

Final Draft (27 August, 2008)

National Health Policy

--- An Update

**Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh**

August, 2008

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1. Introduction

1.01 Health is a state of complete physical, mental and social well being and merely not an absence of disease or infirmity. Health is universally regarded as an important index of human development. Health is also a fundamental right of the population. Constitutionally the Government of Bangladesh is obligated to ensure provision of basic necessities of life including medical care to its citizens [Article 15(a)] and to raise the level of nutrition and to improve public health [Article 18(1)]. Bangladesh is committed to achieving the millennium development goals (MDGs) by 2015 and has been pursuing various programs to translate the MDGs into reality.

1.02 Bangladesh has a population of about 146 million with an area of 147,570 square kilometers. Density of population is around 952 per square kilometers, highest in the world, except the city states. Rural population comprises about 76 per cent while urban constitutes about 24 per cent. Adult literacy rate is 54 per cent (2006). Census of 2001 reveals that 43 per cent of the population is below 15 years of age. This young age structure constitutes built-in *population momentum*. Also urban population is increasing quite fast. Though Bangladesh has made progress in reducing poverty and per capita income has been creeping up, a substantial number of population are poor. Progress made in improving Bangladesh's Human Development Index (HDI) has placed her among the medium-ranking HDI countries.

1.03 Health is an integral part of any development. Ill health is both the cause and effect of poverty, illiteracy and access to knowledge. The link of health with poverty reduction and development is well established now. Improvements in health would translate into higher incomes, higher economic growth, and accelerated declines of poverty. Any significant impact on poverty requires increased equity of access and improved coverage of health care services directed by the National Health Policy (NHP).

2. The Situation Analysis

2.01 **Health Status:** Since independence Bangladesh has made significant progress in health outcomes. Infant and Child mortality rates have been markedly reduced. The under-five mortality rate in Bangladesh declined from 151 deaths per thousand live births in 1991 to 62 deaths/1000 live births in 2006 and during the same period infant mortality rate reduced from 94 deaths per 1000 live births to 45. EPI coverage extended its reach from 54 per cent in 1991 to 87.2 per cent in 2006. The MMR reduced from 574/100,000 live births in 1991 to 290 in 2006. Deliveries attended by skilled birth attendants increased from only 5 per cent in 1990 to 20 per cent in 2006. The prevalence of malaria dropped from 42 cases /100,000 in 2001 to 34 in 2005. Bangladesh has also achieved significant success in halting and reversing the spread of tuberculosis (TB). Detection of TB by the Directly Observed Treatment Short-course (DOTS) has more than doubled between 2002 and 2005, from 34 to 71 per cent. The successful treatment of tuberculosis has progressed from 84 per cent in 2002 to 91 per cent in 2005. Polio and leprosy are virtually eliminated. HIV prevalence is still very low. Development of countrywide network of health care infrastructure in public sector is remarkable. However, availability of drugs at the health facilities, deployment of adequate health professionals along with maintenance of the health care facilities remain as crucial issues, impacting on optimum utilization of public health facilities.

2.02 Nutrition Status: There has been considerable progress in reducing malnutrition and micro nutrient deficiencies in Bangladesh. According to BDHS, percentage of U5 underweight (6-59 months) has reduced to 46.3 (2007) from 67 (1990) and that of U5 stunted (24-59 months) from 54.6 (1996) to 36.2 (2007). Percentage of children 1-5 years receiving vitamin-A supplements in last six months has increased from 73.3 (1999-00) to 88.3 (2007). The rate of night blindness has reduced to 0.04 per 1000 people (IPHN, HKI 2006). However, in spite of efforts taken by the government, high rates of malnutrition and micronutrient deficiencies along with gender discrimination remain common in Bangladesh.

2.03 n Population Status: Bangladesh is now Asia's fifth and world's eighth populous country with an estimated population of about 146 million. Strong policy interventions led to continuous reduction in the annual growth rate of population from the level of 2.33 per cent in 1981 to 1.54 in 2001 and further to 1.48 (2007). The TFR also went down from 3.4 in 1993-94 to 2.7 (2007). The CPR (any method) increased from 44.6 per cent in 1993-94 to 58.1 per cent in 2004, but again fell down to 55.8 per cent in 2007. Life expectancy at birth has continuously been rising, and is now 65 years (2007) from the level of 58 (1994). Reversing past trends, women now live longer than men. The country, however, is over burdened with about two million new faces every year creating extra pressure on food, shelter, education, health, employment, etc., and thus making the anticipated economic growth difficult.

2.05 Urban Health Service: The urban areas provide a contrasting picture of availability of different facilities and services for secondary and tertiary level health care, while primary health care facilities and services for the urban population at large and the urban poor in particular are inadequate. Rapid influx of migrants and increased numbers of people living in urban slums in large cities are creating continuous pressure on urban health care service delivery. Since the launching of two urban primary health care projects, the services have been delivered by the city corporations and municipalities through contracted NGOs in the project's area. Rest of the urban areas and services are being covered by MOHFW's facilities. Moreover, 35 urban dispensaries under the DGHS are providing outdoor patient services including EPI and MCH to the urban population.

2.07 Health Workforce: Health service providers constitute about two-thirds of the health workforce, while the remaining third is composed of health management and support workers. It transpires from a recent report on "The State of Health in Bangladesh 2007" that there is a huge shortage of qualified practitioners and paraprofessionals in the country's formal system of health care providers. Whereas, a large majority of the unqualified allopath providers and homeopaths provide services at the drugstores as the first point of contact for the patients, but not formally recognized.

