover, organizations corruption, transparency and accountability were also important but the study did not cover this. Motivation, awareness development technique for health service users/ providers was also not considered as a matter of concern.

1.5 Organization of the Study

The research comprises of seven chapters. The first chapter describes the research background, rational of the research, its objectives, scope and limitations. The second chapter is devoted to the theoretical framework including health scenario of Bangladesh. The third chapter consists of study methodology. The fourth chapter represent the study finding based on the sample study. The five-chapter is deals with the level of satisfaction. Chapter-six, represents analysis as well as discuss the study result. Finally, the chapter seven summarized major finding of the study, concluding remarks, recommendations as well as state the scope for further study.

CHAPTER - TWO
THEORETICAL FRAMEWORK

2.1 Introduction

Urban primary health care under public private partnership is a new concept in Bangladesh. There has been little investigation and research on urban primary health in Bangladesh. Attempts are made to study literature from published and unpublished materials of local studies as well as abroad.

2.2 Literature of the Study

Urban primary health care services refers to reduce preventable mortality and morbidity, especially among women and children by increasing access to child health with immunization, reproductive health care, limited curative care, nutrition related services, health education and assistance for women through Essential Services Package (ESP) (PP, 2005).

Public-private partnerships (PPP, 2009) ensuring sustainability of programs by enhancing the skills and capacities of local organizations, and by increasing the public's access to unique expertise and core competencies of the private sector and also sharing program costs and promoting synergy in programs.

Since 1998, a promising partnership for health has been forming in Saidpur and Parbatipur municipalities in Northern Bangladesh. Under a Child Survival Programme (CSP), a tripartite partnership has developed between concern, two municipal authorities, and 24 Ward healths Committees (WHC). The CSP's goal is to reduce maternal and child mortality and morbidity, and increase child survival by developing a sustainable municipal health service (Datta et al, 1998).

Partnership with any political institution, especially with local government, is challenging. Local governments do not have sufficient resources. They expect resource endowments from any partnership (Datta et al, 1998).

Merck's 1987 donation of "Mectizan" backed up by public and philanthropic sector provision of the necessary infrastructure to utilize this drug effectively for onchoceriasis control is a shining example of what can be achieved through PPP (Ridely G Robert, 2001). During the 1980s, political and economic disruptions in many areas of the world led to a reassessment of the basis of the reliance on the public sector for health care. Both national Governments and Global Economic organizations began to shift to an increasing reliance on the private sector for improvement in health and welfare systems (Donald, 2007).

In the first Bangladesh interim poverty reduction strategy paper (PRSP) highlighting several key concerns that would in part be addressed by the Second Urban Primary health Care Project (ERD, 2000). The report indicates that urban poverty during second half of 1990s causes by negative growth in per capita real consumption, widening socio-economic differentials in mortality and malnutrition's, poor quality of public health services and weakness in the health sector, in particular reproductive health care.

The PRSP set seven targets (ERD, 2000) in the Interim-Poverty Reduction Strategy Paper (I-PRSP) to be achieved by 2015; the Interim-Poverty Reduction Strategy Paper will address four:

i. Reduction of infant and under-5 morality rates by 65% and elimination of gender disparity in child mortality
ii. Reduction of the proportion of malnourished children under 5 years by 50% and elimination of gender disparities in child malnutrition
iii. Reduction of maternal mortality ratio by 75% and
iv. Ensuring available of reproductive health services to all women.

The Government of Bangladesh and ADB signed a partnership agreement on poverty reduction (PAPR) in April 2007 (ADB, 2000). This PAPR identified the Government's medium term goals as to reduce maternal mortality by 35%, infant mortality by 30% and malnourishment among children by 20% as well as to increase the proportion of women of appropriate age with access to reproductive health service by 50% by 2015.

As identified in the Bangladesh country strategy (ABD, 2004) and program update for 2005-06, HIV/AIDS, nutrition, and urban primary health care (PHC) are ADB's social development priorities in the country. They will be addressed by, among others, building local government capacity to delivery high-quality services to the urban poor, particularly women and children, in partnership with nongovernmental organizations (NGOs).

The UPHCP project addresses key health concerns of the urban poor, especially the most vulnerable groups, women and children, who will constitute more than 75% of the beneficiaries (PP, 2005). The project will help Bangladesh to achieve Millennium Development Goals (MDGs) 4, 5 and 6 (child mortality, maternal mortality and HIV/AIDS, malaria and other diseases). The Project is thus closely aligned with ADB's overarching goal of reducing poverty.

Public Private Partnership (PPP) has become a common approach to health care worldwide (Health, 2008). Many PPP were created during the late1990s, but most of them were focused on specific diseases such as HIV/AIDS, and malaria. Due to the well-documented deficiencies of public sector health systems, the poor in India are forced to seek services from private sector, under immense economic duress. Partnership with the private sector has emerged as a new avenue of reforms, in the past resulting from resource constraints for the public sector by various Governments across the world.

Recent research on Cambodia showed that, when compared with government-run rural health facilities, those contracted out to NGOs were more effective (keller et al, 2000). Through performance-based contracting to NGOs, the project rewards good performance by requiring accountability for effective, efficient social services delivery. The project is consistent with ADB's emphasis on development effectiveness and managing for development results.

2.3 Public-Private Partnership (PPP)

Public-private partnership (PPP) describes a government service or private business venture which is funded and operated through a partnership of

government and one or more private sector companies. These schemes are sometimes referred to as PPP, P3 or P^3.

PPP involves a contract between a public sector authority and a private party, in which the private party provides a public service or project and assumes substantial financial, technical and operational risk in the project. In some other cases, the government may support the project by providing revenue subsidies, including tax breaks or by providing guaranteed annual revenues for a fixed period.

The public private partnership has been defined by different organization in different way (Health, 2008): for example

- "Means to bring together a set of actors for the common goal of improving the health of the population based on the mutually agreeable roles and principles".
- "A form of agreement that entails reciprocal obligations and mutual accountability, voluntary or contractual relationships, the sharing of investment and operational risks, and joint responsibility for design and execution".
- A partnership means that both parties have agreed to work together in implementing a programme and that each party has a clear role and say in how that implementation happens".

It is a variation of privatization in which elements of a service previously run solely by the public sector or provided through a partnership between the government and one or more private sector companies

2.4 Public Private Partnership in Health Sectors

Partnerships with the private sector have emerged as a new avenue of reforms, in part due to resource constraints in the public sector of governments across the world. PPPs seek to complement rather than substitute for public health services. Partnerships in the health sector can be for various purposes. Many of such partnerships have positively contributed to health outcomes in the past;

developing technologies for tropical diseases, surveillance and screening strategies, etc (Health, 2008).

India has one of the highest levels of private-out of pocket financing to the tune of 87% in the world. Such mode of financing imposes debilitating effects on the poor. It is estimated that more than 40% of hospitalized people borrow money or sell assets to cover expenses and 35% of hospitalized Indians fall below the poverty line in one year (Health, 2008).

The inequalities in the health system are further aggravated by the fact that public spending on health has remained stagnant at around 1% of GDP (0.9%), against the global average of 5.5%. Even the public subsidy on health does not benefit the poor. The poorest 20% of population benefit only 10% of the public (State) subsidy on health care (Health, 2008).

On the other hand, the private health sector in India has grown remarkably. In 1947, the private sector in India had only 8% of health care facilities (World Bank, 2004) but it is estimated that 93% of all hospitals, 64% of beds, 80-85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector now, Hence the possibility of a PPP in the health sector can be explored to meet the growing health care needs of the population;

Recognizing that partnerships are needed to sustain programs for the long-term, government authorized PEPFAR to promote public-private partnerships as a priority element of U.S. strategy to combat the HIV/AIDS pandemic and other global health crises. PEPFAR has fostered public-private partnerships that support and complement the prevention, treatment, and care work of the Emergency Plan.

The restructuring of the British National Health Service under Prime Minister Margaret Thatcher and the restructuring of Mexican health care system as a part of the international response to its economic crises were examples of the movement towards privatization and increased reliance on market forces that became increasingly widespread.

In November 2002, the WHO centre for Health Development in Kobe (Japan) convened the Global Symposium on Health and Welfare systems development, in which the participants stressed PPP as a strategy to improve the health and welfare services in developing countries. In the year 2003, the WHO centre for Health Development asked Stanford University researchers to assist in the development of a research protocol to evaluate the effectiveness of PPP model.

2.5 Partnership Model

Several classifications have been proposed to conceptualize and categorize PPP, which may be based on the terms of the constituent membership or nature of the constituent membership or nature of activity (Gupta, 2006).

Michigan State University (MSU) has developed a six-step model that is utilized to initiate public-private partnerships for joint crisis management through the Critical Incident Protocol – Community Facilitation Program (PPP,2000). Agencies, businesses, associations, and stakeholders can implement this model to create or enhance partnerships in the community. This model addresses individual and organizational benefits as well as how members can aid in the creation of a resilient partnership for managing critical incidents.

The effective Partnership Model includes the following steps:

1. Identify public and private sector stakeholders to co-share leadership.
2. Ask leaders to bring others to the table.
3. Identify common issues on emergency preparedness for collaboration.
4. Identify new resources in the community to mitigate the impact of critical incidents.
5. Determine the challenges that participating organizations encounter.
6. Create sustainability in the partnership by conducting a needs assessment, setting goals, and task performance.

2.6 Form of Partnership

"Public-private partnerships (US, 2009) save time and money, can be implemented rapidly, have superior impact and produce a greater return on each dollar invested." In literature review, it was seen that many developed (like-USA, UK) and developing countries (like-India) has developed public private partnership with private sectors particularly in the health.

It was seen that several classifications have been proposed to conceptualize and categorize PPP. So, as per categories formula, the DCC and partnership of NGOs can be classified as *transactional partnerships* because transactional partnerships involve a visible role of the for-profit sector. These usually involve larger partnerships and a complex grouping; depending upon their structure, they may bring together several Government, local and international NGOs, research institutions and UN agencies in transactional programs, often involving the non-profit sector. Such partnerships can be owned by the public sector and have private sector participants such as in the case of Global Alliance for Vaccine Initiative (GAVI), Roll Back Malaria (RBM), Stop Tuberculosis partnership, Safe Injections Global Network (SIGN), etc.

2.7 Satisfaction and Determining Factors about level of Satisfaction

'Something that satisfies will adequately fulfils expectations, needs or desires, and by giving what is required.' (Dictionary definition given in Crow et al 2003)

Satisfaction is associated with technical quality of care (Health, 2003). That's why, patient satisfaction including: overall health care services; hospital care; physician care; community-based care; and telephone health line or tele-health services. Patient satisfaction is an important measure of people's experiences with the health care system. It is also recognized as a measure of effectiveness of provider-patient communication and quality of care. In addition, patient satisfaction is associated with better compliance with medical advice (Patient Satisfaction, 2007).

The level of satisfaction amongst users of a service is a common target for evaluation within healthcare settings. Monitoring satisfaction can be a valuable

part of an organisation's quality assurance programme, which needs to emphasise patient and public involvement and consumer choice.

Although the phrase 'patient satisfaction' is widely used, its precise meaning is not always well defined, and measurement often takes the form of more general evaluations of experience or service quality (Health Service, 2002).

Health care evaluation based on the relationship between customers (patients, their relatives and citizens) and providers (managers, doctors, other technical staff and non-technical staff), and considering four quality items (customer service orientation, financial performance, logistical functionality and level of staff competence) (Eiriz et al, 2005).

2.8 Health Scenario in Bangladesh

Twenty years ago, many experts claimed the nation's conservative culture and low standard of living would be insurmountable obstacles to family planning and child survival programs in Bangladesh. However, over the past three decades health indicators have improved dramatically.

2.8.1 Urbanisation and Health

Rapid urbanization and proliferating slums are leading to serious risks to well-being and health of the urban population. Partnership between local government authorities and citizens (groups) for development of infrastructure and improvement of primary health care services in combination with awareness raising on health and environment linkages and targeted action to improve and promote community-based water supply, sanitation,

Map-2.1 : Location of Bangladesh in World Perspectives

Source: http://www.who.int/countries/bgd/en/

shelter, management of solid and hazardous (incl. clinical) waste, air quality management, etc. is proving a promising way forward (WHO, 2003).

People living in flood-prone areas and urban slums, the poor, disabled persons and the elderly, children and adolescents are affected proportionally more by poor environment and infrastructure. Special attention and advocacy is needed to ensure that health risks are reduced, access to services is established and sustained, and economic and educational opportunities are created. Climate change is affecting Bangladesh disproportionately. Increased risks due to vector-borne diseases, flooding and air quality will need to be assessed. Casual labour, industrial and agricultural workers work long hours in exhausting and often dangerous conditions.

2.8.2 Trends of Policy Development in Bangladesh

The constitutional commitment of the Government of Bangladesh is to provide basic health and medical requirements to all people in the society. The Constitution of the People's Republic of Bangladesh ensured that "Health is the basic right of every citizen of the Republic," as health is fundamental to human development.

Since independence, the government has been pursuing a policy of health development that ensures provision of basic services to the entire population, particularly to the under-served population in rural areas.

Table-2.1: Basic Health and Family Planning Data of Bangladesh

- CDR – 5.2 /1000 population
- Annual Growth rate – 1.48 percent
- MMR – 3.92 /1000 live births
- IMR – 62 /1000 live births
- Under 5 MR – 83 /1000 live births
- TFR – 2.9 ,CPR – 53.8%
- Life expectancy at birth – 68 (m) and 69 (f)
- Fully immunised children – 52%
- TB (smear positive new) detection rate – 31

Source: Directorate of Health and Family Planning, GoB, 2009

The successive health plans of the country emphasize Primary Health Care as the key approach for improving health status of the people. The goal 'Health for All' by the year 2000' has been accepted by the government as a national goal. The past plans in the health sector had endeavoured to provide essential healthcare to the general masses. To attain this goal, many development programmes have been undertaken in the health sector during the past years.

2.8.2.1 Population Policy

Realizing the importance of population policy, the Government prepared a Population Policy Outline in 1976 in which high population growth rate was identified as the nation's "number one problem"(GOB, 2000).

The size of Bangladesh's population is likely to grow up to 172 million by the year 2020 and stabilize at or below 210 million by the year 2060, even if replacement level fertility (i.e. NRR=1) is achieved by the year 2010. However, if it is delayed by another 10 years i.e. up to 2020, population will be stabilized 25 years later (i.e. 2085) at 250 million. This would place severe stress on the national resources and constrain the efforts to improve the living standards of the people. Population stabilization is, therefore, an urgent national priority. Through the medium of this Population Policy, Bangladesh expects to achieve the demographic goal by the stipulated time (GOB, 2000).

2.8.2.2 Health Policy

The cornerstone of national health policy is the Health and Population Sector Strategy introduced in 1998. Priority is given to ensuring universal accessibility to and equity in healthcare, with particular attention to the rural population. There has been improvement in the government financial allocation for health. Efforts are being made to develop a package of essential services based on the priority needs of clients, to be delivered from a static service point, rather than providing door to door visits by community health workers.

This is a major shift in strategy and will require complete reorganization of the existing service structure. This is expected to reduce costs and increase efficiency

as well as meet "peoples' demand". Privatization of medical care at the tertiary level, on a selective basis, is also being considered. Progress made towards achievement of health related MDGs in 2015.

2.8.3 Human Resources for Health

Significant changes in human resources for health have taken place in recent years leading to overall improvement in the coverage of health services. These include production and deployment of more health and health-related personnel, refresher training for health personnel in service, and greater use of health volunteers. In 1997, the distribution of physician per 10,000 populations was 2.03, which has increased to 3.0 in 2005, whereas nurses available per 10,000 populations were only 1.4 in 2004 (DGHS, 2004). Actions are being taken, which include the establishment of a permanent health institute, formulation of a human resource development plan, and enhancing the quality of medical education.

2.8.4 Physical Infrastructure

Since the mid 1980s the government has sought to improve its health services and teaching institutions. The explicit goal was to build one Union Sub centre (USC) or Health and Family Welfare Centre (HFWC) in every union (4415); one health complex in every thana (397); and one general hospital or tertiary facility in every district (59). As of 1996, there were 4200 USCs/IFWCs, 379 health complexes and 59 district hospitals. By 1999, there were 460 Thana health complexes, 1362 Union Sub-Centres and 3315 Community Clinics; there were also 15 government medical colleges and 7 postgraduate/specialized hospitals.

The total number of hospital beds was 43,293 (1999), which has increased to 51, 684 in 2005. In 2005, 3.43 beds per 10,000 populations were available (DGHS, 2004). To overcome many of the local constraints in the construction and maintenance of health facilities, the government is considering introduction of a more need-based health planning process that will involve all stakeholders and the community.

