

**Health financing contextual analysis for family planning and sexual and reproductive health in Bangladesh**

WISH2ACTION

Bangladesh

*By*

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# Acronyms

|  |  |
| --- | --- |
| ADP | Annual Development Plan |
| ANC | Antenatal Care |
| BBS | Bangladesh Bureau of Statistics |
| BDHS | Bangladesh Demographic and Health Survey |
| BDT | Bangladeshi Taka |
| CBO | Community Based Organisations |
| CPR | contraceptive prevalence rate |
| mCPR | Modern contraceptive prevalence rate |
| CSR | Corporate Social Responsibility |
| DGDA | Directorate General for Drug Administration |
| DGFP | Directorate General of Family Planning |
| DGHS | Directorate General of Health Services |
| DGME | Directorate General of Medical Education |
| FP | Family Planning |
| FPAB | Family Planning Association of Bangladesh |
| HCFS | Health Care Financing Strategy |
| HEU | Health Economics Unit |
| HPNSP | Health, Population and Nutrition Sector Programme |
| HPNSIP | Health, Population and Nutrition Strategic Investment Plan |
| IMR | Infant Mortality Rate |
| LAPM | Long-acting and Permanent Methods of Contraception |
| LDC | Least Developed Country |
| LGD | Local Government Division |
| LGI | Local Government Institution |
| MNCH | Maternal, Newborn and Child Health |
| MNC&AH | Maternal, Newborn, Child and Adolescent Health |
| MCWC | Maternal and Child Welfare Centre |
| ME&FWD | Medical Education and Family Welfare Division |
| MOF | Ministry of Finance |
| MOHFW | Ministry of Health and Family Welfare |
| MOLGRDC | Ministry of Local Government, Rural Development and Cooperatives |
| MOSW | Ministry of Social Welfare |
| MOWCA | Ministry of Women and Children’s Affairs |
| MSB | Marie Stopes Bangladesh |
| MTBF | Medium-term budget framework |
| NGO | Non-Government Organisation |
| NIPORT | National Institute of Population Research and Training |
| NSSS | National Social Security Strategy |
| NUHS | National Urban Health Strategy |
| OOP | Out of pocket payments |
| PHC | Primary Health Care |
| PIP | Programme Implementation Plan |
| RMNCAH | Reproductive, Maternal, Newborn, Child and Adolescent Health |
| SDG | Sustainable Development Goal |
| SRHR | Sexual and Reproductive Health and Rights |
| SSK | Shastho Surokkha Kormoshuchi (Health Protection Scheme) |
| TFR | Total Fertility Rate |
| U5MR | Under 5 Mortality Rate |
| UHC | Universal Health Coverage |
| UHSSP | Urban Health Systems Strengthening Project |
| UNESCAP | United Nations Economic and Social Commission for Asia and the Pacific |
| USAID | United States Development Aid Agency |
| USD | US Dollar |
| WHO | World Health Organisation |
|  |  |

# Executive Summary

The Women’s Integrated Sexual Health (WISH) programme is a 3 year, multi-country programme aimed at providing a comprehensive package of Sexual and Reproductive Health and Rights (SRHR). One of the objectives of the WISH programme is to ensure financial sustainability of SRH/FP programmes. It is important that governments deliver on their commitments and ensure citizens’ rights to basic health care, in particular relating to SRH/FP.

Given that public sector investments are “sticky” (i.e., difficult to change once decided), they are considered highly sustainable over time. One of the WISH objectives is to ensure increased financial sustainability via improvements in public sector investments in SRH/FP programmes. The objective of this document is to provide an understanding of Bangladesh’s health financing (HF) landscape, as a pre-requisite and first necessary step to improve public sector investments.

### Background and Context

For a least-developed country, Bangladesh has achieved remarkable success in improving many of its key population health indicators, including raising life expectancies, reducing total fertility rate (TFR), and reducing maternal and under-five mortality rates, and was one of the best performing LDCs in meeting the Millennium Development Goals. Since its inception, Bangladesh’s strong commitment to addressing high population growth rates has led to multiple sexual and reproductive health (SRH) and family planning (FP) interventions, contributing to a significant reduction in the total fertility rate (TFR), rising Contraceptive Prevalence Rates (CPR), and a drop in maternal mortality across all wealth quintiles, all regions and for all major causes of death.

However, during the last decade, progress has stalled and major challenges for the health sector remain the same, including deepening inequalities on the basis of socio-economic status, gender, ethnicity and geography, both in terms of access to good quality healthcare and health outcomes.

|  |
| --- |
| **Key policy & strategy documents** |
| **Policies**:   * National Health Policy 2011 * Bangladesh Population Policy 2012 * 7th Five-Year Plan 2016-2020 * Health, Population and Nutrition Strategic Investment Plan (HPNSIP) 2016 – 2021 * Concept note of 4th HPNSP * 4th Health, Population and Nutrition Sector Programme (HPNSP) January 2017 – June 2022   **Strategies & Plans (health and social protection):**   * Health Care Financing Strategy 2012-2032 * National Social Security Strategy (NSSS) 2015 * National Urban Health Strategy (NUHS) 2014 * National Strategy for Adolescent Health 2017-2030 * Bangladesh National Action Plan for post-partum, post-menstrual regulation and post-abortion care family planning (published in 2017) * Bangladesh Essential Health Service Package (ESP) August 2016   **Other national SRHR/FP Commitments:**   * FP2020 Commitments * SDG Commitments |

Bangladesh is currently experiencing demographic as well as epidemiological transitions – with its population slowly but steadily aging and a double burden of communicable and non-communicable diseases. An intense process of urbanisation is fuelling a sharp rise in the urban slum population, where there is uneven and often poor access to basic services, including SRH/FP services.

### FP/SRH policies, strategies and commitments

The policy environment for SRH/FP in Bangladesh is highly favourable. Both general and health policy documents articulate Bangladesh’ commitment to enabling access to good quality SRH and FP services for all, including young people, those with disabilities, the rural and urban poor, as well as those living in hard-to-reach areas. The government has made ambitious commitments to lower the fertility rate to replacement levels (2.1) and increase the CPR to 75%, to increase the proportion of long-acting and permanent methods of contraception (LAPM) within the method mix to 20%, and to reduce current high contraceptive discontinuation rates.

Additional FP2020 commitments (slightly more ambitious than those in the Government’s 4th Health Population and Nutrition Sector Programme (4th HPNSP) January 2017 – June 2022), Bangladesh also aims to increasing access to post-partum and post-abortion FP services, and addressing the high rates of adolescent pregnancy through the provision of targeted SRH services. Reducing geographic disparities in access to SRHR services by working with local leaders and communities to develop context-specific interventions is a key intervention area for both FP2020 and the Global Financing Facility (GFF).

To achieve these commitments, the Ministry of Health and Family Welfare (MOHFW) has committed to halving the resource gap (although the gap itself is not clear) through reallocation of its development budget, as well as harnessing additional resources through engaging the private sector.

While policy documents acknowledge the importance of family planning for reaping the demographic dividend, family planning services have not been incorporated into social health protection schemes (i.e. social health insurance) to date. Furthermore, the only Govt. initiative of health insurance is currently at pilot phase and account for only a very small proportion of overall health financing, despite ambitious plans to extend them to all segments of the population by 2032.

The MOHFW has so far failed to tackle dual structures for service provision - the oversight of health services (Health Services Division (HSD)) and family planning services (Medical Education & Family Welfare Division (MEFWD)) despite restructuring in 2017. Responsibility for health services organisation, financing and delivery is split between the MOHFW in rural areas, and Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) for urban areas. This adds to the structural complexity, leading to inefficiencies (i.e. high administrative costs), and overlap and duplication of activities in some areas while gaps in service coverage persist in others (i.e. urban slums and certain services for specific groups such as adolescent RH).

### Health Expenditure & Financing

Bangladesh spends too little on health. Per capita total health expenditure (including all sources of financing) is less than any of its South Asian neighbours, less than the average for least developed countries (LDC) and less than the average for lower-middle income countries (LMIC). Although widely acknowledged in policy and strategy documents that low domestic health spending poses a major challenge for improving universal health coverage and quality of health services, this has not translated into increased domestic funding for health. The MOHFW has seen its share of the total budget remain static around 5% for many years.

Bangladesh’s current system is one of general tax-funded health care and publicly-provided services, although a large proportion of people (63%) now meet their healthcare needs in the poorly regulated private sector (private-for-profit and not-for-profit). Health financing in Bangladesh comes from 3 principal sources: the treasury, households and individuals through out-of-pocket payments, and international development partners. Low domestic health spending, together with a lack of pre-payment mechanisms, mean that out-of-pocket (OOP) health care payments – through both official and unofficial fees - account for the majority of total health expenditure, with funds spent mostly on medicines. This is a major factor in the uneven and increasingly inequitable distribution of health care services, both geographically and based on socio-economic status, gender and ethnicity.

Mirroring the national budget structure, the MOHFW has a revenue budget (recurrent costs) financed from domestic revenues, and a development budget to which Govt. contributes quite much as well as a wide range of development partners contribute. The MOHFW finances its development budget through the 4th HPNSP, which is operationalised through a programme implementation plan (PIP) and 29 Operational Plans (OPs), each of which has activities planned against estimated costs and revenues. The OPs are not well linked to sectoral strategies and priorities and not well harmonized with the available revenue budget.

A clear picture of exactly how much is spent on SRH/FP across MOHFW was not available. Responsibility for the 29 operational plans is divided between the Directorates/Offices under the MOHFW, with all the family planning services falling under seven OPs of the Directorate General of Family Planning (DGFP). However, some programmes, which fall under the Directorate General of Health services (DGHS) also provides SRH services and services to adolescent population, like, Maternal, Neonatal, Child and Adolescent Health (MNCAH) OP is tasked with providing health care to adolescents and SRH care to all; National Nutrition Services (NNS) OP is tasked with providing nutrition services to adolescents etc..

Successive Public Expenditure Reviews show that health expenditure is highly skewed towards curative care. Some 70% of funds are spent on drugs and curative care, with 10% on preventive care. Allocative inefficiencies mean that cities account for the majority of health spending, with Dhaka accounting for nearly half of total health expenditure (46%) to cover some 55 million of the country’s 167 million inhabitants. Split responsibilities for healthcare provision between rural and urban areas means that urban slum areas suffer disproportionately from low health spending. Allocations to districts and sub-district level health units are based on bed and staff numbers rather than population size and density, and do not reflect health needs.

It has been estimated that Bangladesh could reduce health expenditures by as much as 10 - 15% and maintain the same health outcomes with improved expenditure efficiencies. Rigid public financial management (PFM) processes delay procurement throughout the health system, and slow release of funds hampers service delivery. Budget execution remains a problem in MOHFW, with uneven but improving absorption rates.

Despite high-level commitments, there seems to be little room for raising domestic revenues for health. Suggestions on the table include earmarked taxes (tobacco tax) and more efficient tax collection; both strategies being pushed by the World Bank. External funding is unlikely to rise as a proportion of health spending (donor funding has shown a steady and slow downwards trend). Both World Bank (WB) and the GFF are investing in strengthening PFM and enhancing the context for implementing the National Healthcare Financing Strategy (NHFS), which could lead to significant efficiencies in future years.

Reprioritisation of the health budget should be possible, as shown by the increases in the education and social welfare budgets in recent decades. Coalitions of government and non-government stakeholders need to coalesce around key health-related issues in order to push for change. Value for money of family planning investments could be one such issue; the FP2020 costed investment plan estimates that, for every USD1 invested in the national FP programme, USD14 will be saved.

### Health sector institutions

Bangladesh has an extensive network of health facilities –public, private and NGO – which reaches deep into rural areas, although significant gaps exist in urban areas. The Essential Health Service Package (ESP) includes FP and is delivered through all nine service delivery channels for primary health care covering both urban and rural areas. These delivery channels cover community, union, upazila, district, and urban city areas. Despite attempts at restructuring, the two-branch system of MOHFW for general health services and family planning has so far been maintained at the decentralised level, with the exception of the community clinic which is the lowest tier health facility and supposed to provide a one-stop destination for all health and FP services.

In the public sector, family planning is provided through a network of facilities under the DGFP comprising Mother and Child Welfare Centres (MCWCs) at the district and upazila level, FP unit (and some MCH unit) of Upazila Health Complex (UHC) at upazila level, Union Health and Family Welfare Centres (UH&FWC) at union level, and community clinics (which provide both health and family planning services). Other public facilities (i.e. General hospitals, district hospitals, Medical College hospitals) also provide some FP services which are also supported by DGFP through providing supplies, training and often manpower.

MOHFW structures for the provision of SRH/FP services suffer from acute shortages in human resources at all levels (i.e. medical officers, counsellors, Family Welfare Visitors (FWV), Family Welfare Assistant (FWA)); the current workforce is aging and recruitment has been delayed, and many of the new posts are being filled with less technically qualified staff. As an attempt to fill some of these gaps, national and international NGOs provide SRH/FP services through static clinics, outreach services and social marketing networks.

In urban areas, city corporations and municipalities have a mandate under the Local Government Act 2009 to promote public health, establish and maintain hospitals, dispensaries and primary healthcare centres, and to promote infectious disease control and health education. However, due to a combination of limited funding and lack of prioritisation of health, the majority of public facilities in urban areas remain under the aegis of the MOHFW.

The government has been providing direct and indirect incentives for private provision of health services for many years, often to address gaps and weaknesses in public provision, contributing to a rapidly expanding private health sector. The capacity of the government to regulate and monitor the private sector is weak, and the predominance of private providers in the fast-growing cities and towns, which are not well coordinated, leads to wide gaps in SRH service provision in urban slum and remote rural areas and quality of care which is highly variable.

### Health service delivery: supply and demand

Progress on increasing the CPR, which remains around 60% for modern methods, has stalled over the last decade, although the latest Bangladesh Maternal Mortality and Health Care Survey (BMMS 2016) recorded a drop in total fertility to 2.05 from the rate in the Bangladesh Demographic and Health Survey (BDHS) of 2.3 in 2014. This means Bangladesh has reached replacement level fertility, which is a National Population Policy commitment.

There remain differences in SRH/FP indicators between different geographical areas (i.e. Sylhet and Chattogram are so-called ‘lagging areas’), and challenges include low utilisation of services by specific groups (i.e. adolescents) and for specific SRH/FP services (i.e. post-partum, post-Menstrual Regulation (MR)[[1]](#footnote-1) and post-abortion FP). By working closely with local leaders and stakeholders, the MOHFW is addressing geographical disparities through the provision of context-specific service packages, tailored to the needs of people living in the lagging areas, which are highlighted in almost all the OPs under 4th HPNSP and are further supported through targeted financing from GFF, USAID and other development partners. This forms part of Bangladesh’ FP2020 commitments.

According to the BDHS 2014, nearly half of modern contraceptive users obtained their method from the public sector, with 20% receiving a method from a government fieldworker (i.e. FWA). The private sector supplied 43% of users with contraceptives, with pharmacies being the most important source (38%), and NGOs supplied 4% of modern methods. Across all age groups, the pill is the method of choice (half of users), followed by injections and condoms, demonstrating the over reliance on short-term methods.

MR services declined sharply from 2010 to 2014, when an estimated 430,000 MR services were provided. However, some 1.2 million illegal abortions were carried out in 2014 - a figure that is likely to be considerably under-stated. Nearly half of all MR services are carried out in public sector facilities (48%), followed by the private sector (33%) and NGOs (6%). The Directorate General of Drug Administration (DGDA) for Bangladesh legalised the combination of mifepristone and misoprostol for medical abortion in 2012, although access for young people remains difficult. However, over the counter availability of the drug also results in some unjudicial use.

Challenges for the supply of SRH/FP services include a lack of readiness to provide quality FP services at all levels of the health system, including widespread stock-outs of contraceptives (particularly IUDs) in the public sector, due in part to poor supply-chain management. Despite the Government’s FP2020 commitment to provide free contraceptives to NGO and private sector providers with trained health staff, supplies are often not available. Quality of care can be a particular challenge in urban areas where the majority of people access services from private providers. Weak referral systems represent a major challenge throughout the system.

Low utilisation of long-acting and permanent methods and high contraceptive discontinuation rates throughout the country are illustrative of severe shortages of human resources at all levels, with insufficient medical staff of the appropriate level and training on counselling and management of side effects. Governance, transparency and accountability, and widespread corruption also serve as barriers to the provision of good quality services.

Challenges on the demand-side include financial barriers related to official and unofficial user fees levied at the point of service by both public and private providers, and uneven access to comprehensive information on SRH/FP in some areas of the country and among certain groups (i.e. urban poor, adolescents). Systems for exemption from user fees are the responsibility of front line health workers and are not uniformly applied. Societal norms mean that family planning for young unmarried adolescents remains taboo, and rates of child marriage remain high, despite concerted efforts to tackle this through legislation, policies and programming.

Key strategies for the MOHFW to address inequalities in access to care and to achieve FP2020 commitments include working with local leaders to reduce disparities in access to SRHR services, working with the private sector and NGOs, and using innovative service delivery mechanisms, and behavioural change interventions to increase the CPR in low-performing areas (Sylhet, Chattagram and Barisal divisions) and urban slum areas all over the country.