2.08 The spectrum of essential workers' competencies is characterized by imbalances – ratio of nurses and paramedics to doctors, dire shortage of public health scientists and health care policy planners and managers. Typically more doctors are male and nurses are female – a marked gender imbalance. Along with inappropriate skill mix, improper distribution characterized by urban concentration and rural deficits is another characteristic of shortage of health professionals.

2.09 Medical Supplies: The present logistics system of the health sector is characterized by centralized procurements with some decentralized provisions. Delay in health sector's procurement has always been questioned and identified as one of the

prime causes of low absorption of budgetary allocations each year by the MOHFW. Irregular supply process and inappropriate supplied items were experienced in procurement. In many cases, supplied goods did not match with the requirement of facilities. In addition, repair and maintenance of equipment and facilities remain inadequate.

2.10 Waste Management: Bangladesh has to move a long way in health care waste management. Health care waste management in the country takes place under inappropriate conditions, be it from an environmental, occupational health and safety or public health point of view. However, a Health Care Waste Management Plan (HCWMP) developed by the MOHFW covering public as well as private sector along with a manual and booklet on it is under implementation. This activity is at its initial phase covering only the district and above level hospitals. Segregation of hospital waste and proper disposal is mostly absent at the Upazila Health Complexes (UHCs) and below.

2.11 Health Governance: There is widespread public perception about the low quality of health service delivery, be it provided by government, private or other non-state actors. Unfortunately, accident and trauma patients as well as those needing emergency attention are least served by the private clinics and hospitals, and it is only the public hospitals which provide services for them. Complaints about the weak governance in the public sector relate to unavailability of designated health personnel, pilferage of drugs and other essential supplies, mistreatment and negligence of the clients, unauthorized and illegal payments at public health premises, etc. The weak governance in health sector caused the poor and the vulnerable members of the society to suffer the most in terms of both costs and deficient service delivery.

2.12 Gender Equality: The country's commitment to and support for women's development programs over the past two decades have resulted in positive gains in female life expectancy, reducing MMR, IMR and child mortality rates, empowerment through education, etc.; however, still a long way lies ahead to further development. Gender disparities are quite evident in some health indicators like low birth weight, nutrition, etc. Incidences involving violence against women are widely reported.

2.13 Health Financing: In Bangladesh, current public and private sources of health finance combined are insufficient to achieve full coverage of health services. On an average, about 3.2 per cent of GDP is allocated to health, nutrition and population (HNP) sectors in Bangladesh. This share of allocation is very low for ensuring a sustainable health systems development in Bangladesh. Per capita expenditure on health is only about US\$ 13.0/year, of which public spending on health care is hovering around US\$ 4-5/year. The rest is privately financed through out-of-pocket spending. Yearly per capita spending on health needs to be raised to at least US\$ 24.0 against the yearly per capita spending of US\$ 34.0 in the developed world.

3. Current and Upcoming Challenges

3.01 Despite many positive trends, numerous challenges remain. There are major differences in health conditions and health care consumption between different groups. Some of these inequities are stark and persistent and are holding the country back from making further gains at the aggregate level. Improvements in some areas are relatively more difficult to sustain while there are indications of stagnation in others. Some important current and upcoming challenges are stated below.

3.02 **Maternal mortality** has been declining, is still one of the highest in the world, so also is neonatal mortality. Bangladesh's current challenge is to improve effective service delivery, health sector governance (especially in primary and maternal health services), and increase the number of trained birth attendants. Further sharp reduction in fertility rate might demand new ways of interventions, and for which concerted inter and multi-sectoral efforts would be required.

3.03 The challenge of **reducing child mortality** is to address the district and regional variations (urban slums, the CHT, coastal belt regions and other ecologically vulnerable areas are falling behind), so that government effort reaches all Bangladeshi people, and that progress made so far is sustained.

3.04 Threats of **HIV/AIDS**, pockets of **malaria** and multi-drug resistant **TB** are also emerging as challenges. Effective surveillance of HIV/AIDS; strong mechanisms to monitor outbreaks of malaria in high-risk districts; developing effective treatments for drug resistant malaria strains; and improvements in the quality of diagnostic services will continue to pose a major challenge for the country.

3.05 **Emerging and changing patterns of threats** such as arsenic related diseases, HIV, Avian Flu, childhood disabilities, mental health problems, road-railway-river accidents and violence (particularly against women) need to be tackled with a concerted effort.

3.06 The challenge of reducing **malnutrition** and redressing its gender bias needs coordinated multi-sectoral interventions on a sustained basis. The recent trend of rise in food prices across the globe is accompanied by the threat of being a long-term feature of the global economy and adds further to this challenge.

3.07 In **urban health**, good health remains beyond the reach of many of the urban poor and particularly of slum dwellers. Morbidity and mortality is the highest for children from urban slums. The pace of urbanization has outstripped the pace of development of social services and infrastructure required to meet people's need. Concurrently, uncontrolled urbanization is leading to creation of slums, overcrowding, poor housing, inadequate water supply and poor environmental sanitation, with detrimental effects on quality of life and outbreak of infectious diseases like the dengue outbreak over the last few years. Meeting the health needs of the fast growing urban poor of Bangladesh will continue to pose major challenges for the government.

3.08 There have been a number of **demographic and lifestyle changes** over the past two decades in Bangladesh. Population is increasing (though at a decreasing rate), is youthful, has more females, is becoming older, is becoming more urbanized and is undergoing lifestyle changes, all of which have implications for health and development. The combined effect of incremental population and the youthful and aging population will create further pressure on social services, such as health and education.

