Government of the Peoples' Republic of Bangladesh

National Urban Health Strategy 2014

English Version (Original in Bangla)

Local Government Division

Ministry of Local Government, Rural Development and Cooperatives

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Contents

Preface

Although the population growth rate in Bangladesh is 1.34% according to the population Census of 2011, this rate is more than 5% in urban areas. In 1974, the country's population was 8.8% in urban areas and increased to near 30% in 2012. In addition to the opportunities of higher and technical education, better health facilities, and employment, many disaster affected climate victims are also migrating to the cities due to push and pull factors. As a consequence of rural to urban migration, urbanization is increasing rapidly. Demographers and statisticians are anticipating that by next 30 years, around half of the population will be living in the urban area.

Owing to rapid migration and unplanned urbanization, poor people are living in unhygienic conditions in disadvantaged locations and slum areas. Most of these homeless people are deprived of primary health care services. They are losing work capability due to suffering from different complicated diseases.

According to Local Government (City Corporation) Act, 2009 and Local Government (Municipalities) Act, 2009, city corporations and municipalities are responsible to provide primary health care to city dwellers. The necessity of formulation of strategy is strongly felt to discharge the bestowed responsibility. Urban Health Strategy 2014 has been prepared considering quality of service and demand of common city dwellers by incorporating different related issues such as development of human resources, infrastructure for health care, strengthening partnerships and poverty reduction activities, inter-ministerial and inter-departmental coordination, improvement of database and monitoring system, decentralization of administration, and improvement of overall management.

During preparation of this strategy, intensive coordination among all related ministries and departments were ensured. Detailed discussions were held on the draft strategy among local government bodies, health and family planning departments, different government and non-government organizations in the regional workshops held in Dhaka, Rajshahi, Rangpur, Khulna, Chittagong, Sylhet, and Mymensingh and finally a central workshop in Dhaka. In these workshops, senior level representatives of the development partners such as Asian Development Bank (ADB), Swedish International Development

Cooperation Agency (SIDA), Department of International Development (DFID) and United Nations Population Fund (UNFPA) were also present. Opinions on the draft were sought through publishing the draft on the website of the Local Government Division. Opinions received from different ministries and departments are incorporated in this national strategy as far as practical.

This strategy has been prepared keeping in view some national goals and targets. The strategy of primary health care, nutrition, and family planning service delivery is presented in ten definite actions, time based implementation strategy and processes. Actions suggested in the strategy are:

1. Universal health coverage for urban population with a pro-poor focus;
2. Strengthen preventive and primary health care management system;
3. Ensure urban poverty reduction;
4. Achieve National Population Policy targets;
5. Achieve national nutrition targets;
6. Adopt innovative service delivery using modern technology, management policy and practices;
7. Improve institutional governance and capacity development;
8. Strengthen health service program of the City Corporations and Municipalities;
9. Financing and resource mobilization;and
10. Attain sustainability.

It is possible to improve the urban health system to an acceptable level by 2020 if the National Urban Health Strategy is implemented. Through the strategy, possible gains by 2021 would be achieved to bring the country to middle income by making urban people particularly the poor happier, healthier and economically more productive. An equitable environment for receiving health service from both public and private sector will be ensured. Above all, through improving the health sector in urban areas, improvement of national health indicators would be possible.

Necessary steps will be taken through discussion and coordination to prepare an operational plan for implementing the urban health strategy. The National Urban Health Strategy is a continuous process. Modification and amendment of this strategy will be done to meet changing demand of the people and to maintain uniformity with the national health policy and other related strategies governing urban health.

National Urban Health Strategy 2014

1. Introduction

1.1. Bangladesh is one of the countries in the world with rapid urban population growth. This is common for a country with declining poverty, increasing industrialization, and a shift towards middle-income economy. This is the reality where people will be migrating to the cities riding on the wheels of a vibrant economy. According to the population census of Bangladesh,the urban share of the national population was 8.8% in 1974 and increased to 27% in 2011. Indication is clear that this trend will continue in the future. It is estimated that the national population will be 230 million by 2040 of which more than half will be living in the urban areas.

1.2. Rural to urban migration, geographical expansion of existing city areas through merging rural areas to cities, inclusion of new areas as city, etc. are the main reasons for the increasing urban population.

1.3. City Corporations, municipalities, and cantonment boards included in the government's gazette are considered as urban areas. The city corporations and municipalities are local government bodies and distinct administrative units being administered under Local Government Division of the government through elected representatives as per provision of Article 59 of the Constitution. The cantonment boards are being administered according to the Cantonment Act.

