PUBLIC HEALTH, URBAN GOVERNANCE AND THE POOR IN BANGLADESH: POLICY AND PRACTICE

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As is the case elsewhere in Asia, urbanization is growing at a rapid pace in Bangladesh. With the increased urbanization, the basic amenities of life are not expanding for the urbanites. Rather, the increased populations have been exerting continuous pressure on the existing limited facilities. The poor, who constitute a large portion (45 per cent) of the urban population, are the principal victims of this predicament and are significantly disadvantaged in access to basic services, particularly public health services. Urban governance has yet to be efficient enough to deal with this urgent issue. The country still lacks adequate policy direction for urban public health and the management of existing services is also quite inefficient. This paper attempts to identify the weaknesses of urban governance that result in the poor having inadequate access to public and primary health services by reviewing the existing policies and institutional arrangements for the provision of services and by examining the extent to which they are put into practice in terms of ensuring access to these services for the urban poor. Thus the study seeks to identify the inadequacies of the policies and practices contributing to the lack of primary and public health services for the urban poor. It draws on the findings of an empirical study conducted in four slums of the capital city of Bangladesh.

I. INTRODUCTION

In recent times, the world has been witnessing rapid urbanization; it is even more rapid in developing countries. According to projections by the United Nations, rapid urbanization of the Asia-Pacific region will continue and, by 2025, the majority of the region's population will live in urban areas (ESCAP 2007, para. 5). In South Asia, the percentage of the population living in urban areas is

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increasing and, as a part of this trend, Bangladesh is urbanizing at a rapid pace. Though the country is rural, a national daily notes that 27 per cent of its population lives in urban areas ("The costs of urbanization", *The Financial Express* (Dhaka), 1 July 2007) and the urban population has been growing at over 3.5 per cent annually (CUS, NIPORT and MEASURE Evaluation 2006, p. 13). The national census conducted in 2001 showed that, over the previous 10 years, the population in urban areas of the country had grown by 38 per cent, compared with only 10 per cent in rural areas (Bangladesh 2003). Hossain (2003, p. 2) notes that, in 1974, only 7.86 per cent of the total population lived in urban areas. This figure had reached 20.15 per cent by 1991, and it is anticipated that the urban population will reach 36.78 per cent by 2015. A projection in the National Water Management Plan also shows that, in the next 30 years, the urban population of Bangladesh will outnumber the rural population and the density of the already overly dense population will increase tremendously (Bangladesh 2005b, p. 10).

In Bangladesh, rural poverty, river erosion and better employment opportunities in urban areas are the reasons that an increased number of rural people move to the cities. The additional rural migrants exert tremendous pressure on the already scarce urban utility services and other amenities of urban life, resulting in a lack of access to basic services relating to primary health and public health services, such as water, sanitation, waste disposal and food safety. In Bangladesh, only 72 per cent of the urban population has access to the water supply (Bangladesh 2005b). No urban area except Dhaka (the capital city) has a conventional sewerage system and only 20 per cent of the population of Dhaka is served by the sewerage network; only 50 per cent of the solid waste generated in urban areas in Bangladesh is collected daily, leaving the remaining waste scattered on the streets and causing environmental pollution (Asian Development Bank 2008).

The urban residents least able to compete for such limited supplies are the poor, who constitute nearly 45 per cent of the urban population (CARE 2005). As they do not have the resources to make alternative arrangements to meet their basic needs, they are almost excluded from access to public health services, including pure water, sanitation, food safety and waste disposal. In urban areas, the poor mostly live in a damp, crowded and unhygienic environment. They are highly vulnerable to environmental hazards and to various infectious and non-infectious diseases, while access to primary health services remains excessively poor.

Impoverishment continues due to a lack of serious concern for the urban poor at the national level. Policy lacks a clear-cut direction regarding urban public health and the urban poor. The legal basis for public health services in urban areas is provided through various local ordinances, the execution of which is very

poor. Urban local bodies, called city corporations[1] and municipalities or *pourashavas*,[2] are mainly responsible for managing public health services in urban areas but they are ill-equipped to provide the required services. In addition to the local bodies, various central Government organizations, private entities and non-governmental organizations (NGOs) are also engaged in the provision of primary and public health services. Despite the existence of multifarious service provisions, access to these services for the urban poor is grossly inadequate due mainly to poor governance.

This paper seeks to identify the weaknesses of urban governance that cause the urban poor to have inadequate access to primary and public health services. Data were collected from both primary and secondary sources for the study, which draws on the findings of a primary research project sponsored by the Asian Development Bank that was carried out in four randomly selected slums in Dhaka city in June 2008. Primary data were collected through observation (of the living conditions of the slum poor) and by interviewing 60 households from the selected slums, while secondary data were collected by reviewing relevant legislation, policy documents and related literature.[3]

The discussion is organized into six sections. The first two sections illustrate the nature of the urban governance of primary and public health services, including water, sanitation, waste disposal and food safety, through a review of existing policy and relevant legislation and the institutional arrangements for their implementation. The next two sections focus on the nature of policy implementation in practice by illustrating the nature of urban poverty in Bangladesh and the extent of access the urban poor have to primary and public health services. Based on these illustrations, the penultimate section pinpoints the policy and institutional weaknesses contributing to the limited access of the urban poor to the existing services. The final section of the paper concludes the study and puts forward certain recommendations for improving the situation which have implications for the Asian region at large.

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1 Large cities are called city corporations.

2 Smaller cities are called *pourashavas* or municipalities.

3 The author and the team collected the primary data.

II. PUBLIC HEALTH IN URBAN BANGLADESH: THE POLICY FRAMEWORK

This section illustrates the legal provisions of urban health services as articulated in the health policy document and the relevant legislation.

According to the Universal Declaration of Human Rights, everyone has the right to a standard of living adequate for health and well-being (United Nations 1948, art. 25), and it is always the responsibility of government to ensure it no matter how daunting the problems of delivery may be (World Bank 2003). Likewise, the provision of basic health services is a constitutional obligation of the Government of Bangladesh. Article 15 of the Constitution (Bangladesh 2004) stipulates that it shall be a fundamental responsibility of the State to ensure the provision of the basic necessities of life, including food, clothing, shelter, education and medical care. Again, article 18 of the Constitution asserts that the State shall raise the level of nutrition of its population and improve public health as its primary duties. The National Health Policy of Bangladesh was first adopted in 2000 and has recently (2008) been revised. It reaffirms the constitutional obligation of providing basic medical services to people of all strata (article 15) and improving the level of nutrition and public health (article 18). The policy also aims to develop a system to ensure the easy and sustained availability of health services to the people, especially communities in both rural and urban areas. It aims to reduce the degree of malnutrition among people, especially children and mothers, and to implement an effective and integrated programme to improve the nutritional status of all segments of the population. It aims to undertake programmes to control and prevent communicable diseases and reduce child and maternal mortality rates to an acceptable level and to improve overall reproductive health resources and services.

The principle of the policy is to ensure health services for every citizen and the equal distribution of available resources to solve urgent health-related problems, with a specific focus on the disadvantaged, the poor and the unemployed. To ensure the effective provision of health services to all, the policy adopts a primary health care strategy and adheres to the principle of facilitating and encouraging collaborative efforts between governmental and non-governmental agencies. NGOs and the private sector will be encouraged to perform a role complementary to that of the public sector in the light of governmental rules and policies. The policy also adopts the strategy of integrating the community and local government with the health service system at all levels.

