Final DRAFT

Multisectoral Urban Nutrition Strategy (MUNS), Bangladesh

Bangladesh National Nutrition Council (BNNC)

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Multisectoral Urban Nutrition Strategy (MUNS), Bangladesh

Preface

The Second National Plan of Action for Nutrition (NPAN2) 2016-2025 recognizes the gaps in nutrition services in urban areas and proposes for enhancing urban nutrition programming through effective coordination among government ministries, and partners including NGOs, and for strengthening linkages with related systems, such as Education, Food, WASH and Social Security programs to address the social along with health determinants of nutrition in urban population groups. While MoHFW is responsible in rural areas, the health, population, and nutrition system in urban areas consists of different legal entities, with limited horizontal and vertical coordination. This results in blurred lines of accountability, further weakened by inadequate coordination among the responsible parties. On this backdrop, the Standing Technical Committee (STC) for nutrition in its ……th meeting felt the need of a multisectoral urban nutrition strategy and approved a concept note to ensure the effective coordination focusing among the responsible stakeholders to result in the optimum nutrition specific and nutrition sensitive interventions targeting the urban population.

The Ministry of Health and Family Welfare sees the strategy as part of the reform agenda emphasized by the current interim government and recalls the directives of the Chief Advisor at the first meeting with secretaries of the government. He asked the secretaries to identify and implement prioritized reforms in their respective sectors. These directives underscore a commitment to comprehensive reform across all sectors and institutional frameworks, with health reform being a key focus. *"We want reforms. It is our sincere request—please don't go to the spectators' gallery after bestowing the key responsibility of reform on us. Stay with us. We will do the reform together." — Chief Adviser Professor Muhammad Yunus.*

This Multisectoral Urban Nutrition Strategy (MUNS) isthe first of its kind in Bangladesh, which reflects the commitments of the government in the HPN sector. It is developed to ensure effective coordination among the five important systems in urban areas to result in positive nutrition outcomes for urban population. These five systems are – nutrition and health, food, WASH, education, and social protection. MUNS will combine the relevant strategies and actions of these systems and will layout a multiyear strategic policy direction from a nutrition lens.

The strategy has been developed through a rigorous process that involved multiple stakeholders from relevant Ministries, Government Agencies, Development Partners, NGOs, academics, and research institutes. A good number of consultations were organised at national and sub-national levels. The entire process was coordinated by the Bangladesh National Nutrition Council (BNNC). Nutrition International (NI) provided the financial and technical support through a Technical Assistance (TA) team.

Acronyms

BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BFSA	Bangladesh Food Safety Authority
BGMEA	Bangladesh Garments Manufacturers and Exporters Association
BKMEA	Bangladesh Knitwear Manufacturers and Exporters Association
BNNC	Bangladesh National Nutrition Council
BTMA	Bangladesh Textile Mills Association
CMC	Central Management Committee
DGFP	Directorate Generate of Family Planning
DGHS	Directorate General of Health Services
DGME	Directorate General of Medical Education
DNCRP	Directorate of National Consumer Rights Protection
DP	Development Partner
EBF	Exclusive Breastfeeding
ESP	Essential Service Package
FFP	Food Friendly Programme
FID	Financial Institutions Division
FSM	Faecal Sludge Management
FYP	Five Year Plan
GED	General Economics Division
GOD	Government Outdoor Dispensaries
HEU	Health Economics Unit (of HSD)
IDRA	Insurance Development and Regulatory Authority.
IPHN	Institute of Public Health Nutrition
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
LGD	Local Government Division
LGI	Local Government Institutes
LIC	Low-Income Communities
MCWC	Mother and Child Welfare Centre
MHM	Menstrual Hygiene Management
MNCH	Maternal, Neonatal and Child Health
MOC	Ministry of Commerce
MoE	Ministry of Education
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MoLGRD&C	Ministry of Local Government Rural Development and Cooperatives
MOP	Ministry of Planning
MoPME	Ministry of Primary and Mass Education
MOSW	Ministry of Social Welfare
MOWCA	Ministry of Women and Children Affairs
MUNS	Multisectoral Urban Nutrition Strategy
NCD	Non-communicable Disease
NNP	National Nutrition Policy
NNS	National Nutrition Service
NPAN2	Second National Plan of Action for Nutrition
NSSS	National Social Security Strategy

OMS	Open Market Sales
PHC	Primary Healthcare
SBCC	Social and Behavioural Change Communication
SSP	Social Security Programme
SWM	Solid Waste Management
TCB	Trading Corporation of Bangladesh
TVET	Technical and Vocational Education and Training
UHCC	Urban Health Coordination Committee
UHS	Urban Health Strategy
UPHCSDP	Urban Primary Health Care Service Delivery Project
WASA	Water Supply and Sewage Authority

CONTENTS

1. BACKGROUND/ INTRODUCTION

1.1 Context

Prior to developing the urban nutrition strategy, we conducted a review of the National Nutrition Policy 2015 and its Plan of Action (2016-2021) to identify actions and areas pertinent to urban nutrition. We observed that certain elements were addressed in a general context. The National Nutrition Policy (NNP) and the National Plan of Action for Nutrition (NPAN-2) function as overarching policies, making it essential for the urban nutrition strategy to align with them.

Furthermore, we have considered the evolving priorities of the government. The current interim administration has initiated reforms across all sectors, including health and nutrition. In the inaugural meeting with government secretaries, the Chief Advisor of the Interim Government instructed the Ministry to identify and implement prioritized reforms within their respective areas. This directive highlights a commitment to comprehensive reform across all sectors and institutional frameworks, with a particular emphasis on health reform.

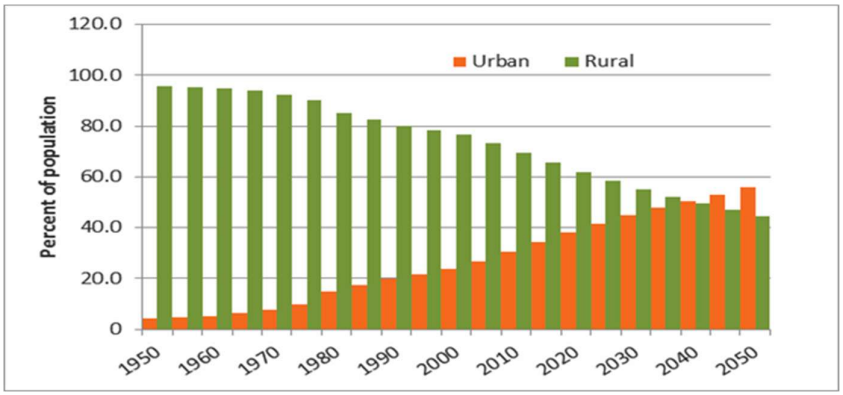
Bangladesh is experiencing demographic, economic, and rapid urbanization resulted from shift in economy from agriculture towards more of manufacturing and services. In Bangladesh 31.51 % of the total population (around 53 million) are urban dwellers, 26,545,982 are men, 25,456,744 are women and 6,346 are hijras [1]. Rural to urban migration is occurring in thousands annually resulting in populous slums. Currently, around 3.5% of urban dwellers reside in urban slums (BBS, 2022). At present, the government's long-term vision is of a city without Low-Income Communities (LICs). This will require comprehensive planning for the 'institutionalisation' of LICs, popularly called slums.

1.1.1 Definition of Urban Areas in Bangladesh

Bangladesh Bureau of Statistics (BBS) in 2017, defined urban centres as an area comprising with 100,000 population (BBS, 2017) along with other parameters[2]. Ministry of Local Government, Rural Development and Cooperatives (MoLGRD&C) took this definition and identified 570 urban centres in the country as "Urban Areas", out of which, 12 have been classified as "City Corporations", 330 as "Municipalities" (*Pouroshava* in Bengali), and the remaining as other towns (MoLGRD&C, 2022)[3].

1.1.2 Urbanization in Bangladesh: process and pace

The urban population is in continuous rise in Bangladesh. In 1961, the urban population was a little over five percent of the total population of the country, which became 20%in 1991, 24% in 2001, 28% in 2011 and 31.5% in 2022. The United Nations population division estimated that almost 58% people of Bangladesh will live in urban areas in 2051[4] (Fig 1). The bulk of these urban populations are concentrated in the large city corporations.



[1] BBS 2022

2 identified central place with amenities, such as paved roads, electricity, gas, water supply, and sanitation system

[3] Urban Health Survey 2021. NIPORT MoHFW, and ACPR, March 2022.

[4] BBS 2022

Figure 1: Rural-Urban Distribution of population in Bangladesh from 1950 to 2010 and projected to 2050.

The growth of urban population in Bangladesh has taken place due to several factors, namely, (i) rural to urban migration is responsible for two thirds of the annual urban growth; (ii) high natural increase of native urban population- responsible for onethird of the annual urban growth; and (iii) the territorial extension of existing urban areas, and a change in definition of urban areas (Ishtiaque & Ullah, 2013)[5]. Both push and pull factors are in play and linked to migration. Push factors include failure to repay NGO microfinance loans, search for work, extreme poverty, homelessness, landlessness, local political infights, natural disaster, marital factors, and income erosion/loss of income sources at villages. The pull factors are ease of access to education, health, employment to informal sector, higher income probability and joining relatives/families.
As a pre-requisite for development, in Bangladesh the rapid urbanization has had positive contribution to its rapidly growing economy. The ongoing process has faced challenges, yet there is an opportunity to enhance the livability of its cities for the population by addressing the existing limitations in stressed, poorly developed, unprepared, and inadequate basic services. (e.g., housing, health services, transport, water supply, and sanitation, etc.) (World Bank, 2016)[6].

1.1.3 Existing relevant policies and strategies

The National Nutrition Policy 2015 (NNP 2015) emphasizes nutritional issues of Children, adolescents, NPLN and non NPLN women, elderly, and disable people for the whole country where having inadequate focus on urban specific nutritional risk and vulnerabilities. , As a result urban issues were not covered adequately in Second National Plan of Action for Nutrition 2016-2025 (NPAN2). Furthermore, the National Urban Health Strategy 2020 (UHS) lacks adequate focus on nutrition. Unlike service delivery systems in rural areas, the health, population, and nutrition system in urban areas consists of different Ministries, departments, and agencies, with limited horizontal and vertical coordination. Although the UHS, 2020, gave importance on the coordination between Ministry of Health and Family Welfare (MOHFW) and MOLGRD&C, there is a need for specific operational guidance to ensure better accountability of all other sectors. In addition, establishment of an effective coordination mechanism among the responsible parties will also be necessary.

The National Social Security Strategy 2015 (NSSS) does not provide any differentiated focus for tackling urban problems. However, a draft of the Urban Social Protection Strategy and Action Plan in Bangladesh, 2020 has been prepared by the Cabinet Division and the General Economics Division (GED) with technical support from UNDP, which is yet to be approved. The broader goal of the urban social strategy is to integrate and merge the system into the overall national social protection system of the country. The strategic direction of urban social protection is to adapt programmes from the rural areas to the urban areas (e.g., VGD, MCBP, etc.), to introduce social insurance and devise programme measures to tackle the challenges of urban poor living in slum like situation[7].

The National WASH Policy of Bangladesh was developed in 1998 and defined the role of government entities like Water Supply and Sewerage Authorities (WASA) for the large city corporations and DPHE for municipalities. The policy states that the government's goal is "to ensure that all people have access to safe water and sanitation services at an affordable cost". Section 8.4 of the policy set the policy directions in the urban areas. The policy, however, puts very little emphasis on LICs like urban slums, apart from only mention of …."WASAs and relevant agencies shall support and promote any collective initiative in slums and squatters in accessing water supply services on payment". The

[5]https://www.researchgate.net/publication/258847945_The_Influence_of_Factors_of_Migration_on_the_Migration_Status_of_Rural-Urban_Migrants_in_Dhaka_Bangladesh/link/0deec5293b7fc7bcdb000000/download
[6] Country Partnership Framework, World Bank, 2016-2020.
[7] Urban Social Protection Strategy and Action Plan in Bangladesh, January 2020.

National Water Supply and Sanitation Strategy, 2014 was based on the Policy. The strategy had detailed intentions of the government for urban population, and particularly had strategies to keep pace with the rapid urbanization. The strategy put the slum population in urban areas under the broad category of "vulnerable people", along with other demographic categories (e.g., indigenous people, tea garden workers, persons with disability, etc.). Hence, although a specific strategy (strategy 3) was specified for vulnerable people, the focus of those living in urban LICs was diluted to some extent.

The National Education Policy, 2010 is the most updated education policy in the country, which did not differentiate policy guidelines or strategic directions for education in rural and urban areas. "The responsibility of primary education cannot be delegated to private or NGO sectors. Any individual or any NGO willing to run primary education institutions must seek permission of the respective authority in compliance with rules and regulations of the State." Therefore, there has been no special focus on children from slums and floating population in the urban areas. Education Sector Plan (ESP) as a comprehensive and time-bound plan for the education sector fits into the overall legal, policy and organizational framework of national development. The national five-year planning process places education within the overall medium-term national development framework. The Medium-Term Budget Framework (MTBF), a three-year rolling public expenditure planning exercise, and the annual national budgets provide the financial resources for the ESP and its implementation.

There is no specific urban food policy as such in Bangladesh. The urban food system in Bangladesh faces unique challenges due to rapid urbanization, population density, and limited agricultural land. Addressing these issues, the LGD has developed the Dhaka Food Agenda where food system approach has been adopted for the first time focusing on supply, processing, safety and hygiene issues of urban dwellers. However, urban agriculture is encouraged through policies that support initiatives such as rooftop gardening, community gardens, and vertical farming through establishment of Metropolitan Agriculture Offices in the Metropolitan cities. Good Agriculture Practice (GAP) Policy 2020 also highlights the importance of urban agriculture. These policies aim to utilize limited urban spaces for food production, improving access to fresh and nutritious food for urban dwellers. Policies and regulations are in place to ensure the safety and quality of food in urban areas. Standards are set for food production, processing, and handling practices to minimize health risks.
Social Security Programmes (SSPs) are the principal vehicles of the Government of Bangladesh (GoB) to support vulnerable population groups in the country, particularly by addressing food and nutrition security, enhancing economic condition, and improving behaviour change. The country adopted the National Social Security Strategy (NSSS) in 2015 to reduce poverty and food insecurity among the vulnerable population. NSSS adopted the lifecycle risk approach that addresses, among others, malnutrition from population from different demographics, including mother, children, adolescents, and elderly population. Social Security programmes offer multiple ways for integrating nutrition considerations through addressing various underlying causes for undernutrition.

It is important that the programmes adequately integrate nutrition considerations into their objectives, targets, actions, and monitoring mechanisms as envisaged under NSSS, 2015. Therefore, efficient public resource utilization for nutrition requires the incorporation of appropriate nutrition issues into the relevant policies and programs of these ministries. Prioritization of targeting nutritionally vulnerable groups including those specific to urban areasshould be an important mechanism to deliver the social protection program's potential nutrition impact.

Alongside transfers, a simultaneous BCC campaign can significantly improve child nutritional status and anthropometric outcomes. Adding BCC to transfers (cash and in kind) leads to an increase in both "diet quantity" and "quality" in terms of household caloric intake, increased consumption of diverse

food groups by children, resulting in a significant reduction in child stunting at 7.3 percentage points[8]. If this is implemented at scale throughout the country by taking all different geographical, economic, social, and other local contexts into consideration, it is likely to positively impact in reducing stunting and other relevant nutritional outcomes.

1.2. Nutrition situation in urban areas

In general, the nutrition situations are better among urban population than in rural areas in Bangladesh. Dietary diversity, prevalence of stunting, wasting and underweight are better in urban areas, except exclusive breast-feeding practices (Table 1)(BDHS 2022) . However, this average figure masks the existing disparities within the urban population. For instance, 54% , 49.4% and 49.9% infants aged 0-5 months from slums, non-slums and the rest urban areas respectively are exclusively breastfed (EBF) signifying that EBF in urban population in the higher quintiles are less as compared to lowest quintile.. In slums 33.7% under-five children are stunted compared to 27.1% in non-slum and 28.5% in rest urban areas. 15.9% of slum children are wasted compared to 14% and 16.2% in non-slums and the rest of urban areas respectively[9]. Wasting levels in all three urban areas (non-slum, slum, and the rest urban areas) are above the WHO cutoff of 15% for emergency threshold, which is a major concern.

Table 1: Status of various child nutrition indicators in urban and rural areas in Bangladesh

Indicator	Urban	Rural
Stunting (U5)	22%	24
Wasting (U5)	10.9%	11%
Underweight (U5)	20.9%	22.8%
Exclusively breastfed (0-6 Months)	47%%	63%

(Source: Child Well-being Survey 2016, BBS-UNICEF, and BDHS 2022).

According to the Second National Micronutrient Survey (2019-20), Iron deficiency was found to be higher among urban children (22.1%) than the rural children (11.5%), while the national average is 15%. Anaemia was also found to be more prevalent among urban children (27%) as compared to the national average (21%); similarly, vitamin D deficiency was more prevalent among children (19.1% in rural areas, whereas 27.4% in urban areas).

Both underweight (48%) and overweight (12%) are higher among slum adolescent girls compared to non-slum (46.9% -underweight and seven percent-over weight)[10]. Twenty one percent of ever-married slum women are short-statured (height less than 145 cm). In slums, low birthweight is 23.9% compared to 22.1% in non- slums[11]. Thirty five percent of teenage female in slums were married compared to 32.3% in non-slum urban households[12].

8 Ahmed, Akhter; Hoddinott, John F.; and Roy, Shalini. 2019. Food transfers, cash transfers, behaviour change communication and child nutrition: Evidence from Bangladesh. IFPRI Discussion Paper 1868. Washington, DC: International Food Policy Research Institute (IFPRI)

9 Urban Health Survey, 2021, NIPORT, ACPR, March 2022.

10 State of Food Security and Nutrition in Bangladesh 2018-19, National Nutrition Services (NNS), IPHN and JPGSPH, BRAC University.

11 National Low Birth Weight Survey, 2015.

12 Urban Health Survey 2021. NIPORT MoHFW, and ACPR, March 2022.

Nationally, the proportion of overweight among women has increased from three percent to 24% to 49% between 1996, 2014 and 2018-19[13]. The increase of overweight/obesity was more pronounced in urban women. About 70% overweight women are from non-slum dwellers.

