Issue 1: Climate change impact on health

Climate change is already contributing to the global burden of disease, and this contribution is expected to grow in the future in Bangladesh. Temperature rise, erratic rainfall, cyclone and storm surge, salinity intrusion, flood and drought are already increasingly affecting the health of the people particularly in the coastal areas of Bangladesh. Bangladesh has started experiencing major public health impact of climate change due to its vulnerable geographical location. The main direct effect will be an increase in water and vector borne diseases, food insecurities, heat and cold related illnesses, and undernutrition. In coastal, char, hill tracts and other vulnerable areas, inadequate primary health care service is a major challenge for Bangladesh. The health sector currently does not have adequate funding, infrastructure, human resource capacity (e.g., shortage of technical staff), logistics and services required to fully address the impact of climate change on human health.

Programmatic gaps

Climate change impact on health

Climate change is expected to increase health hazards as it may facilitate water-borne and vector-borne diseases (such as malaria and dengue). Additional health risks emerge from exposure to contaminated water, especially arsenic poisoning. Due to rising humidity and mean temperature, respiratory diseases are on the rise. Climate change also brings about additional stresses like dehydration, malnutrition, and heat-related morbidity especially among children and the elderly.

Sea level rise may increase the risk of health hazards like cholera. With the increased density and distribution of salinity, cholera germs are getting favorable habitat and spreading in the coastal areas. Outbreaks of cholera often occur after flooding because the water supply becomes contaminated.

At present, dengue fever is the most dangerous epidemic in Bangladesh that has been termed ‘particularly alarming’ given the state of health care in Bangladesh. Climate change may be a vital reason for the prevalence of the dengue disease in Bangladesh. The warmer and humid conditions along with irregular rainfalls help the Aedes mosquitoes to breed.

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1 Ministry of Health and Family Welfare (MOHFW). 2019. Climate Change and Health in Bangladesh. Training Curriculum for Health Managers. Dhaka: Climate Change and Health Promotion Unit (CCHPU), Health Services Division, MOHFW, Government of Bangladesh.
Malaria has been in the epicenter of diseases linked to climate change. Out of 64 districts, 13 bordering districts in the east and northeast are considered as high-risk zone. Prevalence of malaria in 5 south-eastern districts is significantly higher than the 8 north-eastern districts. Chittagong Hill Tracts districts have the highest prevalence than the other endemic districts. Environmental factors like airborne allergens and air pollution have an impact on respiratory diseases. In Bangladesh, 61 percent of an estimated 17,100 child deaths due to acute lower respiratory infections is attributable to household air pollution.

Saline contamination is expected to be aggravated by climate change and sea-level rise. Increasing salinity levels lead to increased incidences of hypertension, pre-eclampsia, and eclampsia among pregnant women in the coastal areas.

Absence of integrated surveillance

The Bangladesh government prepared a Climate Change Strategy and Action Plan in 2008, highlighting the need to implement surveillance systems for existing and new disease risks and to ensure that health systems are prepared to meet future demands. In Bangladesh, the Institute of Epidemiology, Disease Control and Research (IEDCR) mainly conducts disease surveillance and outbreak investigation. IEDCR lacks capacity and resources to conduct integrated surveillance. A data system for infectious diseases linked to climate variability is absent.

Environmental health: Medical waste management

Health facilities produce a bulk of medical waste, which involves a potential risk of injury, infection, and environmental damage. Bangladesh Medical Waste Management and Processing Rules 2008 recommends keeping of wastes separate from other general waste during the collection, wrapping, storing, and transportation. The guideline prescribes different disposal methods for different segregated waste.

There is limited evidence of appropriate compliance with the medical waste management guideline in the health facilities in Bangladesh. Most hospitals dispose their wastes by mixing them with general wastes without sterilizing the same. The regulations devise to establish specialized dumping zones in seven divisional areas. Only Dhaka has the only specialized dumping ground for the disposal of medical wastes; that too is very insufficient to meet the demands of increasing number of hospitals in Dhaka. Unfortunately, neither the divisional authority has been formed nor has anyone looked after the management and disposal of medical wastes.
Recommended Actions

1. Integrated Surveillance:

Integrated surveillance involves the integration of multiple surveillance systems (e.g., disease surveillance and weather surveillance) to improve the use of information for detecting, investigating and responding to public health threats.\(^{14}\) The 8\(^{th}\) FYP clearly outlined the need to strengthen IEDCR as an apex institute for developing an integrated disease surveillance program to early detect and predict epidemics (early warning systems), assess interventions during epidemics, and monitor intervention programs efficiently. The 5\(^{th}\) sector plan needs to echo the same for an expanded role of IEDCR on integrated data surveillance.

2. Decentralized disease surveillance and diagnosis:

National and sub-national health facilities should be well-equipped to test and report climate-sensitive diseases. The 8\(^{th}\) FYP recommended establishing a country-based referral laboratory network by utilizing the existing functional labs in the identified medical colleges and other major centers in the country and linking them with adjoining districts and Upazilas for providing diagnostic services for epidemic-prone diseases during outbreaks. The capacity of all hospitals will be strengthened to assist in disease surveillance and diagnosis.\(^{15}\) The decentralized disease surveillance and diagnosis approach should be included in the 5\(^{th}\) sector plan.

3. Health Workforce:

- Integration of climate risks and management measures into pre-service training is needed so that future healthcare providers are appropriately trained to respond to climate-sensitive diseases.
- In-service training can be provided to managers and service providers on (i) climate change and associated impact (health aspects of climate change) and (ii) procedures to recognize and manage emerging health threats associated with climate change.

4. Institutional capacity:

- The government needs to formulate a “national climate and health strategy”.
- Health and nutrition services in coastal, char, and flood-prone areas need to be reconfigured and strengthened. The 5\(^{th}\) plan also needs to focus on an Area-based Action Plan for climate-vulnerable areas.
- Local-level response plans should be developed and executed in case of new disease outbreaks.
- Public health programs/services should be reviewed, updated, and strengthened to consider short-term influences (i.e., seasonal trends) and long-term climate change (10+year climate projections) in their operations.\(^{16}\)


\(^{15}\) 8\(^{th}\) Five Year Plan 2020-2025.