2.8.5 International Partnership

Bangladesh willingly shares experiences and expertise with other countries, particularly in training, research and disease surveillance. WHO has played a major role in gradually building up the national capacity through regional collaboration SAARC is another forum used to address regional issues including health facilities. Partnership arrangements for health have been established with bilateral agencies, with funds usually channelled through nongovernmental organizations. An NGO bureau regulates and monitors the funding. There is a need to further strengthen coordination between NGOs and government activities/programmes.

2.8.6 ICDDR,B

ICDDR,B is the International Centre for Diarrhoeal Disease Research, Bangladesh - an international health research institution located in Dhaka. Since 1978, the Centre has shared its knowledge with the world, training more than 27,000 health professionals from over 78 countries. ICDDR,B's activities are supported by about 55 donor countries and organizations, including the Government of Bangladesh, UN specialized agencies, foundations, universities, research institutes and private sector organizations (ICDDR,B, 2010).

ICDDR,B translates knowledge from research into policy using strategic health programmes. This allows basic research to rapidly influence policy applications and action if the evidence supports meaningful public health benefit. Research priorities at ICDDR,B are cross cutting, such as to child health, infectious diseases & vaccine sciences, reproductive health, nutrition, population, HIV/AIDS & safe water.

The urban Dhaka and rural Matlab Hospitals at ICDDR,B provide the clinical services to complement the development of lifesaving solutions. The hospitals are aligned with ICDDR,B's strategic research goals and provide an opportunity for scientists and health professionals to co-operate on research, treatment, training and development while delivering quality health services to the people of Bangladesh.

2.8.7 Health and Millennium Development Goals (MDG) in Bangladesh

Meeting at the United Nations Millennium Summit in September 2000, world leaders agreed a far sighted declaration to meet the needs of the world's poorest people. That declaration gave birth to eight goals to be achieved by 2015: the Millennium Development Goals (Eiriz et al, 2005). Which are-

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote equality between men and women and empower women.
4. Reduce under-five mortality by two-thirds.
5. Reduce maternal mortality by three-fourths.
6. Reverse the spread of communicable diseases.
7. Ensure environmental sustainability.
8. Create a global partnership for development, with targets for aid, trade and debt relief.

MDG-4 and MDG-5 are more related with the study. That's why; these are described below-

2.8.8 MDG-4: Reduce Child Mortality

The under-five mortality rate in Bangladesh declined from 151 deaths per thousand live births in 1991 to 62 deaths in 2006- an encouraging 24 per cent ahead of the target for that year. If Bangladesh can maintain this trend, it will meet the final target well before 2015.

Bangladesh's progress in all the three MDG 4 indicators is particularly encouraging. It is likely to meet all targets before 2015, if recent trends are maintained. There are, however, distinct regional variations that need to be addressed. Urban slums, the Chittagong Hill Tracts, coastal belt regions and other ecologically vulnerable areas are falling behind. The government, with the support of its development partners, must ensure that its efforts reach all Bangladeshi people, and that the excellent progress to date is sustained.

Table-2.2: MDG-4 Status in Bangladesh

Goal 4	Targets	Indicators	Base Year (1991)	Current Status (2006)	Target 2015
Reduce Child Mortality	Reduce by two third, between 1990 and 2015, the under-five child mortality rate	Under five mortality rate (per 1,000 live births)	151	62	50
		Infant mortality rate (0-1 year per 1000 live births)	94	45	31
		Proportion of 1 year-old children immunized against measles.	54	87	100

Source: Directorate of Health and Family Planning, GoB, 2009

2.8.9 MDG 5: Improve Maternal Health

Maternal Mortality Ratio Bangladesh needs to reduce its maternal mortality ratio by three quarters from 574 per 100,000 live births in 1991 to 147 if it is to meet this target by 2015. There has been adequate success in reducing maternal mortality ratio from 574 deaths per 100,000 live births in 1991 to 290 against the target of 147 in 2015. If this current rate continues, the country will be able to meet the target by 2015. The government has also undertaken initiatives to accelerate the maternal mortality reduction.

Table-2.3: MDG-5 Status in Bangladesh

Goal 5	Targets	Indicators	Base Year (1991)	Current Status (2006)	Target 2015
Improve Maternal Health	Reduce by the three quarters, between 1990 and 2015, the maternal mortality ratio	Maternal mortality ration (per 100,000 live births)	574	290	147
		Proportion of births attended by skilled health personnel.	5%	20%	50%

Source: Directorate of Health and Family Planning, GoB, 2009

Bangladesh should quick catch up with respect to indicator in MDG 5. The population is relativity young, with 32 per cent of people aged between 10 and 24 years. The makes the challenge of maintaining the maternal mortality reduction rate harder, particularly given the widespread practice of early marriage. Bangladesh must improve effective service delivery, health sector governance (especially in primary and maternal health services), and needs an intensive training programme to increase the number of skilled birth attendants.

2.8.10 Role of Stakeholders

UPHCP has multiple stakeholders besides health professionals and patients. Various government ministries like- MoLGRD&C, Ministry of Economic, Ministry of Planning, Ministry of Health and Family Planning, Dhaka City Corporation.

The stakeholders were directly related with the study. The study has discussed the role of different stakeholders for health development. As a whole the role of MoLGRD&C is became an executive Ministry; DCC is a implementing agency; NGOs is a partner organization for service delivery through service staffs (doctors, nurse etc) and the main target group were service receiver (patients) of the community.

2.9 Health Service under Dhaka City Corporation

2.9.1 An Overview of Dhaka

Dhaka is the capital and largest city of Bangladesh. With its colourful history and rich cultural traditions, Dhaka is known the world over as the city of mosques and muslin (Dhaka, 2009). Dhaka was founded in 1608 and flourished as a provincial capital in the Mughal period (DCC, 2009). Within a few decades, its population rose to around a million and by the year 1670, it became a cosmopolitan trading city. In 1947, when India was partitioned, Dhaka became the seat of the provincial government of East Pakistan. The population increased from 0.28 million in 1951 to around 1.2 million in 1971. As the capital Bangladesh, which emerged as an independent country after the war of liberation in 1971, Dhaka has now become

one of the fastest growing cities in the world and its population is likely 9.3 million (DCC, 2009).

2.9.2 Dhaka City Corporation

According to the 2001 census, the annual growth rate of Dhaka City is about 6% and it is also expected that the population of Dhaka City will be 15 million by year 2015 (Good Governance, 2001). The area of the City Corporation at present is about 360 Sq. km. (DCC, 2009) and Dhaka Metropolitan Development Area is 1526 sq. km. The Dhaka City Corporation area enjoys the distinction of being the centre of Bangladesh culture, government, education, commerce and other activities which is the focal point of enjoying civic amenities.

The density of population is very high with around 200 persons per acre (ppa), in parts of old Dhaka, this goes up to about 325 ppa. In general, about 40% of the population live below the poverty line (i.e. the monthly family income is less than Tk. 3,500) (The daily star, 2009).

Although a wide range of activities are assigned to DCC the main areas in which it is currently engaged in rendering services are: maintenance and repair of municipal roads, drainage, sanitation including solid waste management (street sweeping, collection of solid waste/garbage, transportation/removal of solid. waste), citizen health care, mosquito control and street lighting. The functional organ gram of DCC is shown in appendix-G.

According to the existing law, the executive powers of the corporation is vested in, and exercised by, the Mayor who is directly elected by the people. The City Corporation area is divided into 10 Zone Offices, each headed by a Zonal Executive Officer for the purpose of service delivery. At present there are 90 wards of DCC. One Commissioner elected directly represents each ward. In addition there are 30 women commissioners are directly elected by the citizens. The term of the elected body is five years (DCC, 2009).

The Mayor is assisted by the Chief Executive Officer, who in turn, is assisted by the Secretary, the Heads of Departments and Zonal Executive Officers. There are about 12,000 employees carrying out various duties catering to the civic needs of

the people. The health department of DCC is responsible for providing health services of citizens. About 77 nos. of qualified doctors are providing health services (preventive and curative) to the citizens from different health centres under DCC.

2.9.3 Functions of Health Department Related to Primary Health

The health department of DCC is providing so many health services to the citizens. Among them one of the important functions of DCC health department is primary health care services which are describe below-

- Expanded Program on Immunization (EPI)

Health department of DCC is providing EPI activities through routine immunization program for children & women all around DCC area. There are 69 EPI centres under health department within DCC area.

- Births and Death Certificate.

On of the important function of DCC health department is to issue births and death certificate to the citizens through 10 (ten) zones under DCC. The citizen of the respected zone is to collect their birth/death certificate from zone office of DCC.

2.9.4 Health Service Centres of DCC

At present, Dhaka City Corporation is operating 22 different health centres including charitable dispensaries and homeo laboratories. The list of general health centre, maternity centre and hospital are attached Appendix-E:

Dhaka City Corporation providing primary, maternal and specialized health through these health centres. Most of the health centres of DCC are established in the old part of Dhaka city. Peoples from different areas including outside of DCC comes to these health centres.

2.10 Urban Primary Health Care Project

The Urban Primary Health Care Project, undertaken by the Ministry of Local Government, Rural Development & Cooperatives, and Government of Bangladesh

is demonstrating the viability of a public-private partnership particularly to respond to the needs of the poor.

The project is funded by the Government of Bangladesh, Asian Development Bank, United Nations Population Funds (UNFPA) and Nordic Development Fund (ADB, 2005).

Phote-2.1: UPHCC at Aga Sadek Road, Dhaka

The primary objective of this project is to reduce preventable mortality & morbidity, among women and children by strengthening the Primary Health Care Centre (PHCC) infrastructure and ensuring that the poor receive good quality preventive, primitive and curative services. The other objectives are to sustain the improvements in Primary Health Care Centre by improving the capacity of the local government and changing the role of government in provision of health care services (PP, 2005).

The key strategy is to change the way health services are provided, i.e., contracting service provision out to the private sector or/ and NGOs and retaining the regulatory and stewardship responsibility with the public sector.

2.10.1 Function of Urban Primary Health Care Project

The Urban Primary Health Care Project addresses many functions, including designing the package of services; construction of primary health care and reproductive health care centres; strengthening the city corporation health department and the contracted parties with training, equipment, transport, furniture, medicine and human resources; establishing a management information and reporting system; conducting regular surveys, reviews, monitoring, supervision and evaluation by the public sector of the performance, effect and impact of the service providers; mounting strong counselling and behaviour change communication interventions; conducting operational research, and flexible scheduling of the operational hours of the service facilities to suit the needs of the community.

An important part of the project is cost recovery by the service providers (on the basis of standard rates fixed by the project authority in consultation with the partners, that are half to one third of the market price, with provision for free service for the poorest) to ensure their sustainability after the project is wound up.

2.10.2 Administration Setup of UPHCP

The Local Government Division (LGD) of the Ministry of Local Government, Rural Development, and Cooperatives (MOLGRD&C) implemented the first Urban Primary Health Care Project (PP, 2005) in four city corporations-Dhaka, Chittagong, Kulna, and Rajshahi. UPHCP-I, which was supported the contracting-out of PHC services to Non-Governmental Organizations (NGOs) through partnership agreements. With the request of the Government, ADB approved technical assistance to prepare the UPHCP II Project (Project period up to 31 December 2011), which aims to consolidate the gains of UPHCP-I and expand urban PHC services to the remaining two city corporations-Sylhet and Barisal-and five municipalities-Bogra, Comilla, Sirajgonj, Madhabdi, and Savar (ADB, 2005). The project management setup of UPHCP is shown figure-2.1.

UPHCP is strengthening the PHC infrastructure in City Corporations by establishing 142 PHC centres in the four cities under the project. The numbers of health facilities in DCC are 63. However, of these 43 are in rented houses. Dhaka City Corporation has signed the contract with competitive selected NGOs for the delivery of a package of essential services and Comprehensive Emergency Obstetric Care (EOC) in 10 defined partnership areas, linking contract payments to health improvement of the population of the project area

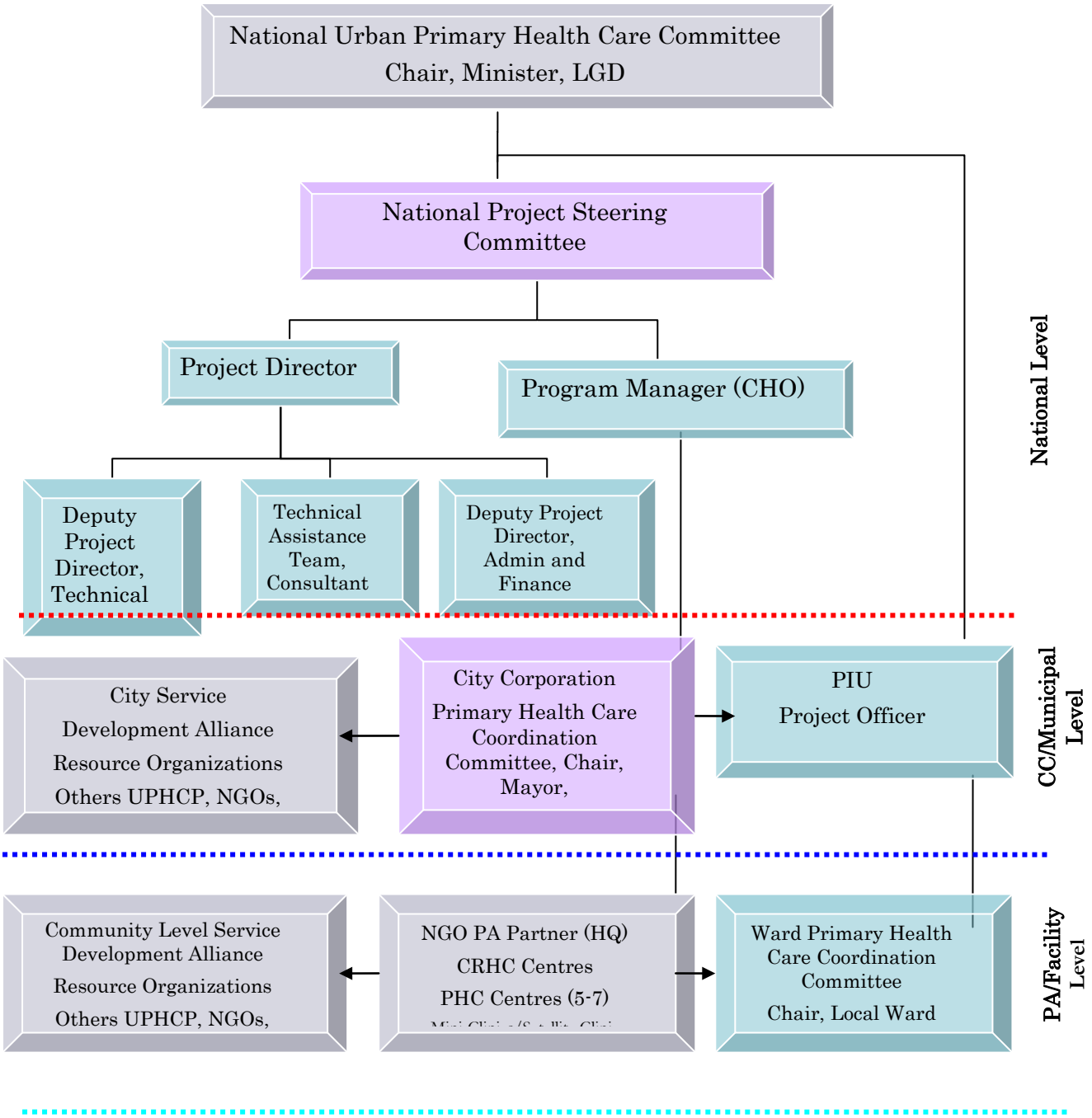


Figure-2.1: Project Management Setup of UPHCP

2.10.3 Services under Public-Private Partnership

The UPHCP project aimed at improving the health status of the poor in six city corporations and five municipalities by providing an essential package of high-impact services. By reducing child and maternal mortality, the project helps Bangladesh achieve the MDGs for child mortality and maternal health. Women and children will constitute more than 75% of all project beneficiaries.

The Project was to improve the efficiency of urban health services by

(i) Improving the spatial distribution of health centre, e.g. PHC centres,, comprehensive reproductive health care (CRHC) centres, and mini-clinics, in accordance with population density and geographical factors;
(ii) Supporting cost-effective interventions to reduce mortality and morbidity;
(iii) Enabling least-cost private sector participation in the provision of preventive and primitive health care services by partner NGOs;
(iv) Allowing appropriate user fees;
(v) Improving the monitoring and supervision system; and
(vi) Concentrating on provision of health services that will create the greatest public good, to use scarce government resources more efficiently.

In Dhaka city the most common health services provided through 63 Nagar Shastha Kendra (Health Centre) and 10 Nagor Matrisodon (Maternity Centre) under partnership program are shown below. The detail about these health services are described and attached in Appendix-D.

