HEALTH, NUTRITION AND POPULATION STRATEGIC INVESTMENT PLAN (HNPSIP) 2016 – 2021

"Better Health for a Prosperous Society"

4th Health Sector Programme
Draft version 3.0
February 2016

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

CONTENTS

Annexes

Figures

Tables

PREFACE

Minister of Health

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
CAO	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	Burden of malnutrition
DGDA	Directorate General of Drug Administration
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DP	Development Partner
DPA	Direct Project Aid
DRS	District Reserve Stores
DSF	Demand Side Financing
ESP	Essential Health Service Package
EU	European Union
FAPAD	Foreign Audit 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 programme
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 Undernutrition
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, neonatal and child health
M&E	Monitoring and evaluation
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
NCD	Non-Communicable Diseases
NEMEMW	National Electro-Medical Equipment Maintenance Workshop
NES	Nursing Education and Service
NNMR	Neonatal Mortality Rate
NPAN	National Plan of Action on Nutrition
NSSS	National Social Security Strategy
NTD	Neglected Tropical Disease
OCA	Organisational capacity assessment
OOP	Out of Pocket
OP	Operational Plan
PIP	Programme Implementation Plan
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 Units
SDGs	Sustainable Development Goals
SSK	Shasthyo Shuroskha Karmasuchi
STG	Strategic Thematic Group
SOP	Standard Operating Procedures
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
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) 2016-2021, 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, the majority of which 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. Many 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 and 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 stakeholder 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 the required skills in public health are available as well as strategies for building community ownership and participation.

The HNPSIP advocates for the establishment of a comprehensive and well managed district and sub-district health system 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. There needs to be 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.

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.

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 funding scenarios presented show that in the coming years finances will remain tight. The MOHFW will need 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 Ministry of Health and Family Welfare 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 newly formulated 7th Five-Year Plan (2016-2021). If fully implemented this Health Nutrition and Population Sector Strategic Investment Plan will result in a substantive and sustained improvement in the health and wellbeing of the people of Bangladesh.

Ten Key messages of the HNPSIP (2016-2021)

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

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 included. 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 FYP and its health policy framework and articulates a set of objectives to move the country towards its goal of Universal Health Coverage. 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.

1.3 The Policy context

Vision 2021 and 2041

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

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 care services. The revised National Health Policy 2011 acknowledges 'health' as a right and its stated 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

[3] *Bangladesh Seventh Five Year Plan FY2016 – FY2020*
[4] *www.undp.org*

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.

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 needs 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.

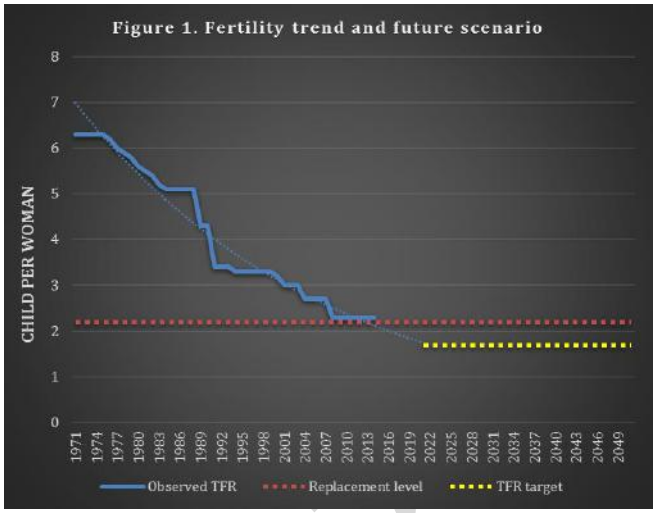
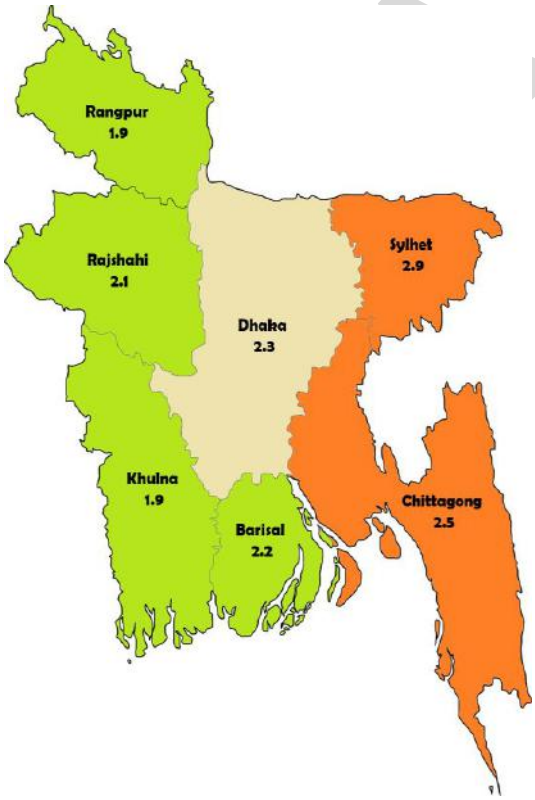


Figure 2: Regional distribution of Total Fertility Rate (TFR)



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 (2012-2014) stands at 2.3 births per woman with TFR in rural areas higher (2.4) than in urban areas (2.0).

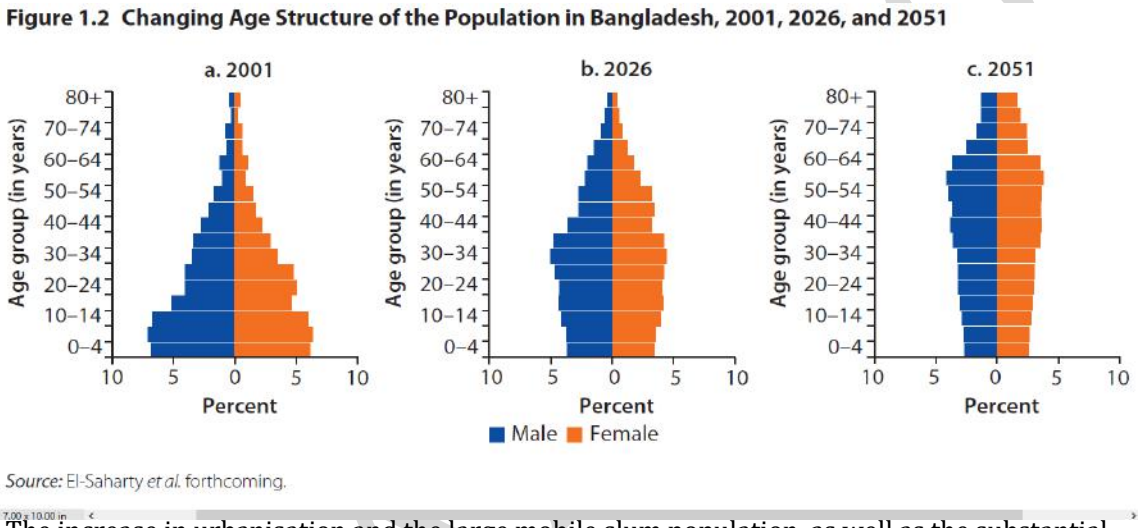
As highlighted in the health sector policy dialogue in 2014 between government and development partners there is still considerable work to be done both to maintain and consolidate the progress made in family planning as well as to tackle some of the regional variations that exist. Figure 2 shows variation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

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

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 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]



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.

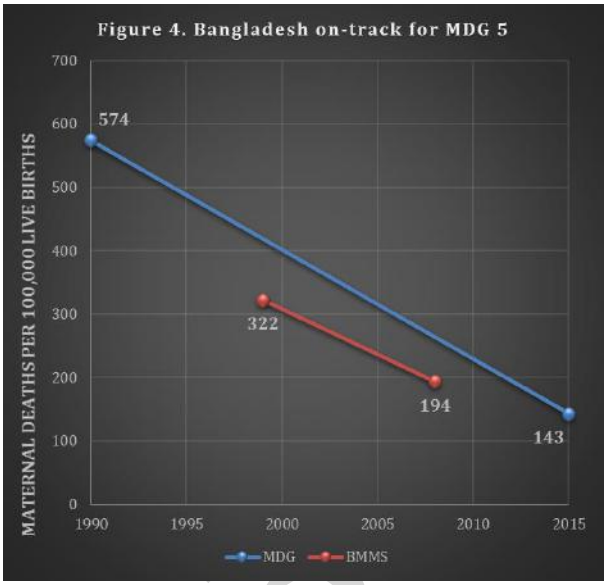
1.5 The State of the Nation's health

Progress towards reaching the MDG

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 due to be achieved by 2015. 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 report*

Maternal, Neonatal and Child Health

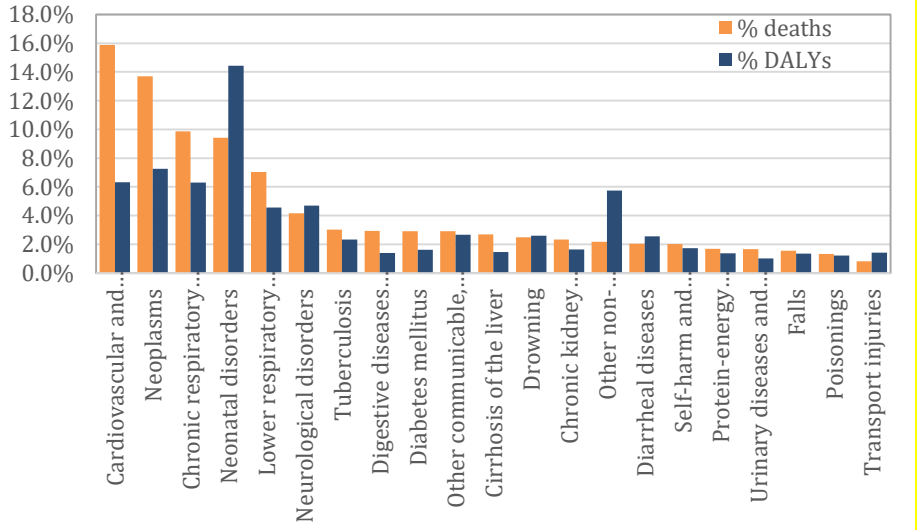


The decline in Maternal Mortality Rate (MMR) between 2001 and 2010 and further projected decline to 170/100,000 live births (UN interagency estimate) indicates remarkable progress. Figure 4 demonstrates the best estimates of maternal mortality decline. This is linked to fertility reduction, access to 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[1]. 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 illhealth 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]



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

The rise of Non-Communicable Diseases – An epidemiological transition

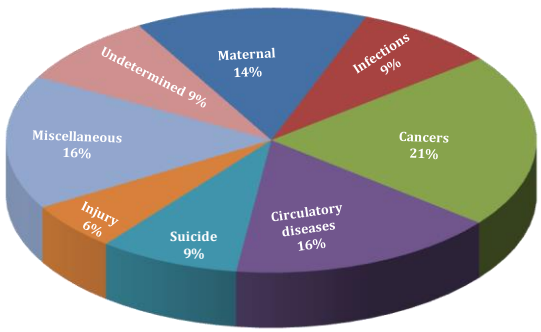
The NCD Country Profile (WHO, 2014) reported that NCDs account for 59% of total death in Bangladesh (17% cardiovascular diseases, 11% chronic respiratory diseases, 10% cancers, 9% injuries, 3% diabetes and 10% other NCDs). In response to this epidemiological transition in Bangladesh, there is a need 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 graphic 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]



[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

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 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[15]. 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[16] of children under five years of age were found to be stunted (short for their age) and underweight (low weight for age) respectively[17]. As per the classification of the World Health Organization (WHO), this represents "very high prevalence" of underweight in Bangladesh, a rate that is higher than that of most sub-Saharan Africa. 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 – 24 per cent of children under-five years of age were underweight in the richest quintile in 2013. Only 29% of children under 2 years in urban and 21% in rural areas gets Minimum Adequate Diet (MAD).

Among women, nutritional status has improved slightly, but undernutrition continues to represent a serious issue for both women and adolescent girls. About 24% of women and

[14] *UN World Population Monitoring 2002- Reproductive rights and reproductive health : selected aspects.*

[16] *Bangladesh Demographic Health Survey (BDHS) 1997, 2000, 2004, 2011, and 2014*

[17] *Utilization of Essential Services Delivery Survey, UESD 2013*

53% of adolescent girls aged 10-18 years were undernourished (Body Mass Index of less than 18.5)[18]. 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[19]. There is, at the same time, a growing concern about the rise in over-weight in 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. Progress was discussed during the MTR (2014) and it was raised as an area of limited progress to date but one that is becoming increasingly important for senior management at the MOHFW. 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 relies on 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, regulatory bodies should be independent and free from financial and other conflicts of interest. The composition of such bodies should make room for including members of civil society to increase participation and transparency.

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) led at senior levels of the Ministry is needed and should pay careful attention to an inclusive process and a change management strategy. Integration of current bifurcated structures with its evident areas of duplication and unclear areas of responsibility need 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.

[18] State of Food Security and Nutrition in Bangladesh, 2013.
[19] UNICEF-Government of Bangladesh Mid-Term Review Report, Country Programmed 2012 – 2016.

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 with the support of WHO. However a comprehensive HRMIS capturing all necessary data is yet to be established and used. Implementation of the HWF Strategy currently under development should be fast-tracked and include regulation and accreditation of the private sector workers.

Human Resources issues affect most OPs[20] 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

[20] 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)

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. It is well known that certain categories of health workforce (especially physicians) take advantage of the deputation policy for studying postgraduate courses. There is absenteeism of health personnel at the workplace and unauthorized while absence is regarded as misconduct as per service regulation[21] and strict disciplinary measures are advised action is often not taken. Local monitoring and supervision mechanisms need to be strengthened in this regard and innovative, unbiased and decentralized models should be worked out to find solutions to the problem.

Procurement and Supply Chain Management

The MOHFW spent a relatively large amount of funds (US $7.7 billion) in procurement of medicines, medical equipment, services and capacity building with both RPA and GOB resources 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 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, with more than 15% of the RADP allocation of HPNSDP to 2014/15. Apart from HPNSDP, MOHFW has 25 development projects in which around 992 crore was released in 2014/15 FY. Around 60% of this expenditure was on new construction and the rest was on procuring equipment.

A comprehensive master plan for civil works is under preparation. This together with the work of SIAPS 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. Decisions on physical facilities development or upgrading needs to be more based on detailed needs assessments. In addition, the need for 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

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

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 80% of allocated amount. The inordinate delay in settlement of audit observations and delayed response from Foreign Audit 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[22]. 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 to progress the MOHFW and 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

[22] *paragraph 74 of UN resolutions on SDGs (A/74/L.1)*

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[23]. 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[24].