### Health Sector Reforms

Relevant health sector reforms include the decentralisation reform and, somewhat linked to this, the integration of health services and family planning services at lower levels of the health system. Bangladesh’ Vision 2021 calls for the administrative and financial decentralisation of the health services department, while it remains silent on the family planning division. There has been slow progress in these areas and decision making for the organisation and financing of health services remains highly centralised.

Further reforms include the delegation of financial authority and management to lower levels of the health system, and the retention of locally-generated income by health facilities, as well as the roll-out of Imprest Funds to health facilities across the country to increase utilisation of LAPM. Further research is needed to fully understand the current status of these reforms, and to identify potential entry points for WISH.

### Potential for increased domestic spending on SRH/FP

It is widely acknowledged (including in policy documents) that Bangladesh cannot achieve UHC without significantly increasing domestic health spending. Possible ways to increase funding for SRH/FP, include:

* Increasing the overall health budget and/or allocating a higher proportion to SRH/FP service delivery. While the former would require greater prioritisation of health within the national budget, which seems unlikely based on recent trends, a great prioritisation of SRH/FP within the health budget may be feasible;
* Exploring alternative sources of funding. The MOHFW has highlighted the private sector as a potential source of additional funding, through public-private partnership arrangements, working with private foundations, and possibly corporate social responsibility;
* Increasing efficiencies in health spending. Both the WB and GFF provide financial and technical assistance to strengthen PFM with the aim of increasing efficiencies in health spending. This is an important area of work with potential cross-over points for WISH.

### Potential entry points for action:

Recommendations for WISH activities and potential further research include (to be prioritised and further discussed as part of the planning for 2020-2021:

* Situation analysis for improving the budget execution and efficiency under DGFP and technical assistance to DGFP for improving budget utilization (both at national and sub-national levels) through advocacy.
* Cost analysis for FP services from user perspective, especially from private and NGO sector, to identify the challenges in accessing FP care with specific attention to adolescent, disabled population, urban poor, and remote rural areas.
* Analysis and identification of the scope for better alignment of the SRH/FP programmes along with the budget line items, with the policies, strategies and commitments. If possible, advocacy with DGFP and MOHFW for increased allocation for those line items.
* Up-dating the Costed Implementation Plan for FP2020 commitments using BHDS 2017 data, identification of financing gap and prioritisation of activities;
* Detailed analysis of Imprest Funds (progress, bottlenecks, potential impact on LAPM use);
* Analysis of the potential to include SRH/FP (particularly LAPM and MR) in social health protection mechanisms, together with a realistic assessment of the potential for scale-up. This is the corner-stone of the Government’s plans for achieving UHC;
* Analysis of all OPs of 4th HPNSP to identify SRH/FP-related activities and costs, and PER data to identify SRH/FP expenditure (if feasible);
* Building on the recent work of the DFID-funded UHSSP, conducting research on access to and financing of SRH/FP in urban slum areas with a view to identifying entry points for improving financing of urban SRH/FP service delivery.
* Documentation of learning and evidence to support the case for requirement of additional financing towards SRH/FP services. It would be good to compile these evidence prior to the formulation of 5th sector plan for health in Bangladesh and also ensuring adequate dissemination and discussion of this evidence with appropriate stakeholders and policymakers.

# 1. Introduction

The Women’s Integrated Sexual Health (WISH) programme is a 3 year, multi-country programme aimed at “providing a comprehensive package of Sexual and Reproductive Health and Rights (SRHR), with a primary focus on increasing the number of additional Family Planning (FP) users according to the FP2020 definition, alongside reducing maternal mortality and improving access to safe abortion”.

Part of the WISH programme is to ensure financial sustainability of SRH/FP programs. Given that public sector investments (i.e., domestic resources) are “sticky” (i.e., difficult to change once decided), they are considered highly sustainable over time. It is also important that governments deliver on their commitments and in ensuring citizens’ rights to basic health care, in particular relating to SRH/FP. The WISH financial sustainability component will therefore ensure increased financial sustainability via improvements in public sector investments in SRH/FP programs.

The objective of this document is to provide an understanding of Bangladesh health financing (HF) landscape for SRH/FP services, as a pre-requisite and first necessary step to improve public sector investments for SRH/FP.

# 2. Objectives

The primary aim of the analysis is to identify the most important challenges and potential ways to improve public sector investments in SRH/FP.

These learning will then be used by the Bangladesh country team as a starting point to design WISH programme activities and further research to improve SRH/FP financing (allocation, absorption, planning, timeliness, etc.).

Given that the health, political and economic context of Bangladesh may change rapidly, this analysis should also be used as a “living” document, adaptable to contextual changes.

Specific objectives are as following:

1. **Understand the health system and health financing context for SRH/FP,** including
   1. SRH/FP government commitments
   2. National and health system financing context
   3. Institutions, supply/demand considerations and political support for SRH/FP health services
2. **Provide an overview of possible ways to improve public sector investment in SRH,** including short term recommendations for the incoming country team
3. Based on information gaps and analysis’ limitations, **identify potential topics for further research**

As mentioned in objective 3, and considering that the WISH programme will last 3 years, it will be particularly important to note the information that is available and the information that is *not* available at the moment, but could be leveraged in the future to improve public sector financing of SRH/FP.

# 3. Methods and structure

This health financing contextual analysis for Bangladesh is based on:

1. **A desk review**: More than 40 documents have been reviewed, including from Ministry of Health and Family Welfare (MOHFW), Ministry of Finance (MOF), websites, peer reviewed journal articles, as well as documents shared by stakeholders;
2. **Key informant interviews:** Two key informants were interviewed as part of the analysis.

Following the objectives stated above, the document is structured as following;

* the first section will present the commitments, policies and strategies of the Government of Bangladesh (GOB) regarding SRH/FP;

the second section will review the health system and financing context, and will include four sub-sections: the national budget and its process, health system financing (flows, budget, etc.) for SRH/FP, institutions and supply/demand of SRH/FP services, and finally the political support and situation regarding SRH/FP. Every sub-section is organized with research questions, key documents, known challenges and information gaps.

* In third section, learning from the overall context is used to present an overview of potential ways to improve public sector investment, and suggestions for further research.
* Finally, conclusions are provided.

# 4. Health financing context for SRH/FP in Bangladesh

With a population of 165 million living in some 148,000 square kilometres - roughly the size of Nepal – Bangladesh’s population density is among the highest in the world (https://data.worldbank.org). The country is currently experiencing demographic as well as epidemiological transitions – with its population slowly but steadily aging, and a double burden of communicable and non-communicable diseases (Ahmed et al. 2015). Poverty, climate change and the search for better economic opportunities are driving an intense process of urbanisation - urban population growth is four times the national growth rate – which is fuelling a sharp rise in the urban slum population (NIPORT et al, 2015).

Along with Cambodia and Myanmar, Bangladesh is benefiting from migration of low-cost manufacturing from higher-wage economies such as China, with positive spill over effects on both consumption and investment. This has contributed to high rates of economic growth over the past decade, culminating in a growth rate of 7.9% in 2018, which is forecast to tail off slightly to around 6% in 2019 – 2021 (UNESCAP 2018; https://data.worldbank.org, 2019).[[2]](#footnote-2) In July 2015, Bangladesh graduated to lower-middle income country status based on GNI per capita,[[3]](#footnote-3) due in large part to strong economic growth, continued high levels of remittances from overseas and a steady exchange rate. However, it remains a Least Developed Country (LDC), taking into account additional measures of wealth and vulnerability.[[4]](#footnote-4)

For a least-developed country, Bangladesh has achieved remarkable success in improving many of its key population health indicators, including raising life expectancies and reducing maternal and under-five mortality rates (NIPORT et al. 2016), and was one of the best performing LDCs in meeting the Millennium Development Goals (MDG) (GOB 2016a). A strong and wide-reaching network of GOB health managers and providers as well as presence of various national and international NGOs have been critical to this success. A conducive policy environment, resourcing and technical assistance by development partners, and a strong research capacity that is adept at translating research into action have also been major contributors (GED 2013). Efforts to address gender inequalities and empower women (including a gender budget statement) have also been important in this regard (Chowdhury et al. 2013; CPD 2017). In the SDG era, Bangladesh reportedly had a universal health coverage (UHC) services coverage index of 50 in 2016, which reflects service delivery across 16 key indicators, including reproductive, maternal, neonatal, child and adolescent health (RMNCAH).[[5]](#footnote-5)

Despite strong progress, major challenges for the health sector remain, including persistent malnutrition and under-nutrition, overarching concern on quality of health care, and deepening inequalities in access to healthcare on the basis of socio-economic status, gender, ethnicity and geography, including for SRH/FP services. Furthermore, the country is facing a worsening crisis on its south-eastern border with Myanmar as more than 700,000 Rohingya refugees have fled to Bangladesh since August 2017, joining about 200,000 already living in the camps in the Cox’s Bazaar area – an estimated 7 out of 10 being women and children. Aid agencies are currently struggling to support at least 1.3 million people in this area, including local populations, without which they would have little access to basic services (World Vision 2019). The World Bank is providing additional financing aligned with its health programme which focuses on the lagging divisions of Sylhet and Chittagong (MOHFW 2018b).

## 

## 4.1 Bangladesh SRH/FP policies, strategies and commitments

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| --- | --- |
| **Research questions** | **Key policy & strategy documents** |
| Which political, financial and health outcomes commitments have been taken by the Government of Bangladesh regarding SRH/FP? | **Policies**:   * National Health Policy 2011 * Bangladesh Population Policy 2012 * 7th Five-Year Plan 2016-2020 * Health, Population and Nutrition Strategic Investment Plan (HPNSIP) 2016 – 2021 * Concept note of 4th HPNSP * 4th Health, Population and Nutrition Sector Programme (HPNSP) Jnauray 2017 – June 2022   **Strategies & Plans (health and social protection):**   * Health Care Financing Strategy 2012-2032 * National Social Security Strategy (NSSS) 2015 * National Urban Health Strategy (NUHS) 2014 * National Strategy for Adolescent Health 2017-2030 * Bangladesh National Action Plan for post-partum, post-menstrual regulation and post-abortion care family planning (September 2017) * Bangladesh Essential Health Service Package (ESP) August 2016   **Other national SRHR/FP Commitments:**   * FP2020 Commitments * SDG Commitments |

### The Policy Context

Bangladesh’s constitution and other legal and policy documents recognise health as a human right and stress the need to alleviate ill health and suffering for all groups. The policy environment for family planning (FP) and sexual reproductive health and rights (SRHR) is highly favourable. The first FP programmes in Bangladesh started in the pre-independence era when the Government of Pakistan started a FP programme in 1960 in what was then East Pakistan. Since independence in 1971, the Government of Bangladesh has consistently prioritised FP and in 1976, declared rapid population growth to be the nations’ number one challenge (Ahmed et al. 2015) led to approval of first National Population Policy outline.

This strong commitment to address high population growth has led to multiple interventions over the ensuing decades which have resulted in a significant reduction in the total fertility rate (TFR), rising Contraceptive Prevalence Rates (CPR), and a drop in maternal mortality across all wealth quintiles, all regions and for all major causes of death (UNICEF 2015). A recent study published in the Lancet by Rahman and colleagues (2018), which modelled the likelihood of Bangladesh reaching its 2030 UHC commitments, predicted that the country would exceed the target of meeting 80% of family planning needs, but would miss the maternal health targets, among others.[[6]](#footnote-6)

In 2021, Bangladesh will celebrate 50 years of independence and the **Government’s Vision 2021** paper, developed by the Awami League in 2008 as a major election manifesto, highlights the need for increased investment in health and education as priority areas for human capital development (CPD 2006).[[7]](#footnote-7) The document calls for more emphasis on informed choice by women, and on enhancing their reproductive rights in order to reduce fertility. It acknowledges that the government will need to finance health services for those who cannot pay and envisages a public health system which is decentralised, flexible and innovative (emphasising the use of digital solutions) and where public resources are targeted to the ‘resourceless’ (i.e. poor and vulnerable) to address rising levels of inequity in both access to quality services and health outcomes. Social health protection schemes are highlighted as a major strategy for achieving this.

**The Ministry of Health and Family Welfare (MOHFW)** is responsible for health policy formulation, planning, decision-making and regulation, as well as the provision of comprehensive health services, financing and employment of health staff. While oversight of health services and family planning services was traditionally allocated to the Directorates General of Health Services (DGHS) and Family Planning (DGFP) respectively, the ministry was recently reformed (mid-2017) and its units consolidated under two main divisions: Health Services Division, hosting the DGHS, and the Medical Education & Family Welfare Division (ME&FWD), hosting the DGFP and other associated departments for Medical Education . According to the key informants, the rationale for this process was largely political - a response to the need to accommodate posts for more of senior administrative cadre posts (like, Secretary, Additional Secretary, Joint Secretary etc.)– and has done little to address the need for more integrated structures for health service delivery with the result that the MOHFW is now divided more than ever.

The **Ministry of Local Government, Rural Development and Cooperatives (MOLFRDC)** oversees the provision of primary health services in urban areas (areas under city corporation and municipality), where Local Government Institutions (LGI) including city corporations and municipalities, are responsible for providing an essential health care package, which they do in partnership with NGOs and the private sector.[[8]](#footnote-8) Policy documents acknowledge the lack of clarity regarding the division of responsibilities for urban primary health care between the MOLGRDC and the MOHFW.

The **National Health Policy** and the **7th Five-Year Plan (2016 – 2020)** are aligned with Vision 2021 and aim to ensure access to essential health services for all, with specific emphasis on vulnerable groups including the elderly, women, children, the poor and disadvantaged, and those living in hard-to-reach areas. Both documents recognise the importance of bringing more funds to the health sector and improved pooling of resources. The introduction and scale-up of social health protection schemes, including social health insurance, is cited by both documents as a long-term objective for the country.

The 7th Five-Year Plan refers to the implementation of the health care financing strategy (HCFS) as one of the main priorities by 2020. Strengthening family planning services is a key objective, both for reaping the demographic dividend and to lower fertility rates to replacement levels, with particular emphasis on lagging areas of the country where fertility is higher (i.e. Sylhet and Chattogram). The Plan also aims to strengthen institutional arrangements to coordinate service delivery between ministries (i.e. MOHFW and MOLGRDC), development partners, NGOs and the private sector, which has so far failed to materialise to any significant degree (FP2020 2018a). Service delivery areas that are highlighted include post-partum FP, strengthening FP awareness (special emphasis on mass communication and site-specific needs), and strengthening male involvement in long-acting and permanent methods (LAPM) and other methods of contraception.

The **National Population Policy** was revised in 2012 and outlines the roles of multiple ministries and other stakeholders including the private sector and NGOs in addressing the population and reproductive health needs of different groups, including young, disabled, poor and elderly people. Targets in the Population Policy include lowering the TFR to 2.1 and achieving replacement fertility by 2015, and increasing the CPR to 72% (see also 4.2.3). The policy highlights the need to improve needs-based provision of services (including addressing context specificities, such as targeting urban slum-dwellers), and sets out a range of strategies, which include the provision of information, behaviour change communication activities and awareness raising on family planning and reproductive health, FP counselling services, and integrating the many initiatives being implemented by government and NGO stakeholders to tackle early marriage and childbearing. It is, however, silent on the integration of health and family planning programmes which would contribute greatly to efficiencies by avoiding duplication and wastage (Ahmed et al. 2015). The **National Population Council** – with the prime minister at its head – oversees implementation of the policy and is responsible for the coordination of activities among stakeholders and partners.

The **Health, Nutrition And Population Strategic Investment Plan (HNPSIP) 2016 – 21** , the planning document for the 4th HPNSP, recognises the on-going and significant social and demographic transitions and rapid urbanisation in Bangladesh, and calls for a substantive change in the way the sector is organised and managed, including integration of health service delivery at the local level (MOHFW 2016a). It also recognises the urgent need to expand existing services to currently underserved groups, including adolescents, the poor and those in urban and hard to reach rural areas, as well as the need to continue to work on stabilising population growth through education and family planning services.

The GOB and development partners have pursued **a sector-wide approach (SWAp) since 1998**, adopting a series of multi-year strategies, programmes and budgets for management and development of the health nutrition and population sector, with support from both domestic and international financing.[[9]](#footnote-9) Funds are channelled to the **4th Health Population and Nutrition Sector Programme (HPNSP) (January 2017-June 2022)**, current health sector programme, which aims to improve equity, quality and efficiency in order to move towards Universal Health Coverage (UHC) and progress towards achieving the health-related Sustainable Development Goals (SDGs). In addition to strategies for health service provision and system strengthening (including improving financial management), the 4th HPNSP includes a ‘strengthening governance and stewardship component’ for the first time (MOHFW 2017a). The HPNSP is operationalised through a Programme Implementation Plan (PIP) with 29 Operational Plans (OP), responsibility for which is divided between the DGHS (14), DGFP (7), MOHFW (5), and one each for the Directorates of Nursing & Midwifery (DGNM), Drug Administration (DGDA) and the National Institute of Population Research and Training (DG NIPORT).