3.09 The rise in aging population and urbanization are accompanied by an increase in non-communicable diseases and mental health problems. The lifestyle changes associated with consumption of fat diets, junk food, lack of physical exercise and rest and recreation, use of tobacco, addiction to drugs, reckless driving, etc., are all changing the epidemiology of morbidity and mortality in Bangladesh. Urbanization is leading to changes in family structure and living arrangements, eroding traditional values and

disrupting social support systems (impacting particularly on health of children and elderly people).

3.10 The World Health Organization (WHO) has recently drawn attention of the world community about the inevitable effect of **climate change** on basic requirements for maintaining health: clean air and fresh water, sufficient food and adequate shelter. The health concerns and vulnerabilities due to climate change are increase in respiratory diseases, heat strokes and cardio-vascular illness; more exposure to vector-borne diseases like malaria, dengue, etc.; increased risk of water-borne diseases such as cholera; and increased malnutrition due to reduced food production. Moreover, loss of life, land and other properties, displacement and forced migration due to disasters bring about psychosocial stress and cause potential social conflicts, affecting mental health. All people will be affected by a changing climate, but the initial health risks will be on the groups bearing most of the resulting disease burden, i.e., poor children, women and elderly people.

3.11 Rapid urbanization, environmental pollution, demographic and lifestyle changes, climate change, etc., are contributing to rising incidence of **communicable and non-communicable diseases**. Addressing this challenge requires the government to invest more on raising public awareness for prevention of communicable and non-communicable diseases. Care, treatment and logistics improvement along with associated manpower development are of great challenge for the society.

3.12 Redressing the shortage of **health human resources**, involves a chain of cooperation and shared intent between the public and private sectors who fund and direct educational establishments; between those who plan and influence health service staffing; and between those able to make financial commitments and sustain or support the condition of services of health workforce.

3.13 With medical technologies increasingly dominant, human resources with appropriate skills for health care provisions are becoming crucial. Quality medical education of both public and private sectors (including NGOs) for all health professionals are to be ensured for improved service delivery at all levels. Vast categories of human resources (super specialist and specialist physicians/surgeons of various disciplines, general physician, specialist nurses for various disciplines, general duty nurses, support services personnel – pharmacist, technicians/paramedics of various disciplines, electro-medical engineers and technicians, facility managers, public health professionals, other health workers, counselors, program managers, policy planners, etc.) with appropriate quality, placement, retention, career-planning are essential, but these are complex areas where both public and non-public sectors need to participate appropriately based on their comparative advantages.

3.14 Bangladesh has a huge shortage of doctors, nurses and technologists by the international standards. The persistent shortage of skilled health care professionals in rural areas and for the urban poor remains one of the most fundamental challenges.

3.15 The **informal system of health care provision** by semi-qualified or unqualified providers including village doctors, pharmacy drug sellers, kobiraj, totka, herbalist, faith healers, trained and untrained TBAs is catering to the needs of probably 80 per cent of the population, particularly the poor and women. A large majority of the unqualified allopath providers and homeopaths provide services at the drugstores. Some informal providers provide adequate care, while some provide unnecessary and even harmful medications, or

fail to refer serious cases, thereby contributing to unnecessary death and impoverishment. However, the large and critical role of the informal health care providers need to be recognized and appropriate strategies developed.

3.16 **Centralized management system** of government health services and prevalent managerial practices at the facility levels are major obstacles for effective and efficient utilization of the countrywide health care infrastructure network. Need based and timely procurement along with repair and maintenance of electro-medical equipment is of great concern for health sector's development.

3.17 **Health research** is essential to improve design of health intervention and systems, service delivery and pro-poor policies. Policies and programs are best done if they are evidence informed. Lack of an effective functional national health research system along with inadequate financial, human and institutional capacity hinder in generating evidence and establishing the research to policy and policy to research links. This situation needs to be improved by increasing research capability and investment in research and research institutions and strengthening coordination among the existing health research and academic institutions.

4. Need for Updating the NHP

4.01 Policy cannot remain static and it is subject to changes, particularly health status of people being an outcome of multi-sectoral interventions, the need for adjustment in health policy is of crucial importance. Over the years, significant changes in epidemiological, demographic, environmental and socio-economic fields have taken place and new challenges (e.g., re-emerging diseases, stubborn MMR, non-communicable diseases, urban health service and issues of equity and access of the poor and gender divide) have appeared. Now is also the time for updating the on-going policy framework, since the present health sector program is half-way through, the mid-term review had already taken place and the outline of a new program needs to be debated and developed. All these have necessitated the government to update the NHP 2000 and offer a policy framework which will be more relevant and timely in meeting the sector's need.

4.02 The MOHFW as part its mandated responsibility has the lead role in policy formulation, regulation, facilitation, monitoring and supervision and coordination among the wide variety of actors engaged in the HNP sector. Three sub-sectoral policies, i.e., national health policy, national food and nutrition policy and national population policy duly approved by the government from time to time are under implementation by the MOHFW. The NHP was issued in the year 2000 reflecting program changes which had already been introduced like SWAp, the adoption of ESP, etc. A review of that policy was undertaken by the government and a draft NHP 2006 was prepared incorporating changes in program and approach which had taken place since the NHP 2000, but it was not finalized. As part of the requirements for updating the on-going policies, MOHFW has decided to update the national health policy 2000 as a first step. Nutrition and population related national policies will also be updated gradually.

4.03 The updated NHP 2008 seeks to build on both the policy documents of 2000 and 2006 and has taken into consideration their strategies for further expansion and utilization of health services especially by the poor and the disadvantaged. This update intends to provide a broad framework of goals and priorities consistent with the sector vision. Detailed programs and time bound plan of action would be drawn up by different role players in the health sector in furtherance of policy goals keeping in view the need for

improvement in service quality, equity and access, and developments in medical education, technology and global best practices.

