National Urban Health Strategy 2020

Health Services Division

Ministry of Health and Family Welfare

Government of the People's Republic of Bangladesh

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CONTENTS

ABBREVIATIONS

#	: Number
AIDS	: Acquired Immune Deficiency Syndrome
ANC	: Ante-natal care
DGFP	: Directorate General of Family Planning
DGHS	: Directorate General of Health Services
DGNM	: Directorate General of Nursing and Midwifery
ESP	: Essential Services Package
HIV	: Human Immune Deficiency Virus
HPN	: Health, Population and Nutrition
HSD	: Health Services Division
LGD	: Local Government Division
MIS	: Management Information System
MOHFW	: Ministry of Health and Family Welfare
MOLGRDC	: Ministry of Local Government, Rural Development and Cooperatives
NGO	: Non-Governmental Organization
PHC	: Primary Health Care
SDG	: Sustainable Development Goal
TB	: Tuberculosis
TFR	: Total Fertility Rate
UHCC	: Urban Health Coordination Committee
UHWG	: Urban Health Working Group

1. Introduction

1.1 Urban areas

Bangladesh Census (2001) defines urban areas as developed areas around (i) an identifiable central place where (ii) amenities like metalled roads, communication facilities, electricity, gas, water supply, sewerage, sanitation etc. usually exist, (iii) which are densely populated and majority of population are non-agricultural and (iv) where community sense is well developed. For the purpose of local government administration, urban local institutions are categorized into (a) City Corporation and (b) Municipalities locally called *Paurashava*. Municipalities are further divided into three categories A, B and C depending on size, population and income. The government, from time to time, notifies in the gazette constitution of urban local institutions. Currently Bangladesh has 12 city corporations and 329 municipalities.

1.2 Urbanization

Bangladesh is an integral part of the urban transformation that the world is witnessed to, and is gradually making the shift from 'rural' to 'urban'. The 1974 census found 8.8 percent as urban population. But the 2011 census indicated that 23 percent of the population lived in urban areas. Currently urban population comprises 39 percent. With an estimated annual growth rate of 3.3 percent, urban population will rise to a majority by around 2030. At the same time, the population living in slums is growing at double the average urban rate – around 7 percent annually. Over the last two decades, Dhaka's population doubled; yet because of land constraints, the city is now among the world's most densely populated. In 2011, population density was already about 8,000/sq.km in Dhaka's metropolitan area, and 31,000/sq.km in Dhaka City Corporation. Population density in slums, meanwhile is estimated at about 205,000/sq.km in Dhaka and 255,000/sq.km in Chattogram. Census of Slum Areas and Floating Population (2014) found rise in number of slums and slum population – 13,935 slums from 2,991 in 1997; 22,32,114 slum population from 13,91,458 in 1997.

1.3 HPN outcomes in urban

Though average health, population and nutrition (HPN) outcomes are better for urban population than rural, disparity between slum and non-slum population is marked widely. Bangladesh Urban Health Survey (2013) found ante-natal care (ANC) 4+ as 29 percent in slum against 58 percent in non-slum of city corporation; total fertility rate (TFR) as 2 in slum and 1.7 in non-slum and stunting (height-for-age) 50 percent in slum and 33 percent in non-slum. Overcrowding with poor housing, environment, water and sanitation conditions resulting poor HNP outcomes, particularly for slum dwellers.

1.4 Commitments

Bangladesh achieved a number of Millennium Development Goals and has committed to attain the Sustainable Development Goals (SDG) by 2030. SDG 3 is to ensure healthy lives and promote well-being for all at all ages. It encompasses the target of achieving universal health coverage, including financial risk protection. SDG 11 is to make cities and human settlements inclusive, safe, resilient and sustainable. It includes the target of ensuring access for all of adequate, safe and affordable housing and basic services, and of upgrading slums. Government's adequate attention in urban health is necessary to achieve these objectives.

2. Responsibilities for urban health

Allocation of Business Among The Different Ministries and Divisions (Schedule I of the Rules of Business, 1996) (Revised up to April 2017) by Cabinet Division mentions that the Health Services Division (HSD) of the Ministry of Health and Family Welfare (MOHFW) is responsible for policy regarding health related matters (# 1), and medical and health services including promotion, preventive, curative and rehabilitative aspects (# 12); while the Local Government Division (LGD) of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) is responsible for matters relating to the Local Government including Local Government Institutions (# 1).

