LOCAL GOVERNMENT INSTITUTIONAL ASSESSMENT

A. Overview

1. Bangladesh is among the most densely populated countries in the world with a built-in population momentum resulting from a large proportion of young people. The country is going through significant social and demographic changes. Population growth in urban areas is 2.5%, compared to the national population growth rate of less than 1.4%. Due to reclassification, the number of urban centers has increased and now stands at 316. Urban population is estimated to be 28% of the total population, and half of the population is expected to live in urban areas in 25 years. The biggest city, Dhaka, accounts for 40% of the urban population. The increasing trend of natural calamities in the country has also contributed to the migration of rural people of marginalized groups to the big cities in search of employment.

2. The rapid influx of migrants and increased number of people living in urban slums in large cities is creating continuous pressure on urban primary health care (PHC). The cities are not well-equipped to accommodate these migrants from the point of view of providing basic services. Poor housing, unsafe water supply, weak environmental health services, poor sanitation, overcrowded living conditions, poverty, and the lack of affordable PHC services have resulted in severe health maladies and malnutrition for the urban poor. The under-5 mortality rate in slums (95 per 1,000 live births) is almost double the urban rate (53 per 1,000 live births) and almost 50% higher than the rural rate (66 per 1,000 live births), reflecting the conditions of slums and subsequent health outcomes.

3. To ensure the health of the urban population, particularly the urban poor, the urban public health program, including PHC, requires expansion, both in coverage and quality, to have immediate impact. A comprehensive and well-coordinated multidimensional approach to address the root cause of ill health is necessary as is the creation of all required provisions for effective health promotion, prevention, and curative interventions. Due to the complex nature of urban health problems, there is a need for joint actions and consolidated efforts of different ministries and other stakeholders. Ideally, urban public health sector programs should be comprehensive, necessitating participation of all public, private, NGOs, community-based organizations (CBOs), civil society, and other stakeholders.

4. Amidst the increasingly complex urban environment and severe health disparities in cities worldwide, urban planners and public health professionals now suggest inclusive approaches to achieve health equity. Against this backdrop, the Local Government Division (LGD) of the Ministry of Local Government, Rural Development, and Cooperatives (MOLGRDC) has drafted a National Urban Policy where health is one of the major dimensions. LGD has submitted a proposal to set up a public and environmental health unit to look after urban and public health issues. A permanent structure for consensual decision-making in urban development exists. A ministerial committee led by the Minister for MOLGDRC and the Minister for Works and Urban Development is now functional. An urban forum has likewise been established with advisory support from the Centre for Urban Studies (CUS), a private think-tank.

5. Creating effective institutional mechanisms to support the ULBs to ensure urban health and the development of the urban health sector is an important responsibility of MOLGRDC and

---

1 Sixth Five Year Plan (SFYP), p. 42.
2 Bangladesh Urban Health Survey (BUHS), 2006.
3 This is a key policy measure under a separate ADB project: Urban Public and Environmental Heath Sector Development Project (UPEHSDP).
LGD. The recently drafted *Urban Health Strategy* provides a framework that supports strengthening the capacity of the ULBs, improving inter-ministerial cooperation and coordination between MOLGRDC and the Ministry of Health and Family Welfare (MOHFW) for urban health, and effective public-private partnership (PPP). In line with the government’s *Sixth Five-Year Plan* strategy for capacity development, the project will focus on strengthening governance in urban PHC through strengthening of ULBs’ public administrative capacity, progressive decentralization to ULBs, instituting and implementing an effective monitoring and evaluation (M&E) framework, and improving planning and budgetary processes.

6. To maximize the development impact related to health outcomes in urban areas, a comprehensive and concerted effort is required to (i) expand the content and access to urban PHC services; (ii) strengthen municipal public health governance (including institutions, policy, legal and regulatory framework, and financial capacity); and (iii) strengthen food and water safety and improve solid waste, including hospital waste, management.

### B. Institutional Arrangements for Urban Health

7. The institutional arrangements for urban PHC lie primarily with MOLGRDC, MOHFW, and the urban local bodies (ULBs) comprising the city corporations (CCs) and municipalities (*pourashavas*) (Fig. 1).