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 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 is US$ 27 which 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 0.1% 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 have 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 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 schemse 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 estimated cost for the 3rd SWAp, i.e. HPNSDP (2011-16) was BDT 56, 993 Crore

[23] Katz et al.

[24] Beane, Hobbs & Thirumurthy

(about US$ 7.7 billion)[25] . Out of this, it was estimated that BDT 43,420 Crore (76%) will be contributed by Government of Bangladesh (GOB) and 24% to be financed by development partners (15% pool fund/RPA[26], 9% DPA). The absorptive capacity of the MOHFW has improved in recent years. During the first three years of 3rd SWAp implementation (2011/12-2013/14), utilization of annual development programme budget was 88% in 2011/12, which increased to 92% in 2012/13 and 91% in 2013/14. Utilization of the revenue budget was more than 95% during the first three 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 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 model

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[27] . 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 result 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 Upazilla account offices result in low utilization of resources.

1.9 Health, nutrition and population services

As part of improving health services good progress has been achieved in maternal, neonatal, child, reproductive and adolescent health and family planning services. Progress has also

[25] PIP of HPNSDP, 2011-2016.

[27] Household Income and Expenditure Survey, 2010

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 need 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.

Essential Service Delivery

The 4th Sector Programme emphasises the importance of delivering a package of high quality essential health services (ESP) through the various accredited 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. The 13029 CCs currently functional, 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. Significant inequities exist across geographical regions and between different wealth quintiles and this needs 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)[28] . The increase in facility delivery is mostly at the private sector. Notably, 23 percent of all deliveries are conducted through caesarean section. 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 are yet to be monitored. Effective coverage of 24/7 C-EmOC[29] 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[30]. 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[31].

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

[28] BMMS 2010

*[29]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)**plusBlood Transfusion, Caesarian Section***

30BDHS 2011.

[31]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

preventable neonatal deaths and stillbirths[32]. 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).

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.

[32]Lancet Newborn Series 2014

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 where 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 undernutrition, 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 are 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 takes root and to incentivise front line staff. In addition comprehensive BCC and Communication 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 undernutrition 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 Medicine 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

It is now essential to tackle the rapidly growing NCD burden in the coming years. This 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 arguments 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, neoplasms 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 effects 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. Bangladesh also has the highest rate of child marriage and the highest rate of marrying girls under 15 years of age in the world. The MOHFW should work to influence the current discussions by providing the evidence of the potential harm of lowering the legal age of marriage and also look at enforcement of legislation in this matter.

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.

Healthy Environments

The most immediate opportunity for the health sector to improve environments 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.

SECTION 2: A PROGRESSIVE AND INCLUSIVE AGENDA FOR THE 4TH SECTOR PROGRAMME (HNPSIP, 2016-2021)

The development of the Bangladesh Health, Nutrition and Population Strategic Investment Plan 2016-2021 is guided by Bangladesh's Vision 2021, which acknowledges that improved health is a critical driver to the achievement of this vision. Vision 2021 aims to transform Bangladesh into a globally competitive and prosperous country with a high quality of life by 2021 by transforming the country from a developing country into a middle-income country.

Health services in Bangladesh is primarily guided by its Constitution which says, 'Provisioning of medical care to improve material and cultural standard of living of the people' (Article 15a of the Constitution). Within the broader context of Bangladesh National Strategy for Economic Growth, Poverty Reduction and Social Development (Bangladesh I-PRSP, March 2003), the government's vision for the health, nutrition and population sector is to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. It is a vision that recognizes health as a fundamental human right and, therefore, the need to promote health and to alleviate illhealth and suffering in the spirit of social justice (MOHFW 2004).

The country is also committed to achieving the universally agreed goals in specific areas as set out in the declarations of various world summits, the Sustainable Development Goals (SDG) and the National Strategy for Accelerated Poverty Reduction (NSAPR) are the policy guides for all sector programmes including health.

Universal Health Coverage

The goal of Universal Health Coverage has been elevated in the global and national agenda in recent years and is part of the Sustainable Development Goals specific to health. Endorsed by the World Health Assembly through a resolution in 2005, UHC is defined as access for all to appropriate health services at an affordable cost. Universal coverage is associated with better health and equity, as well as financial protection. The systemic resilience provided by universal coverage also contributes to poverty alleviation by reducing catastrophic health expenditures. Bangladesh aims to abstain from the current path of increasingly inefficient and regressive health systems with 63.3% of out-of-pocket spending of total health expenditures and moving towards pooling health financing through taxation, social protection or insurance mechanisms and ensuring quality of care to cover large portions of the population.

Bangladesh Strategic Investment Plan is also aligned to the goal of achieving Universal Health Coverage that highlights the right of every citizen of a nation to gain access to quality healthcare without incurring economic hardship. The 4th Sector Programme is designed to develop appropriate strategies and gear all concerted efforts for focused and radical improvements in increasing access and quality of healthcare and improving equity along with financial protection in order to meaningfully realize the UHC objectives.

2.1 Vision, Mission and Goal of the 4th Sector Programme

Vision

"To see the people healthier, happier and economically productive to make Bangladesh a middle income country by 2021" (Vision 2021)

Mission

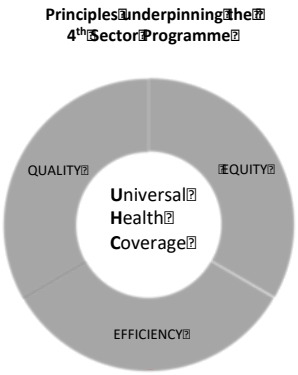
"To create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health"

Overall Goal

"To ensure that all citizens of Bangladesh enjoy health and well-being by ensuring access to quality and equitable healthcare and a healthy and safe living environment"

2.2 Guiding Principles

On the basis of the experience in the previous health sector SWAp periods the participants in consultations held in preparing the 4th Sector programme identified a set of underlying principles for the work over the next five years. Recognising the need to not just provide access to services the intention is to ensure that all citizens have access to high quality services whether these are obtained from the public or private, modern or traditional providers. Quality is therefore the first key principle. The analyses undertaken during the numerous reviews of the health, nutrition and population sector have shown that gains made are often unequally distributed across all sections of society. The need to focus in the next programme on ensuring that all citizen's are treated equally is seen as a central principle. The second principle is Equity. Resources are limited and the needs are great in the sector. While government and development partners remain committed to ensuring the aims and objectives as set out in this document are met the reality is that resources available are and will remain limited. One way to ensure progress is to work towards establishing efficient, transparent and accountable services. Reducing wastage and maximizing the impact of all available resources will be critical to achieving the targets being set. The third principle is therefore Efficiency.



The MOHFW and GOB as a whole is committed to the principle of achieving Universal Health Coverage for the population. The government has signed up to this intention with the full recognition that this will be a huge challenge and will take time and effort to achieve. An overarching principle for the 4th Sector programme is that of Universal Health Coverage.

2.3 Strategic Directions

The sector analysis by the MOHFW, through consultation with government, development partners and other health sector stakeholders, is presented above for the 4th HNP Sector Investment Programme. This included assessment of progress under HPNSDP as well as emerging health issues across the country. Based on this analysis a set of eight strategic

objectives has been formulated for the health sector over the five-year period from 2016 to 2021. These strategic objectives are grouped into three components around governance, systems and services. An outline of the key outputs and priority actions under each strategic objective is presented in section 3 and related performance indicators are presented in the Sector Programme Results framework (Annex 2)

Component 1: Governance and Stewardship of the sector

Strategic objective 1	➢ To strengthen governance and stewardship of the public and private health sectors
Strategic objective 2	➢ To undertake institutional development for improved performance at all levels of the system
Strategic objective 3	➢ To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage

Component 2: Stronger Health Systems

Strategic objective 4	➢ To strengthen the capacity of the MOHFW's core health systems (Financial Management, Procurement, Infrastructure development)
Strategic objective 5	➢ Establish a high quality health workforce available to all through public and private health service providers
Strategic objective 6	➢ To strengthen the evidence base for health sector decision-making

Component 3: Quality Health Services

Strategic objective 7	➢ To improve equitable access to and utilization of quality health, nutrition and family planning services
Strategic objective 8	➢ To promote healthy lifestyle choices within a healthy environment

Each strategic objective has been defined in terms of specific objectives, major areas of activity and key indicators (see section 3). Some strategic objectives are further divided into specific objectives and outputs depending on their scope. Indicators, milestones and targets are further developed in the 4th HNPSIP Results Framework (Summary in Annex 2) and

outlined in detail in the Results Framework document and the Programme Implementation Plan. This allows budget allocation by objectives and has formed the basis for a more results based financing approach.

2.4 Cross-cutting issues

Gender, Voice and Accountability in health

Gender has important health implications for women in terms of access of services, engagement in risk behaviours, exposure to risk factors, understanding of information about disease management, prevention and control. To achieve Sustainable Development Goals (SDGs) approaches that focus on gender issues including male engagement are needed. Gender should be considered at all stages of planning, design, budgeting, implementation and monitoring of the HPN sector. The Gender, NGO and Stakeholder Participation Unit (GNSPU) of MOHFW has worked on the development of a Gender Equity Strategy (2014) and will lead and coordinate the process of implementation over a period of ten years (2014-2024). The primary goals are to respond to the needs and priorities of women and girls; prevent and respond to gender violence including prevention of child marriage and early pregnancy through strengthening health system.

Bangladesh has one of the highest rates of domestic violence in the world, an estimated 50% of women in Bangladesh will experience violence in their home. In 2010, 35% of ever-married adolescents living in rural areas, and 40% living in urban areas had experienced some form of physical violence by their husbands. Sadly, domestic violence is thought to be a major contributor to maternal mortality, research has found that 14% of deaths among pregnant women were a result of injury due to violence.

Female empowerment also influences health outcomes. The BDHS 2011 highlights a decline in infant and under-five mortality rates as women's participation in decision making increases. In the case of women who make no decisions, infant mortality is 49 deaths per 1,000 live births and under-five mortality is 59 deaths per 1,000 live births, compared with an infant mortality of 38 deaths per 1,000 live births and an under-five mortality of 47 deaths per 1,000 live births for women who participate in all four decisions regarding their own health care, major household purchases, child health care, and visits to their family or relatives. Similarly, infant mortality and under-five mortality rise sharply with women's agreement with wife beating. Among women who do not agree with any reason for wife beating, infant mortality and under-five mortality are 39 and 49 per 1,000 live births, respectively, compared with 56 and 71 for women who agree with 3-4 reasons for wife beating.

Gender based violence and female empowerment should be addressed through the health sector plan as part of a comprehensive responsive. The health sector has a unique role to provide GBV screening and health care services unique to survivors of domestic violence, especially related to rape and sexual assault. A multi-sectoral response to gender based violence and gender overall should be prioritized in this health sector plan.

Poverty alleviation - Reaching the Hard to Reach and vulnerable populations

The tribal population in Bangladesh ranges from 1.5 to 2.5 million and constitute about 1-1.5% of the total population of Bangladesh. There are about 45 different tribal groups spread across the country. The proportion of the tribal population in the 64 districts varies from less than 1% in the majority of districts to 56% in Rangamati, 48.9% in Khagrachari and 48% in

Bandarban in the Chittagong Hill Tracts (CHT). Available disaggregated data shows clearly the disparities between sections of society. Reaching the geographically, socially and culturally more marginalised section of society is a major concern that will be addressed during this sector programme. Disaggregated data will be collected and monitored to demonstrate how progress is being made. This in turn will inform decision making on priority action and resource allocation. The GOB's approach is clear as indicated in the Vision 2021, that describes the political commitment to ensure skilled, motivated health service providers are in the right places to ensure that poor, disadvantaged, displaced populations and other vulnerable communities are cared for.

Bangladesh is going through significant social and demographic changes, including rapid urbanization. At present about 27% of people of Bangladesh live in urban areas. DGHS has 35 urban dispensaries in urban areas and provides outpatient services including EPI and maternal and child health to the urban population. The primary and secondary care services to the urban poor, including over one million garment workers in urban slum areas, is a major concern. Urgent attention is needed to introduce a structured comprehensive primary healthcare package for the urban population.

The importance of public health

The need to tackle the rise in Non-communicable and Communicable diseases through prevention is now an essential and urgent priority. Without reducing the rise in NCDs the already over stretched health system will become overwhelmed. The epidemiological transition is now evident and this needs to drive a change in policy focus that puts public health at the heart of the 4th Sector programme. Intense action needs to be on ensuring that people of all ages, but especially the young, adopt healthy lifestyles. This includes more work on improving people's understanding of diet and exercise. Reducing salt and sugar intake, eating a balanced diet, avoiding tobacco and other harmful substances, and taking regular exercise are all key determinants of a healthy life. In support of self-responsibility, the government can adopt legislation to create healthy environments and opportunities for all, including the poor, to have access to safe and clean environments and safe food and water. This is a medium to long term endeavour and the benefits in terms of population well-being will take time to appear, however preventing the rise of ill-health will not be accomplished by the health care system alone.

2.5 Partnerships for health

Partnership with the private sector

In the Vision 2021 action plan, the government sets the goal of becoming a middle-income country by 2021. Participation of the private sector through PPPs is considered as an important route to achieving this goal. There is an increasing emphasis on the complementary role of the private sector through public private partnership and the critical importance of non-state actors.

PPP objectives in healthcare are to contribute to the overall sustainability of the national health system, promote equity and access to primary care and affordable hospital care, promote equity in financing health services, and promote financial sustainability in the public sector. Among the projects currently under consideration, the PPP Office is reviewing two dialysis clinics and the rehabilitation of two railroad hospitals using private sector management with the idea to replicate these pilot projects on a large scale.

The private sector also has a role to play in areas where public facilities are absent or functioning poorly. Private sector facilities can play a key role in provision of services especially in hard to reach areas. Contracting out non-functional health facilities to private (for profit and not-for profit) providers is an option with a clearly defined negotiation, monitoring and supervisory role of the government.

Multi-sectoral approaches

As the SDGs begin to gain traction in national level discussions on development it is clear that sectors such as health, nutrition and population need to work more closely with other sectors. The MOHFW has a key role to play to ensure that it engages with other Ministries whose work has a bearing on HNP. Ensuring that health related evidence is provided to other Ministries to guide there decisions on issues such as air and water pollution, food safety and agricultural practices, urban and school planning that incorporates green spaces and exercise facilities, legislation on issues such as roads, harmful substances and social policies including the role of law enforcement. Similarly the MOHFW should seek advice to ensure it undertakes practices in appropriate ways such as safe waste disposal of medical materials, sanitation and clean energy and water at facilities. Collaboration around healthy lifestyles and healthy environment will play a major role in keeping the burden of NCDs under control.