Thus the priorities of the policy include the following:

- Providing health services for all, particularly the poor and disadvantaged
- Improving maternal and child health services
- Ensuring adequate nutrition for mothers and children through targeted programmes
- Preventing and controlling communicable diseases
- Engaging in public-private partnerships

To support the execution of these policy statements, legislation has been promulgated from time to time, but there is no specific legal provision relating to urban health care. Various city corporation and *pourashava* ordinances deal with urban health issues. The *Pourashava* (Municipality) Ordinance of 1977, the city corporation ordinances of 1982 and 1983 and the recently revised local government (city corporation and *pourashava*) ordinances of 2008 have all clearly assigned urban local government institutions with responsibilities regarding the provision of health services for their residents (Bangladesh 2008). As per the 2008 ordinances (schedules II and III), the city corporations and the *pourashavas* will be responsible for the provision of a wide range of primary and public health services, including the removal, collection and management of garbage; the prevention of infectious diseases; the establishment of health centres, maternity hospitals and dispensaries; and water supply, drainage and sanitation.

The Penal Code of 1860 ensures food safety, stipulating that anyone involved in the adulteration of food or drink and sales of such products shall be punished by imprisonment for a term of up to six months, or by a fine of up to 1,000 taka,[4] or both. The legislation also prohibits the sale of adulterated drugs. Later, the Pure Food Ordinance of 1959 was promulgated with provisions for food safety for the citizens of all urban areas. The Bangladesh Standards and Testing Institution Ordinance was promulgated in 1985 to ensure food safety. The food policy of Bangladesh also aims to ensure the food safety of its population.

There is no specific regulation for waste management in Bangladesh. City corporation and *pourashava* ordinances provide the legal provisions for waste management in urban areas. The Bangladesh Environmental Conservation Act of 1995 provides for conservation of the environment, the improvement of environmental standards and the control and mitigation of environmental pollution.

[4] Bangladeshi currency, $1 = 69.35 taka (as of 19 February 2009).

Under the Act, the Department of Environment was formed under the Ministry of Environment, with the specific authority and responsibility to conserve the environment (waste management) and even to accept assistance from law enforcement agencies and other authorities as and when necessary.

The following section describes how public health services are being managed in urban areas in practice under the guidance of this policy and legislation.

III. URBAN GOVERNANCE AND PUBLIC HEALTH

Urban governance refers to the administration and management of functions and responsibilities mandated to local government institutions, private sector institutions, NGOs and civil society in urban areas. At the central level, the Ministry of Local Government and Rural Development plays a key role in urban governance, with a wide range of controlling authority over urban local government institutions.

Formally, urban local government is the sole authority managing urban public health services under the guidance of the above-mentioned policies and legislation. Two types of urban local bodies, known as city corporations and *pourashavas*, have massive public, environmental and primary health care mandates. They are both directly elected by the local people. Out of the 522 urban areas[5] identified by the 1991 Census Commission (Bangladesh 1993), only 316 urban centres have local governments. The six large metropolitan cities (Dhaka, Chittagong, Rajshahi, Khulna, Barisal and Sylhet) enjoy city corporation status, while 310 small cities have *pourashava* status. The prime determining factors of city corporations include: population size, population density, the economic importance of the area and available infrastructure facilities. City corporations have a higher level of urbanization than *pourashava* towns and are large commercial and administrative centres. In urban centres with no local government, urban services are provided by field administration of the central Government. Centrally, the Ministry of Local Government and Rural Development is the supporting authority of the directly elected urban local bodies. Along with the Ministry of Local Government and Rural Development, the Ministry of Housing and Works and the Ministry of Health and Family Welfare also share responsibility for developing and providing urban infrastructure and water and sanitation services. In this regard, it is worth mentioning the roles of the Local Government and Engineering Department

[5] As per the *Pourashava* Ordinance of 1977, an area can be declared as an urban area upon fulfilment of certain conditions, which include the following: three fourths of the adult male population of the area should be engaged in non-farm activities and the population of the area should be no less than 15,000, with an average density of not less than 2,000 inhabitants per square mile.

and the Water and Sewerage Authority (WASA) under the Ministry of Local Government and Rural Development and the Department of Public Health and Engineering under the Ministry of Health and Family Welfare.

In all urban areas except the two big cities of Dhaka and Chittagong, water supply and sanitation services are provided by the local bodies. According to the 1977 *Pourashava* Ordinance, it is obligatory for city corporations to ensure the availability of safe drinking water to households, while the provision and regulation of water supply and the prevention of infections are to be ensured by the *pourashava.* In the cities of Dhaka and Chittagong, a special government agency called the Water and Sewerage Authority (WASA) is the formal government authority providing drinking water and sanitation. Sometimes, WASA sets up water pumps in slum settlements in partnership with NGOs. Water is delivered through pipe connections to homes, public taps and tube-wells. Piped water supply systems have been installed in a limited number of *pourashavas*. The non-piped urban areas rely mostly on hand pump tube-wells (Bangladesh 2005b). Because of the high population density, coverage of sanitation in urban areas is worse than in rural areas. As mentioned before, only 20 per cent of the population of Dhaka city is served by a highly expensive sewer network; the rest uses septic tanks, pit latrines or no system at all (Bangladesh 2005b).

Garbage disposal in a fixed place is essential to ensure a hygienic environment. Local bodies are responsible for the removal, collection and disposal of solid waste in urban areas. Until recently, the conservancy section of the city corporations and *pourashavas* carried out waste management, including sanitation, cleaning and other associated functions, while the transportation of waste and other engineering functions were performed by another department. As that system weakened the chain of command, Dhaka City Corporation recently inaugurated a waste management department to perform all of the waste management functions in a combined manner under a single line of authority, but this approach has yet to be replicated in other urban areas across the country. In addition to the local government institutions, community-based microenterprise primary waste collection systems are well established across the urban areas of the country.

Public health largely depends on the safety and quality of the food supply. The Ministry of Industry sets the food safety and quality standard and the Ministry of Local Government and Rural Development is its key implementing agency. Sanitary inspectors of local bodies are responsible for the inspection of food manufacturing/processing and selling premises, as well as for the collection of food samples. There is only one food testing laboratory in the country for ensuring food safety; it is located in Dhaka city.

In urban areas, publicly provided primary health care facilities operate under the control of local government institutions. Almost all *pourashavas* have urban-based *upazila*[6] health complexes and some *pourashavas* have district hospitals in their areas. Usually, these two facilities coordinate with each other as a single unit if they are in the same *pourashava.* In addition to these facilities, some *pourashavas* have specialized hospitals, such as tuberculosis and diabetic hospitals. In *pourashavas,* other than the government facilities, there are, on average, 2-15 private clinics, 1-4 NGO clinics and 2-20 diagnostic centres. In addition, there are 35 urban dispensaries across the country that provide primary health services, mainly to the urban poor. Many private for-profit and not-for-profit hospitals also provide health services in urban areas. Private hospitals are mostly located in big *pourashavas* or city corporations.

Despite the existence of all of these institutional arrangements and relevant policies and legislation, the urban poor are grossly deprived of adequate access to services. To provide insight into this deprivation, the following two sections depict the nature of urban poverty and the limited access of the urban poor to the existing services.

IV. URBAN POVERTY: EXTENT AND DIMENSIONS

The Asian region is urbanizing rapidly, and so is poverty, since urbanization is taking place without the desired level of development. Ravallion, Chen and Sangraula (2007) note that, although rural poverty has declined significantly in Asia, urban poverty rose from 136 million in 1993 to 142 million in 2002.

