HEALTH, NUTRITION AND POPULATION STRATEGIC INVESTMENT PLAN (HNPSIP) 2016 – 21

"Better Health for a Prosperous Society"

APRIL 2016

PLANNING WING
MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

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PREFACE

The health, nutrition and population (HNP) Strategic Investment Plan (SIP) has identified the key investment areas required to accelerate the pace of development in the HNP sector in Bangladesh in line with the Sustainable Development Goals (SDG) and targets, and the 7th Five Year Plan (2016-20) strategies of the Government of Bangladesh. The goal is to ensure that quality HNP services are delivered and key services are provided more effectively, with focus on equity. The longer-term aim is to move towards achieving universal health coverage (UHC) as targeted in SDGs.

This SIP is the culmination of a process, led by Ministry of Health and Family Welfare (MOHFW) that began in 2015 with extensive consultations with the sector's stakeholders including development partner (DP) representatives. A set of analytical studies and assessments including surveys were undertaken to identify gaps and continuing challenges. These findings also provided essential inputs to address new priorities and challenges relating to demographic and epidemiological transitions; expanding private investments in health service and medical education; increasing out of pocket expenditure; and a social environment of rising public expectations.

The SIP sets out an analysis of the sector's performance and the prime issues that are needed to be addressed. The SIP has been prepared by MOHFW with the intention to define an overall strategic framework to guide investments in the HNP sector. Guiding principles of the SIP are to address new and continuing challenges through (a) emphasizing service quality, (b) improving efficiency in resource use and reducing wastage; and (c) focusing on equity. Moreover, learning experiences during the last five years of implementation of HPNSDP had also contributed to generate information and understanding for the development of this SIP with a view to improving access, utilisation, poverty targeting and service quality.

The SIP has also developed results framework (RFW) indicators for assessing progress against three components, namely (i) strengthening governance and stewardship, (ii) strengthening HNP systems, and (iii) improving service quality. The SIP highlights essential service package (ESP) and improved financial coordination as tools for achieving efficiency and equity.

An important proposition underlying this SIP is that MOHFW has strategic stewardship and management roles that extend beyond the services it finances or provides directly. As a result, this SIP is sector-wide in scope, covering services related to health, family welfare and nutrition in both rural and urban areas and at primary, secondary and tertiary levels, whether provided by Government, private or NGO providers.

MOHFW is to exercise its constitutional mandate to contribute more effectively to public priorities in the HNP sector. The hallmark of success will be that all Bangladeshi women and men have access to health services that extend life and improve its quality.

The SIP sets out what the sector's medium term priorities and strategies are and why. Its purpose is to create the basis for preparation of the Programme Implementation Plan (PIP) and future Operational Plans for the 4th Sector Programme for five years covering financial years from 2016/17 to 2020/21.

I hope that while the PIP and the OPs are developed for the new sector Program in line with the agreement around SIP objectives and strategies, the Development Partners will also find SIP as a useful document for participation in financing the new Program. I congratulate all belonging to the GOB and DPs who contributed to the demanding process of developing the SIP. I expect, on behalf of the Government of Bangladesh, that our joint endeavour of *"Better Health for a Prosperous Society"* will be fruitful.

(Mohammed Nasim, MP)
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ACRONYMS AND ABBREVIATIONS

ADP	Annual Development Programme
AIDS	Acute Immune Deficiency Syndrome
AMC	Alternative Medicine Care
ANC	Ante Natal Care
BCC	Behaviour Change Communication
BDHS	Bangladesh Demographic & Health Survey
BENAP	Bangladesh Every Newborn Action Plan
BNNC	Bangladesh National Nutrition Council
CGA	Controller General of Accounts
CMSD	Central Medical Store Depot
CSBA	Community Skilled Birth Attendants
CC	Community Clinic
C-EmOC	Comprehensive Emergency Obstetric Care
CHCP	Community Health Care Provider
CHT	Chittagong Hill Tracts
CPR	Contraceptive Prevalence Rate
CVD	Cardiovascular Diseases
DALY	Disability Adjusted Life Years
DBM	Disease Burden of Malnutrition
DGDA	Directorate General of Drug Administration
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospitals
DP	Development Partner
DPA	Direct Project Aid
DRS	District Reserve Stores
DSF	Demand Side Financing
ESP	Essential Service Package
EU	European Union
FAPAD	Foreign Aided Project Audit Directorate
FDI	Foreign Direct Investment
FY	Financial Year
FYP	Five Year Plan
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FMAU	Financial Management and Audit Unit
GATS	Global Adult Tobacco Survey
GDP	Gross Domestic Product
GNSPU	Gender, NGO and Stakeholder Participation Unit
GOB	Government of Bangladesh
HA	Health Assistant
HBB	Helping Babies Breathe
HED	Health Engineering Department
HEU	Health Economics Unit
HFS	Health Financing Strategy
HIS	Health Information System
HNP	Health, Nutrition and Population
HNPSIP	Health, Nutrition and Population Strategic Investment Plan
HPNSDP	Health, Population and Nutrition Sector Development Programme
HRH	Human Resources for Health
HRM	Human Resource Management
iBAS	Integrated Budget and Accounting System
IMR	Infant Mortality Rate
IST	In-service Training
IUFR	Interim Unaudited Financial Reports
LAPM	Long Acting and Permanent Methods
LARC	Long Acting Reversible Contraceptive
LD	Line Director
MA4H	Measurement and Accountability for Results in Health
MAD	Minimum Adequate Diet
MCU	Maternal and Child Under-nutrition
MCWC	Maternal and Child Welfare Center
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
M&E	Monitoring and Evaluation
MOCHTA	Ministry of Chittagong Hill Tracts Affairs
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MOPA	Ministry of Public Administration
MPIR	Mid -Term Programme Implementation Report
MR	Menstrual Regulation
MSR	Medical and Surgical Requisites
MTR	Mid-Term Review
MTBF	Mid Term Budgetary Framework
NCD	Non-Communicable Diseases
NEMEMW	National Electro-Medical Equipment Maintenance Workshop
NES	Nursing Education and Service
NMR	Neonatal Mortality Rate
NPAN	National Plan of Action on Nutrition
NSSS	National Social Security Strategy
NTD	Neglected Tropical Disease
NIPORT	National Institute of Population Research & Training
OCA	Organisational Capacity Assessment
OOP	Out of Pocket
OP	Operational Plan
PHC	Primary Health Care
PIP	Programme Implementation Plan
PMMU	Program Management & Monitoring Unit
PW	Planning Wing
PLMC	Procurement & Logistics Management Cell
PNC	Post Natal Care
PPP	Public Private Partnership
PSE	Pre-service Education
PWD	Public Works Department
R&D	Research & Development
RFW	Results Framework
RPA	Reimbursable Project Aid
SBA	Skilled Birth Attendant
SCANU	Special Care Newborn Unit
SDGs	Sustainable Development Goals
SSK	Shasthyo Shuroskha Karmasuchi
STG	Strategic Thematic Group
SOP	Standard Operating Procedure
SWAp	Sector Wide Approach
TB	Tuberculosis
TFR	Total Fertility Rate
THE	Total Health Expenditure
TMIS	Training Management Information System
TOE	Table of Equipment
U5MR	Under Five Mortality Rate
UHC	Universal Health Coverage
UH&FWC	Union Health & Family Welfare Center
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

The Fourth Five-year Health Sector Programme as outlined in this Health, Nutrition and Population Sector Strategic Investment Plan (HNPSIP) 2016-21, calls for a substantive change in the way the sector is organised and managed. It recognises the need to expand existing services to currently underserved groups, including adolescents, the poor and those in urban and hard to reach areas. It recognises the need to continue to work on stabilising population growth through education and family planning services. It also recognises the demographic and epidemiological transitions taking place that require government and its partners to address emerging health challenges and to work more closely with other sectors whose actions have a direct bearing on health and health outcomes. This plan is underpinned by the commitment of government to safeguard and improve the health of all the population and establish more equitable access to health services. It recognises the important international initiatives and the need for alignment with national commitments, such as the Sustainable Development Goals (SDGs), for achieving these. As such the plan is consistent with the emerging priorities articulated in the SDGs, particularly those are relevant to health and well-being, while building on the gains already made towards achieving the Millennium Development Goals (MDGs). It aligns with the broader national policy framework as set out in the 7th Five-year plan and national policies on health, nutrition, population and social protection.

