Country Report: Bangladesh

Reproductive Health and Family Planning Financing in Bangladesh

Netherlands Interdisciplinary Demographic Institute, The Hague
Indian Institute of Health Management Research, Jaipur

Contents

Foreword

In the light of international agreements on reproductive health (RH) goals, there is a strong interest from both national and donor governments in tracking resources for RH care across countries. An equitable and efficient use of financial resources is essential for the adequate implementation of these agendas. Many of the countries have started creating National Health Accounts, but only a few have been able to create sub-accounts, like RH subaccount, child subaccount, etc. However, interest in reproductive health financing has been increasing for proper mobilization and tracking of resources in order to fulfill the ICPD commitments and achieving MDGs set for the country.

Bangladesh is the signatory of ICPD's programme of action and MDGs both and the Government of Bangladesh has set ambitious agendas for improving RH services, to achieve the targets till 2015. An equitable and efficient use of financial resources is essential for the adequate implementation of these agendas. Although Bangladesh has an established National Health Account, it is devoid of RH account. So this document is an effort to creating RH account which will help policy makers to develop sustainable and informed strategies for expanding RH services and mobilizing additional resources.

This study is an effort to report on the financing for reproductive health and family planning in Bangladesh, based on the existing data, like NHA, various county level studies and information from the Government of Bangladesh. It is hoped that this will provide inputs to strengthen the institutionalization of country-owned systems to produce periodic reports that compare the need for SRH funding at country level with; the allocation of resources (domestic and external); actual expenditure and distribution of resources; as well as projected availability of resources (domestic and external) in the years ahead. This study also demonstrates that under certain conditions, it is feasible at very low cost to generate informative estimates of RH and FP expenditure in countries facing resource constraints.

The study was carried out jointly by Netherlands Interdisciplinary Demographic Institute (NIDI), Netherlands, and Indian Institute of Health Management Research (IIHMR), Jaipur, India. It is a collaborative initiative under the project on Financial Resource Flows for Population Activities, supported by UNFPA.

List of Tables

List of Graphs

Abbreviations

ADB	Asian Development Bank
ADP	Annual Development Programme
AIDS	Acquired Immunity Deficiency Syndrome
ANC	Antenatal care
AO	Administrative Order
BCC	Behaviour Change Communications
BDHS	Bangladesh Demographic Health Survey
BEOC	Basic Emergency Obstetric Care
BNHA	Bangladesh National Health Accounts
BOT	Build-operate-transfer
CAO	Chief Accounts Officer
CC	Community clinics
CEmOC	Comprehensive Emergency obstetric care
CGA	Comptroller General of Accounts
CI	Concentration index
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
DAO	District Accounts Officer
DCA	Development Credit Agreement
DCA	Divisional Comptroller of Accounts
DDA	Directorate of Drug Administration
DFID	Department for International development
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District hospitals
DHS	Demographic and Health Survey
DNS	Directorate of Nursing Services
DOTS	Directly Observed Treatment, Short-Course
DPs	Development partners
DPT	Diptheria, Pertussis, and Tetanus
DSF	Demand-side financing
EC	European Commission
EmOC	Emergency management of obstetric care
EOC	Emergency obstetric care
ESD	Essential service delivery
FMAU	Finance Management and Accounting Unit
FP	Family Planning
FWV	Family welfare visitor
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GGHE	General government expenditure on health

GNI	Gross National Income
GOB	Government of Bangladesh
GTZ	German Development Corporation
HDI	Human Development Index
HIES	Household Income and Expenditure Survey
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
IDA	International Development Association
IDGs	International Development Goals
IEC	information education and communication
IIHMR	Indian Institute of Health Management Research
IMR	Infant Mortality Rate
IUD	Intrauterine device
JICA	Japan International Cooperation Agency
KFW	Kreditanstalt für Wiederaufbau (German Development Bank)
LD	Line Directors
LLP	Local Level Planning
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Centers
MDG	Millennium Development Goal
MICS	Multi Indicator Cluster Survey
MIS	Management Information Systems
MMR	Maternal Mortality Rate
MNCH	Maternal Newborn and Child Health
MNH	Maternal and Neonatal Health
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family welfare
NGO	Non-Government Organization
NHA	National Health Account
NIDI	Netherlands Interdisciplinary Demographic Institute
NIPORT	National Institute of Population Research and Training
OECD	Organisation for Economic Cooperation and Development
PHC	Primary Health Care
PNC	Postnatal care
PoA	Program of Action
RED	Reach Every District
RH	Reproductive Health
RHA	Reproductive Health Account
RTIs	Reproductive Tract Infections
SBA	Skilled birth attendants
SHA	System of Health Accounts
SIDA	Spanish International Development Cooperation Agency
SMPP	Safe Motherhood Promotion Project

SRH	Sexual and Reproductive Health
SSFP	Smiling Sun Franchise Program
STD	Sexually transmitted Disease
STIs	Sexually Transmitted Infections
SWAp	Sector-wide Approach
TB	Tuberculosis
TFR	Total Fertility rate
THE	Total Health Expenditure
Tk.	Taka
U5MR	Under-5 Mortality Rate
UHCs	Upazila Health Complexes
UHFWC	Union Health and Family Welfare Centres
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children Emergency Fund
USAID	U.S. Agency for International Development
USD	United states Dollar
VCCT	Voluntary Confidential Counseling and Testing
WHO	World Health Organization

Executive Summary

Financing for RH and FP in Bangladesh

Bangladesh is the signatory of ICPD's programme of action and MDGs both and the Government of Bangladesh has set ambitious agendas for improving RH services, to achieve the targets till 2015. An equitable and efficient use of financial resources is essential for the adequate implementation of these agendas. Although Bangladesh has an established National Health Account, it is devoid of RH account. So this document is an effort to creating RH account which will help policy makers to develop sustainable and informed strategies for expanding RH services and mobilizing additional resources. The objective of this study is to develop a country report on financing of Reproductive Health and Family Planning in Bangladesh. An effort has been made to map what is currently happening in Bangladesh in the tracking resources for health and supporting the strengthening of country processes.

In Bangladesh, poor access to services, both primary and tertiary care, low quality services, high rate of maternal mortality and child malnutrition are the key challenges in achieving MDGs. Child malnutrition and maternal mortality rate still remain among the highest in the world. About 15,000 mothers die annually at the time of delivery, with 3 maternal mortality per 1,000 live births, and 7,000 infants die every day. High maternal mortality rates are underpinned by the fact that a large majority of deliveries take place at home and most of which are attended to by untrained providers.

In 2007–08, the GoB spending on health was 7 per cent of the national budget, which was 3.4 per cent of Gross Domestic Product (GDP). Bangladesh spends almost $12 per capita in the health sector, of which $4 comes from the public sector. Of the 63 percent spending from out of pocket, 46 percent is on drugs from private pharmacies. The expenditure on health had increased from USD$ 948 million in 2001 to USD$ 2067 million in 2007. Total Health Expenditure (THE) has grown at a nominal rate of 7% over the period 1998-2007. The expenditure on RH is around 10 percent of the total expenditure on health, though it has declined slightly over the years.

Financing for reproductive health in Bangladesh is a combination of different methods, which include households, government revenue, donors and community financing through NGOs. The MOHFW operates as a financial intermediary of the Government of Bangladesh (GOB) obtaining funds from the Ministry of Finance (MOF) and allocating and disbursing them to its reproductive healthcare providing units.

Government budget for Reproductive health and family planning has been increasing over the years, in line with the increase in the overall budget for health. The budget of health ministry for

2011-12 was around USD$ 111 million. The budget allocation for RH and FP is around 11 percent of the total health budget. A large proportion the total expenditure on service provision for RH is spent through the government system, particularly MOHFW, which includes donor support channeled through the government system. The role of other ministries and local governments is marginal in the financing for reproductive health services. Around 3.3 percent of the expenditure is funded through NGOs, while 27 percent is directly through the external donor support.

Out of pocket spending constitutes a significant proportion (around 65 percent) of the total spending on reproductive health.

There are pool funding, non-pool funding and parallel funding mechanisms for development assistance to the Government. Contributions to the pool fund of the HNPSP have been pledged by a consortium of donors led by the World Bank/IDA. A substantial amount of DP funding is channeled, released and expended using government systems. The donor expenditure on RH/Population assistance in Bangladesh had a fluctuating trend in the past, but is showing increasing trend for last 3-4 years. In all, the donor spending has increased from USD$ 71.91 million to USD$ 116.61 million between 2001 and 2009. Of the total donor expenditure, 48 percent is distributed through multilateral channels, 19 percent through bilateral channels, and 33 percent through NGOs in 2008. It may be noted that the role of multilateral channels has increased since 2006.

For contraceptive supplies, the non-public sector continues to be an important source of supplies for around half of the Bangladeshi women in the reproductive age. The private sector share, excluding NGOs, as a source of supply has increased rapidly, from 36 percent in 2004 to 44 percent in 2007, and is focused on short-term methods, primarily condoms and pills. Two bilateral donors, the Canadian International Development Agency (CIDA) and the U.S. Agency for International Development (USAID), have been major donors of contraceptive supplies (2009). The government of Bangladesh had committed to allocating approximately US$ 0.7 million in internally-generated funds to purchase domestically manufactured condoms. The total amount spent on contraceptive supplies in 2009-10 was around US$ 21 million. The share value of donor funded contraceptives was US$ 10.4 million.

Among RH providers, nearly 48 percent of the expenditure is incurred through Family Planning Centres, which are key providers for reproductive health services in Bangladesh. General hospitals and outpatient care centres was providers for 23 percent and 21 percent expenditure respectively.

A large share of spending on reproductive health goes to obstetric complications and reproductive health problems, while spending on family planning and other aspects of maternal care is comparatively low. The relative share of family planning in the overall RH spending seems to be declining over the years. Looking at the existing level of unmet needs, an

appropriate allocation of funds for family planning should be made. Moreover, the MDG need assessment and costing study (2009) estimated promotional allocation of resources on different components of RH and FP services. It estimated that in 2009, more than half of the resources are allocated for obstetric complications and reproductive health problems.

Since two thirds of overall financing for reproductive health consists of household out-of-pocket payments, a key policy goal should be to reduce the burden of total financing borne directly by households. This implies a strong commitment to increase and strengthen public sector financing and delivery of reproductive health services. Keeping in view the large share of out of pocket expenditure and funding from other than domestic sources, it appears that the health system would still require to mobilize funding from donors for many of the components, including drugs and contraceptives.

NGO and private sector has been playing a critical role in delivery of reproductive health services. Since the public health system alone cannot fulfill the needs of reproductive health services, involvement of private sector needs to be increased with greater accountability. Hence, from the funding perspective, performance based payment mechanism for private sector services, would be essential for the development of a public-private partnership for maternal health services provision. The government would be better positioned to control the cost of services while improving/maintaining the quality of services, if the finding is based on performance indicators.

Methodological Issues and Recommendations

Bangladesh had pre-existing health accounts estimates compatible with the OECD health accounts framework. It was not necessary to estimate all expenditures anew in this study, and instead the focus was on apportioning the known expenditures to reproductive health and family planning components. The study recommends that generation of reproductive health accounts should be taken as a regular activity of the agencies that are responsible for national health accounts. Coding of each expenditure on reproductive health according to functional categories is important for proper analysis of reproductive health financing. Following the WHO classification scheme, separate coding of reproductive health would facilitate creation of reproductive health accounts for the country.

Existing household surveys of expenditure and utilization suffer limitations with respect to the detail of their coverage of reproductive health. Several studies have covered cost of maternal health services, but could not cover the other reproductive health issues. Hence, while commissioning such surveys, care should be taken to cover the complete range of components related to reproductive health and family planning. Currently, the Household Expenditure Survey of Bangladesh includes spending on health. However, it needs to accommodate more details to facilitate analysis specifically on RH and FP services.

Tracking expenditure by sources of funding is difficult for government as well as nongovernment entities. The GOB does not track the sources of funding from external partners once it enters the existing Comptroller General of Accounts (CGA) financing tracking system. NGOs in many instances cannot identify the sources of funding, as they receive money from financing intermediaries. Accordingly the expenditure analysis drawn from BNHA is limited by the financing agent only, and not by funding sources for these two entities. Hence the accounting system should have specific coding system for tracking by financing source. In sum, this study demonstrates that under certain conditions, it is feasible at very low cost to generate informative estimates of RH and FP expenditure in countries facing resource constraints. This however does require some preconditions, such as existing health accounts capacity and available health accounts estimates.

Chapter 1: Introduction

1.1 Background for the study

Improving reproductive health (RH) is widely recognized as a key component of social and economic development. The International Conference on Population and Development (ICPD) held in Cairo in 1994, presented a Program of Action (PoA) which pledged to achieve the goal of universal access to reproductive health (RH) services in all countries till 2015. In all, 179 countries became signatories and pledged to make change in their legislation and reproductive health (RH) related policies according to program of action. Five years later, a review of ICPD-PoA, known as ICPD+5 revealed that there was a need of sufficient domestic and external resources to be invested in order to achieve the goals of ICPD in next 15 years in many countries.

UN Millennium Summit in the year 2000 transformed International Development Goals (IDGs) into the Millennium Development goals (MDGs). RH is not an explicit Millennium Development Goal (MDG), but it has been acknowledged that universal access to RH is fundamental for development, fighting poverty, and meeting the MDGs. Reproductive ill-health effects development, reduces quality of life and places heavy burdens on families and communities.

Bangladesh is the signatory of ICPD's programme of action and MDGs both and the Government of Bangladesh has set ambitious agendas for improving RH services, to achieve the targets till 2015. An equitable and efficient use of financial resources is essential for the adequate implementation of these agendas. For the uniform distribution of resources, policy-makers need to understand what is already being spent on RH and who is financing RH care, how much each financing source is spending, and for what kinds of services. To reduce the disparities in the system, information is needed on existing inequities, such as the distribution of RH resources between urban and rural communities or between rich and poor.

Although Bangladesh which is a low-income country has an established National Health Account, but is devoid of RH account. So this document is an effort to creating RH account which will help policy makers to develop sustainable and informed strategies for expanding RH services and mobilizing additional resources.

1.2 International Context

In the light of international agreements on RH goals, there is a strong interest from both national and donor governments in tracking resources for RH care across countries. Reproductive health (RH) subaccount is a tool designed to track shifts in family planning (FP) and RH financing. To

know whether budgetary commitments to FP/RH are being met, it is necessary to track how and where the government, donors, and households actually spend their money. RH subaccounts lead to more effective resource allocation and improved health outcomes. With the information from RH subaccounts, stakeholders can:

- Make more informed, data-driven resource allocation decisions.
- Advocate to mobilize resources from domestic and international sources.
- Inform the policy process to correct imbalances related to neglected priorities, household out-of-pocket payment burden, and absorptive capacity.
- Monitor programs more easily and effectively.
- Increase transparency and accountability

The subaccounts address critical policy questions. Like the general NHA, they answer:

- **Who** finances RH?
- **How** much do they spend?
- **Where** do these funds go?

    - In terms of managers of funds
    - In terms of services/products rendered

In addition, the subaccounts can answer more specific policy questions, such as:

- What is the burden of financing on households to pay for family planning? Does income level affect utilization?
- Does the country have a dependency on donors to finance RH care and programs?
- What is the involvement of the informal sector, such as traditional healers, and street vendors?
- What is the progress of contracting with the private sector for the priority area in question?
- How is spending linked to outcomes (e.g., investment per couple year protection)?

Equipped with this information, government planners, donors, as well as advocacy organizations are well placed to “reposition” reproductive health within national policies and budgets, and to ensure its long-term and sustainable financing.

1.3 Need for RH subaccount in achieving MDGs

After the declaration of Millennium Development Goals (MDGs) countries included it in its various policy documents. Maternal mortality reduction target (by 75 percent by 2015) in the Millennium Development Goals (MDG) has resulted in countries setting ambitious agendas for

enhancing reproductive health (RH) services, such as expanding availability of these services, improving their quality, and adapting them to more appropriately meet user needs. Successful achievement of these targets requires significant resource commitments or reallocation of existing funds. Making investments in sexual and reproductive health would remarkably reduce the global burden of disease and contribute to economic growth.