\(^{16}\) [https://www.who.int/docs/default-source/technical-briefing---health-resilience-to-climate-change.pdf?sfvrsn=b0772759_1&download=true](https://www.who.int/docs/default-source/technical-briefing---health-resilience-to-climate-change.pdf?sfvrsn=b0772759_1&download=true)
5. Health and climate research:

- Research on climate change and health should be promoted at the national level by (a) developing the capacity of researchers and health care professionals, (b) introducing curriculum into public health teaching programs, and (c) making available financial resources.
- It is necessary to establish a stakeholder forum with representatives from the MOHFW, research institutions, NGOs, and the private sector, which will define the national research agenda/priorities on climate change and health.

6. Environmental health: Medical waste management:

- Urgent action is needed to form divisional authorities and establish specialized disposal zones.
- Coordination and collaboration between DGHS, the Department of Environment, city corporations, and municipal authorities is needed for a healthy medical waste disposal system.
- City corporations and municipal authorities need to establish separate infrastructure/dumping zones.
- Hospitals and clinics should ensure the necessary infrastructure and train their staff for safe storage and handling of medical waste.
Recommendations of Bangladesh Health Watch on Fifth Sector Plan Preparation

Issue 5: Health Governance

In Bangladesh, the government health system provides free access to primary health care. The government has a comprehensive infrastructure for delivering primary (in rural areas), secondary and tertiary health care. The full potential of this network of infrastructure is yet to be utilized due to weak health administration and management and lack of client-centered services. People often complain about the quality of health services from government facilities. There continue the problems of irregularities, lack of accountability, and abuse of resources and institutional capacity, largely due to poor governance in the health sector. Private sector services cannot be credited for good governance either. They are unreasonably expensive and largely unregulated. The rights of employees are not fully respected in the private sector.

Governance Issues

Centralized administration

The MOHFW operates through a largely centralized system. Overall, very few decisions are made at the facility level or even at the district level, in terms of planning, procuring, budget and budget execution, staff recruitment and transfers, etc.¹ The overly centralized planning processes inherent to GOB systems thwart priority institutional and policy reform initiatives related to decentralization, autonomy, and local level planning in the MOHFW.²

In the health sector, decentralization has occurred in terms of de-concentration of powers, yet there is no effective devolution of the authority. Some power has been delegated to the level of senior program managers at the national level, but not to the lower tiers of administration such as district and sub-district levels.³ District Hospitals and Upazila Health Complexes simply carry out the plans and programs decided at the national level which often do not reflect the local realities. This results in significant health system inefficiencies and wastage of resources. The centralized structure of the public health system tends to trap voice at the local level, which discourages citizen participation and leaves senior managers disconnected from public attitudes, choices and experiences of health care.⁴

Regulatory role

The Bangladesh Medical and Dental Council (BMDC) is largely non-functional except for its registration function. It has failed to promote and protect patient’s rights for which it was primarily created. It neither has the capacity with current senior MOHFW officials sitting on the committee. BMDC cannot initiate independent investigation against the doctors working in government hospitals. The rest of the regulatory bodies, Bangladesh Nursing Council, State Medical Faculty, Bangladesh Pharmacy Council and Bangladesh Board of Unani and Ayurvedic Systems of Medicine demonstrate similar features in terms of poor functionality, capacity and accountability, and inadequate independence from the government. Ultimately, their poor governance compromises realization of the rights of people. It is worth noting that stewardship and regulatory role is constrained by weak legal framework and institutional inadequacies of regulatory bodies under the MOHFW.

Drug governance

A system of “reward” for physicians from the pharmaceutical companies for prescribing their drugs is in existence (as seen globally). However, some of the adopted marketing techniques do not comply with ethical norms. Medical representatives take away valuable time of the doctors in public places where mostly poor patients go to receive services. There are reports of inappropriate prescribing of drugs and lack of adherence to the list of essential drugs, which is considered as the result of weak supervisory capacity of the regulatory mechanism and aggressive push from the pharmaceutical companies. Such irrational prescribing results in growing anti-microbial resistance (AMR) in the country. The presence of a ‘pluralistic’ health system involving unqualified providers in the informal sector complicates the situation. The regulatory regime in Bangladesh is weak concerning human, technical and logistic capacity to oversee the pharmaceutical vast market. There are major gaps in surveillance, and antimicrobial resistance data were not available for most parts of the country.

The operations of the Directorate General of Drug Administration (DGDA) are seriously handicapped. There are only two laboratories which cannot meet the demand of the sector that has grown exponentially over time. Product literature which is being used to update medical professionals is alleged to contain biased information for pharmaceutical promotion. The DGDA cannot screen them properly due to inadequate human resources. The problem is not only acute at the headquarter but DGDA human resources at the district level and below are very limited.

Voice and accountability

Since the mid-1990s, MOHFW has initiated a number of mechanisms to promote voice and ensure accountability, which include Citizens’ Charter of Rights (CCR) and the formation of committees at district, Upazila and union levels. Until now, CCR is limited to merely the display of information.

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4 Op cit. Ahsan et al. 2015.
7 Op cit. BHW 2010.
10 Op cit. BHW 2010.
Furthermore, service providers are not oriented on CCR and its implementation. Though ineffective, there are a number of initiatives from GOB to establish national-level institutions, including a National Stakeholder Committee formed in 1999 under HPSP but which convened only a few times; and a National Health Service Users’ Forum proposed under HNPSP but never implemented.

Upazila Hospital Management Committees are supposed to act as oversight bodies, but these committees are mostly inactive. The lack of power and authority for organizing meetings, demanding accountability and making decisions is the key challenge. In addition, these committees lack a specific plan of action and require financial resources for carrying out monitoring activities. These committees are too large to be effective. However, as the committee is constituted by office order of MOHFW, there is ample opportunity to utilize the services of human resources in health, infrastructure, medicine, and health equipment locally for the welfare of the local people.