The 4th Sector Programme starts at a time of transition from the MDGs to the newly agreed SDGs. While this reinvigorates the national and international dialogue and support for development it has particular risks and challenges for the health sector. The MDGs had a major focus on health sector specific goals whilst the SDGs encompass a much broader agenda for change. Some of the new SDGs are strongly related to the determinants of health (such as SDG 2 on nutrition and SDG 6 on WASH) as well as there being a health specific SDG (Goal 3). This opens up new opportunities for the Ministry of Health and Family Welfare (MOHFW) and its partners and in response the 4th Sector Programme calls for more action on the underlying causes of ill-health and the need to tackle issues of lifestyle and the environment as well as providing high quality curative care services. The MOHFW cannot do this alone since this needs to build a broad coalition of government, private sector and communities.

Over the period of the MDGs Bangladesh has made remarkable progress in improving health outcomes as demonstrated by the reduction in maternal mortality (MDG 5) and child mortality (MDG 4). This sets the stage from where Bangladesh can now ambitiously look forward towards attaining the Sustainable Development Goals through ensuring universal health coverage, meaning – an end to inequity in health care.

There is now good consensus on the future direction and focus for the health sector. The HNPSIP aims to both consolidate and sustain the achievements gained so far, and strive for more progress on health outcomes through further improvement in access to services, strengthening of core systems and ensuring continuous quality improvement. Expanding and strengthening the country's comprehensive Maternal, Neonatal, Child and Adolescent health care approach (MNC&AH), including sexual and reproductive health services, is therefore being maintained as a priority and a crucial part of the government's efforts to incrementally reduce morbidity and mortality and to ensure the well-being of the population (STG MNCH,

2015)[1]. At the same time, the country has to prepare for addressing demographic and epidemiologic transition that will shape the need of the population during this sector programme and the subsequent ones. The focus of SDG 3 is to reach universal health coverage, and this calls for strengthening public health care services in order to increase utilization of quality primary health care by the poor and those living in geographically challenged areas.

In order to effect the changes outlined in the HNPSIP the MOHFW has set out an agenda to move towards a stronger governance and stewardship role that will be needed to ensure that all health sector stakeholders including the expanding for-profit private sector adhere to policies, procedures and quality standards. More emphasis will be given to regulation and building transparency and accountability across the sector. This will in turn require substantive changes in the way the MOHFW is set up, a programme to develop capacity in governance, leadership and management areas across government departments and agencies, and a new partnership-based relationship with the private sector. In particular more emphasis will be needed on ensuring that the required skills in public health are available as are strategies for building community ownership and participation.

The HNPSIP advocates for a comprehensive and well managed district and sub-district arrangements built around an effective functional integration of health services. This will be underpinned by sound management and planning, coordination and accountability and the need for a progressive roll-out of an essential health services package for all. These call for a renewed emphasis on providing good quality services to the most marginalised and those in hard to reach places. This will require innovative approaches, a motivated and skilled workforce and close collaboration with the private sector. Improvements in quality, equity and efficiency across the health service are a prerequisite to attaining Universal Health Coverage (UHC).

The sector programme recognises the importance of heading off the severe consequences of the rapid rise in Non-Communicable Diseases (NCDs) through a shift in emphasis towards public health and a creative lifestyle change programme and coordinated multi-sectoral action to improve nutrition, environmental conditions through work on road safety, food safety, air and water pollution and agricultural practices that are currently undermining health. It also recognises the need to improve social norms, reduce harmful practices, improve gender relations and tackle the rising mental health problems in rural and urban settings.

The HNPSIP emphasises that more flexibility is needed if services are to be provided to those currently excluded or living in hard to reach areas. This flexibility includes seeking means of protecting the poor from often ruinous out of pocket expenditure on health services and medicines. Through risk protection programmes, better regulation and improvement in service quality more people will be given better access to care. As part of this approach national and local decision-makers will be encouraged to explore diverse and flexible partnerships to extend coverage of services through working more closely with the private for-profit and not for-profit sectors, including community participation/support.

The challenge for the sector is to prevent ill health and provide better services for all within a heavily constrained financial environment. The government allocations to health remain low

[1] MoHFW (2015) Report of the Strategic Thematic Group on MNC&AH. Report prepared as part of the 4th Sector Programme preparation process.

in terms of regional comparisons while performance is high. The MOHFW will like to concentrate on demonstrating improved performance across the sector and building the investment case for health funding as a foundation for future growth in the national prosperity. Achieving sustainable levels of financing for the sector will depend on a combination of managing the demand for health care through prevention and effective treatment, seeking efficiency gains based on reducing wastage and introducing betters ways of providing care, and through advocacy towards government and development partners for an increased investment.

The 4th Sector Programme will be built on the ten key driving forces as mentioned below to be translated into strategies and actions.

Ten Key Driving Forces of the HNPSIP (2016-21)

1. A stronger governance and stewardship role of the MOHFW, building capacities in leadership, management and regulation for better quality services
2. A restructured MOHFW, to increase performance, efficiency and accountability while removing duplication and waste.
3. The roll out of an upgraded Essential Services Package (ESP) with greater functional integration of services at district level and a functional referral system.
4. The development of new approaches and partnerships with the private sector and the community to ensure basic services reach the poor, the hard to reach, the disabled, elderly and those left behind.
5. A focused improvement in quality of care, including ensuring the implementation of a comprehensive health workforce strategy and action plan.
6. Promoting the importance of public health and increased investment in prevention, primary care and strengthening community engagement.
7. Tackling the rising burden of NCDs through cross-sectoral work to establish healthy lifestyles and healthy environment.
8. Tackling the burden of established and new communicable diseases.
9. The adoption of new technologies to strengthen surveillance, data quality and information systems to provide a strong evidence base for decision making.
10. Greater investment in health, ensuring a focus on managing demand, increasing efficiency and developing the evidence base for future health funding.

The MOHFW has captured the spirit of the new health agenda in its vision and mission and has ensured that these are given high profile in the GOB's 7th Five-Year Plan (2016-21) and the health related Sustainable Development Goals (SDGs). If fully implemented, this Health Nutrition and Population Sector Strategic Investment Plan (HNP SIP) will contribute towards a substantive and sustained improvement in the health and wellbeing of the people of Bangladesh.

SECTION 1: INTRODUCTION

1.1 Better Health for a Prosperous Society

Bangladesh has made great strides in improving the health of its population through a combination of political engagement, socio-economic development and a range of health and health related interventions and services. Bangladesh is often cited as a success story with good progress against many of the Millennium Development Goals and related indicators as demonstrated in a series of independent evaluations and reviews across the sector. The independent Mid Term Review (MTR, 2014)[2] concluded that "good progress has been made in improving health outcomes for the people of Bangladesh since the start of the Health, Population and Nutrition Sector Development Programme (HPNSDP, 2011-16) as indicated by the decline in mortality rates and improvements in service delivery". Despite this progress the government recognises that more needs to be done to ensure that the progress made in improved maternal, neonatal and child health, nutrition and family planning services is sustained and made available across the whole country including the more marginalised and impoverished sections of society.

1.2 Scope of the 4th Sector Programme

The 4th Sector Programme outlined in this document encompasses the whole health sector and is relevant to all stakeholders working in health, nutrition and population. It outlines the on-going challenges and introduces new and emerging issues that need to be addressed. The new programme takes into account the importance of government's role in stewardship and regulation, ensuring all providers are working to nationally agreed approaches and standards. It provides a framework for management of public and private (for-profit and not-for profit) sectors and calls for more focus on ensuring high standards of quality and accountability. The programme embraces the wider HNP agenda provided by the recently adopted SDGs and recognises the urgent need to engage society in the tasks of improving health and well-being. Provision of good quality services for all is at the heart of the programme approach, providing the direction to achieve the aims of Universal Health Coverage, equity and quality. It also recognises that improving health will require multi-sectoral action on the wide range of determinants of health.

The 4th Sector Programme will be the first and the foundation stone of the three successive SWAps for realising the health targets of SDGs by 2030. This is why the agenda outlined in this document includes a number of new strategic directions and approaches. This 4th Sector Programme is also consistent with GOB's Vision 2021, 7th Five Year Plan (FYP) and its policy framework on health, population and nutrition. It articulates a set of objectives to move the country towards its goal of Universal Health Coverage (UHC) by 2030. It puts people and choice at the centre of the strategy to prevent ill-health wherever possible and ensure effective treatment where it occurs. It focuses on finding solutions to providing services for those currently not reached in urban and rural settings.

[2] Daniels, D and Kablr, H (2014). *Mid term Review (MTR 2014) of the HPNSDP, 2011-2016.* Ministry of Health and Family Welfare. Final report, October 2014.