The coexistence of over nutrition and undernutrition, even within the same household, is occurring in urban settings.
Nineteen percent (?) of total NCD deaths in Bangladesh can be attributed to dietary risks (????). Prevalence of increased blood pressure, blood cholesterol and cardiovascular diseases is also found higher in urban areas compared to rural areas (WHO, 2018). Diabetes mellitus (DM) prevalence increased across the board from 2011 to 2022, but in 2022, 24% of urban women and 21% of urban men (35+ years of age) had diabetes compared to 14% of rural women and 13% of rural men (BDHS 2022). Hypertension increased in adults (35+) since 2011 and by 2018 affected half of urban women (vs. 43 percent of rural women) and 38 percent of urban men (vs. 33 percent of rural men) (BDHS 2018) All Non-communicable Disease (NCD) risk factors are higher among urban slum adult residents (Rawal, et al., 2017) contributing to enhanced non-communicable diseases and deaths.

WASH-Nutrition Linkage

WASH is closely associated with level of health and nutrition status. For instance, nine percent of deaths and seven percent of burden of disease are attributable to unsafe WASH in children under 5 years[14], constituting almost nine percent of all disability-adjusted life years (DALYs) in this age group[15]. Children are more likely to be undernourished and stunted if they are exposed to Faecal-Transmitted Infections (FTIs)– including diarrhoeal disease and Environmental Enteropathy – or intestinal worms, which are linked to poor WASH and open defecation[16]. Repeated parasitic infections can result in anaemia and inhibit physical and cognitive development. A 20-year multi-country analysis revealed that, five or more diarrhoeal infections in the first 2 years of life accounted for 25% of all stunting observed[17]. Moreover, every five diarrhoeal episodes increased stunting risk by 13%[18]. Repeated episodes of diarrhoea or intestinal worm infections due to unsafe water, inadequate sanitation or insufficient hygiene are associated with half of all malnutrition cases globally[19]. Diarrhoea is a leading cause of death of children under 5 years worldwide, and its constant presence in low-income settings contributes significantly to undernutrition[20].

Education-Nutrition Linkage

Education, particularly, women's education is very important for almost all the nutrition indicators, as completion of secondary or higher education of mother and caregivers is positively related to nutrition

[13] Kennedy G Ballard T, and Dop M. Guidelines for measuring household and individual dietary diversity. FAO.2011.
14 Pruss A, Kay D, Fewtrell L, and Bartram J. Estimating the burden of disease from water, sanitation, and hygiene at a global level. Environ Health Perspect 2002;110(5):537-42.
15 Norman R, Bradshaw D, Schneider M, Pieterse D, Groenewald P. Revised Burden of Disease Estimates for the Comparative Risk Factor Assessment, South Africa 2000. Cape Town: Medical Research Council of South Africa, 2006. http://www.mrc.ac.za/bod/bod.htm (last accessed 31 May 2007).
16 Cumming, O., & Cairncross, S. (2016). Can water, sanitation and hygiene help eliminate stunting? Current evidence and policy implications; Crane et al (2015). Environmental enteric dysfunction: An overview; Checkley et al. (2008). on soil-transmitted helminth infection: systematic review and meta-analysis.
17 Checkley, W; Buckley, G; Gilman, RH; Assis, AM; Guerrant, RL; Morris, SS; Mølbak, K; Valentiner-Branth, P; Lanata, CF; Black, RE. 2008. Childhood Malnutrition and Infection Network. Multi-country analysis of the effects of diarrhoea on childhood stunting. Int J Epidemiol. 37(4):816-30. doi: 10.1093/ije/dyn099
18 ibid
19 Prüss-.stün A, Bos R, Gore F, Bartram J. Safer water, better health: costs, benefits and sustainability of interventions to protect and promote health. Geneva: World Health Organization; 2008(http://apps.who.int/iris/bitstream/10665/43840/1/9789241596435_eng.pdf, accessed 16 October 2015).
20 Liu L, Johnson HL, Cousens S, Perin J, Scott S, Lawn JE et al. Global, regional, and national causes of child mortality: an updated systematic analysis for 2010 with time trends since 2000. Lancet. 2012;379:2151–61. doi:10.1016/ S0140-6736(12)60560-1.

status of pregnant women and children[21]. Moreover, continued schooling of girls results in increased health and nutrition education, increased awareness on nutrition-sensitive issues, more coverage under social security programmes (e.g., school stipend) to ensure resources for food and nutrition and delayed marriage and childbirth. There are evidence of direct relationship of education and intake of healthier and more diverse diet, along with a more balanced and diversified nutritional intake[22]. Improved nutrition in early childhood increased schooling attainment and higher test scores[23]. Another key aspect of education system that affects nutrition of school going children is through the school meal programs.

Social Protection-Nutrition Linkage

Direct undernutrition interventions, even when scaled up to 90% coverage rate, have been estimated to address only 20% of the stunting burden and 60% of severe wasting[24]. Tackling the underlying drivers of nutrition is key to addressing the other 80%. The Benefit-Cost Ratio of social security expansion has been estimated to be about 1:28, meaning one dollar spent on these programmes can result in benefit worth of 28 dollars. The Public Expenditure Review on Nutrition in Bangladesh identified that 98% of public expenditure on nutrition is spent on nutrition sensitive interventions. Moreover, four ministries (i.e., ministries of food, health and family welfare, primary and mass education, woman, and children affairs) account for 80% of the nutrition expenditure in the country[25].

1.3 Relevant Systems for Nutrition in Urban Areas

1.3.1 Urban Health and Nutrition System

Structure and Stakeholders of Urban Health and Nutrition System

The Bangladesh Urban Health Survey (2013) found that 95% of communities within city corporations, including slums, and 90% in municipalities had a health facility available within 2 km. Despite this, the coverage of nutrition services is low and the disparity between nutrition outcomes between slum and non-slum populations is large. In general, there is no dedicated field structure for implementation of nutrition services in Bangladesh. Rather, the existing structures of Health and Family Planning (FP) services provide nutrition services as relevant and additional services under mainstreaming approach. Unlike rural structure, the urban health and nutrition system is not well structured. Urban health services deliveries are divided between multiple providers. A few of the Government Outdoor Dispensaries (GOD), school health clinics and Upazila Health Complex (UzHC) provide nutrition services along with Primary Healthcare (PHC) services for urban people. Tertiary and secondary healthcare facilities under Directorate General of Health Services (DGHS), and the two specialised institutes and 62 Mother and Child Welfare Centers at District headquarters under Directorate General of Family Planning (DGFP) also provide limited nutrition services for urban population.

21 BNNC. 2021. Addressing Bottlenecks for the Coverage of Nutrition Sensitive Interventions in Bangladesh. Bangladesh National Nutrition Council. Dhaka, Bangladesh

22 Andrews, Hannah & Hill, Terrence & Cockerham, William. (2017). Educational Attainment and Dietary Lifestyles. 10.1108/S1057-629020170000018005.

23 Maluccio, John & Hoddinott, John & Behrman, Jere & Quisumbing, Agnes. (2006). The Impact of Nutrition during Early Childhood on Education among Guatemalan Adults.

24 International Food Policy Research Institute. 2016. Global Nutrition Report 2016: From Promise to Impact: Ending Malnutrition by 2030. Washington, DC

25 Bangladesh Public Expenditure Review on Nutrition. 2019. Finance Division, Government of Bangladesh and UNICEF

Local Government Division (LGD), under Public Private Partnership arrangement with NGOs provide PHC services in urban areas through a project funded by Asian Development Bank (ADB). Several NGOs (e.g., BRAC, RADDA, Concern Worldwide, World Vision, Marie Stopes, and the Smiling Sun Network, etc.), through direct DP funding, also deliver primary and comprehensive health and nutrition services under the technical oversight of the DGHS. For-profit private hospitals, nursing, and maternity homes; clinics operated by doctors, nurses, midwives and paramedical workers, and pharmacies provide predominantly curative services and very limited PHC services for the urban population.

Since there is involvement of two ministries, i.e., MoLGRDC and MoHFW, coordination in urban health has been an issue for quite some time. The existing 'Urban Health Coordination Committee' (UHCC), by default, is responsible for coordinating the nutrition services as well. This high-level coordination committee is co-chaired by the Secretary Heath Service Division (HSD), MOHFW and Secretary Local Government Division (LGD). UHCC is scheduled to meet every six months; and the Urban Health Working Group is scheduled to meet quarterly, but meetings are not regular. Furthermore, City Corporations and Municipalities have options to form Standing Committees on health, where expert members can be co-opted.

Gaps and Issues in Urban Health and Nutrition System

- The PrimaryHealthCarehealth system in the urban areas are not as developed as that of rural, especially the health facilities are inadequate in urban LICS. Government-funded health services in the urban areaonly cater to immunization services and Vita min A campaigns. Regular primary health care is provided through NGOs, which hav e been dependent on projects, not mainstreamed yet.
- The available health facilities in urban areas are not adequate to provide health services to the poor population, particularly the growing poor section. Majority 75% of the urban poor seek care from private pharmacies and non-formal or traditional doctors as the first entry point of care. . Evening services are almost exclusively offered by private health service providers. . Insufficient access to public health services by the poor people has opened the opportunity to fill the gap by private for-profit providers and NGOs.
- Maternal and Infant and Young Child Nutrition (MIYCN) remains an underperforming service area in urban settings. Low utilization of health facilities for preventive services and suboptimal quality of services are key challenges. There are significant gaps in the availability of equipment, nutrition commodities and other logistics in health facilities in the urban areas. Stockouts are found to be quite common, resulting in irregular supplement provision from the facilities to the mothers and children including supplies [28] of SAM and MAM management productstherapeutic feeding and medicines. in NGO run facilities in urban areas.

- Although the NPAN emphasizes on life cycle approach for nutritional development, the size and coverage of interventions for adolescents, PNL & NPNL, elderly and disable people are far too below the requirements. Coverage of exclusive breast feeding (EBF) is relatively low in the urban settings because of the high prevalence of C-section deliveries and higher number of working mothers.

- Due to shortage of human resources, particularly physicians and nurses most facilities under city corporations or other government departments located in urban areas usually operate

28 Nguyen, PH; Pramanik, P; Mai, LT; Menon, P. 2020. A Feasibility Study of Integrating Maternal, Infant and Young Child Nutrition Counseling Services in Urban Maternal, Neonatal and Child Health Services in Bangladesh. Alive & Thrive Baseline Survey Report. Washington, D.C.

much below of their capacities to provide PHC services. These facilities usually fail to recruit and retain health human resources because of very limited career progression opportunities[30].

- There are scopes of improving coordination between LGD and MOHFW – the two responsible ministries for urban health and nutrition. Although there are coordination committees, these need to convene regularly with specific targets to be achieved. The LGD circular of March 2021 delineates the responsibilities of LGD,HSD and HED in urban areas and underscores the areas of cooperation and coordination between them. Consistent efforts are required to implement this circular.
- Prevailing gender discriminatory norms and practices affect access to healthcare, health behaviors, and health outcomes. Women have limited freedom and decision-making power over reproductive health independently which creates a barrier for women to receiving MHC services. Husbands were main controllers of all household resources and decisions that lead fewer opportunities for women in making decision about seeking reproductive healthcare services, specially in LICS

- Unstable earnings and unexpected financial shocks, such as medical emergencies, exacerbate the problem, leading to malnutrition as well as obesity. The poor and most marginalised and vulnerable communities also face health risks from unsafe and low-quality foods. These insufficient diets, in terms of both quantity and quality, affect not only the present generation, but the health, productivity and educational development of future generations. This is especially true for young women of reproductive age, the most vulnerable amongst the malnourished, who are at risk of maternal morbidity and mortality and whose condition may negatively impact their children.

- Data for Primary health care and nutrition service delivery specially that of ANC, PNC, growth monitoring, supplementation etc are not regularly monitored, reported and integrated into the DHIS2 due to lack of institutions in the urban settings.

1.3.2 Urban Food Systems

Structure and Stakeholders of Urban Food System

. Food security is governed by several institutions in Bangladesh to reflect the multidimensional nature of food security, including agriculture, rural development, women and children affairs, health, finance, commerce, and disaster management. Three institutional mechanisms are responsible for formulating and implementing food security policies, in particular the National Food Policy and its associated Plan of Action. These are:

a) Food Planning and Monitoring Committee, a cabinet-level committee that provides overall leadership and oversight in the formulation of food security policies.
b) Food Policy Working Group, an inter-ministerial coordination mechanism that facilitates cross-sectoral participation .
c) Thematic Teams, specialized inter-ministerial bodies led by the Food Planning and Monitoring Unit that focus on each dimension of food security and facilitate cross-sectoral collaboration.

30 HSD. 2020. National Urban Health Strategy. Health Services Division, Ministry of Health and Family Welfare. Dhaka, Bangladesh

The Food Planning and Monitoring Unit of the Ministry of Food is responsible for providing secretarial services for these mechanisms and for monitoring and evaluation of the policies. . Activities include collecting, storing, and disseminating information for food security analysis and policy formulation, and delivering evidence-based policy advice to the Government on issues relevant to food security.
The responsibility of ensuring quality of food and food ingredients lies with the Bangladesh Food Safety Authority (BFSA). BFSA is also responsible for enacting relevant food safety related regulations and rules, and the entity has already done several such important regulations. At district and Upazilas level, Deputy Commissioner and Upazila Nirbahi Officers are respectively authorized to implement the Food Safety Act, regulations under this act and other relevant laws to ensure food safety.

The Ministry of Commerce (MoC) regulates the import of food commodities done by the private sector. Trading Corporation of Bangladesh (TCB) is an entity under MoC, responsible for import of food commodities and distribution of those through its own channel of vendors under the Open Market Sales (OMS) mechanism. Directorate of National Consumer Rights Protection (DNCRP) is responsible for addressing complaints regarding quality issues of food, particularly overpricing and adulteration issues.

Unlike other systems, the urban food system is not governed by a single ministry or entity of government. As mentioned before, wet markets are a major source of food for the urban dwellers. While some of these wet markets are being governed by the LGD under MOLGRD&C, several markets are not registered and are being set up by local influential people. There are market committees, i.e., business member organizations (*Bazar Malik Samitee)* of the market-based business owners who govern their respective markets.

Existing Programmes in Urban Food System

For the urban poor and low-income population, Open Market Sales (OMS) is a programme of Ministry of Food under the Public Food Distribution System (PFDS). The budget was 972.9 crore BDT for the year 2020-21, which was equivalent to 114.35 million USD. It covered 867 million urban poor with limited income in city corporations and metropolitans. Dealers are instructed to sell commodities at locations with high population density and poverty-prone areas. However, beneficiaries are not screened when they come to dealers' shop to purchase rice/wheat/flour at subsidized rate.

Scale up the distribution of essential foods through OMS such as rice, wheat flour, and cooking oil along with other nutritious foods at subsidized prices to help stabilize market prices, especially during seasonal price hikes in March-April and September-October can be considered. Prioritize distribution in low-income urban areas by trucks to effectively reach the poorest in addition to strengthening the agricultural supply chains to urban areas.

TCB introduced family card system under which the poor and vulnerable families in urban areas receive cards, which entitle them to receive certain food commodities at a subsidized rate from TCB enlisted dealer shops. Currently there are 10 million of such cards being covered.

Gaps and Issues in Urban Food System

- Unlike rural areas, food commodities are not widely produced in urban areas due to scarcity of cultivable land. Hence, the demands for food of urban population are met either through domestic sourcing or through international import. In both cases, the procurement, storage, distribution, and marketing are entirely done by the private sector. Foods are purchased

predominantly from private sources like wet markets, local shops, and street traders. Supermarkets still have limited penetration and number of wholesale markets and slaughterhouses are inadequate.

- Availability of ready-to-eat, convenient, inexpensive fast and unhealthy foods are abundant in the slums from the local vendors. Community people are highly reliant on fast food (pre- or semi-cooked commercial food typically containing high trans-fat and high salt and sugar contents), particularly for breakfast and snacks[32]. Children are highly attracted to these unhealthy foods for their tiffin. However, often these foods are sold in open space, without having any safety standards.

- In cities, street foods are cheaper and more convenient than cooking at home, making it especially attractive to low-income families[33]. However, food safety is a common concern especially with foods prepared in unhygienic conditions in urban street markets and by street vendors. Furthermore, street foods are often high in sugar/starch, salt and fat which may contribute to increasing levels of overweight/obesity and NCD related morbidity and mortality.

- The mobile vendors, i.e., those selling food on small carts or rickshaw vans are also not regulated or supervised by any government entities. In most of the cases, these mobile vendors are allowed by local influential against an informal service charge, and the quality of their commodities being sold is completely unregulated.

- OMS for eggs, onions and vegetables have recently been introduced with a limited operation.during the price hike

- Due to the shortage of the personnel, particularly Food Inspectors, the enforcement activities of BFSA are limited.

- Though availability of foods in urban is not difficult even within the slums, the price of them, particularly the fresh items, is high in comparison to rural areas. Most slum dwellers cook their food once a day and store it at room-temperature. The kitchen and the space for food preparation are often unhealthy, with high exposure to dust and other contaminants.

Food crisis, existing malnutrition conditions and gender aspects are interlinked. Research shows that many women in Dhaka are aware of the importance of healthy eating practices. But Food taboos prohibit women from eating certain foods during pregnancy. For example, papaya and pineapple are believed to lead to miscarriage, green coconut makes babies' eyes grey or 5 cloudy, catfish makes the baby's mouth wide as the fish, and consuming eels causes epilepsy in babies. Women's limited mobility is another important determinant of women's participation in food systems. (specially in LICs and lower middle class)

- Without specific complaints from consumers, DNCRP often cannot act on its own. While DNCRP has been seen very active for addressing complaints against restaurants in the urban areas due to complaints from consumers, their activities are not very prominent in wet markets. This is predominantly due to lack of awareness of the consumers of these wet markets, i.e., urban poor and urban slum dwellers regarding quality of commodities and the

32 Farhana, N. and Islam, S. 2011. Exploring Consumer Behaviour in the Context of Fast Food Industry in Dhaka City. World Journal of Social Science. 1(1): 107-124

33 Brauw et al. 2019. Food Systems for Healthier Diets in Bangladesh: Towards a Research Agenda. IFPRI Discussion Paper 01902, December, 2019

channels for complaints. The city corporations are supposed to be active in regulating quality of food, however, their activities are not visible anywhere, unless for specific occasions like Ramadan in which there are demands and quality concerns for a few food ingredients.

- Urban food wastage is a significant concern in Bangladesh, particularly in densely populated urban areas like Dhaka and Chittagong. Limited access to proper storage facilities and inadequate handling practices contribute to food spoilage and wastage. In urban areas where space is scarce, many households lack proper refrigeration or storage facilities to preserve perishable foods. As a result, fruits, vegetables, and other perishable items often spoil before they can be consumed.