In Bangladesh, also, the rapid growth of urbanization is not commensurate with a high level of economic development; rather, it causes massive poverty in urban areas since adequate job opportunities are not created. Nearly 45 per cent of the urban population is living in poverty, while 25 per cent are extremely poor, consuming just 1,805 kilocalories per day (CARE 2005). According to the estimate

[6] An *upazila*/subdistrict is an administrative unit in Bangladesh. The organizational structure of the country's public health-care system is in alignment with the country's administrative set-up. Bangladesh is divided into 6 divisions, 64 districts, 481 subdistricts/*upazilas*, 4,441 unions and 68,000 villages. Across the country, there are 300-500-bedded specialized tertiary hospitals at the divisional level, 50-200-bedded district hospitals that provide both inpatient and outpatient care at the district level, 31-bedded *upazila* health complexes at the *upazila* level for secondary care, and union health and family welfare centres at the union level that provide primary care services. In this institutional structure, *upazila* health complexes function as referral hospitals for primary level care and provide support services to primary health care. There are no union health and family welfare centres in urban areas, but urban dispensaries provide primary health services.

of the Bangladesh (2005c) Bureau of Statistics, the average monthly per capita income of the extreme poor is 741.52 taka ($10.88).

It is even more alarming to note that, in Bangladesh, urban poverty is an increasing trend. Nationwide, the urban poor increased from 7 million in 1985 to 12 million in 1999 (Bangladesh 2003). About two decades ago, Anam (1993) estimated that, by 2020, the poor would comprise 40-60 per cent of the urban population. The existing trend of growing urban poverty is about to prove this estimate true. The increase of poor people in urban areas is resulting in the growth of a massive number of slums. Although slums are the most visible face of urban poverty, there are also many other poor people who live elsewhere. The urban poor can be broadly classified into two categories: a) slum dwellers and b) the floating population.

The majority of the urban poor are rural migrants (first or second generation migrants) who turn to slums for shelter. An operational definition of the term "slum" agreed upon by experts at a 2002 meeting of the United Nations Human Settlements Programme (UN-Habitat) is: "a contiguous settlement where the inhabitants are characterized as having inadequate housing and basic services" (UN-Habitat 2003, p. 10) (i.e. access to water, sanitation, security of tenure, durability of housing and sufficient living area) (UN-Habitat 2003, p. 12, table 1.2). It is estimated that 35.2 per cent of the total population of six cities in Bangladesh lives in slums, the largest concentration being in Dhaka, the capital, followed by other big cities: Chittagong, Khulna and Rajshahi (Bangladesh 2003). The total number of slums in six of the country's cities is 9,048, of which 55 per cent are located in Dhaka. The slum population in Dhaka doubled from 1.5 million to 3.4 million between 1996 and 2005 (CUS, NIPORT and MEASURE Evaluation 2006). The slums are mostly located in low-lying areas, marshes, sewage canals, riversides, railway tracks and embankments, which are generally prone to poor drainage systems and flooding. The slums are densely crowded and lack access to piped water, hygienic sanitation and basic civic amenities mainly due to the massive demand for the already scarce services. The scarcity of services has been intensified because of the unwillingness of the public and private sectors and NGOs to invest in slums due to the illegal nature of these settlements. Thus, living in an unhealthy environment with no basic facilities, the slum dwellers are further impoverished through sickness and malnutrition. Women and children are especially vulnerable to this poverty-induced ill health. The slum dwellers mostly have low-paid jobs in the informal sectors of the urban economy. There is a predominance of day labouring and rickshaw pulling among this poor group of city dwellers (Amin 1991), while females are mostly found in such occupations as maidservants, housewives and garment workers.

The second category of the urban poor lives on the pavements of the city streets and in bus stops, railway stations and parks, without the minimum basic amenities of life. These people are mostly known as the "floating population", as they don't stay in the same place for long. They are generally engaged in begging or some other kind of antisocial activity. There is hardly any data about the number of this type of poor. The majority of this category of urban poor are also rural migrants.

Of these two categories of urban poor, the slum dwellers are a bit more organized as a group than the floating population in terms of receiving health services from the existing facilities in a specific location. For this reason, the present study finds it appropriate to look at the slum dwellers in order to gain a fuller picture of the access of the urban poor to public and primary health services and to analyse the efficiency of urban governance in this regard.

V. ACCESS OF THE POOR TO HEALTH SERVICES

Accessibility is determined by the availability and affordability of services. Although the urban poor can manage most of the basic human services informally, by themselves, to survive, health services is the one area that is beyond their control (Riley and others 2007). Despite the fact that services are provided by various types of providers—public, private and NGO—access of the poor to these services is quite limited. On the other hand, their earnings are so low that expenditures for health care consume a negligible amount. The general tendency of the urban poor is to spend a higher proportion of their income on food and housing, while lower priority is given to health and education costs. The present section depicts the extent of the slum poor's access to primary and public health services in the capital city of Bangladesh.

Respondents in the study were randomly selected. As mentioned before, 60 households (15 from each of four slums) were the key respondents. Although slums reflect urban poverty in a concentrated manner, all of those living in slums are not poor. Usually, the per capita income; socio-economic status, particularly the housing condition; and the possession of durable items inside the homes are popular methods of identifying the poor. The present study has considered these factors and the upper and lower poverty lines set by the *Household Income and Expenditure Survey* (Bangladesh 2005c) based on the cost of basic needs method as the basic criterion for identifying the poor. According to the *Survey,* in 2005, for the Dhaka metropolitan area, the per capita income of the poor at the lower poverty line was 820.26 taka ($11.83) and that of the poor at the upper poverty line was 952.67 taka ($13.74). The respondents of the present study fall both between the

two poverty lines and slightly above the upper poverty line, with a monthly average per capita income of $14.42. Broadly, the respondents belonged to three occupational categories: self-employed (petty shopkeepers, beggars, vegetable vendors, tailors), day labourers (domestic help, rickshaw pullers, construction workers) and the working class (garment workers, car drivers, security guards, dairy farm workers). The average size of the households was five. The respondents lived in wooden *macha,* shacks, cutcha houses with bamboo fences and tin roofs, and semi-pukka houses with concrete walls and tin roofs. Data from the slum poor were collected through observation and interviews, which were also used to determine the socio-economic status of the households. The determinants of socio-economic status included occupation, income, household size, durable goods possessed and the type of ownership of the settlement (temporary or transient settlers were worse off than long-term settlers). A small-scale qualitative survey was conducted through in-depth, open-ended interviews. During the interviews, the respondents were asked about their sources of income, health care, drinking water and sanitation, food safety and the condition of their waste disposal. They were also asked why they had opted for specific sources of care and what problems they faced in availing themselves of those provisions.

Access to public health services

As a concept, public health refers to the broader and comprehensive view of health, as it means the promotion and protection of the health of the general public. Public health services are those that are provided to the general public by the government or NGOs to help them live a healthy life. A pure water supply, hygienic sanitation, waste disposal and food safety are significant among these services. The urban slums are the worst victims of the inadequate provision of these services, mainly due to the refusal of the authorities to install infrastructures in their informal settlements and also because of a high population density in a limited space.

Access to water

WASA is the formal government authority that provides drinking water and sanitation to the inhabitants of Dhaka city and to those of the second largest city, Chittagong. As the slum dwellers do not have a mailing address, they are not entitled to water supplied by WASA. They obtain water from WASA through an intermediary elite group or an individual living beside the slum or the slum welfare committee. This intermediary group supplies water to the slum poor at a rate higher than the actual price. However, in the study areas, the sources of water included hand pump tube-wells, WASA pumps, municipal piped water, water vendors

and water supplied by some other specific places, such as mosques. Of these sources, hand pump tube-wells connected to the WASA line were found to be the primary source of water. The distance of the water sources from the dwellings varied from 1 to 500 feet, while the time taken to reach them was from 2 to 10 minutes (see table 1).

Table 1. Distance of the water source (tube-well) from the household

Distance (in feet)	*Time taken to reach the source (in minutes)*	*Number of respondents*	*Percentage of respondents*
1-100	2-3	36	60
101-200	4-5	12	20
201-300	6-7	4	7
301-400	7-8	3	5
401-500	9-10	5	8
Total		60	100

Source: Calculations based on survey data collected by the author.