- Reproductive Health
- Child Health Care
- Communicable Dieses Control
- Limited Curative Care and
- Behaviour Change Communications (BCC)

2.10.4 Service Delivery System

The Project was expected to improve the health status of the urban population, especially of the poor, in all the six city corporations and five municipalities. The project contracted out primary health care (PHC) services to non-government organizations through partnership agreements that were pioneered under the first Urban Primary (PP, 2005) Health Care Project (UPHCP-I).

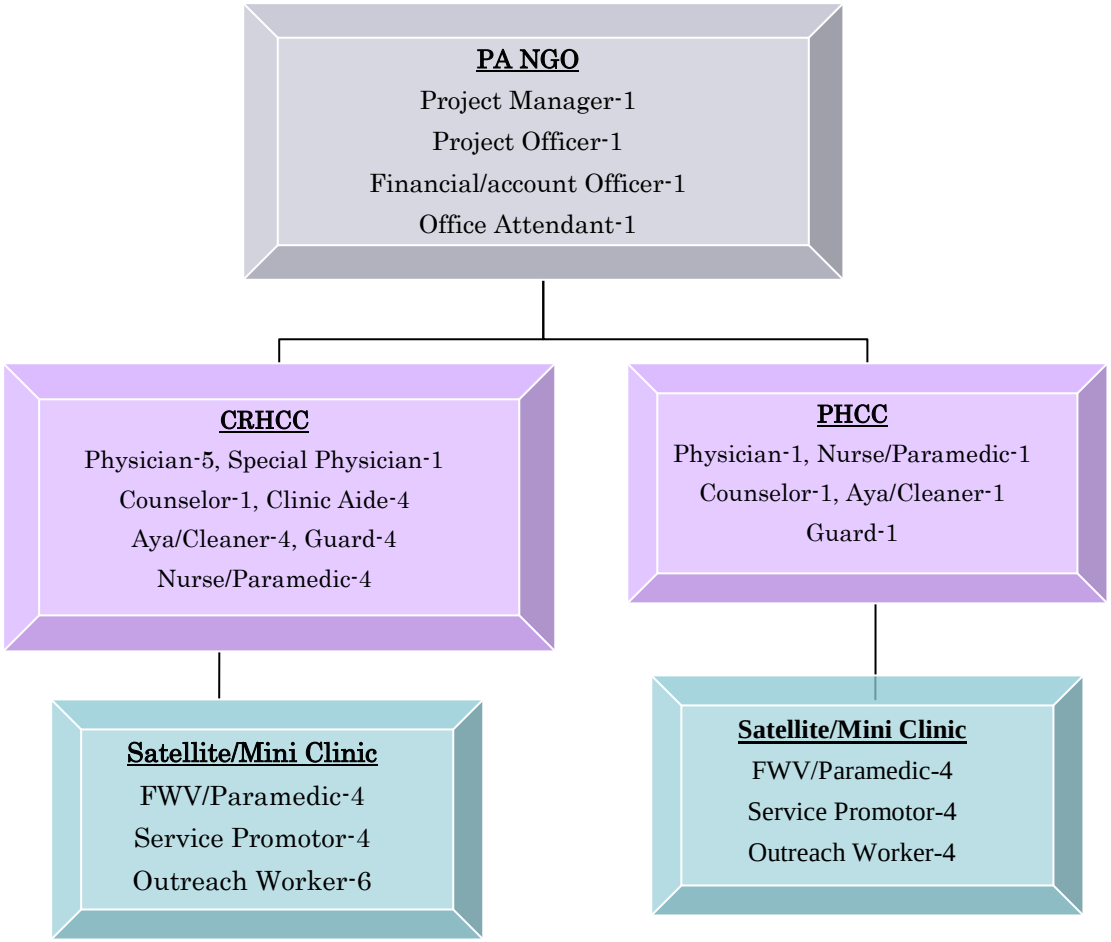


Figure-2.2: Minimum Staffing Standard for Each PHCC, CRHCC and PA HQ

The Project targets all the four groups through mini- or satellite clinics, outreach activities, and domiciliary services. Both demand- and supply-side interventions were used to target the poor. Large slums have mini-clinics, which open in the evening to maximize their use by the poor.

More than 50% of the project population is from four main groups: (i) slum dwellers living legally in slums; (ii) squatters living illegally on land owned by others; (iii) floating populations with no fixed residence; and (iv) Other urban poor living throughout urban areas, mixed with the non poor.

2.10.5 Budgets

The sources of fund both the cases are different. The DCC HC is directly funded by DCC itself. On the other hand, UPHCP is funded by GOB, ADB, UNFPA, NDF etc. In fact, a big gap exists between DCC HC fund and UPHCP HC fund. According to

(2009-2010) financial budget of DCC, the yearly total budget for DCC HC is around 14.0 (fourteen crore). Among them Mohanagar general Hospital-3.04 crore, specialized Sishu Hospital-1.65 and others health centres and miscellenious-9.3 crores. On the other hand, the total budget of UPHCP is about US$ 91.0 Million for the period July 2005 to December 2011. Among them ADB-30.0 million (Loan) ; Grand's GOB-18.0 million, ABD-10.0 million, DFID-25.0 million, SIDA-5.0 million, UNFPA-2.0 million and ORBIS International-1.0 million (PP, 2005).

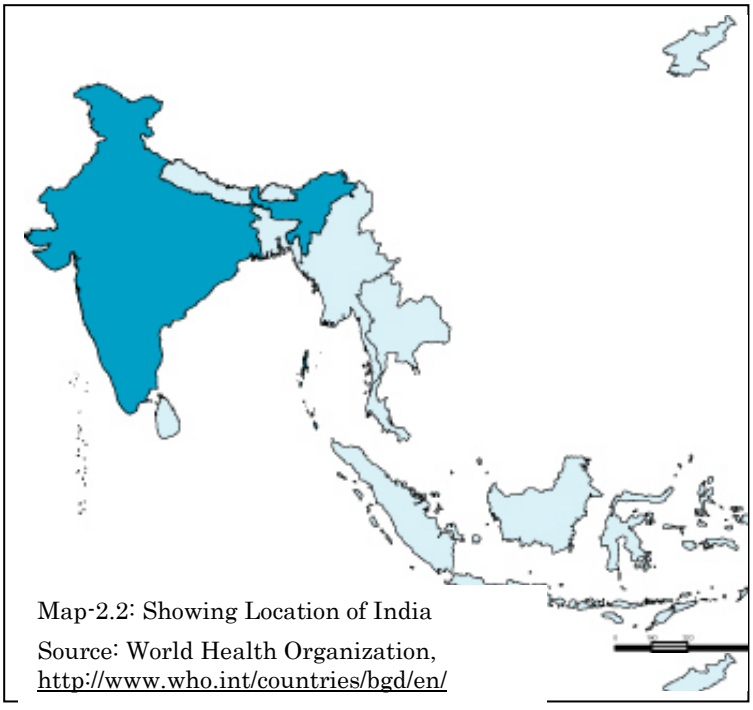
So, DCC HC budget is too small than UPHC HC budget. Normally, the quality of service depends on allocation of fund as well as management efficiency.

2.11 Health Care in other Country

This study studied some others countries health policy, strategy and programme which helps to understand about neighbouring countries health situation that will be a valuable documents for discussion different scenario of the present study. The statement of the different nations was prepared based on the latest report of the World Health Organization (WHO) 2009.

2.11.1 India

Although the National Health Policy (NHP) in India was not framed until 1983, India has built up a vast health infrastructure and initiated several national health programmes over last five decades in government, voluntary and private sectors under the guidance and direction of various committees (Bore, Mudaliar, Kartar Singh, Srivastava), the Constitution, the Planning Commission, the Central Council of Health and Family Welfare, and Consultative Committees



Map-2.2: Showing Location of India
Source: World Health Organization, http://www.who.int/countries/bgd/en/

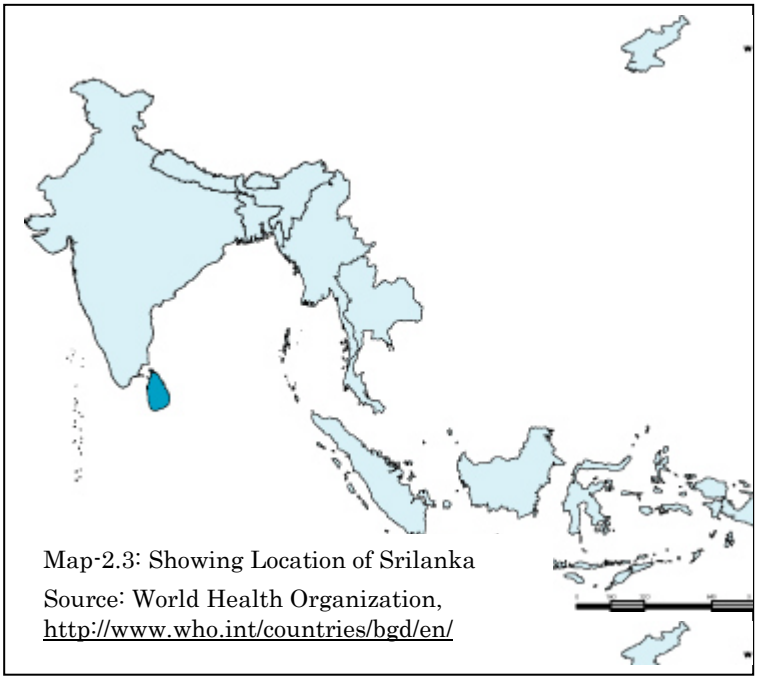
attached to the Ministry of Health and Family Welfare (WHO, 2009).

The period after 1983 witnessed several major developments in the polices impacting the health sector - adoption of National Health Policy in 1983, 73rd and 74th Constitutional Amendments in 1992, National Nutrition Policy in 1993, National Health Policy in 2002, National Policy on Indian System of Medicine and Homeopathy in 2002, Drug Policy in 2002, introduction of Universal Health Insurance schemes for the poor in 2003, and inclusion of health in Common Minimum Programme of the UPA Government in 2004. Map-2.1: Location of others Countries.

The first National Health Policy in 1983 aimed to achieve the goal of `Health for All' by 2000, through the provision of comprehensive primary healthcare services. The main objective of the revised National Health Policy, 2002 is to achieve an acceptable standard of good health among the general population of the country and has set goals to be achieved by the year 2015.

2.11.2 Srilanka

Sri Lanka is a Democratic Socialist Republic. The legislative powers of the country are vested in parliament, and the executive authority is exercised by a Cabinet of Ministers presided over by an Executive President. The President and members of the parliament are elected on the basis of adult franchise in separate elections conducted every six years. In addition to the President and Parliament, there are Provincial Councils to administer provinces, Municipal Councils and "Pradeshiya Saba" for local administration.



Map-2.3: Showing Location of Srilanka
Source: World Health Organization, http://www.who.int/countries/bgd/en/

The Ministry of Health lead in planning and sponsor a major national behaviour change communication programme and set off

activities aimed at healthy life style changes in targeted population groups. During 1983, it will be carried out through inter -sectoral and multi sectoral collaboration with relevant departments and agencies. The objective was to reduce preventable risk factors and the main stakeholders are the people themselves.

The ministry of health in collaboration with other partners will identify the target group and the needed lifestyle changes based on evidence of epidemiology, treatment cost and effectiveness factors. These will include optimising health, productivity and educational performance and ageing through nutrition, exercise, relaxation and sleep, through avoidance of tobacco, alcohol intake, substance abuse, unsafe sex, and observance of road safety including seatbelt use. Behavioural change advertising and lobbying companies will be contracted to design, pre -test, implement and manage these programmes.

2.11.3 Maldives

The health policy is guided by the government's commitment to the goal of Health For All in the 21st century and the goals set out at the World Summit for Children, the Earth Summit, the International Conference on Population and Development, the Social Summit, the International Conference on Women and Development, and the Millennium Summit with its Millennium Development Goals (WHO, 2009).

Ever since Maldives developed its first Country Health Plan in 1981, health has been deemed a basic right of every citizen and the government continues to strive towards the goal of HFA (Health for All) through the primary healthcare approach. The health policy aims to further increase life

Map-2.4: Showing Location of Maldives

Source: World Health Organization, http://www.who.int/countries/bgd/en/

expectancy and improve the quality of life by reducing preventable deaths, disease, suffering and disability.

To achieve these ends, the government continues to develop health infrastructure and provides medical and public health services within the overall framework of a sustainable health system. In framing health policy, special importance is given to preservation of environment, concept of regional development, central role of human beings and their quality of life, basic right to health and education, involvement of the people at community level, and the role of women in development.

2.11.4 Bhutan

'Bhutan 2020: A vision for peace prosperity and happiness' has clearly shown the commitment to improve the quality of life of the people through improving health and education, preserving Bhutan's rich cultural heritage and maintaining is precious environment. The eight five year plan (1997-2002) provides an indication to the stated long-term health services objective as (WHO, 2009)

Map-2.5: Showing Location of Bhutan
Source: World Health Organization, http://www.who.int/countries/bgd/en/

"To promote the health of the whole population so as to enable every citizen to lead a socially and economically productive life and within the broader framework of overall national development to enhance the quality of life of the people through better health care in the spirit of social justice and equity".

Following are some major policy issues related to health care which may have not been written but are understood and implemented:

- Bhutan is committed to establish a relevant and cost effective health care delivery system based on the PHC approach that effectively delivers health care services to all people of Bhutan.
- Provision of health care is free at the point of delivery. While constant efforts will be made to deliver free health care services on a cost-effective basis, possibilities of introducing some kind of cost-sharing will be explored
- Those aspects of traditional medicine, which are complementary to formal health care will be integrated in the system
- The integrated PHC system will be continued; vertical programmes have been phased out (Asian Development Bank: Bhutan-1999 Country Portfolio Review and Country Programming Confirmation for 2000 Mission, Memorandum of Understanding)

2.11.5 Myanmar

The Myanmar government formed a National Health Committee (NHC), the highest level policy making body for health matters, under the chairmanship of the Prime Minister. This committee formulated a new National Health Policy in 1993 envisaging adoption of the HFA (Health For All) goal with primary health care as the main approach and provision for sufficient as well as efficient human resources for development of a national health care system, exploring and developing alternative health care financing systems, inter-sectoral coordination and collaboration, intensification and expansion of environmental

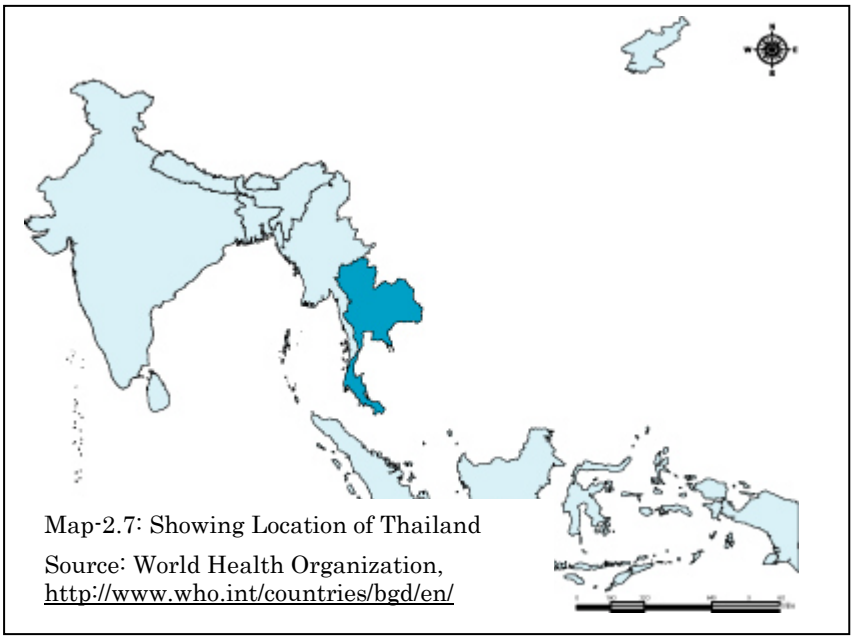
Map-2.5: Showing Location of Myanmar
Source: World Health Organization, http://www.who.int/countries/bgd/en/

health activities, promotion of physical medicine and health system research (WHO, 2009).

The role of NGOs and private sectors was also upgraded under the new policy. The National Health Plan (1996-2001) was formulated in line with the second five-year, short-term economic plan for 1996-2001 which was formulated by the government. The prioritised health needs of the country, HFA targets and relevant component of the ninth general programme of work of the WHO were the key determinants in the formulation of the plan.

2.11.6 Thailand

The general focus of the government administration these days is to introduce reforms for a result-based administration or Management by Objectives (MBO). It is being stressed to decentralize authority to tackle the poverty problems (WHO, 2009). As a result, the Ministry of Public Health, as a government agency responsible for public health, is now realigning and readjusting its administrative set up, in accordance with the prevailing central policy of reform and at the same time to conform to the National Development Plan of Economy and Society. The National Development Plan of Economy and Society is the central development plan of the country.