Importantly, the HPNSP highlights the need for stronger governance and stewardship to ensure that all health sector stakeholders, including the rapidly expanding private for-profit sector, adhere to policies, procedures and quality standards. This includes the need for better regulation, and building transparency and accountability across the sector. A combination of social protection programmes, better regulation and improvement in service quality will enable more people to access care. Partnerships with NGO and private sectors are encouraged, including at local levels, and community participation is endorsed.

The HPNSP has a number of indicators and targets relating to SRH and FP (see also Table 1 below), some of which are World Bank disbursement-linked indicators for the HPNSP funds. This is the first time that World Bank introduced disbursement linked indicators and associated disbursement linked results to MOHFW with the aim of improving efficiencies in MOHFW as well as improving the performance in terms of achieving set targets. [[10]](#footnote-10)

### Strategies & Operational Plans

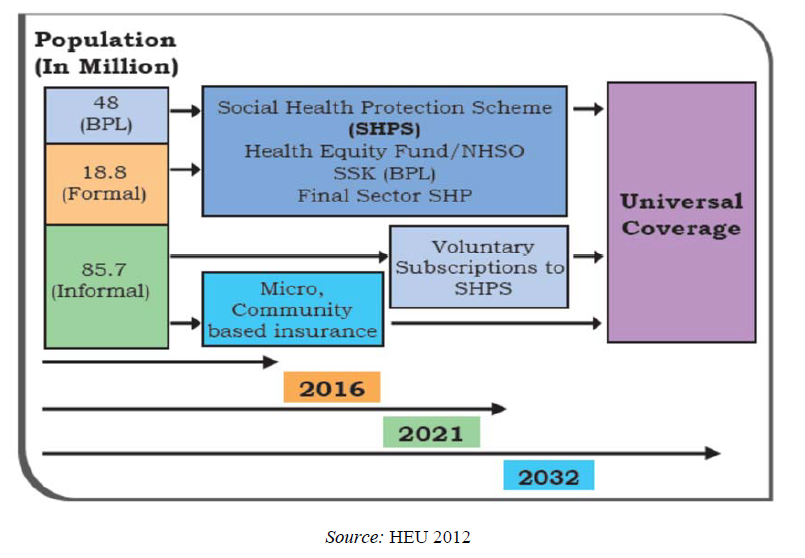
**National Healthcare Financing Strategy 2012 - 2032:** This strategy proposed a roadmap for achieving UHC (see fig. 1 below), highlighting the areas of equal access to care and financial protection. It has been incorporated into the National Social Insurance Strategy (see below), and focuses on three broad areas for improvement:

1. inadequate health financing;
2. inequity in health financing and utilization; and
3. inefficient use of existing resources.

Specifically, it aims for a reduction of out-of-pocket (OOP) payments from 64% to 32% of total health expenditure (THE), an increase in government expenditure from 26% to 30%, an increase in social protection mechanisms as a source of revenues from less than 1% to 32%, and reduced dependence on external funds from 8% to 5% (Ahmed et al. 2015; MOHFW 2012).

The strategy aims to combine funds from tax-based budgets with the proposed social health protection schemes for the poor and formal sectors (see also 4.2.1), existing community-based and other prepayment schemes and donor funding to ensure financial protection against health expenditures for all Bangladeshi people.

**Figure 1: Proposed Sequence of social health protection schemes in the Health Financing Strategy 2012 – 2032.**

Importantly, the **Global Financing Facility (GFF)** of the World Bank has prioritised up-dating and improving the knowledge base for implementing Bangladesh’s Healthcare Financing Strategy. Proposed activities include an analysis of health equity and financial protection, diagnosis of public financial management bottlenecks, engagement with the private sector, and dialogue on domestic resource mobilisation. [[11]](#footnote-11)

**The National Social Security Strategy** (NSSS) aims to create a common funding pool through a Social Health Protection Scheme (SHPS) through the gradual expansion in coverage (fig. 1), starting with people below the poverty line (BPL) and the formal sector (i.e. civil servants and garment factory workers). For the BPL population (31%), subsidies from general government revenues will be provided, and for the formal sector and their families (12%), contributions will be mandated, and they will gradually be incorporated into the scheme. The large non-poor informal sector, which is estimated to comprise 56% of the population, would join the scheme voluntarily and should be incorporated by 2032. The strategy envisages some reliance on community and micro-insurance schemes in the interim for informal sector groups. However, both the Healthcare Financing Strategy and the National Social Security Strategy acknowledge the difficulties in collecting premiums from the informal sector, and evidence showed this to be the case in many low and lower-middle income countries (i.e. Indonesia, the Philippines and Vietnam) (World Bank 2016). Expanding coverage to the urban poor is also highlighted as a significant challenge.

The strategy acknowledges that the social protection arena in Bangladesh is complex with 145 programmes managed by as many as 23 ministries financed by GOB budget, including the Maternal, Child, Reproductive and Adolescent Health programme (GOB 2015). In FY 2014/15, the total amount being spent on these programmes was Tk. 306.4 billion, equivalent to around 2% of GDP. There are no formal mechanisms for sharing information among the various ministries managing NSS programmes, and a major challenge is the lack of coordination and integration of the work of the DGHS (responsible for MNCH) and the DGFP (responsible primarily for FP and to some extent for MCH). Maternal, child, reproductive and adolescent health are cited as accounting for 0.6% of the social sector programme budget in FY 2013.

The NSSS does not mention family planning directly, except in plans to expand the Maternal Health Voucher Scheme (MHVS),[[12]](#footnote-12) which provides subsidised access to safe delivery services in 53 mostly rural upazilas (of the total 489 Upazila). The voucher scheme is supposed to provide post-partum FP and to incentivise uptake of FP by making support conditional upon a woman having used contraception prior to her second pregnancy. However, this is difficult to enforce and monitor and an assessment of the MHVS found the FP component to be particularly weak (Hatt et al. 2010). The NSSS also includes the Urban Community Development programme which should also provide some access to FP for the poor in urban areas.

**The National Adolescent Reproductive Health Strategy** 2017 – 2030 has recently been up-dated from the previous version developed in 2006. It identifies four priority thematic areas of intervention: adolescent sexual and reproductive health, violence against adolescents, adolescent nutrition and adolescent mental health (MOHFW 2016c). The FP2020 up-date states that Bangladesh will fully operationalise its new National Adolescent Health Strategy with special focus on addressing the family planning needs and promoting rights of all adolescents (FP2020 2018a), although this commitment is also flagged up as a major challenge.[[13]](#footnote-13) Specific challenges include unclear roles and responsibilities among different ministries, and (related to this) the lack of integration of the new strategy into ministries such as the Ministry of Youth & Sports, Women and Children Affairs, the MOHFW, and MOLGRDC.

The **National Urban Health Strategy (NUHS)** 2014 outlines a number of health financing options to support urban health provision, such as: introducing a free health card for urban poor; introducing health insurance for formal sector employees and voluntary insurance for others; and ensuring a separate budget for urban health from Local Government Division (LGD). It also aims to mobilise resources from development partners and the private sector through corporate social responsibility (CSR) and other local sources of funding through LGIs and NGOs. The Strategy also suggests the MOHFW should deliver primary health care (PHC) in urban areas where services are not delivered by the LGIs and NGOs (Hamid and Sabur 2016; LGD 2014).

There is a draft **Bangladesh National Action Plan for post-partum, post-menstrual regulation and post-abortion care family planning (September 2017)** which was developed after the FP2020 meeting in Chiang Mai, Thailand in June 2015 on Accelerating Access to PPFP. This includes detailed activities on rolling-out PPFP but no final document or information regarding assessment of progress could be found. PPFP is an area highlighted in the FP2020 up-date as lagging and requiring further support (FP2020 2018a; FP2020 2018b). It includes the provision of post-MR and post-PAC family planning throughout the country, with a focus on vulnerable groups. GFF funds are being channelled to this area including for training health workers, quality improvement, updating the MIS and the provision of equipment, contraceptives and supplies.

The **Costed Implementation Plan for the National Family Planning Program 2016-2020** outlines a multi-year process to achieve the country’s FP2020 goals, and is under the DGFP of the MOHFW. The CIP focuses on six areas required to achieve a CPR of 75% including LAPM of 20% by 2021, as well as setting out the resources needed and the intended impact. These six areas are consistent with national policies and operational plans and include: FP services delivery; information, education and communication; high-performing staff; procurement and supply management of FP commodities; planning and management; and policy and advocacy. Twenty-six strategies are defined to achieve the objectives across all six focus areas (MOHFW 2015; UNFPA 2016). See 4.2.2 below for more detail on CIP costing.

Two important HPNSP Operational Plans for the delivery of family planning services are the **Clinical Contraceptive Services Delivery Programme (CCSDP)**, and the **Family Planning - Field Services Delivery Programme**. The CCSDP in particular outlines plans to increase utilisation of LAPM by channelling additional financing to facilities in the form of Imprest Funds. [[14]](#footnote-14)

### Commitments & targets

In July 2012, the GOB committed to the overall goal of ‘Ensuring quality and equitable family planning services for all eligible couples by improving access to and utilization of family planning services, particularly by the poor’ at the London Summit on Family Planning (FP2020) (MOHFW 2015).[[15]](#footnote-15) The revised commitments (done in September 2015) can be summarised as scaling-up both funding and quality of FP programmes, through:

* Increasing access to LAPM and post-partum and post-abortion FP services, particularly by the poor;
* Addressing high rates of adolescent pregnancy through the provision of adolescent SRHR services, and working with the private sector and NGOs to address the needs of young people, particularly young couples;
* Reducing geographic disparities in access to SRHR services by working with local leaders and communities to develop context-specific interventions;
* Using innovative service delivery, and social and behavioural change interventions, including digital health (mobile phones, social and electronic media) to increase the CPR in low-performing areas (Sylhet, Chittagong and Barisal divisions) and urban slum areas by 2021;
* Strengthening monitoring to ensure quality of care, particularly regarding rights-based FP counselling, client follow-up and timely referrals for management of side-effects and complications;
* Strengthening the FP supply chain, as well as improving the choice and availability of LAPMs (including for men, post-partum and post-abortion services);
* **Minimising the resource gap for FP services by 50% by 2021**, by re-allocating the development budget and mobilising more resources for family Planning. Specifically, Bangladesh has committed to mobilising at least USD 615 million[[16]](#footnote-16) from its development budget for the family planning programme implemented by the DGFP as part of its 4th HPNSP, representing an increase of 67% from the allocation in the 3rd health sector programme (2012-2016) (*see also 4.2.2 below)*.

The targets which the government has committed to for FP2020 are not fully aligned with those in the HNPSP. The two sets of targets are summarised in table 1 below.

**Table 1: summary of targets to which the GOB has committed for FP202 and HPNSP**

| **Indicators** | Measured as | **Value (year), source** | **GOB**  **committed target level in** | | |
| --- | --- | --- | --- | --- | --- |
| **FP2020** | **HPNSP** |
| **To be achieved by year 2021** | **To be achieved by year 2022** |
| Total fertility rate | Children born per woman | 2.05 (2017), BBS 2018  1.68 Urban  2.37 Rural  2.3 (2014) BDHS (2014) | 2.0  (Revised from 1.7) | 2 |
| Contraceptive prevalence rate | % | 62.5% (2017), BBS 2018 | 75%  (Revised from 80%) | 75% |
| Contraceptive prevalence rate (low performance areas and urban slums) | % | Sylhet: 47.6% (2017)  Chattogram: 55.6% (2017) BBS 2018 | 60% | 60% |
| Unmet need among MWRA | % | 12% (2014), BDHS | 10%  (Revised from 7%) | 6% |
| Discontinuation rate | % | 30% (2014), BDHS | 20% | 20% |
| LAPMs | % contraceptive usage | 8.1% (2014), BDHS | 20%  (Revised from 30%) | 20% |
| Delivery | % (by skilled birth attendant) | 72% (2017), SRVS 2018 |  |  |
| Delivery | % (institutional) | 48.2% (2017), SRVS 2018 |  |  |
| Ante natal care | % (at least four visits) | 37% (2016), BMMS 2016 |  | 50% |
| Early marriage <18 yrs (legal age of marriage for girls) |  | 65% (2014), BDHS |  |  |

*Up-dated from Options 2018*.

The Government’s 7th 5-year plan has sectoral targets, including for education, health and population, which include the additional commitments to reducing maternal mortality to 105 per 100,000 live births (currently 196 as per BMMS 2016 and 169 as per SVRS 2018) and increasing skilled attendance at birth to 65% (already surpassed) (GOB 2016b). In addition, the GOB has signed up to the SDGs, including committing to reaching indicators 3.7.1 and 3.7.2 to increase the proportion of married or in-union women of reproductive age with met needs for modern FP to 74.1% and to reduce the adolescent birth rate (per 1,000 women aged 15 – 19 yrs) to 33.9 by 2030.[[17]](#footnote-17)

**FP2020 prioritised actions for the in-country stakeholders and focal point 2018 - 2020** include the following related to financing of SRH/FP:

* Prepare and disseminate directive on how to access and distribute Imprest funds to the health providers and clients in a timely fashion (scheduled for Q4 2018);
* Update costed implementation plan for National FP Program to include adolescents, impact to decrease MMR and procurement for contraceptives to fulfil GOB FP2020 commitments to supply NGO and private sectors (by DGFP, USAID and UNFPA scheduled for Qs 1 – 3 2019);
* Add line item with accompanied budget to the operational plan for emergency and discretionary funding to respond to unexpected crises and emergencies (by DGFP in Q 1&2 2019)

Further prioritised actions for the FP2020 Secretariat, Core Conveners & Global Partners include the application of FP-SDG model in Bangladesh during quarters 1 – 3 of 2019 by HP+. This model allows users to simulate the effects of family planning on a variety of health and non-health SDG indicators, producing results which are useful for advocacy purposes. Projected SDG outcomes of increased FP utilisation include water and sanitation services, poverty, food security, child stunting, education, income, and child labour, among other impacts (FP202 2018).[[18]](#footnote-18)

### Legal context

In order to provide a complete picture of the policy framework in which health financing reforms and safety net mechanisms are being developed, it is important to mention non-policy regulations that affect health provision, and insurance in particular. The health system in Bangladesh is pluralistic, with the majority of clients seeking care in private facilities.[[19]](#footnote-19) A wide set of regulations governs participation in health service delivery, as summarised in Table 2 below.

The regulatory bodies of the health sector are the Bangladesh Medical and Dental Council (BMDC), Bangladesh Nursing Council (BNC), State Medical Faculty (SMF), the Ayurvedic, Homeopathy and Unani Board, and the Bangladesh Pharmacy Council.

Table 2: Summary of key regulations covering the provision of healthcare services in Bangladesh

| **Acts/Ordinance** | **Purpose** | **Key features** |
| --- | --- | --- |
| Medical Practice and Private Clinics and Laboratories (Regulation) Ordinance 1982 (Amendment 1984) | Regulation of medical practice (public and private) and opening and functioning of private clinics and diagnostic centres. | DGHS' is responsible for issuing and renewal of licenses following fulfilment of criteria specified.  Public facilities need no registration.  Private Service providers also need to obtain trade license from the urban local bodies or institutions. |
| Medical and Dental Council Act 1980 | Established the Bangladesh Medical and Dental Council which regulates the practice of medical practitioners and dentists in Bangladesh | Establishes uniform standards of quality and qualifications for medical and dental practitioners |
| Local Government Act: City Corporation (2009) and Local Government Act: Paurashava 2009 | Registration[[20]](#footnote-20) of all private hospitals/clinics, and diagnostic centres[[21]](#footnote-21) and paramedical institutes with CC/Municipalities. | Local Government Acts authorises the Municipality and CC to cancel registration or close down private hospitals/clinics/diagnostics centres/paramedical institutes if deviation occurs. |
| Bengal Medical Act 1914[[22]](#footnote-22) | Functioning of paramedics and health technologists. | Paramedics and health technologists’ certification issued by the State Medical Faculty (SMF). |
| Pharmacy Ordinance 1976 | Registration of pharmacists under the Pharmacy Council of Bangladesh (PCB). |  |
| National Drug Policy 2005 & Drug Control Ordinance | Qualification for holding stock, distribute or sell drugs and medicines. |  |

*Source*: Adapted from Options 2018

Regarding the legality of **abortion**, Bangladesh is still governed by the penal code from 1860, where induced abortion is illegal unless the woman’s life is in danger. However, menstrual regulation has officially been part of the family planning programme and widely practiced since 1979, and in 2012, the Drug Administration for Bangladesh legalised the combination of mifepristone and misoprotol for medical abortion (Zaidi et al. 2014).

The **Child Marriage** Restraint Bill 2017 sets the legal age of marriage as 18 for women and 21 for men, but also introduced exceptions for ‘special cases’ where it is deemed in the interest of the child or adolescent. Punishment for breaking this law is up to one month’s imprisonment or up to Taka 1,000 fine which is felt to be lenient. The government has launched a **National Action Plan to End Child Marriage** and prioritised adolescent health across many policy documents, including FP2020 commitments (see below) (FP2020 2018b). Despite these efforts, half of all girls still marry before the age of 18 years (Ainul et al. 2017).