Table 1 shows that tube-wells, the prime source of water, are located within 1-100 feet of the household in the majority of cases (60 per cent), which means it takes 2-3 minutes to reach them. This means that 60 per cent of the slum dwellers in the survey can access water in 2-3 minutes. On the other hand, only 8 per cent of the slum dwellers need 9-10 minutes to reach the tube-wells.

Despite the existence of various sources of water, their number is quite insufficient. A recent study (Podymow and others 2007) found that from 5 to over 100 families in the study area shared one tube-well. The present study found that, in a good number of cases (47 per cent), one tube-well was shared by 76-110 households (see table 2). In one slum, there was only one hand pump tube-well, which was shared by 170 households.

In the case of rented rooms, the settlers had to pay the water bill (100 taka or $1.44) with the rent and, in other cases, households had to pay 60-100 taka ($0.87-$1.44) per month for tap water. In one slum, it was found that people mostly used water from the nearby river for bathing, washing dishes and clothes, and other daily activities, as it was free.

Table 2. Pattern of tube-well sharing

Number of households sharing one tube-well	*Number of respondents*	*Percentage of respondents*
5-40	5	8
41-75	12	20
76-110	28	47
111-145	0	0
146-180	15	25
Total	60	100

Source: Calculations based on survey data collected by the author.

Box 1. Buying water limits access to water: The tale of Bibi Kulsum

Bibi Kulsum is a domestic helper. Her prime source of drinking water is tap water located 450-500 feet from her house. The source is shared by 70-80 households. She has to pay 80 taka ($1.15) per month for drinking water but quite often she finds it unavailable. In cases when she cannot obtain water, she has to buy one vessel of water for 2 taka ($0.03). For other purposes, e.g. washing clothes and utensils and cooking, she uses river water. When asked why she uses dirty river water for cooking instead of pure water, she replied, "How can I make you understand the sorrowful state of the poor like us? We often see excreta floating on the river water, till then we use this water as it costs nothing. For me, it is hard to buy drinking water, let alone buying water for cooking!!"

Source: Survey information and data collected by the author.

Access to sanitation

Slums are not connected to the WASA sewerage network. As for water services, slum welfare committees, NGOs and other intermediary groups construct toilets in slums. Most of these toilets are water-sealed or linked to septic tanks. For the maintenance of the toilets, people have to pay a fixed amount. Due to the cost, these latrines are not much preferred by the slum dwellers. Moreover, as the space for constructing toilets in slums is limited, they are also limited in number.

In the study areas, two types of latrines were found: water-sealed latrines linked to sewerage or septic tanks and hanging latrines. Hanging latrines are precarious bamboo platforms raised a few feet above the water and screened by rags or polythene, which is called a *tong*. The sludge from these latrines is

discharged straight into the pond below, causing a highly contaminated environment. Open fields and railway tracks are also used by children off and on.

Table 3 shows that 60 per cent of the respondents had access to the hygienic sanitary latrines, while the rest used hanging latrines, which are unhygienic. Latrines are not always very near to the households. Table 4 presents the distance of the toilets from the households. The closest distance ranges from 1 to 50 feet, while the greatest distance ranges from 251 to 300 feet. The encouraging finding is that the majority of people (73 per cent) had access to toilets within the lowest range (1-50 feet).

Table 3. Types of latrines used

Type of latrine	*Number of respondents*	*Percentage of respondents*
Water-sealed/linked to sewerage	36	60
Hanging latrine	24	40
Total	60	100

Source: Calculations based on survey data collected by the author.

Table 4. Distance of latrines from the household

Distance (in feet)	*Number of respondents*	*Percentage of respondents*
1-50	44	73.33
51-100	4	6.68
101-150	3	5.00
151-200	5	8.33
201-250	2	3.33
251-300	2	3.33
Total	60	100.00

Source: Calculations based on survey data collected by the author.

Although the majority of the respondents had access to hygienic latrines, they were shared by many households. Table 5 shows the latrine-sharing pattern in the selected slums, where a minimum of 8 and a maximum of 66 households shared one latrine. The table shows that less than half of the households (48 per cent) fell in the lowest range (1-15), while the larger portion of the households (52 per cent altogether) shared latrines with 16-75 households. This means that fewer people had better access to sanitation. Nine out of sixty households had separate hanging latrines of their own. All other households were sharing hanging latrines.

Table 5. Pattern of latrine sharing

Number of households sharing one latrine	*Number of respondents*	*Percentage of respondents*
1-15	29	48
16-30	4	7
31-45	16	27
46-60	0	0
61-75	11	18
Total	60	100

Source: Calculations based on survey data collected by the author.

Garbage disposal

A study by the Centre for Urban Studies, the National Institute of Population Research and Training, and MEASURE Evaluation (2006) notes that the majority of slums (55 per cent) do not have any fixed place for garbage disposal in their dwellings. Most of the respondents of the present study also reported that there was no fixed place for garbage disposal. Two out of four slums studied had fixed places for garbage disposal from where garbage was collected by the city corporation, but they mostly remained unutilized or under-utilized. Mostly, the slum dwellers threw their garbage in front of their houses or straight into the water under the *macha* or into the pond or river nearby. When asked about the place of garbage disposal, one of the respondents reluctantly showed the space in front of her house and said, "We have no fixed place for garbage disposal; we throw garbage here". She went on, adding that even children's excreta were also sometimes thrown right in front of the dwelling. Another respondent reluctantly said, "The entire place is like a dustbin; hence we do not need a fixed place for garbage disposal". Table 6 shows the garbage disposal practices in the selected slums studied.

The majority of people (38 per cent) threw garbage through the gaps of the wooden platform of the *macha* houses instead of disposing of it in any place set aside for garbage disposal (see table 6). The second most popular method (25 per cent) was to throw garbage in a place designated by the city corporation, while a good number (20 per cent) threw it in front of their dwellings. Garbage disposal practices largely depended on the location of the slum. If the slum was located near an open space, people preferred to throw garbage there, whereas if it was beside any marshy land, they opted for that. Even if there was a fixed place for garbage disposal, they preferred these open spaces, as it was easy and they were unaware of the consequences of being exposed to the garbage.

Table 6. Garbage disposal practices

Site of garbage disposal	*Number of respondents*	*Percentage of respondents*
Through the gaps of the wooden platform of the *macha* houses	23	38.34
Fixed place	15	25.00
In front of the dwelling	12	20.00
Hole	5	8.33
River	5	8.33
Total	60	100

Source: Calculations based on survey data collected by the author.

Box 2. Living with garbage!!

Altabanu, a housewife and inhabitant of Banshbari slum, lives in her two-room bamboo shack with seven family members, including her two minor sons. Her husband works in a dairy firm. She and her neighbours always throw garbage right in front of the house. Therefore, a heap of rubbish has accumulated just outside of her door, emitting an appalling smell. The family members (her in-laws and children) have no reaction to it. The in-laws were gossiping in bed with some guests, the elder son was eating rice and the younger son was playing. Asked whether the smell was always so terrible, she replied, "This has been normal to us. We don't get any smell!!"

Source: Survey information and data collected by the author.

Food safety

Slum dwellers do not have much time to prepare food on their own, as they have to remain outside to earn a living for a significant portion of the day. Therefore, most of them depend on unsafe food of low quality purchased from small shops or vendors. The majority of the respondents of the present study reportedly ate food from street vendors. As is the case with the freshness or purity of food, people are also unaware of the consequences of eating food purchased from street vendors. Although many have expressed doubts about its freshness, the majority are rather indifferent about its freshness and are even reluctant to believe that such food can cause illness. Explaining the reason for eating unsafe food, a respondent said that it was cheaper to eat a purchased bun than making one at home and that the poor had to live with this food and shouldn't be bothered about freshness or hygiene.