Local Government (City Corporation) Act 2009 mentions that Corporation is responsible for health system of the City (Third Schedule) and Local Government (Municipality) Ordinance 2010 mentions that Municipality shall be responsible for health of the Municipality (Second Schedule).

The provision of urban health hence lies within the roles and responsibilities of MOHFW, MOLGRDC and urban local government institutions (city corporations and municipalities).

3. Urban health services providers

As Bangladesh is known for its pluralistic health system, this is also reflected well in urban areas. MOHFW through Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) is involved in providing primary, secondary and tertiary curative services along with different public health interventions including nutrition, family planning and immunization. The wide range of facilities from the MOHFW include urban dispensaries, upazila health complexes, district and general hospitals, school health clinics, chest clinics, maternal and child welfare centers, chest hospitals, infectious diseases hospitals, leprosy hospitals, medical college hospitals, specialized institutes hospitals and specialized hospitals.

Health facilities from other (than MOHFW) Ministries/Divisions include combined military hospitals, Border Guard hospitals, police hospitals, jail hospitals, drug addiction treatment centers, railway hospitals and health centers, *sarkari karmochari* (government employees) hospital. LGD has been implementing Urban Primary Health Care Services Delivery Project through which contracted non-governmental organizations (NGO) are providing services in most of the city corporations and some municipalities.

Several City Corporations have their own health facilities. These include Dhaka South City Corporation's Dhaka Mohanagar General Hospital, Dhaka Mohanagar Shishu Hospital, Nazira Bazar Maternity and 8 Dispensaries; Chattogram City Corporation's Memon hospital-1, Memon hospital-2, Bandortila Maternity, South Bakolia Maternity, East Bakolia Maternity and 20 Dispensaries; Khulna City Corporation's Lal hospital and Taltola hospital; Rajshahi City Corporation's City hospital; Sylhet City Corporation's Dispensary.

Numerous NGOs operate different types of health facilities in urban areas. Their services cover primary, secondary and tertiary curative care together with public health activities. Some of those also have chain/network of facilities operating in several urban locations. Smiling Sun, Marie Stopes, National Health Network (of Bangladesh Diabetic *Samity* - association), Ad-din are few to name.

Private sector is also fast growing in urban areas and providing all types of curative care – primary, secondary and tertiary. However a large number of informal providers also belong to the private sector.

Bangladesh Urban Health Survey (2013) found that 95 percent of communities in slums and non-slums (in city corporations) and about 90 percent in other urban areas (in municipalities) had a health facility available within two kilometers. However this physical accessibility didn't turn into appropriate utilization, as found in Household Income and Expenditure Survey (2016) that found utilization of health services in urban areas as 34 percent from Pharmacy/Dispensary/Compounder, 18 percent from Qualified Doctors' Chamber, 15 percent from Non-qualified Doctor's Chamber, 10 percent from Private Clinic/Hospital, 5 percent from Upazila Health Complex, 4 percent from Government District/Sadar General Hospital and 4 percent from Government Medical College and Specialized Hospital.

4. Updating of National Urban Health Strategy 2014

LGD prepared National Urban Health Strategy 2014. The strategy mentioned that it would be implemented through developing an operational plan. Later on, it was decided to develop an action plan instead of operational plan, which is yet to be finalized.

The National Urban Health Strategy 2014 mentioned that the strategy is a continuous process and, hence aspired modification and amendment of the strategy to meet changing demand of the people. Allocation of Business entrusted HSD of MOHFW with the responsibility of formulating policy regarding health related matters. Keeping this sprit HSD of MOHFW in consultation with all relevant stakeholders updates the urban health strategy as National Urban Health Strategy 2020.

5. Goal

To create conditions whereby the urban population in Bangladesh has the opportunity to reach and maintain the highest attainable level of health and effectively contribute in the prosperity of the country.