1.3 The Policy Context

Vision 2021 and 2041

Over the past few decades, Bangladesh has made remarkable progress in raising incomes, reducing poverty and improving social indicators. The economy has faced numerous challenges such as the global economic downturn of 2008-09 and a series of natural disasters to which Bangladesh is regularly susceptible. Owing to the exemplary resilience of its hardworking population, the country continues to make significant strides even against heavy odds, and is on the cusp of becoming a lower middle-income country.[3]

The Government's Vision 2021 defines several economic and social outcomes for Bangladesh to achieve by 2021. To convert this Vision into long-term development targets, a Perspective Plan 2010-2021 was prepared to be achieved through the implementation of the Sixth Five Year Plan (2011-15) and the Seventh Five Year Plan (2016-2020). Under the 6th FYP solid progress has been made in reducing poverty through a strategy of pro-poor economic growth. The 7th FYP outlines new strategies, institutions and policies to complete the remaining agenda of achieving the social and economic outcomes of the Vision 2021. The Government recognizes that in a market economy like Bangladesh, where the bulk of the economy is privately owned and managed, the role of planning is essentially indicative and strategic in nature.

Transition from MDGs to the new SDGs

The new sector programme coincides with the adoption of the United Nations' Sustainable Development Goals (SDGs) by world leaders in New York on the 25 September 2015. The 2030 Agenda for Sustainable Development articulates an ambitious set of targets aimed at transforming the world by ending poverty, hunger and inequality, taking action on climate change and the environment and improving health and education. The 17 new Global Goals replace and expand the previously agreed Millennium Development Goals. Goal 3 - Good Health and Well-being - aims to ensure healthy lives and promote well-being for all at all ages. As reported by the UNDP, "SDG 3 aspires to ensure health and well-being for all, including a bold commitment to end epidemics of AIDS, tuberculosis, malaria and other communicable diseases by 2030. It also aims to achieve universal health coverage, and provide access to safe and effective medicines and vaccines for all"[4].

Several of the other SDGs have an important bearing on health and wellbeing through improvements in hunger, food security and nutrition (SDG2), inclusive and equitable quality education (SDG 4), water and sanitation (SDG 6), environments (SDG 11 & 16), reducing inequality (SDG 10), gender equity and empowerment of women and girls (SDG 5). The Goal 3 targets are numerous and wide-ranging and cover issues of communicable and non-communicable diseases, lifestyle and healthy environments and provide a holistic framework for development of national responses. The SDGs provide the new background to looking at health, nutrition and population in a more holistic and multi-sectoral way and this is reflected in this 4th Sector Programme document for Bangladesh.

National Health Sector Policy Framework

National health policy 2000 was formulated aiming to provide basic health care to all, particularly the poor, with an emphasis on client centred reproductive health, maternal and child health and cost effective health service delivery through a package of primary health

[3] Bangladesh Seventh Five Year Plan FY2016 – FY2020

[4] www.undp.org

care services. The National Health Policy 2011 acknowledges 'health' as a right and its stated objectives are: to strengthen primary health and emergency care for all; to expand availability of client-centred, equity-focused and high quality health care services and, to motivate people to seek care based on their rights to health. It advocates for equitable access to health care by gender, disability and poverty to achieve better health for all. Similarly, National Population Policy 2012 and National Nutrition Policy 2015 have also been taken into consideration while formulating HNP SIP 2016-21.

1.4 Population and Demographic Transition

A key factor in determining the strategic directions for the sector programme is the demographic situation and the rapid transitions that are taking place. The new sector programme recognises the importance of ensuring that the health of the young is protected for the future and that the need of an ageing population is catered for. It also recognises the substantial and continuing urbanisation of the population and its implications for service delivery. Careful consideration of population dynamics is key to ensuring that good investment and resource allocation decisions are made to maximise efficient use of the scarce resources available and ensure good targeting to reach those who are currently underserved. Figure 1, shows the impressive slowdown in population growth while reminding us that the population is still growing and in some areas of the country rapid growth is still taking place.

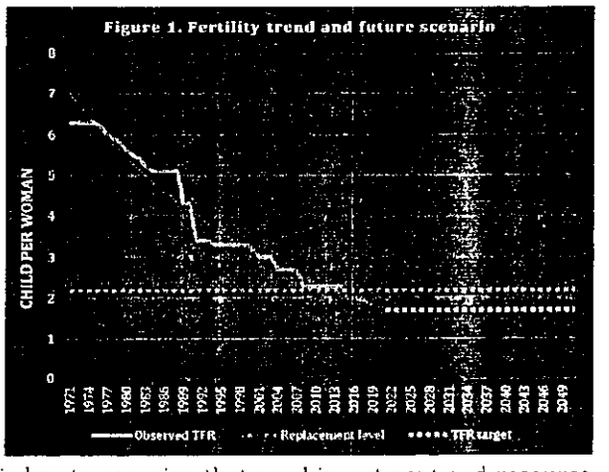
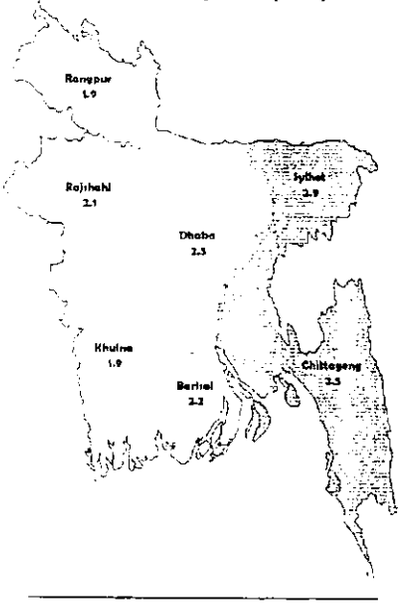


Figure 2: Regional distribution of Total Fertility Rate (TFR)



The UN estimates that population will peak at 203.7 million in 2059[5] and then start to slowly decline - this being **one of the most rapid demographic transitions** in the world (see Figure 1) with replacement levels already met in many parts of the country. Data from the latest BDHS (2014) shows that the total fertility rate for the three years prior to the survey (2012-14) stands at 2.3 births per woman with TFR in rural areas higher (2.4) than in urban areas (2.0).

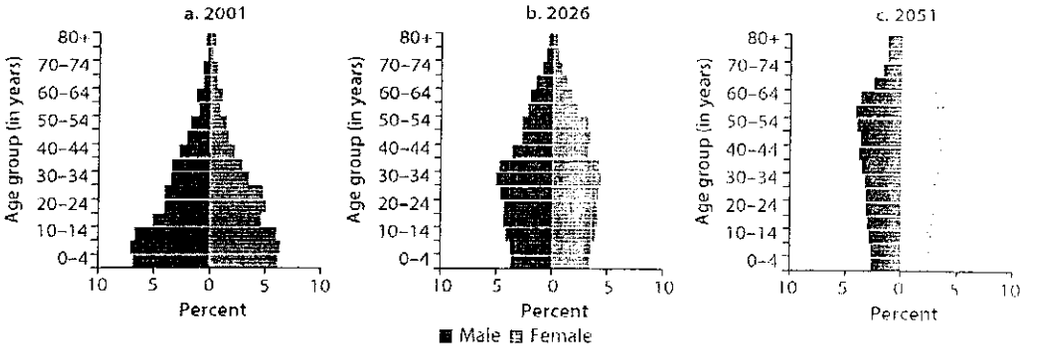
As highlighted in the health sector policy dialogue in 2014 between government and development partners there is still considerable work to be done both to maintain and consolidate the progress made in family planning as well as to tackle some of the regional variations that exist. Figure 2 shows variation in Total Fertility Rate (TFR) and Contraceptive Prevalence Rate (CPR) across the country. Other challenges such as those

[5] Population Division of DESA, UN Secretariat: World Population Prospects – The 2012 Revision

related to early age of marriage, high teenage pregnancy rates, high caesarean section rates in some institutions, the high levels of Menstrual Regulation (MR) uptake are also causes for concern and reflect the fact that there remains a need to reduce the number of unintended and unwanted pregnancies.

Figure 3 below shows the changing demographic composition of the population using data projections. As can be seen the young demographic profile at the turn of the century is rapidly changing and by the middle of the century there will be a very different and older profile, and by consequence an older population. This also underpins the importance given in this sector programme to prevention and treatment of chronic non-communicable diseases as well as beginning to think about issues confronting older people including geriatric care provision.