Table 7. Consequences of eating unhygienic/stale food

Consequences of eating food from street vendors	*Number of respondents*	*Percentage of respondents*
No idea[a]	36	60
Diarrhoea	14	23
Vomiting	5	8
Diarrhoea and vomiting	5	8
Total	60	100

Source: Calculations based on survey data collected by the author.

Note: [a] The respondents had encountered these diseases but were not sure whether they resulted from having eaten stale food.

Table 7 shows that the majority of people (60 per cent) did not have any idea about the consequences of eating unsafe food from street vendors. A good number of people (23 per cent) also admitted to having had diarrhoea, while 8 per cent reported vomiting and another 8 per cent reported having had both diarrhoea and vomiting caused by the purchased food.

Access to primary health care

Bangladesh has achieved impressive progress in some health indicators of the Millennium Development Goals, but there are gaps in the health conditions between the rich and the poor, and also between the urban poor and the rural poor. In fact, the deprivation of the urban poor is worse than that of the rural poor. The Ministry of Health itself admits that the health indicators for the urban poor are worse than those for the rural poor due to the unavailability of urban primary health care and poor living conditions (Asian Development Bank 2008, p. 181). Infant and child mortality rates in urban slums are higher than the national average figures. In urban slums, the infant mortality rate is 63 per 1,000 live births, while it is 29.8 in non-slum urban areas and the national rate is 52. Similarly, the contraceptive prevalence rate and the total fertility rate are higher in slums than in the non-slum urban areas (see table 8).

Table 8 illustrates the poorer health status of the slum dwellers compared to those living in non-slum areas, which gives an indication of the poorer access of the slum dwellers to health services.

The study finds a high prevalence of many communicable and non-communicable diseases among the slum dwellers during a period of six months preceding the study. The respondents reported fever (95 per cent), cough and

Table 8. Comparative health status in city slums and non-slum areas

Health status indicators	*City slum areas*	*Non-slum areas*	*National*
Contraceptive prevalence rate	58.1% (2006 Bangladesh Urban Health Survey)	62.7% (2006 Bangladesh Urban Health Survey)	55.8% (Bangladesh Demographic and Health Survey 2007)
Total fertility rate (15-49 years)	2.46% (2006 Bangladesh Urban Health Survey)	1.85% (2006 Bangaldesh Urban Health Survey)	2.70% (Bangladesh Demographic and Health Survey 2007)
Antenatal care	62.3% (trained & non-trained practitioners) (2006 Bangladesh Urban Health Survey)	84.7% (2006 Bangladesh Urban Health Survey)	60.3% (Bangladesh Demographic and Health Survey 2007)
Facility-based delivery	12.3% (2006 Bangladesh Urban Health Survey)	46.7% (2006 Bangladesh Urban Health Survey)	15.0% (Bangladesh Demographic and Health Survey 2007)
Infant mortality rate (per 1 000 live births)	63.0% (2006 Bangladesh Urban Health Survey)	29.8% (2006 Bangladesh Urban Health Survey)	52.0% (Bangladesh Demographic and Health Survey 2007)

Sources: National Institute of Population Research and Training (NIPORT); MEASURE Evaluation; International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B); and Associates for Community and Population Research (ACPR), *2006 Bangladesh Urban Health Survey* (Dhaka and Chapel Hill, NC, USA, 2008).

National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International, *Bangladesh Demographic and Health Survey 2007* (Dhaka and Calverton, MD, USA, 2009).

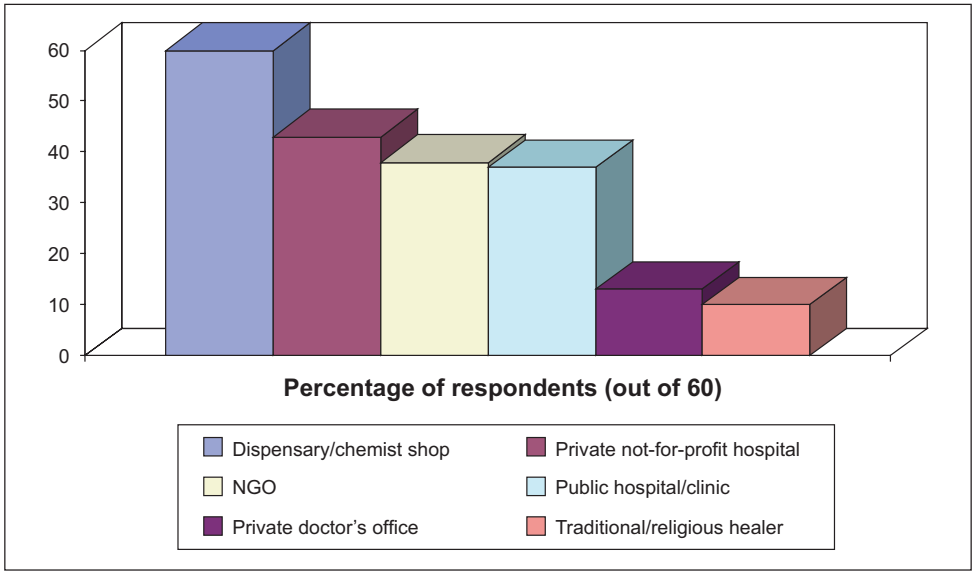
cold (57 per cent), diarrhoea (53 per cent), skin diseases (28 per cent), intestinal worms (17 per cent), rheumatic fever (17 per cent) and jaundice (10 per cent), although they were better protected from six preventable diseases through the Expanded Programme of Immunization. In the selected slums, nearly universal immunization coverage was found, as 91 per cent of the respondents reported that their children had been fully immunized, mainly by the city corporation. Although various types of curative services existed in the study areas, access of the poor to these services was quite limited. Access to services is examined here by eliciting the answers to questions such as: a) Where do slum dwellers go for the treatment

of their illnesses? b) Why are these facilities preferred? c) What is the behavioural pattern for seeking maternal and child health care in urban slums?

Where do slum dwellers go to seek treatment?

The present study finds that the treatment-seeking pattern of the urban poor depends on the severity of the illness. In the case of minor illnesses, they do not see any doctor. Only in the case of major illnesses do they opt for medically trained providers. Multiple sources of treatment were found in the study areas, including: dispensaries/chemist shops, private for-profit and not-for-profit clinics, public hospitals, NGOs and traditional/religious healers. Among these sources, public hospitals provided low-cost and low-quality services, while private not-for-profit hospitals provide low-cost but quality treatment to the poor. A World Bank (2007a) study notes that only 12 per cent of all urban poor report getting medical services from the government service centres. NGO services are also popular among the poor because they are cheap. In the selected slums, NGOs under the Urban Primary Health Care Project of the Ministry of Local Government and Rural Development provided free health cards to the poor, which entitled them to free medical care for simple ailments and delivery services during childbirth. Figure 1 presents the pattern of utilization of the facilities/providers by the poor.

Figure 1. Types of facilities chosen for treatment



Source: Calculations based on survey data collected by the author.

When asked about their first point of contact during an illness, 60 per cent of the respondents cited chemist shops as their preferred facility, making them the most popular choice for the treatment of diseases. The second most popular facilities, preferred by 43 per cent of the respondents, were private not-for-profit hospitals providing quality services at low cost. The NGO clinics were slightly preferred (38 per cent) over public hospitals (37 per cent). Some respondents also sought care from private doctor's offices (13 per cent) and traditional healers (10 per cent). In the case of minor illnesses (e.g. fever, cough and cold, stomach pain and diarrhoea), people usually opted for self-treatment by procuring medicine directly from a dispensary or went to traditional healers. NGO facilities or private low-cost hospitals were also visited for minor illnesses, but these facilities were usually visited when diseases were not successfully treated by the previously cited sources.

Why are these facilities preferred?