- The lack of a robust cold chain infrastructure in the urban food supply chain hampers the preservation and transportation of perishable foods. This leads to post-harvest losses and food wastage, particularly for highly perishable items like seafood, dairy products, and fresh produce. Inefficiencies in the urban food supply chain, including inadequate transportation and distribution systems, contribute to food wastage. Delays in transportation and poor handling practices during transit result in spoilage and deterioration of food products before they reach the consumers.

- The number of the poor and undernourished are increasing faster in urban slums than in rural areas. Nearly two thirds of urban children are not getting age-appropriate diets to meet their nutritional needs and to achieve optimum growth and development. Urban slum children are having a less diversified diet (in between 2011 and 2014, Minimum Dietary Diversity (MDD) decreased by 15% in urban slums but increased by four percent in non-slum areas in urban in the same areas, BDHS 2011 and BDHS 2014). Minimum meal frequency is higher among non-slum children (76%) than slum children (64.5%)[34].

- According to the Household Income and Expenditure Survey (HIES) 2022, between 2010 and 2022 the consumption of rice has decreased in both rural (17%) and urban (21%) households. On the other hand, increased consumptions were revealed of pulses by 20.5% (rural) and 15.7% (urban); vegetables by 20% (rural) and 30% (urban); meat by 141% (rural) and 51% (urban); and fruits by 113% (rural and 109% (urban). Furthermore, though the consumptions of fish and milk & milk products have increased in rural areas by 14% and 0.9 percent respectively, however, contrarily the consumptions of these items have decreased by 20% and two percent respectively among urban households.

1.3.3 Urban WASH Systems

Structure and Stakeholders of Urban WASH System

In the large four city corporations (Dhaka, Chittagong, Rajshahi and Khulna), it is the responsibility of the respective Water Supply and Sewage Authority (WASA) to provide the WASH services. These are state -owned entities/companies under the supervision of the Local Government Division (LGD) of MOLGRD&C. In other city corporations and municipalities, the responsibility to provide WASH services lies with the Department of Public Health Engineering (DPHE), another entity under LGD. WASA and DPHE have, in general, outreach services in the slum areas though they are very limited. The private sector, particularly local influential persons, work as the provider of WASH services in these areas,

34 Child Well-Being Survey 2016, Divisional Reports. Bangladesh Bureau of Statistics and UNICEF Bangladesh 2016, Dhaka, Bangladesh

often illegally and at an exacerbated price[35]. Several UN and multilateral organizations, INGOs and NGOs, are also providing services under the funding from development partners through state and community-based approaches.

Existing Programmes in Urban WASH System

A considerable portion of domestic and external investment in urban areas has gone into urban water supply. The World Bank has been among the first agencies active in the sector and focused on water supply for Dhaka and Chittagong for almost four decades. . Later, ADB was assisting in the rehabilitation and augmentation of water supply systems in Dhaka; DANIDA was to fund the building of a water treatment plant in Dhaka; and the World Bank emphasized on extending these systems to slums. JICA approved a large loan for a water supply project in Chittagong. ADB had, until 2007, dealt mainly with water supply in secondary towns; DANIDA and the Netherlands, worked in some secondary towns as well.

The World Bank launched a major project in Dhaka for drainage and sewerage at the end of 2008. Investments for drainage have generally worked well, although unplanned urban development reduces the impact of the drainage works. Moreover, the actual supply falls short of the demand because of the fact that . the project funding was insufficient to meet the actual need in the towns it covers.

Although at least half of the urban projects of the four development partners (WB, ADB, JICA, FCDO) have had useful components of urban solid waste management, there have been few dedicated projects, and hardly any successful sanitary landfill undertakings in the country. Most of the projects are dealing with garbage disposal and hygiene awareness. A few small dedicated Japanese projects have done pioneering work in Dhaka, including creation of a landfill outside the city. In addition, ADB is supporting eight landfill sites, but the progress is slow.

Over many years, UNICEF Bangladesh has been supporting the provision of improved WASH services to the LICs of Dhaka; experience and expertise that has led to an effective service delivery model that could be used as a template in other similar cities. This model has led to fruitful partnerships with relevant government agencies, non-governmental organisations (NGOs), and other development partners in addressing the WASH needs of the most vulnerable and poorest households in Dhaka LICs. Some INGOs and NGOs have been partnering urban WASH programs in designated slums of city corporations and municipalities to achieve targeted goals such as i) reducing WASH deprivation, (ii) improving the systems for pro-poor WASH services, and (iii) upgrading the WASH policies and strategies.

Gaps and Issues in Urban WASH System

- Though access to improved water source is almost universal among all urban dwellers including slums (97.7%), sharing of drinking water source is common and very high in slums-77.7% compared to 41.5% in non-slums. 54% non-slum households use improved-not shared toilet facility compared to only 27.9% by slum households[36]. Furthermore, 78.5%, 72.1% and

35 Oxfam. 2014. WASH Challenges in Slum Areas of Dhaka City.
36 Urban Health Survey 2021. NIPORT, ACPR 2022.

only 49.2% households use water, soap, and other cleansing materials/agents at the place of hand washing facilities[37].

- Low pipe water supply has been due to a lack of investment funds, often coupled with such systemic constraints as political control over the setting of water tariffs and inadequate operational and financial capacity of water supply services. The tariffs and the revenue they generate have remained too low to fund either investments to improve the water supply infrastructure or adequate repair and maintenance work on existing systems.

- Only 19% of the households had an improved sanitation facility in slum areas compared to 51.3% of the non-slum households in urban areas[38]. Sanitation coverage is higher in Dhaka, where 25% of residents are served by a sewer network. The rest of the population uses on-site options as septic tanks, pit latrines, and unhygienic latrines.

- Only one wastewater treatment plant exists in Dhaka and has a limited capacity. Most wastewater is discharged untreated directly into rivers. Although the sanitation coverage in urban centres is slightly better than before, systems in many high-density urban areas are restricted by a lack of space for developing sewerage treatment plants and networks[39].

- Due to limited availability, sharing of toilet facility is a common sight in urban slums, with an average of 16 households sharing one toilet[40]. When considering faecal sludge management, only two percent of these households were found having access to safe sanitation. Water and sanitation services were found to be operated by middlemen at various stages of service provision such as installation, management, and payment collection.
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  Urban women have limited access to gender friendly toilet facilities while a majority of them lack menstrual hygiene management facilities. Most of the women and girls, though bearing the primary burden of water collection and household hygiene responsibilities, are often subjected to gender-based violence either in the form of physical assault or verbal abuse. Very few of them can control the water resources or take part in the decision-making process. In general, the perception of access to WASH is typically biased in favor of men as the women are responsible for household chores and they seldom can make decision on purchasing hygiene products including menstrual pads.

- Occupational Health and nutrition of workers engaged in waste disposal are not adequately taken care of.
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1.3.4 Urban Education Systems

Structure and Stakeholders of Urban Education System

37 Urban Health Survey 2021. NIPORT, ACPR 2022.
38 Child Well-Being Survey 2016, Divisional Reports. Bangladesh Bureau of Statistics and UNICEF Bangladesh 2016, Dhaka, Bangladesh
39 ADB, 2016. Dhaka Water Supply Network Improvement Project: Report and Recommendation of the President. Asian Development Bank. Manila, Philippines.
40 Arias-Granada, Y; Haque, SS; Joseph, G; Yanez-Pagans, M. 2018. Water and Sanitation in Dhaka Slums: Access, Quality, and Informality in Service Provision. Policy Research Working Paper, World Bank Group

Bangladesh has a centralized Education system administered by the Ministry of Education (MOE) with two divisions, the Secondary and Higher Education Division and the Technical and Madrasa Division, and the Ministry of Primary and Mass Education (MOPME) with their offices at different geographical/administrative tiers. The MOPME and Directorate of Primary Education (DPE) are responsible for planning and management of primary, mass, non formal and pre-primary education. The MOE, Directorate of Secondary and Higher Education (DSHE), Directorate of Technical Education (DTE) are responsible for post-primary education.

The governance or stewardship for urban education is steered through primary and secondary educational offices situated in districts and Upazilas. In addition to the existing mainstream GOB entities, education services in urban areas are also provided by commercial/private providers, religious entities, etc. There are plethora of kindergartens and private primary and high schools, mostly English medium run primarily for children from affluent society. MoPME is primarily responsible for the education of poor children, both formal and non-formal. In the slum areas, several NGOs provide nonformal education services targeting poor and dropout children. MoWCA also run a non-formal education programme in urban slums of Bangladesh.

Existing Programmes in Urban Education System

There are about 2.9 million pupils (16%) under regular school feeding (fortified biscuits) program, a highly nutrition sensitive scheme is targeted to only the rural children. 75g packet and 50g packet of biscuits are given to primary and pre-primary school children respectively three days per week. The biscuits provide 338 kcal/day to primary school children and 225 Kcal/day to pre-primary school children and meet 67% of their daily micronutrient requirements. School feeding offers children a regular source of nutrients for their mental and physical development and help to reduce the prevalence of anaemia by up to 20% in girls[43]. In addition, school meals programs serve as one of the Social Protection Programmes (SPP). Secondly, the stipend scheme of students accounts for 55% of the total Social Security beneficiaries-the highest provider[44]. . The National School Meal Policy has been approved in August of 2019 aiming to transit from current School Feeding Programme (fortified biscuits) to a School Meal Programme (nutritious cooked meal) to cover all school going children in phases all over the country.

With the funding from the World Bank, MoPME implemented the Reaching Out of School Children (ROSC) Phase II, which introduced a pilot ROSC project for urban children in selected areas. Before the completion in 2022, the project worked in 15 slums in Dhaka city through establishment of learning centres for children of age 8 to 14 years that were out of school. The project also had a voucher scheme to finance tuition and education allowances for 700 children being engaged as domestic help[45].

Gaps and Issues in Urban Education System

- In some urban areas, access to any form of education is limited due to inadequate number of educational institutions in the vicinity of urban slums and squatters. .
- Disparities exist in urban areas in terms of the quality of schooling children receive. The gap in total years of schooling between the richest and poorest 20% of the population has been

43 DPE. 2020. Operational Guideline for School Meal Programme in Bangladesh (Draft). Directorate of Primary Education, Ministry of Primary and Mass Education. Dhaka, Bangladesh

44 Household Income and Expenditure Survey 2016, Bangladesh Bureau of Statistics (BBS)

45 Independent Evaluation Group (IEG). 2022. Implementation Completion Report (ICR) Review: Reaching Out of School Children II (P131394).

found to be greater in urban than in rural areas, especially in slums, where public education options are limited. At the secondary school level 21.1 percent of children are out of school and for girls the percentage is 33.7. Proportions of out-of-school girls of secondary school age in urban area is higher (38.3 percent) than that of rural areas (32.6 percent)[48]. High school dropout of slum/poor children especially the girls has been a major challenge in urban education sector. Most of them get involved in doing household chores, income earning activities, child labour/domestic maid or end-up in early marriage, etc. All of which have ramifications on the negative health, nutrition outcomes of their own and their future children as well.

- 55% of children dropped from secondary education were involved in income generating activities. Adolescent girls were engaged in income earning activities (e.g., housemaids and factory workers, etc.) which often motivated their parents to discontinue their education. Sometimes, if both parents were engaged in economic activities, they prefer their adolescent daughter to get involve into household activities rather than pursue education.

- Inadequate sanitation, water and washing facilities at school hinders girls' attendance, and particularly for post-menarche girls when their menstrual hygiene management (MHM) needs are not addressed.

- Children with disabilities also face difficulty to attend school when accessible WASH facilities are unavailable or inadequate.

1.3.5 Urban Social Protection Systems

Structure and Stakeholders of Urban Social Protection System

In general, there are more than 120 SSPs in Bangladesh, implemented by around 23 Ministries and Divisions[53]. Allocation in SSPs was around 1,076.04 billion BDT in 2021-22, which was around 12.58% increase from the allocation in 2020-21, and roughly 3.11 percent of the country's GDP and 17.83% of the national budget of 2021-22 financial year[54]. However, there is no separate provisions for rural or urban social protection system, under the National Social Security Strategy (NSSS), 2015 .

The Cabinet Division is the overall lead authority of Social Security Policy and reforms related with Social Security. With technical support from the General Economic Division (GED) of Ministry of Planning, the Cabinet Division is responsible for the development of the comprehensive Action/Implementation Plan of NSSS based on the plans submitted by the individual implementing and lead ministries . The NSSS has placed the responsibility of coordinating and monitoring of its implementation on the Cabinet Division through the Central Management Committee (CMC) on Social Security , headed by the Cabinet Secretary. The CMC provides backstopping technical, financial, administrative, and logistic support to the line Ministries and Divisions. The Social Protection section of the Cabinet Division provides all sorts of administrative and secretarial services to the CMC. The CMC also coordinates the implementation of Social Security reforms, ensuring inter-ministerial coordination, crisis mitigation and reviewing performance of the social security programmes implemented by different ministries.

[48] https://socialprotection.gov.bd/wp-content/uploads/2017/08/Gender-Diagnostics-of-Social-Protection-Issues.pdf

53 Finance Division. 2021. Budget Document of 2021-22. Finance Division, Ministry of Finance. Dhaka, Bangladesh
54 ibid

The prominent ministries/divisions involved in the implementation of SSPs, include Ministry of Women and Children Affairs (MoWCA), Ministry of Social Welfare (MSW), Ministry of Food (MoFood), Local Government Division (LGD), MOHFW, MOE, MoPME and Finance Division. Ministries implementing SPPs have been clustered into five Thematic Programme Clusters, with one lead ministry for each cluster (e.g.–Social Allowances, Food Security and Disaster Assistances, Social Insurance, Labour/Livelihoods Interventions and Human Development and Social Empowerment).

GED is responsible for results-based M&E of Social Security Programmes and coordination of Social Security plans and policy with five-year plans & other national strategies. Implementation Monitoring and Evaluation Division (IMED) is responsible for monitoring and evaluation of implementation of projects/programmes.

Ministry of Finance approves and disburses public-financed Social Security budget and track financial delivery. The Local Government Institutions (LGIs) help identify beneficiaries following a community participation approach, provide support in resolving grievances and disputes relating to the implementation of NSSS, assist in the implementation of M&E efforts, and support ministries in the delivery of programmes at the root level.

Existing Programmes in Urban Social Protection System

Although there are more than 120 SSPs being implemented in Bangladesh, quite a small number of these programmes have targeted the urban dwellers in the country. As mentioned in Urban Food System – OMS and TCB cards are two SSPs of MoFood for the urban population in Bangladesh. Assistance for Working Lactating Mothers project of MoWCA was targeted for working mothers in urban areas, particularly in the industrial zones. Recently this programme was merged with the Mother and Child Benefit Programme (MCBP) of the same ministry.

Some of the SSPs of MoSW, namely, “Allowance for Widow, Deserted and Destitute Women”, “Old-age Allowance”, “Allowance for Persons with Disability” and “Allowances for Financially Insolvent Disabled” and one SSP of MoEducation, titled “Secondary and Higher Secondary Stipend Program” are being implemented throughout the country, with scope of access for urban population having the required selection criteria. Apart from these, there are very limited scope for urban population to get into SSPs.

Gaps and Issues in Urban Social Protection System

- Nutrition-related vulnerabilities (e.g., families with severe or moderate acute malnourished children, pregnant and lactating mothers with anaemia or similar micronutrient deficiencies), were not often taken into consideration when designing and implementing SSPs but have been shown to give significant positive impacts on nutrition outcomes when they were taken into consideration. Most SSPs which could have an impact on nutrition outcomes, do not contain nutrition-related objectives and indicators within their monitoring and reporting framework, making it difficult to tell what their impact on nutrition outcomes are or could be.

- Most SSPs included women as eligible beneficiaries, and many prioritized their inclusion, with some exclusively targeting women. However, ensuring women benefit from these SSPs fully proved difficult due to their limited economic choices and control over resources, possibly leading to allowance diversion from buying nutritious food to other household activities. Allowance amount may also need to be thought of as it seemed to be inadequate to address their specific vulnerabilities.

- The 2022 HIES data shows that 37.6% of the households have received benefits from SSPs during the previous 12 months of the survey. However, MICS 2019 report reveals that 55% of the household members from two of the lowest wealth quintiles received some/any type of social transfer in previous three months of the survey. About 11% of people in urban areas are covered by social protection whereas 19% of urban population is poor, whereas the coverage in rural areas is higher than the poverty rate, with programs reaching 36% of people, while 26% live in poverty[55]. That means, number of programs operating in the urban areas and their coverage are very low as compare to rural areas.

- The NSSS, 2015 does not provide differentiated focus on tackling urban vulnerability issues . A draft of the Urban Social Protection Strategy and Action Plan in Bangladesh, 2020 has been prepared by the Cabinet Division and the General Economics Division, . the broader goal of which is to integrate urban risk and vulnerability issuesinto the overall national social protection system of the country. The strategic direction of urban social protection is to adaptprogrammes from the rural aeras to the urban areas, introduce social insurance and devise programme measures to tackle the challenges of urban poor living in slum like situation[56].

- Operation research, as well as evaluation of the effectiveness of SSP, are ex limited. Additionally, pilot programs for health vouchers/health insurance are not independently evaluated.

- Apart from inadequate nutrition sensitive components in the urban settings, social security in Bangladesh still faces the following serious shortcomings: (a) its impact is diluted owing partly to very thin spreading of resources and partly to diversion of resources to non-poor households, (b) it fails in one of its most crucial functions, namely, to enable poor households to cope with shocks better, and (c) it bypasses the urban poor[57].

Maternity benefits, childcare and health insurance are some of the key requirement of the working women in urban settings. Women often resort to their immediate families or kin to take care of the children and elderly while they are out on work. As more women are moving to urban areas for work, specifically in RMG sector, they are gradually losing the support from relatives for childcare. The need of child and elderly care is a phenomenon more acute for the working women in the urban areas.

1.3.6 Cross-cutting Themes

Gender Equality and Nutrition

Bangladesh has achieved gender parity in nutrition and in fact, females in all age groups are nutritionally better-off (except overweight and obesity) compared to their male counterparts. Despite this achievement, 28.9% of girls and women between the ages of 15–49 suffer from anemia[58]. Additionally, almost half of the pregnant women in the population suffer from anemia, which is a key indicator for maternal health and nutrition[59]. Limited access to nutritious food and health care affects pregnant and lactating women who require increased nutrients including higher iron and folic acid intake during pregnancy due to physiological factors. Limited access to nutritious food and

55 World Bank. 2021. Bangladesh Social Protection Public Expenditure Review (PER). Dhaka and Washington, DC: World Bank Group.