As Bangladesh looks at **pre-payment and insurance schemes** as options for longer term reforms, there are two principal authorities regulating providers of insurance: the Microcredit Regulatory Agency (MRA) and Insurance Development Regulatory Agency (IDRA). These two agencies are governed by the Micro Credit Regulatory Authority Act of 2006, the Insurance Act of 2010 and the Insurance Development and Control Authority Act of 2010. According to the Labour Act (amended) 2006, it is compulsory for businesses (i.e. garment factories) to have 'group insurance' for workers if an establishment has more than 100 permanent employees.

**Micro health insurance** (MHI) in Bangladesh is almost exclusively offered by NGO micro-finance institutions to serve the underprivileged. According to the Micro Credit Regulatory Authority Act 2006, micro credit institutions can receive deposits from and offer different types of insurance or social loans only to their members. The Insurance Act allows private companies to offer health insurance as part of life insurance, but not as a core product. Regulatory agencies face challenges due to the limited resources available and gaps in regulations (Kabir et al. 2014).

| **Known challenges** | **Information gaps** |
| --- | --- |
| Challenges include:   * Poor coordination between MOHFW and MLGRDC, which impacts on the delivery of urban primary health care, including SRH/FP; * Dual structures in the MOHFW which do not work in a coordinated fashion; * Considerable complexity of structures for oversight of health financing and social protection (i.e. social protection schemes); * Rolling out social health protection schemes to the informal sector; * Weak coordination and regulation of private sector providers leading to duplication and gaps in coverage.   In addition, the revised principal challenges for meeting FP2020 commitments include:   * Implementation of the National Post-Partum FP Action Plan * Mobilisation of sufficient funds * Operationalisation of the National Adolescent Health Strategy * FP commodity supply, particularly the provision of free contraceptives to NGOs and private sector clinics with trained personnel   (*FP2020 2018a)* | * Assessment of overall progress of the HPNSP PIP: annual implementation plans and monitoring reports might provide an overview of progress against the 29 Operational Plans (across the different directorates) * Up-to-date understanding of how the two MOHFW Divisions are working together – or planning to work more closely together * An analysis of the overlaps and duplication between the 29 Operational Plans * Feasibility of including FP in social health protection mechanisms such as SHI and the MHVS (as well as the feasibility to use MHVS to target young people for FP services and information). |

## 4.2 The financial, institutional and political context of Bangladesh

### 4.2.1 The national budget

| **Research question** | **Key documents** |
| --- | --- |
| 1. Show how the national budget is structured, noting in particular any budget allocated to SRH/FP 2. Civil society engagement: are CSOs involved in public financial processes and budget discussions? | * HPNSP Costed Implementation Plan * HPNSP Operational Plans and their budgets (7 which fall under DGFP, and two in particular for FP service delivery:   + OP for Contraceptive Clinical Services Delivery Programme   + OP for the Family Planning – Field Services Delivery Programme * Bangladesh National Health Accounts (1997 – 2012) * Public Expenditure Review (1997 – 2014) * World Bank fiscal space analysis 2016 (World Bank 2016) |

### Budget structure and process

Bangladesh started to implement a medium-term budget framework (MTBF) in FY2004/05, led by the Ministry of Finance (MOF). The minister is responsible for coordinating the overall resources and expenditure programmes of the government and finalises the estimates for domestic resources. The divisions of the MOF involved in the budget process are: the Finance Division; Economic Relations Division; and Internal Resources Division (National Board of Revenue). Line ministries submit their Ministry Budget Frameworks, developed with inputs from departments and agencies down to the district level. The budget is divided into a revenue (non-development) budget and a development budget. After determination of the requirements for the revenue (non-development) budget, the remaining internal resources are set aside for the development budget (Ganguly and Panda 2011).

An independent review of Bangladesh’s budget for FY 2017/18 by the Centre for Policy Dialogue (CPD), included an assessment of ‘budget inclusivity’, highlighting budget allocations for gender, children, climate, local government, and marginalised groups including those with disabilities. The gender budget (c. 28% of the total budget, representing 5% of GDP), provides gender disaggregated budget and beneficiary data for four ministries, including health and family welfare, education, social welfare and food and disaster management. There is reportedly a database of people living with disabilities, cited in the CPD budget analysis (CPD 2017).

Mirroring the national budget structure, the MOHFW budget includes both a Revenue budget (recurrent costs, such as salaries and allowances), and a Development budget (Annual Development Program or ADP), which largely covers capital costs and programme implementation costs.[[23]](#footnote-23) The Development Budget is programme based. While the revenue budget is financed by the Government, the ADP is financed through a combination of sources including government and development partners. Both Revenue and Development budgets are revised half-way through each fiscal year, which runs from July to June. A budget calendar for Bangladesh is included as Annex 3.

Budgets are consolidated at central level by the MOHFW which negotiates with MOF. While decentralised agencies down to district level provide inputs and help to define high level strategies, the budget formulation process is in practice top-down. Upazila Health Complexes receive earmarked budgets for all the lower level facilities in their catchment area and are responsible for consolidating all their inputs. They liaise with the Civil Surgeon (CS) at district level[[24]](#footnote-24) or sometimes with the DGHS directly (see also fig.6 below on health system structures). District hospitals without superintendents send their budget requests through the CS office and District hospitals with superintendents send their budget directly to DGHS. Under the Medical Education and Family Welfare Division, the DGFP allocates both revenue and development budget for Maternal and Child Welfare Centres and the Upazila Family Planning Offices. The CS’s office and Deputy Director Family Planning are directly responsible for budget execution and monitoring, as well as for the overall supervision of activities in their areas respectively for health and FP programmes.

The MOHFW finances its Development Budget through the 4th HPNSP. Each of the 29 Operational Plans of 4th HPNSP has activities planned against estimated costs, although this does not necessarily reflect the actual budget allocation in any one year. Furthermore, the OPs do not reflect the available revenue budget. Annual Performance Reviews are, in theory, undertaken to monitor the progress and spend of each OP by government and donor agencies, and each has a thematic working group comprising ministry, development partners, NGOs, advocacy groups, and others. The Bangladesh public expenditure review (PER) (1997 – 2014) found that the revenue budget is not linked to sectoral priorities because the OPs do not reflect the revenue budget available (MOHFW 2016b).

Some donors pool and channel their funds through the government system, which is known as Reimbursable Project Aid (RPA), while others directly finance activities and projects, known as Direct Project Aid (DPA). However, the situation is complex, with some pool funders also financing through DPA. Special funding arrangements such as GAVI and GFATM, which provide funding for priority health interventions such as immunisation, HIV/AIDS, TB, maternal health and health systems, mostly provide through ADP (World Bank 2016).

The PER also reported inefficiencies in budgeting and financial planning due to the preparation of two budgets on separate time schedules by two separate units: the revenue budget is mainly the responsibility of the Financial Management and Audit Unit of the MOHFW, while the development budget is the responsibility of the Planning Wing of MOHFW. Both budgets have recurrent and capital items, and some line items receive allocations from both budgets, suggesting scope for consolidation and coordination (MOHFW 2016b).

In the national budget for the fiscal year (FY2018 – 19) in Bangladesh, the largest portion of funds (14.6%) is allocated to education and technology, followed by 12% for transport and communication, 11% for interest payments, 7% for subsidies and incentives, 7% for local government and rural development, 6.3% for miscellaneous expenditure, 5.6% for each of three sectors -- defence, public order and security & pension, 5.4% for energy and power, 5.1% for social security and welfare, **5% for health**, 3.7% for agriculture and 3.1% for public administration (Start Online 2018).

This shows low prioritisation of health within the overall budget – a situation which has changed little over many years. This is attributed by key informants to weak negotiating power of the MOHFW with the MOF, poor budget execution, low prioritisation of health generally and a lack of key issues around which government and non-government stakeholders can coalesce to push for change, and a dearth of champions in MOHFW.

### Budget allocation process

The budget allocation process follows a traditional method of resource allocation from the national to the local level with budgets based on a combination of historical allocation, number of beds in a facility and staff salaries. Consequently, the budget is not well-linked to the health needs of the population and the performance level of a health facility: it does not take into account measures such as population size and density, poverty levels and disease burden (Islam et al. 2018). In addition, “there are no adequate systems for tracking the use of public resources for the intended beneficiaries.” (World Bank 2016:26).

### Participation in the budget process

Bangladesh provides few opportunities for the public to engage in the budget process. The Open Budget Survey of 2017 shows Bangladesh with a score of 41, against a threshold of 60 which is deemed to be the level at which the public are able to engage in budget discussions in an informed manner. Recommendations by the Open Budget Network include:

* Publish a Mid-Year Review and a Pre-Budget Statement online
* Produce and publish an Audit Report and a Citizens Budget
* Publish the In-Year Reports online in a timely manner[[25]](#footnote-25)

Furthermore, suggested actions to improve public participation in its budget process, include:

* Pilot mechanisms for members of the public and executive branch officials to exchange views on national budget matters during both the formulation of the national budget and the monitoring of its implementation. These mechanisms could build on innovations, such as participatory budgeting and social audits;
* Hold legislative hearings on the Audit Report, during which members of the public or civil society organizations can testify;
* Establish formal mechanisms for the public to assist the supreme audit institution in formulating its audit programme and to participate in relevant audit investigations.

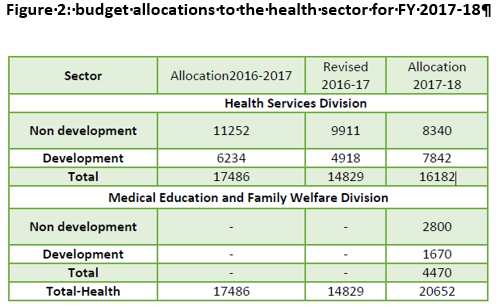
The wide range of stakeholders who took part in the WISH political economy analysis also raised the issue of complicated and highly complex budget negotiation processes leading to difficulties for non-government groups to engage in budget planning.

| **Known challenges** | **Information gaps** |
| --- | --- |
| * Weak negotiating power of MOHFW vis-à-vis the MOF and weak budget execution; * Lack of prioritisation of health within national budget for many years; * Dual budgets made by two separate entities within MOHFW for revenue and development budgets with separate timelines; * Budget is top-down, despite decentralisation policy and health needs are not linked to allocations; * Operational Plans do not reflect the revenue budget. | * Lack of knowledge and information on civil society engagement in the budget process; * Lack of clarity over the overall level of funding dedicated to family planning in the budget (Require further analysis with the estimated costs/budgets for each of the Operating Plans under the DGFP and DGHS); * More detail on how the budgets for the National Family Planning Programme, and HPNSP more broadly, are developed and incorporated into the health budget; * Up-to-date disaggregated data on young people’s SRH/FP (might be available from BDHS 2017, once published) |

### 4.2.2 Health financing, and SRH/FP financing

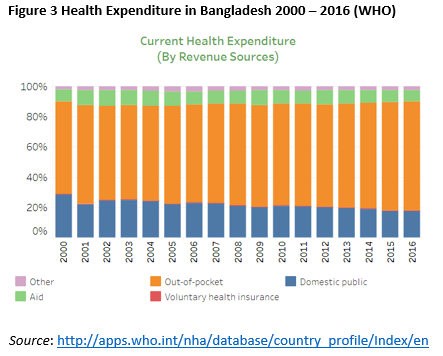
| **Research question** | **Key documents** |
| --- | --- |
| 1. Provide perspective on key health financing indicators, with a SRH/FP focus (total health expenditure (THE) breakdown, health sector as percentage of national budget, budget execution rates) 2. Show funding flows within the health sector | * 7th 5-year plan 2016 - 2020 * Health Care Financing Strategy 2012 - 2032 * Public Expenditure Reviews, 1997 – 2014 * Bangladesh National Health Accounts 1997 – 2015 * Health, Population and Nutrition Strategic Investment Plan (HPNSIP) for the 4th HPNSP * Costed Implementation Plan (CIP) for the National Family Planning Programme * Operational Plans for DGFP (7 out of 29 in total) * FP2020 documents |

Bangladesh’s current system is one of general tax-funded health care and publicly-provided services, although according to some sources, 63% of people now meet their healthcare needs in the private sector (TIB 2018). Annual current health expenditure was USD30 per capita in 2016, up from USD11 in 2000, largely fuelled by an increase in private healthcare spending (WHO 2017b).[[26]](#footnote-26) Although government funding for healthcare has increased in real terms, its share in total health expenditure (THE) has been slowly decreasing from 29% in 2000 to around 18% in 2016, and is now among the lowest in the South and South-East Asia region (Molla and Chi 2017; WHO 2017b; World Bank 2016). A review of the FY2017-2018 national budget showed a moderate increase in the share of funds allocated to the health sector, and a marginally higher allocation to health as a percentage of GDP (0.92% in FY18 vis-à-vis 0.75% in FY17) after many years of slow decline (CPD 2017). Figure 2 below shows that the health budget is roughly equal parts development and revenue funding for FY2017-18. Allocations are often revised substantially downwards at the mid-year point.

Although widely acknowledged in policy and strategy documents that low domestic health spending poses a major challenge for improving universal coverage and quality of health services (particularly in lagging areas and for vulnerable and hard-to-reach groups), this has not translated into increased domestic funding for health. In 2012, the MOHFW accounted for 97% of public health spending and received around 5.5% of the total government budget (World Bank 2016), whereas in the current fiscal year (FY 2018-19), the health sector as a whole has been allocated 5% of the total government budget (see also 4.2.1).

People bear the brunt of their healthcare costs through very high out-of-pocket expenditure on health, as can be seen in fig. 3 below; the largest portion of health expenditure is made up of OOP spending which has been slowly increasing from 67% in 2010 to an estimated 72% in 2016. Bangladesh NHA report of 2015 also showed the similar trend of OOP expenditure for health with 60% in 2010 to 67% in 2015.

External aid has hovered around the 10% (of THE) mark for many years. Most of this is on-budget through the HPNSP. However, official development assistance contributes about a quarter of the MOHFW’s total budget and is therefore an important source of funding for the health sector. Although financial support for the SWAp has increased in absolute terms, it has slightly decreased as a proportion of the MOHFW budget.

The Health Sector Support Project (HSSP) of the GFF comprises a USD 15 million grant from GFF, USD 500 million in IDA from the World Bank, USD 13 million from the Netherlands, USD 23 million from Sweden, USD 60 million from the UK, as well as proposed co-financing from other partners) is a major source of funding for the HPNSP (GFF 2017). Annex 4 contains a map of financing flows to the health sector.

Since 1998, Bangladesh has conducted four rounds of National Health Accounts (NHA) covering the period 1997–2015. The latest NHA, using the internationally accepted System of Health Accounts 2011 framework, show nearly 70% of the health expenditure goes on drugs, health care services and curative health care, while just 10% is spent on preventive care (which is mostly – 85% - made up of spending on reproductive health and family planning & counselling preventive services). Some 2% goes to education and training of medical personnel (MOHFW 2017b).

At the time of publication of the BNHA in 2017, the Director General of the Health Economics Unit (HEU) in the MOHFW attributed the continued rise in out-of-pocket expenditure to changes in disease patterns[[27]](#footnote-27), the availability of expensive and long-term treatments, and the rising prices of medicines. He also mentioned easier access to technology in urban areas, for example unnecessary pathology tests, as a reason for cost escalation.

It is interesting to note that, according to the BNHA, nearly half of THE (46%) is spent for Dhaka division which accounts for about 55 million of Bangladesh’s 167 million people, while Chittagong had 16%, Rajshahi 11% and Khulna 12% of expenditure. Sylhet and Barisal received the lowest proportion of funds in 2015 (4%) (MOHFW 2017b). Sylhet has also suffered poorer health indicators than many other areas for some years, including lower contraceptive prevalence, and is one of the lagging divisions targeted by both FP2020 and the GFF funds (BBS 2018; FP2020 2018b; GFF 2017). Dhaka enjoys the highest contribution from both public (36%) and private (49%) funds and spending is highly skewed towards secondary and tertiary services (including all the national level specialized and referral hospitals) which are mostly located in urban areas.

According to a report by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP), there remains significant room for enhancing the composition and quality of public expenditures in support of Bangladesh’ development priorities, including **“strengthening and reorienting national budgets towards priority areas of social protection, health and education”** (UNESCAP 2018: 39).

### Efficiency

It is estimated that Bangladesh could reduce health expenditures by as much as 10 - 15% and maintain the same health outcomes with improved expenditure efficiencies (UNESCAP 2018; World Bank 2016). Every year, a portion of MOHFW budget remains unspent, reported in successive Public Expenditure Reviews, reflecting overly rigid public sector financial management practices which for example give rise to procurement bottlenecks (World Bank 2016). Delays in release of funds are cited as one of the biggest obstacles to smooth and efficient service delivery in Bangladesh, and slow procurement delays the provision of necessary goods and services (MOHFW 2017a; World Bank 2019). Furthermore, what would usually be predictable recurrent expenditure items, such as salaries, cleaning and training show year-to-year fluctuations, and the same line items show overspending in one year and under-spending in another (MOHFW 2016b).