SECTION 3: STRATEGIC PRIORITIES FOR THE 4TH SECTOR PROGRAMME

Strategic Framework of the 4th Sector Programme

The eight strategic objectives have been formulated that in aggregate cover all aspects of the health sector including governance and stewardship, health systems, health services and the wider determinants of health. This framework presents the strategic objective with a set of output level objectives and broad indicative activity areas that are linked to detailed activity planning provided in the HNPSIP Programme Implementation Plan (PIP). A full set of indicators, targets and milestones are available in detail in the accompanying HNPSIP Results Framework[33] document (outline presented in annex 2).

3.1 Component 1: Governance and Stewardship

Strategic objective 1: To strengthen governance and stewardship of the public and private health sectors

Strengthening of governance and stewardship involves a substantial evolution in the way the sector is managed. There needs to be considerably more focus on stewardship and regulation on the part of the MOHFW and more emphasis on developing partnership between the public and private sectors in ensuring high quality care for all as the country works towards Universal Health Coverage. To do this will require a review of capacity in key areas of stewardship and regulation at different levels of the government system combined with a range of institutional changes in function and structure.

Outputs	Priority activities
1.1 Strengthen the capacity of MOHFW in governance, leadership and management	• Organisational capacity assessments of key Directorates, Departments, Agencies and Professional bodies • Capacity strengthening programme (staff and skills) • Strengthening of regulatory bodies and clarification of roles and responsibilities • Introduction of mentoring scheme for senior managers

1.2 Improve the legal and operational framework on governance and stewardship	• Enact / amend laws, including
	  ○ Law for regulating private medical and dental and nursing colleges
	  ○ Amend Private Clinic Act
	  ○ BMDC Act
	• Development and introduction of standards and accreditation systems for the public and private sectors.

[33] *Detailed definitions and source for each indicator is provided in the Results Framework document*

1.3 Improve local governance and accountability in health	• Build capacity in governance and accountability across local levels of health system • Expand local accountability, transparency and governance mechanisms • Scale up active community participation in operating hospital and community health programmes (learning from existing models such as the Chougachha Model)
1.4 Promote inclusion of public health in inter-ministerial policies through collaboration with relevant bodies	• Inclusion of public health in inter-ministerial policies through evidence based advocacy • Capacity building amongst national and local decision-makers on the role of public health • Agency level (joint) strategy and planning on important inter-Ministerial issues: tribal health, nutrition, food safety, climate change, use of chemicals in agriculture. • LCG and Health Council meetings consider health related inter-ministerial issues

Strategic objective 2: To undertake institutional development for improved performance at all levels of the system

Clear institutional roles and responsibilities are fundamental to improved performance across the sector. Ensuring the correct functions are taking place at the appropriate level of the system, that the institutional arrangements are effective and that there is strong coordination and harmonisation at all levels will enable the efficiency and equitable use of resources. The current institutional set up at national and sub-national levels needs to be reviewed early in the new programme with a view to rationalisation, removal of duplication, establishment of new functions and an overall clarity of roles and responsibilities. Organisational Capacity Assessments (OCAs) of all key institutions will provide a mechanisms for self-assessment and capacity planning and monitoring of continuous improvement.

Outputs	Activities
2.1 Rationalisation of institutional arrangements and functions within MoHFW	• Assessments of organizational capacities, structure, operational plans, and related resourcing to maximize efficiency and effectiveness • Implementation of agreed action plans from assessments (e.g. reorganization of FMAU) • Strengthen aid effectiveness arrangements, practices and reporting • Review existing coordination mechanisms including use and functioning of committees.
2.2 Develop and make functional institutional arrangements at District and below.	• Improved management and administrative structures and functioning at all facilities from District hospitals down to Community Clinics. • Set up institutional arrangements for engaging communities at all levels from District to Community Clinic, including feedback mechanisms.

2.3 Ensure oversight and management capacity is in place for human resource planning and development across the sector	• All laws should be examined in light of human resource needs • Institutional strengthening in support of Health workforce strategy and planning
2.4 Establish new organizational entities and capacity for new stewardship and regulatory role	• Review of regulatory and accreditation bodies and develop new competencies and entities for specialized activities • Establish mechanisms for development and monitoring of health standards • Collaboration with LGD and a permanent institutional mechanism on urban health

Strategic objective 3: To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage

A major focus over the next 5 years will be to increase the total health funding available for essential health care services. This will be achieved through demonstrating the positive economic gains of investment in health as well as ensuring efficient, effective and equitable resource allocation. Financing of the sector will come under increasing pressure from the rise in population, the ageing of the population and the rapid rise of non-communicable diseases. While per capita investment in health by government is still low and the economic growth continues in a positive direction the outlook for more resources from government is by no means clear. Growth and sustainability in the finances for health will be a combination of managing demand for services, the efficient use of available resources and establishing a convincing investment case for government, development partners and the private sector. Three scenarios are provided in section 6 for the HNPSIP financial envelop. The degree to which senior management and its partners can achieve progress in the issues above will have a considerable influence on which of these scenarios actually happens.

Outputs	Priority Activities

3.1 Increase overall financial resources in the health sector	• Evidence based advocacy for increased government budget allocation for the health sector (based on regular PER and NHA)
	• Explore new and innovative sources of financing for the health sector:
	  ○ Tobacco tax ('sin taxes') allocation to health
	  ○ New taxes on environmental pollutants
	  ○ A Trust Fund in line with the NHFS
	  ○ Private sector investment in health systems
	  ○ Public Private Partnerships to mobilize resources.
	  ○ Research into innovative financing
	• Evidence based advocacy for increased on and off budget funding from Development Partners.

3.2 Achieve equitable access to services and financial protection, especially for people in the bottom 40 percent	• Implement the Health Care Financing strategy through close coordination with the NSSS - national social health protection scheme - to strengthen financial risk protection and extend health services and population coverage with the aim to achieve universal health coverage. • Explore pooling mechanisms, as part of the national social health protection scheme, via contributions from the formal sector and the middle and upper-middle classes. • Complete pilot and implement the resource allocation formula.

3.3 Enhance efficiency in financial resource allocation and use	• Increase budget allocation to public health/primary health care activities. • Increase supervision and monitoring systems across all tiers of the health system • Reduce wastage across procurement practices, especially in area of infrastructure development. • Explore contracting out (including PPP) highly specialist services, non-functional facilities, and facilities for underserved hard to reach populations to the private (for profit and not-for profit) sector. • Promote results-based financing as a strategy used to improve health systems efficiency • Improve coordination between sector programme and DP-supported off-budget programmes

3.2 Component 2: Health systems strengthening

Strategic objective 4: To strengthen the capacity of the MOHFW's core health systems (Financial Management, Procurement, Infrastructure development)

Three core systems that underpin administration and operations of the sector are highlighted under this objective:

Procurement and supply chain management
The focus is on improvement of the procurement process, including strengthening procurement planning, distribution and contract management. It looks at improved quality and efficiency, capacity and regulation of the pharmaceutical sector. Procurement needs to be based on actual needs, better coordination between DGFP and DGHS and avoidance of procurement from multiple sources.

Infrastructure development
The focus is on improved coordination, completion of infrastructure into active service centres, new construction in less attended areas only, and developing and implementing comprehensive maintenance plans for both infrastructure and equipment with adequate budget.

Public financial management
The focus is to overcome the existing challenges and make the FM&A of the next sector programme more transparent while reducing the financial and fiduciary risks in the next sector programme, the following measures will be adopted.

These three systems have been highlighted in sequential reviews of the last two sector programmes for more attention. Building capacity in terms of systems and skills is key as is the strengthening of internal supervision and control systems. Substantial efficiency gains could be made if these three core systems are improved.

Outputs	Priority Activities
4.1 **To ensure availability and quality of medical products including life-saving drugs, vaccines, contraceptives and necessary equipment through an effective, efficient and transparent procurement and supply chain management process**	• Strengthen procurement planning, process, distribution and contract management • Improve quality and efficiency of procurement • Strengthen capacity of CMSD and other departments • Improve regulation of the pharmaceutical sector
4.2 To ensure efficient investment on physical infrastructure through enhancing effective use of existing infrastructure and making balance among new construction, maintenance and repair	• Improve coordination between different departments involved in infrastructure development • Make the completed physical structures into active service centres • Prioritize new construction to be focused on areas that lack facilities • Develop comprehensive maintenance plans for both infrastructure and equipment
4.3 To make the Financial Management and Audit more transparent and reduce the financial and fiduciary risks in the next sector programme	• Strengthen Financial Management at individual, processes and systems levels • Increase capacities of the OPs and directorates • Strengthen the Audit System • Establishing advisory role of FMAU • Quickening fund release

Strategic objective 5: To establish a high quality health workforce available to all through public and private health service providers

This objective includes specific objectives related to the roles and responsibilities of all cadres at all tiers of the system, recruitment and retention, quality, efficiency and medical education. It includes all public, private and AMC health workers.

Human resources for health has been identified by all stakeholders in the sector as a key strategic priority. It is an issue that cuts across all the other strategic objectives unsurprisingly as people are at the centre of all systems and services. A range of important priorities has been highlighted in the Human Resources for Health report (STG, MoHFW, 2015)[34]. The need for a comprehensive review of HRH and the implementation of the Health Workforce Strategy and corresponding Action Plan is a major priority. Improvements in the way staff are selected, training, distributed and supported are recurrent themes in all reports looking at the health sector. The need for an improved human resources information system linked to DHIS has been advocated as has the need to tackle issues of skill mix, task shifting and contracting or outsourcing (MTR, 2014).

A through review of capacities and competencies linked to improved pre-service training in-service support is needed. Careful consideration to where and how to allocate resources for production of new health workers of all disciplines is needed as part of the Health Workforce Strategy. The resourcing of new medical colleges needs to be done based on thorough analysis. Academic institutions that produce the required range of skills such as midwives,

[34] *MoHFW (2015). Strategic Thematic Area: HRH – STG Report – August 2015*

nurses, anaesthetists and laboratory technicians must be fully considered as must the incentives and requirements of health workers once qualified.

The current health worker situation is insufficient to produce the quality health care services needed. More must be done to ensure the marginalised and remote areas have health workers that will work in these areas. The Health Workforce Strategy must look beyond the public sector to include AMC and private sector health workers and look creatively at how these different parts of the overall health sector can work together more effectively and efficiently. The regulatory frameworks and capacities needed to develop the HRH strategy and implement the Action Plan must be put in place and the resources provided to enable the managers responsible to carry out their tasks.

Outputs	Priority Activities
5.1 Ensure availability of competent and adequate number of workforce as per health systems need	• Finalise and implement integrated Health Workforce Strategy • Finalise and implement 5-Year comprehensive Health Workforce Action Plan, costed and prioritised. • Review the organogram of all health and family planning facilities and entities • Address shortage and skill mix, including ratio imbalance, task shifting (see HWF strategy) • Develop and implement policy on outsourcing service delivery.
5.2 Develop and sustain quality health workforce at all level	• Improve quality of public and private pre-service health workforce education system (including for AMC providers) • Integrated in-service training, linked with career development. • Capacity development to ensure better management within district level and below • Introduce and/or strengthen quality assurance of medical education at both private and public sector institutions through licensing and accreditation • Review professional licensing and accreditation of health professionals
5.3 Recruit, deploy and retain health workforce equitably	• Rationalize job descriptions of HWF at different level of services based on changing needs • Recruitment and retention planning, including incentives to address distribution issues particularly for underserved/disadvantaged areas, appraisals and career planning. • Introduce innovative, unbiased and decentralized health workforce deployment and transfer system. • Gender sensitive HWF planning and implementation
5.4 Use evidence to support decision making in improving HRM	• Establish one HRIS that is linked to national HIS • Establish monitoring framework for implementation of HWF Action Plan

Strategic objective 6: To improve health measurement and accountability mechanisms and build a robust evidence-base for decision making.

Based on the experiences, situation assessments and comprehensive analyses of the HNP sector programme's annual reviews in the past years, appropriate and strategic advocacy will need to be carried aimed at health sector managers so that they make better use of data and evidence in HNP planning and decision making. Support to strengthening and effectively using national HIS will have to be continued along with ensuring adequate funding. An institutionalized system for regular HIS training and updating of skills of staffs, keeping in mind their specific needs, will have to be established.

The key principles of national HIS and eHealth should be building on existing resources, standardization, interoperability, harmonization, integration and efficiency in every aspect such as in data collection, selection of software and hardware, engagement of human resources, and effective data sharing and use by all relevant stakeholders. Key research organizations will have to be strengthened and possibilities of harmonization of population based health surveys will have to be explored. An effective mechanism will have to be created for the utilization of all the survey and research findings.

Outputs	Activities
6.1 Move towards fully digital routine health information system by 2021	• National scale up of the electronic tracking system of citizen's health • Improve integration of the health information and eHealth platforms existing amongst different agencies and stakeholders. • Strengthen the use of ICD-10 coding system in healthcare facilities • Make routine mechanism for evidence based decision making in MOHFW
6.2 Strengthen sector programme monitoring and evaluation (M&E) processes through effective utilization of evidences available from all possible sources (routine data, surveillance, CRVS, survey, research, etc.)	• Monthly OP-wide ADP Review, both on financial and physical progress. • Annual Programme Reviews (APR) by Independent Review Team (IRT) and ensure use of APIR data in APR • Institutionalize Data Quality Assurance (DQA) mechanisms • Improve coordination and harmonization of the population based health surveys • Develop inventory of survey and research publications and Enhance efforts for disseminating data, reports
6.3 Establish partnerships with relevant institutions for facilitating data demand, updating and utilization in MOHFW and its agencies and departments	• Establish Indicator Reference Group • Promote innovations in data production and utilization • Strengthening community engagement and feedback through data and information sharing for promoting transparency and accountability.
6.4 Develop and implement multi-year, comprehensive HIS, eHealth and M&E training plans for capacity building of managers and staff	• Develop and implement multi-year, comprehensive training plans • Conduct orientation of LDs and core OP staff in Planning, Monitoring and Coordination; • Conduct organizational assessment and restructure and strengthen the MIS units on all required dimensions of national HIS.

6.5 Increase budgetary allocation for HIS, eHealth and M&E activities to sustain and further build on the progress	• Allocate sufficient and adequate fund to sustain, expand and further strengthening HIS, eHealth and M&E activities • Support specific OPs, agencies, organizations and institutions under MOHFW (PMR, NIPORT, NIPSOM, HEU, BMRC, IEDCR) to conduct planned surveys timely; • Develop resource mobilization strategy for sustaining and increasing budget for HIS, eHealth and M&E activities.
6.6 Promote research culture across MOHFW and develop research plan	• Strengthen the key research institutions • Establish BMRC to play its desired role as the competent focal national health research institution; • Strengthen the coordinating role of LD, PMR in DGHS for research; • Review and update the National Health Research Strategy 2009; • Mainstream academic/operational research with national health priorities; • Build up capacity of the policy makers, health managers and health professionals on utilization of data and research findings;

3.3 Component 3: Provision of quality health services

Strategic objective 7: To improve equitable access to and utilization of quality health, nutrition and family planning services

This strategic objective includes the main service delivery component of the 4th sector programme. It captures primary, secondary and tertiary services including preventive and curative services. It is the major cost driver of the sector where the majority of human resources and supplies are focused. It includes district, secondary and tertiary hospitals. A major focus should be on achieving improved service integration while ensuring individual services are of a high quality and accessible to all. There is a clear emphasis on the need to scale up and strengthen community-based public health interventions towards achieving the goal of equity and to enhance the quality of health services. Innovative approaches to improving efficiency are essential as is ensuring motivated staff are present at their designated posts to deliver quality care to all of the population. Collaboration between the public and private sector will be a key element of ensuring access to specialist services as well as functional care in hard to reach areas and for vulnerable groups.