6. Objectives

Expanding access for utilization to quality and equitable healthcare along with efficacy through

i. Strengthening governance and stewardship of public, local government and private sectors;
ii. Institutional development for improved performance;
iii. Equitable access to health, population and nutrition care of urban population;
iv. Strengthening the capacities of city corporations and municipalities;
v. Building a robust evidence base for decision making; and
vi. Promote healthy lifestyle choices, healthy environment and early healthcare seeking

7. Gaps in urban health

i. Lack of effective coordination among MOHFW, LGD/MOLGRDC and Urban Local Government Institutions (City Corporations/Municipalities) on the provision of urban health service
ii. Inability of the public sector urban health system due to inadequate numbers and poor quality public health facilities, particularly at the primary health care (PHC) level, to keep pace with the rapid urbanization.
iii. Lack of targeting the healthcare needs of slum dwellers, working and floating/street population.
iv. City corporations/municipalities lack updated standardized systems to determine who qualifies as poor and should qualify for exemptions from user fees.
v. City corporations/municipalities don't have a separate budget allocation for health services or public health initiatives, and they have limited capacity to mobilize their own funds.

vi. Many regulations are outdated with weak enforcement, especially those related to government responsibilities with NGO/private health service providers in urban areas. For example, the Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance 1982 requires every NGO/private health facility to obtain an operation license from DGHS. Similarly Local Government (City Corporation) Act 2009 and Local Government (Municipality) Ordinance 2010 require NGO/private health service providers to register with the city corporation/municipality and to renew the registration annually. But these are hardly complied.

vii. User fees are not standardized across NGO/private providers, nor measures in place to display fee schedule publicly as required by the law.

viii. Monitoring and evaluation of healthcare facilities remain fragmented. Although Management Information System (MIS) under DGHS maintain data on DGHS-run facilities, it does not do so for other public health facilities or for NGO/private providers. This lack of comprehensive data makes it difficult to measure the performance of the entire urban health system.

ix. Lack of structured referral system puts inadequate emphasis on aspects such as equitable access to quality care, continuity of care, patient-centeredness, and patients' rights.

x. Because of the traditional strong focus on maternal and child health and communicable diseases, services are not widely available for treating certain conditions (such as non-communicable diseases) or patients groups (such as men), particularly among the public and NGO health facilities.

xi. Limited focus on determinants of health (like water-sanitation, education, environment, accidents, injuries etc.), which city corporations/municipalities are uniquely placed to coordinate for improved health outcomes of urban citizens.

xii. Lack of a comprehensive urban health policy/strategy with endorsement of all relevant stakeholders.

8. Strategies for urban health

i. For effective coordination among the MOHFW, LGD/MOLGRDC and City Corporations/Municipalities, coordination mechanisms need to function both at ministry level and local – city corporation/municipality levels.
    a. The existing Urban Health Coordination Committee (UHCC) is scheduled to meet six monthly. This should meet quarterly at least for initial 2-3 years to set the momentum of coordination
    b. The existing Urban Health Working Group (UHWG) is scheduled to meet quarterly. This should meet in every two months at least for initial 2-3 years to set the pace of coordination

c. Dedicated technical assistance need to provide to the UHCC and UHWG for effective functioning – holding meeting regularly with working paper updating the situation and identifying issues for making decision, timely producing and communication of minutes of the meeting and follow-up of the decisions made
d. City Corporations have the provisions of inviting government departmental officials including DGHS/Divisional Director of Health and provisions of forming Standing Committee on Education, Health, Family Planning and Health Safety system, where provision of invitation of experts to get advise exist. So City Corporation may form Standing Committee on Education, Health, Family Planning and Health Safety system with the co-option of respective Civil Surgeon and Deputy Director – Family Planning to support in design and implementation of the urban health system in respective city corporation.
e. Municipalities have option to form standing committee on health, where expert member co-option provision remains. Local DGHS (Civil Surgeon, Upazila Health and Family Planning Officer) and DGFP (Deputy Director – Family Planning and Upazila Family Planning Officer) may be co-opted. Though this health standing committee urban health system may be designed and implement in respective municipality areas.
f. Civil Surgeon, Deputy Director-Family Planning, Upazila Health and Family Planning Officer, Upazila Family Planning Officer should support the Committees to map the health facilities available from MOHFW and other government departments, city corporations, NGOs and private sectors in their respective catchment area.