However, policymakers in most middle- and low income countries lack critical information about current national spending on RH care: how much is spent, the sources of financing, the patterns of resource flows, and how the expenditures link to RH outcomes. This lack of information limits their ability to develop appropriate, sustainable policies that will lead their countries to successfully achieve MDG maternal mortality targets. Hence, RH subaccounts can be utilized to track the flows of funds for RH services through the health care system.

1.4 Linkage between NHA and RHA

NHA tracks the flow of funds from the sources of funds through the intermediaries to the final recipient i.e. from source to final destination .The account describes who is funding what and how funds are channeled through the health system. National health account acts as an input to stewardship for improving health system performance. RH is one of the several areas, along with malaria, HIV/AIDS, and child health, for which data are collected as part of an overall National Health Account expenditure review process.

RH subaccounts are expenditure reviews that follow the globally accepted National Health Accounts (NHA) framework to track the flows of funds (public, private, and donor spending) for RH. While the general NHA framework tracks overall health spending in a given country, the subaccounts shed light on specific areas of concern to national policymakers. RH subaccount exercise tracks national-level expenditure on RH care for a given year. Its successful completion will produce information to serve two goals:

- To contribute to country policy-making
- To allow international comparisons.

As with any NHA exercise, RH subaccount estimations are undertaken primarily to inform the policy process. As such, the primary audiences are RH programme managers, national policymakers, donors, and other stakeholders who use expenditure data for strategic planning in the area of RH care.

RH accounts track individual contribution from public, private and donor side for various years. Hence serves as a useful tool to depict country's economic condition. It informs about the proportion of public health funds spent on RH care. Therefore explicitly explains the relative importance of RH on the government's health agenda. Allocated budget by the government may not be spent in the same year, thus actual amount spent reflects the real emphasis to a particular programme.

Information on out of pocket expenditure gives an indication of the burden on households and the way this expenditure effects usage and non usage of services. RH account monitors resource flow on various RH activities such as family planning, maternal health , information education and communication (IEC) etc. On comparing these results with government policies, actual status of these activities can be discovered. In addition breakdown of expenditure by RH activities inform the priority areas for various interventions.

Ultimate goal of reproductive health service delivery is the improvement of the reproductive health status of women, men and adolescents. Tracking of reproductive health expenditure and tracking of reproductive health status change are interconnected.

This report presents financing for reproductive health in Bangladesh, based on the information obtained from multiple sources, including National Health Accounts of Bangladesh. In analyzing reproductive health financing, the actors and transactions are limited to those that are involved in reproductive health. Reproductive health expenditures encompass all expenditures for activities whose primary purpose is to restore, improve or maintain reproductive health.

The Ministry of Health and Family welfare, Bangladesh has successfully conducted three rounds of National Health Account for the year 1996/97 , 2001/02 and 2006/07 . This is the first time an effort is made to create a subaccount for Reproductive health. RH is one of the several areas, along with malaria, HIV/AIDS, and child health, for which data are collected as part of an overall National Health Account expenditure review process.

1.5 Objective of the study

The objective of this study is to develop a country report on financing of Reproductive Health and Family Planning in Bangladesh.

More specifically, this study aims to:

- Map what is currently happening in Bangladesh in the tracking resources for health and supporting the strengthening of country processes;

- Put together what is available in terms of SRH/MNCH resources and the resource tracking processes of generating this information;

- Review in detail methodological approaches and processes for NHA, generally and RHA, in particular; and

- Develop a framework suggesting possible approaches for implementing RHA estimation in Bangladesh.

1.6 Organization of the report

The report has been structured in 6 chapters. The first chapter is introductory, which presents background of the study and builds context for RH subaccount. Second chapter presents a situational analysis of the state of reproductive health and financing in Bangladesh. It includes demographic and RH indicators, SRH needs, trend in health spending, and progress in MDGs, particularly MDG-5. It also discusses policies and and health system in the context of RH. Chapter 3 discusses data and methods used for the analysis presented in the report. Chapter 4 presents and describes financing mechanism and flow of funds for reproductive health in the country. The analysis particularly focuses on sources, providers, activities, and beneficiaries. The last chapter on conclusion and recommendations presents an analysis of key challenges that affect production of RHA and possible recommendations for implementing RHA estimation in Bangladesh.

Chapter 2: Reproductive Health Status and Financing: Situational Analysis

2.1 Reproductive Health Services

Bangladesh is one of the least developed countries in Asia, with more than half of the population living on less than a dollar a day and a literacy rate of 53 percent (UNDP 2009). It is one of the world's most densely populated countries, with a population of 145 million and an area of 148,000 km (Bangladesh Bureau of Statistics 2009). The country is affected by recurring flooding and cyclones that exacerbate the health and economic situation of its population. In spite of this, Bangladesh has made impressive progress in health and human development since its emergence as an independent nation in 1971. Human rights are recognized as fundamental in the constitution and health and education are prioritized. Moreover, Bangladesh has ratified most international treaties and declarations, including the Alma-Ata Declaration, the International Conference on Population and Development and the United Nations' Millennium Development Goals (MDGs). Health services have received special attention since the Alma-Ata conference in 1978. Over the last three decades Bangladesh has made strides in many areas. This chapter presents a brief situation analysis of Bangladesh, particularly from the perspective of health sector.

Health Service Delivery System

In Bangladesh, health services are provided through a mix of public–private institutions and NGOs. All types of care (both curative and preventive) is provided by the public sector provides, while the private sector mainly provides curative care and NGOs provide mainly preventive and basic care. Some of the services have been contracted out to NGOs which include immunization, nutrition and tuberculosis (TB) control. Notwithstanding a vast network of multiple providers, public sector services are considered as the key source of care for a majority of the population.

A large part of the health services are financed and provided for privately. Over 70 percent of the expenditure and nearly 80 percent of the health-care contacts are in the private sector (World Bank, 2006). Public sector has low facility utilization rates, and there has been increasing demand for services provided by the private sector and non-governmental organizations. Bangladesh has a large NGO sector involved increasingly in providing primary health care. The private sector is diverse, ranging from modern facility-based state-of-the-art services to indigenous medical practitioners, village pharmacists and non-qualified practitioners.

Government health services are provided through a four-tier system of government-owned and staffed facilities. They are:

1. At the union level: Union Health and Family Welfare Centres (UHFWC) covering a population of about 30,000 each. There are 4,400 UHFWCs which provide mainly Primary Healthcare (PHC) services including maternal and child health services, family planning services, Behaviour Change Communications (BCC) and limited curative care. At the ward level, there are community clinics to serve 6,000 people.

2. At the upazila level: There are 417 Upazila Health Complexes (UHCs) with 31–50 beds providing both in-patient and out-patient care, PHC, family planning services and some referral services.

3. At the district level: There are 59 District Hospitals with bed capacities ranging from 50 to 250 providing both primary and tertiary care and both in-patient and out-patient care.

4. Medical College Hospitals at the regional level providing tertiary care accompanied by specialized laboratory facilities for the treatment of complicated cases usually (but not always) referred to them by the lower level facilities. (Rahman 2006).

Health System Structure For RH Services In Bangladesh

Administrative Level	Health Facility	Cadre	Level of Care
National Level	• National and regional training centers • Model Clinics	DG line directors, program managers, trainers	Tertiary
District Level	• Model Clinics • Maternal Child Welfare Clinics (MCWC) • District hospitals(MCH-FP clinics)	DGFP additional Director or Medical Officer, clinical contraception	Tertiary
Upzila Level	• MCH-FP clinics • MCWC	Family Planning Officers Medical Officer, clinical contraception	Secondary
Union Level	• Union Health and Family Welfare Centers • Rural dispensaries • MCWC	Family Welfare Visitor, Family Welfare Assistant, Family Planning Inspector	Primary
Peripheral Level	• Satellite Clinics • Domiciliary Services	Family Welfare Assistant	Community/primary

In addition to these four levels of facilities, at the national level there are six postgraduate institutions providing both in-patient and out-patient specialized care. Of the above-mentioned facilities, UHFWCs and the UHCs are the key facilities to provide services in rural areas. In addition to these facilities, at the ward levels, there are government run satellite clinics for providing immunization and family planning services.

In the public sector, basic emergency obstetric care (EOC) services are available in most health facilities, while comprehensive EOC is available in a few UHCs, most DHs and district-level MCWCs, all medical college hospitals, and one post-graduate institute (Mridha et. al 2009). However, according to a recent health facility survey that categorized providers based on the availability of required drugs and supplies, comprehensive emergency obstetric care services at the public sector primary and secondary level can be effectively provided by only 19% of DHs, 5% of UHCs, and 2% of MCWCs (Tulane University SPHTM and ACPR 2009).

At the central level, the Ministry of Health and Family Welfare (MoHFW) has separate Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). The DGFP supports the maternal health and family planning priorities of the current HNPSP.

Data sources of Indicators of reproductive health

Demographic Data Sources in Bangladesh

In general, demographic data can be obtained from a variety of sources, like census, vital registration system, population register, and sample surveys. In Bangladesh following are the key demographic data sources:

S.N.	Source	Executing Agency	Periodicity	Information Collected
1.1	**Census**	Bangladesh Bureau of Statistics.	Two rounds of census (1872 and 1881) in pre-Independence era. Five rounds of Census after independence have been executed in the year 1974,1981,1991,2001 and 2011.	Covers a wide range of information like name of the person, relationship to head of the household, sex, age, marital status, religion, literacy status, level of education, occupation, birth place, number of children ever born, number of children alive, etc.

1.2	**Sample surveys:** • Bangladesh Demographic Health Survey (BDHS) • Household Income and Expenditure Survey (HIES)	BDHS 2007 was conducted under the authority of the National Institute for Population Research and Training (NIPORT) of MOHFW.	BDHS is conducted in every three to four years. The first one was conducted in 1994 and the latest one, which was the fifth, was conducted in 2007.	Detailed information on basic national indicators like household population characteristics by age, sex, fertility, child and maternal health, knowledge, attitudes and behavior on HIV/AIDS, women's empowerment and demographic outcomes etc.
1.3	**Multiple Indicator's Cluster Survey**	Bangladesh Bureau of Statistics and UNICEF.		Provides estimates on few indicators on the situation of children and women for urban and rural areas, at the national , district and upzila levels.
1.4	**Demographic surveillance system:**	International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B)	Started in the 1960s and ICDDR,B had been recording the data since 1966.	Collects a wide range of data on family planning, child nutrition, epidemiology, child and maternal health etc.
1.5	**Vital registration**			
i)	**Sample Vital Registration System**	Bangladesh Bureau of Statistics	Started in 1980.	Provides data on vital events of sample population like mortality, life expectancy, nuptiality, contraceptive use ,household characteristics.
ii)	**Other Sources of Vital Registration :** Bangladesh Bank, the central bank of Bangladesh, Bangladesh Economic Review published by Bangladesh Bureau of Statistics, Bureau of Manpower Employment and Training, an institute of Ministry of Labour and Expatriate Welfare, Refugee and Migratory Movement Research Unit of the University of Dhaka provide some demographic data.			

Demographic, RH and Economic Indicators

Bangladesh is now Asia's fifth and world's eighth populous country with an estimated population of about 160 million (Table 2.1). Density of population is around 979 per square kilometer, the highest in the world. Rural population comprises about 76% while urban constitutes about 24%. Adult literacy rate is 54% (2006). Census of 2001 reveals that 43 per cent of the population is below 15 years of age. This young age structure constitutes built-in population momentum. Also urban population is increasing quite fast. Strong policy interventions led to continuous reduction in the annual growth rate of population from the level of 2.33 % in 1981 to 1.54 in 2001 and further to 1.4 (2010). The family planning efforts in Bangladesh have long been considered among the most successful in the world. From 1975 to 2007, the total fertility rate (TFR)

decreased from 6.3 to 2.7 children per woman, while the overall contraceptive prevalence rate (CPR) increased from 7.7 to 55.8 percent, including traditional methods, among married women of reproductive age.

The infant mortality rate has decreased by almost 50 percent from 150 deaths per 1000 live births in 1975 to 77 in 1998. The decline has been faster in urban areas than in rural areas. However, health differentials can be found in urban areas as well and mortality indicators are higher in slum areas than in non-slum areas. The Under-5 Mortality Rate (U5MR) dropped from 84 per 1,000 live births in 2000 to 61 in 2007.

Table 2.1: Key demographic, health and economic Indicators for Bangladesh

Indicator	Value	Year
Population*	160	2010
Population growth rate[μ]	1.42	2010
Sex ratio [α]	102.3	2010
Life expectancy at birth[α]	66.94	2010
TFR[β]	2.6	2011
Crude death rate[β]	5.75	2011
Infant Mortality rate[β]	50.73	2011
Child Mortality rate*	48	2010
Contraceptive Prevalence rate*	53	2008
Unmet need for contraception*	17	2007
Percentage of mother women received full ANC(Four visits)[γ]	21	2007
Percentage of pregnant women received 2+TT[γ]	64	2007
Percentage of children 12-23 months received full immunization[δ]	75	2009
GNI per capita (constant 2008 PPP US$) - calculated[α]	1587	2010
HDI[α]	.469	2010
Multidimensional Poverty Index[α]	.291	2000-2008
Adult Literacy Rate[α]	55	2005-2008
Employment to population ratio [α] (Percentage of population age)(15-64)	67.9	2008

***Sources**: *World Development Indicators (World bank database) 2010; [μ]United Nations, 2010; [α]HDR 2010; [β]CIA World Factbook, 2011; [γ]BDHS-2007; [δ]Coverage Evaluation Survey-2009*

Bangladesh which is a low income country ranked 129 out of 169 countries in HDR 2010 . HDI is a summary aggregate of progress made in health, education and income. Population growth rate shows a decreasing pattern over the period from 1990-1995(2.05 percent) to 2005-2010(1.57 percent) (United Nations 2010) which is a good indicator for Bangladesh.

Employment to population ratio which was 48.5 percent in 1990/91 has increased to 67.9 percent. Several constraints have limited the capacity of the country to provide employment for its growing population. Labour force participation rate among the youth is very low and it has declined in recent times because of the general lack of available opportunities for productive work, huge skill deficiencies. Adult literacy rate is only 55 percent. The general quality of higher/tertiary education is poor with adverse implications for employability especially in the high skill-high paying jobs such as information technology.

Considering maternal health indicators, antenatal coverage which was 6 percent (1991) has increased to 21 percent, but the present trend is not sufficient to reach even half of the target set for MDG. There has been a steady increase in the vaccination coverage. Routine EPI activities specifically targeting fifteen low performing districts through the Reach Every District (RED) strategy, increased coverage of fully immunized children from 52 percent (2005) to 74 percent (2009), matching the national coverage rate of 75 percent (GoB 2009).

According to the most recent demographic data, the country continues to improve in terms of many of its family planning indicators. The total fertility rate has decreased from three children per woman in 2004 to 2.7 in 2007. While the overall CPR decreased from 58.1 (2004) to 55.8 percent (2007), this is attributed to a decline in the use of traditional methods (from 10.8 in 2004 to 8.3 percent in 2007) while modern method CPR has remained unchanged at approximately 47 percent over the past three years. Of particular note in the most recent Demographic and Health Survey (DHS) is the increase in unmet need for family planning from 11 (2004) to 17 percent (2007).