Map-2.7: Showing Location of Thailand

Source: World Health Organization, http://www.who.int/countries/bgd/en/

The evolution of the public health policy, besides conforming to the National Development Plan of Economy and Society, is to incorporate many specific factors within the public health domain. Public health initiatives under this policy reflect the reality to tackle the current public health problems.

The Ministry of Public Health (MOPH) have joined in the principal direction in helping mitigate people's plight in the area of public healthcare services, like providing health security, creating public-health related jobs for providing job opportunities. Healthy life as the part of vision is to achieve a Healthy Thailand and the Health Millennium Development Goals (HMDGs).

2.11.7 Indonesia

Indonesia has made substantial progress, particularly in stabilizing political and economic conditions. National Socio-Economic Survey, 2002, showed that in the past 32 years, Indonesia has undergone a major improvement in the area of health and education (WHO, 2009). Health law No. 23 enacted in 1992 provides a legal basis for the health sector activities.

It stipulated the goals of the health programmes to increase awareness, willingness and ability of everyone to live a healthy life. The law emphasized the decentralization of operational responsibility and authority to the local level as a prerequisite for successful and sustainable development. In the second 25-year development plan (1994-2019), economic and human development is identified as the key to national development and self-reliance.

Map-2.8: Showing Location of Indonesia
Source: World Health Organization, http://www.who.int/countries/bgd/en/

Following the National Guidelines on state policy issued in 1993, strategy was adopted to improve the health and nutritional status of the population by improving the quality of health services to all, and to promote a healthy life style with adequate housing and

environmental sanitation. The government of Indonesia places great emphasis on inter-sectoral coordination, joint responsibility of local government and the community, region-specific programmes, targeting of vulnerable groups, and building strong information and communication programme.

2.11.8 Korea

Democratic People's Republic of Korea (DPR Korea) is located in the far east of Asian continent and its territory consists of the Korean Peninsula extending southward and 4,198 islands around it. The area of DPR Korea is 120,538 sq. km. Mountains account for almost 80 percent of the whole territory and the cultivated area is only 17 percent. The core of the public health policy of DPR Korea is to realize the policy of preventive medicine in all health activities and to strengthen the perfect universal free medical care (WHO, 2009).

Map-2.9: Showing Location of Korea
Source: World Health Organization, http://www.who.int/countries/bgd/en/

The household doctor system responsible for the healthcare of all population is enforced in the country. The DPR Korea government shows special care and great concern for the health of women and children. The preventive medicine was already initiated under the leadership of the president Kim II Sung in the 1930s and during the 1950s of socialist construction; the social medicine was formulated as a preventive medicine, thus serving as a basis for the public health policy.

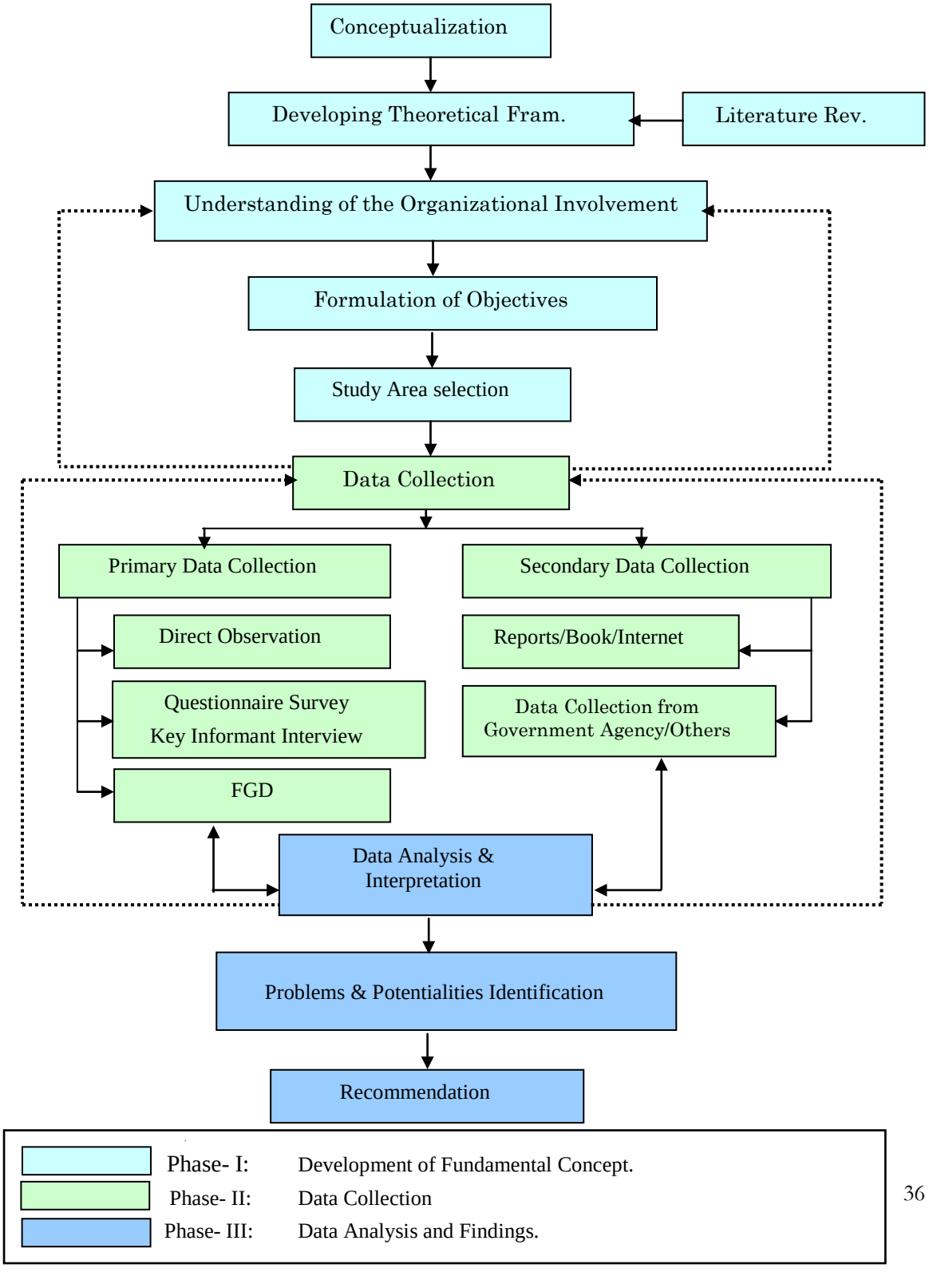
CHAPTER - THREE

METHODOLOGY OF THE STUDY

3.1 Introduction

The study has been conceived and subsequently conducted by following a pre-designed methodology composed a series of tasks. It has been perceived as a composition of three stages/phases and each of these phases has been conceived as a blend of a series of tasks designed to deliver specific output (figure-3.1).

Figure-3.1: Flow Diagram of the Research Methodology



At the first stage of development of fundamental concept, the objectives of the study have been identified through the cross examination of some theoretical concepts and questionnaire survey which stated the way to collect data and how to take the observations. Second phase of data collection includes collection, analysis and tabulation of field data and their interpretation in shaping level of participation. Finally the third stage of analysis and interpretation has been conceived as analyzing the collected information through both primary and secondary investigations.

3.2 Phase 1: Development of Fundamental Concepts

Phase 1 (one) of the study has been the composition of four specific tasks. These are described accordingly,

3.2.1 Conceptualization

The basic aim of this task has been to explore the rationale for suggesting some mechanism to overcome the problems of public health in urban areas and also identify potentialities of public health program to meet future health needs for citizen particularly in low income group. This is the stage of identifying the driving forces that focuses on the problems and prospects of public health program as well as its future strategy, which has been considered as the core research question.

3.2.2 Developing Theoretical Framework

This is the foundation of the whole research. Related and essential fundamental concepts of public health, key aspects of urban primary health care services, significant issues and rational of public health services provided by DCC itself and public health scenario of other countries are examined with the prevailing context of Bangladesh.

3.2.2.1 Literature Review

Books, reports, published and unpublished journals; magazines and internet have been consulted to achieve a clear knowledge about urban health, scope of services, associated problems, importance and potentialities. It helped to better understand and also opened new windows of imagination.

3.2.2.2 Understanding of the Organizational Involvement

In this phase all the core health service providers like The Ministry of Health and Family Planning, Ministry of Local Government, Rural Development and Co-operatives, Health department of DCC, UPHCP etc. are identified and their organizational status and spatial and administrative jurisdiction has been explored.

3.2.3 Specifying the Goals, Objectives and Scope of the Study

Based on the information the study goals, objectives and scope have been framed. The focus in this regard has been to identify the existing problems and potentialities of public health program as well as to recommend some solutions to overcome these problems as nature of public-private partnership.

3.2.4 Selection of the Study Area

The study area has been selected after developing theoretical background on the subject as well as find out prospects of public health program and scrutinizing them through the cross examination with some relevant information. Some related studies were examined as well to select the area for this particular research.

Urban Primary Health Care Project has covered six city corporations and five selected municipalities under 24 (twenty four) partnership agreements. Among these agreements 10 in Dhaka, 03 in Chittagong, 02 in Khulna, 02 in Rajshahi division and seven more partnerships have also established each in the two newer city corporations & five municipalities (PP, 2005). The nature, structure and functions of all city corporations & municipalities are similar. As Dhaka City Corporation is the biggest city Corporation in Bangladesh and Dhaka has the highest number of health partnership with NGOs. That's why, Dhaka has selected for this study as well as the location of selected HC were shown in the map-3.1.

3.3 Phase 2: Data Collection

3.3.1 Primary Data Collection

Primary data were collected from the reconnaissance survey, direct questionnaire survey with patients (respondents), key informants interviews and Focus Group Discussion (FDG).

3.3.1.1 Direct Observation and Field Survey

Direct observation is very important to get an overall view of a study area at the very beginning of the study. It gives an outlook of overall scenario. Under direct observation, find out health services infrastructure, socio-economic condition of respondents and other relative issues of the study.

An overall idea of the present health environmental of the study area can also be found through this survey. Existing communication system and geographical location of HC has been identified through reconnaissance survey.

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3.3.1.2 Selection of Sample Size, Data Collection Technique and Conducted Field Survey.

In DCC area, there are 63 Urban Primary Health Care Centres (UPHCC) which are operated under 10 partnership agreements with NGOs. At the same time, DCC itself is operating 22 different types of health centres (HC). The detail of 10 partnership areas of Dhaka is described below (QPR, 2009).

Table-3.1: The Partnership Areas under UPHCP

Partnership Area	Wards no.	CRHCC *	PHCC **	Name of NGOs
PA-1 (Jatrabari)	76, 80, 81, 82, 83, 84, 86, 87, 88, 90	1	7	Bangladesh Women's health Coalition (BWHC)
PA-2 (Armanetola)	66, 67, 68, 69, 70, 71, 72, 73, 74, 77, 78, 79	1	9	Bangladesh Women's health Coalition (BWHC)
PA-3 (Hazaribagh)	58, 59, 60,61, 62, 63, 64, 65 and Areas under Kamrangir Char Ward 2, 3 & Nawab Char	1	8	Bangldesh Association for Prevention of Septic Abortion (BAPSA)

PA-4 (Malibagh)	27, 28, 29, 30, 31, 32, 33, 34, 36, 75, 85	1	6	Population Services and Training Center (PSTC)
PA-5 (Khilgaon)	22, 23, 24, 25, 26, 35, 53	1	4	Shimantik
PA-6 (Moghbazar)	48, 49, 50, 51, 52, 54, 55, 56, 57	1	7	Nari Maitree
PA-7 (Mohammadpur)	39, 40, 42, 43, 44, 45, 46, 47 and Basila Area	1	6	Marie Stops Clinic Society (MSCS)
PA-8 (Mirpur)	9, 10, 11, 12, 13, 14, 16, 41	1	6	Unity Through Population Service (UTPS)
PA-9 (Mirpur, Pallabi)	2, 3, 4, 5, 6, 7, 8, 15	1	4	Progoti Samaj Kallan Protisthan, Paribar Porikalpana Sangstha (PSKP)
PA-10 (Uttara)	1, 17, 18, 19, 20, 21, 37, 38, and Bailjuri, Faydabad, Ashkona and Uttarkhan Areas	1	6	Unity Through Population Service (UTPS)
Total		10	63	

* City Maternity Centre, ** City Health Centre

Source: Urban Primary Healthcare Project, Nagar Bhaban, Dhaka.

From UPHCP, 10 (ten) CHRCC (maternal centre) has been selected (one from one partnership area) for data collection (about 16% of total), which has described in table-3.2. On the other hand, 4 (four) HC (about 6%) from DCC side has also been selected (out of 22 HC) for this study, which are-

1. Dhaka Mohanagar General Hospital
2. Dhaka Mohanagar Shishu Hospital
3. Nazirabazar Maternity Centre.
4. Moulavi Bazar Maternity Centre.

Mother & child health care and primary health services have given emphasis to collect data. In order to avoid the business of specific day (holiday/weekend/starting of week) and timing, the total sample size of each HC has divided into three groups and data has collected within three weeks, which has covered the whole picture of a month. The updated office registered list was used as the guideline.

Map-3.1: Location of HC under DCC and UPHCP including Study HC

From each sample HC 10% of the daily average patients (whose are taking services from HC) has interviewed. It was noted that the numbers of daily average patients varies/ranges from 30-150 in different health care centre. So, the total sample size was the following.

Table-3.2: Detail of Sample Size of the Study

Total no. of Health Care Centre (HCC)		Average No.of Daily Patients	Sample = 10% of Average Daily Patients (ADP)	Average No of Sample Patients	Days of Survey = 3 Days in a Month	Total No. of Sample Patients
No. of Urban Primary Health Care Centre (UPHC) Selected by DCC-NGO Partnership=10 nos.	14 nos.	30-150 (in different centre)	3-15	3+15 = 18 18/2= 9 Patients Per Health Care Centres Per Day.	3 X 9=27 Patients Per Health Care Centre in a Month 3 days in a month 9P/da So, Total 3x9=27	27 Patient per Centre and total 14 centres. So, 27 X 14= 378
No. of Health Centre Selected by DCC=4. So, total=14.						

A set of questionnaire was prepared for survey to achieve the objectives of the present study (See Annexure-A). Questionnaire survey has conducted on the patients who were taking health services (HS) from DCC and UPHC HC, focusing on their opinion regarding nature, type, quality, problems and level of satisfaction of health care services. The questionnaire was pre-tasted for its adequacy before the final commencement of the field work. After requisite training, eight university students were divided into four groups to carry out the questionnaire survey through face to face interview.

3.3.1.3 Key Informants Interviews

Key informants interview were conducted to get their views, perception and experiences on health care services. This interview was conducted with a structured questionnaire (Annexure-B).

The following key informants both DCC & UPHC HC (10 questionnaires each) has been covered-

- In charge of the respected health centre

- Residence doctors/specialized doctors
- Mother and child specialist
- Management of health officials both DCC and UPHC HC

3.3.1.4 Focus Group Discussion (FGD)

Two focus group discussions (one from each cases, through check list, see appendix-C) also conducted with 10-12 nos. of multidisciplinary participants including respondents both male & female, local leader, teacher, day labor, service men, patients etc.

From DCC side, FDG was conducted in Dhaka Mohanagar Shishu Hospital. On the other hand, from UPHC side FGD was conducted in Uttara Maternity centre.

3.3.2 Secondary data collection

The secondary data were collected from different literature search such as books, journals, reports, newspapers, annual reports, progress report, thesis and others publications and various data from different govt. organizations and development partners. While collecting secondary data, emphasis was given on identification of data gaps.

3.3 Phase 3: Data Analysis and Interpretation

In relation to the objectives of the study, both primary and secondary data were analyzed from quantitative & qualitative perspectives and data were represented in tabular form. Then tabular data were transformed into charts and graphs by using MS Excel computer software.

3.3.1 Research Hypothesis

The research like to attempt to establish/test the following hypothesis-

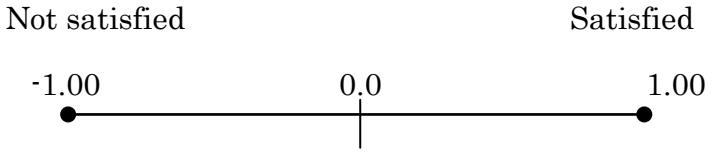
1. There exists no significant difference between the incomes of the DCC HC and UPHC HC service recipients.
2. There exists no significant difference in the nature of health services provided from both DCC HC and UPHC HC.

3. There exists no significant difference in the accessibility options between DCC HC and UPHC HC.
4. There exists no significant difference in the waiting times between DCC HC and UPHC HC.
5. There exists no significant difference in the statements of the service recipients concerning different aspects service governance both at the DCC HC and UPHC HC.