**Figure 1: Responsibility of GOB Organizations**

8. Based on government decision, the mandate to provide urban public health services lies with the ULBs. The MOLGRDC, through LGD, is mandated to provide the required budget and management support from the central government. The role of CCs and municipalities has been redefined through the enactment of the *City Corporation Act, 2009* and the *Municipality Act of 2009*. These Acts have empowered CCs and municipalities to maintain public health and establish and operate hospitals, PHC centers, dispensaries, and mobile health units for urban people. Under the Acts, all private clinics, hospitals, diagnostic centers, and paramedical institutes are subject to licensing from concerned CCs and municipalities. This enables LGD to

---


step in within their respective jurisdictions to improve the health care environment for city dwellers. However, the responsibility of LGD for urban health support has not been fully realized due to (i) the relatively recent health problems associated with rapid urbanization; and (ii) LGD’s limited human and financial resources for coping with this growing unmet need in urban health.

1. MOHFW

As per the allocation of business, MOHFW is the designated ministry for all matters related to health and for ensuring and or arranging health services for the entire country. It is responsible for defining health policies, setting strategies, establishing technical standards, controlling quality, enforcing regulations, as well as procuring and distributing vaccines, family planning (FP) contraceptives, and other essential commodities. The Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) are the two major implementing units in MOHFW for health and FP services, respectively. These units have an extensive network of facilities and centrally appointed personnel, including a limited number of rural health workers.

2. MOLGRDC

MOLGRDC has the mandate to provide PHC in urban areas. It comprises of two divisions: LGD and the Rural Development and Cooperative Division (RDC). LGD is responsible for all ULBs. Although LGD has no direct responsibility for urban health care, the ULBs under its jurisdiction have legal and administrative mandates for carrying out public responsibilities, including primary health. The rules of business mandate the MOLGRDC to have the primary responsibility of supporting the ULBs in carrying out all activities related to public health and PHC service delivery. LGD is mandated to provide the ULBs with the required budget and management support from the central government.

As per the allocation of business, LGD is the support wing of MOLGRDC, including the CCs and pourashavas (municipalities). It is entrusted with a wide range of tasks including (i) development of local government; (ii) financing, regulation, and inspection of all authorities established for local government; (iii) public health engineering; and (iv) rural water supply, water, and sewerage development. LGD has the role of directly supporting the 10 CCs and over 316 municipalities with relatively limited human resources. The legal obligations of the MOLGRDC clearly indicate that the tasks of supporting ULBs to ensure urban health and development of the urban health sector is an unequivocally important responsibility of MOLGRDC through LGD. However, LGD’s support for urban public health might have not been realized mainly due to three reasons: (i) the health problems associated with fast growing urbanization is relatively recent; (ii) LGD is a large division (see Annex 1) with many other high-priority tasks; and (iii) LGD has limited human resources to cope with the growing need to support urban health.

3. Urban Local Bodies

---

6 LGD has four joint secretaries, including the DG for M&E.
8 GOB. Cabinet Division. Clause 32, Page 74, Schedule I: The allocation of business among the different Ministries and department, 1996.
12. The Municipal Administration Ordinance (1960), the Pourashova Ordinance (1977), the City Corporation Ordinance (1983), the recently revised Unified Ordinance for all City Corporations of 14 May 2008, and the Local Government (Pourashava) Act (2009) have clearly assigned responsibilities to the ULBs to ensure urban health for their residents. These pieces of legislation have given them the mandate to provide a wide range of primary and public health services including PHC, sanitation, water supply, drainage, food and drink, birth and death registration, vector and infectious disease control, etc. As independent autonomous bodies, the ULBs are required to ensure good health for all populations within its jurisdiction. ULBs’ responsibilities cover the following charter areas of work: (i) food and environment, sanitation, and environment control; (ii) birth and death registration and certification; (iii) veterinary services and rabies control; (iv) vector control; (v) conservancy services; (vi) medical and relief services including mobile clinic services; (vii) prevention and control of dangerous and offensive articles; (viii) promotion of public health and health education; (ix) hospital and dispensary operation and management; (x) provision of vaccination and community health; (xi) prevention of infectious and communicable diseases; and (xii) slaughterhouse operation (Annex 2).