5. Key Features of the NHP

The main features of the current policy is to maintain continuity of certain elements of earlier health policy with a new look like PHC, FP, Nutrition, PPP, etc. It also includes new elements like urban health service, climate change related health risks and mitigation measures, medical waste management, food safety and quality, etc. and adds new focus on stewardship role of the government, recognition of the informal health care providers, decentralization along with autonomy, etc. The other key features of the NHP are:

- Investments for development of the health sector are viewed as part of the Government's over all Poverty Reduction Strategy (PRS) and are also tuned to achieve the MDGs.
- Priority attention is accorded to raise the health status of the people (with particular emphasis on the poor women, children and the elderly).
- Ensuring improved health service provision by the public sector and an enabling environment for greater participation of the private for profit and the non-profit institutions based on comparative advantage.
- Strengthening and further consolidating the health sector reforms to achieve quality and equity in health care.
- Strengthening Government's capacity for an efficient and effective regulatory and stewardship role, and developing an atmosphere for providing pro-poor community driven health care services.
- Operating in a broader sector wide approach (SWAp) with respect to planning, budgeting, implementation, financial management, human development and focusing particularly on poverty reduction.

6. Sector Vision

The vision of Bangladesh's poverty reduction strategy is to substantially reduce poverty within the next generation. Within this broader context:

The health sector seeks to support creation of an enabling environment whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. With a vision that recognizes health as a fundamental human right the need to promote health is imperative for social justice. This vision derives from a value framework that is based on the core values of access equity, gender equality and ethical conduct.

7. Goal

The goal is sustainable improvement in health, nutrition and family welfare status of the people, particularly of the poor and vulnerable groups, including women, children and elderly with ultimate aim of their economic and social emancipation and physical and mental well being.

8. Objectives and Principles of the NHP

The overall objectives of the NHP will be to (i) increase availability of user-centered quality services for a defined Essential Service Package (ESP) delivery along with other health related services, and (ii) develop a sustainable quality health service system to meet people's need. A set of principles, as described below, for attainment of the objectives will be followed:

- Making health service equitably affordable and accessible to all and ensuring an efficient and effective quality health service.
- Innovations in health care, e.g., geographical targeting to benefit high poverty areas, health insurance coverage for the poorer sections of the society, public private partnership, demand-side financing, etc., will be explored.
- Based on epidemiological data and evidence as well as socio-cultural contexts, strategies and interventions of the health sector will be prioritized and addressed.
- Emerging and re-emerging issues will be addressed taking into account the changing pattern of diseases, including those arising out of demographic transitions and environmental concerns.
- Creating health related safety net to ensure supply of service, medicine, equipment, etc., for emergency relief to the disaster affected people.
- Creating and expanding various types of incentive mechanisms/facilities including in-service training, career development planning, etc., for the health professionals.
- Developing capable, motivated and supportive health professionals and workers at all levels with appropriate skill-mix for overcoming bottlenecks to achieve national health goal.
- Expanding the scope of health service provision to include proven alternative health care system (e.g., Ayurvedic, Homeopathy and Unani).
- Establishing an effective linkage with global and regional information network for strengthening health sector's research and systems development.
- Viewing health as central to socio-economic development, public sector allocations to health will be increased gradually with due recognition to transparency, accountability and participation as the hallmarks of good governance for health at all levels.

9. Strategies of the NHP

9.01 The government is committed to ensuring quality health care service, which is affordable, attainable and acceptable to its citizens. The government focus is on increasing health status, reducing health inequalities, expanding access to social safety network and encouraging affordable service delivery systems for every household, and at the same time strengthening need-based facilities for provider. For the poor and

vulnerable, existing safety nets will be further expanded and consolidated not only to ensure access of the poor to public health care services but also to raise their voice through community participation. Some major areas of interventions, in view of the earlier situation analysis are stated below.

9.02 Nutrition: All issues related to nutrition will be guided by the actions incorporated into the national food and nutrition policy. The National Nutritional Program (NNP) will be expanded to cover the entire country and adjusted on the basis of gathered experience. Nutrition activities will be reinforced by forging links with other activities in the health sector like community-centered immunization and hospital services for referral of the severely malnourished, etc. The multi-sectoral links of MOHFW's nutrition initiatives with programs by other ministries for food fortification and income security would be further strengthened to achieve accelerated decline in malnutrition. Dissemination of proper knowledge about nutrition amongst the citizens will be strengthened. The on-going micronutrient programs will be continuously reviewed for their refinement and expansion with particular emphasis on gender equity. Monitoring and surveillance system will be strengthened to improve nutrition of the poorer sections of the society.

9.03 Population Planning: All issues related to population control and reproductive health including family planning (FP) will be guided by the national population policy. Recognizing reproductive health as a major component contributing to significant reduction in maternal mortality and fertility, contraceptives along with FP services will continue to be made widely available and further expanded to the poor and the marginalized of both rural and urban population. Efforts are underway to popularize the slogan of having one child per couple. The existing FP programs will be expanded and strengthened involving both men and women, and will be popularized through an intensive motivational campaign under the Behavior Change Communication (BCC) program. In addition to temporary methods of FP, clinical and permanent methods will be emphasized in order to increase contraceptive prevalence rate (CPR) and ensure further decline in total fertility rate (TFR).