56 Urban Social Protection Strategy and Action Plan in Bangladesh, January 2020.

57 S. R. Osmani, ,Akhter Ahmed, Tahmeed Ahmed ,Naomi Hossain, Saleemul Huq, Asif Shahan, Strategic review of food security and nutrition in Bangladesh, 2016,WFP

58 National Micronutrient Survey 2019–2020

59 Bangladesh Demographic and Health Survey 2022

consumption practices also affect adolescents and young children who require higher nutrient intake during their growing years.

Besides this, child marriage, one of the root causes of intergenerational cycle of malnutrition remains very high in Bangladesh which is enrooted deep into the societal norms. Discrimination against women and girls are more pronounced on urban slums having huge negative impact on their health and wellbeing.

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Decision-making autonomy of women and girls in accessing health and nutrition services for their own and children remains a critical issue. Obstacles include a lack of economic independence, social and cultural norms, lack of nutrition knowledge, caregiving burdens (particularly lack of childcare support for working mothers)and structural barriers, i.e., location of health facilities, cultural competencies of health care providers, and the sex of service providers are major determinants in the lack of access to health services[60]. Women's status or power impacts child nutrition because women with higher status have better nutritional status themselves, are better cared for, and provide higher quality care to their children. Increases in women's status or power have a strong influence on both the long- and short-term nutritional status of children, leading to reductions in both stunting and wasting.

Climate Change, Disaster emergencies and Nutrition

Existing climate change impact projections for Bangladesh include higher temperatures and sea-level rises[61]. These projections are expected to result in increased frequency, intensity and erraticism of cyclones, flooding, salinity intrusion and drought events affecting livelihoods and public health in Bangladesh. Consequently, pushing greater migration towards already stressed urban centers[62]. Loss of arable land is a major concern due to sealing, urbanization, and the rise of sea levels.

An immediate threat of climate change and disaster on health and nutrition is its potential effect on the continuity of services. Both human resources and the physical infrastructure of health and nutrition services can be affected by the increased prevalence of extreme weather events. Due to climate change the nutrient composition of some crops as well as the ease of growing them are likely to change resulting in food and nutrition insecurity in the long run. Elevated atmospheric CO_2 levels and increases in temperature will reduce crop yields as well as low nutrient density in a range of staple crops[63]. There is a significant impact of these issues in urban areas, as rapid migration happens mostly to urban areas from climate induced rural geography. Such migration has adverse impact on increased food price, food supply, burden on health facilities and other determinants of nutrition.

2. GOAL

The goal of the Multisectoral Urban Nutrition Strategy (MUNS) is to nurture a shared understanding and coordinate strategies across different sectors to addressing the barriers that affect nutritional status of urban populations across the life cycle, including poor and disadvantaged to develop them as strong human capital.

[60] Bangladesh Health Sector Need Assessment, ADB report, 2022.

[61] Karmalkar et al. (2010). UNDP Climate change country profiles: Bangladesh. http://www.undp.org/content/undp/en/home/librarypage/environment,energy/climate_change/adaptation/undp_climate_changecountryprofiles.html, accessed March 2018.

[62] USAID (2016). USAID/Bangladesh comprehensive risk and resilience assessment. Washington, DC. https://www.usaid.gov/bangladesh/documents/2016-comprehensive-risk-and-resilience-assessment. Accessed March 2018.

[63] Myers, SS, Zanobetti, A, Kloog, I et al. (2014) Increasing CO_2threatens human nutrition. Nature 510, 139–142.CrossRefGoogle ScholarPubMed

2.1. Objectives

MUNS essentially accommodates the philosophy of National Nutrition policy 2015 and its plan of action 2016-2025 with specific focus and objectives in the urban areas.

The objectives of the MUNS are to:

- Lay out a broader framework to facilitate coherence of policies and strategies to address urban nutrition for relevant systems including health, food, WASH, education, and social protection.
- Provide a common reference for developing implementation plans and guidelines for nutrition specific, gender responsive and iclusive programmes across relevant systems and sectors to address urban nutrition.
- Strengthen governance, coordination and monitoring of nutrition plans and programmes across systems and sectors.

3. STRATEGIES

Based on the desk review, field visits, stakeholder consultation workshops and Key Informant Interviews (KIIs), several challenges were identified across the five systems under consideration. Among those, for this strategy, the challenges having impact on nutrition have been considered for addressing through the strategies of the MUNS. Some of the challenges identified are specific to each sector which are beyond the scope of MUNS, thus need to be addressed by the sector itself without involvement of other sectors (multisector actors).

Box 1: The basis of considerations for identifying challenges were as follows:

a. The systemic issues have been looked precisely through the nutrition and urban lens, not on the whole spectrum of system issues that is kept outside the purview of this urban nutrition strategy.
b. The strategy broadly captures the issues and challenges that exist in urban areas, without any specific reference to the different categories of the urban local bodies.
c. Challenges that refer to structural constraints and are of cultural nature, and thus need long time to address were not considered when designing strategies to make these feasible and time bound.
d. Challenges have been categorized into three areas: i) Policy and Strategy -those are associated with regulatory environment such as Acts, Policies, and Plans etc.; ii) Program – size and implementation modality, and iii) Governance, coordination, and monitoring.
e. Designed strategies are aligned as much as possible with existing sectoral policies and strategies, and thus should be complementary.

Box 2: The strategies included in the MUNS have the following principles

i. These strategies are inclusive of all urban areas and all urban population, although special emphasis has been given on urban areas with higher population number and density and urban poor.
ii. The strategies are not, in general, service provision strategies, but rather related to system development and strengthening coordination . The services will be provided under the respective systems through their respective plans. The MUNS will help the respective strategies to ensure nutrition-sensitivity in their interventions for urban populations and will support in the multisectoral nutrition coordination among the sectors under consideration. The overall objective here is to guide the sectoral activities in contributing towards the human development goals through nutritional development, as specified in the SDGs. .

3.1 Strategies for Urban Health and Nutrition System

3.1.1 Challenges in the Policies and Strategies

i. Nutrition components are marginal in the National Urban Health Strategy 2020. In this strategy, nutrition under the health sector only refers to BCC and does not include nutrition-specific interventions and that there is no linkage between nutrition under the health sector and other sectors that can be nutrition-sensitive.

ii. Limited linkage of urban health strategy with other sectors to address the underlying determinants of nutrition. Delivery mechanism for the nutrition component of the Bangladesh Essential Service Package (BESP) 2016 does not include provision of nutrition services at domiciliary level and satellite clinics in urban areas.

iii. Emerging nutrition issues such as overweight and obesity are not included in the BESP 2016.

iv. Most households are obtaining most of their health and nutrition services from the private sector and that out of pocket (OOP) expenditure is rising with drugs constituting 64% of OOP expenditure (Bangladesh National Health Accounts (BNHA) and Household Income and Expenditure Survey). With virtual absence of health insurance This affects lower income and poor people adversely, resulting in low use of health and nutrition services by poor.

v. Some of the gaps in urban areas due to limited public PHC infrastructure in urban areas, have been filled by NGOs and mostly by private for-profit provider or facilities, which have flourished in an unregulated market (Evans & Alam, 2017).

vi. Existing nutrition programs and interventions have inadequcies in terms of coverage and gender inequality context and thus intersectionality and differentiated vulnerability aspects are being missed out from systems, structures and services.

vii. **Financial and Systemic Barriers**: The challenges in providing comprehensive maternal and child nutrition services are compounded by financial constraints and a lack of robust community engagement. Few mothers receive home visits for child nutrition, and there is limited involvement in community-based nutrition programs. These gaps in outreach and support highlight the need for a more integrated approach to MIYCN, one that not only strengthens provider knowledge and skills but also enhances community-level interventions and encourages broader social behavior change.

viii.

3.1.2 Strategies to Address Challenges in Policies and Strategies

i. Update National Urban Health Strategy 2020 to integrate gender responsive and inclusive nutrition services as a central element and establish multisectoral collaboration with other urban systems for improvement of nutrition.

ii. Update the BESP, 2016 to incorporate emerging nutrition issues (e.g., overweight and obesity, unhealthy diets etc.) and provision of service delivery mechanism at domiciliary and satellite clinics.

iii. Redesign social protection strategies to address nutrition objectives and targets for the urban poor who are most vulnerable, marginalised and excluded(e.g., introduction of evidence based health vouchers or insurance program, maximizing benefits of existing health protection schemes, etc.). Schemes like the Maternal Voucher Scheme (MVS) and the Shasthyo Shuroksha Karmasuchi (SSK) are good initiatives for extending social protection; however, the scope of services needs to be broadened in the context of UHC.

iv. Introduce a health card scheme for floating population, slum dwellers and urban poor to receive services from selected/enlisted private facilities.

v. Strengthen the policies and institutions to regulate the quality of services provided by the private healthcare institutions in urban areas.
vi. Promote guidelines and protocols for provision of Multiple Micronutrient supplement along with IFA to the specific target group (pregnant, lactating and NPNL women)

3.1.3. Challenges in Program Design and Implementation, including Resource Allocation

i. All forms of malnutrition (e.g., stunting, wasting, underweight and micronutrient deficiencies, etc.) are high among urban slums' children and women except overweight and obesity. However, the overweight and obesity among non-slum women are increasing very fast.
ii. Inability of the urban health system, particularly at the primary level, to keep pace with rapid urbanization.
iii. Public healthcare facilities are usually at the periphery or away from the slums, except in some cities where some clinics have been established inside the slums, mainly run by NGO partners/ Pvt sectors. Thus, most urban health facilities do not provide adequate HNP services and are not accessible to the poor population, particularly slum dwellers.
iv. PHC services from the health facilities in the slums (by the NGO providers) predominantly consists of Maternal, Neonatal and Child Health (MNCH) services, with very limited services for adolescent boys, young men, geriatric population, and children of aged 6 to 10 Growth Monitoring and Promotion (GMP) not-frequently done at health facilities in the slums.
v. Limited availability of human resources with required skills in public service delivery system particularly nutrition services. Lack of standard training system to capacitate service providers to deliver nutrition services mainstreamed within health system.
vi. Shortage of equipment, nutrition commodities and other logistics in health facilities in the urban areas.
vii. Quality nutrition services are lacking by the community health workers, in all urban settings, particularly poor nutrition counselling service in terms of environment and HR capacity.
viii. Limited demand generation activities to mobilize people and inadequate access to information on knowledge, attitude, and practices resulting in weak community engagement. .
ix. High mobility of the slum dwellers. This hinders the service providers the ability to track the recipients and provide a full range of PHC services, including nutrition counseling.
x. Government reporting and recording systems are not always efficient to capture sex and gender disaggregated nutrition specific data and information due to lack of capacities and institutions. As a result, gender integration into nutrition services sometimes becomes challenging.
xi. Health facilities often lack inclusive and gender-friendly physical infrastructure (like a separate corner/space for breastfeeding to maintain safety and privacy) and adequate gender sensitivity among staff to provide good quality, gender-responsive services to people—especially those with special needs and vulnerabilities.
xii. There is a lack of healthcare facilities that provide special care and support to women who are victims of GBV.

3.1.4. Strategies to Address Challenges in Program Design and Implementation, including Resource Allocations

i. Design and implement urban nutrition interventions that consider the specific needs of PL women, men, children, adolescent girls and boys, elderly and marginalized populations including disables.
ii. Put specific emphasis on urban Health and Nutrition in upcoming 5th HNP sector program for strengthening primary care on health, nutrition, and FP services in urban areas.

iii. Strengthen existing PHC facilities of MOHFW at urban facilities (e.g., Government Outdoor Dispensaries, School Health Clinics) with appropriate HR, logistics and equipment. Strengthen urban PHC facilities with appropriate medicines, logistics and equipment.

iv. Improve accessibility of urban slum dwellers to urban health facilities through strategies, including, arranging evening services in all PHC facilities, arranging evening satellite and mobile clinics, and introducing nutrition services as per updated ESP to all service providers (pubic, for-profit, and not-for profit organisations). Collaborate with non-government and private sector for expanding PHC services in urban areas where feasible, under the strategic partnership agreements.

v. Coordinate with industry member associations (e.g., BGMEA, BKMEA and BTMA) to strengthen the PHC services, including nutrition services, for the industrial workers within and/or surrounding industrial setup.

vi. Contract-out PHC services to competent NGO providers in urban areas, particularly poor areas through the strategic partnership agreements. Contract-out underutilized public health facilities (e.g., 10 bed hospitals) at urban areas to NGOs to be used for PHC service delivery, including nutrition services.

vii. Improve HR capacities for provision of quality urban PHC services, including nutrition services (e.g., nutrition counseling), through revising job descriptions of the PHC staff, filling up vacant positions and provision of appropriate pre-service training.

viii. Strengthen competency-based nutrition in-service training for all HNP service providers including urban, along with refresher training, including those from NGOs and private sector.

ix. Establish an uninterrupted supply chain management of nutrition service-related essentials (drugs/supplement/therapeutic food/ equipment/ BCC materials / logistics etc.) across GOB-NGO-private delivery system.

x. Increase community awareness on nutrition and availability of nutrition services at PHC level through utilizing the grassroot level social and community organisations, social media and engaging the male household members.

xi. Mainstream the successes of the nutrition programs.

i. Allocate adequate resources within government urban nutrition programs for collecting sex and gender disaggregated data information and for capacity building of officials, awareness creation and inclusive infrastructure

ii. Alternative mechanism should be established to continue the nutritional service delivery in the disaster situation specially, at the shelters and LICS.

3.1.5 Challenges in Governance, Coordination and Monitoring

i. There are scope to improve coordination between MOHFW and LGD under the MoLGRD&C, NGOs, and private sector for provision of HNP services in urban areas.

ii. Inadequate capacity of urban local governments to deliver health and nutrition services in terms of budget, human resource, technical facility, and management.

iii. Inadequacy in the existing monitoring and supervision system across urban health and nutrition service delivery system.

iv. Short of a common and interlinked information system (DHIS2) of urban health and nutrition services by all type/kind of providers.

v. Private sector health service providers (e.g., RMG) are not trained and utilized by the government to deliver / ensure access to ensuring nutrition services for the vulnerable.

vi. Limited collaboration with the Ministry of Labour and Employment (MoLE) and private sector stakeholders to integrate maternity protection in workplaces.

vii. HR and institutional mechanism working in the project are not mainstreamed .

viii. Involvement of MOWCA in Urban Health and Nutrition coordination system is inadequate.

3.1.6 Strategies to Address Challenges in Governance, Coordination and Monitoring.

i. Improve Urban Nutrition Governance (coordination, planning referral, regulations, and financing, etc.) through strengthening multisectoral nutrition governance platforms like BNNC. Improve institutional capacity for coordination, advocacy and social mobilization, monitoring, and supportive supervision for follow up and corrective action.

i. In line with BNNC guidance, City and Municipal governance will uphold the gender mainstreaming approach into the Multisectoral Nutrition Governance mechanism to ensure urban nutrition services are gender responsive through proper planning, budgeting, implementation, and monitoring. This also requires strong coordinated efforts with Ministry of Women and Children AffairsInstitutionalize engagement of local government actors and the community for generation of additional resources for effective functioning of PHC facilities.

ii. Implementation of urban health and nutrition services involving all service providers (public, for-profit and not-for profit organizations) can be done in a phase wise manner. The MOHFW will enhance capacity of the various service providers under LGIs, NGOs and the private sector for improving service quality.

iii. Prepare an investment case with evidence of value for money for investing in health and nutrition and negotiate with Finance Division for higher budgetary allocations.

iv. Develop an urban HMIS with the ability to share aggregated data with DHIS2 of DGHS. Incorporate urban routine data from all providers (public, NGOs and private) into respective MIS of DGHS and DGFP. Institutionalize mandatory common and interlinked data system (DHIS2) of urban nutrition services for all service providers.

v. Strengthen supportive supervision (e.g., using digital supervision tools) to improve service quality from PHC providers for ensuring standard of health & nutrition services delivery and motivate to provide preventive care along with curative services.

vi. Establish and strengthen collaboration with the Ministry of Labour and Employment (MoLE) and private sector stakeholders to integrate maternity protection in workplaces.

vii. Regulate the community level service providers, including private/individual service providers through training and monitoring for ensuring quality of care for PHC services, including nutrition services.

viii. Set up a mechanism through which nutrition action will be costed and included in the revenue budget of MOHFW and LGD/LGIs for sustainable Health and nutrition programs.

ix.

3.2 Strategies for Urban Food System

3.2.1. Challenges in the Policies and Strategies

i. Food insecurity is relatively high in urban LICs as compared to the rest of the urban areas. Inadequate market linkages between farmers and slums to effectively reach poor customers. Foods channeled from the wet market to the slum dwellers through vendors are damaged and are of inferior quality with high prices.

ii. Food quality and safety issues including adulteration, and unhygienic processing and preservation etc., are high in urban areas, particularly in informal markets including street food vendors

iii. High dependence on relatively cheap unhealthy foods and beverages by the urban poor, which are easily available and packaged attractively targeting to children and adoloscents

iv. High volume of food wastage at households, restaurants/hotels, and wet markets

3.2.2 Strategies to Address Challenges in Policies and Strategies

i. Introduce policies/measures to encourage urban food production (e.g., tax holidays for homestead/rooftop gardening, poultry rearing, etc.)
ii. Invest in urban social safety nets, targeted programs for vulnerable groups specifically women, person with disability, other gender diversified groups and food subsidies, including gradual shift to bio fortified foods (e.g., rice) for PLW, adoloscents & children . Advocacy for scaling up of existing fortification programmes to increase their coverage, availability and promote consumption of fortified foods.
iii. Update existing fresh markets and strengthen the supply chain of fresh commodities, in collaboration with the market actors, to improve availability, accessibility and quality of commodities for the urban dwellers.
iv. Initiate collecting, analyzing and presenting gender-disaggregated data that documents the challenges and needs of women, children and other disadvantaged groups
v.
vi. Introduce policy measures, including tax on ultra processed foods and sugar-sweetened beverages (SSBs), to reduce demands for foods and beverages that adversely affect human health.
vii. Increase partnerships among the marketing groups, agents and contract farmers..
viii. Ensure innovation and compliance with food safety standards and enforce appropriate labelling guidelines. Strengthen the enforcement of Act, laws/regulations including the mandatory information of nutrient information on labels of food packages as per the relevant regulations under Food Safety Act
ix. Promote innovative solutions for packaging and storage to reduce food loss and waste; and facilitated investment for compost generation from food waste
x. Boost in budget allocation for the public-sector R&D on food value chain focusing on urban areas.
xi. Promote GAP, GHP, GMP, in the urban food system for ensuring food safety and improving food environment.