1.4. The Constitution of the Peoples' Republic of Bangladesh, Article 59 provides as follows:

> " (1) Local government in every administrative unit of the Republic shall be entrusted to bodies, composed of persons elected in accordance with the law.
>
> (2) Everybody such as is referred to in clause (1) shall, subject to this Constitution and any other law, perform within the

appropriate administrative unit such functions as shall be prescribed by Act of Parliament, which may include functions relating to:

(a) administration and the work of public officers;

(b) maintenance of public order; and

(c) preparation and implementation of plans relating to public services and economic development."

1.5. Due to rapid population growth in urban areas, like other services, increased demand for health service delivery for the urban people is a common issue. The city corporations and municipalities are public service delivery organizations as prescribed by the law. Among these, delivery of primary health care and public health activities are important services. Though this responsibility has been mandated by the Local Government (City Corporation) Act, 2009 and the Local Government (Municipality) Act, 2009, there are some limitations to perform this responsibility properly in respect of the demands.

1.6. On the other hand, the Ministry of Health and Family Welfare is the leading Ministry to provide health services to the citizens of the country. In rural areas, there is a Community Clinic per 6,000 people, a Health and Family Welfare Center in each Union, a Health Complex in each Upazila, which results in a strong network of primary health and family planning services. However, there is lack of a similar network and program in the urban areas.

1.7. This gap adversely affects the primary health care of one-third of the country's population who are living in the urban areas. Particularly, the poor are deprived of essential health care services.

1.8. The necessity of a well-planned strategy for an urban health system has been discussed several times. Various government policies also emphasized the need of an urban health strategy. In this context, this National Urban Health Strategy has been formulated considering overall national goals and policies. In preparing this strategy, due attention has been given to national and international perspectives and commitments. The views of the stakeholders and grass roots level opinions have been considered.

2. Goals and Objectives

2.1. This strategy has been prepared based on some indications. First, rapid urbanization, specially unplanned urbanization hinders improvement of health and living standard of the urban people. Second, health care, particularly urban health care should not be limited to curative care only. Third, considering the complexity of the urban system, it is necessary to ensure coordination among activities of different organizations and a permanent arrangement to ensure a proper health system. Fourth, due to the reality of the public sector's financial and non-financial limitations, public, private and social partnership is indispensable for urban health care. Fifth, considering the socio-economic condition of the urban poor, it is necessary to work collectively for their health and human development.

2.2. If the National Urban Health Strategy is implemented, it will be possible to prevent the apprehension that urban health will face an acute situation by 2020. Through this strategy, it is expected that the following targets will be achieved:

(1) Attain middle income status by 2021, where the urban population, especially the poor, will be healthier, happier, and economically productive;

(2) Create environment where urban people, especially the poor, have equitable access to utilize public and private sector health services;

(3) Improve overall health indicators of the country through strengthened essential health care system for the urban population.

2.3. This strategy is divided into two parts. The first part contains a brief analysis of the present situation and looks at future expectations. The second part is an annexure on the implementation process of National Urban Health Strategy. This strategy is a living document, which will be updating time to time, if required. Any recommendation from individuals and organizations for improving the strategy would be highly appreciated.

3. Global Perspectives of Urban Health

3.1. The global development trend is toward urbanization. At present, more than half of world's population lives in urban areas. Urbanization does not only mean the increase of urban population or the expansion of urban areas. Urbanization will become inclusive when its structure ensures industrialization, employment, environment for livelihood and socio-economic security.

3.2. Health care is a basic issue in urban life. Globalization, demographic change, climate change, and urbanization—these four major trends are influencing the 21st Century's urban health landscape. Advancement of technology and strategy, increasing opportunities of livelihood, economic and commercial worthiness, good governance, etc. are considered important and positive factors to these trends. To ensure health care for the jobless and slum population, an equitable health system and reasonable employment opportunities are necessary. Inappropriate wages might help reducing unemployment for time being but poverty will not be eliminated and essential commodities including health care services will not be available. In brief, it is difficult to improve expected living standard after discharging other liabilities of urban setting and to get relief from endemic deprivation.

3.3. Migration from rural to urban is the main cause for increasing urban population. Migration is driven by 'pull-push' factors such as economic, cultural, political, or environmental. 'Pull' factors include increased livelihood opportunities and better living conditions. 'Push' factors include less opportunity, social or economic discrimination, political adversity, and natural disasters. Fertility and mortality rate also affects the increase in population. Extended health care services in urban areas contribute to incrase longevity in affluent families. It has been resulted to increase of older population.