9.04 Health Education and Promotion: A major strategy to ensure better health would be to promote public health through health education within MOHFW and channels outside it. The existing institutions of MOHFW will be strengthened for providing effective health messages. Coalition will be built with mass media for providing health education to the population on a continuing basis regarding methods of preventing communicable and non-communicable diseases, caring practices for children, adolescents and the old aged, and creating awareness on nutrition and proper sanitation. Steps will also be taken to reach basic health and reproductive health information through school curricula and utilize NGOs and different religious centers to influence health behavior of the people. Moreover, activities of existing school health clinics will be reviewed and based on learnt lessons, school health program will be scaled up through developing a strategy in collaboration with MOE, MOPME, Girl's Guides, Boy's Scouts, etc.

9.05 Control of Non-communicable Diseases: Reduction of morbidity and premature mortality due to non-communicable diseases (NCDs) will require appropriate actions at all levels from primary prevention to treatment and rehabilitation in an integrated manner. The government will, in partnership with local government administration and private sector create greater awareness of, and provide services for the control of unhealthy diet and lifestyle related major NCDs like-- cardio-vascular diseases, cancer, diabetes, mental illness, etc. It will also take steps to combat common NCDs, such as, hypertension, asthma, blindness, etc., which particularly afflict the poor. Existing preventive and

curative measures with respect to all NCDs will further be expanded and strengthened to increase access of all for health care services.

9.06 Control of Communicable Diseases: The existing programs along with focus will further be expanded and strengthened to intensify prevention and control of communicable diseases, such as, acute respiratory infection, diarrhea, dengue, etc. Special measures will be initiated for combating tuberculosis, malaria, fileriasis and kalazar, which are concentrated in specific pockets of the country.

9.07 Control of Emerging Threats: Existing counseling and treatment services for mental health, drug abuse, Avian Flu, STD and HIV/AIDS, arsenic diseases, injuries, trauma suffers, women and child victims of violence, road-railway-river accidents, etc., would be improved and these facilities will be introduced where not available. Attention will also be paid to provide health services for other emerging and changing patterns of threats such as, childhood disabilities and geriatric care.

9.08 Urban Health Services: The existing practice of providing urban primary health care services through the city corporations and municipalities under the LG Division will continue to be pursued. In addition, MOHFW will continue to provide PHC services in urban areas not covered by the LG Division. Similarly, it will also continue to provide secondary and tertiary level health care in urban areas and try to improve both coverage and quality in response to demand. A priority objective for improving urban health services will be to facilitate access and effective use of available ESP delivery services by urban poor and slum dwellers. To this end, an urban health strategy in collaboration with LG Division will be developed with a view to streamlining urban primary health care services and establishing strong institutional linkage and ensuring primary health care, FP and RH services for the urban poor. Existing linkage with LG Division will also be strengthened for urban disease surveillance and monitoring including MIS, capacity development and quality assurance, etc. Moreover, MOHFW will strengthen its policy directive and stewardship roles in providing effective urban health care services.

9.09 Climate Change and Health Protection: A concerted effort will have to be made to protect health from adverse effects of climate change. To this end, a national program outline will be developed in order to reduce the burden of diseases due to climate change. Strengthening of public health services needs to be a central component of adaptation to climate change. The existing health research agenda will include the adverse effect of climate change on health, and field surveys and studies will be conducted to identify the short, medium, and long term effects of climate change on health. Various steps will be taken to raise public awareness through coordinated efforts and sharing of research findings with all concerned actors. An advanced preparedness plan will be developed to face the consequences of climate change. Moreover, climate change being a global challenge, calls for an unprecedented degree of partnership. An effective response will require actions across the society and from global community, in order to safeguard and enhance national as well as global public health security.

9.10 Primary Health Care: The current commitment of spending at least 60 per cent of the total budgetary allocation of the health, nutrition and population sectors at upazila and below level will continue to be pursued to improve the quality of primary health care (PHC) and make it accessible and acceptable to the people, especially the poor and vulnerable. The provision of essential services package (ESP) delivery will be strengthened and popularized. The present efforts in the field of immunization will be

continued with the commitment of greater resources. Moreover, introduction of new vaccine(s) will be emphasized according to need and priority.

9.11 Functioning of the Upazila Health Complexes (UHCs), Union Health & Family Welfare Centers (UHFwCs) and the Community Clinics (CCs) will be strengthened and further consolidated through providing adequate manpower, drugs and other medical aids. There will be involvement of local government bodies with support from NGOs for greater participation of the community with a view to ensuring community driven PHC services.

9.12 **Secondary and Tertiary Health Care:** Types of services to be offered by secondary and tertiary hospitals depending on bed capacity will be standardized along with manpower needs and TOE linked to the services. A taskforce would be set up to develop such a standardized format. Appropriate manpower development and management structure will be developed for running day to day functioning of the existing hospitals. New branches of sub-specialization will be created in all medical college hospitals, so that patients do not need to rush to the capital city.

9.13 Administrative and financial autonomy will be ensured for better management of the existing public sector hospitals. Management Committees at hospitals will be strengthened for better monitoring. New specialized hospitals will be established by the government as autonomous units and management will be handed over to board of trustees within a guideline to be set by the government. The principle to be adopted will center on maximum delegation of financial power and administrative authority without compromising accountability.

9.14 **Strengthening Referral System:** As far as possible, outdoor treatment will be encouraged. All medical college hospitals will accept referred patients. A network of well-worked out referral system will be developed so that patients are assured of receiving treatment from health facilities and that patient load at the higher levels is not needlessly burdened by those who can be treated at the local level.