3.2.3. Challenges in Program

i. Ease of availability of unhealthy foods high in added sugar and salt, saturated fats in the urban areas, even in urban slums coupled with limited cooking space and fuel, forcing urban slum households to cook once a day and compromise to eat less diversified food – particularly households with working women.
ii. Inappropriate food storage resulting in food contamination leading to enteric diseases and malnutrition as well as food wastage.
iii. Initiatives for food safety has limited focus on generating awareness of urban population, including slum dwellers and street food vendors, about healthy diets and nutrition fact as well as regarding the impacts of junk food and beverages on health and nutrition.
iv. There are limited options and technical support for alternative opportunities for food production in urban settings.
v.

3.2.4. Strategies to Address Challenges in Program Design and Implementation, including Resource Allocation

i. Increase accessibility of urban dwellers to supply chain of quality foods through open market operation of fresh produce.

ii. Develop appropriate programmes to enhance awareness of urban dwellers on food safety, healthy diet, dietary diversity, harmful impact of junk/unhealthy food using all service delivery platforms and media including the social medias. ...
iv. Improve the availability of safe nutritious food through technology and innovation.
iii. Adopt Methods/technologies of urban-based food production and storage specially in the wet market.
iv. Support financial inclusion of cooperatives/ groups-based processing, marketing, and access digital services.
v. Improve food safety/hygiene measures for street foods through training, and quality control measures.
vi. Where possible, promote innovative ideas/approaches to make the processed food healthy and less costly.
vii. Sensitise the value chain stakeholders towards food safety and nutrition.

viii. Promote primary processing, storage and packaging of fresh produce; Encourage safe food outlets selling certified food. Create awareness and provide incentives to retailers.
ix. Promote the fortification and nutrition enhancement of relevant foods where desirable and efficient.
x. Improve food processing and preservation behaviour of urban poor. Promote appropriate cooking techniques and safe food preparation.
xi. Promote Roof top horticulture gardens following the national guideline.

3.2.5. Challenges in Governance, Coordination and Monitoring

i. Limited coordination exists among the stakeholders of Urban Food and Nutrition stakeholders including the private sector.
ii. The process of registration and operation permits remains a challenge for conventional hotels and restaurants.
iii. Weak market monitoring system and inadequate capacity of food safety authority to enforce related roles and regulations regarding food safety.
iv. Lack of adequate and timely access of market information to the producers, suppliers, and consumers.
v. Scanty awareness on food safety by consumers and food processors.
vi. Male dominance in market system hampers women's access and participation and Women have less power and ownership in value chains.
vii.

3.2.6 Strategies to Address Challenges in Governance, Coordination and Monitoring

i. Strengthen collaboration for enforcement of relevant Act and regulations of food safety and food availability.
ii. Include food business companies (both for profit and nonprofit) in local committees for urban health and nutrition like the UHCC .
iii. Strengthen food product certification and nutrition labelling for assuring quality and safety (e.g., compliance with food certification guidelines, appropriate labelling, etc.).
iv. Strengthen market monitoring by increasing capacity of the food safety authority to enforce food safety related rules and regulations.
v. Ensure the existence of efficient agricultural marketing information system specific to urban areas.
vi. Build capacities of food business operators to test, trace, recall foods and communicate with the public.

vii. Strengthen consumer forums, promote education, and build consumer awareness on food safety.

viii. Develop a gender responsive urban food systems governance mechanism to promoting the participation of women and youth in multi-stakeholder platforms and also include gender-specific issues to improve women's position in the food system.

ix.

3.3 Strategies for Urban Education System

3.3.1. Challenges in the Policies and Strategies

i. Inadequate emphasis in education policy targeting slum poor and floating population living in urban areas.

ii. Limited emphasis in education policy on nutrition, particularly in pre-primary and primary education.

iii. The number of public (government) and NGO run formal and non-formal schools is low compared to the need and number of students in highly dense population. As a result, the access, quality of teaching and other services, including nutrition, in public schools is low.

3.3.2 Strategies to Address Challenges in Policies and Strategies

i. Review the Education policy to increase access for students from poor families and floating population into schools and out-of-school education programmes. Update the Education policy to improve nutrition outcomes of the students.

ii. Innovative strategies to increase coverage of education in and around urban poor settlements. .

3.3.3. Challenges in Program Design and Implementation, including Resource Allocation

i. The coverage of school stipend program and school-based nutrition program in urban areas compared to rural areas is low.

ii. Non-formal schools in the urban slums are in severe shortage of resources (teachers, and money, etc.).

iii. Lack of proper coordination among the relevant stakeholders of urban education system including MOPME, Secondary and Higher Education Department, Madrasha Education Board, Non-Formal Education Bureau, Non- Govt. schools etc.

iv. High prevalence of child marriage for girls especially in slums resulting in low attendance and high dropout rate.

v. Frequent migration, engagement in income earning means (especially the boys) and support to household activities (especially by the adolescent girls), etc. among children in urban LIC areas, especially the girls, increases chances of school dropout.

vi. Inadequate sanitation, water and washing facilities at schools, and particularly for post-menarche girls when their menstrual hygiene management (MHM) needs are not addressed hindering girls' attendance and tempt dropout.

vii. School Feeding Program and mid-day meal are largely and not adequately integrated in the urban schools as in rural areas.

viii. IFA supplementation, WASH and MHM interventions are weaker in urban settings.

3.3.4. Strategies to Address Challenges in Program Design and Implementation, including Resource Allocation

i. Mobilise more resource support including teachers and operational funds to non-formal schools in the urban slums.

ii. Promote “adolescent nutrition and healthy lifestyle” through formal and informal academic curriculum/training and SBCC programs.
iii. Scale-up integrated nutrition education strategies to enhance consumption of healthydiets, increase awareness of the nutrient composition of healthy diets a to prevent and control malnutrition.
iv. Expand school health program to urban schools. Enhance health seeking behaviour of adolescents by linking them with School health program/little Doctor program/ Adolescent Reproductive & Sexual Health programmes.
v. Review curricula for inclusion of nutrition education for all students, in primary and secondary level. Update nutrition curriculum at different levels of academic institutions (formal & informal).
vi. Promote and establish school nutrition program including gardening throughout urban cities where possible/feasible.
vii. Adopt motivational, social, and legislative interventions to prevent child marriage. Make access to school easy and safe for girls and motivate them as well as their families to continue and complete education.
viii. Strengthen and expand coverage of adolescent nutrition programmes utilizing schools and educational institutes. Introduce nutrition education, healthy diets, periodic deworming, and weekly IFA supplementation.
ix. Establish Girls-friendly environment including separate toilets and sanitation facilities along with proper MHM system in all schools and academic institutions.
x. Promote interventions to discourage involvement of adolescents (both boys and girls) into income generating activities that result in drop-out from school.
xi. Coordinate with private sector to ensure after-work education of adolescent boys and girls (15-18 years only) for those involved in employment.
xii. Increasing the number of TVET (Technical and Vocational Education and Training) institutions in urban areas and their peripheries where permanent set-ups are not feasible, using alternative methods, e.g., mobile technical schools.

3.3.5. Challenges in Governance, Coordination and Monitoring

i. Existence of several discrete projects with insufficient coordination and duplicative interventions.

3.3.6. Strategies to Address Challenges in Governance, Coordination and Monitoring

i. Greater coordination and coherence in programmes for achieving key objectives, moving towards inter-sectoral approach, involving major stakeholders for efficient skills development.
ii. Establish/utilize urban coordination platforms to coordinate and monitor educational interventions for improving nutritional outcomes, both public and private as well as formal and informal.

3.4 Strategies for Urban WASH System

3.4.1. Challenges in the Policies and Strategies

i. Inadequate harmonization of policies to expand the WASH facilities to the LICss Mechanisms to manage and monitor the private sectors providing WASH services to the LICS are not adequately established.

3.4.2 Strategies to Address Challenges in Policies and Strategies

i. Harmonise and reprioritize the intersectoral policies and strategies for improved WASH system for the urban slum dwellers.
ii. Develop an institutional and regulatory mechanism for faecal sludge management (FSM), explaining the overall responsibility for execution of the entire FSM chain, including the functioning of the private service providers.
iii. Take a long-term institutional development approach with those responsible for Faecal Sludge Management (FSM) (WASA and the City Corporation).

3.4.3. Challenges in Program Design and Implementation, including Resource Allocation

i. Inadequate resource allocation in WASH services for lower wealth quintile communities in the cities (e.g., slums).
ii. Allocation of budget for hygiene is usually much less compared to water and sanitation across all categories of urban local bodies.
iii. Weak capacity of local government institutions for appropriately manage urban WASH services. The weak capacity of local government institutions and mobilization of funding in a timely manner remain major sector development issues/challenges in all its forms
iv. Government charges for the operation and maintenance (O&M) though low, however this cost sharing deters poor people in participating for O&M living in LCIs. The capacity and mechanism of the local government authority for selection of hardcore poor candidates for subsidy as per National Cost Sharing Strategy for Water and Sanitation 2012 is weak.
v. Absence of mechanisms and functional structures at the divisional level to facilitate communication between policy makers and technical staff, national and sub-national divisions, between sectors such as health, WASH, and education and at the community level. Currently 47.6% schools (44.8%primary and 49.4% secondary schools) have basic handwashing facilities. 54% of health care facilities have hygiene materials at the point of care.
vi. The destructive impacts of climate change and emergencies are an increasing threat to water and sanitation systems and are contributing to disparities in access.
vii. Absence of integrated needs-based implementation plan resulting in low coverage and inefficiencies for urban WASH program.
viii. Only 25% of urban households use a proper water treatment method for drinking. In most occasion slum dwellers directly consume water without any purification. Improper water purification and distribution resulting high contamination of drinking water at urban areas.
ix. Low availability of improved sanitation facility in urban slums. Considering fecal sludge management, only 2% of slum households have access to safe sanitation.
x. Most wastewater in urban areas is discharged untreated directly into rivers and waterbodies for not being linked to appropriate sewage network.
xi. FSM and Solid waste (SWM) are a critical challenge for both the LICs and the city. Most toilets in Dhaka are pour–flush, and while many households have septic tanks, they overflow directly into the drainage system. Desludging trucks are available, but official sites for safe disposal are limited.
xii. WASH facilities don't consider the security and protection concerns of women and adolescent girls
xiii. Inadequate programs for hygiene and occupational hazards for WASH workers

3.4.4. Strategies to Address Challenges in Program Design and Implementation, including Resource Allocation

i. Equitable allocation of resources for WASH for poor settlements and slum areas, and for allocation from both government and development partners. Increase allocation for hygiene component of WASH.
ii. Subsidy provision for faecal sludge management (FSM) for operation and maintenance (O&M) cost of the infrastructure built with involvement of the community.
iii. Reduce the financial deficit, increase government allocations, coupled with resource mobilization towards increased domestic private markets and commercial resources and increased efficiencies with more efficient use of allocations.
iv. Explore innovative ways to complement domestic financing with development partners, and private sector financing (e.g., through corporate social responsibility).
v. Develop area-wise needs-based plans that capture the specific and diverse needs of the vulnerable population in urban slums.
vi. Strengthen capacity of City Corporations and Municipalities on managerial, technical, and financial aspects of urban WASH.
vii. Undertake SBCC campaign targeting slum dwellers for water treatment and hand washing.
viii. Improve WASH system in urban slums including health facilities, schools both in terms of physical facilities and management.
ix. Strategic partnership agreement between WASA and NGOs, CSOs and private sector for service delivery and infrastructure development.
x. Setting up the business model along with capacity building for the private entrepreneurs emptying for both FSM and SWM charges.
xi. Stakeholders, including the local government agencies, prioritize a gender-responsive approach with necessary budget while developing WASH facilities for the urban poor communities.
xii. Undertake programs for improving hygiene and addressing occupational hazards of WASH workers.

3.4.5. Challenges in Governance, Coordination and Monitoring

i. Inadequate coordination between LGD and MOHFW for implementing services related to hygiene and sanitation and nutrition.
ii. Limited coordination among service providers including private sector and NGOs.

3.4.6. Strategies to Address Challenges in Governance, Coordination and Monitoring

i. Clarify the roles of agencies supposed to provide standard WASH services to the vulnerable urban poor people.
ii. Functionalise the existing coordination mechanisms in urban local government to improve WASH for urban slum dwellers.
iii. Strengthen the monitoring system of the responsible authority, to enforcement of existing laws.

3.5 Strategies for Urban Social Protection System

3.5.1. Challenges in the Policies and Strategies

i. The number and beneficiaries of social protection programmes are low in urban areas. Guidelines regarding the detailed actions for tackling urban problems are inadequate in the NSSS.

ii. Lack of comprehensive urban dedicated social protection strategy to address the poverty and social determinants of health, food security and nutrition.

3.5.2 Strategies to Address Challenges in Policies and Strategies

i. Enhance nutrition-sensitivity of NSSS, 2015 to address urban nutrition issues, so that the draft Urban Social Protection Strategy and Action Plan in Bangladesh, 2020 and its recommendations are incorporated in NSSS.
ii. Expand coverage of social protection of urban poor specially for nutritional vulnerable groups through updating relevant strategy of the respective Ministries.
iii. Develop a more comprehensive approach to urban social protection, including developing an evidence based and effective national social insurance scheme.

3.5.3. Challenges in Program Design and Implementation, including Resource Allocation

i. Number and coverage of existing SPPs in urban areas are very limited.
ii. Limited allocation of budget and coverage of SSPs for urban poor.
iii. Thin spreading of resources and diversion of resources to non-poor households in SSPs.
iv. Alignment of existing SSPs with nutrition objectives/targets/ outcomes is inadequate.
v. Limited coverage of the rural SSPs in urban areas, despite the beneficiaries having similar economic similarities and vulnerabilities.
vi. Effective programmes like school feeding programmes are not adequately expanded in urban areas.
vii. Nutrition SBCC is often not embedded and inadeqaute with the respective SSPs.
viii. Existing system to identify beneficiaries following a community participation approach by the Local Government Institutions (LGIs) and in the implementation of M& E efforts and supporting ministries in the delivery of programmes is not functioning efficiently.
ix. Delay in payment for the SSPs in the urban areas.

3.5.4. Strategies to Address Challenges in Program Design and Implementation, including Resource Allocation

i. Ensure on-time implementation of the N4G commitments, particularly those targeting urban poor.
ii. Enhance advocacy for increased allocation for urban poor and expanded coverage of social protection programmes. Scale-up productive social protection for women and other excluded groups in urban areas.
iii. Expand existing social protection programs (which are being implemented in rural areas) among urban poor dwellers as proposed in draft Urban Social Protection Strategy and Action Plan in Bangladesh 2020.
iv. Increase nutrition sensitivity of the SSPs through ensuring nutrition situation analysis in the design stage of SSPs and incorporation of nutrition objective, indicators, and targets in the design.
v. Rationalize the resource allocation for urban SSPs considering the population number and vulnerability.
x. Promote the gradual shift to and Scale up the inclusion of bio fortified rice in the Food Friendly Program (FFP) and OMS, diversify the food distributed in social protection programmes, and monitor impacts on nutrition in urban areas.
xi. Expand the School Feeding Programmes in urban slums.
xii. Enhance and integrate quality nutrition SBCC activities into social protection programs along with transfers (cash or in kinds).

xiii. Advocacy for enhanced use of technology-based disbursement to improve governance and to reduce delay.

3.5.6. Challenges in Governance, Coordination and Monitoring

i. The existing coordination among LGD and relevant ministries, departments and local government linked with social security interventions is weak and unreported
ii. A functional system for beneficiary feedback and redress is absent across SSPs.
iii. The linkage and coordination between transfer based SSPs and other basic services such as referral to essential nutrition services, access to safe water supply, or agricultural extension services is absent.
iv. Digitalized transfer and single registry system is yet to establish fully.

3.5.7. Strategies to Address Challenges in Governance, Coordination and Monitoring

i. Strengthen coordination between SSPs and other basic social services offered through different ministries.
ii. Enhance multisectoral coordination to ensure coverage of urban poor under nutrition-sensitive SSPs.
iii. Establish an inter-operable nutrition information system related to SSPs and include the collection of routine data on the status of gender equality to support programme improvement and advocacy for resource mobilization.
iv. Introduce a beneficiary feedback, complaint, and redressal mechanism to increase accountability and programme effectiveness, emphasizing child welfare and gender issues.

4. ACTION PLAN INCLUDING THE ROLES OF KEY STAKEHOLDERS

For effective operationalization of the strategies, action plans have been developed for each system. The action plans consist of specific activities under each strategy, the responsible entities, and a tentative timeline of implementation. These action plans are attached in the subsequent tables.