3.4. For development, there is no alternative to industrialization, but it causes increased emissions of carbon dioxide and other greenhouse gases, resulting in the increase global warming. Densely built houses and treeless cities become 'heat islands'. Air, water, food pollution and different communicable diseases are affecting urban residents. Other health threats are natural disasters for cities close to coastal areas or

riverbanks. Existence of industries in and around cities such as brick kilns, tanneries, and cement factories are curbing the right to enjoy pure air by urban residents and cause serious health risks. There is significant absence of industrial effluent treatment systems in developing countries like Bangladesh. Untreated effluent is dumping in the nearest natural water bodies. As a result, surface water becomes unusable. This situation underscores the necessity of good governance for good health.

3.5. Except natural geographic barriers, horizontal expansion of cities is a continuous process. Apparently, it helps to mitigate overcrowding. However, it also creates health problems. For instance, it demands long commute and traffic related health risk. Horizontal growth may lead to loss of crop lands, which is a threat to food and nutrition security, and creates problems of safe water supply. Lack of play grounds impedes physical and mental growth of children. In Dhaka, one of the world's most populated cities, scope to bicycling safely and play kites in the sky by the romping youth is beyond imagination. Due to the lack of safe walkways, city dwellers are forgetting their walking habit, which causes health risks such as diabetes and cardio-vascular complications.

4. Bangladesh Perspective

4.1. The Government of Bangladesh has been working to achieve the Millennium Development Goals (MDGs). Among eight main goals, three are related to human development (achieve universal primary education, eradicate poverty, and promote gender equality) and three are health related (reduce child mortality rate, reduce maternal mortality ratio, and prevention of HIV/AIDS and malaria). There are intensive interlinkages among these, and without integrated efforts, it will be impossible to achieve the expected results.

4.2. The preface of the National Education Policy 2010 perfectly mentioned, "Education is the main tool for achieving goal of poverty eradication. An educated nation, modern in intelligence and reflection, progressive in sense and wisdom can drive a country to the height of development." It means building an educated nation is not only the final destination of an education system. Similarly, objective of the Health, Population and Nutrition Sector Development Program (July 2011-June 2016) is to make the population healthier, happier, and economically productive to scaling up the country to a middle-income level by 2021. Harmony

among different policies and strategies indicate that the development effort of a country is like an orchestra, where all the sectors, all elements need to perform uniformly and in a common manner.

4.3. Bangladesh has made substantial progress in the human development indicators. Literacy rate is increasing; particularly notable progress has been achieved in girls' education. Enrollment in primary level is around 100% and the drop out rate is also decreasing. The Government's highest allocation to the education sector, stipend, establishment of new schools, increasing number of class rooms, free distribution of books at the beginning of the year, teachers' training, improved education materials, expansion of technical education, increasing scope of higher education, functioning of non-formal education, etc. have been contributing largely for advancement of the sector. In rural areas, it is rare now to find a child never enrolled in school, but there is no such guarantee for the children of slum and floating families in the urban areas. The disabled and autistic children of rich families are also suffering from similar problem. The National Children Policy 2011 highlights the Government's commitment to work in this area.

4.4. In the Sixth Five Year Plan, poverty has been identified as the top most challenge for socio-economic development of Bangladesh. The previous 'National Strategy for Accelerated Poverty Reduction' also explained this issue in detail. The goal of the Government's Perspective Plan (2010-2021) is to reduce poverty; improvement in this field is also encouraging. In Bangladesh, the incidence of poverty in the rural area is still higher than the urban area. This situation is not new, but it is noticeable that poverty in the urban area has been increasing rapidly. According to the population Census of 1974, only 8.8% of the population lived in urban areas, which has increased to 27% in the Census of 2011. Most of the poor in the urban areas live in slums. A large number of them are floating, have no definite place for sleeping at night. Within the thousands of buildings, they are shelterless. Information on these homeless people is absent in household based surveys. Living condition and facilities of the urban ultra-poor is worse than that of rural poor. To ensure improved health of these people is a big challenge.

4.5. Gender equality, empowerment of woman, and prevention of violence against woman are inter related issues. Bangladesh has accorded in the Convention on the Elimination of all forms of Discrimination Against

Women (CEDAW). National Women Development Policy, 2011 reflects this commitment. The most outstanding feature of gender equality in Bangladesh is the reduction of disparity in number of boys and girls students in primary and secondary level. In long term, the socio-economic impact will help to elevate Bangladesh to a higher stage. The power of education is numerous; one example of this is creating scope for livelihood and profession. Employment of women implies their empowerment and upholds their rights to take basic decisions. In this era of globalization, there is no alternative to involve women in the mainstream of the economy. By breaking prejudices and traditional norms, women are involved in employment; their contribution is also increasing the country's economic development.