This section includes: 1) Maternal, Neonatal, Child and Adolescent Health, 2) Family Planning, 3) Non-Communicable Diseases, 4) Nutrition and Food safety; 5) AMC. It addresses the pluralistic service delivery that exists in Bangladesh and includes the public and private sectors, allopathic as well as alternative medical care (AMC).

MNC&AH services remains a key area for health provision in this sector programme and is a major component of the proposed Essential Services Package. Particular attention will be needed to ensure improvement in quality of services and their expansion into hard to reach and other underserved populations. The issue of neonatal mortality has been flagged as an area of special attention as progress has been slow during HPNSDP.

The existing family planning programme will be strengthened through delivering regional packages in less well performing divisions/pockets. Shifting of existing method-mix of

contraceptive use to include an emphasis on long acting and permanent methods (LAPM) will continue to be promoted through informed voluntary choice and counselling. Other FP approaches will be targeting newly-wed couples, particularly adolescents to delay the first birth; addressing the existing unmet need and reducing the discontinuation through improving collaboration with DGHS and others to ensure services of skilled medical personnel like doctor, nurse and paramedics.

The mainstreaming of nutrition needs to be prioritized throughout every level of the health system and integrated effectively into maternal and child health and family planning services (MNCH & FP). Better intra-ministerial coordination, planning and management is required to ensure that nutrition services are meaningfully delivered and the levels of severe malnutrition and stunting are reduced. At the same time the dual burden of nutrition needs to be recognised and attention give to the rising problem of over-nutrition, poor diet and food safety.

The rise in NCDs is now well documented and recognised by MOHFW decision-makers as a major area for action in the sector programme. The current rise in morbidity and mortality will not be manageable within the resources available to the government for health care provision. While treatment services must be provided the access to specialist tertiary care will be limited and in many cases available through private facilities or where some form of PPP arrangement is in place. The combined approach to prevention and treatment is recognised as essential if the rise in NCDs is to be managed. Similarly the importance of providing prevention and treatment for communicable diseases continues to be a priority. The rise in drug resistant TB combined with an alarming rise in antibiotic resistance amongst many pathogens is reaching a crisis point. Rationale use of drugs in now urgently needed, as is their limitation in agricultural usage. Strengthened programmes are needed for the range communicable diseases such as HIV and STDs, vector and water borne diseases. The widespread use of AMC must also be recognised and its value particularly in support of many NCDs promoted.

Outputs	Priority Activities
7.1 Establish service level integration across tiers of the system including role out of (new) ESP and establishment of effective referral systems	• Definition and implementation of Essential Health Service Package (ESP) as per service delivery tiers • Implementation of functional integration of services approach, including collaboration with private sector providers • Establishment of effective referral system including ambulance services
7.2 Achieve effective and equitable coverage of evidence based high impact maternal, neonatal, child and adolescent health (MNC&AH) care interventions	• Upgrade UH&FWCs to provide 24/7 normal delivery and primary care for sick newborns • Endorse National Adolescent health strategy and implement action plan • endorse Maternal Health Strategy prioritisation of facility delivery, PNC and PPFP • Implement BENAP (including new interventions) • Implementation of national midwifery strategy, and increased facility delivery • Continuation and expansion of safety net programme (e.g. DSF)

7.3 Achieve effective and equitable coverage of family planning services	• Strengthen FP services for post-partum, post MR/ PAC • Implement regional service package for FP (HTR, CHT, urban poor and low performing areas) • Raise awareness regarding method mix including LARC&PM, delay of first pregnancy and birth spacing among adolescents
7.4 Improve nutritional status of the population and tackle the dual burden of over and under nutrition.	• Strengthen strategic leadership and investment required to complete and consolidate mainstreaming of nutrition services • Institutionalise NPAN for investment, implementation and accountability across the sectors. • Increase coverage and quality of preventive community outreach services • Increase facility readiness to deliver nutrition services including monitoring • Attention to severe acute malnutrition • Strengthen inter-ministerial and multi-sectoral collaboration on nutrition and food safety
7.5 To reduce mortality and morbidity of NCDs in Bangladesh through strengthening measures for control of risk factors, and health service delivery options for early detection and management.	• Development and implementation of effective, integrated, sustainable, and evidence-based public policies for non communicable diseases • Strengthening the capacity and competencies of the health system for the integrated early detection, management of non communicable diseases and their risk factors. • Development and strengthening of capacity for surveillance of non communicable diseases • Provision of services for conventional and non-conventional NCDs, in particular, mental health, GBV, suicide, injuries and poisoning
7.6 To reduce mortality and morbidity due to Communicable Diseases in Bangladesh through strengthening of measures for control of risk factors, and health service delivery options for early detection and management.	• Intensified programme for control, detection and management of tuberculosis, especially MDRTB • Develop and implement special programme on rationale use of antibiotics • Strengthened programme on vector borne diseases, including elimination programmes for malaria, kalaAzar, filariasis • Strengthened priority programmes, e.g. hepatitis, typhoid, dengue, HIV/STDs
7.7 To provide equitable access to high quality Unani, Ayurvedic & Homeopathic medical service for all citizen of Bangladesh	• Strengthening AMC Counsel to regulate practitioners through a certification/registration system • Raise awareness about AMC and treatments especially for NCDs • To build-up capacity of AMC service providers by conducting orientation, workshop & training and increase collaboration with local health facilities • To promote environmental and health value of medicinal plants and importance of promoting their conservation and cultivation

Strategic objective 8: To promote healthy lifestyle choices and a healthy environment

Investments in lifestyle choices and healthy environments will reduce the future costs of treating the rapidly expanding incidence of chronic non-communicable diseases. The projected increase in NCDs if unchecked will require huge investments in specialist medical

centres, diagnostic equipment, highly trained specialist health staff and expensive pharmaceuticals. Given the existing funding gap that exists in the health sector this will be a financial burden that the country cannot afford. Reaching the young with effective public health messages will be key to averting NCDs.

Outputs	Priority Activities
8.1 Establish legislative framework for healthy lifestyle and healthy environment	• Evidence based advocacy for enforcement of legislation • Introduction of appropriate measures in line with legislation e.g. no smoking zones • Develop guidance and health related evidence for promotion of green urban spaces and recreation areas for the public • Support legislation on air standards and controls in Industrial areas
8.2 Establish a clear strategy and plan of action for lifestyle choice	• Capacity development, including pre and in-service curricula, on lifestyle choices, public health and school health • Promotion around healthy diet, the hazards of salt, oil and sugar, and need for high fruit and vegetable intake • Action to stop smoking and substance abuse • Public education campaigns about the benefits of exercise
8.3 Integrated communication strategy based on new media platforms, including BCC	• Develop lifestyle and environment strategy in collaboration with other Ministries and stakeholders • Establish youth reference group for creative development of strategies to connect with young people • Develop and implement social media strategy • Roll out of targeted knowledge products via media platforms
8.4 Establish inter-sectoral collaboration on healthy environments, including private sector engagement	• Promote safe and healthy environments within health facilities, household, workplaces and schools, including overall cleanliness, clinical waste management, sanitation facilities, • Improved protection of water sources at community level and in urban slum environments • Promote importance of air quality especially involving cooking fuels and urban air controls especially linked to vehicle emissions • Promote value of urban Green spaces including in new urban developments. Promote the important of biodiversity and health • Promote Road and Waterway safety

SECTION 4: AN ESSENTIAL HEALTH SERVICE PACKAGE - THE FIRST MILESTONE ON THE ROAD TO UNIVERSAL HEALTH COVERAGE

An Essential Health Services Package (ESP)

An efficiency-oriented package of essential services of low cost and modest ambition has been advocated in many countries and this approach remains a priority in Bangladesh with lessons learnt from implementing past SWAps. The current ESP is composed of five components: i) Reproductive Health Care; ii) Child Health Care; iii) Communicable Disease Control; iv) limited Curative Care; and v) Behaviour Change Communication. A new version of ESP is under development and will have additional components (and sub-components) of prevention and control of Non-Communicable Diseases (NCDC) and Nutrition services.

Under the 4th health sector programme the intention is to implement a cost-effective ESP as a strategy for ensuring equitable access to quality health, nutrition and population services for the entire population of the country with a view to attaining Universal Health Coverage (UHC). The current proposal for the Essential Service Package (see annex 1 for indicative elements) has been developed by updating and modifying the existing one, based on the following key considerations:

- Ensuring equity and efficiency for universal access to and utilization of quality HNP services at various tiers;
- Prioritizing service components that have high impact on disease burden, and potential for improving health and nutrition services, are cost effective, and can be delivered successfully provided a skilled health workforce is made available at each level;
- Establishing an effective referral system to keep the continuum of care throughout the hierarchal infrastructures up to the higher level care;
- Giving special attention to the varying needs of Hard to Reach (HTR) and vulnerable population groups, and considering long term sustainability and community engagement at all levels.

Bangladesh has a good network of infrastructure but there are still challenges related to the health workforce. This Essential Service Package once finalized will encourage care seeking for common ailments at lower levels, help in establishing a referral system to the higher level facilities, and thereby improve the quality of care at each level.

Implementing ESP by Tiers

The Essential Service Package (ESP) will be delivered through four tiers and strengthen Primary Health Care (PHC) and achievement of Universal Health Coverage (UHC).

- **Community level:** Domiciliary services; satellite clinics; outreach services; and Community Clinic (CC).
- **Union Level:** Health & Family Welfare Center (UHFWC); Sub-Centers and MCWC.
- **Upazila Level:** Upazila Health Complex (UHC) and MCWCs.
- **District Level:** District Hospital (DH) and MCWC.

Tier-1: Community Level facilities

- **Domiciliary Visits; Satellite Clinics; and Out-Reach Services**

- **Domiciliary Visit:** Field staff (both from DGHS and DGFP) conduct house-to-house visits in the community for providing services to the clients in their respective geographical work areas.
- **Satellite Clinics and Out-Reach Services**: Satellite clinics (8 in each union per month) and EPI Out-Reach Services (24 per month in each union) are providing designated services by Health and Family Planning Field Workers.
- **Community Clinic (CC):** 13,500 Community clinics have been established, one for 6000 population to provide health care service to the door step of the community. The Community Clinics are run by Community Health Care Providers (CHCP), Health Assistant (HA) and Family Welfare Assistants (FWA).

Tier-2: Union Level Facilities (UHFWCs; Sub-Centres; and MCWCs at union)
Union Health and Family Welfare Centres are mostly established in each Union. These Union level facilities are mostly staffed with Medical Doctors with additional, Family Welfare Visitors (FWVs); Sub-Assistant Community Medical Officers (SACMO) and Pharmacists. There is provision of residential accommodation (for SACMO and FWVs) in upgraded facilities. There is also provision of office space for the Family Planning Inspector (FPI) in the UHFWCs.

Tier-3: Upazila Level Facilities (Health Complex (UHC) and MCWCs at Upazila)
The Upazila Health Complex is the first level referral center established in each upazila. These hospitals have been upgraded to 50 bedded with necessary manpower and equipment for its operation. They are staffed with Upazila Health and Family Planning Officers (UHFPO), Resident Medical Officers (RMO), Medical Officers (MOs), Medical Officer-MCHFP, Upazila Family Planning Officers (UFPO), Specialist Doctors (Consultants); Staff Nurses; Lab. Technologists; and a cadre of field staff. The Upazila Health Complexes have both outpatient and inpatient facilities.

Tier-4: District Level Facilities (District Hospital and MCWCs at District)
Out of the 64 districts 59 have District Hospitals and these are in the process of being upgraded from 100 to 200-250 bed hospitals in phases, with provision of trained manpower and necessary equipment. District hospitals are specialized health care facilities with consultants from all relevant disciplines to provide services. The district hospitals will serve as the secondary referral centre. Maternal and Child Welfare Centres (MCWCs) in the districts are providing Maternal, Neonatal, Child and Family Planning Services. These facilities are staffed with trained Medical Officers and FWVs. Effective implementation of the ESP will largely depend on the following key elements and supportive policy and strategic directions:

- Standard set of staff by number and categories considering the level and capacity of infrastructure, equipment (ToE), and uninterrupted supply of drugs and commodities.
- Technical capacity and managerial skills of staff and high level of staff motivation.
- Performance based system to be in operation at all tiers of service delivery through effective hierarchical supervision.
- Promoting access to new technology and scaling up ICT and telemedicine/e-Health.
- An updated Comprehensive ESP Implementation Guideline and a Standard Operating Procedures (SOP) need to be developed.

Functioning of an Effective Referral System
To establish an effective referral system the following actions are needed:

- Development and implementation of Referral Guidelines.

- Orientation of service providers on their roles and responsibilities.
- A functional integration in place for implementing HNP services.
- A functional referral system from Community to Union, Upazila and District level facilities with defined referral criteria at each level.
- Support facilities (transportation, referral slips, referral register, preferential treatment at the higher facility where referred to, etc.) are in place;
- Provision of financial back up for the poor.

Special Attention to Hard to Reach and Vulnerable Populations

Providing services to the population of hard to reach (HTR) areas and vulnerable population remain as a major challenge in the HPN sector. This issue needs to be addressed properly and some approaches are:

- Increased participation of NGOs and private sector agencies.
- Mobile clinics and organized specialists' visit.
- Enhanced Inter- Ministerial and inter –sectoral coordination.
- Promoting e-Health system.
- Enhanced budget and financial support.

Essential Service Package for Urban Areas

Urban health services are the responsibility of the MOLGRDC allocating provision of preventive and curative care responsibilities to the City Corporations and Municipalities[35]. Though facilities and services for secondary and tertiary level health care are available in the urban areas, primary health care services for the urban population, and particularly for slum-dwellers, are insufficient.

Since 1998 the implementation of two urban primary health care projects (UPHCPs) has been provided by the city corporations and municipalities through contracted NGOs. The non-project urban areas are being served by the health facilities of MOHFW. To reach the urban poor, there are around 4000 satellite centres and 35 urban dispensaries (under DGHS) for outdoor patient services including EPI and MCH services. Many NGOs provide PHC as well as some specialized services (e.g. 52 HIV/AIDS clinics; 158 PHC centres, 34 comprehensive centres; 56 DOTS centres; and 47 VCT centres; etc.). An Essential Service Package should now be implemented in urban areas by stakeholders under the guidance of MOLGRDC, MOHFW and NGOs. The MOHFW will coordinate and play the stewardship role and provide necessary technical support with a view to ensuring quality HNP services to the urban population.