Community Groups (CGs) are formed for the management and supervision of CCs, but few are working effectively. Meetings are not held regularly and routinely. CGs had too little power and capacity. CGs had not been effective in monitoring service delivery and quality. The lack of knowledge of their membership, roles, and powers suggests limited engagement from the communities.

Union Family Planning Committee is not effectively functioning except in cases where the UP Chairman is interested. Committee members are not trained or oriented on the programmatic issues, and as such knowledge gaps inhibit their full contribution.

Overall, there is little analysis of voice and accountability initiatives in the health sector at the national level, whether regarding consultations on plans and budgets, or media and civil society. The lack of decentralization in the health sector is reflected in the inconsistent GOB efforts to implement voice and accountability initiatives.

There are examples of successful donor-supported projects that showed how people can participate in running health facilities and contribute to improving the services. Findings from an operations research project indicate that Union Family Planning Committee can be reactivated for effective community monitoring and resource mobilization. A key success lies in the regular participation of local government representatives at the monthly meetings of the reactivated committee. Another encouraging aspect is the introduction of the community fund through which local people, primarily committee members and bazaar committees, contributed to improve the physical infrastructure of HFWCs.

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15 Op cit. MOHFW 2012.
17 Op cit. MOHFW 2012.
Focusing on the public sector alone, overlooking the private sector, will not ensure accountability of the health sector. Private sector services still seem to be unregulated and are non-responsive to equity. There is no suitable authority to supervise the contractual issues and work environments for health workers in the private sector. NGO workers, and private clinic associate workers have no mechanism to express and resolve grievances.

### Recommended Actions

1. **Greater autonomy of health administration and management:**
   - Power and activities can be decentralized to the lower tiers of administration such as district and sub-district level. Decentralized governance would be useful for local level planning and budgeting, decision making, monitoring and supervision of local health system, and making local providers accountable to citizens. The 5th sector plan needs to reflect on boarding a health system reform initiative to devolve health administration and management.
   - It is necessary to ensure accountability at all levels by empowering Civil Surgeons and DDFPs and their managers in upazilas to execute programs and budgets (programs need to be closely coordinated).

2. **Strengthening regulatory bodies:**
   - BMDC and other government regulatory institutions should be restructured and strengthened with sufficient authority and resources so that they have mechanisms to a) monitor for compliance, b) enforce compliance issues independently, and c) issue remediation plans/revoke licensing.
   - Patient complaint box in HMIS of DGHS can be linked to BMDC, BNMC, and Pharmacy Council of Bangladesh for taking appropriate actions.
   - Policies should be revisited to promote providers’ rights in terms of capacity and motivation or incentives. A clear framework on how provider complaints or grievances can be fed to the central level is necessary.

3. **Promoting good governance in the private sector:**
   - The private hospital ordinance should be revisited and updated.
   - Capacity and resources of government regulatory bodies need to be enhanced to bring the private facilities under a structured accountability framework.
   - Strengthen the capacity of Hospital Services Management, DGHS to discharge effective oversight to licensing to private clinics and hospitals.
   - To ensure employees’ rights, MOHFW should think about setting up a grievances redress mechanism to support the health workers in the private sector.

4. **Promoting drug governance:**
   - Essential drugs for common illnesses as listed in the national essential drug list should be made available at PHC level facilities, especially the public sector facilities throughout the country. DGHS should ensure the supply and monitor this regularly through their official chain.

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To monitor and controlling the use of antibiotics requires standardization of surveillance methodology and continuous nationwide surveillance.

5. Voice and accountability for promoting patients’ rights:

- Terms of Reference of health management committees should be revised in order to make the committees function and report effectively. The committees should be given sufficient authority and resources for monitoring health facilities so that service providers become more accountable to those committees. In addition, a platform to keep a track on how the committees are functioning can be developed.
Recommendations of Bangladesh Health Watch on Fifth Sector Plan Preparation

Issue 4: Health workforce

The performance of a health system is immensely dependent upon how its workforce is planned, developed, and utilized. Bangladesh is suffering from a chronic health workforce crisis in terms of a shortage of qualified providers (when measured against the WHO estimate for achieving MDG and SDG targets), inappropriate skill mix, and inequity in distribution. The role of the health workforce in achieving SDG health indicators demands focused investment and policy for its development. The 8th Five Year Plan stated that the MOHFW would focus on improving the quality of public and private pre-service health workforce education system to produce a need-based health workforce for the country.

Programmatic Gaps

Production

The quality of education in teaching institutions both in the public and private sectors is mostly challenged by a shortage of qualified teachers. There is an inherent lack of focus on acquiring the required clinical competencies appropriate for each category of health worker. Improved quality of medical education across all health professionals’ institutions and modernisation and transformation of the medical education system to fulfill the aspirations of the SDG and achieve universal health coverage is now major priority. Quality, standardisation, and accreditation issues remain as major challenges. Building capacity and skills within the workforce is an area requiring considerable attention.¹

Density

In Bangladesh, the health workforce (doctors, nurses, and dentists) density was 7.7 per 10,000 population a decade ago, falling far short of the estimate projected by WHO (23 per 10,000 population) needed for achieving MDG targets.² The density has now increased to 9.9 per 10,000 population. Health worker density needs to be raised to 45 per 10,000 by the year 2030.³ In Bangladesh, the majority of health professionals serve in urban areas while the rural areas (comprising 2/3 of total population) are served by less than 40 percent of the skilled providers.

Inappropriate skill-mix

The ratio of nurses to physicians is only 0.4, far short of the international standard of the nurse-doctor ratio of 3.0. Interestingly, the equal nurse-doctor ratio in Khulna and the very low nurse-doctor ratio in Sylhet are associated with better health indicators in Khulna and poor health indicators in Sylhet. A similar imbalance persists for the doctor-technologist ratio as well.⁴ The doctor-to-nurses and midwives-to-technician ratio are currently 1:0.7:0.7, but ideally, the ratio should be 1:3:5.