4.6. To prevent violence against women, there are many laws and their strict application. Nonetheless, violence against women still is a distressing problem. The report of Violence Against Women (VAW) Survey 2011 published by the Bangladesh Bureau of Statistics show that irrespective of rural or urban, 46.4% of wives were physically assaulted in the previous 12 months by their current husbands. Incidence of acid throwing to women is higher in urban areas than rural. Health problems due to violence against women include losses due to physical injury, problem for treatment of physical injury and treatment cost, risk of life for the mother and the child of pregnant women, and mental disease.

4.7. Overall, the child mortality rate has been reducing in Bangladesh, but the situation is yet not at a satisfactory level. Bangladesh Demographic and Health Survey 2011 stated that 1 out of 23 children dies before the age of one year and 1 out of 19 children dies before the age of five years. To prevent childhood diseases, the Extended Program on Immunization covered 86% of children in 2011. Efforts are continuing to increase the coverage rate. The child mortality rate in slum areas are not declining at the same rate as non-slum and municipality areas.

4.8. As a result of a number of initiatives like vitamin and other micronutrient supplementation, iodized salt, the status of child nutriton is improving significantly. Breast feeding is being popularised. Six month maternity leave for working women has accelarated Exclusive Breast Feeding for six months. Malnourished lactating mothers suffer from inadequate of breast-milk that hampers physical and mental growth of baby. In addition to breast feeding, the progress of supplementary

feeding is slow among 6-23 months old children. Stunting among slum children is higher than that of non-slum children. The rate of wasting (low weight compared to height) among them is also higher compared to non-slum children. Both stunting and wasting in children are related to mother's malnutrition. This indicates the importance of investing in mother and child nutrition.

4.9. Bangladesh has acheived remarkable progress in reducing maternal mortailty. In 2001, maternal mortality rate was 320 per 100,000 live births;within a decade, it reduced to 194 in 2011. However, Bangladesh still remains among one of the high maternal mortality countries. Efficient management of health care delivery plays a main role for reducing maternal mortality. Births attended by skilled health persons increased to 32% in 2011, which is double compared to in 2004. The increase of maternity centers is the main reason for this progress, where the private sector plays a major role. In 2011, 29% of births occured in the clinics, of which 15% were in private clinics, 12% in government hospitals, and 2% in NGO clinics. Although the rate of institutional delivery among urban mothers is higher than that of rural, this rate is very low among the urban poor and slums.

4.10. In order to reduce maternal mortality, it is necessary to increase awareness about the importance of antenatal and postnatal care and to make health care service easily accessible to the urban poor mothers. The major segment of working women in Bangladesh is engaged in the ready made garments sector; a proper health care system is necessary for these women and their children. In this context, day care centers for the children are necessary.

4.11. Child marriage and teenage pregnancy is a multidimensional problem for Bangladesh. This problem is related to maternal mortality, neonatal death, risk of reproductive health, malnutrition, exacerbating family poverty due to excessive number of children, and over population. In Bangladesh, 50% of women give birth to their first child within the age of 18 years as revealed in data of 2011. This is a depressing scenario. This scenario is worse in the urban slums. The reality of insecurity and the financial burden of the poor family are the main causes of early marriage in the slums.

4.12. In Bangladesh, 35% of the population is below 15 years of age. An appropriate environment is necessary for proper development of physical and mental health of adolescents. Due to social and family prejudices, adolescents are denied access to information and counseling on reproductive health. Particularly, there is a shortage of counseling and service centers to address problems related to nutrition, reproductive health, mental health, sexual risk, and ethics. These services are few and far for adolescents of urban poor families and adolescent maids. Even many parents are indifferent to these issues. Lack of hygienic and separate toilets for females in the school, workplace, and roadside is also a health problem.

4.13. Health, Population and Nutrition Sector Development Program has targeted to limit two children per woman by 2016; achieving this target in the urban slum is a big challenge. The Bangladesh Urban Health Survey 2006 found that the population growth rate in urban slums was 2.38% and in non-slums 1.79%. To attain the national target of 72% contraceptive prevalence rate by 2016 from 61% in 2011, more attention is needed for one-third of the country's population who live in urban areas, particularly the poor. Examples of limitations in this area include medicine stores or pharmacies that are the main sources of pills and condoms, and injectables are mainly supplied by private sources. NGOs are the main source of contraceptives supply in slum areas. There is a shortage of family planning field workers. Moreover, there is no man power arrangement at all for providing door-to-door service in urban areas.