In the 4th SWAp equitable access to a quality package of essential health care services is emphasized. An effective referral linkage amongst the tiers must also be established to achieve the goal of universal access to and utilization of services at all levels. The Draft Essential Service Package components are detailed in Annex 1. This has been developed based on the existing ESP, and through wide consultation amongst Line Directors, Programme Managers and Deputy Programme Managers of all concerned service components under DGHS and DGFP, Development Partners and other stakeholders. See tables in annex 1: i) Essential Service Package (ESP) by Service Delivery Tiers and ii) ESP-Urban (Component Services) By Tiers.

[35] *Municipal Administration Ordinance, 1960; Pourashava Ordinance 1977; City Corporation Ordinance, 1983; and Local Government, Pourashava Act 2009.*

SECTION 5: HNPSIP IMPLEMENTATION AND PERFORMANCE MANAGEMENT

5.1 Organisation and Management

MoHFW structure and function

There has been considerable discussion during the HPNSDP about the need to improve the organisational arrangements within the MoHFW. The MTR 2014 recommended that, "a review of the institutional and organisational set up of the MOHFW should be commissioned as part of the preparations for the next sector programme. This should look at key functions and organisational issues and include consideration of restructuring, such as number of TGs, OPs and the current DGHS and DGFP arrangement". This has also been debated at the Policy Dialogue in 2014 and again the need to look at improving the effectiveness of sector management was seen as important. In the development of the HPNSDP strategic plan the number of Operational Plans was reduced to 32. This was a positive step forward to both reducing the complexity of budgeting and planning as well as a modest rationalisation of functions to remove elements of duplication.

There are many opinions about the best structure and function of the MoHFW. Some consider the current structure too siloed especially with regard to the DGHS and DGFP dual system that is seen to provide useful division of labour as well as currently containing too many duplicating OPs. One approach is to look to maintain the current DG divisions and strengthening these in areas of core responsibility whilst at the same time merging or reformulating OPs where overlapping responsibilities and duplication exist. This can be accomplished through careful analysis of existing OP's purpose and activities. The 4th Sector programme is well timed to initiate such a revision of structure and function and to move quickly to this more rationalised OP organisation.

Committees and decision-making

Consultations with health sector government and non-government officials highlighted the need to improve the way policy and strategy are formulated and reviewed. This should be seen as a process of continual improvement as there are many recognised positive aspects to the current situation. The JAR process, MTR and Policy Dialogue are all cited as useful. However, as noted in the MTR (2014), the "current mechanisms for health sector policy and strategy dialogue between MOHFW (and other Ministries) and DPs should be reviewed with a view to establishing a more effective mechanism". This relates to meetings such as the LCG (Health) and several of the current Technical Groups. As well as work to rationalise and clarify the purpose of these meetings more specific attention is needed to setting meeting agendas agreed in advance, papers provided in advance, more time for discussion, appropriate level of participation.

Aid Modality/Aid effectiveness:

The establishment of a large "pooled fund", financed by the development partners has certainly contributed to improve working relationships between the government and its development partners. This aid modality will continue in the 4th Sector Programme with the World Bank being responsible to manage the pool fund on behalf of the DPs through a Multi Donor Trust Fund (MDTF). Experience acquired with the funding modalities under the three sector programmes can serve to improve effectiveness of SWAp implementation for the next sector programme.

HPNSDP had 32 different OPs under MOHFW and different agencies and effective coordination among them is immensely important. For more effective SWAp implementation, better coordination and functional relationships are required within MOHFW and agencies under it, for example between DGHS and DGFP service delivery strategies, and with other relevant ministries, notably MOLGRDC and MOCHT. Managing a large number of OPs also remains a challenge, and it is important to reduce the number of OPs for better coordination and effective SWAp implementation for the next sector programme. This will be considered further in the PIP and be a subject for future sector reviews.

Some major players, for example GAVI and GFATM continued to provide complementary support through vertical instruments that are not at all integrated with government implementation arrangements, thereby reducing aid effectiveness. During the 4th Sector Programme work should be done to further integrate these and other off-budget contributions into the donor coordination platforms.

The LCG sub-group on Health will be the meeting point where the senior management structures of the MOHFW meet with the representatives of the DPs in the sector. MOHFW and the DPs should work together to make the LCG sub-group more effective. Various joint task groups and technical committees operate under the sector programme. These arrangements will continue to work during the 4th Sector Programme and additional task groups may also be formed with new membership when new issues and challenges arise.

Improved Financial Management (IFM) OP takes the lead in Financial Management (FM) functions of HPNSDP. Achievements made in FY 2014-15 include – completion of training of 23 batches on FM for DDOs; four FM reports were produced for anchor OPs, internal audits had been outsourced to two audit firms and 32 internal audits were completed. However, MOHFW is yet to make an FMAU with appropriate organizational structure and human resources, which is a key bottleneck. Tracking of resource expenditure of Reimbursable Project Aid (RPA), and accounting and financial reporting does not yet give the impression of a strong control mechanism. There has been delay in release of fund that hampers timely implementation of field level activities, although, Line Director's (LD) delay in budget preparation and getting it approved from MOHFW is also responsible for some delay. Due to the delay in release of fund, spending agencies cannot make proper expenditure planning and consequently there is under spending and a rush of expenditure at the end of the financial year with potential risk of financial irregularities, wasteful expenditure and fraudulent activities. At the same time, there are often objections from the DPs regarding the delay and the process of reconciliation. There are also issues with the audit system for which audit observations are not resolved in a timely or satisfactory manner. These fiduciary issues are key to building trust and partnership and need to be further strengthened in the 4th Sector Programme to ensure continued support and investment of GOB and DPs in the sector.

Performance monitoring and sector reviews

As in previous sector programmes the Results Framework (RFW) will be the main tool against which progress will be measured during annual reviews and the mid-term review of the sector. Adjustments can be made at the time of these reviews to the annual milestones and targets based on measured and verified progress. Annual and Mid-term reviews provide an opportunity for government and its Development Partners to jointly review progress, assess aid modalities and review the allocation of resources and prioritisation of activities. In support of monitoring progress across the different aspects of the sector's performance work must be continued to produce good quality data from both routine and periodic surveys and

studies. New data sets need to be developed to meet the needs of assessing performance in new strategic priority areas such as NCDs and lifestyle and healthy environment issues. As these data become available the RFW can be further developed.

Risk mitigation strategies and management

An important aspect of the sector investment plan is a comprehensive assessment, tracking and management of risk. This includes political, institutional, financial, programmatic and environmental components. As part of the management of the sector a risk matrix has been prepared that will form the basis of on going risk management. This will include development of a risk register and detailed mitigation plans. Where risks cannot be mitigated a plan for management of these risks will be put in place. As part of on-going management of the SIP implementation regular review of the risk register will be undertaken. This should also be part of the annual and mid-term review process.

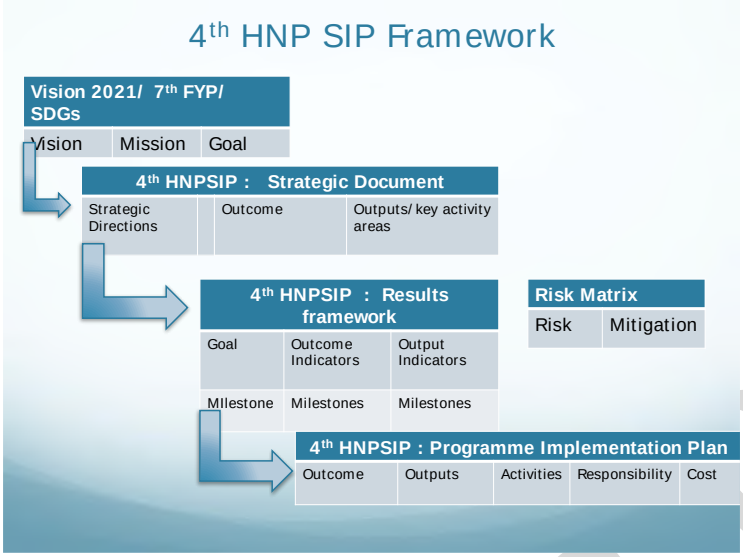
Coordinated Technical Assistance

The pooled TA fund titled "Joint Donor Technical Assistance Fund (JDTAF)" as a new initiative of HPNSDP implementation, is an effective institutional arrangement for sector management and TA coordination. On behalf of the DPs, the JDTAF is coordinated and managed by DFID. A Technical Assistance Committee (TAC) comprising MOHFW, agencies under it and DP representatives oversee the TA proposals, review and recommend for endorsement by the government. A database has been developed with 130 national and 32 international consultants. A Harmonized TA Plan for FY 2014-15 was developed for effective TA coordination. A total of 84 contracts were signed, of which 19 are firms and the rest (65) are individual consultants. A total of 32 of reports were developed against specific studies. This mechanism will be continued in the 4th Sector programme and efforts made to expand the number of partners contributing to the JDTAF. A focus will also be on ensuring a good knowledge management system relating to all the evidence created is put in place.

5.2 The HNPSIP documentation

A set of key documents has been produced for the 4th Sector Programme. These all have a specific purpose and are interlinked (see figure 7 below). The HNPSIP document provides the overall strategic direction for the five-year sector programme. It translates the political and policy decisions into a set of strategic objectives and indicates a number of measurable and achievable targets. The 4th Sector programme Results Framework (RFW) provides the detailed indicators, data sources and specific targets and milestones that will be the basis for assessing progress year on year. These are aligned to the strategic objectives and outputs in the HNPSIP document. The Programme Implementation Plan (PIP) is the operational document for the sector and provides the detail against which each operational department will plan its activities. The PIP is arranged in such a way as to link actions and budgets to objectives. This will allow better budget management and better decision-making around where to invest resources and how to ensure harmonisation of individual OP workplans. In addition there is a Risk Matrix that allows identification of risks to achieving progress. These range from political, institutional, financial, environmental and programmatic areas of risk. Establishing a risk register with identified risk mitigation strategies and actions as well as a risk-tracking tool will allow decision-makers to make better-informed choices.

Figure 7: 4th Sector Programme documentation



Programme Implementation Plan (PIP), 2016-2020

The Programme Implementation Plan (PIP) linked to this SIP has been produced to provide a detailed and comprehensive action plan that provides a breakdown of all strategic objectives and summary activity areas. Under each Strategic Objective and Output detailed activities are provided that contribute to achieving the respective objectives. Process indicators with milestones and targets are provided against which progress in implementation of the activities can be measured. The detailed breakdown provides a basis for budgeting across the whole sector. Activity areas are assigned to relevant OPs and their partners. The PIP provides the opportunity for off budget funding to be identified linked to the overall sector plan. It provides the opportunity for all funding of the sector to be "on-plan".

Results Framework (RFW), 2016-2020

Linked to the objectives in the SIP are a set of performance indicators, milestones and targets. The Results Framework provides a logical hierarchy of indicators that are linked to the three components of the HNPSIP and the eight strategic objectives. Each indicator is described in detail together with the means of verification (source) and other information such as periodicity. The outcome and output level indicators are presented in annex 2. These will become the basis of the joint government-partner annual review and mid-term review of the sector.

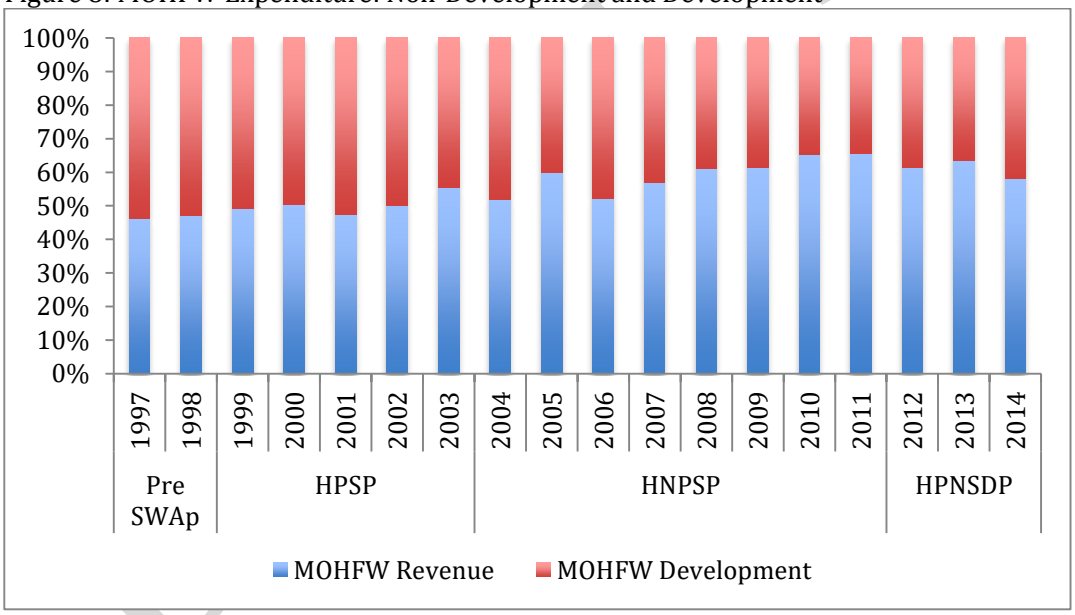
SECTION 6: INDICATIVE BUDGET AND COSTING OF THE 4TH SECTOR PROGRAMME

6.1 Government Expenditure Trends in the HNP Sector

The percentage contribution of Gross Domestic Product (GDP) to health is still very low in Bangladesh. Public health spending comprises less than 1% of the GDP and total health expenditure (THE) is 3.5% as of GDP (BNHA, 2015). Per capita THE is US$ 27, of which only about US$6.20 is the per capita government spending, US$1.90 is contributed by development partners while about US$19 is out-of-pocket (OOP) expenditure by households.

The MOHFW is financed from a combination of GOB revenue and development budgets and external finance from development partners. MOHFW being a service delivery organization, the major portion of the cost is borne out of revenue budget for the service providers. Majority of the expenditure is therefore incurred through the non-development budget (Figure 8). Only 42% of the total MOHFW expenditure was from the development budget in 2014-15, which was slightly higher in comparison to the previous years (37% in 2013-14, 39% in FY 2012-13 and 34% in 2011-2012).