- Then each facility may be assigned with a particular catchment area to serve its population for Essential Service Package (ESP) ideally free of cost.
- Guidelines for establishment and operation of non-government medical college 2011 (revised) require non-government medical college hospitals to reserve 10 percent of its beds to serve free of cost. This provision may be revised to serve the assigned population in lieu.
- Municipality may also use this as condition to provide registration to those organizations by themselves and/or provide incentives in reducing holding tax for those facilities
- Monitoring of functioning of the system of providing ESP to the assigned population may be vested to the Standing Committee

g. LGD of MOLGRDC needs to issue notification in this respect so that city corporation and municipality form above mentioned standing committee with officials from DGHS and DGFP. Similarly HSD of MOHFW also needs to

issue circular so that relevant DGHS and DGFP officials actively participate in those committees.

h. Dedicated technical assistance need to provide at city corporations and municipalities level for facilitating in the formation of above mentioned committees and support the committees to design and implement urban health system. It main start initially in few locations and depending upon the result may be scaled up gradually

ii. Inadequate numbers and poor quality public health facilities, particularly to provide PHC may be improved through adopting one or the other of following approaches:

a. Services of existing urban dispensaries may be strengthened by relocating those, if required; adding required health workforce like laboratory technician; starting the afternoon/evening shift by deploying required health workforce with required supplies and making people, particularly of slum and floating population informed about the availability of services

b. Some other facilities located in the urban areas like school health clinics, chest clinics and maternity and child welfare centers may be assigned with additional role to provide PHC with required additional supplies of human resources and logistics. These facilities may also start the afternoon/evening shift by deploying required health workforce with required logistics. People, particularly of slum and floating population need to be informed through dedicated efforts about the availability of such services from those facilities

c. Other DGHS and DGFP facilities located in urban areas (like upazila health complex, district and general hospital, chest hospital, infectious diseases hospital, leprosy hospital, medical college hospital, specialized institute hospital, specialized hospital, maternity and child health training institute hospital, fertility services and training hospital etc.) may start dedicated PHC center within its building through deploying additional human resources, if required and logistics to increase number of public health facilities providing PHC. These PHC centers may also start the afternoon/evening shift with the support of additional human resources and other logistics. Dedicated efforts need to undertake to publicize such services.

d. After proper mapping, DGHS may start operating additional urban dispensaries, if required from premises owned by the government or city corporation/municipality or by hiring such through deploying required health human resources and other required logistics. Such facilities may also operate afternoon/evening shifts.

e. Facilities belong to city corporations or other government departments located in urban areas usually found to operate much below of their capacities due to shortage of human resources particularly physicians and nurses. Due to very limited career progression, these facilities usually fail to

recruit and retain health human resources. If posts belong these facilities can be transferred within DGHS and Directorate General of Nursing and Midwifery (DGNM), so that DGHS/DGNM recruit against those posts and deploy in those posts regularly. Optimum function of these facilities will also contribute in increasing number PHC centers.

iii. Healthcare need of slum dwellers, working and floating/street population can be better targeted by
    a. Providing PHC close to their residence. This may be done through operating satellite clinics from the nearby government facilities mentioned above. For that dedicated human resources, logistics and transport support need to provide.
    b. Alternately mobile PHC centers may operate mounted on motorized vehicle. Mid-night/late-night clinics operated through mobile vans found to be utilized high by the floating/street population
    c. Slum dwellers, working and floating/street population may be issued with special entitlement card through which they can receive the PHC services free of charge from the government and city corporation facilities

iv. LGD of MOLGRDC may support city corporations/municipalities through required technical assistance, if needed to develop and operate a system to identify the poor and issue special entitlement card to receive the PHC services free of charge from the government and city corporation facilities

v. For better healthcare financing of city corporations/municipalities
    a. LGD of MOLGRDC may negotiate with the Ministries of Finance and Planning for increased allocation and separate revenue and development budget respectively in city corporations and municipalities for health services and public health interventions
    b. City corporation/municipalities may also take initiative to mobilize funds for health services and public health interventions, particularly negotiating with the business entities located within their territory.