4.14. Although Bangladesh has achieved self-sufficiency in food, for the poor people, food security is still uncertain. The report of the National Micronutrients Status Survey, 2011-12 stated that food insecurity was at an alarming level in 12.3% of households. Food security is visible among 53.3% households in urban areas compared with 36.3% in slum areas. A separate survey reveals that malnutrition in males and females living in slums is higher than that of non-slum areas. However, the situation is the opposite in the case of obesity, overweight, hypertension, and diabetes. Smoking habits among men in the slum is highest followed by district municipalities and non-slum areas. In slums, the habit of smoking develops at an early age and increases with age. The drug addiction rate is higher in slums under city corporation areas compared to district municipalities.

4.15. Problems pertaining to daily life are higher among the slum population compared to non-slum and people living in district municpalities. Women suffer more on this count than men. Problem of physical strength and mobility is higher among women than men. Problem of personal care is also higher among women. Loss due to physical injury is an important health issue in urban area. Men suffer more compared to women, although the causes of injuries are different. For men, the main cause of injury is road accidents, while for women domestic violence is the main cause.

4.16. Access to safe water is an important determinant of the health system. Most of the urban people collect their water from a piped source or tube-well. There are variations in access to water depending on location. Most of the residents of district municipalities get water supply from a tube-well. However, the supply of water is inadequate compared to the demand of the urban people, particularly in the city corporation areas. The quality of water is also an issue to consider.

4.17. In urban areas, different types of accidents are a regular phenomena. The most common are fires, which occur both in slums and high-rise buildings. Installations of factories and warehouses in residential areas, use of imflammable materials, and electric short-circuiting are the main causes of fire accidents. Old and dilapidated buildings, construction of sub-standard buildings, lack of sufficient security measures, earthquakes, etc. are the latest addition to causes of urban disasters.

4.18. The existence of factories and commercial establisments in residential areas, uncollected domestic, commercial, industrial and clinical wastes, sound and air pollution, polluted water and inadeqaute swerage system are serious environmental problems for urban public health. A large quantity of undisposed solid waste spreading here and there poses a serious threat for public health. Bronchitis, asthma, and respiratory infections are increasing day by day due to environmental pollution. Gastrointestinal, skin, and respiratory tract infections are increasing alarmingly.

4.19. Health education is an indispensable element of health service. Once it was thought that educated and solvent people only would live in the cities. Because of this, no plan had been taken for city areas to provide health and family planning service through field workers.In fact, a large

number of poor and illiterate people are being deprived of receiving health education to increase awareness on family planning, reproductive health care, adolescent health, drug abuse and addiction, infectious diseases, etc.

4.20. There is difference between urban and rural health systems. In the urban areas, preventive or public health issues are more important. Bangladesh National Health Accounts (BNHA-III), 1997-2007 stated that only 12% of the total health expenditure of the country was allocated for preventive health, in which family planning is also included. Public health related activities are part of preventive health. Allocations for this sector are not sufficient.

5. The Way Forward for Urban Health in the Present Situation

5.1. In the Sixth Five Year Plan, the urban development sector targeted five outcomes. These are (i) full access to pure water and sanitation (ii) access to improved municipal services (iii) strengthened urban policy, local governance and management (iv) improved urban public transport system and (v) sustainable City Corporation and municipal health services.

5.2. In large cities, due to the shortage of public sector primary health care and family planning services, private clinics are providing routine health services to the urban people at higher prices. These costly services are not affordable for the urban poor. In public hospitals, even after waiting for a long time in queue, if they are able to manage free prescription, they are unable to purchase medicine at high price. Thus, health services are becoming more expensive day by day and people are becoming poor to meet health expenses. The poor should get health care services free of cost.

5.3. Public health, preventive health, and family planning services do not attract the private sector because these are non-profitable. In this area, there is a deficiency of service delivery for the urban people. It is necessary to increase activities of city corporations and municipalities in these areas.

5.4. Food, nutrition, housing, fuel, water supply, and physical environment are inclusive issues related to health status of the urban people. This should be taken in view during preparation and implementation of urban related policies.

5.5. At present, road safety is a public health hazard. To provide emergency service for road accidents, establishing Trauma Centers is a commendable initiative. Traffic control in Dhaka is the top most problem for urban life. The Government is working to resolve the problem through the Dhaka Transport Coordination Authority. For a proper urban life, a good urban transport system is crucial.