Figure 8: MOHFW Expenditure: Non-Development and Development



Utilization

The average spending rate of the first three years of HPNSDP was 89%, however, overall spending rate in FY 2014-15 was 83%, with 98% for GOB and 74% for PA fund. The rate of utilization in the fourth year declined due to the reason that a few procurement packages were not cleared and substantial money earmarked for procurement remained unutilized. In addition the revision and re-approval of the RPIP and the OPs based on MTR 2014 consumed much of the implementation time. Utilization of the development budget has also increased from an average rate of 72% in the pre-SWAp period to around 80-85% during the first three SWAp periods. The average ADP utilization rate of last four years of HPNSDP (the third SWAp) implementation stood at 87.5%.

In the first four years of HPNSDP, the proportion of GOB contribution in MOHFW budget (both revenue and development) was 79%, and that for Development Partners' (DP) was 21% (Table 1).

Table 1: MOHFW Budget and Expenditure (in Crore Taka)

Financing Source	**2011-16**	**2011/12**		**2012/13**		**2013/14**		**2014/15**	
	Estimated PIP (%)	**Budget (%)**	**Exp (%)**	**Budget (%)**	**Exp (%)**	**Budget (%)**	**Exp (%)**	**Budget (%)**	**Exp (%)**
GOB Revenue	34,817 (61%)	5133 (63%)	5073 (66%)	5,529 (60%)	5254 (61%)	6163 (62%)	5990 (63%)	7006 (61%)	**5352 (58%)**
GOB Development	8,603 (15%)	1517 (19%)	1397 (18%)	1676 (18%)	1611 (19%)	1526 (15%)	1491 (16%)	2200 (19%)	**2092 (23%)**
Sub-Total of GOB	**43,420 (76%)**	**6649 (81%)**	**6471 (84%)**	**7205 (79%)**	**6864 (80%)**	**7689 (77%)**	**7482 (79%)**	**9206 (80%)**	**7445 (81%)**
Pool Fund/RPA	8,698 (15%)	1138 (14%)	972 (13%)	1634 (18%)	1404 (16%)	1758 (18%)	1521 (16%)	1708 (15%)	1279 (14%)
DPA	4875 (9%)	381 (5%)	292 (4%)	313 (3%)	301 (4%)	533 (5%)	449 (5%)	655 (6%)	480 (5%)
Sub-total of PA	**13573 (24%)**	**1519 (19%)**	**1557 (16%)**	**1947 (21%)**	**1706 (20%)**	**2291 (23%)**	**2418 (21%)**	**2362 (20%)**	**1759 (19%)**
Total Development (GOB Dev + PA)	**22,177 (39%)**	**3036 (37%)**	**2662 (34%)**	**3623 (40%)**	**3316 (39%)**	**3818 (38%)**	**3461 (37%)**	**4562 (39%)**	**3851 (42%)**
Grand Total (Rev + Dev)	**56,994 (100%)**	**8169 (100%)**	**7736 (100%)**	**9152 (100%)**	**8570 (100%)**	**9981 (100%)**	**9452 (100%)**	**11568 (100%)**	**9204 (100%)**

An analysis of revenue budget by line item shows that the major share of the revenue budget is allocated for salary and allowances. The allocation for salary and allowances increased from 55% in 2005/06 to 64% in 2014/15, mainly for recruitment of health personnel and introducing new pay scale in 2010/11. Allocation for medical and surgical requisites (MSR) increased to 11% in 2014/15 from 6% in 2005/06. In addition to provision of salary and operational costs of a huge set of service providers, a certain portion of the GOB revenue budget allocations is always spent every year for small equipment, medical and surgical requisites (MSR), maintenance of public and autonomous hospitals (e.g., BSMMU). Besides, private sector health research organizations like National Foundations on Heart, Kidney, ENT, and international organization like icddr,b get regular grants out of revenue budget allocations for provision of HNP services in the country. All these added together form a significant development expenditure borne out of MOHFW's revenue budget from GOB source. In the last five years (2011/12-2015/16), Taka 1,003.7 Crore has been allocated as 'Grants-in Aid' to nearly 42 organizations under the revenue budget. The allocation for these grants constituted 3.2% of MOHFW's revenue budget over the same period (2011/12-2015/16). On an average, the allocation for Grants-in Aid grew at 9% per annum since 2011/12. Moreover, a considerable amount of fund is allocated to Non-Government Organizations (NGOs) as special grants (one time) in each year through the revenue budget. For example, in 2015/16, Taka 2 Crore has been allocated to 140 NGOs.

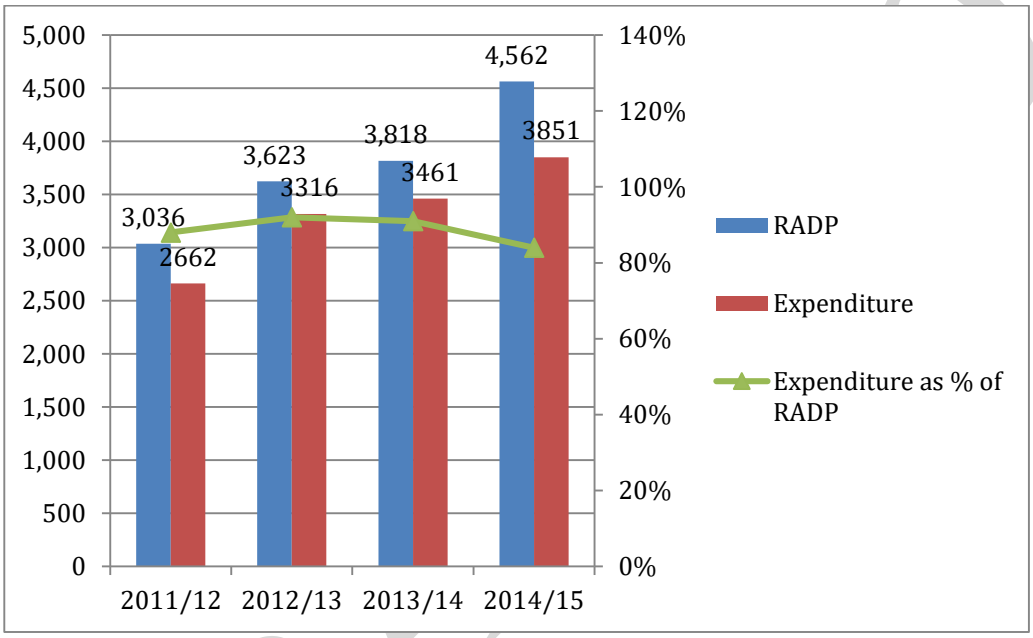
The MOHFW's absorption capacity has increased during the 3rd SWAp implementation period (2011-2016). Utilization of the development budget was 80-85% during the first two SWAp periods (1998-2011). During the first four years of HPNSDP implementation (2011-2015), overall utilization of annual development programme budget was 88.4%. Utilization of the revenue budget was more than 95% during the first three years of the 3rd SWAp.

6.2 HPNSDP Expenditure Structure and Budget Implementation

Total estimated cost for the 3rd SWAp, i.e. HPNSDP (2011-16) was BDT 56, 993 Crore (about US$ 7.7 billion)[36]. Out of this, it was estimated that Taka 43,420 Crore (76%) will be contributed by Government of Bangladesh (GOB) and 24% to be financed by development partners (15% pool fund/RPA, 9% DPA). Development budget was estimated to be 39% of the HPNSDP cost, which was 53% for HPSP and 44.3% for HNPSP.

The allocation for RADP was Taka 4,562 crore and expenditure was Taka 3,851 crore, which represents 84% of RADP (Figure 9).

Figure 9: RADP allocation and expenditure (in crore taka) and utilisation (2011-2015)



In the ADP of MOHFW, the allocation for 32 OPs constitute a large share. Allocation for 32 OPs in total MOHFW ADP allocation was 54% in 2012/13, which increased to 77% in 2014/15. The proportion of expenditure for 32 OPs to ADP expenditure was 78% in 2012/13 and 76% in 2014/15. The total allocation for 32 OPs under HPNSDP was Taka 3,499 Crore Taka in 2014/15 of which Taka 3,283 Crore had been released (94% of allocation) and Taka 2939 Crore was spent (84% of allocation). In 2014/15, out of total OP expenditure, the contribution of GOB was 42%, and that of RPA was 44% and DPA was 15%.

The development budget fund is also allocated for parallel/discrete projects. The allocation and expenditure for the 25 parallel projects under the development budget was Taka 2,765 Crore (95.2% GOB and 4.8% PA) and Taka 2676 Crore (97% GOB and 3% PA) respectively in the previous four years (2011/12 - 2014/15). Over this period, expenditure was 95% of released fund. The allocation and expenditure for these parallel projects constituted 18.4% and 20% of MOHFW's ADP allocation and expenditure respectively over the period (2011/12 - 2014/15). The growth of GOB allocation of the ADP is taken away by over 20 of the GOB funded discrete projects.

[36] *PIP for HPNSDP (2011-16)*

6.3 MTBF Allocations and Resource Envelope for the 4th Sector Programme

Medium Term Budgetary Framework (MTBF) projection shows that the estimated non-development and development budget for 2016/17 is Taka 8,114 Crore and Taka 5,884 Crore respectively. The 7th Five Year plan of Bangladesh projects a total development budget of Taka 41,340 crore to be channelled to the health sector. As 97% of the total health budget is being allocated for the MOHFW, the development budget for the MOHFW for the next five years is expected to be Taka 40,100 Crore. The resource envelope for the 4th HNP sector programme has been estimated based on these forecasts, and is presented in Table 2 with three different scenarios.

Considering the non-development budget of Taka 8,114 Crore and development budget of Taka 5,884 Crore in the base year, and assuming a 10% annual increase in non-development budget, and constant development budget and off budget contribution of DP over next five years, the estimated total budget for the next sector programme stands at Taka 98,825 Crore under the baseline scenario. The estimated budget for the moderate scenario is Taka 116,767 Crore with the assumption of 15% annual growth of non-development budget, Taka 40,100 Crore of development budget as of 7th Five Year plan, and 5% increase in DP's off budget contribution. A total of Taka 124,743 Crore is estimated under optimistic scenario with 20% increase in non-development budget, Taka 40,100 Crore of development budget as of 7th Five Year plan, and 10% increase in off budget.

Table 2: Resource Envelope for the 4th Sector Programme- 2016-2021 (in Crore Taka)

Budget by type	**Scenario**		
	Baseline	**Moderate**	**Optimistic**
Non-development budget of MOHFW	49,535	54,708	60,381
Development budget	29,420	40,100	40,100
Total budget of MOHFW	**78,955**	**94,808**	**100,481**
Off budget contribution of DPs	19,870	21,959	24,262
Total	**98,825**	**116,767**	**124,743**

MOHFW needs to achieve efficiency gains through improved budget management, which in turn will bring additional resources to the sector. Efficiency gains can be realized from improved procurement process, needs-based infrastructure development, and appropriate maintenance of equipment. Introducing new methods of payment such as results-based financing and allocating resources geographically based on resource allocation formula can enhance efficiency in resource use. Reducing absenteeism of staff, ensuring appropriate staff-mix and enhancing quality of care can also contribute in efficiency gain.

ANNEXES

Annex 1: The Essential Service Package (draft service outline)

Essential Service Package (ESP) by Service Delivery Tiers

Note:

- The ESP Template describes **four tiers** viz. i) **Community** (include: Domiciliary services; Satellite clinics; Outreach centre and Community Clinics); ii) **Union** (includes: Union Health and Family Welfare Centres (HFWC); and Sub-Centres/Rural Dispensary (SC/RD); iii) **Upazila** (include: Upazila Health Complex (UZHC); and iv) **District** (include: District Hospital and Maternal and Child Welfare Centre (MCWC).
- The first column lists Component/sub-components of ESP from each tier and the **(√) mark** in next columns signifies that service is available/will be offered from the facility.
- An onward referral system to next tier/higher level facility is considered for the continuum of quality care under ESP.

[Dom.=Domiciliary; Sat.Cl.=Satellite Clinic=Union Health & Family welfare Centre; SC=Union Sub-centre; RD=Rural Dispensary; UZHC=Upazila Health Complex; DH=District Hospital; MCWC=Maternity and Child Welfare Centre]

Component and Sub-Component	Community			Union		Upazila	District	
	Dom.	Sat. Cl./ Outreach	CC	UHFWC	USC/RD	UZHC	DH	MCWC
Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)								
Registration of eligible couples	√	√	√					
Registration of pregnancy	√	√	√	√				
Birth registration	√	√	√	√	√	√	√	√
Maternal Health Care								
Ante Natal Care (ANC)	Screen/ Refer	√	√	√	√	√	√	√
Normal Vaginal Delivery			√ (Trained HR)	√	√	√	√	√
BEmOC				√	√	√	√	√
Ante partum Hemorrhage						√	√	√
Post Partum Hemorrhage	Prevention		Prevention	Managemen & refer	Management & refer	Management & refer	Manageme nt	Management
CEmONC						√ Selected	√	√
Postnatal care	√	√	√	√	√	√	√	√
Management of Eclampsia				√	√	√	√	√
Management of Puerperal sepsis						√	√	√
Early management of Obstetric Fistula						√	√	
Management of genital prolapse							√	
Family Planning Services								
Short acting contraceptives (Condom, Pills, Injectable)	√	√	√	√	√	√	√	√
LARC (IUD, Implant), PM (NSV, Tubectomy)				√ (IUD) selected	√ (IUD) selected	√	√	√
Post Partum contraception and post MR Contraceptive services				√	√	√	√	√
Management of Gender-based Violence (one-stop crisis cell)						√	√	
Maternal Nutrition								
Distribution of Vit-A		√	√	√	√	√	√	√
Iron Folic Acid and Calcium Supplementation		√	√	√	√	√	√	√
Menstrual Regulation and Post Abortion Care (PAC)								
Menstrual Regulation-MR				√	√	√	√	√
Post Abortion Care-PAC				√	√	√	√	√
Newborn and Child Health Care								
Umbilical cord care with 7.1% Chlorhexidin	√	√	√	√	√	√	√	√
Initiation of early breast feeding	√	√	√	√	√	√	√	√
Thermal Care	√	√	√	√	√	√	√	√
Management of Birth asphyxia				√	√	√	√	√
Newborn eye care (White reflex)	√	√	√	√	√	√	√	√
Pre-term and low birth weight baby management						√	√	√
Expanded Programme on Immunization (EPI)		√	√	√	√	√	√	√
Integrated Management of Childhood illness (IMCI)				√	√	√	√	√