To test these hypothesis, the research resorted to a specific statistical tool - "t-test". The reason for resting this specific tool has been that compared to study areas total population, a small section/percentage has been used as samples. Time and other resources i.e, lack of support equipments, manpower, monetary resources; have compelled the researcher to select a small section as sample. This establishes the classic rationale of using student's t-test to test the research hypothesis. To determine the outputs, the research used SPSS 19 software.

3.3.1 Level of Satisfaction

The study examine the level of satisfaction both natures of services, the study used level of satisfaction index (Hossain, 1998). Based on the respondent's views, two values namely "satisfied" and "Not satisfied", a scale was formulated for measuring satisfaction as follows:



The satisfaction index is a useful device to analyze and inter, has been computed using the following simple computational formula:

$$IS = \frac{Fs - Fd}{N}$$

Here,

IS= Index of satisfaction such that $-1 \leq I \leq +1$

Fs= Frequency of Respondents indicating satisfaction

Fd= Frequency of respondents indicating not satisfaction/dissatisfaction and

N= Total number of respondents/observation.

Finally, the problems and potentialities both the health services were identified. Some effective measures and solution were also prepared based on study finding and literature.

4.1 Introduction

The health service under public-private partnership is the key concerned of this study. So, this chapter is trying to discuss comparatively finding between DCC HC and UPHC HC to meet the objectives of the research.

4.2 Characteristics of the Respondents

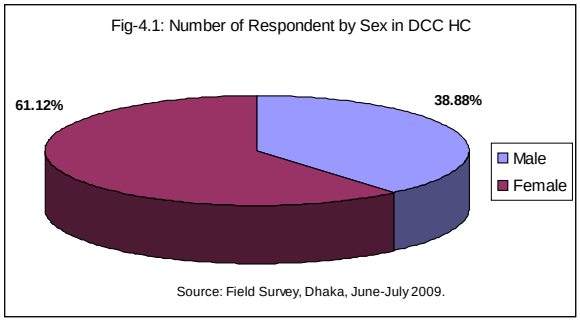
4.2.1 Socio-economic and Gender Perspective of Respondent

The information on the socio-economic characteristics of the population is important, since population of different socio-economic background tend to have different pattern of life. In Dhaka, many professionals as well as different income group peoples are living all around the city. But from the study health centre, it was seen that most of respondent were coming from lower or lower middle income family which was shown in figure-4.5.

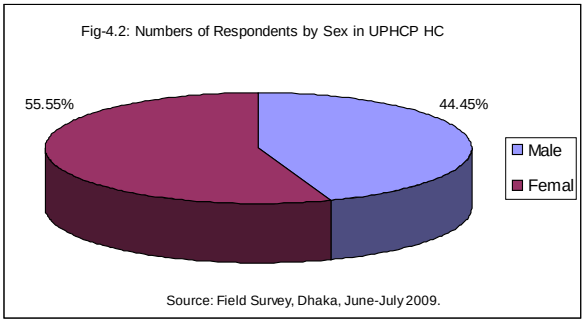
Table-4.1: Numbers of Respondent by Sex

Sex	DCC HC		UPHC HC	
	Frequency	Percentage	Frequency	Percentage
Male	42	38.88	120	44.45
Female	66	61.12	150	55.55
Total	108	100	270	100

Source: Field Survey, Dhaka, June-July 2009.

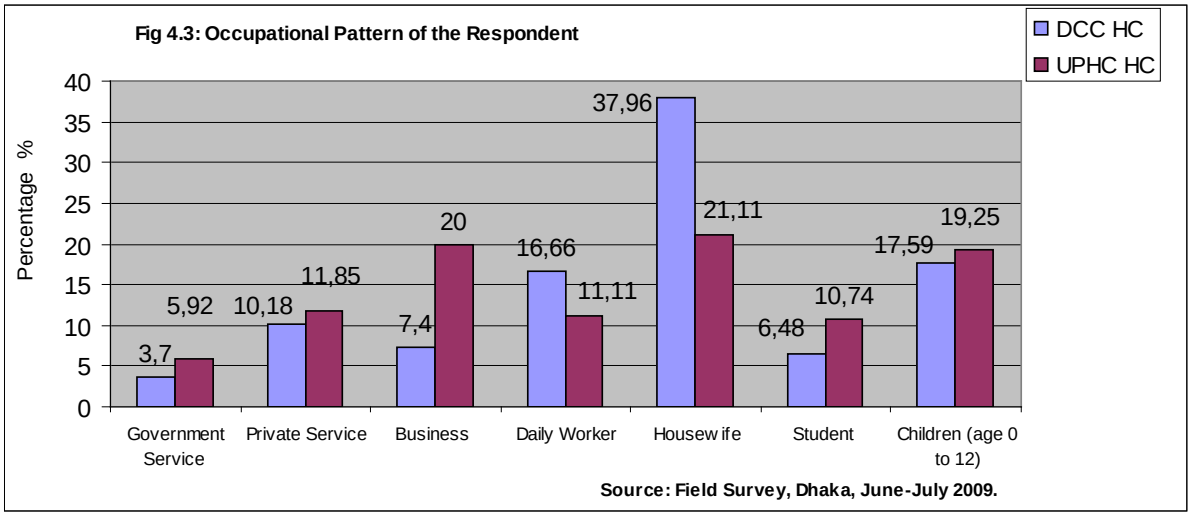


From the fig-4.1 and 4.2, it was found that most of the cases mothers and children's were taken more health services than others groups.



About 61.12% patient of the DCC HC

were women, mostly they were housewife and daily worker. On the other hand, about 55.55% patient of the UPHC HC were women, mostly they were housewife, students, govt./private service holders and daily worker. The male respondents were also 38.88% and 44.45% in DCC and UPHC HC respectively. In gender perspectives the respondents were classified as male and female including small (male/female) kids.



At the same time, it was found that in DCC HC about 17.59% patients were children their age group between 0 to 12 years, where as it was about 10.74% in UPHC HC.

It was also found (fig-4.3) that multi-professional patients were taking health services (HS) from DCC HC, among them 3.70% government service holders like-DCC, PWD, PDB etc but mostly them were 3rd or 4th class employee. It was about 5.92% in the UPHC HC but their professionals were similar like DCC HC.

Some private service holders (10.18%) like-NGO, multinational company, construction/consulting firm employees; small business men/women (7.40-%), daily worker (16.66%) like construction labors, house workers, rickshaw puller, driver etc. and students (6.48%) were taking health services from DCC HC. it was about 11.85,%, 20.00%, 11.11%,10.74% in UPHC HC respectively. As a professional point of views, the housewife and children were the most dominating profession than other professional categories.

So, finally it was seen (fig-4.3) that multi professional peoples were taking health services both DCC and UPHC HC. And in gender perspectives, the level of female participations was little bit more than male participants.

4.2.2 Age Distribution Pattern of the Respondent

From the table-4.2, it was found that in DCC HC about 44.44% of the patients were under the age group 20 years, among them 11.11% were male and 33.33% were female. It was about 26.29% in UPHC HC and among them 10.37% were male and 15.92% were female.

Table-4.2: Age and Sex Structure of the Respondent

Ages Range (Years)	DCC HC						UPHCP HC					
	Male		Female		Total	Total	Male		Female		Total	Total
	Fre.	%	Fre	%	Fre.		Fre	%	Fre	%	Fre	
Upto 20 Years	12	11.11	36	33.33	48	44.44	28	10.37	43	15.92	71	26.29
21-30 years	8	7.40	10	9.25	18	16.66	32	11.85	35	12.96	67	24.81
31-40 years	7	6.48	7	6.48	14	12.96	10	3.70	13	4.81	23	8.51
40-50 years	0	0	0	0	0	0	15	5.55	29	10.74	44	16.29
51-60 years	11	10.18	7	6.48	18	16.66	23	8.51	14	5.18	37	13.70
61+ years	4	3.70	6	5.55	10	9.25	12	4.44	14	5.18	28	10.37
Total					108	100					270	100

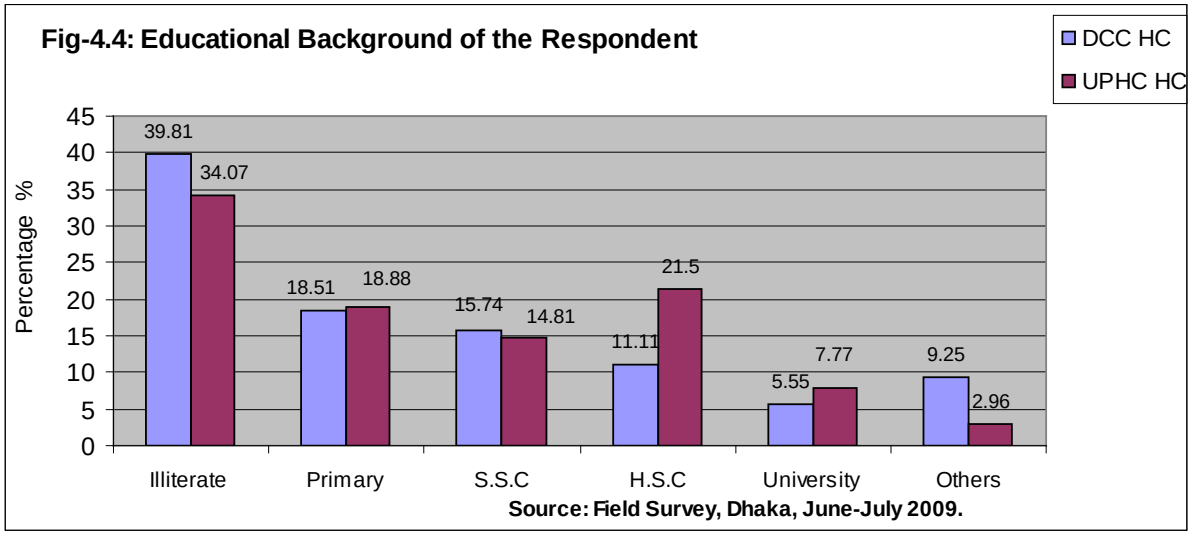
Source: Field Survey, Dhaka, June-July 2009.

The important picture is here that 40-50 age groups DCC HC have no respondents but UPHC HC has about 16.29% respondents. Both the cases (DCC & UPHC HC), it was found that female respondents were more than male respondents. Mostly women were taking reproductive health care, maternal health care services both the HC.

4.2.3 Education

People of different educational level were coming in both HC. In fig-4.4, about 39.81% of respondents of DCC HC were found to illiterate. It was about 34.07% in UPHC HC. The study results also shown that about 18.51% respondents of DCC HC were passed in primary, under this respondent group most of them were children. It was about 18.88% in UPHC HC.

Besides, some technical & madrasa educated peoples were also taking health services both the HC. This group were shown under "others" category in fig-4.4.



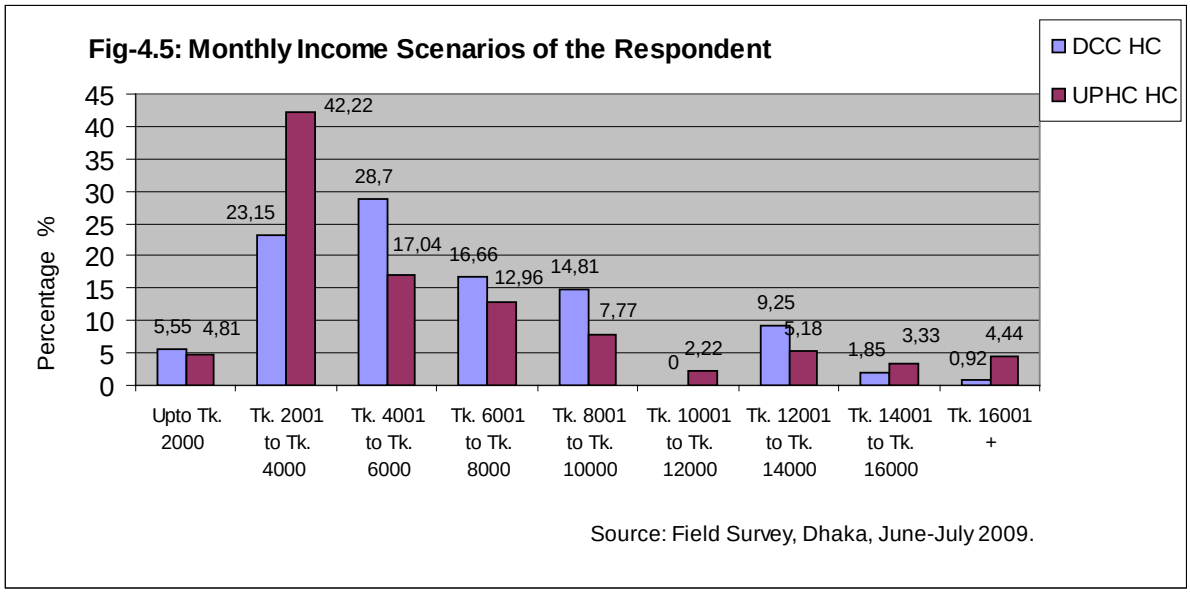
In fact, the level of educational in both the cases was more or less similar. But their attitude and opinion regarding health services was little bit different which was described in table-5.1 and 5.2.

4.3 Income Scenarios of the Respondent

It was mentioned earlier that different level of professionals were taking services from both the HC. In DCC HC, it was found that about 28.70% respondent monthly income range was Tk. 4001 to Tk. 6000 and 23.15% respondents monthly income range was about Tk. 2001 to Tk. 4000.

At the same time, in UPHC HC about 42.22% respondent monthly income range was Tk. 2001 to Tk. 4000 and 17.04% respondents monthly income range was about Tk. 4001 to Tk. 6000.

In both the cases, it seems that most of the respondents were coming below the monthly income of tk. 6000/-per month (that is below poverty level). In Dhaka city, hardcore poverty level is considered below monthly income tk. 3500/-per month (The daily star, 2009) and poverty level is below month income tk. 6000/- per month as well as lower, lower middle were considered as income below tk. 10,000/- per month. It indicates that the upper income group (middle and above) of peoples is not taking services from DCC or UPHCP HC and the clients of UPHCP are mostly ultra poor.



In fact, scope of govt. good quality health facilities in lower class or lower middle class people is very limited in Dhaka City. Because most of the good quality govt. health centers like Dhaka medical college hospital, PG hospital, Sorwardah hospital etc numbers of beds are very limited in respect of population size in Dhaka. The things are very similar in private clinic/hospitals of Dhaka city.

The below tables represent the significant of t-test result.

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	DCC HC	12.11	9	11.107	3.702
	UPHC	30.00	9	34.103	11.368

Paired Samples Correlations				
		N	Correlation	Sig.
Pair 1	DCC HC & UPHC	9	0.733	0.025

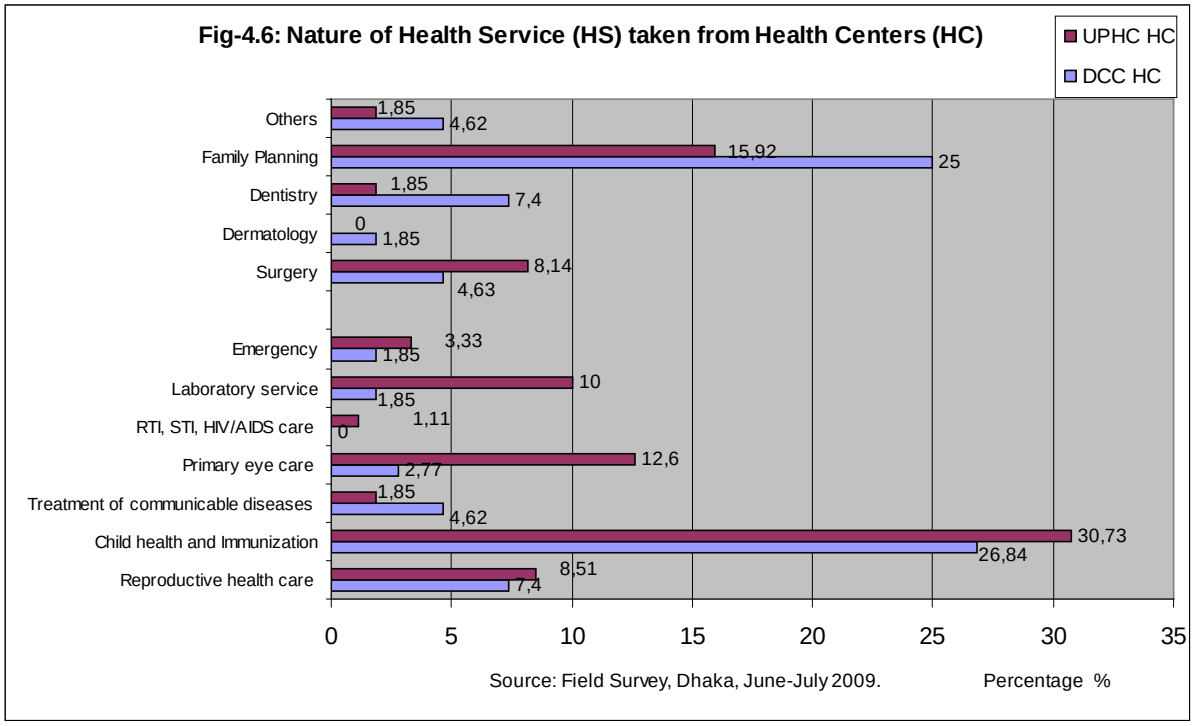
Paired Samples Test									
		Paired Differences							
					95% Confidence Interval of the Difference				
		Mean	Std. Deviation	Std. Error Mean	Lower	Upper	t	df	Sig. (2-tailed)
Pair 1	DCC HC - UPHC	-17.889	27.044	9.015	-38.677	2.899	-1.984	8	0.082

The t-test result shows there are exists significant difference in the incomes between DCC health centre service recipients and UPHC health centre service recipients. The mean value statistics shows that UPHC service recipients have higher average income than DCC service recipients. Comparatively higher income groups prefer UPHC services.