Figure 3: Demographic composition (changing age structure)[6]



Source: El-Saharty et al. forthcoming

The increase in urbanisation and the large mobile slum population, as well as the substantial number of migrant workers is considered as important in the new sector programme. This has a range of influences on the health of people due to exposure to new infections, with possibilities of bringing epidemic infections back to Bangladesh from other countries, lack of access to safe and clean environments and poor quality health care. A range of social issues are also evident with young families split when one of the parents seeks work away from home leading to a range of stress and other problems.

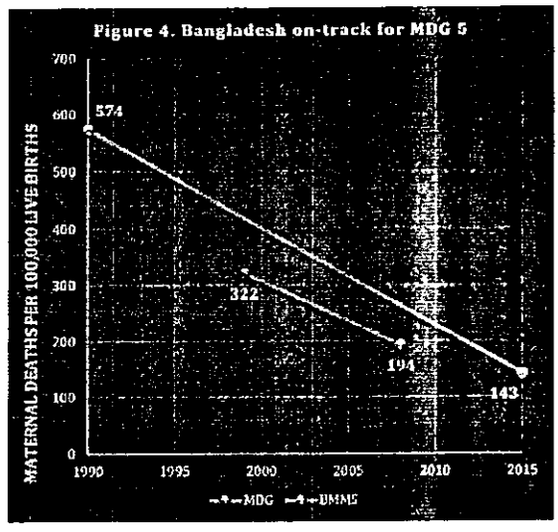
1.5 The State of the Nation's Health

Progress towards reaching the MDGs

Recent surveys and reviews have concluded that Bangladesh has attained the target for MDG 4 on under five year old mortality and was on-track in achieving many of the other MDG targets. These are major achievements by the country that have occurred through extensive and coordinated action by government and development partners (MTR, 2014). Overall, significant progress has been achieved across several key health, nutrition and population outcomes, as further evidenced by the findings of successive Bangladesh Demographic and Health Surveys (BDHS).

[6] El-Saharty et al (2013). *Tackling Non Communicable Diseases in Bangladesh*. World Bank.

Maternal, Neonatal and Child Health

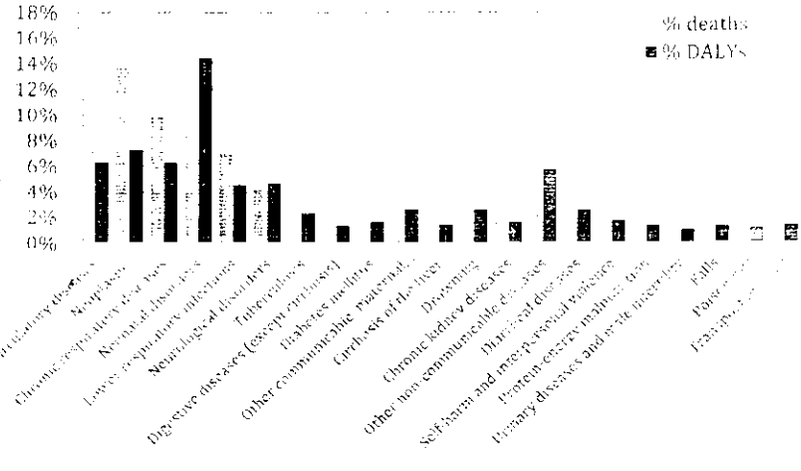


The decline in Maternal Mortality Rate (MMR) between 2001 and 2010 and further projected decline to 170/100,000 live births (UN interagency estimate) indicates remarkable progress. Figure 4 demonstrates the best estimates of maternal mortality decline. This is linked to fertility reduction, access to qualified maternal health care; and overall care seeking during the antenatal period. The reduction in neonatal mortality[7] is still less than the desired level and stands at around 24 per 1000 live birth[8]. Bangladesh has been able to reduce the under-five mortality below the MDG 4 target, and the rate now stands at 46[8], against the target of 48 per 1000 live births by the year 2015. Bangladesh has reduced the under-five mortality by 72% since 1990 with an annual rate of reduction of over 5.4%, which stands highest in the SAARC countries. The infant mortality rate is 38 deaths per 1,000 live births, and the child mortality rate is 8 per 1,000 children.

Mortality and Morbidity in Bangladesh

The burden of ill health in Bangladesh is changing with a very clear rise in the prevalence of non-communicable diseases. As presented in Figure 5 the top three causes of death in Bangladesh (2010) are NCDs, responsible for 40% deaths.

Figure 5: Leading Causes of Mortality and Morbidity in Bangladesh, 2010 Estimates[9]



The rise of Non-Communicable Diseases – An epidemiological transition

The NCD Country Profile (WHO, 2014) reported that NCDs account for 59% of total death in Bangladesh (17% cardiovascular diseases, 11% chronic respiratory diseases, 10% cancers,

[7] Strategic Report on STG #3: MNCH, FP, Nut-Food Safety
[8] BDHS 2014
[9] Murray et al. 2012

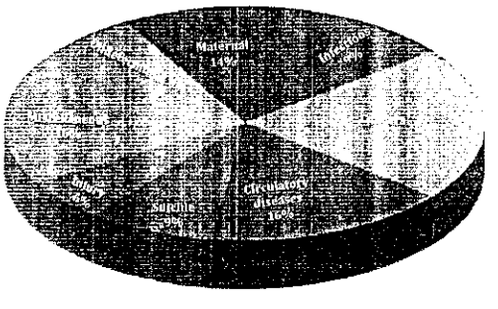
9% injuries, 3% diabetes and 10% other NCDs). In response to this epidemiological transition in Bangladesh, there is a need for a policy and legislative shift to meet the challenges of ever increasing NCDs. WHO definition of NCDs includes primarily cardiovascular diseases (heart disease and stroke), cancers, COPD and diabetes mellitus. They are linked to four shared risk factors: tobacco use, unhealthy diet, low physical activity and harmful use of alcohol. These risk factors contribute to maturation of the NCDs through a few intermediary risk factors: obesity, high blood pressure, abnormal glucose tolerance, and abnormal blood lipids. Other important factors include indoor air pollution, road traffic accidents, drowning, autism, mental health, drug abuse and suicide. NCDs are largely preventable by lifestyle modification and importantly treatable.[10] The SDG 3 (target 3.4) calls for a one third reduction in premature mortality from non-communicable diseases by 2030[11].

This transition towards NCDs has a huge direct impact on financial vulnerability, particularly for the poor, and an indirect impact on the economy. The prevention and management of NCDs are largely governed by the available capacity of the health system, but the government's role in NCDs is limited to providing health education at primary level and preventive and clinical treatment at tertiary level, with less focus on preventive clinical care at primary and secondary levels, while the private sector provides mainly treatment services. There is currently no good awareness-raising system to keep policy makers abreast of these concerns (El-Saharty et al. 2013)[12].

The Health of Women

The wider situation on reproductive age women is presented in Figure 6. It describes the main causes of female death amongst 15-49 year olds by category. It demonstrates the complex challenges that face women in particular. The on-going success of MNCH work will be somewhat determined by the ability of future programmes to account for causes of death that are prominent yet underserved, such as suicide. It is also clear that thinking about deaths associated with pregnancy and childbirth, while very important, is not sufficient. This graph demonstrates why more investment is needed in the health of the nation to reduce the high mortality, not to mention morbidity from a wide range of causes, many of which are currently not being addressed and are social and environmental in origin.

Figure 6: Causes of female death (15-49 year olds),[13]



Adolescent Health

Adolescent pregnancy and child bearing entail a high risk of maternal death among adolescents, and the children of the young mother have a higher level of morbidity and

[10] Report on STG# 3 CDC, NCDC and AMC
[11] https://sustainabledevelopment.un.org/?menu=1300
[12] El-Saharty et al. 2013
[13] Source: USAID (2014) BMMS Secondary Analysis

mortality[14]. The birth rate among adolescents is currently 113, which is one of the highest in the world. It is estimated that annually there are about 569,000 births among 15-19 year adolescent girls in Bangladesh. These girls face a number of serious health risks arising out of early pregnancies, violence and inadequate nutrition. Directly linked to these issues is the practice of early marriage, a prevailing and persistent social norm across the country that is increasingly a subject of debate. The Bangladesh National ARSH strategy was formulated in 2006 and a corresponding action plan was developed in 2013.