vi. To address regulatory enforcement with the NGO/private health service providers
    a. MOHFW needs to take move for updating law regarding private clinics/ hospitals/ diagnostic facilities
    b. MOHFW also needs to increase the capacity for the law enforcement regarding private clinics/hospitals/ diagnostic facilities
    c. LGD of MOLGRDC needs to take initiative, may be through contracting if required to capacitate city corporation and municipality for compliance of legal requirement to register and annual renewal of NGO/private health service providers

vii. Healthcare market is different from other markets where the purchaser makes decision that depends on the ability to pay. But in healthcare market healthcare

provider makes decision for purchasing service which is purchased by the healthcare seekers. Thus uncertainty exists in healthcare market which deters early care seeking. Display of service fee schedule can minimize market uncertainty and encourage early care seeking. MOHFW needs to take initiative for standardization of service fee structure by the NGO/private providers and display of those mandatory.

viii. HSD, MOHFW needs to take initiative to bring all other public health facilities and NGO/private sector facilities reporting regularly to the MIS of DGHS through coordination and legal compliance so that comprehensive data supports in the performance measurement of the different urban health systems in the city corporations and municipalities

ix. HSD, MOHFW needs to develop a structured referral system in urban areas. After allocating catchment areas to the designated PHC centers, secondary and tertiary care facilities may only entertain referred cases. To have adequate number of PHC centers, strategies mentioned under number i. f above may be adopted. Structured referral system will allow equitable access to quality care, continuity of care, patient-centeredness, and patients' rights.

- The General Practitioner system if operates can also support in assigning catchment area for providing the PHC and contribute in establishment of referral system.

x. City corporations and municipalities while designing and implementing their respective urban health systems in close collaboration with the DGHS/DGFP as mentioned under i. f strategy above need to take care so that assigned PHC center provide care for non-communicable diseases and men

xi. With near universal knowledge on family planning and immunization, MOHFW through DGHS and DGFP may continue awareness raising through standard communication channels to maintain high level of awareness. Supply side can be managed through the PHC outlets, mentioned in various options.

xii. For awareness raising on nutrition and different public health interventions (TB, Dengue, Chigunmonia, HIV/AIDS, malaria, type II diabetic, hypertension etc.), respective city corporation/ municipality may be supported by the DGHS to carry on awareness campaign and routine awareness activities by utilizing scouts, girls' guides, other student organizations, and NGOs working in the respective areas. Supply side can be managed through the PHC outlets, mentioned in various options.

xiii. LGD of MOLGRDC needs to support city corporations and municipalities so that they coordinate with the entrusted agencies for improved education, water-sanitation, environment situation and less accidents and injuries – all contributing to the improved health outcomes of urban dwellers.

xiv. HSD of MOHFW should take necessary steps for the approval of National Urban Health Strategy 2020.

9. Roles for urban health

9.1 MOHFW through DGHS and DGFP

i. Expedite functionality of the UHCC and UHWG through arranging technical assistance, if required
ii. HSD needs to issue circular so that relevant DGHS and DGFP officials actively participate in the Standing Committee on Education, Health, Family Planning and Health Safety system and health formed by the city corporation and municipality respectively
iii. DGHS needs to strengthen services of existing urban dispensaries by relocating those, if required; adding required health workforce like laboratory technician; starting the afternoon/evening shift by deploying required health workforce with required supplies and making people, particularly of slum and floating population aware about the availability of services
iv. MOHFW to assign additional role to provide PHC in some other existing facilities located in the urban areas like school health clinics, chest clinics and maternity and child welfare centers with required additional supplies of human resources and logistics. These facilities may also start the afternoon/evening shift by deploying required health workforce with required logistics. People, particularly of slum and floating population need to be informed through dedicated efforts about the availability of such services from those facilities
v. Other DGHS and DGFP facilities located in urban areas (like upazila health complex, district and general hospital, chest hospital, infectious diseases hospital, leprosy hospital, medical college hospital, specialized institute hospital, specialized hospital, maternity and child health training institute hospital, fertility services and training hospital etc.) may start dedicated PHC center within its building through deploying additional human resources, if required and logistics. These PHC centers may also start the afternoon/evening shift with the support of additional human resources and other logistics. Dedicated efforts need to undertake to publicize such services.
vi. After proper mapping, DGHS may start operating additional urban dispensaries, if required from premises owned by the government or city corporation/municipality or by hiring such and through deploying required health human resources and other required logistics. Such facilities may also operate afternoon/evening shifts.
vii. DGHS and DGFP to initiate operating satellite clinics from their facilities mentioned above through dedicated human resources and other logistics targeting the slum dwellers, working class, street/floating population
viii. DGHS to start operating mobile clinics targeting the slum dwellers, working class, street/floating population