The choice of care was determined by various factors, which included proximity to the home, low cost, the reputation of the facility, referrals, less time required for care and personal beliefs. In all cases, the respondents mentioned more than one reason. Table 9 ranks the reasons for choosing the facilities/providers obtained from the respondents of the study.

Table 9. Reasons for choosing sources of care

Reason	*Number of respondents*	*Percentage of respondents*
Proximity to home	26	43.33
Low cost	20	33.33
Reputation of the facility	16	26.67
Referred by others	9	15.00
Refused by a facility	9	15.00
Saves time/simplicity	6	10.00
Personal belief in a provider	4	6.67
No serious illness	2	3.33
No faith in the public hospital	1	1.67

Source: Calculations based on survey data collected by the author.

Among the various factors, proximity to home is the most dominant one (43.33 per cent) influencing the choice of providers. A facility within walking distance was the first point of contact in most cases of minor illness. The second key factor was low cost (33.33 per cent). Some respondents mentioned more than one reason for choosing their providers. For instance, many respondents said that proximity, low cost and simplicity (no waiting time) were the main reasons for preferring their provider. These factors were influential, particularly in cases where services were sought from traditional/religious healers and chemist shops. NGO facilities were also preferred because of cost-free treatment. In the case of minor illnesses, though, the poor preferred traditional healers and chemists to NGO facilities, as visiting these providers was more convenient and less time-consuming. Although NGO facilities provide free services, the slum dwellers did not prefer them for minor illnesses, as the service hours (most often from 9 a.m. to 1 p.m.) conflicted with their working hours and, more importantly, waiting times were too long.

Maternal and child health: care-seeking pattern

The majority of the households (82.76 per cent) in the selected slums had their last children delivered at home, assisted by the elderly women in the family or in the neighbourhood, mostly mothers/sisters/mothers-in-law or untrained traditional birth attendants, because it was cheap (see table 10).

Table 10. Behaviour for seeking maternal health care

Type of care	*Number of respondents*	*Percentage of respondents (out of 58)*[a]
Child delivery:		
At home	48	82.76
In a facility	10	17.24
Antenatal care (Frequency of visits to a health facility)	32	55.17
Post-natal care	8	13.79

Source: Calculations based on survey data collected by the author.

Note: [a] Two respondents had no children.

Cost is a key barrier to access of the poor to delivery in an institution. The study found a good number of women (55.17 per cent) having antenatal visits (1-3) during pregnancy, while the number of them opting for post-natal care was negligible (13.79 per cent). Family planning services were usually obtained from

four sources: chemist shops, NGO facilities, domiciliary health workers and the city corporation. Of these sources, the utilization of city corporation services was the least common (10 per cent), while NGOs were the most popular source (24 per cent) and chemist shops were the second most popular.

In urban slums, minor diseases of children are usually treated by nearby dispensaries/chemist shops or traditional healers. If they are not cured from these sources, then they are taken to hospitals or clinics. Children are usually taken to the hospital with end-stage complications, as the illiterate poor parents know little about the magnitude, distribution and risk factors of these illnesses. The consequences of these end-stage treatments are cost escalation and even, in some cases, the death of the child.

Thus, the urban poor are highly impoverished in terms of having access to public and primary health services. The following section describes how the various factors of urban governance contribute to this impoverishment.

VI. POLICY AND INSTITUTIONAL WEAKNESSES: CONSTRAINTS ON ACCESS TO HEALTH SERVICES

The preceding discussions demonstrate that the Government has a national health policy and, from time to time, various pieces of legislation relating to health have been promulgated. Furthermore, various types of public, private or NGO services (both targeted and non-targeted) exist, but their implications for the poor are quite limited, as various studies show that the health status indicators of the slum poor are significantly lower than those of the non-slum urban residents (see table 8). The present study also depicts a disquieting picture about the access of the urban poor to primary and public health services. All of these facts signal poor governance in the provision of public health services for the urban poor. Governance weaknesses causing inadequate access of the urban poor to primary and public health services are manifold, but they fit broadly into two categories: policy weaknesses and institutional weaknesses (in implementing the policy). This section attempts to identify the policy and institutional weaknesses causing inadequate access of the poor to the services provided.

Policy weaknesses

The policy weaknesses that cause the urban poor to have limited access to health services include inadequacies in policy content resulting in an inability to address urban health issues properly.

In the health policy arena, public health has not been considered a priority issue. In the National Health Policy, the term "public health" has been referred to in a vague manner without any clarification. The policy has a narrow focus on health issues, as it has stressed the importance of primary health and maternal and child health services to achieve its objective of improving public health, without adequately emphasizing the improvement of water supply, sanitation, food safety and solid waste management.

Another weakness of the existing policy is that it lacks a specific policy objective or principle regarding the health of the urban poor. The policy has a clear bias towards rural areas, as national statistics indicate that that is where the majority of the poor and disadvantaged inhabitants of the country live. At the same time, a significant portion of the urban population is poor, their number is increasing, and they live in more unhygienic conditions than their rural counterparts. These realities have yet to receive due attention in the national policy. On the whole, the policy objectives are too broad to have a specific impact on urban health.

In 2008, the health policy was revised by the non-party caretaker Government, paying attention to the health of the urban poor for the first time. It proposed to adopt an urban health sector strategy with the help of the Local Government Division of the Ministry of Local Government in order to ensure primary health, family planning and reproductive health services for the urban poor. In addition, it also proposed to undertake steps to revise and update the laws related to food safety and emphasized proper hospital waste management. The revised policy was left unapproved by the previous Government. Currently, the newly elected Government has also expressed its intention to revise the health policy soon, the outcome of which has yet to be seen.

In addition to the health policy document, there are many acts and regulations that provide the legal basis for public and primary health services in urban areas. However, the majority of these regulations are outdated and, for some public health issues, there is no regulation at all.

The absence of any act, regulation or guideline regarding waste management creates a serious vacuum in the case of waste disposal. In the absence of a policy or any specific legislation, the local bodies cannot set the requirements, standards or guidance for developing their waste management services and infrastructure. The city corporation and *pourashava* ordinances of 2008 that regulate waste management in urban areas have no specific article regarding the involvement of NGOs or other community-based organizations in waste management and their rights to collect revenue to cover the cost of the

services provided. Although the ordinances have provided for the delivery of services by public-private partnerships, in practice, they have failed to encourage adequate private sector participation, as the rights, responsibilities and incentives for participation have not been specified (Asian Development Bank 2008).

Institutional weaknesses

Besides the policy inadequacies, the lack of implementation of the policy and legislation due to institutional weaknesses is another aspect of poor governance. As the local bodies are the key implementing agencies, the effectiveness of public health services is closely influenced by their leadership quality and managerial capacity. Most of the local government institutions lack the capacity required to implement the policy, legislation and associated programmes. The following institutional weaknesses cause the poor to have limited access to public health services:

Local bodies lack vision

In Bangladesh, urban local government bodies have yet to have visionary leadership, mainly because they lack autonomy. Local bodies are not financially independent and they have no autonomy in decision-making. They are financially dependent on grants from the central Government, as locally mobilized resources (mainly from property taxes) are often insufficient even for their basic operation, let alone for public services. Thus, local bodies depend on the centre for policies, plans, financial resources, human resources and even for budgetary decisions, which severely restricts the creativity and innovativeness of local leaders. Moreover, local leaders lack adequate knowledge and proper training to become visionary with regard to the socio-economic development of their locality. In most cases, the local government functionaries act as agents of the Government to execute its decisions. This state of local government has been continuing since the country's independence in 1971, and the situation remains unchanged. Although the present Government in its election manifesto pledged to create a strong and autonomous local government by decentralizing power to the *upazila* (subdistrict) level through the formation of elected bodies, since assuming power, it has been retreating from its promises. Such locally elected bodies have been formed, but they have been kept non-functional as controversy has arisen over the Government's decision to retain central control over local affairs by granting power to the members of the parliament to interfere in local level development activities, which the elected local leaders are not ready to accept. To empower the lawmakers to intervene in the functioning of the newly elected *upazila* parishads (councils), the parliament also recently passed the *Upazila* Parishad Act of 2009. According to this law, the

parishads are not allowed to send development plans to the Government without recommendations from the lawmakers (S. Liton, "*Upazila* Parishad law goes against SC [Supreme Court] verdict", *Dhaka Daily Star,* 19 April 2009). Thus, visionary local leadership is still far from a reality in Bangladesh.