4.4 Nature of Services taken by the Respondents

Different types of respondents were coming to both health centres for taking health services, among them the most common health service categories were presented in the Fig-4.6.

From the study result (fig-4.6), it was found that about 25% of respondents in DCC HC taking family planning services and child health & immunization (26.84%) services. Respondents of DCC HC were taking reproductive health care (7.40%), emergency (12.88%), surgery (4.63%), dentistry (7.40%) and treatment of communicable diseases (4.62%) etc.



On the other hand, the study result was shown that about 15.92% of respondents in UPHC HC taking family planning services and also taking child health & immunization (30.73%) services, reproductive health care (8.51%), emergency (7.4%), surgery (8.14%), dentistry (1.85%), treatment of communicable diseases (1.85%) and primary eye care (12.60%).

The below tables represent the significant of t-test result.

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	DCC HC	9.00	12	9.601	2.772
	UPHC	22.50	12	23.442	6.767

Paired Samples Correlations				
		N	Correlation	Sig.
Pair 1	DCC HC & UPHC	12	0.791	0.002

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	DCC HC - UPHC	-13.500	16.903	4.880	-24.240	-2.760	-2.767	11	0.018

The t-test result shows there exists no significant difference in the received services between DCC health centre service recipients and UPHC health centre service recipients. The mean value statistics shows that UPHC service recipients received higher services than DCC service recipients since the number of service recipients in this group is higher than that of the DCC health services.

4.5 Accessible Facilities

Under UPHCP is trying to establish PHC in each ward of DCC to provide health facilities to minimize distance of the user and to provide health service within the ward population. However, people comes this health centre far from the ward. Meanwhile, most of the HC in Dhaka City Corporation are located in the old part of Dhaka city.

Table-4.3: Distance of HC from Home

Distance	DCC HC		UPHC HC	
	Frequency	Percentage	Frequency	Percentage
Upto – 0.25 KM	22	20.33	14	5.18
0.25 – 0.5 KM	23	21.29	67	24.81
0.5 – 1.0 KM	25	23.15	53	19.63
1.0 – 1.5 KM	4	3.70	33	12.22
1.5 – 2.0 KM	9	8.33	7	2.59
2.0 – 2.5 KM	7	6.48	16	5.92
2.5 – 3.0 KM	2	1.85	3	1.11
3.0 – 3.5 KM	7	6.48	14	5.18
3.5 – 4.0 KM	0	0	24	8.88
4.0 – 4.5 KM	2	1.85	11	4.07
4.5 – 5.0 KM	4	3.70	17	6.29
5.0 KM +	3	2.78	11	4.07
Total	108	100	270	100

Source: Field Survey, Dhaka, June-July 2009.

It is also a major drawback of DCC to provide health services in the new part of Dhaka city like Gulshan, Banani, Uttara, Baridhara etc.

The following table (table-4.3), the majority of the users actually comes within 1.5 Km from HC. In DCC HC, about 64.77% respondents were coming within 1.0 km. On the other hand, in UPHC HC, 49.62% respondents were coming from 1.0 km and 61.84% were coming within 1.5 km.

So, the average distance for DCC and UPHC HC are 1.0 km and 1.5 km respectively. The map-4.1 reveals that a considerable area are beyond the UPHC and DCC HC service area if we consider that an HC have served limited people who reside more than 1.5 km of an HC.

The below tables represent the significant of t-test result.

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	DCC HC	9.00	12	6.661	1.923
	UPHC	22.50	12	19.365	5.590

Paired Samples Correlations				
		N	Correlation	Sig.
Pair 1	DCC HC & UPHC	12	0.632	0.027

Paired Samples Test									
		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	DCC HC - UPHC	-13.500	16.009	4.621	-23.671	-3.329	-2.921	11	0.014

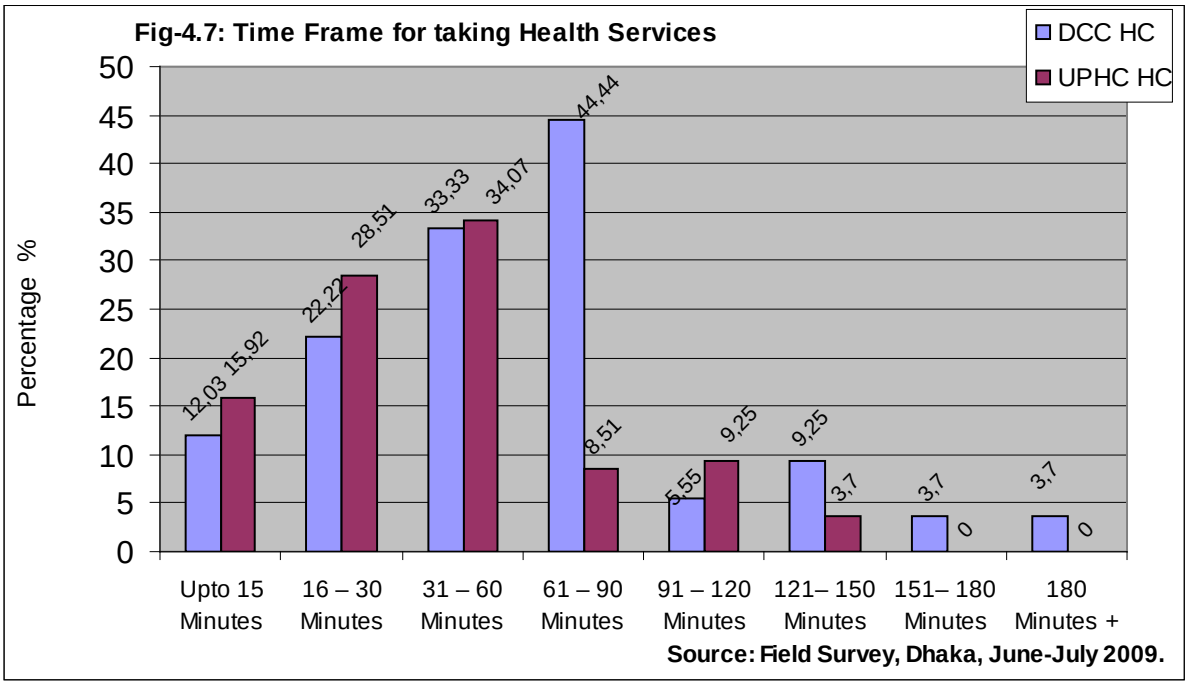
The t-test result shows there exists no significant difference in the distances

between DCC and UPHC health centres.

Map-4.1: Average Served Area of Study HC in Respect of Rrespondents Living.

4.6 Waiting Time for Services

One of important parameter of good service is waiting time for service for selection of HC. The fig-4.7 shows that DCC HC takes little bit more time compare to UPHC HC. About 44.44% respondents of DCC HC expressed their opinion that they have to spend 61- 90 minutes for taking service. On the other hand, about 8.51% respondents of UPHC HC were spending same time for taking service.



Both the cases the most common health services taken by the respondents were described in figure 4.7. The time frame for health service depends on the nature of health services taken from the HC. The present study mostly focuses on the mother and child health services as well as select same nature of HC both the cases.

From DCC HC, except Dhaka Mohanagar General Hospital all other 3 (three) hospitals like- Dhaka Mohanagar Sishu Hospital, Nazirabazar Maternity Centre and Moulavi bazar maternity centre are specialised hospital for mother and child care. So, maternal and antenatal care for mother required regular care with certain interval.

The below tables represent the significant of t-test result.

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	UPHC	12.78	12	15.311	4.420
	DCC HC	24.44	12	30.864	8.910

Paired Samples Correlations				
		N	Correlation	Sig.
Pair 1	DCC HC & UPHC	12	0.648	0.023

Paired Samples Test									
		Paired Differences							
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
					Lower	Upper			
Pair 1	DCCHC - UPHC	-11.665	23.974	6.921	-26.897	3.567	-1.686	11	0.120

There exists significant difference in the waiting time between DCC and UPHC HC. The mean waiting time of DCC HC is higher than that of the UPHC's.

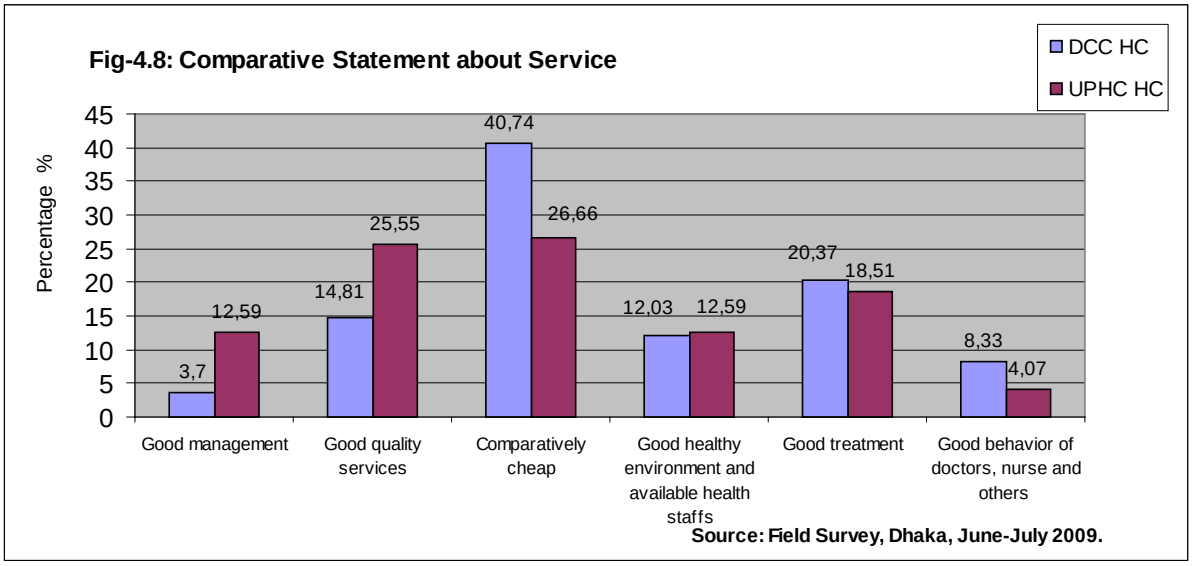
4.7 Opinion on Service

Fig-4.8, shows about 40.74% respondents of DCC HC given their opinion that DCC HS is comparatively cheaper than UPHC HC. On the other hand, the same statement was given 26.66% respondents of UPHC HC that UPHC HS is comparatively cheaper than DCC HS. In fact, in DCC HC a patient pay 5/-(five) taka entry fee (outdoor) for treatment and 15/- (fifteen) taka for hospital (bed) admission fee (if required). The hospital is providing free medicine both outdoor and indoor patients. The hospital also served free food for the indoor patients three times a day. Similarly in UPHC HC the outdoor fee is 10/-(ten) taka and service

charge is 20/-(twenty) taka.

In DCC HC, about 14.81% respondent gave their opinion on good quality of service. Only 12.59% claim that good health environment & available health staffs, 8.33% also claim about good behavior of doctors, nurse and others. On the other hand, in UPHC HC, about 25.55% respondent gave their opinion on good quality of service. Only 12.03% claim that good health environment & available health staffs (12.03%), 4.07% also claim about good behavior of doctors, nurse and others.

In DCC HC, the major operation (surgery) charge is 520/-(five hundred twenty) and 220/- (two hundred twenty) for minor operation charge. The important feature of the study was that both the respondents have knowledge/experience about services of DCC and UPHCP HC.



So, from study data, it was seen that the management and good quality services point of views, the UPHC HC is little bit advanced than DCC HC. Regarding treatment cost and behavior of doctors & staffs point of views, the DCC HC is little bit advanced than the UPHC HC.

The below tables represent the significant of t-test result.

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	UPHC	45.00	6	23.358	9.536

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	UPHC	45.00	6	23.358	9.536
	DCC HC	18.00	6	14.128	5.768

Paired Samples Correlations				
		N	Correlation	Sig.
Pair 1	UPHC & DCC HC	6	0.721	0.106

Paired Samples Test									
		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	UPHC – DCC HC	27.000	16.420	6.703	9.769	44.231	4.028	5	0.010

The t-test results shows that there exists no significant difference in the service recipients statement concerning health services received from both DCC HC and UPHC HC.

CHAPTER - FIVE

LEVEL OF SATISFACTION

5.1 Introduction

The level of satisfaction depends on individual perception and way of thinking regarding health services and facilities. Satisfaction is normally express individual fulfilment or gratification of a desire, need, or appetite of a particular service.

5.2 Level of Satisfaction

From the field survey, both DCC & UPHC HC, the level of satisfaction is differs greatly between statements of individual respondent. Under the study, the level of satisfaction was measured based on the following services:

- Good management of HC
- Good quality services/Treatment
- Treatment cost
- Good health environment and available health staffs
- Good behavior of doctors, nurse and others
- Waiting time for services
- Accessible facilities

As a whole the satisfaction was categories as satisfaction and not satisfaction/dissatisfaction. According to the statement given by the respondent, the level of satisfaction with different components of health services was present in the following table-5.1.

From table-5.1, it was found that most of the HS of DCC HC is under satisfactory (dissatisfaction) level except treatment cost and good behavior of doctors, nurse and others. On the other hand, in UPHC HC most of the health services seem to satisfactory level except waiting time for services and accessible facilities.

Table-5.1: Shows the Satisfaction in Respect of different Health Services.

Services	Frequency of DCC HC Respondents			Frequency of UPHC HC Respondents		
	Satisfied	Not Satisfied	Total	Satisfied	Not Satisfied	Total
Good management of HC	50 (46.29%)	58 (53.71%)	108	160 (59.25%)	110 (40.75%)	270
Good quality services/Treatment	37 (34.25%)	71 (65.75%)		172 (63.70%)	98 (36.30%)	
Treatment cost	84 (77.77%)	24 (22.23%)		145 (53.70%)	125 (46.30%)	
Good health environment and available health staffs	30 (27.27%)	78 (72.23%)		167 (61.85%)	103 (38.15%)	
Good behavior of doctors, nurse and others	63 (58.33%)	45 (41.67%)		156 (57.77%)	114 (42.23%)	
Waiting time for services	20 (18.51%)	88 (81.49%)		104 (38.51%)	166 (61.49%)	
Accessible facilities	40 (37.03%)	68 (62.97%)		99 (36.66%)	171 (63.34%)	

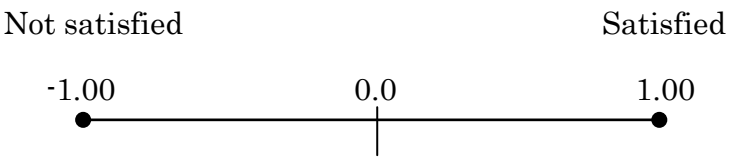
Source: Field Survey, Dhaka, June-July 2009.

Note:

- *Satisfaction: satisfaction on service or service as desire level.*
- *Dissatisfaction: Service quality not good enough as desire.*

5.3 Comparative Level of Satisfaction

From the above table-5.1, the respondents were expressed only in two values namely "satisfied" and "Not satisfied", a scale can be constructed for measuring satisfaction as follows:



Now on the basis of the scale a satisfaction index, which is a useful device to analyze and inter, can be computed using the following simple computational formula (Hossain, 1998):

$$IS = \frac{Fs - Fd}{N}$$

Here,

IS= Index of satisfaction such that $-1 \leq I \leq +1$

Fs= Frequency of Respondents indicating satisfaction

Fd= Frequency of respondents indicating not satisfaction/dissatisfaction and

N= Total number of respondents/observation.

By using this formula the indexes were summarized in table-5.2. Ranking are also shown to have the comparison of satisfaction level both the cases against different health services.