9.15 **Affordable Health Care Services:** Existing system of affordable health care services will be further expanded and consolidated ensuring proper safety net for the poor. Facilities providing health care outside the public sector (but receiving government fund) will ensure that at least 30 per cent of their bed capacities are kept for free treatment in their hospitals for those who cannot pay. Necessary fund will be mobilized through user fees, government allotment, social organizations, private donations, corporate social responsibility, community financing schemes, social insurance, etc.

9.16 Fees for providing medical advice or diagnostic service will be reviewed and regulated as necessary. Government will also encourage establishment of network of evenly spread specialist and super-specialist services through private investment for patients who can pay, so that the pressure on government facilities remains limited to those entitled to free services.

9.17 **Food Safety and Quality:** The problem of major health hazards stem from drinking unsafe water and consuming unhygienic and low quality food. Definitive food standards would be established to serve as benchmark for evaluating and maintaining standards. Presently, the MOHFW covers issues related to drugs, while the Pure Food Ordinance, which is administered by the Local Government Municipal Authorities, covers issues related to food standards. An institutional partnership will be developed

with the LG Division in collaboration with MOC, MOHA, MOA, MO Food and other relevant ministries for ensuring safety and quality of food and water. All existing food safety laws will be reviewed by the government and strengthened incorporating penal provisions for providing sub-standard and unhygienic food to the public. The government will examine the need for an integrated authority for food and drug administration and take necessary follow-up action with the aim of removing threat to health of the citizens from substandard and or adulterated food and drugs.

9.18 Surveillance of Diseases: The existing disease surveillance system will be reviewed for its updating keeping in view the international health regulation system. Disease information monitoring and management system will be strengthened not only to issue public alert and increase availability of adequate information concerning the incidence and prevalence of diseases at regional and national levels, but also to establish a network with the global disease information system. The incidence and prevalence of diseases vary widely across different regions of Bangladesh. Therefore, maps of all major diseases, on the basis of their incidence and prevalence, will be constructed for each district.

9.19 Medical Waste Management: The government has recently introduced waste management initiative for hospitals at the upazila and below to ensure safe, environment friendly and cost-effective management of sharps and other hospital wastes derived from curative, diagnostic, immunization and other services both in public and private sector. The on-going efforts of hospital waste management at all levels will be strengthened further and expanded all over the country. A coordinated mechanism along with different level committees will be established involving hospital authorities, city corporations and municipalities for management of both in and out house hospital wastes. Steps will also be taken to improve the capacity of DGHS for inspection and monitoring of medical waste management. This will require direct involvement of and increased investment by both the public and private sectors.

9.20 Health Governance: Good governance in the health sector will be strengthened through prudent staff deployment, preventing all sorts of mal practices and creating a more customer friendly health service delivery system in the public facilities in partnership with all stakeholders. The stewardship capacity of public sector will be improved for monitoring quality of care and safety of patients in both public and private sectors.

9.21 The on-going collaborations between the state and the non-state actors in strengthening family planning, nutrition, EPI, TB and leprosy, HIV/AIDS etc. activities have been found encouraging through active involvement of the communities. Therefore, these initiatives will be scaled up as necessary and lessons from these experiences will be replicated in other areas of concern. The community-based organizations will be involved in monitoring the quality and coverage of services.

9.22 Expansion of private sector's health service provision will continue to be encouraged, so that private sector can support and complement the government activities. But, the private sector will also be kept under constant review to ensure proper treatment of patients and make them more transparent and accountable to the citizens. The existing regulations relating to the operation of the private clinics and diagnostic centers would be strictly enforced.

9.23 The Citizen's Charter for health service delivery has been put in practice in the public hospitals and health complexes. Practicing of the said charter will be monitored and strict adherence to its implementation will be ensured.

9.24 With the recent renewed commitment of strengthening the local government administration and institutions at different levels, opportunities have cropped up for exploring devolution of health programs and utilization of fund through different levels of local government institutions. Adaptation of such approach will enable need based allocation of resources and close supervision through the locally elected representatives.

9.25 The NHP will equally focus on improvement of public health services through better planning, reallocation of existing resources as well as increasing resources, establishing transparency and accountability, reducing wastage and improving efficiency by better management practices.

9.26 **Sector Reforms:** A health sector reform body will be set up under the chairmanship of the Minister for Health and Family Welfare for overseeing the progress of on-going reforms. The on-going reform measures need to be closely monitored and reviewed for their successful implementation. Efforts are on to reestablish functioning of the BMDC through an amendment of the concerned law. Gradually other laws will be reviewed and strengthened to make them functional and effective. Both administrative and financial authority, as far as possible, will be decentralized with a view to increasing accountability and establishing quality health care services at all levels. A system of collection, retention and utilization of "user fees" at all public health facilities (ensuring adequate safety net for the poor) will be established and for this a set of guidelines developed.

9.27 **Gender Equality in Health:** The NHP will focus on (i) ensuring rights of women for a better physical and mental health at all stages of their life cycle, (ii) strengthening PHC for women with emphasis on reducing MMR and IMR, (iii) strengthening reproductive rights and reproductive health of women at all stages of population planning and implementation, (iv) preventing women from HIV/AIDS and STD through awareness raising, and (v) creating women-friendly physical facilities at all public health complexes. Moreover, efforts will continue to (i) communicate the importance of ANC, delivery care and PNC to all household heads at the grass root level, (ii) give special training to service providers at the community and higher levels on gender equity and (iii) include topics on the health needs of both males and females and their impact on gender disparities in school curriculum.