Inequitable distribution

In terms of health workforce supply, Bangladesh currently presents an estimated total density of 49 health workers per 10,000 population, including 33 recognized workers and 16 unrecognized workers. These numbers are unequally distributed geographically, with an average of 74 recognized health workers in urban areas and only 12 in rural areas.\(^5\) Also, these providers are inequitably concentrated in Dhaka and Chattogram regions.\(^6\) The gaps elsewhere are filled by a combination of unregulated providers, pharmacies, paramedics, and community health workers. This raises an important question about the deployment of qualified personnel, their work condition, training for the future health workforce, and the role of government and private sectors.\(^7\)

There is a high proportion of unfilled sanctioned positions in the public sector, which indicates an important undersupply of doctors, paramedics, dentists, medical technologists, and midwives.\(^8\) The Health Labor Market Analysis 2021 report suggests the adoption of measures to reduce vacancy rates in the public sector from about 32 percent on average to below 15 percent.

Quality of life issues and high turnover rates may contribute to the vacancies found in remote and rural areas. Doctors and nurses resist posting in remote areas, due to challenging living and working conditions. Also, turnover rates are elevated for higher-level local officials, who are often posted for less than a year, which means that doctors remain in remote area posts for less time.\(^9\)

Imbalance in specialist physicians

The posts for medical officers and specialist physicians in the government health system in Bangladesh are not adequate. The demand and supply of specialist medical doctors are not addressed or evaluated properly. Imbalance exists due to doctors’ interests in certain specialties and inertia in others. As such, the production of specialist physicians is high in certain disciplines and low in others. This hampers the need-based service delivery systems and career pathways of physicians.\(^10\)

Quality of service

There are few mechanisms to monitor and regulate the quality in both public and private sectors. The connection between medical training and quality of care deserves attention for the 5th sector plan, as does the quality of the education provided by the blossoming medical education sector. While doctors often perform poorly according to measures of the quality of care, the precise connection between education and performance has not been established. Also, the effectiveness of medical training institutions to create a capable workforce has not yet been established.\(^11\)

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11 Op cit. Rose, Lane, and a Rahman. 2014.
There are several disincentives for healthcare providers to perform at their best potential. Low salary, lack of reward, inadequate clinical facilities, physical and social insecurity, lack of supportive supervision, and limited opportunities for higher and continuing education are notable disincentives.\(^\text{12}\)

The Workload Indicator of Staffing Need (WISN) study indicates that the public sector healthcare providers in Bangladesh, in general, are suffering from extremely high workload pressure. Despite the overall high workload, some staff categories in some health facilities enjoyed a low workload. Among the highest number of health workforce required, the most frequent category is the nurses both in the different departments of medical colleges and in Upazila Health Complexes.\(^\text{13}\)

**Health workforce information system**

There is a lack of comprehensive data on human resources for health in the formal and informal sectors.\(^\text{14}\) The absence of a robust health workforce information system is further worsened by a lack of health systems research for evidence-based planning and management of the health workforce. The government lacks the capacity and resources to monitor the health workforce data of the private sector.\(^\text{15}\) The existing system for private sector monitoring is outdated and non-functional.

Bangladesh Health Workforce Strategy 2015 calls for determining service level-wise health workforce needs and for the projection of demands up to 2030. While public sector health workforce data is collected quite regularly and available in public domains, there is very little evidence or data for the private sector health workforce.\(^\text{16}\) Although data from the public sector is available and reliable, this covers only an estimated one-fifth of the health labor market. There is a clear need to ensure the reliable and timely collection of data on all health workers in the private sector.\(^\text{17}\)

**Recommended Actions**

**Addressing shortage and skill-mix issues**

- The production of different categories of health workforce should be based on the need to balance an appropriate skill mix in delivering healthcare services at all levels. The production of the health workforce should be aligned in line with projected requirements in view of Vision 2030 and 2041.

- In line with global medical standards and regulations, it is important that the government upgrade both pre-and in-service training and curriculum for different types of health workers in the public and private sectors.

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\(^{12}\) Op cit. BHW 2008.

\(^{13}\) Ministry of Health and Family Welfare (MOHFW) and World Health Organization (WHO). 2021. “Application of the workload indicator of staffing need (WISN) in Barisal and Mymensingh districts in Bangladesh.” Dhaka: Human Resource Branch, Health Services Division, MOHFW, Government of Bangladesh and WHO


\(^{16}\) Ministry of Health and Family Welfare (MOHFW) and World Health Organization (WHO). 2021. “Assessment of healthcare providers in Bangladesh.” Dhaka: Human Resources Branch, Health Services Division, MOHFW and WHO.

A new organogram for staffing PHC facilities considering universal health coverage, NCDs, and climate change impact on health is needed.

To reduce the high workload of government healthcare providers, more healthcare providers should be produced and recruited. The vacant positions should be filled out. Those remaining out-of-duty stations must be made available through better staff supervision.

A long-term policy response is needed to increase the intake of nurses and medical technologists in the health system.

Bangladesh needs to optimize its existing health workforce, reallocating staff from low to high-workload health facilities. In order to facilitate such management approaches, there should be a gradual policy shift towards flexible recruitment and health workforce planning, in line with the local patient load and disease burden. The 5th plan can highlight the need for mainstreaming WISN study into DGHS MIS, which can aid the health decision-makers in identifying the burdened staff categories, pinpointing which services are leading to the workload, and eventually bringing in support from lower workload departments or health facilities.\(^{18}\)

Addressing the quality of services:

- Existing service standards at the secondary and PHC level requires updating.
- Existing Quality Assurance guidelines need to be reviewed and updated. In addition, the accountability framework needs to be updated by redesigning the roles and responsibilities of the ministry, directorates, and other government bodies.
- Continuing medical education can be mainstreamed to improve the technical quality of care in the formal sector.

Data for health workforce projection and career planning:

- It is necessary to conduct a health workforce assessment in every four to five years, taking both government and non-government (private and informal) health workers, and updating health workforce strategies and action plans accordingly.
- A reliable and accurate database for the private health workforce in the country is essential. The health workforce situation of the private and informal sectors needs to be explored and systematically recorded.