ix. MOHFW needs to take move for updating law regarding private clinics/hospitals/ diagnostic facilities
x. MOHFW also needs to increase the capacity for the law enforcement regarding private clinics/hospitals/diagnostic facilities
xi. MOHFW needs to take initiative for standardization of service fee structure by the NGO/private providers and mandatory display of those fee structure by the facilities
xii. HSD, MOHFW needs to take initiative to bring all other public health facilities and NGO/private sector facilities reporting regularly to the MIS of DGHS
xiii. HSD, MOHFW needs to develop a structured referral system in urban areas
xiv. MOHFW through DGHS and DGFP need to continue awareness raising for immunization and family planning through standard communication channels to maintain high level of awareness. Supply side also needs to manage through the different PHC outlets.
xv. DGHS and DGFP need to continue awareness raising on nutrition and public health interventions and ensure adequate supplies through the different PHC outlets for nutrition and other public health interventions (TB, Dengue, Chigunmonia, HIV/AIDS, malaria, diabetic, hypertension etc.).
xvi. MOHFW needs to approve the National Urban Health Strategy 2020

9.2 LGD of MOLGRDC

i. LGD needs to issue notification so that city corporation and municipality form Standing Committee on Education, Health, Family Planning and Health Safety system and health respectively with officials from DGHS and DGFP.
ii. LGD to arrange technical assistance for the city corporations and municipalities for facilitating in the formation of Standing Committee on Education, Health, Family Planning and Health Safety system and health respectively and support the committees to design and implement specific urban health system
iii. LGD to initiate the process of transferring posts of physicians and nurses of the facilities belong to different city corporations and posts of physicians belong to city corporations and municipalities to the DGHS and DGNM in collaboration with the MOHFW
iv. LGD to support city corporations/municipalities through required technical assistance, if needed to develop and operate a system to identify the poor and issue special entitlement card to receive the PHC services free of charge from the government and city corporation facilities
v. LGD to negotiate with the Ministries of Finance and Planning for increased allocation and separate revenue and development budget respectively in city corporations and municipalities for health services and public health interventions

vi. LGD to take initiative, may be through contracting if required to capacitate city corporation and municipality for compliance of legal requirement to register and annual renewal of NGO/private health service facilities
vii. LGD needs to support city corporations and municipalities so that they coordinate with the entrusted agencies for improved education, water-sanitation, environment situation and less accidents and injuries

9.3 City Corporations and Municipalities

i. City corporation to form the Standing Committee on Education, Health, Family Planning and Health Safety system with co-option of respective Civil Surgeon and Deputy Director – Family Planning to support in design and implementation of respective urban health system
ii. Municipalities to form standing committee on health with local DGHS (Civil Surgeon, Upazila Health and Family Planning Officer) and DGFP officials (Deputy Director – Family Planning, Upazila Family Planning Officer) as co-opted member. Though this health standing committee urban health system is to be designed and implement in respective municipality areas.
iii. City corporations and municipalities to issue special entitlement cards to the slum dwellers, working class, floating/street population for free of charge PHC services from the public sector and city corporation facilities
iv. City corporation/municipalities to take initiative to mobilize funds for health services and public health interventions, particularly negotiating with the business entities located within their territory.
v. City corporations and municipalities while designing and implementing their respective urban health systems through the standing committees need to take care so that assigned PHC centers provide care for non-communicable diseases and men
vi. City corporations and municipalities with support from the DGHS and DGFP to initiate awareness raising through routine and special campaigns on family planning, nutrition, immunization and different public health interventions (TB, Dengue, Chigunmonia, HIV/AIDS, malaria, diabetic, hypertension etc.) by utilizing scouts, girls' guides, other student organizations and NGOs working in their respective areas.
vii. City corporations and municipalities coordinate with the entrusted agencies for improved education, water-sanitation, environment situation and less accidents and injuries – all contributing to the improved health outcomes of urban dwellers.

10. Conclusion

To achieve SDGs and universal health coverage, implementation of this strategy is urgently required to mitigate the gaps persisting in urban health. Close cooperation and working together by the MOHFW, MOLGRDC, city corporations, municipalities and other relevant organizations of the government is required to ensure proper and smooth implementation of this strategy.