Reproductive Health Status and Needs

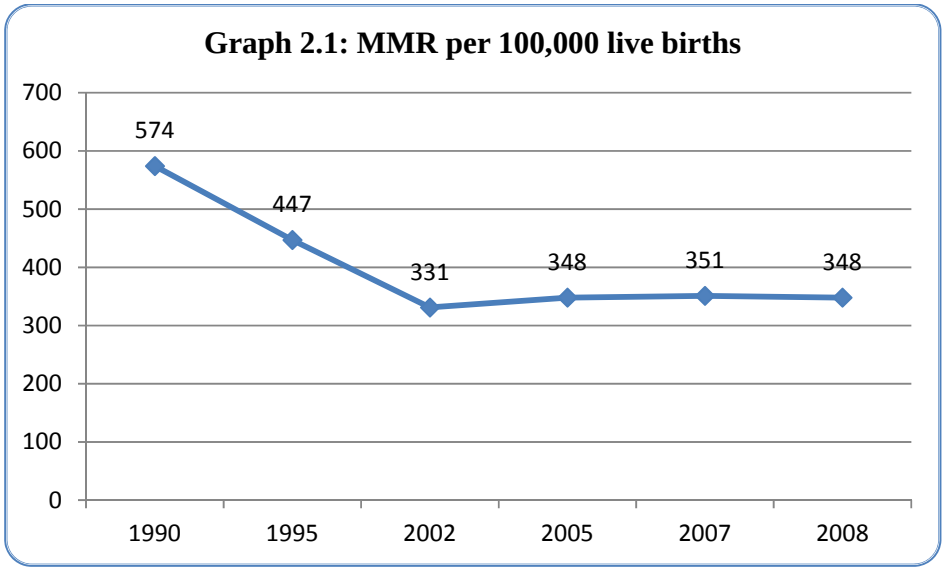
In spite of various initiatives by the Government, number of births attended by skilled health personnel is still low . Around 85 percent of deliveries still take place at home and the proportion of those receiving assistance during delivery by medically trained providers was only 18 percent (BDHS-2007). Training of skilled health personnel, improvement in infrastructure and regular monitoring is essential to reach MDG target by 2015.

Comprehensive EmOC services in public health facilities, especially at district level and below, is also not adequate to reach the target level. Though obstetricians and anaesthetists are being trained and appointed as per Maternal Health Strategy 2001, but there is also a frequent failure to retain both the obstetricians and the anaesthetists to perform caesarian sections in a facility due to variety of reasons (MTR 2008). The Government should take steps to overcome this problem by giving special emphasis to reducing absenteeism in rural areas.

Currently, CEmOC is provided at district and upper level facilities with very limited access in Upazila level. The government should strengthen the existing facilities to provide EmOC and increase coverage in public and not-for-profit private health facilities, specially in all UHCs.

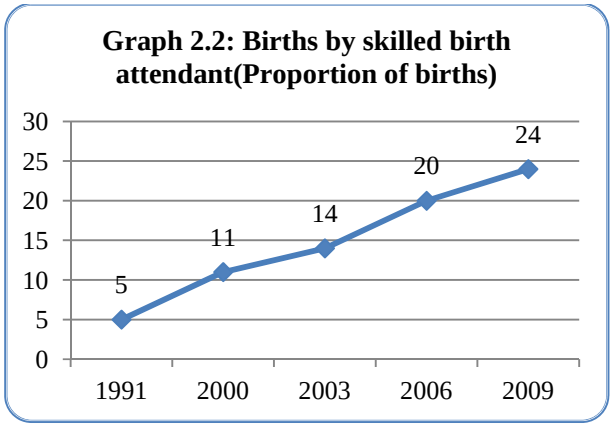
Trends in Health Indicators

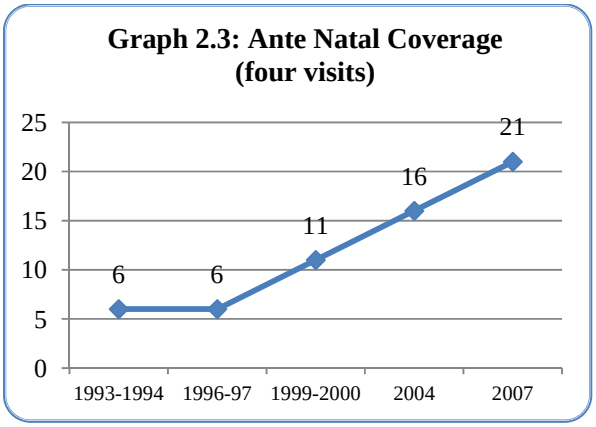
Bangladesh experienced a remarkable decline of approximately 40% between 1990 and 2005 in maternal mortality (Graph 2.1). In the following three years MMR remained at approximately 350/100,000 live births.



***Source**: Sample Vital Registration System, Bangladesh*

This tremendous decline occurred due to various medical, socioeconomic and demographic factors. Education of young women have been rising rapidly, increasing use of maternal health services. There had been a substantial improvement in the use of medically trained attendant and use of facility for deliveries. The number and distribution of facilities offering maternal health services has increased. Due to improved road transport (roads, bridges, bus services) access to health services has become easier . Also income at national and household levels have improved, due to which number of people visiting a health facility has increased.





***Source**: BDHS, Bangladesh*

Only 15% of deliveries occur in health facilities, about half of them in public sector and the remaining half in private and NGO facilities (BDHS 2007). Nearly all women who deliver at home are assisted by providers that are not medically trained, friends, relatives, or no one at all (BDHS 2007). Although 52% of women receive ANC from a medically trained provider, only 21% complete the WHO-recommended minimum of four or more ANC visits (BDHS 2007).

The overall proportion of births attended by skilled health personnel has increased by nearly fivefold in the last two decades (5% in 1991 to 24.4% in 2009).

In Bangladesh, evidence indicates that women from the richest quintile, with secondary education, are more likely to have access to institutional or skilled care during delivery. The BDHS 2007 survey shows that the proportion of skilled attendance at delivery is ten times higher among the richest (51%) compared to the poorest (5%) households. Skilled attendance is nearly three times higher in urban areas compared to rural areas.

The GoB and WHO recommend at least four ANC visits for routine monitoring of pregnancy. BDHS 2007 reveals that only one in five women received the recommended visits. Although the number of women who receive at least four ANC has increased steadily.

In spite of this increase in ANC coverage, the present rate is below expected level to reach even half of MDG target by the year 2015. The other major reasons came out to be restrictions by family members, religious reasons and issues related to quality were also reported.

Table 2.2: Variation in RH indicators by province –regional variation

Divisions	Barisal	Chittagong	Dhaka	Khulna	Rajshahi	Sylhet
Percentage of institutional deliveries	9.5	13.6	16.9	22.5	13.2	8.2
Percentage of delivery assisted by medically trained personnel	13.4	18.5	19.8	26.6	15.4	10.9
Contraceptive Prevalence Rate	56.3	43.9	56.4	63.1	65.9	31.5
Percentage receiving ANC from a medically trained provider	43.7	52.4	48.2	62.6	55.0	46.0

Source: BDHS, 2007

Bangladesh has 6 administrative divisions. The data presented in Table 2.2 shows RH situation in different provinces . Though situation in different provinces is quiet unimpressive but Sylhet is the least performing division in terms of RH indicators.

Progress in Achieving MDG 5

Bangladesh is committed to achieve the MDGs set by the nation and is making continuous efforts in this direction. The table given below gives an overview of the MDG 5 in terms of base year values, current status and target for 2015.

Table 2.3: Millennium Development Goals (MGD 5), Bangladesh

Goals, Targets and Indicators	Base year 1990/1991	Current Status 2009	Target 2015	Status of progress
Goal 5 :Improve Maternal Health				
Target 5 A : Reduce by three quarters, between 1990 an 2015, the maternal mortality ratio.				
5.1 Maternal mortality rate, per 100,000 live births	574 (1990)	348(2008)	144	↓
5.2 Proportion of births attended by skilled health personnel %	5.0	24(2009)	50	↓
Target 5 B : Achieve by 2015, universal access to reproductive health				
5.3 Contraceptive Prevalence rate %	39.7	60(2008)	-	-

5.4 Adolescent birth rate, per 1000 women	77	60 (2008)	-	-
5.5 a Antenatal care coverage (at least one visit)%	27.5(1993)	60(2007)	100	↓
5.5 b Antenatal coverage (at least four visits)%	5.5(1993)	21(2007)	100	↓
5.6 Unmet need for family planning %	19.4(1993)	17(2007)	7.6	↓

Maternal mortality rate (MMR) declined by 40 percent during the 1990-2005 period and remained stable around 350 per 100,000 in the following four years. The proportion of child birth attended by skilled birth attendants (SBA) increased substantially but it is still very low- 1 out of 4 births are attended by SBAs. Contraceptive Prevalence Rate (CPR) has increased by 20 percentage points rising from 40 percent to 60 percent during the 1991-2008 period. The adolescent birth rate has declined from 77 per 1000 births to 60 per 1000 births during the same period. Antenatal care coverage (at least four visits) is very low – only one in five women receive the recommended visits. ANC shows wide differences across income classes and regions. About 17 percent married women currently have unmet need for family planning services.

Health spending in Bangladesh

Bangladesh's Total Health Expenditure (THE) in 2007 was US$ 2.3 billion, which constituted 3.4% of the GDP. THE has grown at a nominal rate of 7% over the period 1998-2009. However, as a percentage of GDP, THE has shown a steady increase from 2.8 % in 2000 to 3.4% in 2009.

Total Health expenditure as percentage of GDP, which is 3.4%, provides an indication of overall economic activity by the health sector. Per capita health expenditures in Bangladesh are approximately US$12, of which 64% are borne by households as out-of-pocket spending (HEU/MOH, 2003). Health services are provided by the public sector, not-for-profit non-governmental organizations (NGOs) and the for-profit private sector. In terms of financing agents there is a massive difference between the health expenditure made by Private and Public Sector. Private sector acts as a major source of financing. This can be correlated with data on Out of pocket spending on health as percentage of private expenditure on health, which is 96.52%.

Table 2.4: Trend in Health spending in Bangladesh

Indicator	1995	2000	2005	2009
Total Health expenditure as % of GDP	3.52	2.8	3.2	3.4
Public Health expenditure as % of total health expenditure	36.19	39.02	34.90	31.73
Private Health expenditure as % of total health expenditure	63.81	60.98	65.98	67.13
Public expenditure on health as % of general government expenditure	8.84	7.56	7.46	7.52
External resources for health as % of Total Health expenditure	3.00	6.86	8.18	7.87
Private insurance for health risks as % of private expenditure on health	0.01	0.13	0.29	0.29
Social Security funds as % of general government expenditure on health (GGHE)	0.00	0.00	0.00	0.00
Out of pocket spending on health as % of private expenditure on health	95.94	95.13	96.22	96.52

Source:*WHO-Global Health Expenditure database*

Public health services are free or subsidized, but widespread shortages of drugs in pubic facilities mean that households seeking care in the public sector often have to pay for treatment. Services in many public health facilities fall short of required quality standards (Tulane University and ACPR, 2009).

2.2 Reproductive Health Context Policy and System

Bangladesh did not have a coherent health policy for the first three decades since independence in 1971. In the absence of a formal health policy, all health-related planning and programming were guided by the health sector components of successive Five Year Plans. It was after the formation of National Health Policy in 2000, health programmes were directed by a Health policy.

Major plans of the Bangladesh Government and relevance to maternal health

Plan	Strategies related to Maternal Health
First 5-year plan (1973-1978)	• Establishment of 31-bed hospitals in 'Thana Health Complexes' in rural thana (now upazila) • Increase the manufacturing of essential drugs • Develop and expand training facilities for doctors, nurses, and paramedical staff

	• Develop a national population policy • Set up a separate family-planning wing of the Ministry of Health and Family Welfare • Set up family welfare visitor (FWV) training institutes and organize training of FWVs
Second 5-year plan	• Accept primary healthcare for all as the strategy to reach the goal 'Health for All by 2000' • Set the target for completion of setting up Thana Health Complexes in each rural thana (now upazila) and establish one Union Health and Family Welfare Centre' in each union by 1985 • Start menstrual regulation as a method for family planning • Train traditional birth attendants
Third 5-year plan (1985-1990	• Integrate maternal and child healthcare and family-planning care • Continue with the strategy 'primary healthcare' for all
Fourth 5-year plan (1990-1995)	• Continue with the strategy for primary healthcare for all • Intersectoral collaboration • Integrate maternal and child healthcare, family-planning care, nutrition care, and health education
Fifth 5-year plan (1997-2002)	• Health and Population Sector Programme • Implement essential service package (reproductive healthcare, child healthcare, communicable disease control, limited curative care; and behaviour change communication) in all facilities • Set up 13,000 community clinics—1 per 6,000 people to provide one-stop services • Decentralize the process for programme planning, strategy formulation, and resource mobilization • Ensure equity of access to services • Unify health and family-planning wings of the Ministry of Health and Family Welfare to improve programme management and service-delivery • Develop a national health policy • Develop a national strategy for maternal health
First 3-year plan (2003-2006)	• Health, Population and Nutrition Sector Programme • Provide essential service-delivery (reproductive health, child health, limited curative care, urban health services, healthcare, waste management, support services, and coordination) • Upgrade facilities, train manpower, ensure equipment and supplies, and further develop referral linkages • Implement Women-Friendly Hospital Initiative in tertiary and secondary-level healthcare facilities • Implement Demand-Side Financing Pilot: Maternal Health Voucher Scheme in 21 upazilas • Separate health and family-planning wings of the Ministry of Health and Family Welfare

.

Health, Nutrition & Population Sector Program (2003-2010)

HNPSP is a programme under Government of Bangladesh through which reproductive health care services are provided to the people from the grass root to the central level. Under HNPSP (2003-2011), there are 38 Operational Plans (OPs).

In 38 OPs, 7 are under MOHFW, 19 under Directorate General of Health Services (DGHS), 9 under Directorate General of Family Planning (DGFP), 1 under Directorate of Nursing Services (DNS), 1 under Directorate of Drug Administration (DDA) and 1 under National Institute of Population Research and Training (NIPORT) and of the 14 projects/programs, 1 is under MOHFW, 9 under DGHS, 1 under DGFP, 2 under DNS and 1is under NIPORT.

Policy Documents in Bangladesh for Reproductive Health :

Some key policy and strategy documents that are relevant for reproductive health programme in Bangladesh are as follows:

- National Strategy for Economic Growth, Poverty Reduction and Social Development
- United Nations Millennium Development Goals
- 1994 International Conference on Population and Development and sectoral strategies
- Bangladesh National Strategy for Maternal Health,
- MOHFW Strategy for Contraceptive Security in Bangladesh
- MOHFW's Conceptual Framework for the Health, Nutrition and Population Sector Programme (HNPSP) July 2003-June 2006.
- Poverty Reduction Strategy Paper, 2005-2008
- National Reproductive Health Policy
- Essential Service Package
- National Contraceptive Security Strategy, 2002
- Age of marriage policy
- Adolescent Reproductive Health Strategy, 2006
- Essential Drugs List, 2008 Revision
- National Maternal Health Policy (2001-2010)
- National Health Policy
- National Population Policy
- National Policy on HIV/AIDS and STD-related Issues
- National Drug Policy
- National Food and Nutrition Policy
- Gender Equity Strategy, 2001

Chapter 3: Data and Methods

The study is primarily based on desk research. Besides other data sources, it exploits the availability of health accounts (BNHA) estimates. In Bangladesh, that are standardized according to international standards, and the existence of technical capacity to undertake health accounts-related analyses. The underlying approach involves taking these existing health accounts estimates of national health expenditures, and disaggregate each element of expenditure into the portions that are related to reproductive health and family planning. The base estimates of national health expenditure used are those produced in the third round (2007) of national health accounts estimates in Bangladesh. These estimates are organized according to the Bangladesh national health accounts framework, which was itself based on the OECD SHA framework. This describes, in an integrated way, the sources, uses and channels for all funds utilized in the health system.

Bangladesh NHA defines Total Health Expenditure as the sum of all expenditures for the final use of resident units of health care goods and services, plus gross capital formation in health care provider industries (institutions), plus education and research by health care provider institutions.

3.1 Reproductive Health System and Actors

RH providers are defined as institutional entities that produce and provide reproductive health care goods and services, which benefit individual or population groups. There are a wide range of health care providers in Bangladesh and their proper identification and classification is important. Three broad categories of providers are: public, private and NGOs.

Public providers: Public providers include MOHFW with its countrywide facility network, and facilities of other ministries, including Defense, Transport and Communication, Autonomous Corporations, Local Bodies, and Public Health Research and Training institutes.

Facility-based services in the public sector are provided at three levels: (1) primary health care facilities at the upazila and lower level; (2) secondary level facilities including district hospitals and other health facilities located in the district/division headquarters; and (3) tertiary level facilities including specialized and teaching health institutions, most of which are in the capital and other large cities. Primary level public facilities include Upazila Health Complexes (UHC), Union Health and Family Welfare Centers (UHFWC), and community clinics (CC). Secondary

level public facilities include district hospitals (DH), and Maternal and Child Welfare Centers (MCWC).