Innovative approach to address retention issues:

- A provision of incentives (cash or kind) to doctors and other public-sector providers can be introduced. Performance-based financing schemes can be introduced for the deployment and retention of service providers in remote, hard-to-reach, and climate-sensitive areas.

Recommendations of Bangladesh Health Watch on Fifth Sector Plan Preparation

Issue 2: Non-Communicable Diseases

Bangladesh is facing an epidemiological transition in disease burden. Like many countries in the world, the burden of non-communicable diseases (NCDs) in Bangladesh is an emerging public health challenge. Bangladesh is also at a ‘crossroads’ as it is currently undergoing a demographic transition towards a relatively aging population (population ≥ 60 years projected to be 19% by 2050). Currently, in Bangladesh, communicable diseases are not yet fully controlled, but there is a simultaneous rise in NCDs, accounting for 67 percent of total deaths. Despite its growing significance, the health system is primarily geared toward addressing communicable diseases and maternal, neonatal and child health. Combined with the yet-to-be-controlled communicable diseases, the Bangladeshi population now face the ‘double burden’ of diseases. This has thrown up a challenge to the existing yet unprepared health system of the country which is characterized as weak in terms of inadequate physical and human infrastructure and logistics, and low performance.

Programmatic issues and gaps

Weaknesses in health systems

- The health workforce engaged in delivering primary health care (PHC) services currently lack skills in NCD prevention and management. An updated list of essential medicines that take into account NCD conditions is yet to materialize. Besides, the provision of requisite instruments at the PHC level facilities is needed for assessing the prospective candidates for possible NCDs.

- Primary prevention of NCD risk factors is crucial. Although the current health sector plan includes prevention and care of NCDs at all levels to be a high public health priority, there has been little focus on prevention over the conventional program targeting maternal, neonatal, and child health for achieving global targets. The OP of the 4th sector program identified the low priority of the government in adopting a comprehensive prevention strategy as a weak point in the NCD strategic plan.

- The OP of the 4th sector program emphasized introducing a tier-specific health system essential package for NCD. Specific packages are needed to define the roles and responsibilities of the tiers from tertiary to primary care down to community clinics. Overall, there is no notable progress. The community-based screening program is not yet introduced for NCD control.

There is no structured referral system in Bangladesh, from ‘where’ the patients will go to ‘where’ and the system is yet to develop a formal inter-facility referral system. The patients are at liberty to seek care from any healthcare professional and in any facility of his/her choice. Most of the time ‘social referral’ happens.\(^7\)

Weak surveillance system for NCDs and their risk factors is another gap in the NCD control program. A comprehensive, inclusive, and integrated NCD risk factors and disease burden database is necessary for informed decision-making, designing innovative interventions, and monitoring and evaluation of ongoing programs, all in a cost-effective way.\(^8\) Routine hospital-based surveillance is incomplete and inaccurate. The inclusion of major NCDs is relatively new. The capacity of the systems is still weak. HMIS needs to assimilate data from all sources.\(^9\)

**Elderly and palliative care**

Life expectancy is gradually increasing and is now 73 years and as a result, the proportion of elderly people has also increased. The 8th FYP stressed the need for reorienting the existing institutional arrangements for health service delivery and to increase investment – both financial and human resources – in developing an appropriate elderly and palliative health care service system.\(^10\)

**Mental and autism healthcare:**

In Bangladesh, 17 percent of the adult population and 14 percent of children are suffering from mental disorders. The 4th sector program so far witnessed several achievements in policy formulation. Mental Health Policy 2019 and National Mental Health Strategy Action Plan 2020-2030 have been developed. Besides these, the National Strategic Plan for Neurodevelopmental Disorders 2016-2021 has been developed, and it is being implemented by different ministries.\(^11\) The 5th sector plan should utilize the opportunities to translate those policies into action.

Widespread social stigma limited human resource capacity and lack of formal initiative to address mental health problems still remain as notable obstacles.\(^12\) The 8th FYP noted that mental health problems are increasing amid changing lifestyles. COVID-19 has aggravated the situation.\(^13\)

**Recommended Actions**

In order to achieve universal health coverage, Bangladesh needs to integrate NCD prevention, curative and rehabilitative services at different tiers of the health systems and introduce the provision of NCD services at the PHC level, which will take some pressure off the over-crowded secondary and tertiary

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level facilities. In addition, the cost of diagnosis of the NCDs for the poor/disadvantaged populations should be subsidized.

- **Provision of palliative care in tertiary hospitals:** The 8th FYP emphasized establishing palliative care units in all medical college hospitals and introducing modern medicines and advanced equipment to all medical colleges. It is considered an important element of the government’s strategy to achieve the SDG goal of UHC by 2030.

- **Strengthen district health service for NCDs:** In view of the growing share of an aging population, emphasis will be given to developing the capacity of District Hospitals (DHs) to handle geriatric patient care. In addition, it is necessary to integrate ESP services at the DHs, with requisite physical and human capacity. At the same time, a referral linkage with lower-level facilities and a provision of preferential treatment of referred patients is needed.

- **Mainstreaming NCD service provision at the PHC level:** As NCDs are on the rise in Bangladesh, it is imperative that the government focus more efforts on strengthening PHC facilities to provide population-based cost-effective services in prevention, screening, and referral at a higher level, and follow-up of chronic cases. Lessons from Upazila NCD Project can be adopted for nationwide implementation. In addition, NCD prevention services (diabetes and hypertension) at Community Clinics with referrals to UHCs can be developed.

- **Emphasizing prevention over treatment:** Most programs and interventions around NCDs focus on curative management rather than prevention, especially at the secondary and tertiary level health hospitals. Given the risk factors associated with NCDs (i.e., lifestyle changes, smoking, rise in obesity, urbanization, climate change, etc.), it is important that primary-level health facilities be appropriately equipped, both with a trained health workforce and necessary equipment for screening and referral.