9.28 **Transparency, Accountability and Stakeholder Participation:** Management committees along with government service associations, and professional organizations like Bangladesh Medical and Dental Council (BMDC) and Bangladesh Medical Association (BMA) can play a more effective role in achieving good governance and ensuring transparency and accountability in health sector. The stakeholders, including non-state actors, media and civil societies will be involved in formulating policies and included in managing committees of hospitals. They will also be consulted on major issues of health sector's development in order to increase participation, transparency and accountability.

9.29 **Stewardship Role of the Public Sector:** The government has been emphasizing on wider involvement of the private sector including non-state institutions for enhancing effective health service delivery. To this end, the stewardship role of the MOHFW has to

be strengthened. The following are some of the important areas where effective regulatory mechanism of the government will be established.

I. MOHFW will gradually assume strategic stewardship and governance roles for policy management in the following and related areas.

- Setting up a coordinating system for synergistic, effective and efficient contribution from public and non-public including private sector and health related NGOs for extending and improving health services.
- Necessary steps will be taken for formulation, implementation, review and periodic updating of a comprehensive (i) Maternal, Neonatal and Child Health Strategy, (ii) Population Strategy by updating the existing NPP, (iii) Infant and Young Child Feeding Strategy, (iv) Strategy for Combating HIV/AIDS, (v) Strategy to reduce the burden of TB, Malaria, Kalazar and Fileria, (vi) Urban Health Strategy, (vii) Non-Communicable Diseases Strategy, (viii) Emergency Preparedness and Response Strategy, (ix) Accident and Violence Management Strategy, (x) Occupational Health Strategy, (xi) Mental Health and Drug Addiction Strategy, (xii) Tribal Health Strategy, and (xiii) Food Safety and Drug Strategy.

II. MOHFW strengthens its regulatory and supervisory roles.

- Regulatory bodies (Bangladesh Medical and Dental Council (BMDC), State Medical Faculty (SMF), Bangladesh Nursing Council (BNC), Bangladesh Pharmacy Council (BPC), and Ayurvedic, Homeopathy and Unani Board will be made more effective and functional through revising their mandate, structure and capacity building for enforcement of standards .
- The existing structure and capacity of DGHS will be reviewed and strengthened for increasing supervisory performance and enhancing institutional capacity.
- Professional medical ethics and code of conduct will be established among the service providers through enforcement of regulatory framework in consultation with the professional associations.
- The need for separate regulatory body for effective service delivery system for both the public and private sectors will be reviewed.

III. Public sector notably MOHFW will increasingly focus on ensuring proper safety net for the poor, vulnerable and marginalized.

- Existing health delivery system in both public and private sectors will be further expanded and strengthened, ensuring proper safety net for the poor, vulnerable and marginalized. Individuals receiving old age stipends from the government will get full free treatment in all public hospitals.
- Alternative health delivery systems will be explored leading to an eventually self managed system with community participation in managing the facilities on pilot basis and then scaled-up, based on lessons learnt.

- Public-private partnership in health delivery system will be further expanded and strengthened with an effective monitoring and regulatory mechanism.

IV. *MOHFW assumes responsibilities for proper information generation, collection and effective management feeding into policy formulation and planning.*

- Develop comprehensive plan including performance indicators for monitoring and evaluation of health interventions with sound demographic and socio-economic data including those on burden of disease, inequality and gender disparity.
- Improve existing communicable disease surveillance system to support a more rapid response to tackle disease outbreaks. Surveillance of major non-communicable diseases will also be integrated with communicable disease surveillance.
- Formulation, implementation and periodic review of comprehensive behavior change communication strategy for stimulating informed demand for health services.
- Formulation of an improved planning and budget through pilot introduction of local level planning (decentralized at district and upazila level) supported with resource allocation.

9.30 **Human Resources for Health:** Human resource is a critical element in the effective delivery of health services. The comprehensive HR strategy under preparation by MOHFW would address the issues of shortages, mal distribution of personnel, skill-mix imbalance, negative work environment and weak knowledge base. Steps would be devised for improving the quality of existing workforce in both the formal and the informal sectors. Measures would also be taken for production of additional workforce (doctors, nurses, paramedics, technologists, etc.) in the public sector and the private sector, based on need assessment. Moreover, the following are some of the important areas of focus for health sector's human resources development (HRD).

- The public sector HRD strategy will, among other things, involves establishing career plans for specific lines of specialization, based on competence and experience, and clear principles for promotions, posting and transfers.
- Private sector participation in medical education has expanded over the past few years. Maintaining the quality of medical education has since become crucial. The MOHFW would reexamine the current accreditation arrangements for pre-service educational institutions of both public and non-public health professionals and consider the need for a uniform accreditation body to coordinate and regulate all types of medical education.
- Client's satisfaction is an important outcome of quality of care combined with the perception of provider's behavior. Awareness of the importance of this issue needs to be inculcated during pre-service education. To this end, steps would be taken to provide community exposure and patient-friendly orientation in medical education and training.
- The marked imbalance in the skill-mix of service providers need to be addressed on an urgent basis. Priority would be given to the recruitment and training of

additional nurses, technicians and SBAs to meet existing shortage and improving service delivery.

- Personnel management procedures will be reviewed and updated as required. The updates will include introduction of incentives for service providers working in remote and hard-to-reach areas and modifications of the transfer-posting practices for field level managers.
- Performance management (supervision and annual performance evaluations) of individual staff will be strengthened. This will include application of merit-based incentives as well as disciplinary measures in response to absenteeism or misuse of public-sector facilities for private practice.
- The large and critical role of the informal health care providers will have to be recognized and appropriate strategies developed with a view to managing and improving their practices to minimum levels of acceptable care. They will be given need based short training of different durations at both public and non-state facilities, particularly on appropriate drug use and prevention of drug resistance, routine curative care management and referral of complex cases to the appropriate public facility.
- Bangladesh needs to take more initiatives to accelerate the maternal mortality reduction. To this end, the untrained TBAs will be brought under the formal system for regulation and they will be given appropriate training of short duration on maternal care and safe delivery to ensure quality service.