Private providers: These consist of NGO providers, which include non-government providers working at the grass root and in urban areas, for-profit providers, which include ambulatory providers, diagnostic and imaging service providers, dental service providers, clinics and hospitals, business firms, traditional healers including ayurvedas, unani practitioners, homeopaths, and traditional birth attendants.

It is estimated that around sixty percent of health care services occur in the private sector, however, an expansive network of primary, secondary and tertiary government health facilities exists. As of March 2010, 2506 non-government organizations (NGOs) are present in Bangladesh and out of them 48% big and 60% small NGOs are providing health care services in the rural, urban and semi-urban areas where government's services are inadequate (Alam and Ahmed 2010).

Private healthcare providers also include healthcare enterprises, including private clinics and hospitals, diagnostic and imaging centres, private modern ambulatory practitioners as well as a large number of traditional healthcare providers operating as unincorporated enterprises. All three categories of providers also perform health related functions of capital formation, education and training of varying degrees. The Government and NGO providers are non-market providers in that the services they provide are generally not offered in the market.

Financing System and Agents

Financing for reproductive health in Bangladesh is a combination of different methods, which include households, government revenue, donors and community financing through NGOs (Osman 2008). The MOHFW operates as a financial intermediary of the Government of Bangladesh (GOB) obtaining funds from the Ministry of Finance (MOF) and allocating and disbursing them to its reproductive healthcare providing units. It also provides regular annual transfers or grants-in-aids to NGOs operating in this sector. As in other government ministries in Bangladesh, MOHFW expenditures are funded from and classified under two GOB budget categories:

a) Revenue Budget and
b) Development Budget or the Annual Development Programme (ADP).

Revenue Budget is financed by the GOB by its tax and non-tax revenues including borrowing from the domestic market and self-financing by Public (or GOB owned) autonomous corporations. The ADP is primarily financed by the GOB revenue surpluses. ADP also relies on

development partner assistance in the form of development grants and loans. The MOHFW recurrent expenditures (termed revenue expenditures) are funded through the Revenue Budget.

Regarding external funding, the revised HNPSP follows the SWAp concept, and places greater emphasis on serving vulnerable populations through client-focused and better utilized essential health services. There are pool funding, non-pool funding and parallel funding mechanisms for development assistance to the Government.

In Bangladesh, the disbursement and flow of funds vary, depending on whether the funds are pooled or not by the DPs. With respect to Pooled Funds provided by Pooled DPs, disbursement arrangements are made in accordance with the provisions of the Development Credit Agreement (DCA) between GOB and IDA and of the relevant bilateral agreements (between IDA and the respective DPs, or between GOB and the respective DPs, as the case may be). For Non-Pooled Funds, disbursements are in accordance with the provisions of the bilateral agreements between GOB and the respective DPs. Arrangements for the disbursement and the now of non-pooled funds (to be provided by DPs who want to finance specific projects or activities of the Programme) is negotiated between GOB and each Non-Pooled DP and incorporated into bilateral, financing agreements between the two parties. There are many options available, including but not limited to disbursements of funds directly to Line Directorates for specific projects and activities, direct provision of technical assistance, and direct payments to contractors, suppliers and consultants for works, goods and services to be provided in kind.

Release of funds to cost centers**:** MOHFW releases funds for three quarters at a time by issuing a single order at the beginning of the year treating HNPSP as a single programme for the purposes of funds release. This procedure helps avoid the bureaucratic delays of the fund release system within MOHFW. For the fourth quarter fund release, MOHFW has to submit to the MOF a number of utilization reports reflecting usage of DPs and Government funds by Line Directors. The MOF does not release funds for the fourth quarter unless information regarding the previously released funds for the first three quarters is provided. According to existing GOB system of release of funds, Line Directors disburse funds to various cost centers, i.e. Drawing & Disbursement Officer at Regional level, Districts and Upazilas. Disbursements are made quarterly on the basis of approved Administrative Order (AO) [or each Operational Plan. The Chief Accounts Officer (CAO) of MOHFW transmits copies of the AO to the Divisional Comptroller of Accounts (DCA), District Accounts Officer (DAO) and Upazila Accounts Officer for ensuring that expenditures are consistent with approved spending.

For the purpose of NHA, when the funds are provided directly to health care providers, the external donor is acting as a financing agent, but when it provides funds through an intermediary, such as Ministry of Finance, it is acting as a financing source, and the intermediary is regarded as the financing agent. External donor financing to the health sector is primarily made to GOB and NGOs. The government receives donor money either as grants or as loans. Funds are either channeled through the Ministry of Finance or channeled directly to programmes and institutions

that administer the funds. Donor funding through MOF is not classified as external funding since the financing agent is ultimately MOHFW, instead it is reported as government financing. 'Rest of the world (ROW)' includes those sources which are not channeled through government system (MOF).

ROW expenditures reported in the BNHA estimates, which classify expenditures according to the financing agent and not by financing source, are likely to vary considerably with the estimates derived through disbursement data provided by donor agencies. Disbursement data reflects expenditures by external donors acting both as financing agents and as financing sources, and disbursements may not necessarily be the same as actual expenditures in a given year. Actual expenditure may either be the same as disbursed funds, or may be less.

Tracking expenditure by sources of funding is difficult for government as well as nongovernment entities. The GOB does not track the sources of funding from external partners once it enters the existing Controller General of Accounts (CGA) financing tracking system. NGOs in many instances cannot identify the sources of funding, as they receive money from financing intermediaries. Accordingly the expenditure analysis drawn from BNHA is limited by the financing agent only, and not by funding sources for these two entities. For enabling tracking by sources, the CGA system needs to do accounting with coding by sources also.

However, the donor expenditure or support to Bangladesh has been available though the Resource Flows Survey. It provides distribution of donor expenditure on population activities according to broad categories of distribution channels: (1) bilateral (2) multilateral, and (3) NGOs.

Estimates on out of pocket expenditure (OOPE) has been drawn from studies carried out in Bangladesh. One study carried out by Khan et.al (2009) and another by Hatt et.al (2010) provided important inputs for this report. However, these include out of pocket expenditure on maternal health (services related to antenatal care, delivery, postnatal care, managing complications, etc.) but does not include the component of family planning. However, it was noted that the proportion of out of pocket expenditure for RH is almost in the same proportion as it is in case of overall out of pocket expenditure on health (Chankova et.al, 2010; Khan et.al 2009).

BNHA gives classification of expenditure according to functions, but it was difficult to segregate the RH specific expenditure according to the functions since it was not coded separately. Hence the classification on the functions could not be done as per the standard definitions. However, the expenditure information could be triangulated using the Government data and other available studies on private providers and OOPE.

Government data: Under the system, the FMAU of MOHFW continue receiving and recording financial information both for GOB and pooled donors funds following CGA system and is responsible for maintaining the accounts.

Activities produced by RH providers

The package of reproductive health services comprises of:

- ***Family planning services:*** All programs, goods and services intended to assist women control their fertility, all counseling, and health education and information in support of the same.
- ***Maternal health services:*** All special programs designed to provide antenatal and postnatal care to mothers, including provision of dietary supplements for malnourished pregnant and lactating mothers, such as iron and vitamins.
- ***Childbirth services:*** Services to provide medical care for women delivering and giving birth.
- ***Infant care:*** All services intended to promote and improve the health and development of infants (defined as children aged less than 1 year), including baby health care, growth monitoring and growth promotion, and provision of dietary supplements such as micronutrients.
- ***Child Health Services:*** All services for children, including immunization.
- ***Other personal reproductive health services for women:*** All other clinical services for women, which intend to enable women to safely exercise their reproductive health functions, to be operationalized as the equivalent of all obstetric and gynecological services.

Boundaries

It includes expenditure on health care by citizens and residents who are temporarily abroad and excludes spending on health care by foreign nationals within the country. Regarding time boundary, it covers a period of one year. Expenditures are recorded for the time period in which the activity takes place. For instance, if the activity carried out in fiscal year 2008 and the payment is made in year 2009, it is counted in the fiscal year 2008.

Overlap

For the financial analysis, it was found that the reproductive health services are mostly mentioned in two broad categories, maternal and child health (MCH) and family planning (FP). Since there is no separate coding for maternal health and child health expenditure, it is accounted in one single category of MCH. Expenditures of FP are coded separately. This classification was found in service provision as well as accounting management. Hence, the reproductive health financing in this analysis includes child health services, since those could not be segregated for the analysis of BNHA information.

3.2 Data Source and Analysis

The study began with an intensive desk review on the information available through different sources. The key sources, as found in the initial review, may include: National Health Accounts of Bangladesh; Budget 2010-11, Ministry of Finance, Bangladesh; MDG Financing Strategy of Bangladesh. MDG Need Assessment and Costing, Bangladesh, MDG Progress report. Public expenditure tracking system in Bangladesh, Publication of Health Economic Unit (Ministry of Health and Family Welfare), Management Information System (Directorate General of Health Service, Bangladesh).

Apart from these available sources, the information was also extracted through the government departments of: Director General of Health Services; Department of Statistics; Management Information system of Ministry of health and family welfare, and Health Economics Unit of the Ministry of Health and Family Welfare, Economics Unit of Planning Commission of Bangladesh. Some of the information will be obtained by existing documents, while some other will be obtained by personally approaching these sources.

Several other documents were also referred, like: Sixth Five Year Plan of Bangladesh, Six-point policy priorities for poverty, Health care financing perspective, Policy Study on Financing growth and poverty reduction: policy challenges and option in Bangladesh, Financing Health care in Bangladesh (Govt. of Bangladesh), Health Policy Programme and Systems in Bangladesh, Private household out-of-pocket expenditure in Bangladesh, Equity in Financing and delivery of health services in Bangladesh, Nepal and Srilanka, World health statistics (WHO), Annual Programme Review of HNPSP (Govt. of Bangladesh), Analysis of National Budget (by CPD), Health Bulletin (Govt. of Bangladesh), Year Book DGHS, Bangladesh.

While analyzing BNHA data, efforts were made to follow the WHO guidelines that are made for creating reproductive health accounts. The WHO 2003 considers five of the dimensions to be critical for accurate estimation of total health expenditures (financing source, financing agents, providers, the beneficiaries and the activities/functions. Consequently four tables are recommended that include health expenditures by financing source and financing agent (FS x HF), health expenditures by financing agents and provider (HF x HP), health expenditure by providers and functions (HP x HC) and health expenditures by financing agent and function (HF x HC). However, since the classification by funding sources was not available in BNHA, expenditure could be presented only according to functions by funding agents, and functions by provider in tables.

Regarding segregation of RH expenditure from BNHA, BC 6.1 (HC 6.1 of ICHA) category was considered most critical to analysis since it includes maternal health, family planning and counseling. This health area comprises public and personal care components, as well as preventive, curative and rehabilitative elements. The classification retains functions of largely preventive nature (e.g. pre-natal and post-natal care, family planning service delivery) in this

category, whereas curative and rehabilitative functions (e.g. obstetric care, fistula treatment, maternity care) are classified under respective categories HC.1 and HC.2, which was difficult to explored specifically for RH expenditures. Hence HC 6.1 was used mostly for analysis, which was further segregated as BC 6.1.1 for maternal and child health, and BC 6.1.2 for family planning, which enabled comparative analysis of expenditure on these two components.

Chapter 4: Reproductive Health Financing

In Bangladesh, historically, supply-side financing of health care services has been the backbone strategy for improving the access of poor households to essential health care services. More than two-thirds of the total expenditure on health is privately financed, through out-of-pocket payments. Of the remaining one-third (public financing), about 60% are financed by the Government from tax revenues and the other 40% are financed by the Government from international development assistance.

In Bangladesh the Ministry of Health & Family Welfare has two distinct wings: Directorate of Health (DGHS-Directorate General of Health Services) and Directorate of Family Planning (DGFP- Directorate General of Family Planning Services).Though most of the activities under the DGFP are categorized as RH activities but the RH component crosses the boundary of DGFP and encompasses several activities performed under the DGHS, such as, activities related to Essential Service Package (ESP), Maternal & Child Health and Clinical Contraception Services etc. This section gives an overview of the financing for reproductive health in Bangladesh.

4.1 Trend in Spending on Health and Reproductive Health

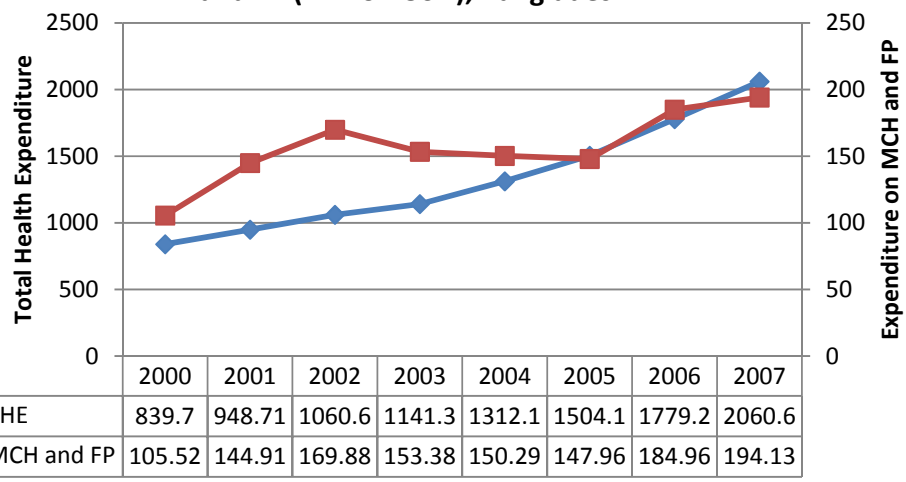
The financing of health in Bangladesh is dominated by two main methods: taxation/development partner funding and out of pocket payments. The first mostly finances the public provider system whilst the second is used mainly to finance pharmaceutical products and diagnostic tests. Social and private insurance and official user fees currently form a very small proportion of total finance. More than two-thirds of the total expenditure on health is privately financed through out-of-pocket payments. Community financing mechanisms and risk pooling systems are nearly non-existent except on a limited scale from NGO-innovated activities.

In 2007–08, the GoB spending on health was 7 per cent of the national budget (MTR 2008), which was 3.4 per cent of Gross Domestic Product (GDP). Bangladesh spends almost $12 per capita in the health sector, of which $4 comes from the public sector. Of the 63 percent spending from out of pocket, 46 percent is on drugs from private pharmacies. In 2007, per capita spending on health was USD $16.2 compared to USD $14.7 the preceding year. Growth in real per person health expenditure between 1998 to 2007 averaged 6.6% per year.

As per the National Health Accounts of Bangladesh (BNHA-III), the expenditure on health had increased from USD$ 948 million in 2001 to USD$ 2067 million in 2007. THE has grown at a nominal rate of 7% over the period 1998-2007. The analysis of expenditure specifically on RH

(MCH and FP) indicates that it has also increased from USD$ 145 million to USD$ 194 million during this period. The expenditure on RH is around 10 percent of the total expenditure on health, though it has declined slightly over the years.

Graph 4.1: Total Health Expenditure and Expenditure on MCH and FP (Million USD), Bangladesh



	2000	2001	2002	2003	2004	2005	2006	2007
THE	839.7	948.71	1060.6	1141.3	1312.1	1504.1	1779.2	2060.6
MCH and FP	105.52	144.91	169.88	153.38	150.29	147.96	184.96	194.13

Source: Based on NHA-III- Bangladesh

The financing for reproductive health needs to be substantially increased in order to achieve the MDGs set for the country. According to the need assessment and costing done by the Government of Bangladesh, 17992 million BDT (USD$ 234 million) will be required in 2012, which will increase to 24584 million BDT (USD$ 319 million) by 2015. The table given below gives the estimated resource need for various RH interventions.