Communicable Diseases

Bangladesh has achieved significant success in preventing and controlling communicable diseases, and as these are linked to poverty, it is envisaged that improvement in overall living conditions and an increase in household income will help in further reducing the burden of communicable diseases, especially HIV/AIDS, malaria and tuberculosis, and a range of Neglected Tropical Diseases (NTDs). During the last SWAps the country has scaled up the interventions for prevention and control of communicable diseases. The country is on-track to achieving its HIV-AIDS, TB and Malaria targets. Action taken on diseases targeted for elimination (Filaria, Kala-azar) has achieved the desired results. The leprosy elimination target has been achieved and the programme is in its post elimination phase.

Nutrition - The Double Burden of Malnutrition

The GOB has positioned nutrition as central to development and the process of mainstreaming nutrition has started. The Cabinet has endorsed the National Nutrition Policy (2015) and work has focused on developing a costed National Plan of Action on Nutrition (NPAN). The Bangladesh National Nutrition Council (BNNC) has been revitalized to coordinate the nutrition activities across the sectors and monitor the progress of both Nutrition Specific and Nutrition Sensitive interventions. Bangladesh is currently facing the challenge of addressing two "seemingly-paradoxical" nutrition concerns of under-nutrition (stunting, underweight and wasting) and over-nutrition (overweight and obesity), a phenomenon known as the double burden of malnutrition (DBM).

Although under-nutrition has declined gradually since the 1990s, the prevalence remains high: in 2013, 36 per cent and 33 percent[15] of children under five years of age were found to be stunted (short for their age) and underweight (low weight for age) respectively. Moreover, under-nutrition does not seem to be a phenomenon that is common only amongst the poor people of Bangladesh as the under-nutrition rates amongst the richest income quintile are also relatively high – 17 per cent of children under-five years of age were underweight in the richest quintile in 2014. Only 29% of children under- two years in urban and 21% in rural areas get Minimum Adequate Diet (MAD).

Among women, nutritional status has improved slightly, but under-nutrition continues to represent a serious issue for both women and adolescent girls. About 19% of women and 31% of adolescent girls aged 15-19 years were undernourished (Body Mass Index of less than 18.5)[16]. Over the past decade, mixed progress has been observed in reduction of anaemia among women but anaemia continues to remain highly prevalent, affecting on average half of all women[17]. There is, at the same time, a growing concern about the rise in over-weight in

[14]UN World Population Monitoring 2002- Reproductive rights and reproductive health: selected aspects.
[15] Bangladesh Demographic Health Survey (BDHS) 1997, 2000, 2004, 2011, and 2014
[16] BDHS 2014
[17] UNICEF-Government of Bangladesh Mid-Term Review Report, Country Programme 2012 – 2016.

some section of adult women which needs to be tackled early to prevent the rise in obesity related health problems such as type-2 diabetes.

1.6 Governance and Stewardship of the Health Sector

Governance and stewardship

Governments are considered as "stewards" of their national resources and take on the task of maintaining and improving those resources for the benefit of their populations. The focus of governance and stewardship has been on increasing regulation, transparency and participation of citizens in institutional decision-making and accountability. A range of actions by government to increase regulation over the public and private sectors is needed to improve quality standards and ensure accreditation of individuals and organisations. In this context, the Ministry of Health and Family Welfare is considering its role in policy making and oversight and that of its agencies and departments in implementation, monitoring and supervision, and performance improvement. This aspect of the health system is a key element of the 4th Sector Programme as government revises its ways of working to provide governance and stewardship of the whole sector including both public and private stakeholders. This shift in emphasis and role requires functional and structural change.

To perform its regulatory responsibility the MOHFW works through organizations like DGHS and DGFP. While regulatory responsibilities should be best vested through legal instruments, often government continues to perform such functions through executive orders or instructions. While Departments are directly accountable to MOHFW, statutory bodies have separate boards and separate governance arrangements that reduce the MOHFW's influence over them. However, in general the MOHFW remains in a position to assert its control through peer pressure and if necessary through regulatory instruments. To be effective, ideally regulatory bodies should be independent and free from financial and other conflicts of interest.

Institutional development

More attention to clarifying roles and responsibilities and for rationalising the current institutional arrangements of the MOHFW is needed (MTR, 2014). To address the principle of efficiency as well as improved effectiveness across the public sector will require improvements in functioning of many departments including removing duplication of effort. A thorough organisational capacity assessment (OCA) is needed and should pay careful attention to an inclusive process and a change management strategy. Functional integration of current bifurcated structures, with its evident areas of duplication and unclear areas of responsibility needs to be addressed. The organisational assessment should develop a strategy agreed by all senior management to determine a more optimal structure and function at the Ministry involving all directorates, departments and institutions.

1.7 Strengthening Health Systems

Human Resources for Health (HRH)

Human resources are the most valuable health systems resource. Recently a Health Workforce Strategy has been developed by MOHFW. A comprehensive HRMIS capturing all necessary data is yet to be established and used. Implementation of the HWF Strategy has been fast-tracked and an action plan is in process of development.

Human Resources issues affect most OPs[18] in the MOHFW in one-way or another and as such this sector programme highlights its importance. There has been considerable recruitment during the HPNSDP with vacancy rates declining to around 15% in 2014 (compared to 20% in 2011). Over 7,000 doctors and 4,100 nurses have been recruited and in total over 42,000 positions across the sector have been recruited (MPIR, HPNSDP, MTR – 2014). At the last MTR the proportion of service provider positions functionally vacant at district level and below, by category, are Physicians: 46.1%, Nurses: 19.59%, FWV/SACMO/MA: 21.2%. Issues of skill mix and task shifting are now a priority for action.

Health workforce development in the country, and for MOHFW, predominantly involves institutional education before entering the services. The quality of education in these institutions both in public and private sectors is mostly challenged by a shortage of qualified teachers for basic science subjects. Improved quality of medical education across all health professionals' institutions and modernization and transformation of the medical education system to fulfil the aspirations of the SDGs and achieving Universal Health Coverage are now a major priority. Quality, standardization and accreditation issues remain major challenges. Building capacity and skills within the workforce is an area requiring considerable attention. Very large numbers of training course and workshops are held annually and during this sector programme more attention needs to be given to ensuring the effectiveness of all types of training being provided.

In-service training demands a need-based structured curriculum. Historically trainings are conducted in an ad-hoc manner based on training modules developed to serve programme activities. This needs to change and a plan for in-service training and the use of a Training Management Information System (TMIS) should become an integrated part of the DGHS, DGFP and DNS.

Recruitment of appropriate staff and their deployment and retention in the right job at the right place are important HRM functions. Vacancies in the health facilities are a common phenomenon and on an average 20% of the total sanctioned posts remain vacant. The vacancy rate is very significant in rural, remote and hard to reach areas. Skill mix imbalance is a priority concern for policy makers. The National Health Policy (2011) focuses on skill mix with standard ratios between physician, nurses and allied professionals based on the international standards. The current staffing pattern in the country needs to be improved to ensure the right people are in the right places and providing the right services. .

The workforce is pre-dominantly linguistically and culturally homogenous and transferable across the country though deputation and deployment practices in the public health system. A number of challenges have been well documented through recent reviews such as keeping health workers in the rural and hard-to-reach areas; is still a big challenge for the health sector and providing continuous professional development, career planning and engagement opportunities could be important options to retain them. There is absenteeism of health personnel at the workplace and unauthorized absence is regarded as misconduct as per service regulation[19]. Local monitoring and supervision mechanisms need to be strengthened in this regard and innovative models could be worked out to address the issues.

[18] Five HR related OPs in HPNSDP (2011-2016) that are directly linked with overall HRM functions. The OPs are i) In-service training (IST) with DGHS; ii) Pre-service education (PSE) with DGHS; iii) Training, Research and Development (TRD) with NIPORT, iv) Nursing Education and Services (NES) with DNS and v) Human Resource Management (HRM)

[19] The Government Servants (Discipline & Appeal) Rule, 1985

Procurement and Supply Chain Management

The MOHFW spent considerable amount of funds in procurement of medicines, medical equipment, services and capacity building for this sector programme (3rdSWAp). MOHFW has introduced web-based supply chain portal for processing and approval of the procurement packages formed Procurement and Logistics Management Cell (PLMC), and developed Table of equipment (TOE) for 10, 50 and 250-bed hospital facilities. A review of Central Medical Stores Depot (CMSD) and development of TOE for 500-bed hospital are in process. The above measures have resulted in reduced overall lead-time for procurement of equipment by CMSD, improvements in the quality of documents prepared on procurement, and freeing up space in warehouses.