In regard to the financing of health services in urban areas, local government is completely reliant on central government for funding which creates inefficiencies. Financial matters are so centralised and bound by bureaucratic rules and regulations that local officials, even DGHS officials, cannot switch money between budgetary subheads without the agreement of the MOHFW (Ahmed et al. 2015).

The PER (1997 - 2014), however, found evidence of some improvement in execution rates of larger budgets, indicating greater efficiencies (MOHFW 2016b), and a recent bulletin of the DGHS reported rising budget utilisation rates with 68.28% of the allocated amount spent in FY2016-17, and 92.52% of the allocated amount for FY2017-18 (MOHFW 2018a).[[28]](#footnote-28) For the seven OPs which relate to the FP2020 commitments (7 of 29 OPs), expenditure against allocation for FY 2017-18 was 89% of the USD325.35m allocated under ADP.

While Ahmed and colleagues (2015) point out that, at around 0.4% of GDP, improving efficiencies in health expenditure would not translate into significantly higher fiscal space, budget analysis for FY18 shows *allocation* of 0.92% of GDP to health, which would generate considerably more funding if fully executed and not revised downwards (CPD 2017). It is also worth noting that, although Bangladesh spends a smaller proportion of government funds on health than most other countries in South and South-East Asia, it outperforms many of these countries in terms of certain health outcomes (i.e. maternal and child mortality indicators), so it is arguably gaining better value for its limited investments (Ahmed et al. 2015:158; Chowdhury et al. 2013).

Improved PFM systems are recommended by several authors and institutions, particularly as a source of additional fiscal space (i.e. IMF 2016; Islam et al. 2018; World Bank 2016). The World Bank has recently approved a USD100 million credit for improving fiscal forecasting, budget preparation and execution, which will include a diagnostic study on PFM to identify and document PFM issues as they relate to public health, service delivery and implementation of the health care financing strategy (World Bank 2016, Islam et al. 2018).

Finally, there are widespread concerns about accountability and transparency in the use of funds and an important need for strengthened governance of the health system, particularly regarding public financial management (Islam et al. 2018; UNESCAP 2018). This is acknowledged and forms a key priority of the 4th HPNSP. Corruption is widely cited as an important cause of both high OOP expenditure for health and inefficiencies in health system management (i.e. Naher et al. 2018; TIB 2018).

### Equity

A high percentage of OOP in THE, as is the case of Bangladesh, is associated with low financial protection (WHO 2017a), and a study by Molla and Chi (2017) found **health systems financing in Bangladesh to be regressive**.[[29]](#footnote-29) This is demonstrated by high levels of impoverishment and catastrophic health expenditure; Bangladesh has the highest incidence of catastrophic health payments in the Asia Pacific region (Ahmed et al. 2015). Statistics vary but approximately 4-5% (around 8 million people) incur catastrophic healthcare payments annually (using the threshold of 25% of monthly household consumption expenditure),[[30]](#footnote-30) and in 2014 14% of people spent more than 10% of their household's total expenditure on health care (Ahmed et al. 2015).

The PER shows some improvement in the equity of public health spending. For example, the ratio between the poorest and richest women in using public facilities for delivery improved from 1:7 in 2007 to 1:2 in 2014, and poorer divisions of the country received a higher share of total public spending compared to their respective share of the population.[[31]](#footnote-31)

### Collection & pooling of revenues, & fiscal space

As stated above, the MOHFW finances its revenue budget from public funds (general taxation made up predominantly of income tax and VAT) and the development budget through the 4th HPNSP. At present, the only real pooling mechanism is through general taxation, which as shown above constitutes only a small portion of overall health expenditure. Pre-payment mechanisms, such as health insurance, either by private or community initiatives, account for only a very small proportion of health expenditure, and the Government’s plans to scale up SHI gradually to different population groups risks further fragmentation, not to mention being administratively difficult to design and manage (World Bank 2016).

Public financing for MOHFW facilities in rural areas is channelled through MOHFW, whereas PHC provision in urban areas is the responsibility of the health departments of the Local Government Institutions, and financed through the Local Govt Division (LGD) budget and other ministries. Specific financing mechanisms have been implemented by other line ministries, such as Social Welfare, which provide reimbursements direct to facilities providing key services to poor clients or direct cash transfers to lactating mothers.

At facility level, clients are charged user fees depending on the services utilised and the type of provider. In public facilities, clients are charged a flat fee for diagnostics, and registration for both in-patient and out-patient departments. Drugs and consumables on the Essential Drugs List are provided for free when available, but many facilities experience frequent stock outs, when clients are expected to buy them directly.[[32]](#footnote-32) Income from user fees at public facilities is nominal and not retained at the facility but sent to the Government treasury, although current health reforms aim to allow facility to retain part of this income (see section 4.2.4). Many facilities also levy informal fees, which is a major driver of the high OOP payments. There are multiple exemption systems in place for specific groups and rationing of available resources is done directly by frontline health staff in both public and private sectors.

Opportunities for increasing domestic financing for health are limited. The Healthcare Financing Strategy suggests a combination of taxes, social health insurance contributions and community-based health insurance. However, the social protection scheme pilot for the BPL population, Shasthyo Shuroksha Karmasuchi (SSK), has yet to be scaled up, despite commitments and plans to do so in many of the MOHFW’s strategy documents (MOHFW 2012; World Bank 2016).[[33]](#footnote-33) Currently, HEU, the authority who is managing the pilot phase of SSK, has initiated an evaluation of SSK pilot to document the learnings and achievements as well as challenges faced.

The World Bank assessed the potential for different forms of insurance to contribute to raising domestic revenues for health and concluded that any scale-up of SSK would need to be financed from general government revenues, and that a national or regional insurance scheme will require long term planning and substantial investment capacity that is not evident at present. The current SSK benefit package covers mostly in-patient care and referral to district hospitals; family planning has not yet been integrated into SSK schemes, although this is part of the FP2020 agenda (FP2020 2018b).

Some good progress has been made regarding provision of private health insurance in the garment sector. For example, a Dutch-funded pilot, was introduced in 2015-16 and provides access to a basket of services including SRH and FP services for insured women. Efforts are underway to scaled up the approach. Annual premiums are around BDT 500, paid through a combination of external assistance and cost-sharing by business owners and the insured. It has been estimated that, with some 4.2 million garment factory workers, such a scheme could raise around BDT 2 billion if extended to all garment sector workers (Uddin 2018). Other schemes have sprung up with different cost structures, although it is not clear how many garment workers are currently covered by such schemes (Malik 2018).

At 7.5% of GDP, Bangladesh’s tax-gap (the gap between a country’s potential and actual tax revenues) is among the highest in the region, indicating substantial room for improvement (World Bank 2016).[[34]](#footnote-34) Key areas for improving tax collection are strengthening governance and tackling corruption. Both UNESCAP and World Bank have raised the possibility of a carbon tax, rationalising foreign direct investment tax incentives, and earmarked taxes for health (i.e. the tobacco tax), as potential mechanisms for increasing domestic financing for health, education and social welfare programmes (UNESCAP 2018, World Bank 2016). This year, Bangladesh will introduce a long-delayed flat rate of VAT at 15% (delayed due to pressure from businesses), which will raise considerable additional domestic resources. However, based on historical trends, it does not seem likely that a greater proportion of the newly raised funds will be allocated to the health sector.

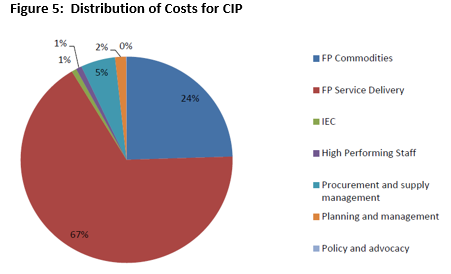
Similarly, it is unlikely that external development assistance will provide a major source of health sector revenues in years to come.

### 4th HNPSP Budget and SRH/FP

The total budget for the 4th HPNSP (January 2017 – June 2022) is shown in figure 4 below. The total is equivalent to approximately USD 13,685 million over the period, using current exchange rates.[[35]](#footnote-35)

It is not clear what proportion of these funds are allocated to, or actually spent on FP and RH. The budget for DGFP is about 11% of the total 4th HPNSP budget and includes the implementation of 7 of the 29 OPs. These are: (i) planning, monitoring & evaluation; (ii) management information systems; (iii) procurement, management and supply of FP commodities; (iv) maternal, child reproductive and adolescent health (MNCR&AH), (v) clinical contraceptive services delivery programme (CCSDP), (vi) FP field services delivery (FP-FSD); and, (vii) information, education, and communication (IEC).

However, some expenditure for FP and SRH (i.e. adolescent health and post-partum family planning) falls under the maternal, neonatal, child and adolescent health (MNCAH) OP of DGHS. A minor part also goes to the national nutrition services (NNS) OP of DGHS. The picture is therefore far from clear in terms of total funds allocated to SRH/FP.

The current costed implementation plan for the National Family Planning Programme to meet the FP2020 commitments (using projections based on data from the BDHS 2014) estimates USD 1,377.36 million will be needed to implement activities across 6 focus activity areas plus FP commodities, provided by both public and private sectors from 2016 – 2020 (UNFPA 2016) (see fig. 5 below). CIP costs rise from USD 227.73 million in 2016 to USD 327.67 million in 2020 (MOHFW 2015), and are highest in 2019 (21.67%) and 2020 (23.78%) due to the projected increase in demand for services, the need to improve service quality, the costs of multi-sectoral engagement and inflation. The MOHFW acknowledges the need to up-date projections (FP2020 2018b).

FP service delivery costs include staff time and commodities which together account for more than 90% of the total estimated CIP. The CIP shows that Bangladesh has committed to mobilise at least USD 615 million from its development budget as part of the 4th HPNSP (2017-2021), representing a 67% increase from the allocation in the 3rd health sector programme (2012-2016). This commitment must be met largely from domestic financing and is the responsibility of the DGFP, working with the Bangladesh Country Engagement Working Group, which plays an important role in ensuring collaboration and coordination of efforts (UNFPA 2016).

This is, however, highly unlikely given current levels of domestic health spending. Although not straightforward, a comparison of the CIP costs for 2016 with those of the DGFP budget for the same year shows that the CIP (if fully funded) would absorb nearly 90% of the entire DGFP budget, even though many activities that are supported by the revenue component of the DGFP budget and administrative costs at national and sub-national levels (divisional, district, sub-district and community) are not included in the CIP.

Significant additional funds will have to be mobilised for its implementation, and strategies and activities need to be prioritised. Named sources of funding in the CIP are:

* Greater allocations to FP by the MOHFW
* Fund raising from the private sector and NGOs
* Private foundations and other innovative financing mechanisms.

| **Known challenges** | **Information gaps** |
| --- | --- |
| * Very low overall spending on health and very low prioritisation of health within the national budget * Multiple OPs for the HPNSP across the DGFP and DGHS, each with different activities, budgets, monitoring and reporting schedules, which overlap to some extent. * PFM inefficiencies and rigidity of systems leading to procurement bottlenecks and delayed release of funds which impacts on expenditure and implementation; * Poor budget execution for HPNSP; * Weak negotiating power of MOHFW with the MOF; * Limited fiscal space to raise additional revenues; * Lack of critical issues around which govt and non-govt stakeholders can coalesce to push for additional funding | * Clear understanding of how much is a) allocated and b) spent on FP and SRH * The funding gap between the CIP and funds available for implementation * Clear understanding of contributions by NGOs, CSOs to health spending generally and SRH/FP spending in particular (off-budget) * Find out which organisation or individuals are assisting the Government on the World Bank-supported PFM improvements and the GFF-targeted health financing areas (aligned with WISH) -assess entry points and opportunities * Contraceptive commodity financing gap |

### 4.2.3 Health sector institutions and supply/demand of SRH/FP services

| **Research question** | **Key documents** |
| --- | --- |
| 1. Show institutions and main mechanisms within the health sector and in particular for SRH/FP 2. Show SRH/FP health services offered at different health system levels and health facilities (as per policy and in reality), including barriers to access (user fees, accessibility) | * 7th five-year plan (2016 – 2020) * Operational Plan for clinical contraceptive services delivery program (CCSDP), DGFP, 4th HPNSP * Operational Plan for MNCAH, DGHS, 4th HPNSP * Bangladesh Demographic and Health Survey 2014 (*2017 survey not yet available publicly)* * FP2020 2018 Bangladesh-Commitment-Self-reporting-Questionnaire-2018 * FP2020 Bangladesh Actions for Acceleration 2017-2018 * FP2020 Bangladesh Prioritized Actions 2018-2020 v2 |

### Brief SRHR context

Progress across several key health indicators for SRHR have stalled over the last decade, including the CPR and TFR. The sample vital registration system (SVRS) for 2017 (BBS 2018) show CPR of around 62% (60% for modern methods) between 2013 – 2017, with slightly higher rates in urban areas (BBS 2018; NIPORT et al. 2016).[[36]](#footnote-36) Unlike most other indicators (i.e. nutrition, skilled attendance at birth or ANC) there is little difference in the CPR between the poorest and richest quintiles of the population (WHO 2017a). Low utilisation of LAPM and post-partum family planning, as well as stock-outs of contraceptives (particularly IUDs) have been identified as contributing factors to this lack of progress (F2020 2018a; FP2020 2018b; Options 2018).

In an assessment of the modern CPR (mCPR) rate in Bangladesh, Track2020 assessed the country as being in Stage 3 of its CPR ‘S’ curve where growth slows and eventually stops as mCPR reaches its maximum. During this stage, rather than focusing on further growth, goals and objectives should be focused on equity indicators and increasing government financial commitments (Track2020 2016). The 4th HNPSP includes a commitment to increase the CPR to 75% by 2022, with an even more ambitious FP2020 target of 75% by 2021 (see also 4.1).

Performance is also lagging among certain groups (i.e. the urban and rural poor, adolescents) and in specific areas of the country (i.e. Tribal Areas, Barisal, Sylhet and Chittagong Divisions). Due to high population growth in urban slum areas, living conditions and access to basic services in urban slums areas is particular poor. The predominance of the private for-profit and non-profit sectors in the delivery of services, with the attendant imposition of user fees for health services, impacts negatively on financial protection.

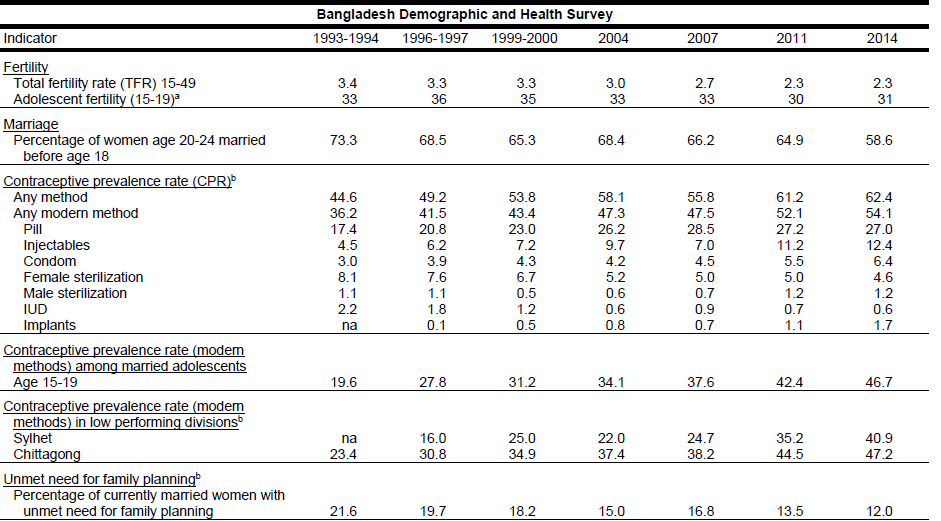
The latest estimates for maternal mortality are from the Bangladesh Maternal Mortality and Healthcare Survey (BMMS) 2016 which gives a rate of 196 maternal deaths per 100,000 live births, little changed from the earlier survey in 2010 (NIPORT et al. 2017). Postpartum haemorrhage and eclampsia account for 55% of maternal deaths, and the risk of dying from these causes remained unchanged between 2010 and 2016. There is a consensus that poor quality of care is an important factor in continued high maternal mortality, although quantitative data are scarce (NIPORT et al.2017).

In the report on Bangladesh sample vital statistics 2017, a large proportion of births took place in private clinics, ranging from a low of 8.1% in Chattogram division, to 33.6% in Rangpur division (BBS 2018). In 2017, an estimated 43% of births took place at home more, while 72% of overall deliveries were attended by skilled birth attendants and 27.7% by unskilled attendants, with unskilled attendance twice as likely in rural areas (BBS 2018). In urban areas, the last two Urban Health Surveys show large disparities in the use of MNH services between slum and non-slum populations in 2006 and 2013, although the gap has narrowed slightly over time (NIPORT et al. 2015).