13. ULB Health Departments. Each CC and municipality (pourashava) has a health department called a CC or municipal health department (CCHD/MHD), which provides public health services. Each HD is headed by a chief health officer (CHO), assisted by medical officers, a number of paramedics, and other staff to deal with public and environmental health, basic sanitation, and water supply. The health departments in the ULBs have institutional problems which contribute to the non-attainment of needed program results. The responsibility for all HD activities in the CCs and pourashavas is centralized with the CHO, but the CCHDs and MHDs have insufficient resources and authority to effectively provide public health and PHC services in urban areas. To illustrate, the organizational structure of the Dhaka City Corporation’s HD (Annex 3) shows that all program work falls under the CHO, but there are insufficient senior-level officers to manage assigned areas of work under his direction. Similar conditions exist in all the CCHDs and MHDs, each of which has a CHO who, in turn, is supported by a health or medical officer. The CHO in each CC is responsible for six to ten major health-related areas of work, which require planning, organization, management and coordination, and monitoring and supervision. The actual organization varies considerably among ULBs, with no proper job descriptions and clear lines of authority. HD staff often perform tasks according to priorities set by the respective CC/municipality CEOs, mayors, and LGD. Managers have little control over the resources to ensure performance of their staff. ULBs have difficulty in recruiting qualified health personnel due to low salaries, a lack of career progression and job transfers, and inadequate pension and benefit systems. The HDs have huge staff vacancies, particularly among senior management and mid-level medical officer positions.

4. Urban PHC Providers

14. Health infrastructure facilities owned and operated by different entities can be categorized into (i) public, (ii) private, (iii) NGOs, and (iv) ULBs. Urban PHC is prominently run under the private sector, which offers a range of staff from pharmacists to highly trained specialists. The urban areas provide a contrasting picture of availability of different facilities and services for secondary and tertiary level health care. Medical clinics and diagnostic centers have become numerous all over the country, while PHC facilities and services for the urban population at large and the urban poor, in particular, are inadequate. Due to the rapid urbanization, the government and external funding agencies have started addressing urban
PHC seriously during the last two decades. A number of NGOs and voluntary organizations are playing a potential role as PHC providers. Funded by several donor agencies, the NGOs contribute significantly to the provision of public and environmental health as well as PHC services in urban areas. These include programs and awareness raising campaigns on health education, food security, and immunization; water supply and sanitation in slum areas; income generating programs; and maternal and child health (MCH), nutrition, FP, and TB control.

15. The ADB-supported Urban Primary Health Care Project (UPHCP I and II), the USAID-supported NGO Services Delivery Program, which preceded the ongoing Smiling Sun Franchise Program (SSFP), and the Gates Foundation-supported MANOSHI run by the Bangladesh Rural Advancement Committee (BRAC) are the only major urban PHC projects in Bangladesh. There are also a few other large ongoing projects and programs related to primary and public health in the urban sector. These include the (i) Sanitation, Hygiene Education, and Water Supply in Bangladesh Project (SHEWA-B); (ii) Bangladesh Water Supply Program; (iii) Bangladesh Local Government Support Project; (iv) Global Fund-supported program interventions; (v) Municipal Services Project; and (vi) Avian Influenza Preparedness and Response Project. In addition to the international donor agencies, WHO, UNICEF, UNDP, UNFPA, and WB, as well as the bilateral agencies (Sida, DANIDA, JICA, NORAD, etc.), and other international organizations (viz., Save the Children's Fund (UK, US, Australia), Terre des Hommes, CARE, Pathfinder, HEED, OXFAM, etc.) also deserve mention. The activities of these projects and programs are centrally coordinated by LGD.

16. LGD has taken responsibility for urban health care with the launching of UPHCP in all CCs and selected municipalities since 1998. With the implementation of the two UPHCPs, services have been delivered by the CCs and municipalities through contracted NGOs under MOLGRDC in the project areas. The project provides free services to 22% (as per the 2007 household survey) of the total population in the project area. Non-project urban areas are being covered by the health facilities of MOHFW. In total, there are around 4,000 satellite centers to reach the urban poor. Various NGOs provide essential services as well some special services. LGD has a wealth of experience in providing urban PHC services through contracted NGOs. There have been impressive gains in terms of coverage, quality of services, and exemption schemes for the poorest. However, the various urban PHC services are largely inadequate in view of the needs of the fast growing urban population. The success of UPHCP-I has encouraged the development partners (DPs) to cooperate with LGD and support UPHCP-II over the period 2005–2011.