Table-5.2: Index of Satisfaction for different Health Services

DCC HC			UPHC HC		
Services	Index Value	Rankings in order of Satisfaction	**Services**	Satisfied	Rankings in order of Satisfaction
Treatment cost	0.55	I	Good quality services/Treatment	0.27	I
Good behavior of doctors, nurse and others	0.16	II	Good health environment and available health staffs	0.23	II
Good management of HC	-0.07	III	Good management of HC	0.18	III
Accessible facilities	-0.25	IV	Good behavior of doctors, nurse and others	0.15	IV
Good quality services/treatment	-0.31	V	Treatment cost	0.07	V
Good health environment and available health staffs	-0.44	VI	Waiting time for services	-0.22	VI
Waiting time for services	-0.62	VII	Accessible facilities	-0.26	VII

Note: + 1 means full satisfaction

- 1 means gross dissatisfaction.

According to satisfaction formula, the 0 + (plus) value indicate the satisfaction level and the full satisfaction value is 1.0 (One). On the other hand, - (minus) value is indicating the gross dissatisfaction.

From the table 5.2, it was seen that in DCC HC five components of health service were seems to below satisfaction level out of seven. On the other hand, in UPHC HC five components of health service were found as satisfaction level and another two were seems to as dissatisfaction level. Both the cases the satisfaction level is below full satisfaction level 1.00 (One).

In DCC HC, treatment cost and behaviour of doctors & staffs were seems as ranking one and two respectively. On the other hand, in UPHC HC, Good quality services/treatment and behaviour of doctors & staffs were seems as ranking one and two respectively

One of the important pictures of the study is that, both the cases behaviour of doctors & staffs were found as satisfaction level with similar ranking two. Waiting time and accessible facilities both the cases were seems as dissatisfaction level. Overall, most of the components of DCC HC were not satisfactory.

Finally, in DCC HC five components of health service were seems to below satisfaction level out of seven. On the other hand, in UPHC HC five components of health service were found as satisfaction level. So, as a whole, the level of satisfaction index of UPHC HS is good enough than DCC HS.

CHAPTER - SIX

ANALYSIS AND DISCUSSION OF RESULTS

6.1 Introduction

To achieve the objectives of the research trying to collect information from different sources which was mentioned in chapter-three and also trying to analysis the finding as well as incorporate all literature & relevant materials for preparation of final result of the research.

6.2 Satisfaction

The study is trying to examine the satisfaction level of the service users from different point of views. It was one of the critical tasks of the research. Different peoples were expressed different opinion about the same service, depending on personal views as well as mentality to receive the service.

The satisfaction of individual respondents was very critical to find out because it is associated with technical quality of care and also including: overall health care services; hospital care; physician care; community-based care; and telephone health line or tele-health services. So, patient satisfaction is an important measure of people's experiences with the health care system. It is also recognized as a measure of effectiveness of provider-patient communication and quality of care. In addition, patient satisfaction is associated with better compliance with medical advice (Patient Satisfaction, 2007).

In fact, the study result shows (table-5.1) that, both DCC & UPHC HC, the level of satisfaction differs greatly. From the study, the level of satisfaction was categories as satisfied and dis-satisfied.

The study result shows, in DCC HC five components of health service were seems to below satisfaction level out of seven. On the other hand, in UPHC HC five components of health service were found as satisfaction level. So, as a whole, the level of satisfaction index of UPHC HS is good enough than DCC HS.

6.3 Performance Comparison

Different socio-economic, cultural motivation, budget allocation, operational and management factors are related to draw a comparative statement between DCC HC and UPHCP HC. From the study result, the following performance statement has been prepared in connection with the study objectives.

6.3.1 Operational and Management

The study result shows that (Table-4.3) in DCC HC maximum respondents were coming from the nearest areas. Sometimes peoples come from outside DCC areas like-Keranigang, Narayangang, Nababgang etc. The modal distance for UPHC and DCC HC are 1.5 km and 1.0 km respectively. In UPHCP HC, respondents were coming from different areas with different distance because child delivery and surgical treatment organized in CRHCC (each zone of DCC have only one CRHCC). So, peoples have to come from long distance to taking HS from UPHCP HC.

6.3.2 Waiting Time

Taking good quality service within minimum time is one of the important indicators for selection of HC. The fig-4.7 shows that about 44.44% respondents of DCC HC expressed their opinion that they have to spend 61- 90 minutes for taking service. On the other hand, about 8.51% respondents of UPHC HC were spending same time for taking service.

Both the cases it was also shown the people have to expand maximum of 150 minutes for taking HS. As a whole, respondents of DCC HC were spending little bit more time than UPHC HC.

6.4 Monitoring and Evaluation

The UPHCP was directly monitoring by the MoLGRD&C, DCC as well as donor organizations. The UPHCP has prepared quarterly or yearly progress report, evaluation and monitoring report and taking feedback from concern ministry, donors (Role of different stakeholder, 2.8.10) after that the report was reviewed and prepared final statement of the project.

DCC HC was directly monitored by the Health Department of DCC. Health department also prepared health report, progress report for DCC and MoLGRD&C. Moreover, internal and external audit department of DCC is regularly auditing the health care activities of DCC. So, both DCC and UPHC HC have a regular monitoring and evaluation system.

Besides, as per requirement by the standing committee (Health) of National Parliament both DCC and UPHC have to provide health information and tried to follow the instruction of the committee.

CHAPTER - SEVEN

CONCLUSION AND RECOMMENDATION

7.1 Introduction

The last chapter tried to summarize the major findings both the cases as well as prepared some recommendation based on the study result/findings. The study also tried to give some direction for future studies/researches.

7.2 Major Findings

The major findings of the study were presented below based on the respondent's views in connection with study objectives.

- Regarding nature of primary health services taken by the respondents from both the HC, it was found that about 25% respondents in DCC HC taking family planning services and also taking child health & immunization (26.84%) services. At the same time, about 15.92% respondents in UPHC HC taking family planning services and also taking child health & immunization (30.73%) services.

- From accessible point of views, it was found that in DCC HC; about 64.77% respondents were coming within 1.0 km. On the other hand, in UPHC HC, 49.62% respondents were coming from 1.0 km and 61.84% were coming within 1.5 km. So, the average distance for DCC and UPHC HC are 1.0 km and 1.5 km respectively.

- As part of service performance regarding waiting time and service charges, it was found that about 44.44% respondents of DCC HC expressed their opinion that they have to expend 61- 90 minutes for taking HS. It is about only 8.51% in UPHC HC. So, the respondents of DCC HC takes little bit more time compare to UPHC HC. Regarding service charges, about 40.74% respondents of DCC HC given their opinion that DCC HS is comparatively cheaper than UPHC HC. On the other hand, the same statement was given 26.66% respondents of UPHC HC.

- The management and good quality services point of views, the study result shown that UPHC HC is more advanced than DCC HC and behavior of doctors & staffs point of views, it was found that DCC HC is little bit advanced than the UPHC HC.
- The t-test result shows there are exists significant difference in the incomes between DCC HC service recipients and UPHC HC service recipients. The mean value statistics shows that UPHC service recipients have higher average income than DCC service recipients. So, comparatively higher income groups prefer UPHC services.
- The t-test result shows there exists no significant difference in the distances between DCC and UPHC HC.
- There exists significant difference in the waiting time between DCC and UPHC HC. The mean waiting time of DCC HC is higher than that of the UPHC HC.
- The satisfaction index result shows, in DCC HC five components of health service were seems to below satisfaction level out of seven. On the other hand, in UPHC HC five components of health service were found as satisfaction level. So, as a whole, the level of satisfaction index of UPHC HS is good enough than DCC HS.

7.3 Conclusion

Primary health care is the main concerned area of the study with two different forms of institutions. In fact, different environmental and baseline condition exists both DCC HC and UPHC HC but immunization, primary eye care, reproductive health care, family planning services were found as leading service area both the HC.

Good management of HC, good quality services/treatment, treatment cost, good health environment & behavior of health staffs, waiting time for services and accessible facilities were used as indicator to scrutinize the level of satisfaction both nature of HS from individual respondents point of views. The study results shows, the level of satisfaction fluctuate greatly on both natures of HS.

The study also tried to examine performance based on the waiting time, service charges, management as well as quality of services. The study results show that DCC HC takes little bit more time to serve individual respondents than UPHC HC. Regarding service charges, DCC HS is comparatively cheaper than UPHC HC. The management and good quality services point of views, UPHC HC is more advanced than DCC HC and behavior of doctors & staffs point of views, DCC HC is little bit advanced than the UPHC HC.

As a whole, DCC and UPHC HS have a positive impact on the society particularly in the low income people of Dhaka city although both the service providers have little bit different with some extent.

7.4 Recommendation

The study has prepared some recommendation based on the study findings, which are presented below:

From the study it was found that most of the health centres of DCC were established in the old part of Dhaka city (Map-3.1). This area was very congested and highly crowded area of Dhaka city. So, it should be established more HC in new part of Dhaka City with suitable location, based on population size and area characteristics.

From the study it was observed that UPHCP has provided only primary health care services and limited surgical and child delivery facilities through CRHCC. Map-3.1 reveals that the newer part of Dhaka has lack of HC. So, new HC should be established in those parts. DCC should establish more HC to lower average in those areas where it is absent. But it was found that majority of their user are poor and ultra poor (fig-4.5). So it should be prudent to introduce general and specialised health facilities in UPHC HC. It would also encourage other groups to visit there.

From the study result it was seen that UPHCP is able to create a positive role for health care service delivery in Dhaka city. But UPHCP-II was funded by external sources and the project period will finish December 2011. So, regarding this

situation sustainable UPHC project approach is very important for providing sustainable health care service.

7.5 Future Scopes

The research has actually aimed to identify the nature of urban primary health care services provided by Government on its own and public-private partnership as well as to determine satisfaction index of both the nature of service users.

However, there could also be some provision to examine the role of present health & population policy to explore private sector participation in health sector development as public-private partnership.

A future scope is available for study on sustainable urban health, motivation and awareness technique as well as to conduct a detail insight study on role of good governance (organizations corruption, transparency and accountability) for development of urban primary health care delivery system.

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Only for Academic/Research Purpose

Questionnaire Type: Individual Assessment Serial No:……

URBAN AND REGIONAL PLANNING DEPARTMENT
BANGLADESH UNIVERSITY OF ENGINEERING AND TECHNOLOGY, BUET, DHAKA

Questionnaire for Urban Primary Health Care Services through Public-Private Partnership: A Performance Evaluation Approach in DCC Area.

(For Interviewer)

Name of Clinic and Location:----------

Service provided by

o DCC o NGOs

(For Respondent)

Instruction: Please tick the appropriate box (one or more than one) and fill up the form.

A. Information about the Respondent

Name of the Respondent:……..

Occupation: o Government Service o Private Service o Business o Student o Daily Worker o Others (specify)……

Age: o Up to 20 years o 21-30 years o 31-40 Years o 41-50 Years o 51-60 Years o Above 60 years

Education: o Nil o Primary o Secondary o College o University o Others (specify)……

Gender: o Male o Female
Nos of family members:

Address:…….
……
.....
.....

B. Opinion about Services

01. Which types of Health Service (HS) you have taken from this Health Centre (HC)?

o Reproductive health care o Child health o Treatment of communicable diseases o Limited curative care o Behavioural change communication o Primary eye care o RTI, STI,HIV/AIDS care o Laboratory service o Other (specify)	o Emergency o Medicine o Surgery o Dermatology o Dentistry o Immunization o Family Planning

02. How much distance of this HC from your home : .....km.

03. How much your family monthly income: Tk.-……

04. This is your first time to come this health centers

- o Yes
- o No

05. You have taken HS from other HC?

- o Yes
- o No

If yes, name of the HC:

06. Have any difference between these two HC? Yes/No, if yes, what

- o Good quality HS
- o Poor HS
- o Comparatively low cost
- o Good behavior of doctors/staffs
- o Good communication network
- o High cost
- o Others (specify)

C. Satisfaction Index

07. You are satisfied/dissatisfied on the following services (tick the applicable box, DCC or UPHC)

Services	DCC HC		UPHC HC	
	Satisfied	Dissatisfied	Satisfied	Dissatisfied
Good management of HC				
Good quality services/Treatment				
Treatment cost				
Good health environment and available health staffs				
Good behavior of doctors, nurse and others				
Waiting time for services				
Accessible facilities				

08. From your point of view, what is the main difference between DCC HC and NGOs HC.

DCC Health Centres	NGOs Health Centres
o Good management o Good quality services o Comparatively Cheap o Good health environment and available health staffs o Good treatment o Good behavior of doctors, nurse and others o Others(specify)	o Good management o Good quality services o Comparatively Cheap o Good health environment and available health staffs o Good treatment o Good behavior of doctors, nurse and others o Others(specify)

09. How much time you have to spend for taking services: ……min/hour.

10. Did you have any recommendation for improving HS?

Thanks for your kind co-operation.

Name of the Interviewer

Signature and Date

Only for Academic/Research Purpose

Questionnaire Type: Key Personnel's Serial No:……

URBAN AND REGIONAL PLANNING DEPARTMENT
BANGLADESH UNIVERSITY OF ENGINEERING AND TECHNOLOGY, BUET, DHAKA

Questionnaire for Urban Primary Health Care Services through Public-Private Partnership: A Performance Evaluation Approach in DCC Area.

(For Interviewer)

Name of Clinic and Location:----------

Service provided by

o DCC o NGOs

(For Respondent)

Instruction: Please tick the appropriate box (one or more than one) and fill up the form.

A. Information about the Key Respondent

Name of the Respondent:

Designation:

Age: o Up to 20 years o 21-30 years o 31-40 Years o 41-50 Years o 51-60 Years o Above 60 years

Gender: o Male o Female

B. Responsibility and Personal Statement about Services

- What is your Main Responsibility :
- What types of patients came to this health centre (HC):
- Where they live, their level of income group:
- How many patients came to this HC every day? You can served all patients properly:
- What are the main profession of the patients:

- Which income group of peoples come mostly in your health centre:
- What is the main strength of the Health centre:
- What are the weakness of this centre:
- That is the main different between DCC and NGOs health centre:
- How many doctors and staffs are working this centre:
- Quality of health and how you ensure quality of services:
- What is the main problem for providing HS (health service), how can improve it?
- What is the management and operational procedure of HC
- Did you have any recommendation/opinion for improving HS?

Thanks for your kind co-operation.

Name of the Interviewer
Signature
Date

URBAN AND REGIONAL PLANNING DEPARTMENT
BANGLADESH UNIVERSITY OF ENGINEERING AND TECHNOLOGY,
BUET, DHAKA

Urban Primary Health Care Services through Public-Private Partnership: A Performance Evaluation Approach in DCC Area.

CHECK LIST

For

Focus Group Discussion (FGD)

01. What types of health services you have taken from this health centre (HC)?
02. Where are you living and your profession?
03. Why you came to this health centre?
04. What is the quality and cost of health service?
05. That is the main different between DCC and NGOs health centre as well as others health centre in Dhaka city?
06. How much time you need to take service?
07. What is the behavior of doctors and staffs in this health centre?
08. What is the main problem associated with this health centre?
09. What is the main strength of this health centre.
10. How can improve the better health environment?

Operational Definitions

Public-Private Partnership (PPP)

Public-private partnership (PPP) describes as a government service or private business venture which is funded and operated through a partnership of government and one or more private sector companies. These schemes are sometimes referred to as PPP, P3 or P^3.

Primary Health Care

Urban primary health care service refers as to reduce preventable mortality and morbidity, especially among women and children by increasing access to child health with immunization, reproductive health care, limited curative care, nutrition related services, health education and assistance for women through Essential Services Package (ESP)

Public Organization

Dhaka City Corporation worked under Ministry of Local Government, Rural Development and Co-operatives. Under this study, DCC has treated as public organization.

DCC Health Centre (HC)

Health centre directly operated by Dhaka City Corporation (DCC) under "The Dhaka Municipal Ordinance 1983 and latest City Corporation Act 2009.

UPHC Health Centre (HC)

Health centre directly operated by Urban Primary Health Care Project (UPHCP) through Public-Private Partnership (PPP) with NGOs.

Functions of Health Department

Health is one of the important functions of DCC. The main function of health department of DCC are described below-

- Mosquito control activities
- EPI(Expanded Program on Immunization) activities through routine immunization program for children & women
- Disinfection activities during Eid- U-Azha as or when necessary.
- Clinical service through hospital, maternity centres and charitable dispensaries.
- Register all Births and Death within the area of the city.
- Food and sanitation activities.
- Laboratory tests of food sample to detect adulteration through Public Health Laboratory.
- Veterinary activities like supply of healthy animal meat, registration of pet dogs, and legal action against illegal meat seller.
- Control the Stray Animals

List of DCC's Health Centres

A. **General (Charitable) health centre**: Hajaribagh health centre, Tajgaon health cantre, Siddek Bazar health centre, Rokonpur health centre, Faridabadh health centre, Shahtakhan kollan centre, Purana mugultuli health centre, Dhanmondi health centre, Islambagh health centre, Jurain health centre, Katra health centre, Mohakhali health centre, Topkhana health centre, Mukdapara health centre, Forasgang homeo health centre, nagirabazar homeo health centre, Shahtakhan health centre.