However, the centralized procurement process, inadequate coordination among LDs in DGHS and between DGHS and DGFP, procurements by LDs for vertical programmes, no formal mechanism for stock control and distribution, inadequate storage space, inadequate capacity of CMSD, vacant posts in PLMC, inadequate maintenance budget for procured medical equipment and limited local expertise in bio-medical engineering are the major challenges. The limited synchronization between the procurement of equipment and drugs, civil works and deployment of human resources also leads to instances where buildings are constructed or equipment are procured but cannot be made operational due to inadequate staffing or inappropriate input-mix.

Infrastructure

Physical infrastructure development continues to attract the highest investment in MOHFW's development budget. A comprehensive master plan for civil works is under preparation. This together with the work on TOE for hospitals and that of HRM on staffing will synchronize physical construction with supply of equipment and human resource in a timely manner. Physical facilities development or upgrading is to be based on detailed need assessments. In addition, the construction of UHCs in the tribal areas or the urgency of meeting central/regional warehouses for family planning or having facilities for drug storage in the hospitals need attention.

The basic services in health facilities (such as a separate toilet for women and facilities for the disabled) and condition of residential facilities for staff and security measures such as boundary walls, bio-waste management systems are often ignored in renovation, repair and maintenance plans for all levels. This calls for the adoption of more objective, evidence-based criteria for deciding on prioritization for construction/maintenance, and a thorough assessment of maintenance followed by the development of a comprehensive maintenance plan for infrastructure and equipment. Due to inadequate quality and capacity of implementing agencies, the number of incomplete and non-functional physical facilities is expected to rise.

Financial Management and Audit

There has been significant improvement in budgeting procedure, resource allocation, resource tracking, financial monitoring and reporting because of the last three HNP SWAps. Further improvements in FM and Audit during HPNSDP period include the engagement of qualified FM Consultants to support FMAU and LD as a temporary measure; finalization of FMAU's restructuring proposal by MOHFW and submission of the revised organization structure along with revised recruitment rules for FMAU to Ministry of Public Administration (MOPA) for final approval; drafting of an audit and FM strategy; training of FM officials and establishment of connectivity between Integrated Budget and Accounting System (iBAS) and FMAU; strengthening of the management of the revenue budget and audit functions by

putting them under the FMAU of MOHFW; timely production of Interim Unaudited Financial Reports (IUFRs); outsourcing of internal audit to private audit firms.

However, Financial Management and Audit Unit (FMAU) lacks with appropriate organizational structure and human resources. Many OPs were found not being able to spend to a target of 90% of allocated amount. The inordinate delay in settlement of audit observations and delayed response from Foreign Aided Project Audit Directorate (FAPAD) are other challenges. There are also issues with the audit system for which the audit observations are not met timely or satisfactorily.

Building the evidence base for decision making

In recent years the MOHFW has made substantial improvement in its health information system (HIS) and eHealth, being recognized both at home and abroad. Bangladesh is to be one of the global champions in terms putting in place an effective and robust technology-supported M&E platform[20]. However, the existing efforts will have to be sustained and new investments made to fit to the SDG principles, so that they become country-led, open, inclusive, participatory and transparent for all people and reported by all relevant stakeholders. To gain benefits out of the SDGs' follow-up and review process in the health sector, the WHO is providing leadership through two recent developments. These are a 15-year Roadmap for Measurement and Accountability for Results in Health (MA4H) and Global Reference List of 100 Core Health Indicators. Capitalizing on the existing progress of MOHFW Bangladesh can be taken to the next level to fulfil the M&E needs of the 4th SWAp as well as for global reporting with the routine data generated through a country-led process. The MOHFW is also experienced in conducting population based health surveys and there are institutions both in public and private sectors to carry-out research and related products.

To overcome current challenges and to progress, the MOHFW and its partners will have to pay attention to a number of issues. It will need to place evidence based planning, progress monitoring and decision making at the heart of 4th SWAp. It will need to improve integration of the health information and eHealth platforms existing among different agencies and stakeholders with a view to making a seamless national data capture, data flow, and data reporting system. Amongst other actions it will also need to introduce periodic routine data review and data-driven decision-making process at each level of management and organizations and improve coordination and harmonization across all data generation activities.

1.8 Financing the Health Sector

In a vast majority of low- and middle-income countries, national health systems face financial sustainability challenges as donor funding declines[21]. As the current economic climate has led donor governments to reduce spending in all areas, including global health initiatives, increased funding for global health may be unlikely in the current scenario[22].

Macroeconomics and health

The overall economy of Bangladesh is growing at around 6% per year despite slow implementation of economic reforms, and the global financial crisis and recession. With the overall GDP growth, funding in health is also increasing in absolute terms. However, the

[20] paragraph 74 of UN resolutions on SDGs (A/74/L.1)
[21] Katz et al.
[22] Beane, Hobbs & Thirumurthy

percentage contribution of Gross Domestic Product (GDP) to health is still very low. Public health spending comprises less than 1% of the GDP and total health expenditure (THE) is 3.5% as of GDP. Per capita THE of US$ 27 is relatively low compared to Nepal (US$36), Pakistan (US$39), India (US$61) and Sri Lanka (US$ 89). The out of pocket expenditure is unacceptably very high at the level of 63.3% of THE; government spending is around 23% only, and voluntary health insurance payment was 5.25% of THE in 2012. The budget of Ministry of Health and Family Welfare (MOHFW) as a percentage of national budget is in continuous decline. MOHFW's share of national budget reduced from over 6% in FY 2010/11 to 4.31% in FY 2015/16. The HNP budget as a percentage of GDP and the MOHFW's ADP as a percentage of total ADP has been declining.

The fiscal space of the country is restricted given the lowest tax-to-GDP ratios in the world that limits the government's capacity to translate this growth into public revenues. A reprioritization towards the health sector needs strong evidence-based advocacy and negotiation with the Ministry of Finance (MOF).

Sustainable health financing

The government has consistently shown commitment in ensuring sustainable financing for health care in Bangladesh. A Health Care Financing Strategy (2012) has been approved which proposes to cover the entire formal and non-formal sectors and those below the poverty line under a common scheme. The HCFS (2012) has recently been embedded in the approved National Social Security Strategy (NSSS) 2015. The NSSS focuses on strengthening financial risk protection and extending health services and population coverage especially to the poor and vulnerable segments of the population to achieve universal health coverage.

The government has taken the initiatives to pilot a health protection scheme for the poor (Shasthyo Shuroskha Karmasuchi -SSK) and garment workers (the Ready Made Garment Workers' scheme). A social health protection scheme for the formal sector is being designed, the required law has been drafted and a communication strategy has been approved. A resource allocation formula has been developed by MOHFW.

A considerable amount of resources has been invested in the health sector during the 3rd SWAp. Total revised estimated cost for the 3rd SWAp, i.e. HPNSDP (2011-16) was BDT 51, 571 Crore (about US$ 6.5 billion)[23]. Out of this, it was estimated that BDT 39,748 Crore (78%) will be contributed by Government of Bangladesh (GOB) and 22% to be financed by development partners (17% pool fund/RPA[24], 5% DPA). The absorptive capacity of the MOHFW has improved in recent years. During the first four years of 3rd SWAp implementation (2011/12-2014/15), utilization of annual development programme budget was 87% in 2011/12, which increased to 91% in 2012/13, 89% in 2013/14 and 83% in 2014-15. Utilization of the revenue budget was more than 95% during the first four years of the 3rd Swap.

There is a high level of commitment from government to bringing health care as close to the communities as possible. This was made possible by establishing about 14,000 community clinics nationwide and prioritizing Primary Health Care for increased budget allocation. There is also an increasing emphasis on the complementary role of the private sector through public private partnership (PPP), outsourcing models and increased community engagement, such as is seen in the Chougachha and Narsingdi models.

[23] PIP of HPNSDP, 2011-2016.

Despite the initiatives, in Bangladesh, households constitute a major financing source of the Total Health Expenditure at 63.3%, which is unacceptably high, followed by Government contribution at 23%, Development Partners at 8.4%, while voluntary health insurance payment was 5.25% of THE in 2012 (BNHA, 2015). Every year, 14.2% of the households face catastrophic health spending while 3.5% of the population falls into poverty due to health expenditures in Bangladesh[25]. Inadequate pre-payment mechanisms to protect the population from catastrophic spending, very little revenue raised through pre-payment of insurance contributions (0.2% of total health expenditure), slower than expected progress in SSK implementation, and little progress made in other pilot initiatives are major challenges. The experience of Demand Side Financing is also not very satisfactory.