Annexure

Action Plan

Strategies/Activities	Responsibility
Short-term (within 1 year)	
Strategy 1: Effective coordination among the MOHFW, LGD/MOLGRDC and City Corporations/Municipalities	
Activities:	
a. The existing UHCC meets quarterly	MOHFW, LGD
b. The existing UHWG meets in every two months	MOHFW, LGD
c. Dedicated technical assistance to the UHCC and UHWG for effective functioning	MOHFW
d. City Corporations will form Standing Committee on Education, Health, Family Planning and Health Safety system with the co-option of respective Civil Surgeon and Deputy Director – Family Planning to support in design and implementation of urban health system in respective city corporation	City Corporations, DGHS, DGFP, and other related organizations
e. Municipalities will form standing committee on health with local DGHS (Civil Surgeon/Upazila Health and Family Planning Officer) and DGFP (Deputy Director – Family Planning/Upazila Family Planning Officer) officials coopted to design and implement urban health system in respective municipality areas.	Municipalities, DGHS, DGFP, and other related organizations
f. Mapping the health facilities available from MOHFW and other government departments, city corporations, NGOs and private sectors in their respective city corporation/ municipality area.	City Corporations, Municipalities through Standing Committees
g. Each facility requires to be assigned with a particular catchment area to serve its population for Essential Service Package (ESP) ideally free of cost.	City Corporations, Municipalities through Standing Committees
h. Monitoring of functioning of the system of providing ESP by the assigned facility to the population of catchment area	City Corporations, Municipalities through Standing Committees
i. Issue notification to the city corporations and municipalities to form Standing Committee on Education,	LGD

Health, Family Planning and Health Safety system and Standing Committee on Health respectively with co-opted members from DGHS and DGFP officials	
j. Issue notification to DGHS and DGFP so that their officials actively take part in the Standing Committee on Education, Health, Family Planning and Health Safety system and Standing Committee on Health formed by the city corporations and municipalities respectively	HSD and MEFWD of MOHFW
k. Dedicated technical assistance to the city corporations and municipalities for facilitating in the formation of the Standing Committee on Education, Health, Family Planning and Health Safety system and Standing Committee on Health respectively and support the committees to design and implement urban health system.	LGD
Strategy 2: Improve in numbers and quality of public health facilities to provide PHC	
Activities:	
a. Services of existing urban dispensaries strengthen • by relocating those, if required; • adding required health workforce like laboratory technician; • starting the afternoon/evening shift by deploying required health workforce with required supplies; and • making people, particularly of slum and floating population informed about the availability of services	DGHS
b. Some other facilities located in the urban areas like school health clinics, chest clinics and maternity and child welfare centers are • assigned with additional role to provide PHC with required additional supplies of human resources and logistics. • These facilities may also start the afternoon/evening shift by deploying required health workforce with required logistics. • People, particularly of slum and floating population need to be informed through dedicated efforts about the availability of such services from those facilities	HSD, MOHFW
c. Other DGHS and DGFP facilities located in urban areas (like upazila health complex, district and general hospital, chest hospital, infectious diseases hospital, leprosy hospital, medical college hospital, specialized institute hospital, specialized hospital, maternity and	HSD and MEFWD of MOHFW

child health training institute hospital etc.) may start dedicated PHC center within its building through deploying additional human resources, if required and logistics. • These PHC centers may also start the afternoon/evening shift with the support of additional human resources and other logistics. • Dedicated efforts need to undertake to publicize such services.	
d. After proper mapping, DGHS may start operating additional urban dispensaries, if required from premises owned by the government or city corporation/municipality or by hiring such through deploying required health human resources and other required logistics. Such facilities may also operate afternoon/evening shifts.	HSD, MOHFW
Strategy 6: Address regulatory enforcement with the NGO/private health service providers	
Activity: MOHFW to take move for updating law regarding private clinics/ hospitals/diagnostic facilities	MOHFW
Strategy 7: Standardization of service fee structure by the NGO/private providers and mandatory display of those	
Activities:	
a. Standardization of service fee structure for the NGO/ private providers	HSD, MOHFW
b. Enforcement of mandatory display of service fee structure by the NGO/ private providers	HSD, MOHFW
Strategy 10: Provision of care for Non-communicable diseases and men	
Activity: While designing and implementing respective urban health systems, attention needed so that assigned PHC outlets provide care for non-communicable diseases and men	City Corporations, Municipalities Standing Committees
Strategy 11: Provision of supplies for family planning, nutrition, immunization and other public health interventions	
Activity: Ensure adequate supplies for family planning, nutrition, immunization and other public health interventions through the PHC outlets	HSD and MEFWD of MOHFW
Strategy 14: Approval of the National Urban Health Strategy	
Activity: Necessary steps for approval and notification of the National Urban Health Strategy 2020	HSD, MOHFW
Medium-term (within 2-3 years)	
Strategy 2: Improve in numbers and quality of public health facilities to provide PHC	