C. Institutional Challenges in Urban PHC

17. Significant social and demographic changes, including rapid urbanization, heterogeneity of the urban population, and plurality in disease burden in Bangladesh, necessitate an effective institutional arrangement to support PHC delivery. The current institutional arrangements for urban health care are spread thinly across MOLGRDC, MOHFW, ULBs, NGOs, the private sector, and others, and are not strong enough to cope with the growing needs and challenges in urban health. Heterogeneous standards, approaches, and overlapping services create contradiction and confusion both to clients and providers. The stewardship role of the public sector is constrained by a weak legal framework and institutional linkages and coordination. There is no forum to coordinate the programs provided by different providers. The health care system, in a broader sense, transcends clinical care. It has a close relationship with a reasonably good system of preventive care. Apart from immunization and other medically dependent services, it includes access to safe drinking water facilities, solid waste disposal,
prevention of pollution, and access to safe food in urban areas. Overall, for such areas, the responsibility allocation lies with parastatals/departments across more than one ministry.

18. The CCs and pourashavas have legal obligations and administrative responsibilities to provide the required public services for their residents. However, due to competing demands and growing urban infrastructure needs, PHC and public health are not prioritized in terms of both financial and human resource allocations. Limited local revenue collection, heavy dependence on central budgetary support, political interference, and central administrative controls are some of the factors that constrain the achievement of the ULBs’ public health mandate. The current organization of CC/municipality HDs impedes the attainment of needed program results. Organizational and management issues include the lack of effective decentralization, conflicts among departments, and levels of authority, etc. Work effectiveness is hampered by lack of qualified personnel. A critical challenge for any future program will be to improve management efficiency and accountability.

19. The Sixth Five Year Plan, 2011-2016 underscores the need for (i) establishing a permanent coordination structure between MOHFW and MOLGDRC (LGD) to jointly address urban health challenges with LGD, CCs, and concerned stakeholders by thorough assessment, mapping, and planning health, population, and nutrition services in urban areas. It also put emphasis on urban health and involves close collaboration between MOHFW and MOLGRDC, NGOs, and others. It further refers to the fact that, in addition to UPHCP, MOHFW will further extend the coverage of PHC services in urban areas not covered by the Project. The strategy should achieve coherence and consistency at the policy management level.

20. There is a need to address issues related to coordination among the institutions responsible for PHC program; planning, implementation, M&E of PHC delivery through ULBs; community-based services backed by static facilities; career progression to attract professionals to work for ULBs; capacity in the LGD and ULBs to plan, implement, monitor and evaluate, and coordinate comprehensive urban PHC delivery. Better population-based health status data are also needed for planning, benchmarking, and monitoring progress, as well as disease surveillance. In parallel, sustainability should be done through a shift from a project to a program approach, where there would be predictable budgetary allocations for urban PHC. This necessitates institutional and governance reforms in the urban PHC sector.

D. Lessons Learned from UPHCP-I and II

21. In general, CCs and municipalities have limited knowledge of, and responsibility for, PHC services. Their geographic and population base is large, the staffing and financial resources devoted to health matters are inadequate, and technical (medical) expertise is limited. Formal coordination of CCHDs and MHDs with other stakeholders has also been limited, and UPHCP project steering committee meetings have not been held regularly. PA-NGOs have held regular meetings with stakeholders (donors, ward commissioners, project implementation units [PIUs], target communities) in their respective operating areas, and zonal health officers of the ULBs attend regular monthly meetings. Partnership committees have been established in each CC/municipality, chaired by the Mayor and composed of the CHO, civil surgeons, PMU and PIU officers, and representatives of NGOs and other private sector groups. In practice, the health standing committees of the CCs and municipalities meet regularly and are kept abreast of the urban health situation in their respective areas.