Component and Sub-Component	Community			Union		Upazila	District	
	Dom.	Sat. Cl./ Outreach	CC	UHFWC	USC/RD	UZHC	DH	MCWC
Screening and referral of Autism spectrum disorder (ASD)	√	√	√	√	√	√	√	√
Management of Autism spectrum disorder (ASD)						√	√	√
Management of Child Malnutrition								
Growth Monitoring and Promotion (GMP)			√	√	√	√	√	√
Infant and Young Child Feeding (IYCF)	√	√	√	√	√	√	√	√
Management of Moderate Acute Malnutrition (MAM)	√	√	√	√	√	√	√	√
Management of Severe Acute Malnutrition (SAM), uncomplicated			√	√	√	√	√	√
Management of Severe Acute Malnutrition (SAM), complicated						√	√	
Adolescent Health Care								
Counseling on puberty, safe sexual behavior, mental health, HIV-AIDS, Tobacco & drug abuse			√	√	√	√	√	√
Counseling on prevention of early marriage and delaying pregnancy	√	√	√	√	√	√	√	√
Prevention and management of RTI and STDs				√	√	√	√	√
Iron Folic Acid Supplementation		√	√	√	√	√	√	√
Communicable Disease Control (CDC)								
Management of Diarrhoea	√	√	√	√	√	√	√	√
Identify suspect cases of TB and refer for diagnosis	√		√					
Diagnosis and treatment of TB						√	√	
DOTS (follow up and compliance)	√		√	√	√	√	√	
Distribution and promotion of Long Lasting Insecticidal Nets-LLIN	√		√	√	√	√	√	√
Diagnosis and treatment of Malaria	√		√	√	√	√	√	
Treatment of severe malaria cases						√	√	
Identify suspected kala-azar and refer for diagnosis	√		√	√	√	√	√	
Diagnosis and treatment of kala-azar						√	√	
Diagnosis and management of Hepatitis		√	√	√	√	√	√	√
Treatment of Intestinal Parasites (Deworming)			√	√	√	√	√	√
Diagnosis & management of Dengue Fever						√	√	
Diagnosis & management of Typhoid						√	√	
Non-Communicable Disease Control (NCDC)								
Screening for hypertension and referral		√	√	√	√			
Management of Hypertension (incl. non-drug treatment			√ (non-drug)	√ (non-drug)	√ (non-drug)	√	√	√
Screening for Diabetes Mellitus and referral			√	√	√			
Management of DM (incl. non-drug treatment			√ (non-drug)	√ (non-drug)	√ (non-drug)	√	√	√
Management of Chronic Obstructive Pulmonary Disease (COPD)						√	√	
Identification and referral of Cardiovascular Diseases (IHD, Stroke)			√	√	√			
Diagnosis and management of IHD						√	√	
Diagnosis and management of stroke						√	√	
Early detection of breast and cervical cancer through screening						√	√	√
Mental illnesses - recognize , counsel ,primary treatment and referral						√	√	
First Aid of Drowning			√	√	√	√	√	
Identification and referral of Arsenicosis			√	√	√			
Management of Arsenicosis						√	√	
Common Illness and Injury								
First aid and treatment of minor injury, cuts, burn etc.			√	√	√	√	√	
RTA related injury						√	√	
Management of Poisoning and snakebite						√	√	
Emergency Care (one Annex to be added)			√	√	√	√	√	
Common Skin, Eye, Ear and Dental Diseases								
Treatment of Scabies, Ringworm, Impetigo, dermatitis			√	√	√	√	√	√
Treatment of Conjunctivitis and Corneal Ulcer			√	√	√	√	√	√

Component and Sub-Component	Community			Union		Upazila	District	
	Dom.	Sat. Cl./ Outreach	CC	UHFWC	USC/RD	UZHC	DH	MCWC
Early detection of cataract and visual impairment			√	√	√	√	√	√
Management of cataract and visual impairment							√	
Management of Acute and Chronic Suppurative Otitis Media				√	√	√	√	
Management of hearing impairment							√	
Treatment of common dental diseases (gingivitis, bleeding gums, carries, tooth extraction)						√	√	
Differently abled and Senior Citizen								
Promote and support health behavioral change	√	√	√	√	√	√	√	√
Geriatric corner							√	
Behaviour Change Communication								
Sensitization and promotion for increased utilization services offered at each level	√	√	√	√	√	√	√	√
Promote personal hygiene practices (also in school health package)	√	√	√	√	√	√	√	√
Promote health, family planning, nutrition, child survival and safe motherhood	√	√	√	√	√	√	√	√
Promote healthy lifestyle for NCD control, including mental health	√	√	√	√	√	√	√	√
Education on causes, prevention and control of communicable diseases	√	√	√	√	√	√	√	√
Awareness on climate change, food safety, injuries (incl. poisoning and snakebite) and healthy aging	√	√	√	√	√	√	√	√
Awareness on sexual and reproductive health rights, prevention of gender-based violence and early marriage	√	√	√	√	√	√	√	√
Distribution of regionally focused BCC/IEC materials	√	√	√	√	√	√	√	√
Providing need based BCC/IEC support in order to increase awareness and community participation	√	√	√	√	√	√	√	√
Nutrition education and Good Hygiene Practice (GHP	√	√	√	√	√	√	√	√
Awareness on prevention of Diarrhoea	√	√	√	√	√	√	√	√
Awareness of prevention of hearing impairment	√	√	√	√	√	√	√	√
Education and information service for senior citizen	√	√	√	√	√	√	√	√
Promotion of oral hygiene	√	√	√	√	√	√	√	√
Community engagement for prevention of Drowning	√	√	√	√	√	√		
Promoting arsenic free water	√	√	√	√	√	√		
Awareness on prevention of Cancer	√	√	√	√	√	√	√	√
Awareness on prevention and control of malaria, kala-azar, 54ilarial and dengue	√	√	√	√	√	√	√	√
Awareness on use of LLIN for malaria control	√	√	√	√	√	√	√	√
Awareness on prevention and control of Hepatitis	√	√	√	√	√	√	√	√
Advocacy and awareness development on PPFP and Post MR/PAC -FP	√	√	√	√	√	√	√	√

ESP-Urban (Component Services) By Tiers

[CRHCC=Comprehensive Reproductive Health Care Centre; PHCC=Primary Health Care Centre]

	Service Delivery Activities	CRHCC	PHCC	Satellite Clinic	Domiciliary
	Antenatal Care				
1	Pregnancy Registration, Regular Follow-up and update including maternal deaths				√
2	Counsel women and husband / family on Nutrition, care (rest) danger sign, clean delivery, Trained birth assistance, delivery planning, Preparation for possible emergency, breast feeding, and Contraception	√	√	√	√
3	Antenatal care (check weight, height, eyes, blood pressure, edema, urine sample, blood sample)	√	√	√	
4	Obtain antenatal history	√	√	√	
5	TT Vaccination (pregnant women)	√	√	√	
6	Fe/Folate Supplementation	√	√	√	√
7	Detect early, refer promptly women with danger signs/ complications	√	√	√	√
8	Mobilize community to arrange transportation, blood donors for obstetric emergencies, (blood will be supplied to EOC referral locations for screening prior to possible use)			√	√
	Delivery Care (NVD & CS)				
1	Create awareness on safe and clean delivery	√	√	√	√
2	Conduct clean and safe delivery by skilled health personnel at facility level	√			
3	Detect early and refer promptly women with Danger signs or complications	√	√	√	√
	Postnatal Care				
1	Counsel women/family on diet, Exclusive Breast Feeding (EBF), Infant and Young Child Feeding (IYCF), danger signs (mother & infant), immunization, Post Partum Contraception, Birth Spacing	√	√	√	√
2	Provide Postnatal Care	√	√	√	
3	Provide post partum contraceptive	√	√	√	√
4	Vitamin A Supplementation within 42 days of delivery	√	√	√	√
5	Detect early and refer promptly women with danger signs/complications	√	√	√	√
	Menstrual Regulation				
1	Encourage use of post MR FP methods	√	√	√	√
2	Create awareness on unsafe abortions and its complications	√	√	√	√
3	Provide MR on medical grounds only	√	√		
4	Provide contraceptive supplies	√	√	√	√
5	Detect complications and refer promptly	√	√	√	√
	Post Abortion Care				
1	Encourage use of post abortion FP methods	√	√	√	√
2	Encourage MR within safe period	√	√	√	√
3	Provide PAC	√	√		
4	Detect complications and refer promptly	√	√	√	√
	Population & Family Planning Services				
	Family Planning				
1	Eligible Couple Registration, regular update				√
2	Create awareness on Family planning with emphasis on permanent and longer acting methods	√	√	√	√
3	Counsel on appropriate method	√	√	√	√

	Service Delivery Activities	CRHCC	PHCC	Satellite Clinic	Domiciliary
4	Provide contraceptive supplies- Temporary Methods (Pill, Condom, Injectable)	√	√	√	√
5	Provide Long Acting & Permanent methods (IUD, Implant, NSV)	√	√		
6	Provide Permanent method (Tubectomy)	√			
7	Treat/refer for side effects and complications	√	√	√	√
8	Refer for other methods (Sterilization, IUD, Implant)			√	√
9	Provide ECP	√	√	√	
	Neonatal Care				
	Neonatal Care				
1	Counsel women/family on Exclusive Breast Feeding (EBF), Infant and Young Child Feeding (IYCF), hygiene, cord care, danger signs (mother and newborn), prevent hypothermia, immunization	√	√	√	√
2	Health education for mothers on cleanliness and care for the newborn				√
3	Provide Neonatal Care	√	√	√	
4	Detect early and refer promptly neonates with complications	√	√	√	√
	Child Health Care				
	Immunization Program – EPI				
1	Mobilize caretakers to have their children fully immunized by 12 months of age	√	√	√	√
2	Conduct immunization sessions	√	√	√	
3	Surveillance and notification including acute flaccid Paralysis, measles and neo-natal tetanus	√	√	√	√
	Immunization Program – NID				
1	Observe National Immunization Program	√	√	√	
2	Child to Child Search				√
	Diarrhea				
1	Detect, manage and refer severe cases with “danger signs”	√	√	√	√
2	Advise caretaker on correct home care (fluids, feeding, referral)	√	√	√	√
3	Advise caretaker on prevention	√	√	√	√
	Measles				
1	Detect and manage; refer severe/complicated cases	√	√	√	√
	Acute Respiratory Infections				
1	Treat pneumonia with oral antibiotics	√	√	√	
2	Advise caretaker on correct home care	√	√	√	√
3	Detect and manage; refer severe/complicated cases	√	√	√	√
	Other Childhood Illness				
1	Detect and manage; refer severe/complicated cases (including drowning, accidental poisoning, autism, disability, other injuries etc.)	√	√	√	√
	Reproductive Health Care				
	RTI/STI Care				
1	Counsel on RTI/STI & related Infertility	√	√	√	√
2	Health Education on RTI/STI & related Infertility				√
3	Supply condoms	√	√	√	√
4	Refer for complaints of vaginal discharge, lower abdominal pain, genital ulcers, swellings in groin in men	√	√	√	√
5	Follow syndromic approach	√	√	√	
6	Supplier management	√	√	√	
7	RTI/STI Screening	√	√		
	Other Reproductive Health Care				

	Service Delivery Activities	CRHCC	PHCC	Satellite Clinic	Domiciliary
1	Identify & Refer Out of Breast Cancer, Cervical Cancer, Fistula etc.	√			
2	Other Reproductive Tract Disease	√	√		
3	TT Vaccination (19+ non pregnant women)	√	√	√	
	Adolescent Health Care				
1	Counsel/create awareness of sexuality, safe sex, menstruation, special nutrition, hygiene, TT vaccination; reducing early marriage, pregnancy; high risk behavior, psychological issues, gender issues to both girls and boys	√	√	√	√
2	Identify and treat anemia for girls and boys	√	√	√	
3	Identify and treat RTI/STI for girls and boys	√	√	√	
4	Identify and treat Dysmenorrhea and other RH problems	√	√	√	
5	TT Vaccination (adolescent girls)	√	√	√	
	Nutrition (N)				
	Maternal Nutrition				
1	Create awareness on Nutritional issues; promote health and caring practices that prevent Malnutrition	√	√	√	√
2	Counsel pregnant & lactating women (+ Husband/ Family) on diet.	√	√	√	√
4	Provide elements such as community nutrition including nutritional assesment with targeted supplementation as per national program, detection & referral of severe cases of malnutrition	√	√	√	√
	Child Nutrition				
1	Promote (& support) exclusive breast feeding, Correct weaning and child feeding practices	√	√	√	√
2	Provide elements such as community nutrition including GMP with targeted supplementation as per national program, detection & referral of severe cases of malnutrition	√	√	√	√
	Control of Micronutrient Deficiency				
1	De-worming of Under 10 high risk Children	√	√	√	
2	Promote consumption of iodized salt	√	√	√	√
3	Vitamin A for post partum lactating women	√	√	√	√
4	Vitamin A for children (6 months to 6 years)	√	√	√	
5	Vitamin A Supplimentation for sick children (ARI, diarrhea, severe malnutrition, measles)	√	√	√	
6	Detect and manage children with night blindness & Refer other cases	√	√	√	√
7	Detect and refer suspected iodine deficiency cases	√	√	√	√
	Communicable Diseases Control				
	Tuberculosis Control				
1	Counseling on prevention of communicable diseases				
2	Detect and refer suspect cases	√	√	√	√
3	Support and promote DOTS		√		
4	Advise patients/families/close contacts on TB Symptoms and treatment compliance		√	√	√
5	Defaulter tracing				√
6	Promote self-reporting of patients		√	√	√
	Other Communicable Disease Control				
1	Counseling on prevention of communicable diseases				
2	Detect and refer suspect cases	√	√	√	√
3	Advise patient/families/close contacts on symptoms and treatment compliance	√	√	√	√
4	Diagnosis, Treatment and referal of Leprosy, Malaria, Dengue, SARS, Kala-zar, Filariasis, Enteric Fever, Hepatitis etc.	√	√		