The infant mortality rate has declined gradually from 31 per 1,000 births in 2013 to 24 in 2017 and neonatal morality rate has declined from 20 per 1,000 live births in 2013 to 17 in 2017 with no difference between rural and urban rates (BBS 2018). After pneumonia, which accounts for nearly a third of infant deaths (28%), 8% of infants die from malnutrition and 6% from respiratory diseases (BBS 2018). There is an urgent need to improve nutrition, particularly among the poor; the Urban Health Survey (2013) found one in two slum children under 5 were stunted. At the aggregate level, the Bangladesh Demographic and Health Survey (2014) found nearly 31% of urban children under 5 stunted, with a higher proportion in rural areas (37.9%) (NIPORT et al. 2016).

To date there has been no national survey of disability, and there are few data on the type, severity and causes of disability in Bangladesh. Unsurprisingly, one study showed an almost linear relationship between the probability of having a disability and level of wealth, while also acknowledging the often complex relationship between the two (Tareque et al. 2014).

Reproductive health among young people is a key strategic area for the Government and implementing the new National Adolescent Reproductive Health Strategy, which is also a FP2020 commitment (FP2020 2018a). Despite improvement, Bangladesh continues to have the highest rates of child marriage in the world (Ainul et al. 2017) and half of girls still get married before their 18th birthday which is an important factor in high rates of adolescent fertility. Use of contraceptives among young people is low and unevenly distributed throughout the country. According to the BHDS 2014, teenage pregnancy has hardly declined since the 1990s, although more recent research shows a small reduction. Table 3 below provides an overview of the BDHS 2014 data:

Table 3: selected data from the Bangladesh Demographic and Health Survey 2014

*Source: NIPORT et al. 2016 (BDHS 2014)*

### Health system structure

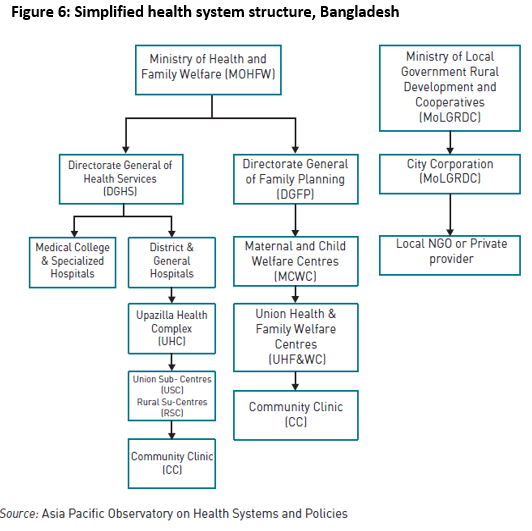
The MOHFW has a number of Directorates General (DG) and specialist institutions,[[37]](#footnote-37)which are responsible for translating and overseeing implementation of policies. The health system follows the administrative structures of government: officials at division and district levels report to the MOHFW at central level. Health offices at the Upazila level are meant to serve defined rural populations, but catchment areas are not well-defined or enforced and referral systems are weak, which means that in practice people chose their preferred provider.

The re-structuring of the MOHFW into three main branches under two separate divisions (see 4.1 above) is still ongoing.[[38]](#footnote-38) The two-branch system (of DGHS and DGFP) has so far been maintained at the decentralised level (*with the exception of the community clinic – see below*) for rural areas, while separate health system structures and financing exist for rural and urban areas. Despite decentralisation efforts over many years, the public health system remains highly centralised, with planning undertaken by the MOHFW and little real authority delegated to local levels (Ahmed et al. 2015). Rolling out MOHFW restructuring to lower health system levels, and greater functional integration at district level and below to reduce waste and duplication, are key priorities of the HPNSP (see also 4.1 above).

Bangladesh has an extensive network of health facilities – both public and private – which reaches deep into rural areas, although significant gaps exist in urban areas. The Essential Service Delivery Package, which includes FP (see below) is delivered through four main levels:

* Community level: domiciliary services; Satellite Clinics; Outreach Services; and Community Clinics
* Union Level: Union Health & Family Welfare Centres; Union Health Sub-Centres; Family Welfare Centres; and some union level Maternal and Child Welfare Centres
* Upazila Level: Upazila Health Complex (with 10 to 50 beds) (which includes Upazila FP office and MCH unit); and some upazila level Maternal and Child Welfare Centres
* District Level: District Hospital; Maternal and Child Welfare Centres ; Comprehensive Reproductive Health Care Centre (CRHCC); and Primary Health Care Centre (PHCC)

A simplified health system structure is shown in fig. 6 below (old system), and a more detailed depiction of institutions and health facilities at each level of the MOHFW is included at Annex 1.

Community Clinics (CCs) were introduced in 1998 (as part of first health sector programme) and revitalized from 2009 as the lowest tier in the health system (taking services ‘to the doorstep’) and is a flagship programme for the health sector (MOHFW 2016a). These clinics aim to provide a one-stop service outlet for health, FP and nutrition services, and have contributed significantly to the improvement of the overall antenatal and postnatal care in Bangladesh (WHO 2019). The clinics provide counselling on RH and consequences of early marriage, and also supply contraceptives. However, the BDHS 2014 shows that only 4.3% of women obtained their family planning at a CC, although this was higher for injectables at nearly 10% (NIPORT et al. 2016).

Key informants stated that the CCs fall clearly under the DGHS which may serve to de-prioritise FP services. People’s participation is supposed to be an important element of CCs although it is not clear to what extent communities participate in practice.

MOHFW structures for the provision of SRH/FP services suffer from acute shortages in human resources at all levels (i.e. midwives); the current workforce is aging and recruitment has been delayed. Many of the technically qualified staff are retiring (particularly at the field level) and posts are being filled with people that have more administrative skills and who are not familiar with the SRHR/FP needs of different groups (*key informant*).

In addition to the MOHFW, many other ministries and departments are engaged in health services delivery, including MOLGRDC, the combined Military Hospitals, Border Guard Bangladesh Hospitals, Police Hospitals and Railway Hospitals to name a few. There are well-functioning disease surveillance and notification systems for early detection and control of communicable diseases and a number of vertical programmes have been implemented and made a positive impact on health, particularly child survival.

The private sectoris made up of formal and informal providers, with formal providers of both western and traditional medicine concentrated in urban areas, and non-formal providers in rural areas (i.e. largely untrained providers of western, homeopathic and traditional medicine). Financial incentives for the development of the private healthcare sector have been provided directly and indirectly by the government for many years, often to address gaps (i.e. HRH) and weaknesses in public provision, which has led to a proliferation in private providers (Rahman 2014). This growth, coupled with weak enforcement of the regulations governing private healthcare provision, have led to poor quality of care and widespread use of formal and informal fees, to the detriment of clients including the poor (TIB 2018). NGOs have for many years played an important role, both in direct service delivery, and in social mobilisation for behavioural change through extensive mass promotion services (Ahmed et al. 2015).

National and international NGOs provide SRH/FP services through static clinics, outreach services and social marketing networks. Marie Stopes Bangladesh (MSB) provides SRH and MNCH services through 600 service outlets, including 141 clinics; a wide network on IUD outreach teams and LAPM Roving teams to support GOB providers; and a social marketing network across Bangladesh’ 64 districts, targeting the poor, young people, factory workers, and vulnerable groups including slum dwellers, homeless people, drug users, sex workers, and transgender people (MSI 2019). The USAID-financed Advancing Universal Health Coverage Programme (Oct 2017 - Sep 2022) is supporting the introduction of social health protection through innovative financing with the aim of reducing OOP for healthcare, primarily targeting the urban areas. It is working to transform the Smiling Sun social franchise network of 399 clinics (which provide MNCH and SRH services) into the Surjer Hashi Network, which will be a centrally managed, private social enterprise, with the goal of achieving financial sustainability.[[39]](#footnote-39)

In urban areas, city corporations and municipalities have a clear mandate under the Local Government Act 2009 to promote public health, establish and maintain hospitals, dispensaries and primary healthcare centres, and to promote infectious disease control and health education. The majority of public facilities that are historically established at district headquarters, are managed and funded by the MOHFW. Even though municipalities are able to build and manage their own facilities, this requires funding that is rarely available or prioritised. The capacity of LGIs to raise funds locally is limited; restricted funding and poor coordination between the MOHFW and MOLGRDC together pose a barrier to the delivery of good quality health services, specifically outpatient services, particularly for the urban poor, but also in rural areas where LGIs are playing an increasingly important role in service delivery (Ahmed et al. 2015; Options 2018). Most of the LGIs in rural areas (upazila and below) has allocated budget for health, however, rarely coordinated with health facilities for efficient utilization of that budget.

#### Service delivery, utilisation and access to care

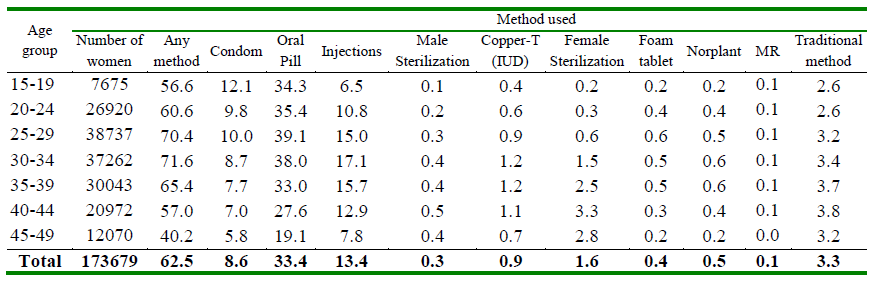
The GOB introduced an Essential Service Package in 1998, and updated it in 2003, renaming it the Essential Service Delivery Package. The list was revised and updated again in 2016 and named as Bangladesh Essential Health Service Package (ESP). This package is defined at a high level (Wright 2015), and includes:

1. Maternal, neonatal, child and adolescent health care
   * Maternal and Newborn Care
     1. Maternal care: pre conception, antenatal, delivery, postnatal
     2. Newborn care: during delivery, after delivery
     3. Obstetric and neonatal care
   * Child Health and Immunization
     1. Integrated Management of Child Illnesses (IMCI)
     2. Expanded Programme of Immunization (EPI)
   * Adolescent Health
     1. Adolescent Sexual and Reproductive Health
     2. Adolescent Nutrition
     3. Adolescent Mental Health
     4. Risk taking behaviour
2. Family Planning
   * Pre-Conception
   * Post-partum
   * Post-abortion
   * Post-MR
3. Nutrition
   * Child Nutrition: assessment of nutrition status, prevention of malnutrition, management of malnutrition
   * Maternal Nutrition
   * Adolescent Nutrition
4. Communicable Diseases includes Tuberculosis, Malaria, HIV/AIDS, Neglected Tropical Diseases (Kala Azar, Lymphatic Filariasis, Leprosy, Dengue, Rabies, Intestinal Parasites), Other Communicable Diseases
5. Non-Communicable Diseases (NCD) including screening of NCDs and Sexual and Gender-Based Violence (SGBV)
6. One complementary service: Management of other common conditions including cares for eye, ear, dental, skin, emergency, and geriatric health
7. The three support (non-clinical) services are:
   1. Laboratory
   2. Radiology and other image tools
   3. Pharmacy

The recent revision happened under 4th HPNSP and prioritised service components which have a high impact on the current (and changing) burden of disease in the country, and took into account the need to improve the referral system to ensure continuity of care, and to prioritise attention to vulnerable and hard-to-reach groups (MOHFW 2016a).

According to the BDHS 2014, nearly half of modern contraceptive users obtained this method from the public sector, with 20% receiving the method from a government fieldworker. 43% used the private sector for family planning methods, with pharmacies being the most important source (38%). NGOs supply 4% of modern methods and a further 4% percent of modern users obtain their methods from a private non-medical source, mainly a shop (3%). Table 4 below provides an illustration of method use by age group. Challenges include an over-reliance on short-term methods and high contraceptive discontinuation rates, particularly for LAPM.

Although out of date, an estimated 430,000 MR procedures were performed in health facilities in 2014 nationwide, representing a sharp decline since 2010. In addition, an estimated 1.2 million induced abortions were performed, likely to have been carried out in unsafe conditions or by untrained providers (Guttmacher 2017). Nearly half of all MR services are carried out in public sector facilities (48%), followed by the private sector (33%) and NGOs (6%) (BBS 2018).[[40]](#footnote-40) Private hospitals and clinics, and Upazila Health Complexes together provide most of the MR services (22% each), followed by medical college hospitals and district hospitals (13%) and private doctors (9%).

Table 4: Method-specific contraceptive use by age (SRVS 2017)

The dual responsibility of adolescent reproductive health across the DGFP and DGHS and lack of progress on integrating health service delivery at the local level, together with the failure to date to integrate the Adolescent Reproductive Health Strategy across relevant ministries, have combined to de-prioritise family planning for young people, particularly unmarried adolescents. The subject of adolescent SRH and access to FP for non-married young people still remains taboo and the government prefers instead to tackle the issue from the angle of prevention of child marriage (Ainul et al. 2017).

An assessment of **adolescent reproductive health** by Ainul and colleagues (2017) found, among other things:

* A lack of SRH programmes that exclusively focus on adolescents (and are designed to suit their specific needs);
* Uneven provision across the country (as with other areas of health services provision);
* The majority of programmes that do focus exclusively on young people tackle SRHR only as a secondary issue, incorporating it into less sensitive topics such as child marriage;
* Services may be tailored to the needs of girls, but often ignore the needs of boys;
* A critical gap in the provision of information and services to unmarried young people;
* Health facilities tend to be thought of as FP clinics which makes them difficult to access for unmarried young people
* Some good examples of school-programmes, but FP for young people is still largely a taboo subject, even among teachers.

Other service delivery areas which are challenging include the roll-out of post-partum family planning which is a key area in the FP2020 commitments.

Challenges for the supply of, and access to quality SRH and FP services in general include:

* Official and unofficial user fees at public and private providers which give rise to uncertainties for clients and pose a barrier to access for the poor. Linked to this, systems for exemption are not uniformly applied and are the responsibility of front line health workers (Rahman et al. 2018);
* Severe HRH challenges across the health sector with insufficient medical staff of the appropriate level and training, compounded by widespread absenteeism (TIB 2018). There is a critical shortage of trained health providers and an inappropriate skill mix. The ratio of doctors to nurses to paramedics is much lower than the WHO recommended ratio of 1:3:5. (Ahmed et al. 2015);
* In addition, there is particular pressure at secondary and tertiary level providers due to weak referral systems, absence of gate keepers and poorly enforced catchment areas;
* Weak transparency and accountability mechanisms and widespread corruption (TIB 2018), as well as particularly weak regulation of private providers and poor management of public-private partnerships. This leads to poor quality of care, particularly in urban areas;
* Poor supply chain management and problems with storage (MOHFW 2016a)
* Insufficient hospital beds for the Bangladeshi population, despite a very fast-growing private sector.

Given slow progress, the planned scale-up of social protection schemes (i.e. SSK, MHVS, micro-health insurance) is likely to have little impact on access to FP, particularly given that FP is not explicitly incorporated into these schemes at present. Hatt and colleagues (2010) concluded that the MHVS needed to introduce a specific voucher for FP in order to increase the impact on FP up-take (particularly post-partum FP which is a major strategy for the MOHFW). However, site-specific packages of care which are part of the FP2020 programme are starting to show results in lagging areas (i.e. Sylhet).

In urban areas, a combination of high urban population growth, insufficient public provision of services, and official and unofficial user fees have put significant pressure on the health system, especially in out-patient departments of secondary and tertiary level hospitals. This has resulted in many people seeking care from unqualified providers and directly purchasing over the counter drugs. Pharmacies are the first port of call for more than a third of those seeking care in urban areas (BBS 2011).

Challenges related to FP highlighted by the MOHFW to be addressed through the implementation of the 4th HPNSP include: widespread lack of readiness to provide quality FP services, particularly in the private sector where quality is poor and regulation and oversight is weak;[[41]](#footnote-41) low utilisation of long-acting and permanent methods (LAPM), menstrual regulation (MR) services[[42]](#footnote-42) and post-abortion care (PAC); and inequalities in access to quality health services and geographical disparities in resource allocation.