11 Reorganization of the City Corporation Health Departments, 2000, pp. 4-5. (Draft).
The ongoing UPHCP-II is intended to sustain improvements in PHC by building the capacity of ULBs to manage, finance, plan, evaluate, and coordinate urban health services. To achieve this, the project aimed at assisting in the organizational restructuring of the ULB’s health departments. To date, there has been little progress with such restructuring and medical staff deployment. The 2001 reorganization report recommended 2,000 additional positions, but there have been delays in the acceptance of the proposal, given its financial, management, and sustainability implications. Consequently, the CCHDs and MHDs are not fully operational. In this context, the LGD and ULBs, through the UPHCP projects, adopted four institutional strategic policies, namely: (i) establishment of effective coordination among government and non-government health service providers; (ii) formation of an essential service delivery (ESD) coordination committee; (iii) establishment of ward health committees with involvement of community, local government, LGD, and NGOs; and (iv) contracting NGOs for service delivery.

UPHCP-I and II have provided useful lessons in providing urban PHC services. The NGO performance-based contracting has been effective in providing the health services to the urban poor. However, scaling up to cover all the CCs and municipalities through this approach remains a challenge. Centrally contracted NGOs remain accountable to the Project Management Unit (PMU), not to the ULBs. The NGOs, which worked successfully as PA-NGOs, had to meet certain requirements in terms of managerial and organizational capacities. Some of the challenges in the projects include: (i) the lack of, and ineffective, coordination among stakeholders and providers of urban health care; (ii) shortage of physicians and skilled health workers, including high staff turnover; (iii) inadequate governance and empowerment of ULBs in urban health care delivery; (iv) insufficient PPP and referral system for effective management of pro-poor health care system; (v) inadequate institutional mechanisms and linkages for a multisector approach to address ill health; (vi) lack of reliable urban health database linked to the national health management information system (HMIS); (vii) need for more effective regulatory and policy environment in urban health; and (viii) inadequate monitoring and quality assurance of urban PHC delivery. UPHCP-II’s institutional capacity-building component aimed to address institutional issues through a comprehensive management capacity development of LGD, ULBs, PA-NGOs, PMU, PIUs, and other stakeholders.

E. The Path Forward

In support of GOB’s Vision 2021 of a healthier, happier, and economically productive urban population, MOLGRDC and MOHFW should agree on a set of strategies for urban health. These strategies would include the following:

(i) ULBs to ensure PHC for its inhabitants and to develop a referral system for ensuring emergency, secondary, and tertiary care and coordination with relevant sectors who determine health outcomes;
(ii) LGD to support ULBs in discharging their assigned roles;
(iii) MOHFW to provide support to the ULBs, set standards and regulations, ensure quality of care, and provide emergency, secondary and tertiary care;
(iv) Preventive and promotive health programs particularly targeting slum dwellers, floating populations, and marginalized communities, capacity building of ULBs, LGD, and MOHFW and urban health care financing ranging from increased financial support by the central government to ULBs, resource mobilization, formation of urban health fund by the government and DPs, and PPP; and
(v) Formation of national urban health steering committee and urban health committees.
25. A program-based approach using the *Urban Health Strategy* framework is necessary to ensure that urban PHC is vertically and horizontally extended nationwide, covering all CCs and municipalities. The institutional capacity building and human resource development (HRD) plan under the proposed Project will focus on strengthening the health unit within LGD and the ULBs, as well as the PA-NGOs, PMU/PIUs, and PHC facility management and staff. Appropriate and skilled manpower has been planned at all levels, with parallel capacity development in the areas of clinical (technical), health management, and behavior change communication (BCC) and advocacy. It is expected that cost-efficiency and IT-based measures will require concurrent capacity building in the improved management systems in line with the progressive delegation of PHC management. Salaries, benefits, and performance incentives will be built into the Project to ensure effective provision of basic PHC services. PHC service delivery activities will be strengthened through increased outreach workers as well as community engagement in the partnership areas (PAs). Advocacy and resource mobilization in local government and in the private sector will require the development of effective management skills at all management levels.