Table 4.1: Yearly resource-needs estimates for attaining MDG 5 (Million USDs)

Interventions	2012	2013	2014	2015
Family Planning	38.08	43.05	46.49	51.21
Antenatal Care	19.95	23.74	27.77	32.77
Skilled attendance at birth	20.68	24.62	27.13	29.49
Post Partum Care	25.26	29.10	33.22	36.86
Obstetric Complications/RH Problems	129.64	148.04	164.94	168.91
Total	233.66	268.58	299.58	319.27

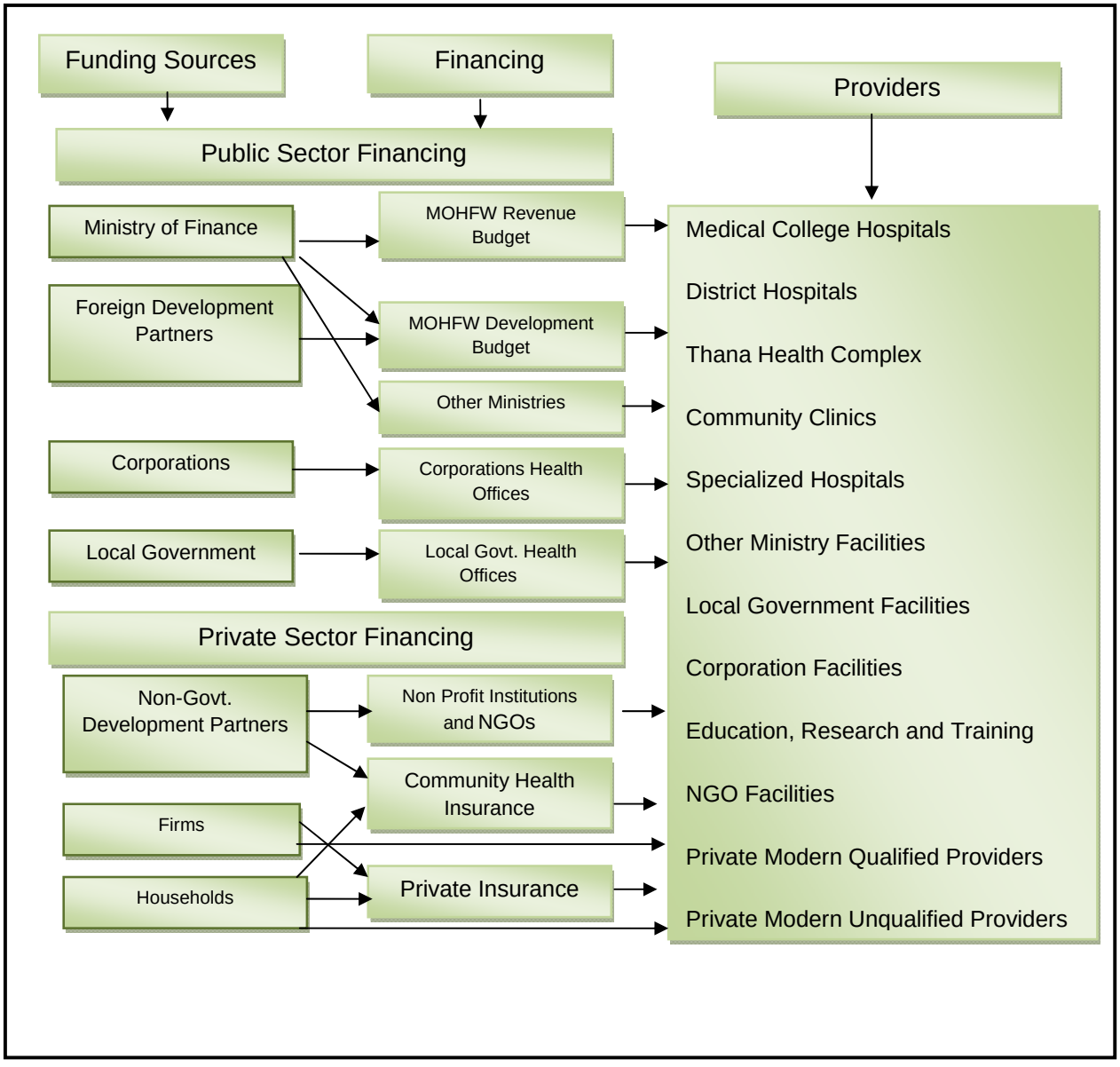
Source: Report on 'Millennium Development Goals Need Assessment and Costing 2009-2015, Bangladesh; General Economic Division of Planning Commission, Government of Bangladesh, July 2009.

4.2 Sources of RH Funds

Financing for reproductive health in Bangladesh is a combination of different methods, which include households, government revenue, donors and community financing through NGOs (Osman 2008). The MOHFW operates as a financial intermediary of the Government of Bangladesh (GOB) obtaining funds from the Ministry of Finance (MOF) and allocating and disbursing them to its reproductive healthcare providing units. It also provides regular annual transfers or grants-in-aids to NGOs operating in this sector. As in other government ministries in Bangladesh, MOHFW expenditures are funded from and classified under two GOB budget categories:

a) Revenue Budget and
b) Development Budget or the Annual Development Programme (ADP).

Figure 1: Flow of Funds to the Health System of Bangladesh



Revenue Budget is financed by the GOB by its tax and non-tax revenues including borrowing from the domestic market and self-financing by Public (or GOB owned) autonomous corporations. The ADP is primarily financed by the GOB revenue surpluses. ADP also relies on development partner assistance in the form of development grants and loans. The MOHFW recurrent expenditures (termed revenue expenditures) are funded through the Revenue Budget.

According to BNHA, all health spending is disaggregated according to where the funds come from, i.e. by financing agent. These are broadly characterized into (i)public, (ii) private, and (iii) Rest of the world, which includes all foreign development partner's expenditure excluding funding directly provided to the GOB by external partners and is then used by GOB to directly finance services.

According to National Health Accounts of Bangladesh, the Central Government and the local governments had a major role in financing for services for curative and preventive care services. Although the figures presented in Table 4.2 are for total health expenditure, the trend is assumed to be similar for reproductive health expenditures. Private out of pocket expenditures are mostly funding for the medical goods including medicines. NGOs are providing both curative as well as preventive services in Bangladesh.

Table 4.2: Health Expenditure on Functions by Financing Agents, 2007

Type of Services	Central government	Local/Municipal government	Private household's out of - Pocket expenditures	Non-Profit institutions serving households	Rest of the world
Services of Curative Care	41.6	46.2	23.9	59.0	52.3
Services of rehabilitative care	0.6	0.0	0.0	0.2	0.1
Ancillary services to health care	0.0	0.0	7.7	0.0	0.0
Medical goods dispensed to outpatients	17.8	0.0	68.5	0.0	0.0
Prevention and public health services	34.9	53.8	0.0	40.8	47.5
Health administration and health insurance	5.1	0.0	0.0	0.0	0.0
	100.0	100.0	100.0	100.0	100.0

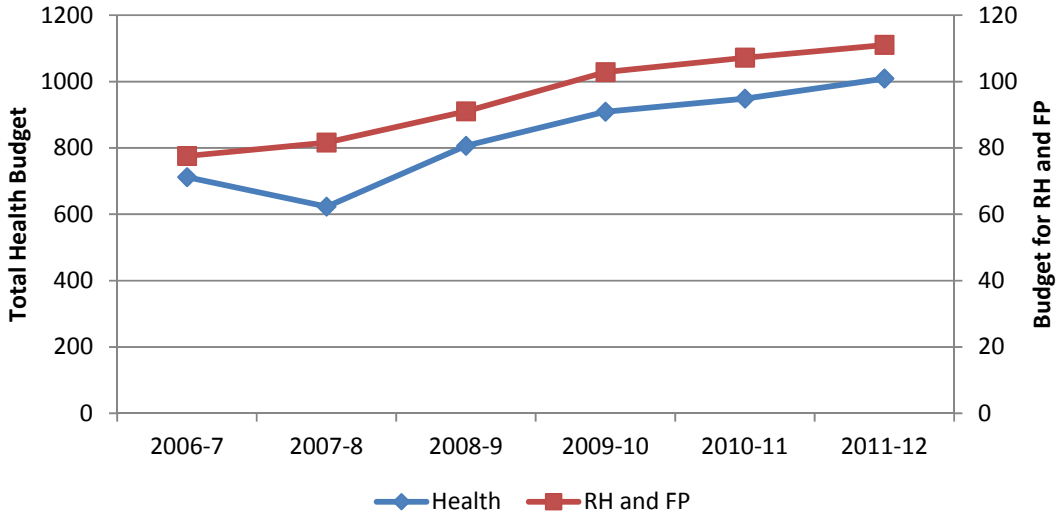
Source: Based on NHA-III.

Public Financing for RH and FP

The Ministry of Health and Family Welfare (MOHFW) is responsible for health policy formulation, planning and decision-making at the macro level. Under MOHFW, there are two implementation wings: the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP). The DGHS is responsible for implementation of all health programmes and technical support to the ministry. The DGFP is responsible for implementing family planning (FP) programmes and providing FP-related technical assistance to the ministry. DGHS and DGFP work independently. The DGHS advises and supports medical college hospitals, district hospitals and upazila health complexes (UHC), while DGFP oversees operations of district-level maternal and child welfare centres (MCWC) and union-level Union Health and Family Welfare Centres (UHFWC). At the most peripheral level both wings work at the domiciliary level to bring essential services to the people's door step.

Government budget for Reproductive health and family planning has been increasing over the years, in line with the increase in the overall budget for health. The budget of MOHFP for 2011-12 was around USD$ 111 million. The budget allocation for RH and FP is around 11 percent of the total health budget.

Graph 4.2: Government Budget for Health and for RH and FP, Bangladesh (Million USD)



Source: Mid Term Review, 2009 and Health Bulletin, MoHFW, Bangladesh (Figure for 2011-12 is projected)

A large proportion the total expenditure on service provision for RH is spent through the government system, particularly MOHFW, which includes donor support channeled through the government system. The role of other ministries and local governments is marginal in the financing for reproductive health services. Around 3.3 percent of the expenditure is funded through NGOs, while 27 percent is directly through the external donor support.

Table 4.3: Expenditure on Reproductive Health and Family Planning service (Prevention and Public Health) by Funding Agents

	%Total	% RH	%FP
Revenue Budget of MOHFW	35.9	0.1	73.8
Development Budget (ADP) MOHFW	33.6	58.5	7.3
Other Ministries	0.1	0.0	0.3
Local Governments	0.0	0.0	0.1
Non Profit Org/NGOs	3.3	3.6	2.9
Rest of the World	27.0	37.9	15.6
Total	100.0	100.0	100.0
Amount (USD $ million)	194.13	99.81	94.32

Source: Based on NHA-III, Bangladesh. (RH included maternal and child health services)

The government spending on RH is either from revenue budget or from development budget. It seems that most of the expenditure on family planning are funded through revenue budget, while the proportion of development budget is quite significant in case of maternal and child health services. Similarly, funding from external donors (rest of the world) is also relatively higher for maternal and child health services as compared to family planning.

Out of Pocket spending

Out of pocket spending constitutes a significant proportion of the total spending on reproductive health. According to a study conducted by Khan and others (2009) out-of pocket spending was found to be major source for paying (more than 65%) for delivery and other RH services for most of the households. In the same study, the median costs to households who obtained ANC ranged between USD $ 2.6 and 3.9. The median cost of home delivery ranges from USD $ 1.3 to 4.5, whereas for home delivery with skilled attendant the median cost ranges between USD $ 2.6 and 3.9. Normal delivery care at public facility in those areas would costs the mothers from USD $ 25 and 40.

A study conducted by Chankova and others (2010) tried to estimate the cost incurred by consumers on key maternal health services at different levels of institutions. An overview of consumer cost of different types of primary and secondary level institutions is presented in the table 4.4.

Table 4.4: Consumer Cost for key maternal health services

Services and Level	Medical cost (in USD)			Non medical cost (in USD)
	Public	NGO	Private for profit	
ANC				
Secondary*	7.73	1.43	25.97	0.55
Primary**	1.35	1.04	27.27	0.88
Normal Delivery				
Secondary*	9.84	9.09	48.70	26.74
Primary**	9.75	8.12	32.47	21.48
Postpartum Care				
Secondary*	4.56	0.39	3.90	0.55
Primary**	0.74	0.26	3.90	0.88
C-Section				
Secondary*	15.73	71.43	175.32	26.74
Primary**	10.74	0.00	129.87	21.48

***** *District level;* ******** *Upzila and below*

Source: Chankova et.al. 2010.

Note: Non-medical cost includes travel, expenditure for companion, etc.

Another recent study (Hatt et.al. 2010) conducted for voucher scheme estimated the OOP on pregnancy and delivery related services to be USD $ 28.45. These studies indicate that the OOP for RH services is more that 65 percent of the total expenditure on these services.

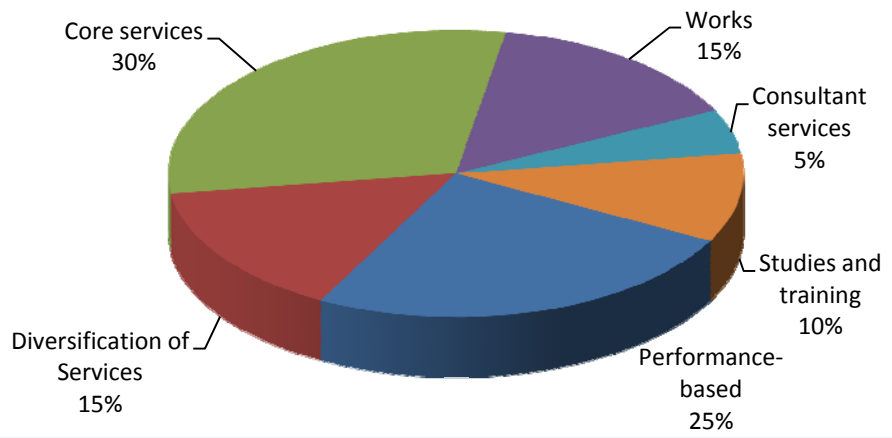
Assistance from Development Partners

Before 1998 funding was channeled to different health projects with their defined objectives and activities in specific areas. In order to bring efficiency to the system of planning, monitoring and management, and for harmonization and alignment of donor support to national plans and strategies, a sector-wide approach (SWAp) was introduced in the health and population sector, with the launch of the Health and Population Sector Programme in 1998. The revised HNPSP continues to be structured on the SWAp concept, and places greater emphasis on serving vulnerable populations through client-focused and better utilized essential health services. There

are pool funding, non-pool funding and parallel funding mechanisms for development assistance to the Government.

The pool funding mechanism is designed to align support from development partners according to the needs of the country, as well as for coordinating the funding for health development. Pooled financing includes that from partners including World Bank, the Department for International Development (DFID), the Netherlands, and the European Union (EU). Contributions to the pool fund of the HNPSP have been pledged by a consortium of donors led by the World Bank/IDA. A substantial amount of DP funding is channeled, released and expended using GOB systems. All RPA contributions from the DP are held in a Trust Fund managed by WB. Expenditure financed from pool funds is first made from the GOB Taka Treasury using the same procedures applicable to expenditure of GOB own funds. In HNPSP, the expenditure is funded in six broad categories: (1) Performance-based funding (2) Diversification of service provision, (3) Support categories/core services (4) Works (5) Consultant services, and (6) Studies and training. The proportion distribution in these categories is presented in the graph. The performance based funding applies to 25% of the pooled fund, to be released on completion of specified actions.

Graph 4.3: Expenditure Categories in DCA- 2005-10



The financing mechanism in Bangladesh also includes an element of DP funding to be provided within the framework of the HNPSP operational plans but by direct disbursement rather than inclusion in the DP funding pool. Use of this mechanism provides some flexibility, enabling a rapid response to changing requirements. Parallel funds have mostly focused on urban health care, family planning and social marketing of contraceptives, though a few are also supporting select areas such as maternal health.

Most of the UN agencies are non-pool contributors. Non-pool funding has been pledged by DPs to accomplish their specific objectives within the umbrella of the HNPSP. Development partners with non-pool funding are providing support in maternal and child health, HIV-AIDS, women's health, equitable access to health-care finance and facilities, and micronutrients.

For the purpose of NHA, when the funds are provided directly to health care providers, the external donor is acting as a financing agent, but when it provides funds through an intermediary, such as Ministry of Finance, it is acting as a financing source, and the intermediary is regarded as the financing agent. External donor financing to the health sector is primarily made to GOB and NGOs. The government receives donor money either as grants or as loans. Funds are either channeled through the Ministry of Finance or channeled directly to programmes and institutions that administer the funds. Donor funding through MOF is not classified as external funding since the financing agent is ultimately MOHFW, instead it is reported as government financing. 'Rest of the world' includes those sources which are not channeled through government system (MOF).