	Service Delivery Activities	CRHCC	PHCC	Satellite Clinic	Domiciliary
	Non-Communicable Diseases Control				
1	Detect and Refer Suspected cases of Diabetes, Mental Health and Cardiovascular disease etc.	√	√	√	√
2	Support and promote preventative/control measures	√	√	√	√
3	Advice patients to seek treatment, improve lifestyle and promote self reporting	√	√	√	√
	Limited Curative Care and First Aid				
1	Provide Basic First Aid for Common injuries (cut, burn, fracture, etc)	√	√	√	
	Emergency Care				
1	Treat Medical Emergencies – Management and Referral of Pain, high fever, shock, asphyxia, poisoning, drowning and other incidence of emergencies	√	√		
	Minor Infection & Disease Control				
1	General Health Checkup, Asthma, Skin Diseases (Scabies etc.), Dental Diseases, Ear diseases, Peptic Ulcer, Geriatric care and Other Minor Ailments	√	√	√	
	Primary Eye Care				
1	Clinical Consultation; Medical Treatment, Refraction Test, Prescribed/Provided Spectacles, Identification and refer out for Cataract Surgery		√		
	Disaster Management				
1	Extended services for any emergency outbreak within the scope of work	√	√	√	√
	Behavior Change Communication (BCC)				
	Health Education				
1	Health Education on cross cutting all categories above				√
2	Health Education on Personal hygiene, hand washing, gender awareness				√
3	Awareness on availability of PHC services (branding) at UPHCSDP centers				√
	Clinical Counseling				
1	Clinical Counseling on cross cutting all categories above	√	√	√	
	Diagnostic & Emergency Transport* (DET)				
	Diagnostic Service				
1	Blood Grouping, Urine for Pregnancy	√	√	√	
2	Blood for Routine (TC, DC, ESR, Hb), Cross Matching, Sugar, Platelet Count, Serum Bilirubin, CRP, RF, Widal, ASO Titre, BT, CT, MP, KOS, WetMount, Hbs Ag, Hepatitis B Confirmation, VDRL, TPHA etc.	√	√		
3	Urine for Routine (Sugar, Albumin, PS, Phosphate) etc.	√	√		
4	Stool for Routine (Occult Blood, RS), Floatation Method etc.	√	√		
5	Biochemical Tests	√	√		
6	Ear Swab, Puss Swab, High Vaginal Swab, Skin Scrapping Fungus, Mauntox etc.	√	√		
7	VIA	√			
8	Ultra-sonogram	√			
9	Sputum (AFB)		√		
	Emergency Transportation Service				
1	Ambulance Service	√			
	Violence Against Women* (VAW)				
1	Identify and register cases, provide medical care	√	√	√	√
2	Refer victims for legal assistance, counseling and Crisis management	√	√		
3	Provide psychological support	√	√	√	√
4	Increase community awareness				√

	Service Delivery Activities	CRHCC	PHCC	Satellite Clinic	Domiciliary
	Miscellaneous				
1	Medical Waste Management	√	√	√	
2	Diet for admitted patients	√			
3	Evening Clinic		√	√	
4	Medicine distribution	√	√	√	
5	Monitoring & Quality Assurance	√	√	√	√
6	Record Keeping & Reporting	√	√	√	√
7	Financial Management	√	√	√	
8	Regular update of Pro-poor listing, pregnancy registration, eligible couple registration etc.				√

Annex 2: 4th Sector Programme Results Framework

Results Framework for the 4th HNP Sector Program 2016-2021

RESULT	INDICATOR	MEANS OF VERIFICATION & TIMING	BASELINE & SOURCE	TARGET 2021
Goal: *All citizens of Bangladesh enjoy health and well-being.*	GI 1. Under 5 Mortality Rate (U5MR)	BDHS, every 3 years	46, BDHS 2014	37
	GI 2. Neonatal Mortality Rate (NNMR)	BDHS, every 3 years	28, BDHS 2014	21
	GI 3. Maternal Mortality Ratio (MMR)	BMMS; MPDR	176, WHO 2015[37]	105
	GI 4. Total Fertility Rate (TFR)	BDHS, every 3 years	2.3, BDHS 2014	1.7
	GI 5. Prevalence of stunting among under-five children	BDHS, every 3 years; UESD, every non-DHS years	36.1%, BDHS 2014	25%
	GI 6. Prevalence[38] of diabetes and hypertension among adult women	BDHS, every 3 years; NCD-RF, every 2 years	Dia: 11.2%; Hyp: 31.9%, BDHS 2011	Dia: 10%; Hyp: 30%
	GI 7. % of public facilities with key service readiness[39] as per approved Essential Service Package	BHFS, every 2 years	FP: 38.2; ANC 7.8%; CH 6.7%, BHFS 2014	FP: 70%; ANC 50%; CH 50%
Program Objective: *To ensure quality and equitable healthcare for all citizens of Bangladesh by gradually achieving Universal Health Coverage (UHC).*				
Component 1: MOHFW's governance and stewardship roles strengthened				
Result 1.1 Legal and operational framework on governance and stewardship in place	1.1.1 Governance and Stewardship Action Plan implemented in line with milestones	Admin records; APIR	GSAP developed and approved, Planning Wing 2016	GSAP implemented

[37] http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/

[38] Estimated as elevated blood sugar and blood pressure among women and men aged 35 years or older

[39] Defined as facilities (excl. CCs) having a) for FP: guidelines, trained staff, BP machine, OCP and condom; b) for ANC: guidelines, trained staff, BP machine, hemoglobin and urine protein testing capacity, Fe/folic acid tablets; c) for CH: IMCI guideline and trained staff, child scale, thermometer, growth chart, ORS, zinc, Amoxicillin, Paracetamol, Anthelmintics

Result 1.2 Overall sector governance improved	1.2.1 Number of public and non-public facilities accredited	Admin records; APIR	Process initiated, Planning Wing 2016	a) Accreditation mechanism established; b) 22 MCH, 59 DH and 50 non-public hospitals accredited
	1.2.2 % of DPs submitting annual reports on off-budget activities	APIR	54%, MPIR 2014	100%
	1.2.3 Incremental budget for MOHFW ensured	ADP; APIR	14.0% increase of ADP between FY'11-16, APIR 2015	Annual increment of ADP >15%
Component 2: Health systems strengthened to increase performance and efficiency				
Result 2.1 Quality workforce made available in health sector	2.1.1 % of service provider positions functionally vacant in public facilities, by category (physician, nurse/midwife, paramedics)	BHFS, every 2 years	Physician: 30.5%, Nurse: 7.8%, Paramedic: 7.1%, BHFS 2014	Physician: 15%, Nurse/midwife: 4%, Paramedic: 4%
Result 2.2 Core systems (FM, infrastructure, procurement) strengthened	2.2.1 % of OPs with spending >80% of ADP allocation	ADP; APIR	50%, APIR 2015	80%
	2.2.2 % of serious audit objections[40] settled	APIR	68%, APIR 2015	80%
	2.2.3 % of procurement packages tracked under SCMP	Admin records	NA	90%
Result 2.3 Disease surveillance and implementation monitoring strengthened to promote evidence-based decision making	2.3.1 No. of performance monitoring reports prepared and disseminated annually	Reports; APIR	4 (HB, MIS/FP AR, APIR, SmPR)	08 (APIR, SmPR, MISs, NIPORT, DGDA, DNS, HEU[41])
	2.3.2 Number of districts under RHIS scale up	Admin records	Pilot ongoing at 01 district (Tangail) and 2 upazilas of Habiganj	64

[40] As defined by the World Bank

[41] For HEU, the report will be Public Expenditure Review (PER)

Component 3: Quality basic services reach the disadvantaged population to progress towards UHC				
Result 3.1 Public health services strengthened to promote healthy behavior	3.1.1 % of children less than 6 month receiving exclusive breastfeeding	BDHS, every 3 years; UESD, every non-DHS years	55.3%, BDHS 2014	65%
	3.1.2 % of infants age 6-23 month are fed with minimum acceptable diet	BDHS, every 3 years; UESD, every non-DHS years	22.8%, BDHS 2014	45%
	3.1.3 % of women age 15-19 who have begun childbearing	BDHS, every 3 years; UESD(?), every non-DHS years	30.8%, BDHS 2014	25%
Result 3.2 Equitable coverage of ESP ensured	3.2.1 Contraceptive Prevalence Rate (CPR)	BDHS, every 3 years; UESD, every non-DHS years	62.4%, BDHS 2014	75%
	3.2.2 % of delivery by skilled birth attendant (SBA)	BDHS, every 3 years; UESD, every non-DHS years	42.1%, BDHS 2014	65%
	3.2.3 CPR (modern methods) in lagging regions	BDHS, every 3 years; UESD, every non-DHS years	Syl: 40.9%, Ctg: 47.2%, BDHS 2014	60%
	3.2.4 % of public health facilities without stock-outs of essential medicines/FP supplies	BHFS, every 2 years	Drugs[42]: 66%, FP methods[43]: 84.4%, BHFS 2014	Drugs: 75%, FP methods: 90%
	3.2.5 % of births in health facilities by 2 lowest socio-economic groups	BDHS, every 3 years; UESD, every non-DHS years	15.0% : 69.5% = 1:4.6, BDHS 2014	1 : 3.5
	3.2.6 ANC coverage (at least 4 visits)	BDHS, every 3 years; UESD, every non-DHS years	31.2%, BDHS 2014	50%

[42] Defined as availability of at least six of eight essential medicines of a DDS kit: amoxicillin tablet/capsule, amoxicillin syrup, cotrimoxazole, paracetamol tablet, paracetamol syrup, tetracycline eye ointment, iron tablet, and vitamin A capsule.

[43] Defined as availability of See Table 3.14 of BHFS 2014 Preli Report

	3.2.7 TB case detection rate	NTP MIS, every year	53%, GTBR[44] 2014	75%
	3.2.8 Measles immunization coverage among children under 12 months	CES, every year	86.6%, CES 2014	95%
Result 3.3 Quality of care improved	3.3.1 % of public health facilities with staff trained in IMPAC (labor management and CNCP) in last 24 months	BHFS, every 2 years	9.9%[45]	75%
	3.3.2 No. of districts implementing comprehensive maternal perinatal and newborn death review	Admin records	10, CIPRB 2014[46]	64
	3.3.3 % of public facilities with regular quality assurance activities[47]	Admin records	NA	100% DHs, 70% UHCs, 50% of UHFWCs and CCs

[44] Global Tuberculosis Report 2014 by the World Health Organization (WHO)
[45] Staff in facilities up to union-level trained in integrated management of pregnancy and child birth (IMPAC) during the last 24 months
[46] http://www.ciprb.org/wp-content/uploads/2015/01/MPDR-Fact-Sheet.pdf
[47] QA activity to be specified by HEU/HSM; check baseline with HEU

Annex 3: Estimates for resource envelope for the 4th SWAp

Baseline Scenario

Medium Term Budgetary Framework (MTBF) projection shows that the estimated non-development budget for 2016/17 is Taka 8,114 Crore and for 2017/18 is Taka 8,925 Crore. Using the average growth rate of 10% of the non-development budget in the above mentioned years, a projection has been made for the non-development budget for 2018/19 (Taka 9,818 crore), 2019/20 (Taka 10,799 Crore), and 2020/21 (Taka 11,879 Crore). The total estimated non-development budget for 2016-21 thus stands at Taka 49,535 Crore (US$ 6,192 million). The MTBF projects Taka 5,884 Crore as the development budget for 2016/17. Assuming constant development budget for the next five years, the total development budget stands at Taka 29,420 Crore. Therefore, the total estimated budget for the MOHFW is Taka 78,955 Crore for the next sector programme, inclusive of the development and non development budget.

Some DPs also support health programmes/ projects/ activities through non-state actors (e.g. NGOs, CSOs) and fund directly to the non-state actors. This off budget contribution is estimated as 3,974 in 2016/17 based on BNHA 2015. If this off-budget contribution remains constant over the next five years, a total of Taka 19,870 Crore will be channeled through off budget.

The total resource envelope for the baseline scenario is Taka 98,825 Crore (US $12,353 million).

Table 1: Resource envelope for HNP sector (2016-2021) in Crore Taka-baseline scenario

Budget by type	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Non-development budget of MOHFW	8,114	8,925	9,818	10,799	11,879	49,535
Development budget	5,884	5,884	5,884	5,884	5,884	29,420
Total budget of MOHFW	**13,998**	**14,809**	**15,702**	**16,683**	**17,763**	**78,955**
Off budget contribution of DPs	3,974	3,974	3,974	3,974	3,974	19,870
Total	17,972	18,783	19,676	20,657	21,737	98,825

Assumptions at a glance:

1) Non-Development budget grows at an annual rate of 10%
2) Development budget is constant
3) Off budget is constant

Moderate Scenario

The Seventh Five Year plan of Bangladesh projected a total development budget of Taka 41,340 Crore to be channeled to the health sector. As 97% of the total health budget is being allocated for the MOHFW, the development budget for the MOHFW for the next five years is assumed to be Taka 40,100 Crore. MTBF projection shows that the estimated non-development budget for 2016/17 is Taka 8,114 crore. Assuming a 15% annual growth, the total estimated non-development budget for 2016-21 thus stands at Taka 54,708 Crore (US$ 6,839 million). Therefore, the total estimated budget for the MOHFW is Taka 94,808 Crore (US$ 11,851 million) for the next sector programme, inclusive of the development and non development budget. If off-budget contribution grows at an annual rate of 5%, a total of Taka 21,959 Crore will be channeled through off budget.

The total resource envelope for the moderate scenario is Taka 116, 767 Crore (US $14,596 million).

Table 2: Resource envelope for HNP sector (2016-2021) in Crore Taka-moderate scenario

Budget by type	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Non-development budget of MOHFW	8,114	9,331	10,731	12,340	14,191	54,708
Development budget	8,020	8,020	8,020	8,020	8,020	40,100
Total budget of MOHFW	**16,134**	**17,351**	**18,751**	**20,360**	**22,211**	**94,808**
Off budget contribution of DPs	3,974	4,173	4,381	4,600	4,830	21,959
Total	20,108	21,524	23,132	24,961	27,042	116,767

Assumptions at a glance:

4) Non-Development budget grows at an annual rate of 15% (based on MTBF)
5) Development budget is 40,100 as per 7th Five Year Plan for the next 5 years
6) Off budget grows at an annual rate of 5%
7) The revenue budget is 58% of the MOHFW budget

Optimistic Scenario:

The Seventh Five Year plan of Bangladesh projected a total development budget of Tk 41,340 crore to be channelled to the health sector. As 97% of the total health budget is being allocated for the MOHFW, the development budget for the MOHFW for the next five years is assumed to be Tk 40,100 crore for the high scenario. MTBF projection shows that the estimated non-development budget for 2016/17 is Tk. 8,114 crore. Assuming a 20% annual growth, the total estimated non-development budget for 2016-21 thus stands at Tk. 60,381 crore (US$ 7,548 million). Therefore, the total estimated budget for the MOHFW is Tk. 100,481 crore (US$ 12,560 million) for the next sector programme, inclusive of the development and non development budget. If off-budget contribution grows at an annual rate of 10%, a total of BDT 24,262 crore will be channelled through off budget.

The total resource envelope for the moderate scenario is Tk 124,743 crore (US $15,593 million).

Table 3: Resource envelope for HNP sector (2016-2021) in Crore Taka

Budget by type	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Non-development budget of MOHFW	8,114	9,737	11,684	14,021	16,825	60,381
Development budget	8,020	8,020	8,020	8,020	8,020	40,100
Total budget of MOHFW	**16,134**	**17,757**	**19,704**	**22,041**	**24,845**	**100,481**
Off budget contribution of DPs	3,974	4,371	4,809	5,289	5,818	24,262
Total	20,108	22,128	24,513	27,330	30,664	124,743

Assumptions at a glance:

1) Non-Development budget grows at an annual rate of 20%
2) Development budget is 40,100 as per 7th Five Year Plan for the next 5 years
3) Off budget grows at an annual rate of 10%
4) The revenue budget is 60% of the MOHFW budget