26. The current approach to urban health care has evolved, rather than having been systematically planned. It is characterized by unclear responsibilities and a fragmented structure, with the MOLGRDC and MOHFW having shared responsibilities. Current support to urban PHC from ADB and other donors is on a project basis. To manage the project, a PMU and PIUs have been established that act as the implementing organization of LGD and ULBs, respectively. The UPHCP PMU already has a functional structure comprising deputed officials from the LGD and DGHS. The DG LGD is the official chief coordinator of the PMU, but for all practical purposes, he reports to the Joint Secretary for Development. It is currently located outside the Ministry (at DCC) and, as such, is limited with no effective arrangements (*no assigned desk officer*) for regular liaison or to obtain the required administrative support from LGD. The need for augmentation and institutionalization of the UPHCP PMU is essential to build on that effort to develop a more comprehensive urban public health sector program.

27. Experience indicates that while the PMU/PIUs have been effective in project implementation, there is need to institutionalize some of the key functions at both LGD and ULB (CCHD and MHD) levels. Under the Project, it is planned to have a progressive and phased delegation of Project management responsibilities, including procurement, contract management, finance, and training. The PMU/PIUs have deputed and contractual staff under the Project, which will vary depending on the areas served (e.g., DCC, CCC). Inter-ministerial coordination is required due to the cross-cutting issues related to health. Coordination between MOLGRDC and MOHFW has been weak in the past. The inter-ministerial steering committee for urban PHC that is established could not function optimally.

28. LGD has submitted a proposal to set up a public and environmental health unit to look after urban and public health issues. The proposed urban health unit in LGD will need to strengthen urban PHC functions in the following areas: (i) policy and planning; (ii) M&E; and (iii) reporting. Institutional sustainability of the urban health sector will require concurrent financial sustainability measures such as: (i) increased budgetary allocation for urban health from the LGD central block grants to ensure an effective functioning PHC unit (staffing and funding for the required functions); and (ii) increased and effective utilization of the Sustainability Fund for

---

12 This is a key policy measure under the ADB-funded Urban Public and Environmental Heath Sector Development Project (UPEHSDP).
reinvestment in urban PHC development. Urban PHC needs to be institutionalized as a program, and the capacity of ULBs to implement such a program needs to be built.

29. To maximize the development impact related to health outcomes in urban areas, a comprehensive and concerted effort will be required to (i) expand the content and access to urban PHC services; (ii) strengthen municipal public health governance (organization development and organization change, evidence-based policy and strategies, regulatory framework, and financial capacity); and (iii) strengthen urban basic services (water supply and sanitation, food safety, solid waste and medical waste management). The responsibility of LGD for urban health support has not been fully realized due to: (i) the relatively recent health problems associated with rapid urbanization; and (ii) LGD’s limited human and financial resources for coping with this growing unmet need in urban health. LGD has taken the responsibility of urban health care with the launching of UPHCP in six CCs and selected municipalities. A PMU and several PIUs have been effectively functioning to date.

30. Creating effective institutional mechanisms to support the ULBs to ensure urban health and development of an urban health sector is an important responsibility of MOLGRDC and LGD. The draft Urban Health Strategy (UHS) has included institutional reforms in the urban PHC subsector. The governance and management issues that need to be strengthened include: empowerment of ULBs in the field of health care, effective coordination among health care providers, increased PPP, improved PA-NGO contract management, institutionalized quality assurance (QA), adequate governance and transparency systems, information-based decision-making, and improved M&E systems. There is need to build on the permanent coordination structure between MOLGRDC and MOHFW to take up the mutual mandated responsibility on a sustained and effective manner. MOLGRDC will join in tackling this challenge through a consultative process with MOHFW, ULBs, and concerned stakeholders to jointly assess, map, and plan urban PHC services. Determining the role and accountability of different stakeholders in the delivery of urban health and formalizing relationships will be essential. Through PPPs and through diversification of health service delivery strategies, there is a need to more specifically define private sector as distinguished from NGOs. Upscaling PPP initiatives in PHC will need to be explored. The recently drafted Urban Health Strategy also provides a framework that supports strengthening the capacity of the ULBs, improving inter-ministerial cooperation and collaboration between MOLGDRDC and MOHFW for urban health, and effective PPP. In line with the government’s Sixth Five-Year Plan strategy for capacity development, the project will focus on improving governance in urban PHC through strengthening ULBs’ public administrative capacity, progressive decentralization to ULBs, instituting and implementing an effective M&E framework, and improving planning and budgetary processes.
Ministry of the Local Government, Rural Development and Cooperatives
Local Government Division