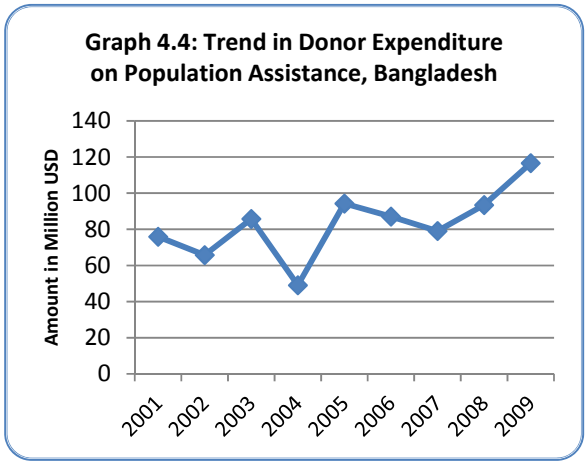
Priority Areas of Support of non-pool and parallel funding agencies

Development Partner	Priority areas in HNP
Non –Pool Funds	
CIDA	Life Cycle approach , line of commodity, gender and health, health systems reform.
GTZ	HNPSP Monitoring and evaluation, demand-side financing schemes, social health insurance, HIV-AIDs, reproductive health.
Japanese Government	For any HNPSP area, as assessed by the Annual Programme Review as a well-performing sector.
JICA	Reproductive health, maternal and child health, measles control, immunization, filariasis elimination.
KfW	Contraceptive security, quality control of contraceptives, reproductive health and HIV-AIDS, diversification of service-providers, support to the HNP consortium Secretariat and the Programme Support Office
SIDA	Reproductive health, women's health and rights, essential service package.
UNFPA	Gender, Population development, reproductive health.
UNICEF	Child health, EPI, Diarrhoeal diseases, Integrated Management of Childhood Illness (IMCI), acute respiratory infection control, emergency obstetric care, women's health, women-friendly hospitals, nutrition, mineral and nutritional deficiencies, vitamin- A, arsenic and HIV.

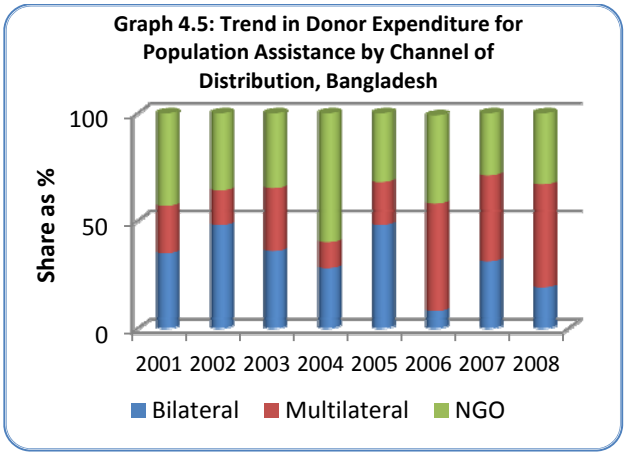
WHO	Technical assistance for all health aspects.
Parallel funds	
ADB	Urban primary Health care Project.
DFID	Urban Primary Health care Project, Maternal health.
EC	Urban Primary Health care Project
SIDA	Co-financing of the Urban Primary Health care Project.
USAID	Social marketing, contraceptive supply, family planning, operations research in HNP, child and maternal health, urban health

Source: WHO Country cooperation strategy, 2008-2013 : Bangladesh.

The donor expenditure on RH/Population assistance in Bangladesh had a fluctuating trend in the past, but is showing increasing trend for last 3-4 years. In all, the donor spending has increased from USD$ 71.91 million to USD$ 116.61 million between 2001 and 2009.



Source: Resource Flows Project.



Source: Resource Flows Project

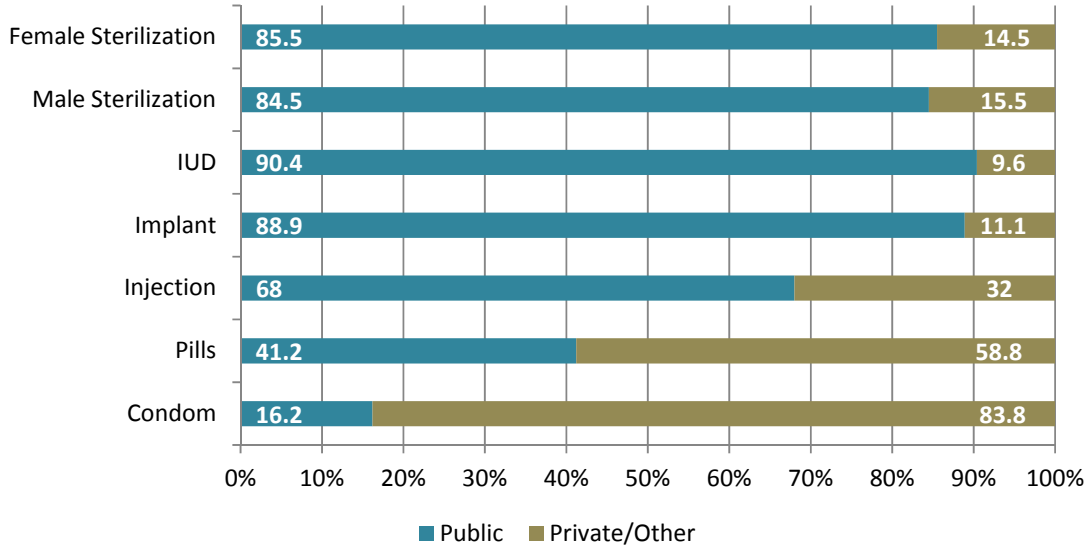
Of the total donor expenditure, 48 percent is distributed through multilateral channels, 19 percent through bilateral channels, and 33 percent through NGOs in 2008. It may be noted that the role of multilateral channels has increased since 2006.

Spending on RH Supplies

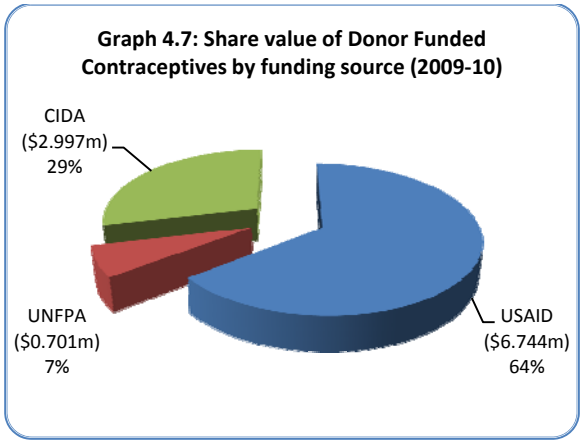
For contraceptive supplies, the non-public sector continues to be an important source of supplies for around half of the Bangladeshi women in the reproductive age. The private sector share, excluding NGOs, as a source of supply has increased rapidly, from 36 percent in 2004 to 44 percent in 2007, and is focused on short-term methods, primarily condoms and pills. For oral

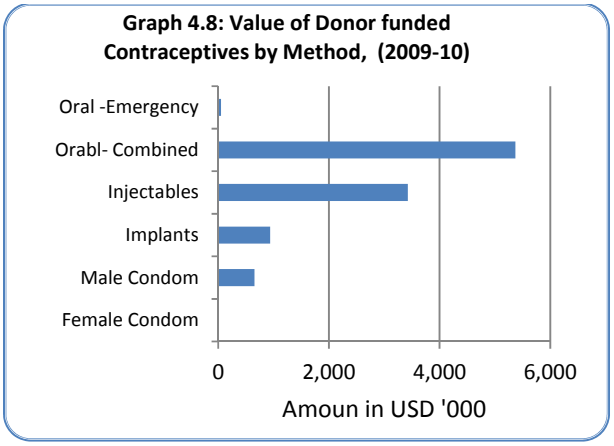
contraceptives, the non-public sector accounts for nearly 60 percent of source of supply, 45 percent of which is made up of socially marketed brands. Public sector contraceptives are distributed for free, and the government applies pricing regulations to private sector supplies, with the exception of condoms. Non-government organizations in Bangladesh receive contraceptive supplies from the government at no charge.

Graph 4.6: Source of Contraception (%)



Resources for reproductive supplies are channeled through a single budget line item in the HNPSP, managed by the World Bank. This combines government and donor funds. Two bilateral donors, the Canadian International Development Agency (CIDA) and the U.S. Agency for International Development (USAID), have been major donors of contraceptive supplies (2009). The government of Bangladesh had committed to allocating approximately US$ 0.7 million in internally-generated funds to purchase domestically manufactured condoms. The total amount spent on contraceptive supplies in 2009-10 was around US$ 21 million. The share value of donor funded contraceptives was US$ 10.4 million.





Source: Reproductive Health Supplies Coalition

4.3 Financing Management at different levels

The MOHFW operates as a financial intermediary of the Government of Bangladesh (GOB) obtaining funds from the Ministry of Finance (MOF) and allocating and disbursing them to its reproductive healthcare providing units. The pool funding mechanism is designed to align support from development partners according to the needs of the country, as well as for coordinating the funding for health development. Pooled financing includes that from partners including World Bank, the Department for International Development (DFID), the Netherlands, and the European Union (EU). Contributions to the pool fund of the HNPSP have been pledged by a consortium of donors led by the World Bank/IDA. A substantial amount of DP funding is channelled, released and expended using GOB systems. All RPA contributions from the DP are held in a Trust Fund managed by WB. Expenditure financed from pool funds is first made from the GOB Taka Treasury using the same procedures applicable to expenditure of GOB own funds. The performance based funding applies to 25% of the pooled fund, to be released on completion of specified actions.

Partnership and development aid coordination

Strong partnership exists among the development community in Bangladesh, which is fully committed to support the ministry in its health development programmes that are focussed on achieving goals including the health-related MDGs. The key elements of the coordination mechanism are as follows:

- **Local Consultative Group:** is the apex body of DPs tasked with donor government coordination. It has a sub-group to coordinate activities in each area.

- **Health, Nutrition and Population (HNP) Consortium:** is a sub-group of the Local Consultative Group which deals with matters relating to the HNP sector. It is the group of DPs that provides funds to the HNPSP, and maintains a continuous dialogue with the MoHFW on HNP issues.

- **HNP Forum:** is a government-led mechanism which facilitates the exchange of information and policy dialogue between the DPs and the government on all matters related to the HNP sector.

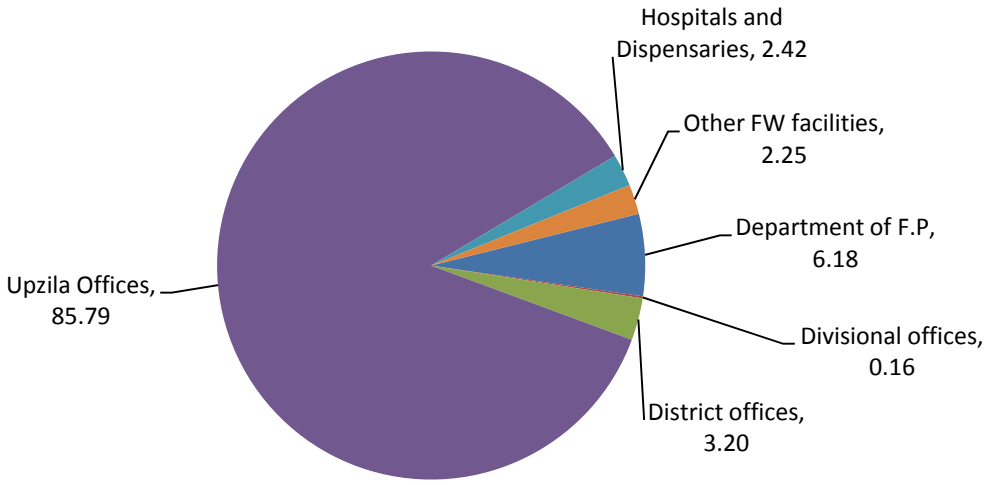
- **United Nations Development Assistance Framework (UNDAF):** is an umbrella programming mechanism of the UN Country Team in Bangladesh, which works in close cooperation with and has aligned its priorities to that of the government. It is also engaged in monitoring progress made by Bangladesh towards achieving MDG targets by 2015.

- **There are other mechanisms also to coordinate resources from different agencies.** The Country Coordination Mechanism is actively involved in policy-making and monitoring of the GFATM activities, and an Inter-agency Coordination Committee is functioning for GAVI-funded activities. The implementation and policy directions for the Health Metrics Network programme in the country are steered by two groups, namely "the Steering Group" and "the Stakeholders' Group" respectively.

Since GOB and pool funds are channeled through the Government treasury system, accounting follows the system of Comptroller General of Accounts (CGA). Under the system, the FMAU of MOHFW continue receiving and recording financial information both for GOB and pooled donors funds following CGA system and is responsible for maintaining the accounts.

According to GOB system of release of funds, Line Directors (LD) disburse funds to various cost centers, i.e. Drawing & Disbursement Officer at Regional levels , District and Upazila quarterly on the basis of approved Administrative Order (AO) for each Operational Plan. The Chief Accounts Officer (CAO) of MOHFW transmits copies of the AO to the Divisional Comptroller of Accounts (DCA), District Accounts Officer (DAO) and Upazila Accounts Officer for ensuring that expenditures are consistent with approved spending. As indicated in the graph, a large proportion (86%) of the budget is managed at the Upzila Offices.

Graph 4.9: Allocation of DGFW Budget for RH and FP at Different Function Levels, 2010-11, Bangladesh (%)



Source: Department of Planning, Government of Bangladesh, 2011

4.4 Providers of RH Services

Facility-based services in the public sector are provided at three levels: (1) primary health care facilities at the upazila and lower level; (2) secondary level facilities including district hospitals and other health facilities located in the district/division headquarters; and (3) tertiary level facilities including specialized and teaching health institutions, most of which are in the capital and other large cities. Primary level public facilities include Upazila Health Complexes (UHC), Union Health and Family Welfare Centers (UHFWC), and community clinics (CC). Secondary level public facilities include district hospitals (DH), and Maternal and Child Welfare Centers (MCWC).

Government of Bangladesh has been emphasizing on strengthening EmOC services. Different types of institutions, both government and non-government, have varying role in providing EmOC services to the people. Upzila Health Complex and private clinics/hospitals have a major role in providing ANC service, delivery and PHC services. However more than half of the C-sections are conducted at Private clinics/hospitals. Medical collages and district hospitals have greater role in management of complications.

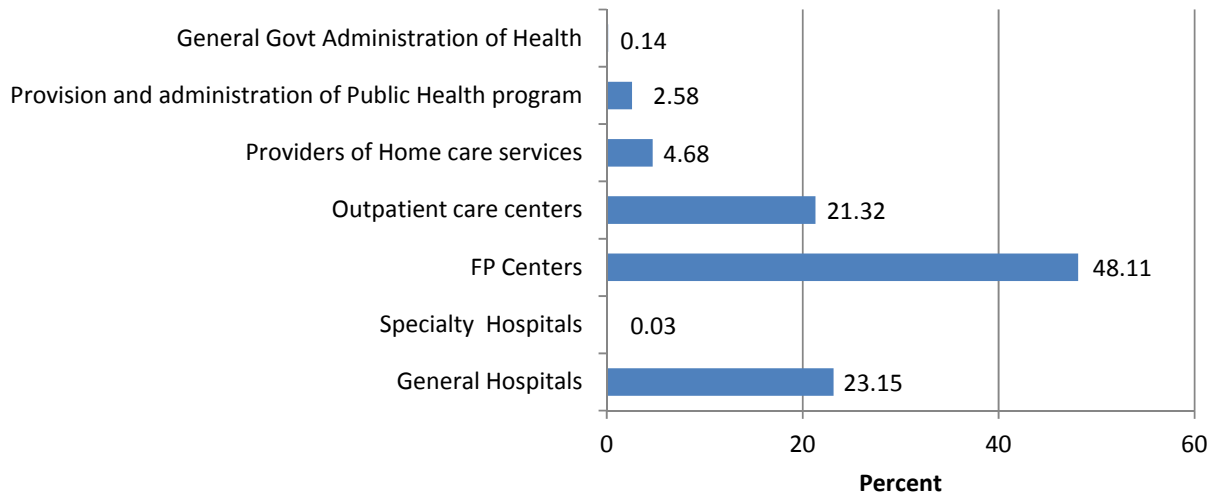
Table 4.5: Role of Different Health Facilities in Providing EmOC Services in Bangladesh (2010)

Type Health Facility	Visit for ANC Services	Total Delivery	Management of Complications	Cesarean Section	PNC Services
Medical College Hospital	7.98	14.43	21.28	17.66	10.41
District Hospital	9.63	14.06	23.30	12.40	13.33
Upzila Health Complex	32.48	25.97	23.18	8.67	33.02
Maternal &Child welfare Centre	16.94	7.88	2.75	4.31	10.63
NGO	12.65	6.41	1.97	5.31	6.58
Private Clinics/Hopitals	20.03	30.77	27.20	51.56	25.62
Others	0.29	0.48	0.32	0.09	0.41
Total	100.00	100.0	100.00	100.0	100.0

Source: UNICEF 2011.