The budget of Ministry of Health and Family Welfare (MOHFW) as a percentage of national budget is on a continuous decline, it decreased from 6.1% in 2010/11 to 4.1% in 2015/16. It thus remains below the HNPSP target (10%) and the Sixth Five Year Plan target (12%). A number of development partners are leaving the sector. There has also been a shift in the priority at post-MDG era moving from health towards the new international targets focusing more on sustainable systems, climate change and environment.

The government budget provided to public hospitals is allocated on the basis of number of beds and staff employed. The allocation is not linked to performance or results achieved. Proportion of allocation for repair and maintenance in revenue budget declined over time. Health spending disparities across wealth quintiles and geographic regions persists. Gender differentials in health status and health care access persist, though reduced over the past decades. Weak capacity in budget planning as well as poor procurement planning results in under spending of resources. In general, delay in disbursement of fund, the complex procurement process, and delay in settlement of claims (bills) in the CAO (Health) office and at District and Upazila account offices result in low utilization of resources.

1.9 Health, Nutrition and Population Services

As part of improving health services good progress have been achieved in maternal, neonatal, child, reproductive and adolescent health and family planning services. Progress has also been made in the areas of nutrition and food safety, disease control and disease surveillance. However, the Annual Program Implementation Report (2015) highlighted some key indicators of low performing areas such as strengthening identification and management of MDR TB patients and scaling up infant and young child feeding. These areas should now be prioritized. Primary healthcare provision and informing people about health issues through behaviour change communication (BCC) activities have expanded. However, there has been more limited progress in service provision to hard to reach populations and various disadvantaged and marginalized groups. There is more work to do on developing the Essential Health Service Package (ESP), secondary and tertiary healthcare and in developing the relationship between public and private sector providers whether through partnership arrangements or through regulation and accreditation. More attention is needed to improve urban health, environmental health and the health implications of climate change, and better integration of services including those through alternative medical care services.

[25] Household Income and Expenditure Survey, 2010

Essential Service Delivery

The 4th Sector Programme emphasises the importance of delivering a package of high quality essential health services (ESP) through the various health delivery outlets in a holistic way. This includes partnership with private sector hospitals and clinics, AMC providers and will need to stress the importance of an effective referral system. This requires that services are available to all sections of society, addressing the current inadequate services to rural and urban hard to reach areas.

Achievement of the sustainable development goal (SDG) for health and the ambition of UHC will depend to a large extent on providing high quality integrated primary health care delivered by strongly linked domiciliary services including counseling and referral, community clinics and comprehensive static health facilities at Union, Upazila and District levels. Meeting the ambitious targets requires registering, tracking and responding to each citizen's needs. The Community Clinic (CC) is the lowest tier health facility and aims to be a one stop service outlet for health, family planning and nutrition services. It is meant for health education, health promotion, treatment of minor ailments and injuries, immunization, ANC, PNC, screening of NCD with referral to higher facilities for better management. Currently functional 13,136 CCs, and 308 more that are planned are providing services in the rural areas including hills, haor, char & coastal areas. It is Primary Health Care provision at the doorsteps of the community and acts as a unique example of PPP. The CC is a flagship programme of the Government of Bangladesh and is being recognized globally as a model for delivering universal health coverage.

Maternal, neonatal and child health services

Political commitment has been evident in the area of maternal, neonatal and child health (MNCH) and this is articulated in several policy and strategic documents and formed the basis of considerable progress. 'Promise Renewed: Bangladesh Call for Action to End Preventable Child Deaths by 2030', launched in July 2013 has prioritized 11 interventions focusing on maternal, newborn and child health. Bottlenecks have been identified and costed action plans developed. There are now national level benchmarks as well as a dashboard to monitor progress. The "Bangladesh Every Newborn Action Plan" (BENAP) identifies a set of priority maternal and newborn interventions. A wide consensus now exists for a comprehensive newborn care package including several high impact interventions. Revision of the Bangladesh Maternal Health Strategy and development of Standard Operating Procedures (SOP) for both maternal and newborn care are important steps taken.

Maternal health services have improved steadily through ANC uptake (ANC4: 26 % 2011 to 31% in 2014) and access to skilled delivery (SBA delivery: 32% to 42%, facility delivery: 29 % to 37 %).. The BDHS (2014) indicates progress in postnatal care with 36% of mothers and children receiving check-ups from a medically trained provider within 42 days of delivery, importantly 34% of women and 31% of children receiving this within 2 days of delivery. More than 80 percent of the neonatal deaths occur within 7 days, 50 percent within first 24 hours of life and most of these deaths are at home without the care of a skilled birth attendant and are often unregistered.

Despite the tremendous effort in reduction of maternal deaths nationwide, the country still loses 14 mothers a day[1]due to complication of pregnancy delivery and post-partum period and largely due to delivery by unskilled birth attendants at home and lack of appropriate care for obstetric complication from a skilled provider at facilities. Lessons show that there is high utilization of services if women friendly services can be made available nearer to the communities. Inequities exist across geographical regions and between different wealth

quintiles, which need to be tackled. MMR is the highest in Sylhet division (425 per 100,000 live births) and the lowest in Khulna division (64 per 100,000 live births)[26]. The increase in facility delivery is mostly at the private sector. Notably, 23 percent of all deliveries are conducted through caesarean section (CS). About four fifths of the deliveries in the private sector are by CS which is very costly for the poorest and quality of care in these facilities is yet to be monitored. Effective coverage of 24/7 C-EmOC[27] is now crucial to address maternal deaths resulting from pregnancy-related complications, provision of which relies on the availability of skilled human resources such as anaesthesiologists and obstetricians, equipment, drugs and infrastructure.

Adolescent sexual and reproductive health services

Bangladeshi teenage mothers are more likely to suffer from severe complications (e.g. obstructed labour, delayed labour, fistula, etc.) resulting in high neonatal mortality and both neonatal and maternal morbidities. Young women must have better information on availability of MR and PAC services. Due to lack of such comprehensive information and knowledge they are more likely to seek these services at a later gestational age, which is more risky. Almost twice as many newborn deaths (45 per 1000 live birth) occur among very young pregnant women, less than 20 years old, compared to older age[28]. Teen pregnancy is also linked with stunting with the odds of a child becoming stunted significantly increased (by 22%) if born to a mother who is a minor[29].

Neonatal health services

Progress on neonatal mortality has been slow and more attention is needed. More than 80 percent of the neonatal deaths occur within 7 days, 50 percent within first 24 hours of life and most of these deaths are at home without the care by skilled birth attendants and are often unregistered[1]. These are largely preventable and treatable conditions – complications due to prematurity, intrapartum-related deaths (including birth asphyxia) and neonatal infections (sepsis, meningitis and pneumonia). Care during labour, around birth and the first week of life; and care for the small and sick newborn- have the greatest impact on ending preventable neonatal deaths and stillbirths[30]. High coverage of interventions before, during and after delivery could save the most newborn lives as well as prevent maternal deaths and stillbirths. Further progress is needed to address newborn complications and deaths due to birth asphyxia, prematurity and infection through establishing Special Care Newborn Units (SCANU) and rolling out ETAT, sick newborn care and the "Helping Babies Breathe" (HBB) initiative.

Child health services

Despite the reduction in mortality over time, continued disparities are observed between richest and poorest quintiles, urban and rural areas and between divisions. Mothers' education was found to be associated with under-five mortality, with the highest mortality rate (82) noted among mothers with no education compared to mothers with secondary education or higher (39).

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[26] BMMS 2010

[27] CEmOC is defined if any facility performs 6 Signal Functions for BEmOC (Parenteral Antibiotics, Parenteral sedatives, Parenteral Oxytocic, Manual removal of placenta, removal of retained products, Assisted vaginal delivery) plus Blood Transfusion, Caesarian Section

28 BDHS 2011.

[29] Raj, A. et al (2010). The effect of maternal child marriage on morbidity and mortality of children under 5 in India: cross sectional study of a nationally representative sample.. BMJ 2010;340:b4258doi:10.1136/bmj.b4258

[30] Lancet Newborn Series 2014

As for under-five deaths, pneumonia, neonatal causes and drowning are major causes. Diarrhoeal deaths among under-five have decreased substantially over the last few years (2 per cent), however pneumonia remains the single most important cause (21 per cent) of under-five mortality followed by neonatal causes. Although deaths due to preventable communicable diseases continued to decrease over times, the share of deaths due to drowning has resulted in a sharp rise from 26 per cent in 2007 to 42 per cent in 2011 among the age group of 1-4 years. New focus is now needed to reduce these areas of mortality.