4.1 Action Plan for Urban Health and Nutrition System

Strategy	Activity	Responsibility	Timeline
A. Strategies to address policy-related challenges			
Update National Urban Health Strategy 2020 to address gender-responsive and inclusive nutrition components adequately	Revise Urban Health Strategy 2020 to strengthen the nutrition component.	MOHFW LGD	Short
Update the ESP, 2016 to incorporate emerging issues and services on nutrition	Review the existing ESP from the context of urban population till 2030	DGHS, DGFP, BNNC LGD DPs UN Agencies, NGOs	Short
	Assess feasibility for alternative approaches for delivering nutrition services and update ESP as per the review and assessment result		Medium
	Make provision of delivery channels/platforms like domiciliary and satellite approach, mobile services to address emerging nutrition issues in the ESP.		Medium
	Put more emphasis on awareness building regarding healthy lifestyle, NCDs, all forms of malnutrition and relevant emerging diseases in the updated ESP.		Medium
Redesign social protection strategies to address nutrition objectives and targets for the poor who are most vulnerable, marginalised and excluded.	Conduct evidence-based advocacy for redesigning social protection schemes for urban population (e.g., health insurance)	MOHFW, Cabinet Division, LGD, MOWCA, MOF, MOSW, MOP. DPs, NGOs	Short
	Introduce health insurance starting with the public sector and gradually expanding to formal private sector.		Medium
	Consolidate and maximize benefits of the already existing health protection schemes including Shasthyo Shurokhsha Karmasuchi (SSK), Demand Side Financing (DSF); and health insurance for garments workers (HIGW), etc.		Medium
Introduce a health card scheme for floating population, slum dwellers and urban poor to receive services from selected/enlisted private facilities.	Develop the specific characteristics of the health card scheme based on operations research and evidence generation.	Health Economics Unit of HSD	Short

Strategy	Activity	Responsibility	Timeline
	Advocacy for resource allocation for health card.	Planning Wings, Budget Wings of HSD and MEFWD, LGD, BNNC	Medium
Strengthen the policies and institutions to regulate the quality of services provided by the private healthcare institutions in urban areas.	Strengthen supportive supervision (e.g., using digital supervision tools) to improve service quality from PHC providers. Regulate and monitor the community level private/individual service providers for ensuring quality of care for PHC services.	MOHFW, LGD	Medium
Promote guidelines and protocols for the provision of Multiple Micronutrient supplements along with IFA to the specific target group (pregnant, lactating and NPNL women)	Formulate guidelines and protocols for MMS and IFA.	MOHFW, LGD, INGOs and NGOs	Short
B. Strategies to address challenges associated with Urban Health and Nutrition Programmes			
Put specific emphasis on urban Health and Nutrition in upcoming 5th HPNSP for strengthening primary care on health, nutrition, and FP services in urban areas.	Incorporate specific nutrition interventions for urban areas in the respective OPs of the 5th HPNSP	OPs of 5th HPNSP (PHC, NNS, MNCAH, MCRAH, HSM), BNNC, Planning Wings of HSD and MEFWD	Short
Strengthen existing PHC facilities of MOHFW at urban facilities (e.g., Government Outdoor Dispensaries, expand school Health Clinics) with appropriate HR, logistics and equipment. Strengthen urban PHC facilities with appropriate medicines, logistics and equipment	Keep provisions for medicine, logistics, equipment, and HR in the PHC OP of 5th HPNSP	Planning Wings of HSD and MEFWD, BNNC, IPHN/NNS	Short
	Enhance capacities of OP officials for appropriate planning, budgeting and supply chain management of urban facilities	CMSD, PHC OP	Short
Improve accessibility of urban slum dwellers to urban health facilities through strategies, including, arranging evening services in all PHC facilities, arranging evening satellite and mobile clinics, and introducing nutrition services as per	Coordinate with operating and development budget, and among different OPs to avoid duplication of expenditure.	MOHFW (BNNC, IPHN, NNS, NCD, MNCAH, MCRAH, PHC), LGD, MOWCA, MOF, MOSW, MOP.	Short
	Introduce evening shifts at OPDs in health facilities in urban areas.		Medium

Strategy	Activity	Responsibility	Timeline
updated ESP to all service providers (pubic, for-profit, and not-for profit organisations). Collaborate with non-government and private sector for expanding PHC services in urban areas where feasible, under the strategic partnership agreements.	Initiate evening mobile/satellite clinics in slum areas	DPs, UN Agencies, NGOs	Medium
	Introduce GMP in all health facilities as well as outreach sites.		Short
	Collaborate with private sector to introduce nutrition services at subsidised rate in private facilities		Medium
Coordinate with industry member associations (e.g., BGMEA, BKMEA and BTMA) to strengthen the PHC services for the industrial workers.	Sensitise and aware management to develop a workplace policy to upholding exclusive breastfeeding, especially among working mothers	BNNC, NNS, MOC, MOInd, MOLE, LGD, DPs, NGOs	Short
	Sensitize and aware management to establish and maintain breastfeeding space at workplace		Short
	Orient Company's Senior Management or owner on minimum standards required for provision for MIYCF		Medium
Expand the number of PHC clinics upto ward level based on population ratio, especially near LICS. Contract-out PHC services to competent NGO providers in urban and hard-to-reach areas through the strategic partnership .	Establish GP system where necessary with strong monitoring and supervision to avoid malpractices.	MoH&FW, LGD, MOP, MOC (Directorate of National Consumers Right Protection), BMDC. DPs, NGOs	Medium/Long
	Contract-out HNP (nutrition) service provision to competent NGO providers in urban slum areas		Medium/Long
Improve HR capacities for provision of quality urban PHC services through revising job descriptions of the PHC workers, filling up vacant positions and provision of adequate in-service training	Revising the job descriptions of PHC workers (for addressing emerging nutrition issues.) along with task shifting	HSD, MEFWD, DGHS, DGFP, NNS, LGD, DP supported projects in urban areas, NGOs	Medium
	Fill-up all the vacant positions at PHC level		Short
	Provide adequate in-service training to enhance capacity of the PHC workforce in line with the revised job responsibilities. Develop/update the age-appropriate/Life cycle-based training curriculum on nurturing care and conduct in-service/on-the-job training for nurturing care for the community health workers of GoB, private sector and NGOs.		Medium
Strengthen competency-based nutrition training for all HNP service providers including urban, along with refresher training, including those from NGOs and private sector.	Capacity building of the staff on nutrition services following national protocol including access to digital platforms	HSD, MEFWD, DGHS, DGFP, NNS, LGD, DP supported projects in urban areas, NGOs	Short/Medium
	Implement standard training package to provide essential nutrition services.		Short/medium
	Avail the customize nutrition training package for urban integrated with the MNCAH		Short

Strategy	Activity	Responsibility	Timeline
	Adaptation of existing national training packages (CCTN+ SAM, MAM, Micronutrients, GMP during EPI)		Short
Establish an uninterrupted supply chain management of nutrition service-related essentials (drugs/supplement/therapeutic food/ equipment/ BCC materials / logistics etc.) across GOB-NGO-private delivery system.	Amend relevant procurement rules and guidelines for enhanced efficiency in supply chain of nutrition commodities	HSD, MEFWD, LGD, relevant DGHS and DGFP OPs	Short/Medium
	Enhance supply chain efficiency of DGHS and DGFP in planning, procuring, storing and distributing nutrition commodities		Short
	Enhance capacities of the health and FP personnel on supply chain management		Short
	Provide measuring equipment, materials, guidelines, growth charts, IEC materials and nutrition supplements in all tiers of facilities at urban areas		Short
	Ensure the supply of approved Multiple Micronutrient supplements along with IFA to the specific target group (pregnant, lactating and NPNL women) and implement of the MMS program following approved protocol of the government	MOHFW, LGD, INGOs and NGOs	Short/Medium
	Enhance awareness-raising programs and activities for MMS and IFA	MOHFW, LGD, INGOs and NGOs	Short/Medium
Increase community awareness on nutrition and availability of nutrition services at PHC level through utilizing the grassroot level social and community organisations, social media and engaging the male household members.	Utilise grassroots level social organizations (e.g., adolescent clubs, youth clubs, etc.) for raising awareness on public health and nutrition issues at urban areas, including urban slums	BNNC, NNS, MOWCA, MOE, MOPME, MOInf, MORA, LGD, DPs, NGOs	Short
	Use social media platforms for awareness creation on public health and nutrition issues		Short
	Strengthen the infrastructure and protocols for SAM (Severe Acute Malnutrition) and CMAM (Community-based Management of Acute Malnutrition) would ensure more effective management of malnutrition in urban populations.		
	Organising periodic engagement sessions at PHC facilities to enhance community participation		Short

Strategy	Activity	Responsibility	Timeline
	Involve male family members in the care and nutrition for infants and young children for positive impacts on eating feeding practices.		Short
Design and implement urban nutrition interventions that consider the specific needs of PL women, men, children, adolescent girls and boys, elderly and marginalized populations including disables.	Identify and Implement the actions described in NPAN 2	MOHFW, LGD	Short/Medium
Mainstream the successes of the nutrition programs	Evaluate and identify the successful programs and their modalities Insert the successful program in the routine service delivery system Mobilize yearly revenue budget from the government.	MOHFW, LGD	Medium and Long
Allocate adequate resources within government urban nutrition programs for collecting sex and gender-disaggregated data information and for capacity building of officials, awareness creation and for expansion of service delivery centres	Link the gender-disaggregated service delivery data with the DHIS2 Develop training modules for officials: develop IEC materials for awareness. Undertake projects for setting up service delivery centres at ward and zone levels.	MOHFW, LGD	Medium and Long
Alternative mechanism should be established to continue the nutritional service delivery in the disaster situation specially, at the shelters and LICS.	Keep budgets and procure supplies for service delivery during and after disaster situation specially for LICs and shelters.	MOHFW, LGD, MODMR	Short/medium
C. Strategies to address challenges associated with governance, coordination, and monitoring			
Improve Urban Nutrition Governance (coordination, planning referral, regulations, and financing, etc.) through strengthening multisectoral nutrition governance platforms like BNNC. Improve institutional capacity for coordination, advocacy and social mobilization,	Ensure appointment of adequate human resources for BNNC office, as well as enhance human resource capacity for sub-national coordination of multisectoral nutrition-related services and linkages.	HSD, MEFWD, LGD, DP supported projects in urban areas, NGOs	Short
	Activate and sustain the Ward level public committees, that exist in every Ward of the UPHCSDP areas should be activated		Short

Strategy	Activity	Responsibility	Timeline
monitoring, and supportive supervision for follow up and corrective action.	Institutionalize mechanism and regularise the meetings of UHCC and UHWG to improve coordination between MOHFW and LGD.		Short
Institutionalise engagement of local government actors and the community for generation of additional resources for effective functioning of PHC facilities.	Incorporate the LGI engagement at local level as one of the strategic objectives for strengthening 24/7 PHC services and develop subsequent strategies for effective implementation of LGI engagement in the 5th HPNSP	DGHS, DGFP, BNNC, LGD, DPs, NGOs	Short
	Based on the strategic objectives of 5th HNP SWAp, incorporate specific interventions for LGI engagement, in the appropriate Operational Plans of the sector program, with specific guidelines and budgetary allocations		Short
	Incorporate LGI engagement in PHC service delivery as one of the Annual Performance Agreement (APA) indicators; Support the orientation of LGIs as resource team members to ensure the effective sensitization of their role in PHC service delivery immediately after election		Short
	Link the performance of personnel in LGI engagement and subsequent HNP outcomes as key performance indicators in the departmental personnel appraisals; Arrange an orientation program for the LGIs after subsequent local government elections to sensitize them on their roles in the strengthening of PHC services; Consider introduction of a specific reward or recognition for the local government representative in a specific area for the highest contribution in healthcare		Medium
implementation of urban health and nutrition services involving all service providers (public, for-profit and not-for profit organizations). The MOHFW will enhance capacity of the various service providers under LGIs, NGOs and the private sector for improving service quality.	Undertake a mapping exercise of service providers (who does what and how)	MOHFW (PHC OP, NNS OP, LGD	Short
	Enhance capacities of the service providers		Medium/Long
	Establish GP system where necessary with strong monitoring and supervision to avoid malpractices.		
Prepare an investment case with evidence of value for money for investing in health and nutrition and negotiate with Finance Division for higher budgetary allocations.	Develop an investment case through appropriate research	Health Economics Unit of MOHFW, DPs	Short
	Advocate for research increase based on the investment case	MOHFW, LGD	Medium

Strategy	Activity	Responsibility	Timeline
Develop an urban HMIS with the ability to share aggregated data with DHIS2 of DGHS. Incorporate urban routine data from all providers (public, NGOs and private) into respective MIS of DGHS and DGFP. Institutionalize mandatory common and interlinked data system (DHIS2) of urban nutrition services for all service providers.	1.Build capacity of existing human resources with additional knowledge and capacity to collect, collate and use related data to measure performance	DGHS, DGFP, BNNC, NNS, NGOs	Medium/Long
	2.Update the existing HIMS with required nutrition information & indicators		Short
	3.Establish a real time monitoring system (app based)		Medium/Long
	4.Effective joint monitoring by health, FP and Local Government authorities including private sector, NGO etc.		Medium/Long
	5.Build capacity of NGO service providers with access on DHIS2 reporting system		Short
	6.Build capacity of NGO workers/staffs with additional knowledge and capacity to collect, collate and use related data to measure performance		Short
Strengthen supportive supervision (e.g., using digital supervision tools) to improve service quality from PHC providers and private health services providers for ensuring standard of health & nutrition services delivery (including BMS Code compliance monitoring) and motivate to provide preventive care along with curative services.	Develop private sector engagement guideline for delivering/ensuring nutrition services	DGHS, Private sectors organization, Private health practitioner association	Short
	Introduce workplace-based nutrition program/ interventions and create linkages with private and public health service platform		Medium/Long
	Create strategic purchasing/ financing system for accessing critical nutrition services from public and private platforms		Medium/Long
	Monitoring of standard of private health services providers regarding health and nutrition service delivery		Medium
Establish and strengthen collaboration with the Ministry of Labour and Employment (MoLE) and private sector stakeholders to	Like in Rural areas (DNCC, UNCC), develop a multisectoral coordination committee with the relevant stakeholders under the leadership of Cabinet Division/LGD.	Cabinet Division, LGD, MoLE, BGMEA, BKMEA, BTMA, BNNC	Medium

Strategy	Activity	Responsibility	Timeline
integrate maternity protection in workplaces.	Arrange regular coordination meeting with the relevant private sector stakeholders to oversee the integration of maternity protection in the respective workplaces.		
Regulate the community level private/individual service providers through training and monitoring for ensuring quality of care for PHC services.	Identify the private and individual service providers at urban areas providing PHC services	BNNC, LGD	Short
	Enhance capacities of the private and individual service providers for quality PHC service provision	BNNC, DGHS, DGFP, LGD	Short
	Supervise the activities of the trained private and individual service providers	DGHS, DGFP	Medium
In line with BNNC guidance, City and Municipal governance will uphold the gender mainstreaming approach into the Multisectoral Nutrition Governance mechanism to ensure urban nutrition services are gender responsive through proper planning, budgeting, implementation, and monitoring.	Identify and apply the approaches for gender mainstreaming including budget, service delivery data, and separate spaces in the service delivery centres and WASH facilities. Establish a coordination mechanism with MOWCA.	MOHFW, LGD, MOWCA	Short/Medium
Set up a mechanism through which nutrition action will be costed and included in the revenue budget of MOHFW and LGD/LGIs for sustainable Health and nutrition programs.	Evaluate the PER-N and PER-H. Prepare the costing guideline and set up the working group for urban areas.	MOHFW, LGD	Medium

4.2 Action Plan for Urban Food Systems

Strategy	Activity	Responsibility	Timeline
A. Strategies to address policy and strategy-related challenges			
Introduce policies/measures to encourage urban food production (e.g., tax holidays for homestead/rooftop gardening, poultry rearing, etc.).	1. Negotiate with City Corporation/Municipalities for reduction of holding tax for roof-garden, bio-flock, poultry/livestock rearing in urban areas	NBR, City Corporations	Medium
	2. Negotiate with NBR for rebate on Tax on sell of food commodities produced by urban households		
	3. Encourage urban agriculture production including roof top horticulture gardens		
Invest in urban social safety nets, targeted programs for vulnerable groups, specifically women, person with disability, other gender diversified groups and food subsidies, including gradual shift to bio fortified and food subsidies, including fortified basic foods (e.g. rice) for PLW & children.	1. Establish egg bank/ community-based food banks/ nutrition corners run by community women with CC and BFSA's support.	Cabinet Division, MoFood, DAE/DLS/DOF, Poultry/Dairy Fisheries/ Association, BARC	Medium/ Long
	2. Introduce food exchange with plastics/polyethylene/kitchen waste.		
	3. Expand OMS including fresh produce in poor areas		
	4. Promote sales of foods in small quantities/ packages.		
	5. Keep emergency stock of vital foods.		
	6. Set price ceilings for basic food items/ major food groups.		
	7. Update the OMS (Open Market Sale) food package targeting urban poor to ensure dietary diversity		
Update existing fresh markets and strengthen the supply chain of fresh commodities, in collaboration with the market actors, to improve accessibility and quality of commodities for the urban dwellers.	1. Facilitate establishment of farmers market near slum areas	DAE/DLS/DOF, Poultry/Dairy Fisheries/ Association BARC, BLRI, BFDC BFRI, City Corporations	Medium
	2. Ensure cold chain for perishable goods from source to the market.		
	3. Improve hygiene and quality of fresh commodities sold by mobile vendors through appropriate training and awareness raising.		
	4. Review the improvement required for existing markets to maintain quality and freshness of the commodities and facilitate the subsequent upgrading of these markets		
	5. Confer awareness to the vendors of fresh commodities in the existing markets on quality,storage hygiene issues		

Strategy	Activity	Responsibility	Timeline
	6. Establish at least one registered fresh market in each Ward, and one standardized model market in every CC with proper spatial planning, and human-centric women- friendly design, ensuring all necessary facilities (WASH, waste management, safety, loading- unloading stations, parking, ventilation, wider space for navigation, separate entrance and exits for waste collection and customers).		
Initiate collecting, analyzing and presenting gender-disaggregated data that documents the challenges and needs of women, children and other disadvantaged groups.	Prepare gender-disaggregated data collection format (including online software) and use it in the facilities. Work out the M&E framework and reporting schedule and implement...	MOHFW, LGD	Short
Introduce policy measures to reduce demands for food with adverse impact on human health, including tax on junk foods (e.g., sugary drinks, trans-fat etc.).	1. Negotiate with NBR for introduction of sugar tax and trans-fat tax to discourage fast food, junk food and food and beverages with high sugar content	NBR, HSD (MOHFW), MoInf, MoInd, Associations of Food and Beverage Manufacturers, Mass Media	Medium
Increase partnership among the marketing group, agents, contract farming.	1. Initiate public-private partnership with private sector for production, distribution, and promotion of safe and healthy diet. 2. Increase innovative solution with online platform for connecting the producers and the consumers.	MOI, MOCom, MoFood, BFSA, DNCRP, Associations of Food and Beverage Manufacturers	Long
Ensure innovation and compliance to food safety standards. Make sure the enforcement of Act, laws/regulations including the mandatory information of nutrient information on labels of food packages as per the relevant regulations underh Food Safety Act.	1. Promote nutrition labelling to encourage wise food purchase, stimulate healthy food demand and discourage consumption of junk foods. 2. Ensure appropriate labelling of packaged food commodities with nutrient contents through enforcement of the relevant regulations of Food Safety Act.	MOI, MOCom, MoFood, BFSA, DNCRP, Associations of Food and Beverage Manufacturers	Medium/Long
	1. Where possible reuse of leftover foods for human consumption.		Medium