Furthermore, the need for strengthened organisation and governance of health services; inadequate and uneven service provision and coverage, with both inefficient duplication in some areas and gaps in coverage for specific groups; insufficient financing of health services and high costs of treatment; quality constraints; weak referral systems; and disconnected information and management systems are all cited as major constraints to the provision of and access to quality services in the HPNSIP (MOHFW 2016a).

| **Known challenges** | **Information gaps** |
| --- | --- |
| * Poor integration of health service delivery (i.e. MNCH with FP) below central level (i.e. at lower levels of the health system) and poor use of Community Clinics for FP services; * Weak oversight and regulation of private providers (where the majority of people access care); * Uneven progress across the country with lagging areas for both access to services and health outcomes; * Poor access in urban slum areas, coupled with high levels of private provision and lack of coordination between providers (overlap, duplication and gaps); * Weak financial protection due to official and unofficial charges, driving catastrophic health spending; * Rolling out of post-partum family planning services with greater emphasis on LAPM; * Access to SRHR (particularly rights-based FP) for young people (married and unmarried). | * Analysis on access to RH/FP services by people with a disability (although apparently there is a database, referenced in the FY2017-18 budget (CPD 2018) * A clear picture of contraceptive stock-outs in the public sector and analysis of the challenges * Progress on the roll-out of the decentralised structures below district level – why don’t more women use Community Clinics for their FP needs? * Potential to link Operational Plans for the HPNSP to the budget (including revenue budget) * Up-dated analysis on why women are not using LAPM |

### 4.2.4 Political context for SRH/FP and other relevant reforms

|  |  |
| --- | --- |
| **Research question** | **Key documents** *(as above in 4.1)* |
| 1. Who’s the most important political champion/supporter for SRH/FP in Bangladesh? Who takes the most important decisions or influence the decision-making process within the MoH, even informally beyond formal responsibilities? 2. Present policies that are under discussion or have been implemented that are relevant for SRH/FP (budget reforms, decentralization reforms, health services reforms such as performance based financing or health insurance)? | * 7th Five-Year Plan 2016-2020 * 4th Health, Population and Nutrition Sector Programme (HPNSP) 2017 - 2022 * Health Care Financing Strategy 2012-2032 * National Social Security Strategy (NSSS) 2015 * National Strategy for Adolescent Health 2017-2030 * Bangladesh National Action Plan for Post-Partum Family Planning (PPFP), Post-MR and post abortion |

### 

### Political Champions

Key informants stated that they are not aware of champions for SRH/FP within the MOHFW. This should be further explored by the Bangladesh country programme.

#### Decision makers:

Focal points for FP2020 are given as per below:

|  |  |  |
| --- | --- | --- |
| List of FP2020 Focal Points | Government | Director General, DGFP, MOHFW |
| Donor | Chief of Health, UNFPA |
| Representative of USAID |
| Lead Health Advisor, DFID |
| Civil Society | Dr. Abu Jamil Faisal |
| Youth | Ms. Sadia Rahman |

The line Directors for the Contraceptive Clinical Services Delivery Programme (CCSDP) and the Family Planning Field Services Programme are both key stakeholders in Government, under the DGFP. When the Operational Plan for CCSDP was signed, the Line Director was Dr. Md. Moinuddin Ahmed.

Additional family planning stakeholders in MOHFW (drawn from KIIs and other documents) include: the Directors of MC&RAH, IEM Unit (DGFP), Planning unit (DGFP), Logistics &Supplies (DGFP), MNCAH (DGHS), Health Economics Unit, and NIPORT, and the Ministries of Women and Children’s Affairs (MOWCA), and the Ministries of Youth and Sports.

### Health Sector Reforms

**Integration of Directorate Generals of Health Services and Family Planning**

The 5th Five Year Plan (1997–2002) and the earlier version of National Health Policy (2000) both advocated for the integration and the unification of the Health and Family Planning Directorates of the MOHFW. Both Directorates implement programmes related to RMNCAH, and the DGHS also provides some FP (post-partum, post-MR and PAC, adolescent RH), which leads to overlap, duplication and gaps in service coverage. In order to provide health and family planning services in a package under the ESP and to ensure efficiency gains, attempts were undertaken to integrate them. By 2000, the two wings were structurally integrated at Upazila level and below. However, after many years when the FP programme performed poorly and the TFR stagnated, the issue became increasingly politicised and the promised integration was abandoned when the Bangladesh National Party (BNP) came to power in 2007. Services remain integrated at community level through the Community Clinics although these facilities account for a tiny proportion of FP services. The 2017 restructuring has contributed further to the dual structures by establishing two Secretaries of MOHFW – one for Health services and another for medical education and family welfare.

The lack of coordination and collaboration between the two Directorates is listed as a major challenge for several of the FP2020 commitments, including the operationalisation of the National post-partum family planning Action Plan and the roll out of adolescent reproductive health (FP2020 2018a).

Decentralisation Reform

While the process of decentralisation in Bangladesh started in 1959, when Bangladesh was known as East Pakistan, with the introduction of a four-tier local government system, successive reforms to local government structures have not achieved real devolution of political power to the local level (Paul S and Goel PR, 2010). Central government retains a high degree of control across all sectors, including health. For example, with regard to supplies and commodities, each level of local administration can submit their needs to the central level, but actual supply depends on decisions at the centre, which has led to widespread stock-outs including of contraceptives at lower tiers.

Goal 4.8 of Bangladesh’ Vision 2021 calls for the administrative and financial decentralisation of the health services department, while ensuring community involvement in formulating and implementing healthcare programmes and reforms (CPD 2006). The document states “Structural changes in health systems will be necessary to support such a community involvement process in the health sector. These changes include decentralisation of planning, management, and budgeting of health sector expenditure, and will be implemented with fast speed in the shortest possible time” (CPD 2006: 26). However, progress has been slow and the Government has faced considerable challenges in planning, prioritisation and resource allocation for decentralisation (Andersen and Hipgrave 2015).

#### Other reforms

Further reforms which are either on-going or being considered, include:

* The delegation of financial authority and management, and the retention of locally-generated income by health facilities, as well as the roll-out of Imprest Funds to health facilities across the country to increase utilisation of LAPM and support costs of clinical FP for PPFP service delivery;
* Continued support for public-private partnerships in the health sector;
* The Government has also highlighted CSR and involvement of private foundations as possible sources of additional health financing, particularly in urban areas.

|  |  |
| --- | --- |
| **Known challenges** | **Information gaps** |
| * Slow pace of decentralisation reform, with unclear delegated authority and responsibilities at lower levels of the health system * Roll-out of Imprest Funds as part of plans to increase utilisation of LAPM/FP * Lack of adequate regulation and monitoring of private sector providers through PPP mechanisms * Lack of critical issues around which govt and non-govt stakeholders can coalesce to push for additional funding | * Up to date information on health sector decentralisation * An analysis of the Imprest funds, progress in implementation and how these impact on the delivery of PPFP services (particularly LAPM) * Current view on health sector integration, both at central and lower levels of the MOHFW |

# 5. Potential ways to improve public investments in SRH/FP, and further research considerations

## 5.1 Potential ways to improve public investments in SRH/FP

Before reviewing possible ways to improve public investments in SRH/FP, it is necessary to present known strengths and challenges for the health financing system and specifically for SRH/FP.

Strengths are as following:

1. A highly favourable policy environment for SRH/FP, and strong commitments by government and non-government stakeholders to address weak areas of performance, including unequal access to services for specific groups and lagging areas of the country, adolescent reproductive health (including access to contraception and realisation of reproductive rights), and post-partum family planning (including post-MR and post-PAC FP);
2. Strong economic growth forecast to continue over next 5-year period;
3. Some limited potential fiscal space through increasing efficiencies of tax collection and discussions on earmarking tobacco taxes for health;
4. MOHFW commitments (as part of FP2020) to reallocate additional funding from the Development Budget to SRH/FP;
5. Strong health service provider networks (public and private) reaching deep into rural areas (less coverage in urban areas);
6. Large numbers of NGOs working the field of SRH/FP, which have contributed over many decades to meeting the needs for SRH/FP services and information;
7. Strong commitments made by the government and partners to reduce the financing gap for the FP2020 commitments (although it is not clear what this gap is or how it can be met);

Challenges are as following:

1. Despite these strong commitments, health is not a priority in the national budget and funds allocated to health overall remain very low, despite strong economic growth in recent years (in per capita terms, and as a % of THE and GDP). Weak negotiating power of MOHFW with the MOF, uneven budget execution by MOHFW and inefficiencies are some of the issues contributing to the low allocations;
2. Limited current opportunities to raise additional domestic financing unless key stakeholders in Government and civil society can be galvanised around specific SRH/FP issues;
3. Very high OOP for health, which impact negatively on financial protection and serve as a barrier to accessing care, particularly in urban areas where LGIs work with NGOs and private providers to deliver services. KIs identified poor attention to FP in urban slums as a major future challenge for the sector
4. Very high costs for the FP2020 costed implementation plan and large financing gap (which needs to be up-dated and actions prioritised once the funding gap becomes clear);
5. Complexity of structures for social health protection and very ambitious plans for scaling-up social health insurance which rely on collection of premiums from a large informal sector (very challenging);
6. Poor regulation, coordination and monitoring of private sector providers - PPPs are an important strategy for raising additional financing for health, but will not contribute to increased coverage of quality services without corresponding improvements in governance and accountability;
7. Quality of FP and SRH services in general, and readiness of service providers to provide good quality care is poor and there are widespread stock-outs of contraceptives in the public sector;
8. Low utilisation of LAPM in the contraceptive method mix with high discontinuation rates;
9. Family planning for young unmarried adolescents remains taboo and child marriage remains a problem, despite concerted efforts to tackle the latter;
10. The government has not been able to roll-out post-partum family planning successfully, partly due to dual structures which separate the provision of health services and family planning services;

Some of the ways in which Bangladesh is already considering increasing financing for health are included in table 5 below:

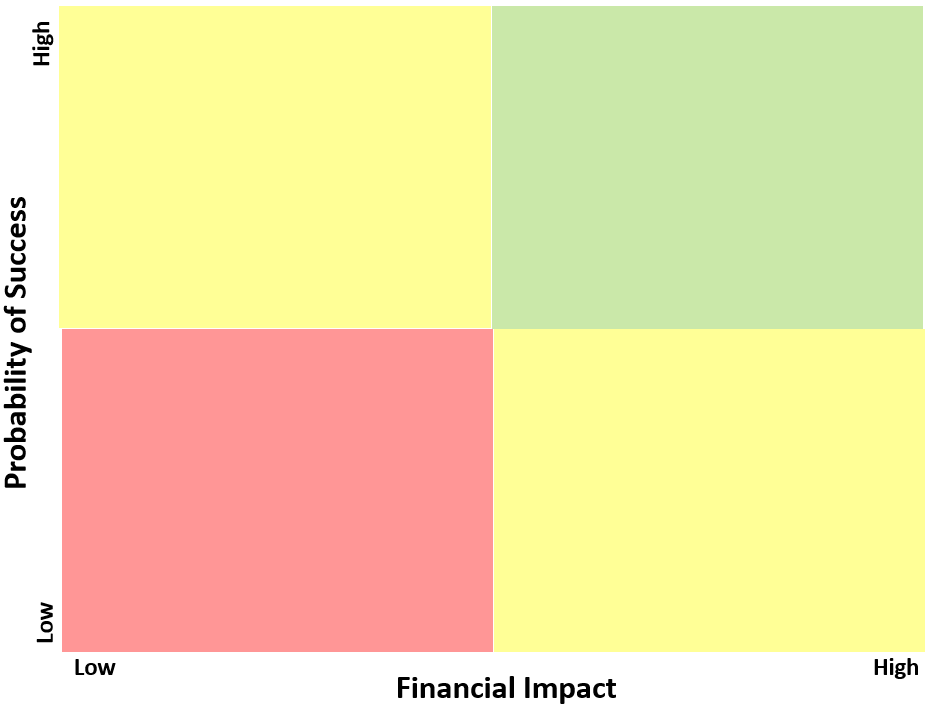
| **Intended/existing reform or action** | **Relevant details** | **Potential to impact on SRH/FP** |
| --- | --- | --- |
| Expansion of social health insurance schemes including scale-up of *Shasthyo Shuroksha Karmasuchi* (SSK) | * Cornerstone of Government’s UHC strategies * For poor and BPL (est. covering 400,000 people in 100,000 HH in Tangail District in Aug’18). * Non-contributory * Inpatient care, plus emergency and outpatient care for chronic diseases * Currently in rural areas * In theory, to be financed through government revenues when scaled up | FP not included in benefit package  Difficulty of collecting revenues from large informal sector, including the relatively well-off self-employed  Risk of fragmentation of risk pools and inequalities in benefit packages when combined with other SHI initiatives (formal sector, non-poor informal sector)  Administratively difficult to design and implement |
| Public private partnerships | * Referenced in many policy documents as a means to expand service coverage * PPPs used in urban slums to provide access to SRHR; * Lack of oversight and coordination leads to duplication and gaps in coverage | Would need to look at the capacity of LGIs and MOHFW to contract effectively, to coordinate providers and to monitor the quality of care provided as well as contract fulfilment |
| Increasing private sector financing and insurance (pre-payment mechanisms) | * Various schemes in the garment sector (insurance mandated for factories employing > 100 women)   (see section 4.2.3) | High potential for garment sector -pilots showing some success in enabling women to access health services including SRH and FP services for highly subsidised cost.  Potential for Govt to regulate (i.e. minimum benefit package to include SRH/FP)?  Introducing concept of pre-payment |
| Innovative financing | The NSSS suggests exploring innovating financing and set up a Task Force to look at the feasibility of the following, among others:   * Corporate Social Responsibility (CSR) * Zakat * Contributions from Non-Resident Bangladeshis (NRB), * International Philanthropic Funds | Low potential in terms of increasing sustainable sources of domestic financing. |

Table 6 and Figure 7 present a review of possible ways to improve public sector investments specifically in SRH/FP (aligned with WISH indicators), in terms of likelihood of success and expected financial impact. It should be noted that:

1. For some of the reviewed items, there is not enough information to provide a point of view on their likelihood of success and/or expected financial impact
2. Further research and new information collated by the in-country team will help finding new ways to improve public sector investments and/or adding perspectives regarding identified ways

Table 6. Review of possible ways to improve public sector investment in SRH/FP

|  | **Likelihood of success** | **Expected financial impact** |
| --- | --- | --- |
| **Formal commitment made to increasing financing for SRH/FP investments** | Med  *(Inefficiencies and uneven budget execution likely mitigate against increased allocations)* | High  (need clear picture of the current financing gap) |
| **Opening of a new budget line for SRH/FP in the national budget** | Unknown  *(Development budget is programme based with 7 OPs which cover FP)* | unknown |
| **Increasing GFF funds allocated to SRH/FP** | Unknown  (*see below suggested short-term actions)* | high |
| **Increasing allocation to SRH/FP budget lines in the national budget** | Low  *(uneven budget execution, inefficiencies could mitigate against this)* | Med |
| **Allocation aligns better to strategic priorities for SRH/FP** | Med – High  *(Costing CIP for FP2020 using latest data, identification of priorities would go some way towards this)* | High |
| **SRH/FP included in health insurance package**  **Potential to include FP more explicitly in the MHVS (see below)** | Med  *(this is cited in the FP2020 updates - MOHFW aware of issue)* | Med  *(depends on feasibility of scaling up SHI in terms of implementation and financing. More success with private insurance in garment sector?)* |
| **Improved execution of budget lines related to SRH/FP** | Med - High  *(WB doing PFM assessment and GFF strengthening basis for implementation of Nat. Healthcare Financing Strategy)* | Med - High |
| **Increase in donor on-budget financing** | Low  *(based on current trends this is unlikely)* | Low |
| **Potential for earmarked tobacco taxation for health** | Unknown | High  *(if successful at allocating to SRH/FP - using FP2020 commitments as basis)* |

Figure 7. Overview of possible ways to improve public investments for SRH/FP

* SRH/FP included in health insurance package
* Potential to include FP more explicitly in the MHVS
* Allocation aligns better to strategic priorities for SRH/FP
* Improved execution of budget lines related to SRH/FP
* Formal commitment made to increasing financing for SRH/FP investments
* Increasing allocation to SRH/FP budget lines in the national budget
* Increasing allocation to SRH/FP budget lines in the national budget
* Increase in donor on-budget financing
* Potential for earmarked tobacco taxation for health

NB: the feasibility of many of the suggested interventions above is unknown at present. Where there are unknowns, the interventions have not been included in figure 7, which should be up-dated as more information becomes available to the country team.

## 5.2 Perspectives on further research

Considering the information gaps identified in section 4, potential topics for further research have been developed in Table. This contextual analysis has covered all topics below, although not in an exhaustive way. The country team in Bangladesh may use these topics for further research to improve this health financing contextual analysis.