5.6. The scope of work, financial capacity and man power of the city corporations in Bangladesh are not negligible. A very small portion of revenue expenditure of the city corporations are used for health care. It is necessary to increase capacity and give attention to ensure an effective role in this area.

5.7. Although there are questions on the quality and cost of private sector health services, in reality, the contribution of the private sector cannot be discounted. It is necessary to rationalize service quality and cost of the private sector.

5.8. Accurate diagnosis of disease and the use of quality and rational drugs are substantially related to health care service delivery. For a number of reasons, there are noticeable weaknesses in these issues. Prudent monitoring and quality control is necessary to overcome the situation.

5.9. Drug addiction is a major health problem in urban areas. It is easy to work to restrict drug abuse but very challenging to control illicit trafficking. Proper avenues and opportunities should be explored to combat the drug abuse problem.

5.10. The Directorate General of Health Services has introduced a Health Management Information System. Linkage to this system should be established with all service provider agencies. City Corporations and municipalities should work to develop capacity to keep all health service information in their own areas.

5.11. There is a shortage of skilled health workers. Without skilled health workers, it is not possible to improve the health care situation. It is

necessary to establish more institutions to train health workers to meet the demand.

5.12. There are many organizations working for urban development, planning, and delivery of services. Some of these are providing services directly, others supporting environment for service delivery and undertake governance responsibilities. To all these organizations, there are reasonable public expectations. Coordination of activities among these organizations is necessary through a comprehensive urban policy, where good health for the urban people will receive priority.

5.13. According to the Rules of Business, the national level health care policy and strategy, technical guidance, etc. are the responsibilities of the Ministry of Health and Family Welfare. As local government bodies are working under Local Government Division, it plays a leading role for financing, supervising, and implementing health services provided by the local government institutions. To ensure the quality and usefulness of these services, there should be effective coordination between both Ministries.

5.14. Several NGOs have been delivering health care services satisfactorily in the urban areas; most of them depend on foreign donations. For their contributions, the health status of the urban poor has significantly improved. It is necessary to increase involvement of the NGOs to provide health care services and to facilitate coordination with Urban Local Bodies.

5.15. Under the Public Private Partnership model, it is necessary to establish and manage more health care centers.

6. Implementation of the National Urban Health Strategy

6.1. The National Urban Health Strategy shall be implemented through integrated efforts at different levels. The urban poor will be the main focus of urban health care and the system will be gender responsive.

6.2. The Urban Development Wing of the Local Government Division will coordinate the strategy centrally.

6.3. A high level coordination committee combined with the Ministry of Health and Family Welfare and the Local Government Division will be

supervising the implementation of the National Urban Health Strategy and will be taking necessary policy decisions in this respect.

6.4. Urban health service related issues would be highlighted in all urban development activities through coordination with other organizations/ departments involved in urban development. Different Ministries and Divisions will be encouraged to deliver health services in their own jurisdiction wherever possible.

6.5. Primary and public health services delivery on a permanent basis shall be ensured through increasing efficiency, manpower, and financial capacity of the city corporations and municipalities.

6.6. Cooperation will be extended to coordinate activities of similar services provided by private and non-government organizations.

6.7. Bilateral and multilateral international cooperation shall be encouraged for financial and technical support to foster urban health care services.

6.8. Alternative options for health financing, Public Private Partnership Model, health insurance and other innovative system shall be used. Large-scale industries and commercial enterprises shall be motivated to take initiative to provide health services to their employees under Corporate Social Responsibility.

6.9. A list of activities for implementation of the National Urban Health Strategy is attached in the Annexure. In the list, the strategic plan and implementation process against targeted goals are identified and highlighted. This strategy will be implemented through an Operational Plan to be developed shortly.

Signed/-
(Monzur Hossain)
Senior Secretary

Dhaka: November 2014

Annexure

Implementation Process of the National Urban Health Strategy

Actions	Strategy	Implementation Process	Time-frame
1. Universal health coverage for urban population with a pro-poor focus	▪ Introduce free health card for the urban poor ▪ Introduce health insurance for employees work in offices and factories ▪ Introduce voluntary health insurance for others	▪ Identify acceptable model by reviewing present situation ▪ Give responsibilities to Local Government Institutes in partnership with NGOs for the poor ▪ All public and private organizations will take steps for health insurance for their employees	Continuous
2. Strengthen preventive and primary health care management system	▪ Coordination across cross - cutting sectors: safe water supply, road and food safety, housing and environmental health for urban area ▪ Expand and strengthen elements of Primary Health	▪ Introduce management model by Local Government Division for primary health care, solid and medical waste management through Local Government Institutes ▪ Delivery of primary health care service by Ministry of Health and Family Welfare in the urban areas where	Continuous