As far as public expenditure on RH and FP is concerned, nearly 48 percent of the expenditure is incurred through Family Planning Centres, which are key providers for reproductive health services in Bangladesh. General hospitals and outpatient care centres was providers for 23 percent and 21 percent expenditure respectively.

Graph 4.10: Expenditure on RH and FP by Facility Provider in 2007, Bangladesh



Source: Based on NHA, Bangladesh, 2007.

Table 4.6: Health Expenditure on Functions by Providers, 2007

Types of services	General Hospitals	Specialty hospitals	Family Planning Centers	Outpatient care centers	Medical and diagnostic Laboratories	Providers of home health care services	Provision and administration of public health programs	General Government administration of health
Services of Curative Care	74.1	61.8	0.0	24.5	0.0	42.0	0.0	92.7
Services of rehabilitative care	0.0	7.7	0.0	0.0	0.0	0.2	0.0	0.0
Ancillary services to health care	3.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0
Medical goods dispensed to outpatients	3.0	4.5	34.7	0.0	0.0	0.2	1.5	0.0
Prevention and public health services	9.0	0.3	63.2	75.4	0.0	57.5	73.8	7.3
Health administration and health insurance	0.4	0.0	1.5	0.0	0.0	0.0	19.5	0.0
Capital formation of healthcare provider institutions	10.3	25.8	0.6	0.0	0.0	0.1	5.2	0.0
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

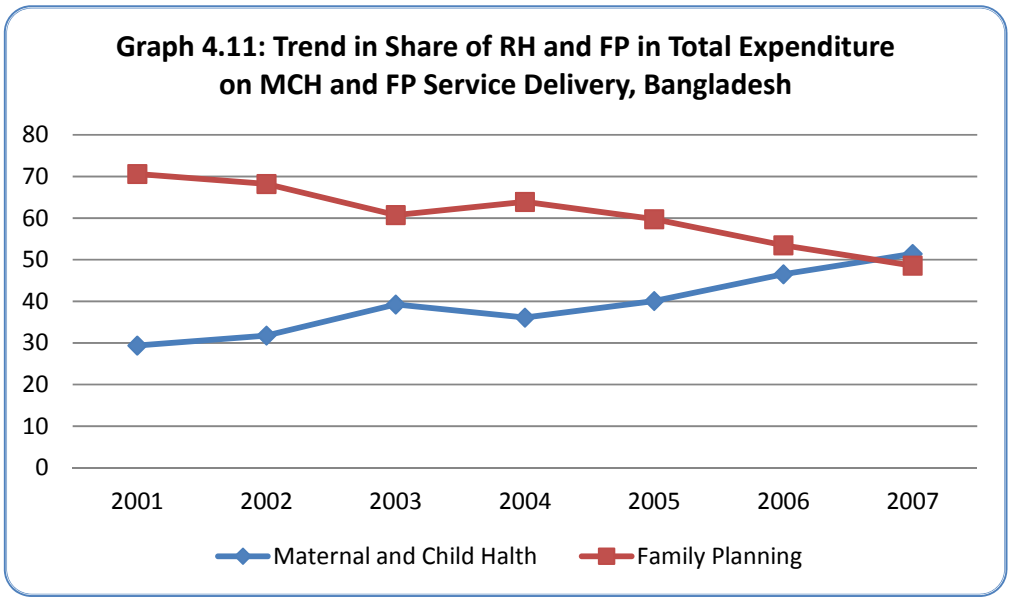
Source: Based on NHA-III.

The analysis of total health expenditure on different functions by the providers indicates that general hospitals and specialty hospitals are mainly providing curative services while the preventing services are provided mainly through the Family Planning Centres, Out-patient care centres and through the public health programmes. Such analysis could not be done specifically for reproductive health components due to non availability of data. This may be possible if the expenditures on reproductive health are coded separately for accounting.

4.5 RH Services/Activities

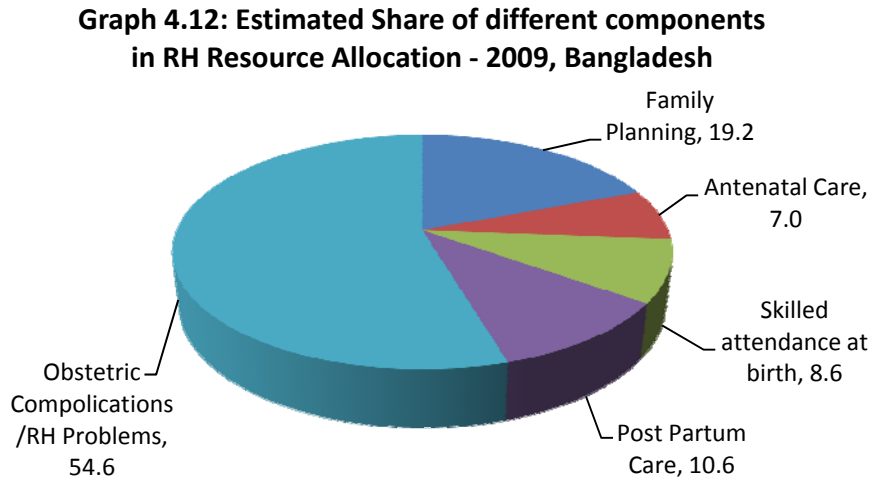
The services include maternal health, child health, family planning and other sexual and reproductive health problems. Data on maternal and child health and family planning could be segregated, but data on other sexual and reproductive health services could not be separated for further analysis. As indicated in the graph, the proportional share of RH shows an increase, while share of spending on family planning has been declining over the years. The proportion of FP in

the overall expenditure on RH and FP was around 70 percent in 2001, which came down to 49 percent by 2007.



Source: Based on NHA, Bangladesh, 2007

The MDG need assessment and costing study (2009) estimated promotional allocation of resources on different components of RH and FP services. It estimated that in 2009, more than half of the resources are allocated for obstetric complications and reproductive health problems.

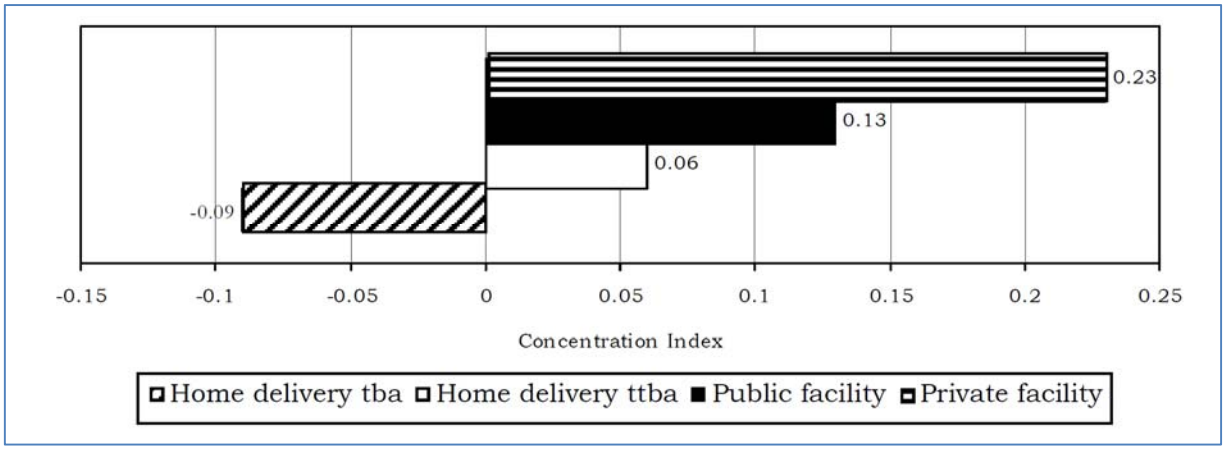


Source: Report on 'Millennium Development Goals Need Assessment and Costing 2009-2015, Bangladesh; Government of Bangladesh, July 2009.

4.6 Beneficiaries

As mentioned earlier, the OOP expenditure on reproductive health has been quite substantial in Bangladesh (nearly 65 percent). The role of poverty in access to public and private health facilities is quite evident. The study of Khan and others (2009) as a measure of inequality in utilization of facility-based care or skilled care among different income quintiles, estimated the concentration index (CI) for utilization of major types of facility/place of delivery and types of attendants.

Graph 4.13: Inequities in Use of Place of Delivery



Source: Khan et.al, Household Costs of Obtaining Maternal and Newborn Care in Rural Bangladesh: Baseline Survey; 2009.

The study suggests that there is a disproportionate concentration of mothers obtaining delivery care at home or using unskilled providers suggesting utilization of home delivery services and unskilled providers at home are pro-poor. Utilization of public facility is pro-rich and are more pro-rich than the use of trained TBA at home. Utilization of private facilities is pro-rich. Out-of pocket spending was found to be major source for paying (more than 65%) for delivery care for most of the households.

As also indicated by the BDHS (2007), pregnant women in the top quintile are almost four times more likely to have received antenatal care from a medically trained person than those in the bottom quintile. One in every five women in the richest quintile delivered at a facility (whether public or private) as opposed to one in every 100 women in the poorest. Alarmingly, the gap in these measures between the rich and the poor increased over the years.

For better analysis of expenditure by beneficiaries requires such indicators to be included in the existing household expenditure surveys. Currently, the Household Expenditure Survey of Bangladesh includes spending on health. However, it needs to accommodate more details to facilitate analysis specifically on RH and FP services.

Chapter 5: Innovative Approaches in RH Financing

5.1 Demand Side Financing

As part of its Health, Nutrition and Population Sector Programme (HNPSP), Bangladesh's Ministry of Health and Family Welfare (MOHFW) is implementing a pilot demand-side financing (DSF) maternal health voucher program in 33 upazilas (sub-districts) around the country. The main objective of the DSF program is to accelerate progress toward Millennium Development Goal 5 (MDG 5) to improve maternal health, by stimulating increased utilization of safe maternal health services by poor pregnant women, including antenatal care (ANC), delivery by qualified providers, emergency obstetric and postnatal care (PNC).

Poor pregnant women receive vouchers which entitle them to free maternal health services, transport subsidies, cash incentive for delivery with a qualified provider (either at home or at a designated facility), and a gift box. Providers receive incentives to distribute vouchers and to provide services covered by the vouchers.

The DSF voucher program is implemented by Bangladesh's Ministry of Health and Family Welfare (MOHFW) using pooled funds co-financed by the World Bank, United Kingdom (UK), European Community, Germany, Sweden, Canada, Netherlands, and United Nations Population Fund (UNFPA). The World Health Organization (WHO), with co-funding from the UK's Department for International Development (DFID), provides technical assistance to the DSF program, including administrative and monitoring support through the posting of DSF organizers to each DSF upazila. These organizers are overseen by a National DSF Coordinator, based in the national DSF cell in Dhaka.

Funds for the DSF program are transferred from the Central level to Sonali Bank accounts in each DSF upazila to cover incentive payments to providers and voucher beneficiaries, as well as the cost of procuring gift boxes for beneficiaries. Each DSF pilot upazila was given a one-time lump sum budget of USD$ 1,000, which was deposited into the "seed fund" account. This was to be used to improve the quality of care at UHCs, through infrastructure improvements or the purchase of medicines and equipment.

Women receive a booklet with separate "coupons" in triplicate for each covered service under the program. When a service is sought, providers keep two copies of the relevant voucher slip, one to submit for reimbursement and one to keep for documentation, and the third copy is returned to the woman. The Bangladesh DSF voucher program provides the following benefits to eligible women:

- 3 antenatal care (ANC) check-ups
- Safe delivery care in a health facility or at home with a qualified provider (such as CSBA)
- Emergency care for obstetric complications, including Cesarean sections
- 1 postnatal care (PNC) check-up within 6 weeks of delivery
- Tk. 500 for routine transport costs (up to Tk. 100 per health facility visit for 3 ANC, 1 delivery, and 1 PNC visit)
- Tk. 500 for emergency transport to referral facility if needed
- Tk. 2,000 cash incentive to mothers who deliver in health facilities or at home with a qualified provider, to be used for the purchase of nutritious food and medicines for the mother and infant
- A gift box worth up to Tk. 500, including a bottle of Horlicks malted drink powder, a towel, a bar of soap, and two outfits for the newborn.

After distributing the voucher booklet, the distributor is to inform women about the participating facilities and providers from which they can obtain covered services. In case of referral for complications, pregnant women can access services at specific hospitals with a referral certificate. They are also entitled to Tk. 500 to cover the cost of ambulance transport, fuel, or other vehicle rental for referrals.

Findings of an evaluation study for demand side financing reveal that the utilization rates of maternal health services were found to be higher for all socioeconomic groups in the project area than in the comparison areas. Voucher recipients in the project area were 3.6 times more likely to be assisted by skilled health personnel during delivery, 2.5 times more likely to deliver the baby in a health facility, 2.8 times more likely to receive post natal care (PNC), 2.0 times more likely to get antenatal care (ANC) services and 1.5 times more likely to seek treatment for obstetric complications than pregnant women not in the program. (Ahmed and Khan 2011)

5.2 Community Ownership of Government Settings

(The Chougacha & Narsingdi Models)

The Ministry of Health and Family Welfare of Bangladesh is emphasizing on community ownership for accelerating the achievement of health related MDGs and other health development goals. Two models are very frequently spoken of. These are Chougacha Model and Narsingdi Model.

Chougacha is a upazila (sub-district) under Jassore district of Bangladesh. The Government owned upazila hospital of this area has been successful in mobilizing active community participation in operating the hospital and community health programs. Local elites and people

participate in funding additional human resources, equipment, reagent, tracing vulnerable clients and health campaigns. Begun in 1996 by the local hospital manager, achievement with the national reference data the initiative has shown remarkable successes with respect to National & International health goals. Later Ministry's HNP Sector Program, UNICEF and JICA took part in further improvement of the services. The Chougacha model made improvement in almost all the health indicators in the area.

The Narsingdi Model is in fact a Safe Motherhood Promotion Project (SMPP), began as a pilot by Ministry of Health and Family Welfare in July 2006 aiming with support from JICA to improve health status of women and neonates in the target district of Narsingdi through strengthening safe delivery services and supporting women and neonates to utilize obstetric and neonatal care. It has developed a community support system for pregnant women and newborn during obstetric emergencies organized by the community people. Regular meetings, engagement of private community birth attendants, pregnancy registration and mapping, transportation for emergency referral, funding support for poor pregnant women are amongst others, the key elements of the activities. Local union Parishads are active partners of the project. This is a successful model of Maternal and Neonatal Health built in the cultural and economic context of Bangladesh for achieving MDG 4 and 5.