Strategy	Activity	Responsibility	Timeline
Promote innovative solution for reducing food loss and waste.	2. Promote collaboration between stakeholders e.g., livestock departments and municipalities which collect waste some of which may be used as cattle feed.	MoA, MOFL MOCom, MoFood, DLS, CC, Municip.	
Promote innovative solution for packaging and storage (e.g., smart packaging, enforce appropriate labelling guidelines, etc.).	1. Promote smart packaging (e.g., plastic crates, paper bagging) for fruits and vegetables. 2. Increase research for packaging innovation from reduced contamination as well as environmental sustainability. 3. Enforce the food packaging and labelling guideline of BFSA. 4. Sensitise people to the problem of food waste and to the measures that can be taken.	MoA, MOFL MOCom, MoFood, DLS, CC, Municip. Associations of Food and Beverage Manufacturers	
Boost in budget allocation for the public-sector R&D on food value chain focusing on urban areas.	1. Provision of direct funding to priority areas: 2. Develop capacities to carry out research with special emphasis on advanced and novel fields notably in academia. 3. Carry out policy reforms to incentivise private sector investments, especially in proprietary technologies such as the development of hybrid varieties of nutrient-dense vegetables and fruits for urban agriculture (e.g., roof-top gardening, and poultry rearing, etc.) 4. Expand and promote off-farm employment and other employment along the food value chain by expanding vocational training opportunities for urban youth, women, and disabled people.	MOA, MOFL, BARC, INFS, Associations of Food and Beverage Manufacturers	Medium/ Long
Promote GAP (including organic), GHP, GMP, in the urban food system for ensuring food safety and improving food environment.	Organize training for producers/vendors on the guideline of GAP, GHP and GMP. Prepare IEC materials and organize SBCC campaigns for GAP, GHP and GMP	MOHFW, MOE, LGIs,	Short
B. Strategies to address challenges associated with program design and implementation including resource allocation			
Increase accessibility of urban dwellers to supply chain of quality foods.	1. Define and allocate specific spots/ zones for mobile/ street food vendors and cluster them.	LGD, HSD (MOHFW), MoInf, Mass Media,	Short/Medium

Strategy	Activity	Responsibility	Timeline
	2. Encourage consumers to buy from regulated/ authorized shops/ markets instead of unorganized street shops/ vendors.	Market Management Committees, Associations of restaurants and food vendors, Industry Associations (BGEAM, BKMEA, BTMA, etc.), Consumer Association of Bangladesh, CC/Municipalities, etc.	
	3. Strengthen and collaborate with community leaders and key actors to manage markets efficiently and keep them accessible for all.		
	4. Strengthen and collaborate with Market Management committees (MMCs) and residential societies to operate/ manage markets efficiently and keep them accessible for alli. Establish area-based weekly markets/ farmers markets, or allocate space for farmers inside fresh markets, to sell quality fresh products at reasonable prices. Collaborate with industry associations (e.g., BGMEA, BKMEA, BTMA) to introduce subsidized food shops in industrial zones to increase availability of quality and healthy food commodities viii. Enable online shopping facilities at fresh markets. Develop provision to keep a multi-purpose common space inside residential complexes (e.g., for weekly farmers'/ fresh market)		
Develop appropriate programmes to enhance awareness of urban dwellers on food safety, health diet, dietary diversity, harmful impact of junk/unhealthy food using all service delivery platforms and media including the social medias.	1. Include local government representatives, religious leaders, and other community leaders to enhance awareness of the harmful impact of junk food and beverages on health and nutrition.	LGD, CC, Municipalities, MOWCA, MoInf, Media	Short/Medium
	2. Utilise the network of adolescent clubs and similar youth forums in such awareness creation.		
	3. Introduce mass awareness programmes to sensitize consumers on diversified and healthy foods, harmful effects of junk food and optimal spending for nutritious foods.		
	4. Use social media for promotion of healthy and diversified food.		
Improve the availability of safe nutritious food through innovation and expansion of appropriate methods/technologies of urban-based food production.	1. Conduct mass awareness campaigns to promote household level nutritious food production at urban areas	MoA, MOFL, MoCom,BARC, DAE, DLS	Medium/ Long
	2. Expand rooftop gardening: Provide incentives to households or businesses (e.g., tax incentives). Set up demonstrations in cities on roof gardening and micro-gardens.		

Strategy	Activity	Responsibility	Timeline
	3. Develop vertical farming: Carry out R&D so that a greater array of fruits and vegetables can be grown through vertical farming. Promote extension services for vertical farming. Facilitate funding to those wanting to invest in vertical farming. Research to bring down the costs of setting up and running vertical farming.		
	4. Promote hydroponics and aquaponics: Train stakeholders to use hydroponics in a safe and sustainable way. Provide knowledge resources, guidance, and training.		
	5. Establish market linkage of producer households with input sellers, output collectors and other market actors for marketing of excess food produced.		
Adopt Methods/technologies of urban-based food production, and storage specially in the wet market.	Identify and implement the technologies for urban food production and processing and packaging (primary/secondary) Identify and implement the storage technologies in the wet market	MOA, LGD, HSD,	Short
. Support financial inclusion of cooperatives/ groups-based processing, marketing, and access digital services.	1. Provide special attention, dedicated lines of credit, low-interest enterprise loans and financial managerial support to cooperatives.	MOFin., MOLGRDC, MoA, DAE, MoCom	Medium
	2. Ensure their access to digital services through the implementation of the National ICT Policy 2018.		
	3. Promote nutrition labelling to encourage wise food purchase, stimulate healthy food demand and discourage consumption of junk foods.		
Improve food safety/hygiene measures for street foods through training, and quality control measures.	1. Conduct training and promote education and sensitization/promotional activities among food handlers for safe, sanitary, and hygienic food handling practices.	DAE, BFSA, DLS,CC	Short
	2. Support the food vendors in getting access to food preservation equipment and technology.		
Where possible, promote innovative ideas/approaches to make the processed food healthy and less costly.	1. Encourage private sector for introduction of healthy diet in small sachets/packets to increase accessibility for the urban poor.	BARC, CC, Municip.	Medium

Strategy	Activity	Responsibility	Timeline
	2. Boost R&D for urban and peri-urban agriculture: Promote cooperation between government agencies, non-state research institutes and the private sector with adequate incentives. Promote R&D to develop new techniques for urban/peri-urban agriculture		
Sensitise stakeholders of the value chain to food safety and nutrition.	1. Promote adequate storage at all stages of value chain: in farms, processors, wholesalers, and retailers, and even consumers.	DAE, DLS, MoInf. Food safety authority, CC/Municipalities.	Medium /Long
Promote primary processing, storage and packaging of fresh produce; Encourage safe food outlets selling certified food. Create awareness and provide incentives to retailers.	1. Enhance capacities of food retailers (e.g., restaurants, street food vendors) on production of safe and hygienic food and maintaining quality of food	BFSA, MOInf. Food safety authority, CC/ Municipalities.	Medium/ Long
	2. Promote nutrition labelling to encourage wise food purchase, stimulate healthy food demand and discourage consumption of junk foods.		
Promote the fortification and nutrition enhancement of relevant foods where desirable and efficient.	1. Advocacy and provision of technical support for expanding the range of fortified foods.	MoFood, WFP	Short
	2. Develop techniques to improve the bioavailability of nutrients such as the germination and malting of grains and pulse (for example), and ways to enrich foods.		
Improve food processing and preservation behaviour of urban poor. Promote appropriate cooking techniques and safe food preparation.	1. Develop food-based nutrition training, BCC, and mass media activities to encourage appropriate cooking techniques, safe food preparation, handling, storage, sanitary food service, hygiene practices and safe food consumption as per urban context.	DAE, MoInf. CCs/Municipalities.	Medium/ Long
	2. Increase awareness of slum dwellers on food preservation, safe food processing/cooking and quality of food.		
	3. Introduce community kitchen, community freezers and other group initiatives for safe processing and preservation of food.		
Promote Roof top horticulture gardens, aquaponics and vertical agriculture following the approved protocols.	Develops/Revise the guideline for roof top gardening, aquaponics and vertical agriculture reflecting the dengue and waste disposal concern. Educate the urban dwellers/producers	MOA, HSD, LGD	Short/Medium

Strategy	Activity	Responsibility	Timeline
C. Strategies to address challenges associated with governance, coordination, and monitoring			
Strengthen collaboration for enforcement of relevant Act and regulations of food safety and food availability.	1. Establish active inter-ministerial coordination body on urban food systems. 2. Establish coordination committee among relevant agencies with regular meetings. 3. Administering joint vigilance team and mobile courts to enforce regulations. 4. Introduce registration system for restaurants and food stores.	BFSA, CAB, DNCRP, City Corp Private sector associations, Food safety authority, CC/Municipalities.	Medium/ Long
Include food business companies (both for profit and nonprofit) in the UHCC as deemed necessary.	1. Strengthen alignment of urban service providers (including NGO and private sector) through strong agreements, guidelines, and SOPs/MOUs between MOLGR&C and MOHFW. 2. Strengthen collaboration for enforcement of relevant Acts and regulations of food safety and food availability. 3. Prioritize the set-up of formal distribution channels through the increased enforcement of food safety standards along with the consumer awareness and sensitization campaigns.	MOLGDR&C, MOHFW, BFSA, BSTI	Short
Strengthen food product certification and nutrition labelling for assuring quality and safety (e.g., compliance with food certification guidelines, appropriate labelling, etc.).	1. Encourage safe food outlets selling certified food. Create awareness and provide incentives to retailers. 2. Review and ensure compliance with food certification guidelines harmonized with Codex standards and BSTI certification. 3. Ensure technical teams periodically review certifications of products and establishments. 4. Provide appropriate nutrient labelling and product information in line with legal requirements and dietary recommendations.	BFSA, BSTI	Medium
Strengthen market monitoring by increasing capacity of the food safety authority to enforce food safety related rules and regulations.	1. Incorporate multisectoral actors in the market monitoring, including the market committee, business member associations, relevant government authorities and civil society. 2. Monitor/regulate markets for prices, unethical stocking, and prevent syndicates and enforce laws.	BFSA, BSTI, DNCRP	Short
Ensure the existence of efficient agricultural marketing information system specific to urban areas.	1. Favour ICT-based approaches. 2. Strengthen ICT-based market information system to provide real time support to urban growers/farmers.	DAE, MoCom, ICT	Short/Medium

Strategy	Activity	Responsibility	Timeline
	3. Target E-commerce platforms, digital marketplaces and individual sellers beyond Dhaka and other urban areas.		
Build capacities of private sector to test, trace, recall foods and communicate with the public.	1. Strengthen capacities of all private sector actors along the value chain-so that they understand the importance of and are able to engage in activities relating to testing food safety and recall management.	CC, BFSA, Associations of Food and Beverage Manufacturers	Medium/ Long
	2. Train private sector to communicate with the public to advertise adherence to food safety standards but also in cases of breakdowns in food safety.		
Strengthen consumer forums, promote education, and build consumer awareness on food safety.	1. Develop an extensive field public information campaign.	MoInf, DNCRP, CAB	Medium/ Long
	2. Support and strengthen forums such as CAB and BFSN.		
Develop a gender responsive urban food systems governance mechanism to promoting the participation of women and youth in multi-stakeholder platforms and also include gender-specific issues to improve women's position in the food system.	Develop gender responsive urban food system Ensure the particitipation of women and youth in multisectoral platforms Include gender-specific issues in the Food system for improve women's position	MoFood, MOA, MOHFW	Medium

4.3 Action Plan for Urban WASH Systems

Strategy	Activity	Responsibility	Timeline
A. Strategies to address policy-related challenges			
Harmonise and reprioritise the intersectoral policies and strategies for improved WASH system for the urban slum dwellers.	1. Review the existing policies and strategies of WASH of different public entities and identify the areas of synchronization to Develop a position paper	Cabinet Division, MoHFW, LGD, WASA, CCs/	Short

Strategy	Activity	Responsibility	Timeline
	harmonizing the policy directions of different entities.	Municipalities, DPHE, WDB, NGOs, private WASH service providers	
	2. Identify policy directions to incorporate the private sector along with public entities in WASH service delivery.		
	3. Advocacy for a harmonized WASH service delivery for the urban slum dwellers, synchronizing the efforts of public as well as private actors.		
Expand WASH services to people living in LCIs in all cities.	1. Based on experience from urban WASH program advocacy with policy makers and Water and Sewerage Authority (WASA) to provide/expand WASH services in other cities to people living in Low Income Communities (LICs).	LGD, WASA, CCs Municipalities, DPHE, WDB NGOs, private WASH service providers	Short/Medium
	2. Harmonise the intersectoral policies and strategies for improved WASH system for the urban slum dwellers.		
Take a long-term institutional development approach with those responsible for Faecal Sludge Management (FSM) (WASA and the City Corporation).	1. Develop a policy agreement, and related MOUs along with action plan between responsible authorities, NGOs, and private sector.	LGD, WASA, CCs Municipalities, DPHE, WDB NGOs, private WASH service providers	Long
	2. Establishment of a FSM Support cell to address the safely managed sanitation systems in urban areas throughout the country.		
	3. Support Dhaka Water and Sewerage Authority (DWASA) to implement the sewerage masterplan developed for the city with the goal of having 100 per cent coverage by 2025.		
Develop an Institutional and regulatory framework for faecal sludge management (FSM), explaining the overall responsibility for execution of the entire FSM chain, along with the National Action Plan.	1. Advocacy to expedite implementation of the Costed action plans that has been developed to address the priority gaps.	WASA, BNNC, DPs, NGOs	Short/medium
B. Strategies to address challenges associated with program design, implementation and resource allocation.			

Strategy	Activity	Responsibility	Timeline
Equitable allocation of resources for WASH for poor settlements and slum areas, and for allocation from both government and development partners. Increase allocation for hygiene component of WASH.	1. Advocacy to increase allocation of public resources for WASH services in the poor settlements, including urban slums 2. Advocacy to increase allocation of public resources for hygiene component of WASH services. 3. Identify alternative mechanisms for resources to improve WASH services, including public-private partnership and contract out models in urban slums.	MoFinance, LGD, MoHFW WASA, DPHE, CCs	Short/Medium
Subsidy provision for faecal sludge management (FSM) for operation and maintenance (O&M) cost of the infrastructure built with involvement of the community.	1. Advocacy for the 100% subsidy for O&M cost for FSM for the slum dwellers in line with the revised pro-poor strategy 2020. 2. Leveraging private funding for sanitation and solid waste management operation and maintenance and capital expenditure and develop Public–Private Partnership (PPP).	LGD, WASA, DPHC, CCs.	Medium
Reduce the financial deficit, increase government allocations, coupled with resource mobilization from the private sector and DPs and enhance allocation efficiencies.	1. Encourage private sector, local entrepreneurs, Micro Finance Institutions and external support agencies and NGOs to participate WASH business in line with the revised pro-poor strategy 2020.	LGD, WASA, DPHC, CCs, DPs, Private sectors (for profit and non-profit).	Medium/Long
Explore innovative ways to complement domestic financing with development partners, and private sector financing (e.g., through corporate social responsibility).	1. Work with the private sector to provide goods and services, and support efforts to mobilize the broader business community's contribution to SDG 6 in urban areas.	LGD, WASA, DPHC, CCs, DPs, Private sectors (for profit and non-profit).	Medium/Long
Develop area-wise needs-based plans that capture the specific and diverse needs of the vulnerable population in urban slums.	1. Mapping specific urban slums and poor settlement and develop a costed plan for appropriate WASH service delivery at these settlements. 2. Link the urban informal settlement with government service providers, build inclusive WASH facilities for minors, the elderly and physically challenged populations, and	LGD, WASA, DPHC, CCs, DPs, Private sectors (for profit and non-profit).	Short/Medium

Strategy	Activity	Responsibility	Timeline
	implementing climate resilient WASH infrastructure.		
Strengthen capacity of City Corporations and Municipalities on managerial, technical, and financial aspects of urban WASH.	1. Conduct a training needs assessment for the urban authorities on improved WASH service provision. 2. Provide training and technical assistances to urban authorities (CC and Municipalities) on targeted work plan and implementation.	MoFinance, LGD, WASA, DPHE, CCs, Municipalities	Short
Undertake SBCC campaign targeting slum dwellers for water treatment and hand washing.	1. Undertake BCC activities targeting urban poor involving all family members, community groups and leaders for water treatment and hand washing in three critical conditions. 2. Promote community management of water and sanitation services.	LGD, DPHC, NGOs	Short/Medium
Improve WASH system in urban slums including health facilities, schools both in terms of physical facilities and management.	1. Promote supply of safe water and sanitation in all urban areas including health facilities, schools, mosques, madrashas to impact household nutrition outcome through involving government departments, NGOs, private sector, and communities. 2. Strengthen flood protection and drainage facilities, river training and dredging. 3. Ensure provision of setting-up sustainable hand washing safe adequate water in health care facilities and schools with soap to prevent infections and sufficient spread of disease. 4. Provide safe water including proper waste management supply and training on safe water to schools , healthcare facilities and public settings. 5. Undertake behaviour change communication. Promote hygiene messages focused on hand washing with soap, latrine usage and maintenance, safe water handling and menstrual hygiene.	City Corporations, Municipalities, private sector, NGOs, WDB, DPHE	Shor/Medium/Long

Strategy	Activity	Responsibility	Timeline
	6. Scale up piped water supply for the urban poor with emphasis on underserved, un-served areas.		
	7. Building customized system and infrastructure for urban slums /poor settlements.		
	8. Implement sock pit/septic tank and ensuring safe sewerage systems.		
	9. Conduct partnership with research institutes to develop low-cost sanitation technology for slums.		
Strategic partnership agreement between WASA and NGOs, CSOs and private sector for service delivery and infrastructure development.	1. Develop strategic partnership with private sectors (for profit and nonprofit organisations) for scaling-up WASH service delivery, infrastructure development and faecal sludge management in LICs (based on experience from Urban WASH programming in megacities, Bangladesh).	LGD, Private sector (for profit and nonprofit organizations including NGOs)	Medium
	2. Promote community financed and managed sanitation facilities.		
	3. Promote gender-sensitive communal and shared toilets.		
Develop an Institutional and regulatory framework for faecal sludge management (FSM), explaining the overall responsibility for execution of the entire FSM chain, along with the National Action Plan.	2. Advocacy to expedite implementation of the Costed action plans that has been developed to address the priority gaps.	BNNC, DPs, NGOs	Short/medium
Setting up the business model along with capacity building for the private entrepreneurs emptying for both FSM and SWM charges.	1. Develop a cross-subsidy mechanism to encourage a willingness to pay for the service by the LICs.	LGD, WASA, Private sector (for profit and nonprofit organizations including NGOs)	Short/medium/long
	2. Advocacy for developing on-site treatment options for FSM, such as 'Ecosan' _or anaerobic digesters for larger systems.		
	3. Undertake awareness raising campaigns and forging linkages with community groups.		