Activity: Initiate process of transferring physicians, nurses and others posts within DGHS, DGNM in consultation with MOHFW and others concerned	LGD
Strategy 3: Targeting healthcare need of slum dwellers, working and floating/street population	
Activities:	
a. Operating satellite clinics from the nearby government facilities (outdoor dispensaries; facilities like school health clinics, chest clinics and maternity and child welfare centers assigned with PHC roles; other DGHS/DGFP facilities having dedicated PHC centers) with dedicated human resources, logistics and transport support	HSD and MEFWD of MOHFW
b. Mobile clinics operate from mobile vans with dedicated human resources and logistics	HSD of MOHFW
c. Slum dwellers, working and floating/street population issued with special entitlement card through which they can receive the PHC services free of charge from the government and city corporation facilities	City Corporation, Municipality
Strategy 4: Develop and operate a system by the city corporations and municipalities to identify the poor and issue special entitlement card to receive the PHC services free of charge	
Activities:	
a. Support city corporations/municipalities through required technical assistance, if needed to develop and operate a system to identify the poor and issue special entitlement card	LGD
b. Develop and operate a system to identify the poor and issue special entitlement card to receive the PHC services free of charge	City Corporations, Municipalities
Strategy 5: Better healthcare financing of city corporations/municipalities	
Activities:	
a. Negotiate with the Ministries of Finance and Planning for increased allocation in separate revenue and development budget respectively with city corporations and municipalities for health services and public health interventions	LGD
b. City corporation/municipalities may also take initiative to mobilize funds for health services and public health interventions, particularly negotiating with the business entities located within their territory.	City Corporation, Municipality
Strategy 6: Address regulatory enforcement with the NGO/private health service providers	
Activities:	
a. MOHFW to increase the capacity for the law enforcement regarding private clinics/hospitals/ diagnostic facilities	HSD, MOHFW

b. LGD needs to take initiative, may be through contracting if required to capacitate city corporation and municipality for compliance of legal requirement to register and annual renewal of NGO/private health service providers	LGD, City Corporation, Municipality
Strategy 8: Building robust evidence base for decision making	
Activity: Take initiative to bring all other public health facilities and NGO/private sector facilities reporting regularly to the MIS of DGHS	HSD, MOHFW
Strategy 9: Development and functioning of a structured referral system	
Activity: Development and functioning of a structured referral system in urban areas	HSD, MOHFW
Strategy 11 & 12: Awareness raising and demand creation	
Activities:	
a. Continue awareness raising for family planning, nutrition, immunization and other public health interventions through standard communication channels to maintain high level of awareness.	HSD and MEFWD of MOHFW
b. City corporations and municipalities with support from the DGHS and DGFP continue awareness raising through routine and special campaigns on family planning, nutrition, immunization and different public health interventions by utilizing scouts, girls' guides, other student organizations and NGOs working in their respective areas.	City Corporation, Municipality, DGHS, DGFP
Long-term (within 4-5 years)	
Strategy 13: Coordination with the determinants of health for improved health outcomes	
Activities:	
a. Support city corporations and municipalities so that they coordinate with the entrusted agencies for improved education, water-sanitation, environment situation and less accidents and injuries – all contributing to the improved health outcomes of urban dwellers.	LGD
b. City corporations and municipalities to coordinate with the entrusted agencies for improved education, water-sanitation, environment situation and less accidents and injuries – all contributing to the improved health outcomes of urban dwellers.	City Corporation, Municipality