Actions	Strategy	Implementation Process	Time-frame
	Care and attention to emerging issues. ▪ Better organization and management of existing urban health delivery infrastructure of Local Government Division, Ministry of Health and Family Welfare, Urban Local Bodies, private and NGO facilities ▪ Improve human resources for primary health care services delivery. Steps to remove weaknesses in urban family planning services, doctor, nurse, paramedics and strengthening community health solution approach. ▪ Adopt a more inclusive approach ▪ Give more attention to	services not delivered by the Local Government Institutes and NGOs ▪ Take long term human resource development plan for the Local Government Institutions ▪ Similar plan for public and private sector. ▪ Mobilize resources locally by Local Government Institutes and other service providers. Utilize corporate and charitable organizations. ▪ Develop effective referral system by Ministry of Health and Family Welfare among Local Government Institutes, private organizations and NGOs using experiences of private organizations ▪ Strengthen social involvement of Local Government Division and related NGOs and more intensive monitoringby Local Government Institutes and Local Government Division	

Actions	Strategy	Implementation Process	Time-frame
	curative care of non-communicable diseases in urban areas ▪ Ensure working hours at service centers to suit the needs of the clients	▪ Adopt more inclusive approach by Local Government bodies, Civil Society Organizations and NGOs to include in the health service activities for the people such as socially segregated classes, ageing population ,mentally retarded and physically disables/handicap, adolescent and others. ▪ Strengthen health education on proper life style, dietary intake for all ages particularly for the aged people, mental health care, etc. ▪ Determine suitable working hours for the service delivery centers under Local Government Institutes and NGO partnership or under only NGOs to meet needs of the clients urban poor, in particular	
3. Reduce urban poverty	▪ Ensure reduction of urban poverty ▪ Strengthen social safety net program in urban areas	▪ To accelerate reduction of urban poverty Local Government Division to establish greater linkages to Urban Governance Infrastructure	Continuous

Actions	Strategy	Implementation Process	Time-frame
	▪ Implement the concept to mitigate health problems to reduce poverty ▪ Strengthen integrated programs as a part of the urban sector development policy by capturing the synergies of preventive health care with greater focus on mother, child care, adolescent and old age groups. ▪ Establish greater linkages to all existing urban development related programs and projects with a special focus on accelerated reduction of urban poverty.	Improvement Project (UGIIP) and sanitation and sewerage related programs and projects ▪ To accelerate reduction of urban poverty similar actions by Local Government Division to establish linkages with ongoing and future programs/ projects of other ministries having a bearing on urban poverty. ▪ Provision of urban poverty reduction steps in Urban Development Policy ▪ Take measures in cities with higher incidence of poverty and after reviewing Sixth Five Year Plan ▪ Taking stock of all public agencies across different Ministries involved in urban development programs and ensure coherence and consistency for gains in urban health outcomes	
4. Achieve National Population Policy targets	▪ Give greater attention to remove the mismatch of supplies of needed materials in those urban	▪ Directorate General Health Services and Directorate General Family Planning to attach more importance in demand and supply side management.	2016 and Continuous

Actions	Strategy	Implementation Process	Time-frame
	areas where population growth rate is higher. ▪ Focus on partnerships with NGOs for supply system	▪ Give more importance to urban areas where health service activity is weak. ▪ Intensify supply of Family Planning materials at ward level through community workers in partnership with NGOs. ▪ Increasing coverage of Family Planning services with more emphasis in urban slum. ▪ Establish a good referral system ▪ Map urban slums ▪ Establish service centers for Long Acting and Permanent Method ▪ Avoid overlapping of services in each slum	
5. Achieve national nutrition targets	▪ Integrated activities among Local Government Institutes, private organizations and NGOs.	▪ Health care for those affected by severe malnutrition ▪ Promote good and functional nutritional practices.	2016 and continuous

Actions	Strategy	Implementation Process	Time-frame
		▪ Ensure intensive food safety measures ▪ Intensify nutritional education using both traditional and modern methods with emphasis on food-based nutrition. ▪ Ensure social safety for the urban poor. ▪ Strengthen monitoring and evaluation including surveillance	
6. Adopt innovative service delivery using modern technology, management policy and practices.	▪ Local Government Division's steps as a part of Vision 2021 with Local Government Institutes and NGOs to implement Health, Population and Nutrition Sector development Program ▪ More supportive role among Local Government Institutes ▪ Adopt flexible management practices and operative system by the	▪ Use computers and introduce referral system in Primary Health Care Centers ▪ Local Government Division to review the recruitment rules of Local Government Institutes to empower them to meet personnel shortages in health and related units. ▪ Simplify operative procedure supported by decentralization.	2016 and continuous