B. **Meternaty Centre**: Moulavi bazar maternity centre, nazira bazar maternity centre and Wori maternity centre.

C. **Hospital**: Dhaka Mohanagar general hospital and Dhaka Mohanagor Shishu Hospital.

The function of major health centres of DCC's are described below-.

Dhaka Mohanogor General Hospital

Dhaka mohanagar general hospital, a 50 bed hospital is located in the old part of the Dhaka city near the bank of river Buriganga. This centre gives 24 hours medical care to patients attending outdoor, indoor or emergency department. The treatment is provided at nominal cost. Following services are available:

Emergency	Medicine
Surgery	Gynecology
Eye	Ear Nose Throat (ENT)
Skin and VD	Dental surgery
Radiology	Pathology (routine pathology, biochemistry, serology and microbiology
Blood bank	Family planning
Immunization	

Dhaka Mohanagor Sishu Hospital

Dhaka mohanagor sishu hospital is a 100 (hundred) bed hospital designed for the treatment of children aging 0-15 years was established in 1990 at Chadnighat. A densely populated area near the ancient trade centre Chwakbazzar. This centre provides health care round the clock to the sick children attending its emergency.

The cost of out door and indoor treatment is quite low. Both the outdoor and indoor departments are supervised by highly skilled post - graduates consultants. The major health services are-
a) Emergency b) Medicine c) Surgery d) Dermatology e) Dentistry f) immunization.

Nazira Bazar Maternity Centre

This health centres is situated in nazira bazar area of Dhaka City. It's a 31 beds maternity centre. Following Services (free) are given in nagira bazar maternity centre:

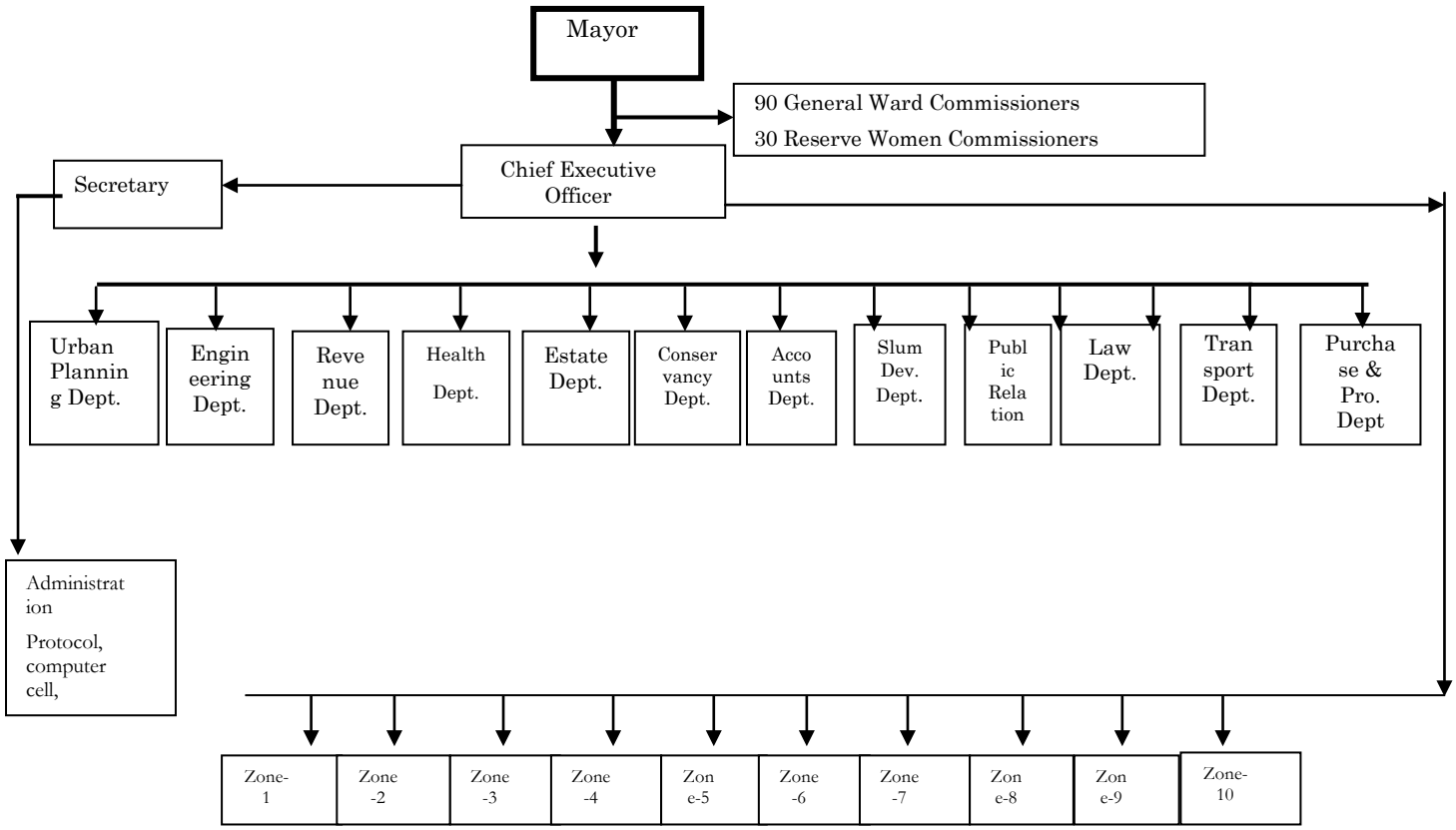
- Hour's emergency normal delivery services.
- 24 caesarean Section, tubectomy and D & C operation from 8.00 AM to 2.00 pm.
- Out door treatment services, Antarctic and postnatal check-up. From 8.00 AM to 2.00PM.
- Treatment of gynaecological Disease and sexually transmitted disease from 8.00 AM to 2.00 PM.
- Treatment of under five children.
- E.P.I services to pregnant woman and children.
- Family planning advice, treatment including copper- T, Norplant implantation and removal.

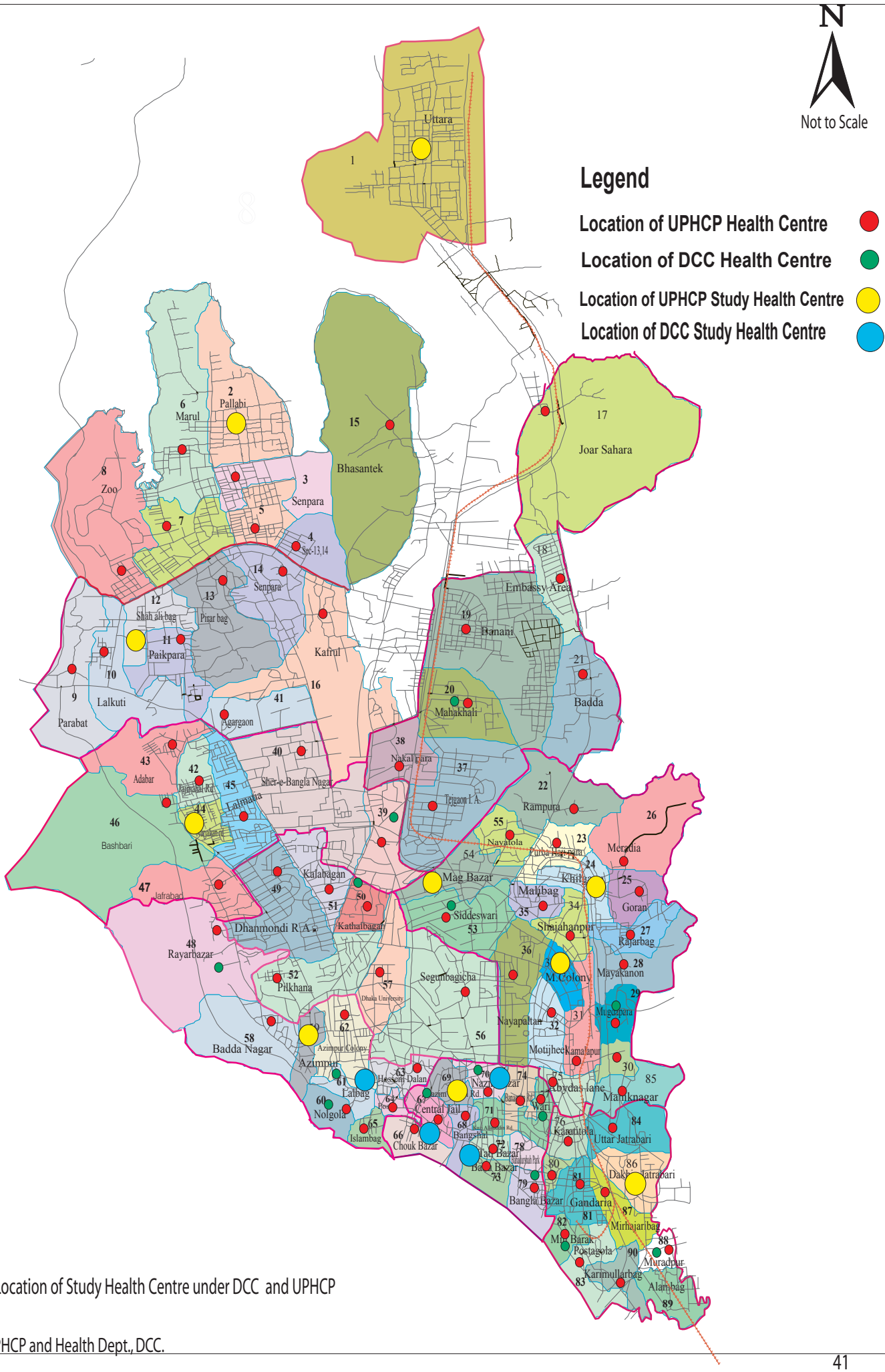
Types of Services under UPHCP

ESP Component	Intervention	Clients	Service
Reproductive Health	Maternal Care	Mothers	Safe mother, antenatal care, safe delivery (including by skilled birth attendants), Emergency Obstetric Care (EOC), prenatal and post-natal including essential newborn care, prevention of unsafe abortion through safe MR services and maternal nutrition.
	Family Planning	All men and women	Provision of contraceptive commodities (oral contraceptives, condoms, inject able and IUDs), information and services for other options such as Norplant, vasectomy, tubectomy, menstrual regulation and natural family planning and side effects information and how to deal with them.
	Maternal Nutrition	Mother	Maternal nutrition services, including pregnancy weight gain monitoring and targeted supplementation of underweight (BMI<18.5) pregnant women and lactating mother, nutrition education.
	Assistance for women who are survivors of violence	women	Health workers will be able to properly refer survivors of violence to the appropriate legal assistance, counselling, and crisis management.
	Adolescent Health Care	Boys and Girls	Information and health care services for adolescent boys and girls between the age group 10 to 20 years.
	Prevention of RTI, STI and HIV/AIDS	All Men and Women	Information on preventing HIV/AIDS and other STDs, and treatment using both standard and syndromes approach.
Child Health Care	Immunizatio n	Children	Immunization against diphtheria, tetanus, measles, polio, tuberculosis, hepatitis B and immunization of mothers with tetanus toxoid.
	Control of Diarrhoea and other childhood dieses	Children	Case management using the integrated management of childhood illness (IMCI) approach and essential newborn care within public sector health services and to facilities its introduction at NGO facilities.
	Control of	Children	Treatment of acute otitis media,

	Acute Respiratory Infections		pneumonia and asthma through appropriate case management, and education mothers how to identify the warning signs of pneumonia, appropriate treatment with antibiotics, control of asthmatic attacks, etc.
	Control of Micronutrient Deficiency	Children	High-dose vitamin a capsules for children 12 to 59 months and increase the coverage of therapeutic supplementations for children night blindness, measles, persistent diarrhoea and severe malnutrition.
Communicable Dieses Control	TB, Malaria, Dengue, SARS, Kala-Azar, Filariasis and Leprosy	Children and Adults	-
Limited Curative Care	First aid for Injuries	All children and Adults	Including treatment of cuts, burns and fractures.
	Emergency care	All children and Adults	Treatment and care for pain, snake bite, poisoning, shock and drowning
	Treatment of minor Infections	All Children and Adults	Treatment of ear, eye and skin infections.
Behaviour Change Communications (BCC)	Strengthened interpersonal communication, raise awareness on existing EPS service, promote health lifestyle behaviour and minimize gender	All children and Adults	To develop client-oriented positive attitudes on part of service providers, to enhance health seeking behaviours on part of users, promote health lifestyle behaviours and to promote informed decision-making regarding the use of private-sector health care especially ESP, diagnostic services and therapeutic drugs.

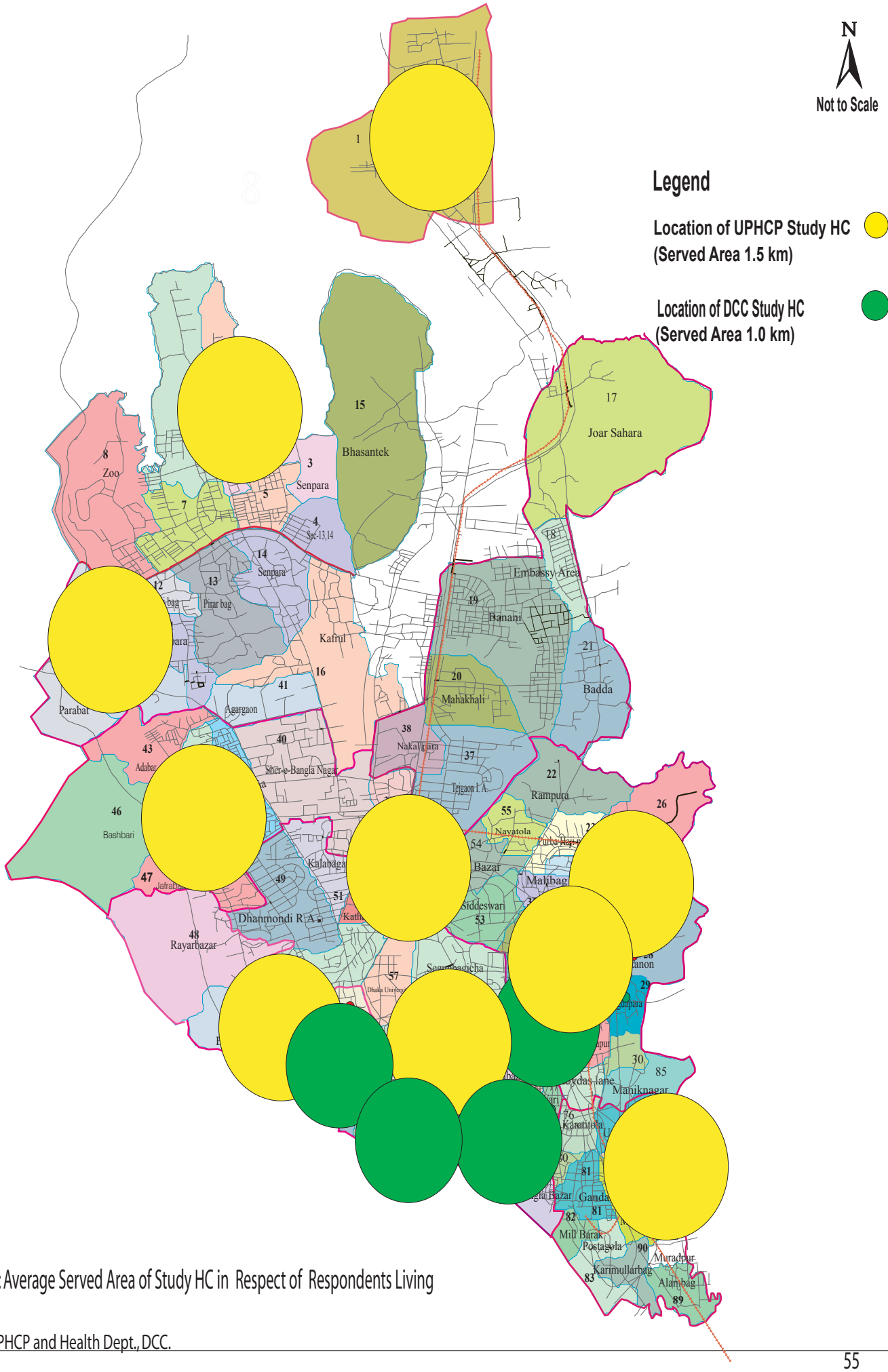
Organogram of Dhaka City Corporation





Map 3.1 : Location of Study Health Centre under DCC and UPHCP

Source : UPHCP and Health Dept., DCC.



Map - 4.1 : Average Served Area of Study HC in Respect of Respondents Living

Source : UPHCP and Health Dept., DCC.