Strategy	Activity	Responsibility	Timeline
Prioritize a gender-responsive approach with necessary budget while developing WASH facilities for the urban poor communities. .	Build gender responsive WASH facilities for the urban poor Allocate the necessary budget for establishing gender responsive WASH facilities.	LGD/LGIs HSD, INGOs, NGOs	Medium and Long term
Undertake programs for improving hygiene and addressing occupational hazards of WASH workers	Provide training to the WASH workers on occupational health and safety Provide the wearing gears and supplies to WASH workers	LGD, LGIs, HSD	Short/medium
C. Strategies to address challenges associated with governance, coordination, and monitoring			
Clarify the roles of agencies supposed to provide standard WASH services to the vulnerable urban poor people.	1. Clearly delineate area of responsibility between city corporation and WASA for urban WASH services.	LGD, CCs/ Municipalities, WASA	Short
	2. Clarification of relevant Acts for defining specific role of hygiene and sanitation for both the Ministries.		
	3. Increased advocacy and mobilization for improved coordination among the LGD and MOHFW.		
Functionalise the existing coordination mechanisms in urban local government to improve WASH for urban slum dwellers.	1. Regularise the meetings of urban coordination committee and relevant standing committees at Ward level	MOHFW, LGD, WASA, CCs, municipalities, local government representatives	Short/Medium
	2. Develop specific targets for respective committees on improvement of WASH situation and implement a performance-based resource allocation for that.		
	3. Utilise non-monetary incentives for the local government representatives with highest contributions towards improvements in WASH services (e.g., national award).		
	4. Include WASH authority into the Health Coordination Committee (UHCC) and other relevant standing committees (UHCC) and utilize UHCC and other relevant standing committees to improve urban WASH services.		

Strategy	Activity	Responsibility	Timeline
Strengthen the monitoring system of the responsible authority, to enforcement of existing laws.	1. Strengthen and capacity building and monitoring mechanism of the local government authority.		

4.4 Action Plan for Urban Education Systems

Strategy	Activity	Responsibility	Timeline
A. Strategies to address policy and strategy-related challenges			
Review the Education policy to increase access for student from poor families and floating population schools and out-of-school education programmes.	Review relevant education policies and programs to expand educational program among urban slum dwellers, floating population and other urban poor through formal and non-formal interventions.	MOPME, MOE, MOP, Cabinet Division, City Corporations, Municipalities, DPs	Medium
Innovative strategies to increase coverage of education in and around urban poor settlements	Advocacy for rational and equitable allocation of resources for urban poor areas.	MOPME, MOE, MOP, MOP, Cabinet Division, CCs, DPs	Short
	Policy advocacy to increase area coverage of school feeding/meal programme to cover urban areas in city corporations, including the non-formal schools.		
B. Strategies to address challenges associated with Program Design and Implementation, including Resource Allocation			
Mobilize more resource support including teachers and operational fund to non-formal schools in the urban slums.	Advocacy to increase coverage of the school stipend programs for the urban poor students. Improve the coordination among various service providers providing formal and non-formal education at slums.	MOPME, MOE, BNFE, NGOs	Short
Promote "adolescent nutrition and healthy lifestyle" through formal and informal academic curriculum/training and SBCC programs including the stipend program	Sensitize school management, schoolteachers, parent teacher associations on nutrition. Scale up school-based informal nutrition education activities linking wider platforms such as Nutrition Club, Community Support Groups, Girl Guides and Scouts.	MOE, MOHFW, MOWCA, DGHS, DSHE, DWA, NNS, NGOs	Medium

Strategy	Activity	Responsibility	Timeline
Scale-up integrated nutrition education strategies to enhance consumption of healthy, diets, increase awareness of the nutrient composition of healthy diets as well as to prevent and control malnutrition.	Expedite similar behavioral outcomes on dietary practice and nutrition awareness among nutrition education interventions through process and message.	MOPME, MOE, MOHFW, MOWCA, NNS	Medium
Expand school health program to urban schools. Enhance health seeking behaviour of school going children and adolescents by linking them with School health program/little Doctor program/ Adolescent Reproductive & Sexual Health programs embedding nutrition into them	Establish linkage among School health program and Little Doctor program under DGHS, Adolescent Reproductive & Sexual Health program under DGFP and Adolescent Nutrition program under DSHE-NNS.	MOE, MOHFW, DGHS, DSHE, DGFP	Short
Review curricula for inclusion of nutrition education. Update nutrition curriculum at different levels of academic institutions (formal & informal).	Include/update nutrition curriculum for primary, secondary, non-formal schools, managed by public, private and NGOs.	MOPME, MOE, DSHE, DGPE, NCTB, NNS	Medium
Promote and establish school nutrition program including gardening throughout urban cities where possible.	Establish school nutrition gardens where feasible in urban areas. Arrange rewards system for successful performer on school gardening.	MOE, MOPME, DSHE, DGAE, CC, Municipalities,	Medium
Adopt motivational, social, and legislative interventions to prevent child marriage. Make access to school easy and safe for girls and motivate them to continue and complete education.	Ensure collaboration among the relevant stakeholders, including local administration, law enforcement agency and civil society to enforce relevant acts and regulations.	MOPME, MOE, MOWCA, MOHA, LGD. MOF, Police, MOPA, Ministry of Planning and Civil Society	Long
	Conduct community mobilization with the support from civil society and community leaders in relieving social pressure off the guardians to prevent child marriage.		
	Utilise social media in mass awareness raising for improving safe environment for girls to continue education and prevent child marriage.		
Strengthen and expand coverage of adolescent nutrition programmes utilizing schools and educational institutes. Introduce nutrition education, healthy diets, periodic deworming and weekly IFA supplementation.	Implement Adolescent Nutrition Operational Guidelines both for school and out of school adolescents. Utilise the adolescent clubs to enhance awareness of nutrition among the adolescents in the out-of-school settings.	MoE, MOHFW, BNNC, DGHS, DGFP, DSHE, NNS	Short

Strategy	Activity	Responsibility	Timeline
	Strengthen the school health programme among all schools to ensure coverage of adolescent nutrition interventions in urban areas.		
Establish Girls-friendly environment including separate toilets and sanitation facilities along with proper MHM system in all schools and academic institutions.	Collaborate among relevant stakeholders to ensure safe passage for girl students to their school and safe environment at the school. Arrange appropriate washroom and MHM facilities at school and academic institutions.	DPHE, MOPME, MOE, Facilities Dept., CCs, municipalities, Local government representatives	Medium
Promote interventions to discourage involvement of adolescents (both boys and girls) into income generating activities that result in drop-out from school.	Increase coverage of school stipend particularly targeting urban poor. Sensitize parents and guardians on the importance of completion of education for students, particularly girl students. Collaborate with formal sector employers to strictly monitor and enforce the regulations regarding employing child workers and adolescent workers. Establish student tracing mechanism and formalize inter-school transfer system to mitigate high girls drop out.	MOPME, MOE, MOWCA, MOHA, LGD. MOF and Planning	Long
Coordinate with private sector to ensure after-work education of adolescent boys and girls for those involved in employment.	Advocacy with employers to arrange after-work education sessions for adolescent boys and girls in urban and peri-urban areas.	MOE, MOWCA, MOHA, LGD. MoL&E, DGVE BGMEA, BKMEA, Employers' Association	Medium
Increasing the number of TVET (Technical and Vocational Education and Training) institutions in urban areas and its peripheries where permanent set-ups are not feasible, using alternative methods, e.g., mobile technical schools.	Establish Technical and Vocational Education and Training (TVET) institutions in urban and its peripheries. Increase proportionate intake capacity of existing vocational education institutes to allow access for urban poor adolescents. Arrange mobile technical schools' units where permanent set up is not feasible targeting urban poor areas.	MOE, DGVE, UCEP	Medium
C. Strategies to address challenges associated with governance, coordination and monitoring.			

Strategy	Activity	Responsibility	Timeline
Greater coordination and coherence in programmes for achieving key objectives, moving towards a sector-wide approach, involving major stakeholders for efficient skills development.	Moving towards sector-wide programming approach on education instead of project-based implementation.	MOPME, MOE, MOP	Long
Establish/utilize urban coordination platforms to coordinate and monitor educational interventions, both public and private as well as formal and informal.	Form intersectoral coordination committees/platforms on Education in urban areas to coordinate and monitor interventions.	MOPME, MOE, LGD, BNNC, CCs, LGI, DPs, Private entrepreneurs.	Long

4.5 Action Plan for Urban Social Security Systems

Strategy	Activity	Responsibility	Timeline
A. Strategies to address policy-related challenges			
Enhance evidence based nutrition-sensitivity of NSSS, 2015 to address urban nutrition issues, so that the draft Urban Social Protection Strategy and Action Plan in Bangladesh, 2020 and its recommendations are incorporated in NSSS.	Review NSSS, 2015 and develop evidence for advocacy to incorporate issues to address urban nutrition issues (e.g., unhealthy diets, all forms of malnutrition, diet-related NCDs)	Cabinet Division, GED, LGD, BNNC	Short
	Incorporate appropriate actions in the draft Urban Social Protection Strategy and Action Plan, 2020 to safeguard nutrition status of the urban poor		
Expand coverage of social protection of urban poor	Conduct advocacy with relevant stakeholders to introduce new SPPs for urban poor	Cabinet Division GED of Planning Commission, Finance Division MOHFW, MODMR, MOFOOD, MOE, MOSW, MOWCA	Medium
	Pilot PPP for operation of social infrastructure (Day care, child home, Orphanage, old home etc.)		
	Conduct advocacy for expansion of existing SPPs in urban areas and expansion of purview of some of the rural SPPs in urban areas		Medium

Strategy	Activity	Responsibility	Timeline
	Promote shock-responsive and anticipatory social protection by building on 2019 conference on shock-responsive social protection and 2020 experience of forecast-based social protection	MOPME, LGD, DPs, NGOs	Medium
Develop a more comprehensive approach to urban social protection, including developing an evidence based and effective national social insurance (?) scheme.	Define the comprehensive approach for urban social protection.	Cabinet Division, BNNC, Planning Commission	Medium
	Develop a national social insurance scheme based on operational research and international experiences, lessons learned and best practices	LGD,FID, IDRA, HSD,HEU,	Medium/Long term
	Pilot and Introduce the national social insurance scheme	LGD/LGI, Finance & Banking division, IDRA, HSD,HEU	Medium
B. Strategies to address challenges associated with Programme			
Ensure on-time implementation of the N4G commitments, particularly those targeting urban poor	Prepare an operational plan on N4G commitments with monitoring and coordination mechanism for effective operationalisation of N4G commitments	MOHFW, MoFood, MoFin, BNNC	Medium
Enhance targeting efficiency of social safety net programs	Introduce GIS-based mapping of malnutrition and poverty and use it for geographic and beneficiary targeting	All SSP implementing agencies.	Medium
Enhance advocacy for increased allocation for and expanded coverage of urban poor including floating population and slum dwellers in social protection programmes	Prepare an Urban Social Protection Policy with a Policy Brief on urban social protection issues having strategic directions to GED, Cabinet division and Ministry of Finance to increase allocation and improve targeting .	Cabinet Division GED of Planning Commission, Lead ministry of five thematic programme clusters, MOPME, LGD MODMR, MOSW, BNNC, DPs, NGOs, UN Agencies	Short
Expand existing social protection programs (which are being implemented in rural areas)	Conduct dialogue with respective ministries to expand and adapt the appropriate rural SSPs to urban areas	Cabinet Division, Planning	Medium

Strategy	Activity	Responsibility	Timeline
among urban poor dwellers (including floating population) as proposed in draft Urban Social Protection Strategy and Action Plan in Bangladesh 2020.		Commission, Finance Division, MOWCA, MOHFW, MOSW, MOE, MOPME.	
Increase nutrition sensitivity of the SSPs through ensuring nutrition situation analysis in the design stage of SSPs and incorporation of nutrition objective, indicators, and targets in the design	1.Prepare a technical guideline for designing a nutrition-sensitive Social Security program.	BNNC, DPs, NGOs, UN Agencies	Short
	2.Advocacy for keeping participation from BNNC in the design phase of SSPs to ensure the nutrition sensitivity		
	3.Conduct periodic review of all SSPs and provide feedback to the relevant ministries on nutrition sensitivity of the programmes		
Rationalize the resource allocation for urban SSPs considering the population number and vulnerability.	Conduct thorough analysis of the urban SSPs in the context of population number and vulnerability in different urban areas	BNNC, LGD, DPs, NGOs, UN Agencies	Short
	Advocacy with respective ministries for rationalisation of resource allocations based on evidence		Medium
Promote the gradual shift to and Scale up the inclusion of fortified rice in the Food Friendly Program (FFP) and OMS, diversify the food distributed in social protection programmes, and monitor impacts on nutrition in urban areas.	Expand cultivation of bio fortified rice, and Include fortified rice in the distribution of SSPs providing food grains in urban areas	MOA, BNNC, MOFood, MOWCA, MOSW, MODMR, LGD, Cabinet Division, UN Agencies, NGOs	Short
	Package innovative BCC message with the distribution in the SSPs		Short
	Conduct operational research to identify the impact of fortified rice and BCC on the nutrition of urban population		Medium
	Conduct evidence-based advocacy for expansion of programme along with increased resource allocations based on the results of the research		Medium
Expand the School Feeding Programmes in urban slums.	Conduct advocacy to expand school feeding programme in urban areas, particularly in schools within and on the periphery of urban slums	MOE, MOPME, LGD, UN Agencies, NGOs	Medium
Enhance and integrate quality BCC activities into social protection programs along with transfers (cash or kinds).	Package innovative BCC message with urban SSPs, and update the program design based on the results	MOWCA, MOSW, MOFood, MOE, MOPME, LGD, BNNC, UN Agencies, NGOs	Medium

Strategy	Activity	Responsibility	Timeline
Strengthen Advocacy for enhanced use of technology-based disbursement to improve governance and to reduce delay.	Identify and adopt appropriate technology-based disbursement methods (G2P) and advocacy for using those	FD, BNNC, ICT Division, MOWCA, MOSW, MOEd, MOPME, LGD, UN Agencies, DPs, NGOs	Short
C. Strategies to address challenges associated with governance, coordination, and monitoring			
Strengthen coordination between SSPs and other basic social services offered through different ministries	Conduct operational research to identify gaps in delivery mechanism, management, and coordination between basic social services (typically delivered as core service of the respective ministries) and the SSPs (typically delivered as project) of different ministries and conduct evidence-based advocacy to minimise those gaps	BNNC, Cabinet Division, LGD, MOWCA, MOFood, MOSW, MOE, MOPME	Medium
Establish an inter-operable nutrition information system related to SSPs and include the collection of routine data on the status of gender equality to support programme improvement and advocacy for resource mobilization.	Develop a Nutrition Information System capable of incorporating the existing MIS of different ministries having SSPs, preferably under the new NNS OP of 5th HPNSP	BNNC, NNS, ICT Division	Short
	Conduct advocacy to the ministries to allow their SSP information from MIS to be linked to the Nutrition Information System	Cabinet Division, LGD, BNNC, ICT Division	Medium
	Allow the NGOs working in urban areas to link their project data into the Nutrition Information System	BNNC, NNS, ICT Division, LGD, DPs, UN Agencies, NGOs	Short
Enhance multisectoral coordination to ensure coverage of urban poor under nutrition sensitive SSPs.	Identify the bottlenecks for proper functioning of existing various coordination mechanisms and develop an action plan to overcome those bottlenecks for better stewardship, governance, monitoring and supervision of SSPs	Cabinet Division, GED LGD, BNNC, WFP, UNDP	Short
	Design and institutionalize a common database of beneficiaries, particularly the urban poor, to facilitate regular monitoring, reporting, and evaluation.		

Strategy	Activity	Responsibility	Timeline
	Ensure regular functioning of the coordination committees for SSPs, including regular meetings and follow up		
Introduce beneficiary feedback, complaint, and redressal mechanism to increase accountability and programme effectiveness, emphasizing child welfare and gender issues.	Update the existing GRS system of Cabinet Division or develop a new such system to capture the child welfare, gender issues and other aspects of the SSPs	Cabinet Division, LGD, BNNC, all ministries having SSPs, UN Agencies, DPs, NGOs	Medium
	Conduct mass awareness campaign so that the beneficiaries can use the GRS system to send their feedback and complaints		Medium
	Coordinate with the respective ministries to monitor the progress of utilisation of GRS and subsequent redressal mechanism		Long

Financing and Investment:

The Multisectoral Urban Nutrition Strategy has prioritized a comprehensive set of actions and interventions that require financial estimation for successful implementation. Each proposed action must encompass distinct, geographically disaggregated, multi-year targets to ensure optimal resource alignment for effective execution. The financing of the costed strategy presents a significant challenge, as the national government alone may not be capable of mobilizing all necessary resources. Consequently, local government institutions, development partners, and the private sector must engage actively, not only in resource mobilization but also in program implementation according to their respective competencies and strengths. Public-private partnerships are imperative, particularly for mobilizing resources towards the construction of essential infrastructure, such as the development of wet markets and cold chain facilities, as well as establishing general practitioner clinics for primary health care and nutrition service delivery. Funding should also be sourced from local government institutions, including city councils and municipalities, to ensure the execution of regular programs adopted by the government. While it is the government's responsibility to establish service standards and protocols, development partners—such as the Asian Development Bank (ADB), the World Bank (WB), the Foreign, Commonwealth & Development Office (FCDO), and bilateral donors—serve as essential sources of financing for both infrastructure projects and technical assistance, including capacity building initiatives.

Monitoring &Evaluation:

The government plans to establish a strong monitoring and evaluation (M&E) system that emphasizes progress tracking and reporting using SMART indicators. This will follow the principles outlined in the National Plan of Action for Nutrition (NPAN) and align with the Sustainable Development Goals (SDGs). The emphasis will be on assessing and producing evidence through research, which will support the development of evidence-based policies and informed investment decisions. In this process, consistently collecting service delivery data is essential, and integrating it into DHIS2.

Way forward

To implement priority programs and actions, it is advisable to formulate a detailed action plan that includes cost assessments. This plan will facilitate the mobilization of resources from the government, local government institutions (LGIs), development partners (DPs), and through public-private partnerships (PPP). This strategy serves as a dynamic document and may require modifications in response to evolving circumstances.