- **Establish a comprehensive surveillance system and a registry for the four major NCDs:** At the national level. Designing and implementing a sustainable model of surveillance for NCDs is the call of the day. The currently existing fragmented and disconnected databases in specific NCDs, DHIS 2 and other small-scale datasets in the non-state sectors need to be consolidated and brought under a common platform.

- **The 8th FYP emphasizes establishing autism corners and child development centers in medical colleges and Upazila and district-level hospitals for autism health care development.** The Child Development Center (Shishu Bikash Kendra) model introduced earlier in medical college hospitals can be utilized, as appropriate. The 8th FYP also recommended the provision of genetic testing facilities for autism in every medical college hospital. The 4th HPNSP proposed implementation of the policy on the integration of mental health into primary health care, with a new provision of ‘psychosocial first aid’ (screening, identification and

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14In 2007, the MOHFW introduced this project in three upazilas and later on expanded to 137 upazilas by 2011-12. The project trained healthcare providers on NCDs and their detection and management at PHC level, established dedicated NCD corners with one doctor and two nurses, equipped with necessary equipment, ensured the availability of common anti-hypertensive and anti-diabetes medicines, and developed referral linkage for advanced management of the NCD illnesses. The focus of this project is mainly on diabetes and hypertension.


counseling of priority mental health conditions). If not started yet, this model is worthy of being executed.

- **Mental health management approach:** The NCD OP of 4th sector program outlined a mental health management approach. The approach is well crafted, but the status of implementation is yet to be noted. The entire district health system needs to develop human and physical capacity to integrate this approach.

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19 Identification of the signs of the most common priority mental health conditions (autism and neurodevelopmental disorders, epilepsy, and common mental health disorders including depression, psychosis, anxiety and substance abuse) and their referral to UHC and DH is essential for management. Community and union-level facilities will also participate in the support to the rehabilitation of mental health patients, including the fight against stigma. The DH is the main facility for organizing these services, and will host the Community Mental Health Team, in charge of providing specialized support to UHC and others in the territory.
Universal health coverage (UHC) means every person has access to quality health services when and where they need them without risking financial hardship. Health service coverage and quality, financing, and governance are the three key components that create an enabling environment for universal health coverage. WHO suggests that two dimensions of coverage should be secured:

- A comprehensive set of quality services according to need ranging from public health prevention to community-based primary care to facility-based tertiary treatment and rehabilitation
- Financial protection in accessing care that avoids individuals being inhibited from accessing care due to cost as well as ensuring that individuals are not economically compromised in paying for care

Bangladesh continues to reach less than half of the population with essential health services, among the lowest in the South-East Asia region. Bangladesh scored 49 out of 100 on the UHC service coverage index. Low UHC service coverage raises questions on set of considerations related to systems capacities for delivery of quality health services. Critical inputs to universal coverage are production, distribution and retention of health workforce, medicines, infrastructure, information technology, and governance.

With regard to financial protection, Bangladesh still has a long way to go towards achieving UHC. Bangladesh has the highest catastrophic health expenditure rates in South Asia, with 25 percent of the population is affected by catastrophic health expenditure and over 5 million people are impoverished by healthcare costs each year. Health shock is the most common shock to Bangladeshi population, accounting for 22 percent of all economic shocks.

**Programmatic gaps**

**Service coverage:**

There are shortfalls in coverage in the current context. The first is the limited coverage of priority interventions such as skilled attendance at birth, or screening for modifiable risk factors of chronic disease such as high blood pressure, smoking or glucose intolerance. The second relates to inequities in the patterns of coverage: those with more resources and fewer health needs are much more likely to access care than the poorer and needier segments of the population. Moreover, inequities persist across

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4 Ibid.
6 Ibid.
different geographical locations and socio-economic groups. Access to maternal health services reveals inequities across different socioeconomic groups. This gap in access to maternal health services is reflected in a high maternal death rate (173 per 100,000 live births).

**Government underfunding:**

The country’s health system is chronically underfunded. Bangladesh government has comparatively low spending on health care at 0.7 percent of GDP. This must be increased to at least 2 percent of GDP to reach the target established in the government’s 8th Five-Year Plan. The Perspective Plan 2041 outlines the objective to increase government healthcare spending from 0.7 percent of GDP to at least 1.5 percent of GDP by FY2031 and 2 percent of GDP by FY2041.

**Dominance of out-of-pocket expenditure:**

Out of pocket (OOP) payments are one of the most inequitable sources of healthcare financing. Only 23 percent of the total health expenditure comes from the government. Total per capita expenditure on health is only $37, which falls far short of the $86 per capita that Chatham House recommends spending on primary healthcare. This figure includes government, donor, and household contributions (OOP payments). OOP contributions to health expenditure in Bangladesh are among the highest in the world with 67 percent of health expenditure coming from households, more than triple the recommended maximum 20 percent that OOP should contribute to health expenditure. Further breakdown of OOP shows that medicine and medical goods accounts for 65 percent of OOP expenditure. A negative consequence of the large share of OOP purchases is the burden it places on the population in the lowest quintile who has the least ability to pay for health care.

**Government health expenditure on hospitals:**

There has been a decrease in the proportion of government expenditure going to upazila- and lower-level facilities, from 60 percent in 1997 to 45 percent in 2012, which is a cause for concern, as it reduces the access of rural populations to these first-level hospital facilities. Since 2000, the share of government budget for PHC level facilities at upazila level and below remains at the lowest level. Primary healthcare accounted for one-fourth of the total health budget. Secondary healthcare received the highest share (39%), whereas tertiary healthcare’s share is 36 percent. As the largest share of service recipients seek primary healthcare, there is need to reconsider and increase the allocation for primary healthcare. Investing more at PHC level is expected to reduce over-burdening of secondary and tertiary levels.

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Inequity in health financing and utilization:

The government budget provided to public hospitals is allocated on the basis of number of beds and staff employed, irrespective of the need of the catchment population and service utilization. Lack of attention to the population size and other demographic and epidemiological measures reflecting health needs gives rise to serious inequities in resource distribution. The inefficiency of the system for allocating resources from national to local level is perhaps one of the major obstacles to universal access to quality care.