It should be noted that:

1. It is potentially unknown who are key informants or which documents are related to the research topics below. For this reason, key informants and relevant documents may and should be integrated once the local in-country team is in place and more information is available
2. The priority noted in the table is also based on information available at the moment; as the context changes, so the priorities could change

Table 7. Potential further research

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Section** | **Priority** | **Potential further research/actions** | **Key Informants** | **Relevant documents** |
| 4.1 | High | 1. Detailed analysis of Imprest Funds (progress, bottlenecks, potential impact etc.) | HEU (MOHFW) | OP for Contraceptive Clinical Services Delivery Programme |
| 4.1 | High | 1. Up-dating the Costed Implementation Plan for FP2020 commitments using BHDS 2017 data and prioritisation of activities | FP2020 focal points (see above) | FP2020 documentation; BDHS 2017, other data sources |
| 4.2 | Mid | 1. Analysis of the potential to include SRH/FP (particularly LAPM and MR) in social health protection mechanisms (SHI, SSK etc.) together with a realistic assessment (+ costing?) of the potential for scale-up (including the potential to collect payments from the informal sector) . This is the corner-stone of the Government’s plans for achieving UHC. | HEU (MOHFW) | NSSS; Costed operational plans for SHI (where these exist) |
| 4.1/4.2 | High | 1. Analysis of the potential to include a FP (post-partum, post-MR and post-PAC FP) and MR vouchers in the Maternal Health Voucher Scheme as it is scaled up. What is potential to extend to urban areas? | TBC |  |
| 4.1/4.2 | High | 1. Analysis of HPNSP OPs to identify SRH/FP-related activities and costs, and PER data to identify SRH/FP expenditure (if feasible). Assessment of gaps –how much does Bangladesh allocate to/spend on FP? | TBC | Operational Plans for HPNSP; HPNSIP; PIP (HPNSP); PER |
| 4.2.3 | Mid | 1. Building on work of DFID UHSSP, conduct research on access to and financing of SRH/FP in urban areas | TBC | Health Financing for Urban Poor UHSSP Bangladesh |

## 5.3 Recommendations for the short term

While the above further research questions and potential ways to improve public sector financing in SRH/FP are both focused on the medium to long term, the following recommendations provide entry points to those same objectives in the shorter term. These points need to be further discussed and prioritised by end 2019:

1. Meet country focal points for the Bangladesh Global Financing Facility (planned activities are aligned to some extent with WISH) to identify cross-over areas of work and identify potential entry points for WISH
2. Discussions with FP2020 Focal Points (see above) to identify areas for potential WISH inputs and possible detailed analysis of challenges for meeting FP2020 commitments and prioritisation of actions to support reduction of financing gap (identified as a key action in the FP2020 up-date)
3. Discussions/up-dates with World Bank regarding the on-going PFM assessment and assessment of entry points to support efficiencies at MOHFW.
4. Discussions with HEU (MOHFW) and other stakeholders relevant around the potential to include SRH/FP into social health protection schemes and MHVS
5. Dialogue with MOHFW on progress with rolling-out imprest funds for improving up-take of FP (particularly LAMP)
6. Discussions with World Bank and Government counterparts (to be identified) on feasibility of earmarked tobacco taxes and allocation to health (in particular SRH/FP)
7. Analysis and identification of the scope for better alignment of the SRH/FP programs along with the budget line items, with the policies, strategies and commitments.
8. Situation analysis for improving the budget execution and efficiency under DGFP (both at national and sub-national levels) through advocacy.
9. Cost analysis for FP services from user perspective, especially from private and NGO sector, to identify the challenges in accessing FP care with specific attention to adolescent, disabled population, urban poor, and remote rural areas.
10. Documentation of learning and evidence to support the case for requirement of additional financing towards SRH/FP services, if possible, prior to the formulation of 5th sector plan for health in Bangladesh.

# 6. Conclusions

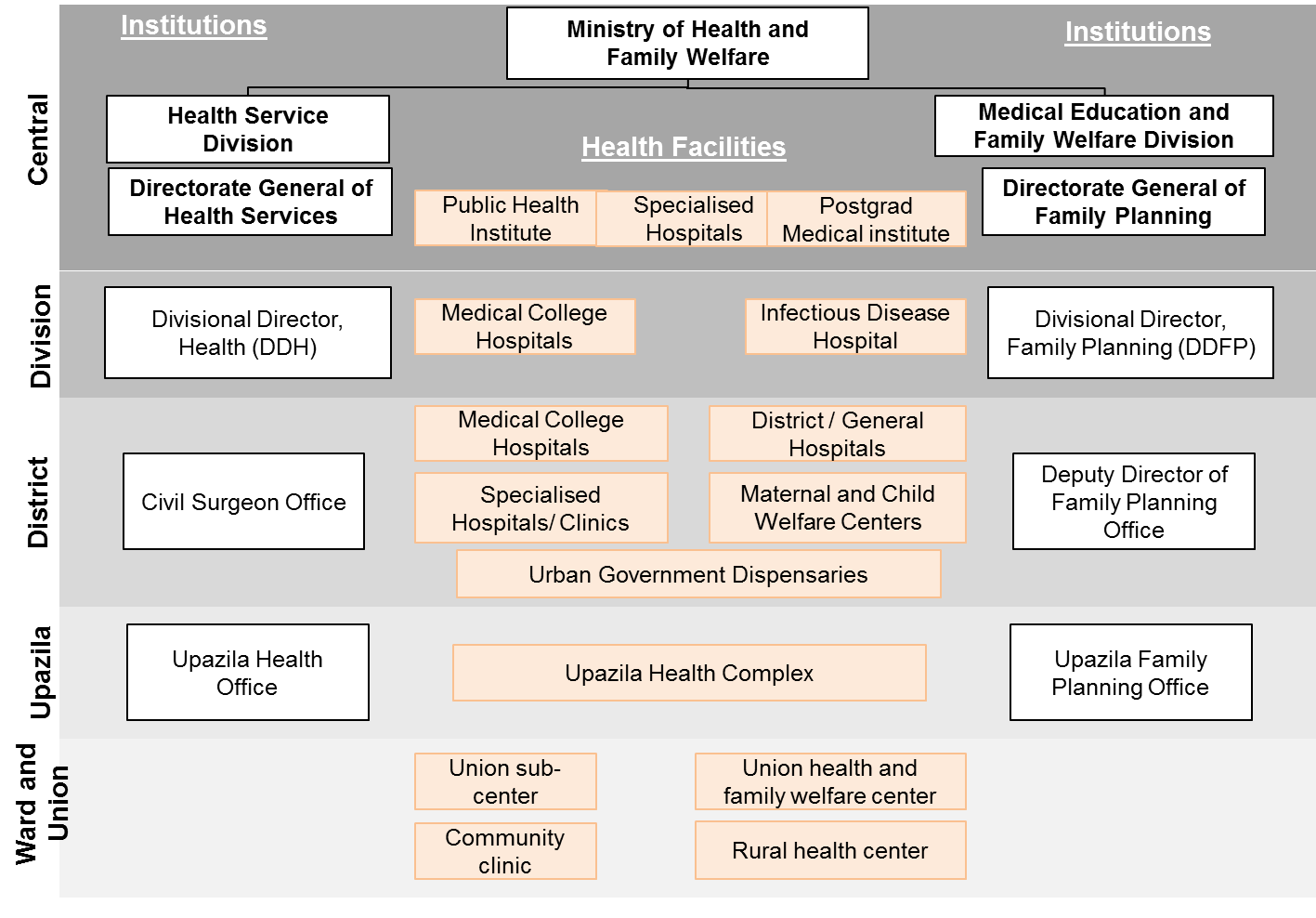
In this Health Financing Contextual Analysis different economic, political and health aspects of Bangladesh have been reviewed. Different possible ways to improve public sector investment for FP/SSR in Bangladesh have been identified.

On the other hand, this analysis prompts further research, and the political/economical context in Bangladesh may as well change rapidly during the next 3 years of WISH execution. Because of this, this analysis should be considered as a solid starting point to design WISH national ownership activities for the next years, and also a living document, to be adapted based on new information and context changes.

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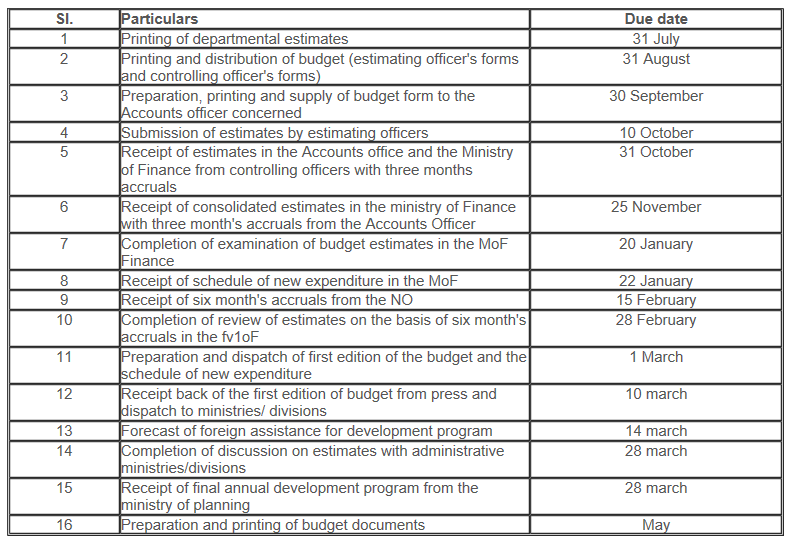
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## Annex 1: Bangladesh Health System Structure



## Annex 2: Bangladesh Revised FP2020 Commitments

## Annex 3: Bangladesh Budget Calendar



Source: BNPS 2012 (<https://bnps.org/roundtable_budget_processes.html>)

**Medium-term Budget Framework Different Stages of preparation**

1. Finance Division issue BC-1 with Preliminary Indicative Expenditure Ceiling for each Line Ministry
2. **Line Ministry prepare Ministry Budget Framework (MBF) with the help of departments/agencies (up to district level)**
3. Finance Division and Planning Commission jointly review and finalize agreed Budget numbers and MBFs
4. Finance Division issue Budget Circular-2 with Ministry-wise Indicative Expenditure Ceilings
5. The estimates are reviewed and finalized by FD
6. Finally, Budget is presented to the Parliament

## Annex 4: Funding Flows to the Health Sector

*Source: Asia Pacific Observatory on Health Systems and Policies, cited in Ahmed et al. 2015.*

1. Menstrual Regulation or MR is a procedure that uses manual vacuum aspiration or (for medical abortion) a combination of mifepristone and misoprostol to regulate the menstrual cycle when menstruation is absent for a short duration (up to 10 – 12 weeks). [↑](#footnote-ref-1)
2. This high rate of economic growth slightly exceeds the SDG 8 goal of 7%. [↑](#footnote-ref-2)
3. Lower middle-income country status is defined by the World Bank based on GNI per capita. [↑](#footnote-ref-3)
4. LDC is defined by the UN according to: GNI per capita, the Human Assets Index, and the Economic Vulnerability Index [↑](#footnote-ref-4)
5. The UHC coverage index ranges from 0% to 100%, with 100% implying full coverage. Bangladesh’s score places it lower than Sri Lanka (62) and India (56), but above Pakistan (40) and Afghanistan (34) (https://data.worldbank.org). [↑](#footnote-ref-5)
6. Satisfaction of FP needs was defined as ‘The proportion of married women aged 15–49 who do not want any more children or want to wait 2 or more years before having another child and are using modern contraception’ and Rahman et al. (2018) used a Bayesian model with data taken from BDHS surveys. [↑](#footnote-ref-6)
7. The Awami League won a landslide victory in the December 2018 elections (although there were serious allegations of vote rigging and electoral fraud) and have reinvigorated commitments set out in the Vision 2021 document. [↑](#footnote-ref-7)
8. In 2015, NGOs and the private sector were providing 30% of urban health services through the Urban Primary Health-care Services Delivery Project (UPHCSDP) covering 3 city corporations and 5 municipalities. [↑](#footnote-ref-8)
9. The 4th HPNSP comprises funds from more than eleven development partners who pool their resources—mostly grants and the World Bank’s credit (IDA) of USD500 million. [↑](#footnote-ref-9)
10. The World Bank, Report No: PAD2355, International development association. Project appraisal document. Bangladesh - Health Sector Support Project, IDA/R2017-0270/1. July 11, 2017 [↑](#footnote-ref-10)
11. [globalfinancingfacility.org/bangladesh](https://www.globalfinancingfacility.org/bangladesh) [↑](#footnote-ref-11)
12. This is a scheme of the MOHFW and was introduced (designed and initially financed by development partners) to make progress on MDG 5 on maternal health. [↑](#footnote-ref-12)
13. The new strategy is reportedly being implemented in 27 districts (out of 64) and the MCH Services Unit of DGFP is implementing adolescent friendly health services through 64 Mother and Child Welfare Centers and 339 Union health and family welfare centers by providing training to service providers (FP2020 2018a). [↑](#footnote-ref-13)
14. Imprest funds are funds held at the health facility which are used to incentivise the delivery of certain services such as long-acting family planning methods. Funds go to both the client and the service provider, potentially setting up perverse incentives. [↑](#footnote-ref-14)
15. A full list of Bangladesh’ FP2020 commitments is included at Annex 2. [↑](#footnote-ref-15)
16. This figure needs verifying. [↑](#footnote-ref-16)
17. This was 113 births per 1,000 girls aged between 15 and 19 yrs in 2014 (Niport et al. 2016), and 75 per 1,000 births in 2015 (SRVS 2015). The age-specific marital fertility rates in the SRVS 2017 show highest fertility among married young people aged 15 – 18 years, but only 5.2% of total births were to girls aged under 18 yrs in 2017 showing a decline in adolescent fertility (BBS 2018). [↑](#footnote-ref-17)
18. So far this model has been applied to Malawi, and Bangladesh now intends to follow suit with the support of HP+ (FP202 2018). [↑](#footnote-ref-18)
19. According to the National Household Survey (2015) of Transparency International Bangladesh, 63% of households sought healthcare from approximately 15,698 private healthcare facilities across the country, almost double the rate in 1982 when this figure was 33% (TIB 2018) [↑](#footnote-ref-19)
20. Registration fees are determined by the government and registration is renewable annually. [↑](#footnote-ref-20)
21. Municipality Act 2009 mentions private hospitals or clinics and paramedical institutes and Diagnostic centres are not mentioned while City Corporation Act 2009 added diagnostic centres. [↑](#footnote-ref-21)
22. The Act had been amended in 1949. There is another proposal to further amend the Act. [↑](#footnote-ref-22)
23. The Revenue Budget also includes some capital costs allocated directly to different institutions, while the Development Budget covers some recurrent costs allocated to different Operational Plans, each implemented by a line directorate in the MOHFW. [↑](#footnote-ref-23)
24. The Civil Surgeon’s office is the administrative health office under the DGHS at district level, while the Deputy Director Family Planning fills is under the DHFP. [↑](#footnote-ref-24)
25. From <https://www.internationalbudget.org/open-budget-survey/results-by-country/country-info/?country=bd> [↑](#footnote-ref-25)
26. The BNHA 1997 – 2015 give figures of total health expenditure per capita of US$ 27 in 2012 rising to US$ 37 in 2015 (WHO Country Office for Bangladesh - <http://www.searo.who.int/bangladesh/bnha/en/> ), while the GFF gives per capita domestic expenditure of USD 14 in 2017. [↑](#footnote-ref-26)
27. Bangladesh is suffering a double burden of communicable and non-communicable diseases (Ahmed et al. 2015). Top causes of death reported in the SVRS 2017 are (not including old age) were heart attack (16.2%), cancer (9.7%), respiratory disease (5.5%), and heart disease (4.5%). [↑](#footnote-ref-27)
28. This is a zero-draft available on the DGHS site, so figures may be subject to change. They do not include those Operational Plans which fall under the DHFP. [↑](#footnote-ref-28)
29. Their conclusions are based on the fact that differences between the Gini coefficient and the Kakwani index for all sources of finance are negative, indicating regressivity, and that financing is more concentrated among the poor. [↑](#footnote-ref-29)
30. Other studies show slightly lower percentages for people incurring catastrophic expenditure (3.3 – 4%), i.e. Islam and Biswas (2014) and Hamid et al. (2014). [↑](#footnote-ref-30)
31. This is, however, complicated since poorer areas do not receive a higher proportion of the revenue budget which is calculated on staff and bed capacity without considering service utilisation data or poverty levels in the surrounding population. [↑](#footnote-ref-31)
32. Clients also have to purchase any drugs which are not on the Essential Drugs List. [↑](#footnote-ref-32)
33. The pilot was launched with financial support from the German Government and technical assistance from Oxford Policy Management (M4H 2018). [↑](#footnote-ref-33)
34. The CPD assessment of the budget, however, does show some movement in the right direction with estimated total tax revenue as a percentage of GDP increasing by 1.8 points in budget FY 2017-18 compared to the revised budget for FY2016-17. [↑](#footnote-ref-34)
35. The GFF gives a total cost in USD of 14.7 billion (likely due to exchange rate differences). [↑](#footnote-ref-35)
36. The BDHS for 2017 has been carried out but the report is not yet available as of March 2019. [↑](#footnote-ref-36)
37. These include the Directorate General of Health Services (DGHS), the Directorate General for Medical Education, the Directorate General for Family Planning (DGFP), the Directorate General of Drug Administration (DGDA), and the Directorate General of Nursing & Midwifery (DGNM), and specialist agencies include NIPORT (National Institute of Population Training and Research), and CMMU (Construction Management and Maintenance Unit) among others. [↑](#footnote-ref-37)
38. The diagrams included in this document refer to the previous structure (fig 3 and Annex 1). [↑](#footnote-ref-38)
39. The Smiling Sun social franchise network is the world’s largest network of NGO maternal and child health clinics. [↑](#footnote-ref-39)
40. This is only measured among ever-married women who have used MR in the last three years so ignores unmarried women who may be more likely to use MR services. [↑](#footnote-ref-40)
41. About a quarter of public facilities, half of NGO facilities and only 5% of private sector facilities were found to be ‘ready’ to provide FP services in a survey in 2014 (BUFS 2014). [↑](#footnote-ref-41)
42. Menstrual Regulation is a procedure that uses manual vacuum aspiration up to 10 – 12 weeks after the last menstrual period, or a combination of mifepristone and misoprostol (known as MRM) up to 9 weeks, to “regulate the menstrual cycle when menstruation is absent for a short duration.” (Guttmacher 2018) [↑](#footnote-ref-42)