9.31 Drug Issues: All drug related issues will be guided by the actions incorporated into the National Drug Policy (NDP). The NDP will be reviewed with the objective of ensuring easy access to essential drugs, promoting competition among the local pharmaceutical industries and supporting and strengthening the existing regulatory measures to ensure quality drugs. Moreover, increased attention will be given to “rational use of drugs” by educating both prescribers and users on appropriate prescription practices and use of appropriate drugs. For all these to be materialized, the Department of Drug Administration (DDA) will be strengthened and expanded.

9.32 Supply Management: The MOHFW has continuously been monitoring and reviewing the process of procurement for developing a need based, efficient and cost-effective system. The Procurement and Logistics Management Cell (PLMC), being processed for recruitment, is expected to take care of the weaknesses in procurement and supply of goods in the health sector. The new contracting-out system is already in place keeping provision for repair and maintenance for ten years by the supplier for certain electro-medical equipment. This system along with functioning of the NEMEW will be further reviewed for strengthening the repair and maintenance of electro-medical equipment for their proper functioning. The NHP will further emphasize on improvement in CMSD’s capacity, staff training, storage and distribution, computerized inventory control system (CICS) and logistics management information system (LMIS). The scope for further expansion of decentralized procurement will be explored to achieve greater flexibility and timeliness in procurement of supplies.

9.33 Strengthening Health Research: The health research will emphasize on priority areas of biomedical, public health, epidemiological, health systems and policy, social and behavioral, and operational research. National health research system will play a

stewardship role in identifying priority and engaging research institutions and researchers for generating reliable evidences. The national health research system will also play a vital role in advocating research findings for policy and programmatic adoption, as well as for raising citizen's awareness. The capacity of various research institutions and individuals will be strengthened to achieve the above stated goals. Bangladesh Medical Research Council (BMRC) will be strengthened after reviewing its mandate and structure for assuming strategic stewardship and governance roles for health related research.

9.34 Health Budget and Financing: The share of budgetary allocation to the HNP sectors needs an upward rise year by year. It is, therefore, imperative to adequately raise the share of HNP allocation to national budget in phases, and gradually raise it to 12 per cent by 2015 from the present level of around seven per cent. Public funding increases are dependent upon economic growth per se. However, irrespective of progress in per capita GDP, the health sector is a case for demanding higher allocations in every fiscal year. A significant part of the increased budget will be devoted to improving supply of drugs in public hospitals, especially for providing PHC services, with provision for strict monitoring of its utilization.

9.35 Health Sector's financing by the government alone is insufficient to ensure improved health care for all in Bangladesh. Expansion of private sector investment would help to bridge the gap in needed resources for extending and improving the services. The government will continue to provide incentives (e.g., land at a lower price, bank loan, tax exemption for import of electro-medical equipment, training to health professionals and workers, lump sum grant, etc.) to the private sector engaged in health care service provision.

9.36 Health sector's financing will be raised through the cost-sharing by well-to-do patients' when they are treated in public hospitals. Moreover, the government (through a set of guidelines) will encourage gradual promotion of health insurance at different levels.

9.37 There is substantial involvement of external funding in the health sector, e.g., project aid funds, global funds, social business funds, etc. The government would welcome increase in such funding in a harmonized way and well aligned with the national system.

10. Monitoring and Evaluation

10.01 A multiphase approach to monitoring the implementation of the NHP will be adopted. The principle of peer review will also be applied in cross-sectoral assessment of implementation of the policy. Output and performance based monitoring as appropriate will be used to evaluate results in the field to make sure that people's health and daily lives are really being improved with the money invested.

10.02 The NHP should be treated as a living document – updating periodically through review. Annually, MOHFW is to produce a status report about implementation of the NHP and make that report public for scrutiny, comments and suggestions. In every five years the policy needs to be reviewed, evaluated and updated.

11. Multi-Sectoral Collaboration

It is well recognized that health and overall well-being of citizens depend on the synergistic functioning of the various sectors of the socio-economy. Development of the

health sector requires direct involvement, interaction and collaboration with policies and programs of ministries, agencies and a variety of different role players. (A) Within the government, of a number of relevant ministries whose programs reinforce health outcomes are MOLGRDC, MOE, MOPME, MODMR, MOWCA, MOSW, MOA, MOFL, MOI, MOC, MOF, MOLJPA, etc. Besides, participation of various technical organizations/agencies both within and outside MOHFW is vital for the successful implementation of the NHP. (B) Private sector led health service providers and drug producers are also key actors in the implementation of the NHP. (C) Implementation of the NHP requires direct partnership and active participation of the mass media, academia, professional groups, non-governmental organizations (NGOs), community based organizations (CBOs), civil society organizations (CSOs), etc. The NHP will strengthen the existing linkages and institutional arrangements for collaboration and explore new channels of interaction to further the achievements of health sector goals.

Conclusion

Achievement of HNP results requires a well-organized and sustainable health system, capable of responding to the needs at the community and at the country level. An urgent effort is required to strengthen health systems to succeed in improving the health conditions of the people. This is contingent upon spending more (broadening and deepening the resource base); spending better (doing the right things in the right way); and spending on right groups (determining how costs and benefits are to be distributed). For all these to be materialized, **a strong political commitment is the key to successful implementation of the National Health Policy.**