The government budget provided to public hospitals is not linked to performance or results achieved. The proportion of allocation for repair and maintenance in revenue budget declined over time. Weak capacity in budget planning as well as poor procurement planning result in underspending of resources. In general, delay in disbursement of fund, the complex procurement process, and delay in settlement of claims (bills) in the CAO (Health) office and at District and Upazila account offices result in low utilization of resources.

In Bangladesh curative services and preventive care by government service providers are provided for free or at a nominal price to clients. On the other hand, expenditure on medicine and ancillary services (laboratory and imaging) is generally high, which is often obtained from private sources. The overreliance on largely unregulated private providers for laboratory and imaging has led to a high burden of financial stress for low-income populations.

Government subsidies to hospitals are not optimally utilized by the low-income section of the population. In most cases, subsidies to hospital care (indoor curative care) are pro-rich while non-hospital care (outdoor services) is pro-poor. The richest quintile receives more than 30 percent of the total subsidy.

The divisional breakdown of total health expenditure shows that Dhaka accounts for highest (46%) while Sylhet and Barisal are jointly lowest (4%). Dhaka enjoys highest amount of contribution from both public (36%) and private (49%).

Inadequate social protection of health:

Health Care Financing Strategy 2012–2032 aims at bringing all the citizens under the financial protection for healthcare by 2032. The Health Economics Unit of MOHFW is testing a social health insurance scheme, known as Shasthyo Surokhsha Karmasuchi (SSK). The scheme covers approximately 400,000 people living in around 100,000 households considered to be poorest (below poverty line) in three upazilas of Tangail district. The SSK is a non-contributory health insurance scheme for the below poverty line population to provide comprehensive inpatient care. Medical costs up to USD 570 per household per year are covered. To ensure that hospitalized SSK cardholders get

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17 https://m4health.pro/ssk-shasthyo-surokhsha-karmasuchi-social-health-protection-scheme-bangladesh/
the medicines they need, the three pilot Upazila Health Complexes have contracted a local private pharmacy to set up a special pharmacy for SSK patients within the hospitals. If successful, the benefit package is planned to be extended to include private health providers.\textsuperscript{18}

Community financing mechanisms and risk-pooling systems are nearly non-existent except in small pockets of NGO innovation, which have a health insurance component within their package of microcredit programs.\textsuperscript{19} Private health insurance coverage is minimal in Bangladesh. Private pre-paid health insurance premiums account for an insignificant share (<1\%) of total health expenditure.\textsuperscript{20}

Private pre-payment scheme is not feasible for rural populations and low-income urban populations.

**Recommended Actions**

- **Improve systems capacities for delivery of quality health services:** Increase allocations to health to address critical shortages of skilled health workers, medical equipment and supplies from current public health expenditure of 0.7 percent of GDP to 2 percent as per the 8\textsuperscript{th} Five Year Plan.

- **Increase government expenditure on primary healthcare as a priority for achieving UHC:** Public financing is the most reliable source of health financing. Bangladesh should increase government expenditure on primary healthcare to the levels recommended by national costings for the essential service package. The government needs to increase allocation to the health facilities at the upazila level and below and to introduce demand-based allocation of resources for upazila-level facilities to address regional inequalities and population needs.

- **Introduce health insurance schemes to mobilize resources:** The government plans to halve out-of-pocket expenditures for health from the current level of 67 percent to 32 percent by 2032.\textsuperscript{21} Most-high income countries rely heavily on either general taxation and/or mandated social health insurance contributions, whereas Bangladesh, like many low-income countries, depends far more on out-of-pocket financing. In Bangladesh, other funding sources must grow faster than out-of-pocket payments. Bangladesh is committed to achieving universal health coverage by 2032 and the government recommendations for creating a national health insurance scheme as mentioned in Health Care Financing Strategy 2012–2032 and financial protection should be reflected in the 5\textsuperscript{th} sector program.

- **Financial protection for households:** The concept of health insurance is still in a nascent stage in Bangladesh and prepayment for health will not be a popular idea. The poor and disadvantaged should be exempted from user fees and policy directives to provide free basic healthcare should be complied with. In addition, piloted health insurance interventions to reduce out-of-pocket payments should be expanded. A provision of a ‘Free Drugs for All’ can reduce the OOP payments by over 50 percent (as this constitute 67\% of OOPs).

- **Stronger central planning:** A professionally sound and well-trained planning unit at MOHFW is needed, which can envision the future needs and the strategies and resources required to meet those needs for Vision 2041. The 5\textsuperscript{th} plan needs to reflect on the need to develop stronger leadership, planning, management, and governance role of the MOHFW. A long-term plan along with significant investment is needed for capacity development at the central planning level of the Ministry.


In Bangladesh, existing urban health structures are mostly inadequate to ensure universal access to health care in view of the needs of the fast-growing urban populations. In urban areas, the role of the Ministry of Health and Family Welfare (MOHFW) is limited to the provision of secondary and tertiary care. Primary health care (PHC) in urban areas is principally the responsibility of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC), which provides services through contracted non-government organizations (NGOs). These NGO clinics ensure pro-poor targeting by requiring that at least 30 percent of the services be provided free for the poor.

Health and nutrition policies and programs have largely focused on providing health services to rural areas. Urban primary health care is a neglected area and access to affordable quality health services is extremely limited. The MOLGRDC has more than two decades of experience in providing urban primary health care services with limited coverage. Yet, the need to ensure universal access and sustainability remain the key concern for addressing the fast-growing urban populations. The government needs to redefine the role of NGOs for urban PHC services, as NGO programs have limited coverage and are time-bound and are subject to the availability of development assistance.

Programmatic gaps

Limited availability of PHC services

The structure of government primary health care in cities is inadequate. Primary health care in urban areas is delivered through the City Corporations and Municipalities which run a number of small to medium-sized hospitals and outpatient facilities in partnership with NGOs. Urban areas in the country are served by less than 200 PHC service delivery points, including 35 health centers operated by MOHFW.