Secretary

Man power: 183

Director General

Total Manpower - 183

Particulars
Personnel Officer
Office Assistant cum Typist
MLSS
PA

Jt. Secretary (Admin)

Jt. Secretary (Water Supply)

Jt. Secretary (Development)

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Deputy Sec. (Law)

Deputy Sec. (Audit)

Deputy Sec. (Justice)

Deputy Sec. (Planning)

Deputy Sec. (Development)

Deputy Sec. (Finance)

Deputy Sec. (Field)

Deputy Sec. (Upazila)

Deputy Sec. (PS-1)

Deputy Sec. (PS-2)

Deputy Sec. (PS-3)

Deputy Sec. (UZ-1)

Deputy Sec. (UZ-2)

Deputy Sec. (UPZ-2)

Deputy Sec. (UPZ-1)

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.

Sr. Asst. Sec.
<table>
<thead>
<tr>
<th>No.</th>
<th>Area</th>
<th>City Corporation Ordinance, Schedule III</th>
<th>Pourashava Ordinance, Schedule II</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Health Management</td>
<td>1.1 To administer health management system and initiate relevant measures.</td>
<td>1. To administer health management system and initiate relevant measures.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2 To send notice to owners of buildings in unhygienic and threatening conditions to clean or keep them proper, whitewashed, repaired etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4 To remove garbage from all public roads, latrines, urinals, drains, buildings, and places under its control.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.6 To arrange dustbin as garbage drop and give directives to nearby possessors of houses to put dust in the dustbins.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.8 To keep separate latrines for male and female and maintain and clean.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.10 To serve notice to house owners having no or insufficient latrine or latrine made in objectionable place to arrange, alter, or remove those latrines or urinals.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Unhygienic buildings</td>
<td></td>
<td>2. To send notice to owners of buildings in unhygienic and threatening condition to clean or keep them proper, whitewashed, repaired, etc.</td>
</tr>
<tr>
<td>3.</td>
<td>Removal of garbage, collection, and its management</td>
<td>3.1 To take measures to prevent and control it.</td>
<td>3. To remove garbage and its removal from all public road, latrine, urinal, drain, building and place under its control.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.2 Establish and maintain hospitals for treatment of infectious diseases.</td>
<td>To arrange dustbin as garbage drop and give directives to nearby possessors of houses to put dust in the dustbins.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.3 To introduce and implement prevention of infectious diseases.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Latrines and urinals</td>
<td></td>
<td>4. Public toilet - To keep separate latrines for male and female and maintain and clean.</td>
</tr>
<tr>
<td>5.</td>
<td>Infectious diseases</td>
<td></td>
<td>5. To serve notice to house owners having no or insufficient latrine or latrine made in objectionable place to arrange, alter or remove those latrines or urinals.</td>
</tr>
<tr>
<td>6.</td>
<td>Health center and maternity</td>
<td></td>
<td>6. To take measures to prevent and control it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish and maintain hospitals for treatment of infectious diseases.</td>
<td>To introduce project and implement prevention of infectious diseases.</td>
</tr>
<tr>
<td>No.</td>
<td>Area</td>
<td>City Corporation Ordinance, Schedule III</td>
<td>Pourashava Ordinance, Schedule II</td>
</tr>
<tr>
<td>-----</td>
<td>-------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7.</td>
<td>Hospital and dispensary</td>
<td>7. To facilitate treatment of city dwellers and establish sufficient number of hospitals and maintain them. Rules will prescribe conduct of hospital and dispensary.</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Treatment assistance and health education</td>
<td>8. To establish primary medical centers and conduct mobile medical assistance, to encourage forming cooperatives in order to accord medical assistance, to develop medical education, provide finance to extend medical assistance and to examine health of school students.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9. No digging of tube wells for supply of water shall be made.</td>
<td></td>
</tr>
</tbody>
</table>