Lack of adequate authority of local bodies

Although the *pourashavas* and city corporations are formally autonomous, in reality, their autonomy is quite limited. The city corporation and *pourashava* ordinances of 2008 empower the elected local bodies to plan, implement, operate and maintain public health infrastructure and services without providing adequate financial and human resources and the required authority. The World Bank (2007b, p. 109, para. 5.25) explains the lack of authority of local bodies in this way: "Local autonomy is further stifled by the fact that local governments have little or no choice on the staffing, nor do they have control over the wages for their employees. Further, key personnel at the local levels are central Government employees with limited accountability to residents". The administrative operations of local bodies, including the daily implementation and management of their budgets, are also subject to the rule-making authority of the central Government (2008 *Pourashava* Ordinance, section 146; 2008 City Corporation Ordinance, section 157). Due to these weaknesses, local bodies fail to perform their assigned functions properly.

Inadequate budgetary allocations for local bodies

According to the city corporation and *pourashava* ordinances, local bodies are supposed to spend 8 per cent of their budget on public health and 1 per cent on primary health care. However, in practice, they spend only 4 per cent of the total budget on public health and less than 0.5 per cent on primary health care. The reduced expenditure on public health and primary health care is perhaps due to the lower priority placed on public health in the national health policy document and partly because local bodies have scarce resources. As mentioned earlier, local bodies are heavily dependent on central Government grants and the internal revenues raised are not sufficient to perform their functions. Funds are often disbursed at a reduced level and the disbursement usually specifies the areas on which funds are to be spent. At this point, infrastructure development and road maintenance usually take priority over public and primary health services. The processing of tax returns and the collection of taxes by local bodies is at least ten times less than is required for the efficient management of public services (Asian Development Bank 2008). Although holding taxes account for two thirds of the total tax revenue, they are collected inconsistently, as people have a tendency to evade taxes and the tax administration is not efficient enough to raise a fixed amount of tax regularly. Externally funded projects for primary health care in

urban areas are also scant. There is no dedicated project targeted towards public health care, in general, and towards urban primary health care, in particular, except the Second Urban Primary Health Care Project. Finally, as a wide variety of functions compete for limited resources, public health receives a lesser allocation (as a lower priority issue). Usually, a major portion of the revenue earned is spent for staff salaries and benefits. In fiscal year 2006/07, for instance, 63 per cent of the revenue earnings of Dhaka City Corporation was spent for employee salaries and allowances (Asian Development Bank 2008).

Inadequate human resources

The manpower of the local bodies is quite inadequate to perform the functions assigned to them. A large number of vacancies in both city corporations and *pourashavas* is common. For instance, although the *Pourashava* Ordinance of 1977 has a provision for a slum improvement officer in *pourashavas,* the position has yet to be introduced. Although the Pure Food Ordinance of 1959 provides for the appointment of a public food analyst by the local bodies, in practice, they do not yet have such staff. In addition, many important positions, such as health officer or chief executive officer, are often vacant. Moreover, the existing human resources of local government institutions are not adequate to provide public health services to city dwellers. For instance, Dhaka City Corporation has only two posts for food and sanitation officers, four posts for health inspectors and four posts for sample suppliers in its food and sanitation branch, which is quite inadequate to manage the huge task of food safety and quality control in Dhaka city (Asian Development Bank 2008).

Lack of monitoring

Although in urban areas, various community-based organizations and private associations are involved in the provision of health services, sanitation services and waste management, their jobs are not monitored effectively and they are not accountable to the local bodies or to the Local Government Division of the Ministry of Local Government and Rural Development.

Lack of coordination

Public health is a complex issue with multisectoral mandates. It involves the functioning of various ministries, including the ministries of local government, environment, health, food, commerce, and housing and works. These ministries are performing their public health functions in an uncoordinated manner, which often causes an overlap of functions and services. There is no common platform to coordinate the activities of all of these ministries. Due to a lack of coordination,

the roles and responsibilities of different ministries with regard to health are not clearly delineated and, consequently, resources are not allocated in an effective manner. Although local government institutions are the key implementing agencies of public health programmes, they are not strong enough to coordinate their functions with the relevant ministries. A wide range of private organizations and NGOs supplement government functions, but they are not working in a coordinated manner, either. The activities of these NGOs are not properly linked with the *pourashava* activities. The absence of an integrated sectoral approach to manage urban health services is the reason for this lack of coordination.

Inefficiencies and weaknesses of the institutions providing health-care services

Despite the existence of some targeted programmes for the poor—for instance, free or subsidized health cards provided by NGOs and subsidized low-cost services at public hospitals and not-for-profit private hospitals—the poor do not have adequate access to them. The prime causes include the following: public sector and NGO services are not always cheap for the poor because they often still have to buy medicine (in most cases, it is not provided for free) and make many informal payments (in the form of "tips") at the facilities; the institutions are not poor-friendly; the poor are not fully aware of the entitlements of the NGO health cards; and waiting times are long, which leads to a loss of working hours when visiting the health facility.

The present study finds that cost is a major barrier preventing the poor from accessing services. Low cost attracts the poor to public hospitals (mostly as the last resort), but varieties of informal payments and the negligence and poor attitudes of providers towards the poor cause them to lose confidence in the facilities and, ultimately, poor patients feel discouraged from utilizing the services. One respondent commented: "Health services are not for the poor. It is rather something that the rich can manage (through money or power)". The lack of poor-friendly services at the facilities is another major factor impeding access to services. The health service institutions, particularly the public facilities, are allegedly not poor-friendly for a few reasons. In part, the service providers are not properly educated about patients' rights, as this vital component is missing from the medical training curricula; doctors are also apathetic about their duties due to low salaries and a lack of incentives. Another reason may be that the facilities are overcrowded (due to the lack of a referral system), which overburdens the providers.

The study also found that the poor were not fully aware of their entitlements in different targeted programmes (e.g. the free NGO health cards), as information, education and communication services were quite limited for the urban poor. In urban areas, there are no government domiciliary health workers, while this category

of provider plays an important role in making the rural poor aware of the existing services.