Family planning services

While exceptional progress has been made in family planning over several decades, disaggregated data shows where more attention is needed in terms of reducing inequities, ensuring sustainable services and meeting unmet need. The issue of adolescent pregnancy rates is linked to current practices of early marriage as well as the lack of information and supportive services for adolescent girls and young women. The need for more attention across the country to this group is recognised. Uptake of services is good and more is needed to ensure prevention of first pregnancy until at least age 18, and healthy pregnancy spacing and birth outcomes.

BDHS (2014) provides a comprehensive overview of contraceptive use and summarises that, as of 2014, 62% of women use contraception and 54% use a modern method. Teenage pregnancy is recorded at 31percent for adolescents aged 15-19 and more common in rural areas. All-method discontinuation has declined from 36 percent in 2011 to 30 percent in 2014. One of the major strategies of DGFP is to increase the wider availability of LAPMs, now only 8% in the method-mix (BDHS-2014). Increased method choice can help meet family planning demand and reduce unmet need.

Communicable diseases

The Communicable Diseases Control area must remain a priority of the 4th Sector Programme especially linked to the equitable delivery of an essential package of HNP services based on the tiers of service delivery infrastructures and the available health workforce. Continued attention is needed to the major diseases such as tuberculosis, malaria and HIV/AIDS with special attention given to reach the hard-to-reach areas, and the most vulnerable population groups. Water-borne, vector-borne as well as some of the neglected diseases require more focused attention. As issues of drug resistance start to impact on effectiveness of treatment the MOHFW must engage in more work on medical practice and regulation.

Secondary and tertiary care services

The secondary level district hospitals are a key part of the overall public health care system providing specialist care services in addition to primary care. Considerable upgrading of hospitals has taken place under the last sector programme and this district hospital system provides a considerable proportion of overall services. Many people by-pass lower tiers of the health system preferring to seek initial care from the district hospitals. Here they are more likely to be seen by a medical doctor and where drugs and supplies are more available.

The rapid expansion of the private hospital sector is also evident across the country with many new facilities opening. Quality of care and cost of services is an increasing cause for concern. The need for greater regulation of the private secondary and tertiary care facilities is well recognised and will be a focus of attention during this sector programme. More supervision and accreditation will be introduced along with clinical management protocols. More attention will be given to establishing the lower tiers of the system with appropriate referral systems in place, including improved patient tacking systems.

Continued attention will be given to supporting and monitoring Divisional level Hospitals, Medical College Hospitals and Specialised Hospitals. As for district hospitals the referral systems need to be strengthened. Blood transfusion services will also continue to be developed and expanded together with regulatory systems to ensure good practice.

More attention will be given to working in partnership with the private sector hospitals and where appropriate service level agreements will be developed to improve access to specialist services for those that would not otherwise be able to afford such treatments.

Nutrition Services

Persisting high levels of under-nutrition, combined with rising levels of nutrition-related Non-Communicable Diseases (including obesity and diabetes), represents an avoidable and high economic cost, dampening potential growth and draining national resources. Good nutrition must be recognised as a fundamental condition for the country to reap the full benefits of the demographic dividend. Sustained mainstreaming of nutrition services within MOHFW and other ministries requires consistent policy and strong leadership of MOHFW. Overarching accountability and coordination mechanism need to be in place through concerted effort of different ministries and department at all level. The introduction of comprehensive nutrition interventions incorporating specific and sensitive interventions with a special focus on life style modification is important to address the double burden of malnutrition. Integration of these nutrition interventions in the services provided by community-based health workers linked to effective supervision is critical to ensure mainstreaming. In addition comprehensive BCC needs to be enhanced for curbing the double burden of malnutrition.

Micronutrient deficiency among children aged less than five years old, indicated by anaemia is also high at 33.1% (Micronutrient Survey, 2013). The universal coverage of interventions to address factors that contribute to stunted growth and development include poor maternal health and nutrition, inadequate infant and young child feeding practices, and infection need to be achieved if the reduction of under-nutrition to be accelerated and sustained. The BDHS 2014 shows that the coverage of infant and young child feeding practices needs to be improved. Exclusive breastfeeding among infants less than six months old showed reduction from 2011 (BDHS 2011) from 64% to 55%. The timely and appropriate complementary feeding practices indicated by the minimum acceptable diet among infants and young children aged 6-23 months is still very low at 23%.

Alternative Medical Care (AMC) services

Alternative Medical Care is mainly focused on Unani, Ayurvedic and Homeopathic systems of medicines. Most of the treatments are derived from herbal, animal and mineral materials. These systems of medicine have been used in Bangladesh for many years, and traditionally these are used most by rural communities. Bangladesh is very rich in medicinal flora and these systems are closely linked to culture and diet. Alternative medicine is often the first place for people to seek medical attention. It is popular and generally seen as accessible, cheap, simple and without serious side effects. A National Strategy for AMC in Bangladesh is under preparation and one of the areas under discussion is the better integration of traditional or alternative medical care systems with modern medicine and public funded health services.

Non-communicable diseases

Tackling the rapidly growing non-communicable disease (NCD) is perhaps one of the major new areas of focus in the sector programme. This entails a two-pronged approach.

Prevention, with a focus on young people to head off the rise in NCDs, through lifestyle and environmental actions, and the support and care for those suffering from NCDs. Urgent attention is needed on both fronts to head of the human and financial costs that will occur if not addressed.

Promoting healthy lifestyles

NCD risk factor control though lifestyle intervention is now a priority. Without a lifestyle change focus the health system is likely to become rapidly overburdened by chronic diseases. The economic argument for this shift in emphasis is being recognised across the world. STEPS and GATS surveys show almost nine in ten adults have at least one risk factor. Three-quarter have two or more risk factors. Low intake of fruit and vegetables is the commonest. Tobacco use is still very high in Bangladesh. Salt intake is also very high. These risk factors are amenable to lifestyle and other interventions. Interventions will work better only if political and legislative support is provided.

Promotion of healthy diet with high fruit and vegetable content that is readily available and that provides the nutrients required for health, growth and immunity is a major lifestyle choice for health. It avoids the problems of diets with excessive salt and sugar content, low fiber and over reliance on animal protein. This in turn deprives the person of the necessary daily intake of protective anti-oxidants. The markers of cardiovascular disease, diabetes, neoplasm and other non-communicable diseases are high cholesterol, high blood pressure. Linked to this is the need for the promotion of regular exercise among all age groups. Schools, businesses and local authorities need to look at ways to make exercise more accessible to people, living in crowded environments and provide opportunities for people through access to open spaces.

Other lifestyle change areas include traditional and harmful practices. Substance abuse has a devastating and costly effect on individuals, families, and the country as a whole, whether it is the antisocial effect of recreational drugs or the insidious multiple harmful effects of tobacco. The matter requires an in-depth look at the reasons why people seek these substances, at how to break the dependency, and what alternatives there are for coping without them. Child marriage and marrying girls under 15 years of age also affect healthy life of under-aged mother and child. So, MOHFW needs to work on influencing the policy makers by providing evidence of the potential harm of child marriage.

Gender based violence, suicide and mental health

Promotion of gender relations amongst youth, education about consequences of bullying and other harmful acts through to more law enforcement for acts of violence, such as rape and harassment, are all part of a wider set of strategies that are needed to reduce pressures on people and especially women and girls. The health sector has an important role to play in advocacy and service provision.

Mental health and well-being are fundamental to a healthy nation. MOHFW needs to promote mental health and well being including access to essential care. The priority areas to be addressed include: depression, psychosis, bipolar disorders, epilepsy, developmental and behavioral disorders in children and adolescents, dementia, drug use disorders, self-harm/suicide, etc. To address this problem, a comprehensive mental health service delivery plan needs to be developed with the aim of gradual expansion of service to address the growing need of psychological aspects of health. To uphold health rights and ethics, such

issues will be incorporated in all medical, nursing and other education curricula along with proper sensitization initiatives for the health service providers.

Healthy environment

The most immediate opportunity for the health sector to improve environment is through proper waste management at all facilities. There is a huge amount of improvement possible at all tiers of the system. Facilities could be provided with renewable energy sources and water catchment technologies. The health sector should also be lobbying and providing evidence of the positive effects of wider government efforts to provide green spaces and conservation of biodiversity efforts. The recognition of the link between biodiversity and health is growing rapidly and this is true for Bangladesh with its rich and diverse natural world.