Actions	Strategy	Implementation Process	Time-frame
	NGOs		
7. Improve institutional governance and capacity development	▪ Local Government Division to establish and strengthen its cooperation with all relevant Ministries and agencies such as Ministry of Environment and Forest, Communications, National Housing Authorities, Ministry of Home Affairs, etc. to achieve desirable outcomes of urban health.	▪ Local Government Division to review its interface with different bodies such as central government agencies (e.g. Urban Development Directorate, National Housing Authority, Public Work Directorate under Ministry of Works etc.) Specialized Authorities, those responsible for water supply and sewerage, Dhaka Transport Coordination Board under Ministry of Communications and Development Authority such as Rajdhani Unayyan Kortipokkho, Chittagong Development Authority, Khulna Development Authority and Rajshahi Development Authority since these bodies are responsible for urban development in order to ensure growth of healthy cities. ▪ The existing level of coordination by Local Government Institutes with above agencies/ bodies be reviewed for more strengthening to obtain gains	2016 and continuous

Actions	Strategy	Implementation Process	Time-frame
		of urban health	
8. Strengthen health service program of the City Corporations and municipalities	▪ Appoint physicians, nurses and health workers by Local Government Division in all zone or wards of all city corporations and wards or zone in case of municipalities ▪ Establish health care centers through ensuring Institutional capability	▪ Local Government Division through intensive collaboration with Ministry of Health and Family Welfare will Establish citizen's health care centers supplement to existing district and Upazila based health system structure ▪ Besides existing structure of Ministry of Health and Family Welfare, will establish suitable health care center through determining public demand	2016
9. Financing and resource mobilization	▪ Ensure separate budget allocation for urban health care increase partnership among Local Government Institutes and continuity and NGOs ▪ Mobilize local resources and side by side allocation from government to Local Government Institutes for health service delivery	▪ Local Government Division to take priority action for separate budget to carry out Health, Population and Nutrition activities from revenue part of the budget by making it a well-argued case for consideration and approval by the Ministry of Finance and/ or Planning Commission ▪ Local Government Division to ensure more allocation in all relevant areas supportive of urban health.	Continuous

Actions	Strategy	Implementation Process	Time-frame
	▪ Explore the availability of resources from private corporate bodies as part of their social responsibility ▪ Ensure more support from development partners in short and medium term ▪ Ensure transparency and accountability, monitoring, evaluation and supervision ▪ Strengthen Public Private Partnership ▪ Avail opportunities for more investment in urban health by NGOs and Urban Local Institutes ▪ Examine feasibility to use funds from Municipal Development Board	▪ Local Government Division to develop procedures and guidelines to ensure transparency and financial probity in the use of funds without limiting the flexibility of operations of Local Government Institutes and partner NGOs. ▪ Similar action to strengthen monitoring, evaluation and supervision by Local Government Institutes ▪ Establish and strengthen urban health related management information system with linkage to HMIS of Directorate General of Health Services ▪ Review the existing Public Private Partnership framework; identify its strength, weakness, opportunities and threats to fully exploit the achievable gains for urban health. ▪ LGD to establish linkages with the NGO-Private Sector Unit proposed to be established by Ministry of Health and Family Welfare through its own	

Actions	Strategy	Implementation Process	Time-frame
		separate wing for HMIS. ▪ Review and update proposals from interested NGOs/ Local Government Division for approval by Ministry of Finance for Public Private Partnership funding support. ▪ Hold discussions with Municipal Development Board for obtaining funds based on their existing framework and procedures.	
10. Sustainability	▪ Ensure sustainability of urban health program based on Public Private Partnership and other programs	▪ Apart from stable fund flow for sustainability, establish a permanent structure for bi-annual consultations with partner NGOs, private sector and health governance policy makers and think tanks for delivery of quality services in all areas connected with urban health. To reinforce through involving non-health sources who do not provide health services but related to the services. ▪ Constitute an effective coordination committee with Ministry of Health and	2016 and continuous

Actions	Strategy	Implementation Process	Time-frame
		Family Welfare, Local Government Division and other related ministries ▪ Consolidate coordinating mechanism across ministries dealing with cross-cutting issues. ▪ Decentralize greater authority ▪ Build more effective alliances with the NGOs, private sector, businessmen and other relevant non-state actors ▪ Build capacity at Local Government Division, NGOs, private sector and Local Government Institutes	