VII. CONCLUSIONS AND RECOMMENDATIONS

Rapid urbanization in Bangladesh, as elsewhere in Asia, is posing a tremendous challenge for meeting the growing demand for public and primary health services of the increased population. The present study demonstrates that the urban poor of Bangladesh are at a significant disadvantage in terms of access to basic public and primary health services. Although 60 per cent of the slum dwellers interviewed had access to water at a reasonable distance from their homes, access was quite limited in terms of the number of households per source of water. In a good number of cases (47 per cent), one source was shared by 76-110 households. Similarly, in the case of sanitation, although 60 per cent of households had access to hygienic sanitation, the situation in terms of sharing latrines was quite depressing, as one latrine was found to be shared by between 8 and 66 households. On the other hand, the poor always lived in an unhygienic environment. Only 25 per cent of slum dwellers were found to throw their garbage in a fixed place, while others threw it in various places, usually in front of their dwellings. It was also found that the majority of slum dwellers (60 per cent) had no idea of the consequences of eating unsafe food. Access to primary health services provided an even more disquieting picture, as 60 per cent of slum residents opted for a chemist shop as the first point of contact when they were ill. The study identified a wide array of deficiencies in the urban governance of public health services, ranging from policy weaknesses to institutional weaknesses that contribute significantly to depriving the poor of access to these services. They include: the absence of a comprehensive policy and even any specific legislation on urban public health, poor implementation of the existing rules and a lack of adequate resources (both financial and human) in local bodies, managerial inefficiencies in local bodies and inefficiencies in the institutions that provide services. Based on these findings, the study puts forward the following recommendations for improving the access of the urban poor to public and primary health services, which might have implications in the Asian region at large:

1. The country needs a comprehensive policy on urbanization. The growing number of poor people in urban areas and their inadequate access to health facilities, water, sanitation and solid waste facilities are increasing the risk of communicable diseases. The consequences of this problem are affecting millions every day but, unfortunately, this grim reality of urban health has not yet gained

currency in the policy arena as, conventionally, the rural poor are considered to be more vulnerable than the urban poor, and the majority of the poor live in rural areas. As more and more people are likely to move towards the cities in the future due to climate change and for other reasons, the country needs to formulate a comprehensive policy on urbanization, the urban poor and public health immediately.

2. An in-depth understanding of urban poverty trends and conditions is critical for the design of effective policies and programmes. Many targeted programmes failed to produce the desired result due to a lack of or improper identification of the poor. Therefore, at the outset, research should be conducted to determine the nature of urban poverty in the country.

3. As rural-urban migration plays a central role in urbanization, efforts should be undertaken to promote rural development and reduce rural poverty to minimize migration. At the same time, the decentralization of economic and administrative activities should be given serious consideration to reduce pressure on cities. For this purpose, industrial and economic zones could be set up outside of the cities and the devolution of authority to the local level should be ensured.

4. The national health policy should be holistic, encompassing public health issues such as water, sanitation, food safety and waste management, in addition to primary health care and maternal and child health. Primary health care alone is inadequate to make the impact necessary to improve urban health. In addition to primary health care, broader issues of public health should be given adequate attention in policies and the relevant legislation.

5. As cost is a major barrier to the access of the urban poor to primary health services, the Government could contemplate introducing cash transfers to poor women to encourage them to use institutional delivery services for childbirth, as has been done in India, or providing free health services for poor mothers, as has been done in Nepal.

6. Policy should emphasize making health service institutions poor-friendly by providing relevant training to providers.

7. The budgetary allocation for public health services should be increased from the present 4 per cent to 8 per cent, as has been done in neighbouring countries. Moreover, the Government orders that accompany the release of the funds to the city corporations/ *pourashavas* need to specify that the funds are to be dedicated to public and primary health in urban areas. To make the expenditure allocation and disbursement transparent and efficient, computerization of the accounting system is also imperative.

8. Strengthening information, education and communication services to inform the poor of the existing facilities and make them aware of their entitlements is crucial for improving their access to services. Information, education and communication services should also be intensified to educate the poor about the consequences of being exposed to an unhygienic environment and eating stale food.

9. Local government is a key actor in the provision of public and primary health services in urban areas. The capacity of local government institutions to deal with public health issues needs to be improved by making them truly autonomous and financially independent. Across Asia, central Governments are delegating responsibilities for local problems to lower levels of government without devolving adequate authority to address them (ESCAP 2007, para. 56). Bangladesh is no exception. Without a real devolution of authority, local government will find it hard to be effective in managing public health services.

10. To coordinate, monitor and oversee the functions of various public and primary health service providers in urban areas and to manage public health funds, there should be a central coordinating authority or unit on urban health in the Ministry of Local Government and Rural Development.

11. A community-based development programme could be undertaken in order to improve the provision of services by integrating all of the stakeholders in the process. Community-driven programmes treat poor people and the groups to which they belong as their assets and partners in the development process. To address the limitations of the community organizations in providing services, a public-private partnership strategy could be adopted.

REFERENCES

Asian Development Bank (2008). *Bangladesh Urban Public and Environmental Health Sector Development Program,* Draft Final Report, vol. 3 (October, Dhaka).

Amin, A.T.M.N. (1991). "Dhaka's informal sectors and its role in the transmission of Bangladesh economy", in S.U. Ahmed, ed., *Dhaka Past Present Future* (Dhaka, Asiatic Society of Bangladesh), pp. 446-470.

Anam, S. (1993). *Staying Alive: Urban Poor in Bangladesh* (Dhaka, UNICEF).

Bangladesh (1993). *Population Census 1991* (Dhaka, Bureau of Statistics, Ministry of Planning).

_____(2003). *Population Census 2001* (Dhaka, Bureau of Statistics, Ministry of Planning).

_____(2004). Constitution of the Peoples' Republic of Bangladesh, as modified up to 17 May 2004 (Dhaka, Ministry of Law, Justice and Parliamentary Affairs).

_____(2005a). *National Plan of Action* (Dhaka, Ministry of Health).

_____(2005b). *Sector Development Programme: Water and Sanitation Sector in Bangladesh,* main report, vol. 1 (Dhaka, Ministry of Local Government and Rural Development).

_____(2005c). *Household Income and Expenditure Survey (HIES)* (Dhaka, Bureau of Statistics, Ministry of Planning).

_____(2008). *The Bangladesh Gazette,* 14 May, third schedule, section 41 (Dhaka, Ministry of Law, Justice and Parliamentary Affairs).

CARE (2005). *Dialogue with Donors on Urban Poverty Issues* (Dhaka, CARE Bangladesh).

Centre for Urban Studies (CUS), National Institute of Population Research and Training (NIPORT) and MEASURE Evaluation (2006). "Slums of Urban Bangladesh: Mapping and Census, 2005" (Dhaka and Chapel Hill, USA).

ESCAP (2007). "Urban poverty and the working poor: Facing the challenges of urbanization and urban poverty in Asia and the Pacific", Committee on Poverty Reduction, 24 September (E/ESCAP/CPR(4)/4).

Hossain, S. (2003). "Urban Poverty and Household Strategies in Dhaka City, Bangladesh", in Quality-assured Stream: in *Conference Proceedings of the 2003 Sociological Association of Aotearoa Conference: "Knowledge, Capitalism, Critique",* 9-11 December, Auckland University of Technology, available at http://saanz.rsnz.org/hossain. doc.

Podymow, T., J. Turnbull, M.A. Islam and M. Ahmed (2007). "Health and Social Conditions in the Dhaka Slums" (The International Society for Urban Health), accessed from www.isuh.org/download/dhaka.pdf on 25 June 2008.

Ravallion, M., S. Chen and P. Sangraula (2007). "New evidence on the urbanization of global poverty", Policy Research Working Paper No. 4199 (Washington, D.C., World Bank).

Riley, L.W., A.I. Ko, A. Unger and M.G. Reis (2007). "Slum health: Diseases of neglected populations", *BMC International Health and Human Rights,* vol. 7, No. 2, online publication.

United Nations Human Settlements Programme (UN-Habitat) (2003). *The Challenge of Slums: Global report on human settlements 2003* (London and Sterling, VA, Earthscan Publications Ltd.).

United Nations (1948). "Universal Declaration of Human Rights", General Assembly resolution 217 A (III), in *Human Rights: A Compilation of International Instruments,* Volume I (First Part): Universal Instruments (United Nations publication, Sales No. E.02.XIV.4 (Vol. I, Part 1)), sect. A, No. 1.

World Bank (2003). *Making Services Work for Poor People,* World Development Report 2004 (Washington D.C.).

_____(2007a). *Bangladesh at a Glance,* The World Bank Group: Fact Sheet 9/8/07.

_____(2007b). *Bangladesh: Strategy for Sustained Growth,* Bangladesh Development Series, No. 18 (Dhaka).