Lack of coordination between service providers

The government provides health services in urban areas through two ministries. The urban health system lacks effective coordination between MOLGRDC and MOHFW as well as among various providers. The MOLGRDC does not have the capacity to provide PHC services. On the other hand, there is a lack of coordination between hospital services provided by MOHFW and other ministries. No standard protocols are followed by hospitals and diagnostic centers. There is an extremely inadequate MOHFW monitoring of the hospital services, particularly of private and NGO sectors, for quality and licensing. PHC services in urban areas are not consolidated and coordinated resulting in service gaps. Also, there is no referral linkage of PHC service to higher-level care in the secondary and tertiary facilities. There is an absence of a structured referral system between NGO clinics and government institutions.

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3 Op cit. BHW 2015.

4 Op cit. BHW 2015.
primary healthcare clinics on the one hand and the government’s secondary or tertiary level hospitals on the other.⁵

**MOHFW’s role in urban primary care:**
As in rural areas, the MOHFW does not have an organized primary care structure in urban areas. This ministry operates only 35 urban dispensaries (that provide outdoor services such as vaccination and maternal and child health) in several large cities and provides outpatient services in secondary and tertiary hospitals. Unfortunately, the urban dispensaries are mostly non-functional. These dispensaries need a thorough review and overall improvement.⁶

The MOHFW runs well-structured secondary and tertiary care services in urban areas across the country. Private healthcare providers are another major source for the delivery of curative care, including tertiary and specialized services to the urban people, but private providers seldom provide preventive and promotional health services. The monitoring of private healthcare providers is unsystematic and incomplete. Moreover, the enforcement of regulations is weak.

**Urban health governance**
Urban PHC services bring the government, NGOs, and donors into a tripartite pluralistic financial and governance relationship. There are problems with the role definition of the partners, the inexperience of the government agencies, lack of mutual trust, operational inflexibility, and stringent donor requirements.⁷ There continue the challenges of lack of communication between the two ministries, inadequate financial and human resources, and a largely inactive coordinating body. The roles and responsibilities of different ministries and agencies are unclear and there is no clear accountability framework either. It is necessary that MOHFW takes the leading role in the coordination of different partners.⁸

Recently, attempts at greater coordination within the government are taking place. For example, an Urban Health Coordination Committee (UHCC), chaired by the secretary of MOHFW and co-chaired by the secretary of the Local Government Division, has been established but requires further working improvements to identify roles and responsibilities and better planning and coordination.⁹

**Use of unqualified or informal providers**
For first-line clinical care for non-communicable diseases, most people, including the poor, use private practitioners. Private facilities operating in and around the slums provide limited general clinical services including prescriptions. Nutrition and diagnostic services are largely absent in those service delivery points. For general health problems, the urban poor prefer drug sellers as they provide low-cost treatments for a range of illnesses. Traditional doctors and formally recognized Unani or Homeopath doctors treat a range of diseases from simple coughs to tumors and cancer.¹⁰ Access to affordable treatment for non-communicable diseases is extremely limited in urban areas.

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⁵ OP cit. GOB 2015.
⁶ OP cit. GOB 2015.
⁷ Op cit. BHW 2015.
⁸ Op cit. BHW 2015.
**Recommended Actions**

- **Establish an effective governance framework:** The lack of collaboration between MOHFW and MOLGRDC remains a major barrier, highlighting the need to establish a permanent coordination mechanism between the two ministries toward developing a structured PHC system. The MOHFW should be the key technical ministry in the partnership—meaning that it leads the creation of the essential services package, clinical standards, quality assurance, and HMIS, while the MOLGDRC will be the executing agency responsible for urban PHC.\(^{11}\) MOHFW can collaborate with MOLGRDC, city corporations, donors and concerned stakeholders to jointly assess, map, project and plan health, population and nutrition services in urban areas.

- **Establish PHC facilities under the MOHFW:** The MOLGRDC has a wealth of experience in providing urban PHC services through contracted NGOs. There are some impressive successes in terms of coverage and exemption schemes for the poorest. The MOHFW can venture to extend the coverage of PHC services in the urban areas not covered by the MOLGRDC.

- **Provision of PHC outlet for secondary and tertiary hospitals:** PHC outlets can be built for urban secondary (district hospitals) and tertiary hospitals (medical college hospitals, both public and private) for providing ESP for catchment populations. These outlet centers will provide general practice and ESP services. Urban inhabitants will need a referral from a PHC outlet to be able to access specialist care. A PHC outlet model can be piloted under the 5\(^{th}\) sector program.

- **Universal health coverage for the urban population with a pro-poor focus:** The poor and disadvantaged people should get subsidized services from the private sector. City Corporations can mainstream the health card scheme for the urban poor to access services from selected/accredited NGOs and private facilities.

  The Health Economics Unit of MOHFW has taken the initiative to launch Urban *Sasthya Surakhya Karmashuchi* (SSK), which is a health protection scheme for those who fall below the poverty line. The 5\(^{th}\) sector program needs to reflect on that initiative.

- **Structured urban referral system.** To develop a structured referral system in urban areas, MOHFW needs to define and allocate catchment areas to each designated PHC facility/provider. Then, secondary and tertiary care facilities can receive referred cases from public, NGO, and private sector providers. Particularly, a referral system between NGO clinics and MOHFW’s secondary- and tertiary-level hospitals is needed, which will prevent the urban poor from accessing expensive private sector services.

- **Domiciliary services to reach the urban poor.** Urban PHC services need to be expanded to reduce access inequalities. The Local Government Division will be responsible for establishing additional health centers in selected informal settlements and low-income agglomerations in cities and recruiting physicians, nurses, and health workers. In addition, services will be delivered at doorsteps to improve access to preventive services and increase awareness about the availability of facility-based services.

- **Urban Health Policy.** Formulating an Urban Health Policy apart from the National Health Policy will help focus on specific problems of organizing, governing, and delivering equitable and quality urban health services.\(^{12}\)

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\(^{12}\) OP cit. BHW 2015.