Table 5.1: Performance of the Chougacha Model

Indicator	National	MDG target 2015	Chougacha
Hospital delivery	18%	100%	72%
MMR per 100,000 live births	290	120	42
NMR per 1000 live births	30.9	-	19.3
IMR per 1000 live births	41.3	31.3	23.9
Under-5 MR	53.8	48.0	25.8
Total fertility rate	2.3	-	2.1
Contraceptive prevalence rate	55.8%	-	67%
TB case detection rate	74.0%	>70%	83%

5.3 Emergency Obstetric Care (EOC) Program

To improve the maternal health situation targeting to achieve the Millennium Development Goal 5, the government of Bangladesh in collaboration with UNICEF is conducting facility based Emergency Obstetric Care (EOC) program in all the districts of Bangladesh. All the government medical college hospitals, district hospitals, Upazila hospitals, and maternal and child welfare centers take part in providing EOC. A number of private clinics or hospitals and NGO providers also participate in the program. The service is provided in two forms, viz. Comprehensive

Emergency Obstetric Care (CEmOC) and Basic Emergency Obstetric Care (BEOC). Currently all medical college hospitals, 2 district hospitals and 269 Upazila health complexes provide BEOC. NGO and private providers from a number of districts also provide similar services. Under a program jointly operated by Management Information Systems (MIS) of DGHS and UNICEF, data are collected from the EOC facilities. These data are then translated into a format called United Nations Process Indicators.

There were 448,564 reported delivers in the country's EOC facilities in 2009 and there were 434,502 live births. The number of newborn deaths in these EOC facilities was 2,385 and that of maternal deaths was 1,307.

5.4 Maternal and Neonatal Health (MNH) Program

With the assistance of UNFPA, UNICEF and WHO and funded by EC and DFID; the Director of Primary Health Care of the Directorate General of Health Services started to implement a Maternal and Newborn Health Program in four districts of Bangladesh. The districts are Thakurgaon, Jamalpur, Narail, and Moulavi bazaar. All the Upazilas under these four districts are included in the program. The program focuses on saving maternal and newborn lives through creating need based demand and priority-based actions. The broad principle of the program is Local Level Planning (LLP) and decentralization. The offices of the Civil Surgeon and the Deputy Director of Family Planning serve as the two focal locations for the project. The three UN agencies help ensuring inclusion of the three "added values" viz. participation of civil society organization, direct disbursement of funds to agreed cost centers, and reaching the difficult-to-reach populations. National level authorities deal with major procurement, training, partnership arrangements with NGOs and national communication campaigns.

The project plans to allocate a fixed ceiling of fund to each district based on needs, defined by its poverty level, population and number of Upazilas. The fund is in addition to ministry's routine allocation. It is proposed that over the lifetime of the project at least 30% of resources at the district level must be devoted to demand side interventions and involving both state and non-state agencies. There is a coordination mechanism to ensure that local level planning fits to the national MNH policies, strategies and guidelines.

The project is designed for implementation for five years in two phases. The first phase is a start-up phase covering a period of 18 months and includes four districts. After 18 months of operation, a review will be conducted. If found satisfactory, agreement will be reached for expansion and covering an additional 16 districts (implementation for 42 months). If after review found unsatisfactory , then this project will remain only in 4 districts and end after a further 18 months. The project has a number of "novel and innovative" approaches, to accelerate progress towards achievement of MDGs 4 and 5.

The Programme has following elements:

- A district-focused approach with direct resource allocation to identified cost centers and the application of WHO problem-solving techniques to develop, monitor and implement the plans.
- Continuum of care that links mother and newborn, also addresses three delays model.
- Rights-based equitable approach in planning, monitoring, implementation and supervision through involvement of consumer groups and public health watch groups to ensure accountability to women, families and communities.
- Piloting initiatives such as contracting of private practitioners to provide specialized services, in an attempt to improve human resources for MNH at the district and Upazila level.
- Pilot testing of demand-side financing schemes (vouchers and other means) targeting the vulnerable and marginalized households to address equity.
- Pilot testing of ARH community-based and clinic-based "youth-friendly" services also Voluntary Confidential Counseling and Testing (VCCT) centers in selected districts with high risks of HIV and STIs.

5.5 Smiling Sun Franchise Program (SSFP)

The Smiling Sun Franchise Program is a project funded by the United States Agency for International Development (USAID). Value for services for SSPF is $46.5 million. It is intended to complement the wide network of health and family planning facilities of the Government of Bangladesh resorting to an innovative approach to health care franchising. To achieve relevant health outcomes, SSFP jointly works with partnering NGOs to convert the existing network into a viable social health franchise.

The project uses a build-operate-transfer (BOT) methodology to set a plan for developing the Franchise Manger Organization into an operational entity so that it can fully assume franchise operations by the end of the project. Presently project is in transfer phase.

Currently 28 NGOs are providing health care services to women, children and youth through its clinics in 64 districts of Bangladesh. SSFP is comprised of four levels of clinics. The four levels of clinics include:

- 9,133 "Satellite" clinics: Nonstatic or mobile outreach clinics offering limited ESD
- 276 "Vital" clinics: Offer basic outpatient ESD and limited laboratory service
- 46 "Ultra" clinics: Provides basic outpatient ESD, emergency EmOC, and comprehensive Laboratory services

- 1 “Maxi” clinic: Clinic with the facilities to offer outpatient ESD, EmOC, enhanced diagnostics and limited inpatient care (open March 2011)

These clinics offer a governmentally approved package known as essential service delivery (ESD). Package includes family planning, maternal, newborn, child health services, curative care, emergency management of obstetric care (EmOC) and diagnostic services both in urban and rural areas of Bangladesh. SSFP has a rigorous quality management system that ensures routine tracking through specific indicators

34 clinics of this network are providing Emergency Obstetric Care (EmOC) services. This network will continue to expand the volume and types of quality health care under ESD provided to the able-to-pay customers as well as underserved and poor clients. During the first and second year of the project, SSFP worked with local implementing partners and increased their ability to cover operation expenses from 25 percent to 31 percent, and currently sustainability is approximately 41 percent. By the fourth year of the project, SSFP aims to generate sufficient income to support approximately 70 percent of the operational cost while maintaining access to those who cannot afford to pay for services. In order to attain cost recovery through its operations SSFP has taken many steps to increase revenues. For example, clinics are directed to increase client volume as well as to increase the number of paying clients. Revenue-generating services, such as emergency obstetric care (EmOC) have also been added, and SSFP has founded several strategic revenue-generating partnerships with local commercial businesses in Bangladesh. Provision of non-service delivery components such as diagnostics have more than doubled.

Through February 2011, the project had increased cost recovery from 20 percent to more than 40 percent. The project and partner NGOs continue to work on improving quality of care, especially in antenatal care and deliveries. Results include:

- 58,910 deliveries assisted by a skilled birth attendant
- 98,918 children receiving newborn care
- 976,378 children receiving DPT3 immunization (three doses of vaccine against diphtheria, pertussis, and tetanus)
- 6,819,386 children receiving Vitamin A supplementation
- 56 franchise clinics with newly established centers for the delivery of Directly Observed Treatment, Short-Course (DOTS) for tuberculosis
- 23,913 cases of tuberculosis treated

Chapter 6: Conclusions and Recommendations

In Bangladesh, poor access to services, both primary and tertiary care, low quality services, high rate of maternal mortality and child malnutrition are the key challenges in achieving MDGs. Child malnutrition and maternal mortality rate still remain among the highest in the world. About 15,000 mothers die annually at the time of delivery, with 3 maternal mortality per 1,000 live births, and 7,000 infants die every day (Nath 2008). High maternal mortality rates are underpinned by the fact that about 85 per cent deliveries take place at home and most of which are attended to by untrained providers. Although the government has established physical facilities at upazila and lower levels and arranged BCC and training of doctors, nurses and field staff to provide emergency obstetric care (EMOC) at these facilities, the utilization of these services are still low.

In Bangladesh, two thirds of overall financing for reproductive health consists of household out-of-pocket payments. At the national level, a key policy goal should be to reduce the burden of total financing borne directly by households. This implies a strong commitment to increase and strengthen public sector financing and delivery of reproductive health services.

Keeping in view the large share of out of pocket expenditure and funding from other than domestic sources, it appears that the health system would still require to mobilize funding from donors for many of the components, including drugs and contraceptives.

The relative share of family planning in the overall RH spending seems to be declining over the years. Looking at the existing level of unmet needs, an appropriate allocation of funds for family planning should be made.

A large share of spending on reproductive health goes to obstetric complications and reproductive health problems, while spending on family planning and other aspects of maternal care is comparatively low.

NGO and private sector has been playing a critical role in delivery of reproductive health services. Since the public health system alone cannot fulfill the needs of reproductive health services, involvement of private sector needs to be increased with greater accountability. Hence, from the funding perspective, performance based payment mechanism for private sector services, would be essential for the development of a public-private partnership for maternal health services provision. The government would be better positioned to control the cost of services while improving/maintaining the quality of services, if the finding is based on performance indicators.

The financing for reproductive health needs to be substantially increased in order to achieve the MDGs set for the country. According to the need assessment and costing done by the Government of Bangladesh, 17992 million BDT (USD$ 234 million) will be required in 2012, which will increase to 24584 million BDT (USD$ 319 million) by 2015.

Methodological Issues and Recommendations

The national health accounts framework provides the basis for the production at relatively low cost of internationally consistent estimates of expenditures on health services. An effort has been made in this report to use the information from the perspective of reproductive health financing. The key methodological issues immerged during the analysis are as follows:

(i) Bangladesh had pre-existing health accounts estimates compatible with the OECD health accounts framework. It was not necessary to estimate all expenditures anew in this study, and instead the focus was on apportioning the known expenditures to reproductive health and family planning components.

(ii) Bangladesh had some health accounts technical capacity. In particular, the skills required to find and develop methods to apportion items of expenditure by specific purpose were critical and central to the analysis. Although the expenditure could not be appropriated according to functional categories specific to reproductive health due to coding problem, separate mention of expenditures maternal and child health and family planning service provision facilitated the analysis for this study.

(iii) Bangladesh had some recent studies on out of pocket expenditure and also had information of demographic surveys regarding utilization of services. These studies provided important inputs for this study.

(iv) In the function classification, National Health Accounts of Bangladesh had further sub-classification of expenditure on collective care - BC6.1 (HC6.1 of ICHA) – for maternal and child health, and for family planning. It enabled separate comparative analysis of these two components, though some components like reproductive health problems/RTIs etc. might not have been covered completely.

(v) The budget allocation and expenditure information is mostly merged for maternal and child health components. It is difficult to analyze them separately. Hence the estimates include child health component in the RH estimates.

The study recommends that generation of reproductive health accounts should be taken as a regular activity of the agencies that are responsible for national health accounts. Coding of each expenditure on reproductive health according to functional categories is important for proper analysis of reproductive health financing. Following the WHO classification scheme, separate

coding of reproductive health would facilitate creation of reproductive health accounts for the country.

Existing household surveys of expenditure and utilization suffer limitations with respect to the detail of their coverage of reproductive health. Several studies have covered cost of maternal health services, but could not cover the other reproductive health issues. Hence, while commissioning such surveys, care should be taken to cover the complete range of components related to reproductive health and family planning. Moreover, currently, the Household Expenditure Survey of Bangladesh includes spending on health. However, it needs to accommodate more details to facilitate analysis specifically on RH and FP services.

Tracking expenditure by sources of funding is difficult for government as well as nongovernment entities. The GOB does not track the sources of funding from external partners once it enters the existing Controller General of Accounts (CGA) financing tracking system. NGOs in many instances cannot identify the sources of funding, as they receive money from financing intermediaries. Accordingly the expenditure analysis drawn from BNHA is limited by the financing agent only, and not by funding sources for these two entities. This aspect needs attention for proper analysis of RH financing in Bangladesh. In sum, this study demonstrates that under certain conditions, it is feasible at very low cost to generate informative estimates of RH and FP expenditure in countries facing resource constraints. This however does require some preconditions, such as existing health accounts capacity and available health accounts estimates. Such exercise can be replicated in other Asian countries also, like SriLanka, Nepal, Vietnam, etc.

References

Khurshid, Alamo and Ahmed Shakil 2010. Cost recovery of NGO primary health care facilities: A case study in Bangladesh; Cost Effectiveness and Resource Allocation, 8:12.

Amin, Zulfiquer Ahmed 2011. Health care financing in Bangladesh perspective; The Daily Star, Tuesday, September 13, 2011.

Bangladesh National Health Accounts, Round III, Government of Bangladesh., 2007.

BBS: Bangladesh Bureau of Statistics, Report on Welfare Monitoring Survey 2009. Available from: <www.bbs.gov.bd/ project/welfaresurvey_09.pdf>.

Chankova, Slavea, Sushil R. Howlader, Syed A. Hamid. Subrata Routh, Tasnuva Sultana, Hong Wang. February 2010. Costing of Maternal Health Services in Bangladesh. Bethesda, MD: Review, Analysis and Assessment of Issues Related to Health Care Financing and Health Economics in Bangladesh, Abt Associates Inc.

Chowdhury, Omar Haider & S. R. Osmani 2010. Towards Achieving the Right to Health: The Case of Bangladesh; The Bangladesh Development Studies Vol. XXXIII, March-June,1 & 2.

Dawson, Angela, Tara Howes, Natalie Gray et al 2011. Human resources for health in maternal, neonatal and reproductive health at community level: A profile of Bangladesh, Human Resources for Health Knowledge Hub UNSW and Burnet Institute, Sydney.

EC: European Commission, Country Strategy Paper: Bangladesh 2002–2006. Available from: <eeas.europa.eu/bangladesh/ csp/02_06_en.pdf>.

Emergency Obstetric Care (EmOC) Performance Report 2010 Issue 08 March 2011.

Emergency Obstetric Care (EmOC) Performance Report 2010 Issue 09 June 2011.

Government of Bangladesh, Millennium Development Goals Needs Assessment and Costing 2009–2015: Bangladesh.

Hatt, Laurel, Ha Nguyen, Nancy Sloan, Sara Miner, Obiko Magvanjav, Asha Sharma, Jamil Chowdhury, Rezwana Chowdhury, Dipika Paul, Mursaleena Islam, and Hong Wang 2010. Economic Evaluation of Demand-Side Financing (DSF) for Maternal Health in Bangladesh. Bethesda, MD: Review, Analysis and Assessment of Issues Related to Health Care Financing and Health Economics in Bangladesh, Abt Associates Inc. February.

Mid Term Review (MTR). 2008. Bangladesh Health, Nutrition and Population Sector Programme (HNPSP), Vol. 1, Main Consolidated Report 31 March 2008. Dhaka: Ministry of Health and Family Welfare, Government of Bangladesh.

Ministry of Health and Family Welfare (MoHFW). 2005. Health, Nutrition and Population Sector Programme: Revised Programme Implementation Plan (HNPSP-RPIP): July 2003–June 2010. Dhaka: Ministry of Health and Family Welfare, Government of Bangladesh.

Osman, Ferdous Arfina 2005. 'Implementation Constrained by a Lack of Policy Ownership: Evidence from Bangladesh', The Asia Pacific Journal of Public Administration 27 (1), June: 19–36, available at http://sunzi1.lib.hku. hk/hkjo/view/51/5000803.pdf.

Osman, Ferdous Arfina, 2008. Health Policy, Programmes And System In Bangladesh: Achievements And Challenges; South Asian Survey 15 : 2 (2008): 263–288.

Osmani, S. R. 2010. Realising the Right to Development in Bangladesh: Progress and Challenges; The Bangladesh Development Studies Vol. XXXIII, March-June 2010, Nos. 1 & 2.

Rahman, Redwanur M. 2006. 'Human Rights, Health and the State in Bangladesh', BMC International Health and Human Rights 6 (4), April, accessed from http://www.biomedcentral.com/content/pdf/1472- 698X-6-4.pdf (on 17 November 2007).

Tulane University SPHTM and ACPR. 2009. Bangladesh Health Facility Survey, Draft Final Report, June 2009.

UNICEF 2011a. Voice of MIS-Health; Newsletter, MIS-Health, DGHS, Dhaka, Bangladesh

UNICEF 2011b. Voice of MIS-Health; Newsletter, MIS-Health, DGHS, Dhaka, Bangladesh

WHO 2006. The World Health Report 2006: Working together for health. Geneva: World Health Organisation, accessed from http://www.who.int/whr/2006/whr06_en.pdf (on 15 January 2008).

World Bank: Bangladesh Public Expenditure Review: Volume II, Poverty Reduction and Economic Development Sector Unit, South Asia Region; World Bank, Report No. 47767 BD. June 2010.