Centre of Excellence for
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Current scenario of the marginalized population in Bangladesh: identifying data gaps for action towards "Achieving Universal Health Coverage by 2030"

Country Report: 'Achieving UHC: Who are left behind in Bangladesh'

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Institutional Partners

Current scenario of the marginalized population in Bangladesh: identifying data gaps for action towards "Achieving Universal Health Coverage by 2030"

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This report present findings from a rapid review of the conditions of the 'marginalized populations' in Bangladesh, existing data gaps for informed interventions, and a way forward to address the scenario towards achieving Universal Health Coverage by 2030. It is part of a larger study "Leave no one behind' sponsored and coordinated by the ICSO (International Civil Society Organizations) consortium of 12 partners who are working to improve the lot of these marginalized populations, having exceptional outreach and experiences in reaching out to them worldwide. The goal of this collaboration is to identify, support, and empower marginalized and vulnerable groups worldwide in the context of SDG implementation. BRAC is one of the 12 partners. BRAC partnered with the BRAC JPGSPH to conduct this review.

The CoE-HS & UHC acknowledges the BRAC Advocacy program for their valuable support and insight in preparing the report.

Key words: Marginalized populations, Universal Health Coverage gaps in addressing marginalized populations.

CONTENTS

SYNOPSIS OF KEY FINDINGS

To ensure that the true spirit of 'inclusion' underlying the SDGs are translated into effective actions, detailed information on different sections of the population is needed to understand 'who are left behind' in the context of a particular country, including their needs and priorities for healthcare services. This study aimed to fill-in this knowledge gap in Bangladesh, to inform the relevant stakeholders at the policy and practice levels for designing an evidence-based and inclusive heath system towards achieving UHC by 2030. Due to constraints in time and resources, a Rapid Review (RR) method was adopted 'to provide actionable and relevant evidence in a timely and cost-effective manner.'

The key findings from this RR are summarized below for ready reference:

- In the RR (Rapid Review) findings, no formal/standard/legal/universally agreed definition or benchmark has been found for 'marginalization' and 'social exclusion' to describe the 'population left behind'... This is because the concept is 'highly depending on the historical and socio-economical context of a society.' From the review of different definitions, the following **characteristics of 'marginalizaion'** become apparent: (this is) a process, originating from lack of awareness or negative attitudes of the larger society, by which certain population groups are denied access to resources and services essential for living a decent life.

- Similarly, '**social exclusion**' is defined in various contexts...It is a 'process that involves the systematic denial of entitlements to resources and services...on the basis of ethnicity, race, religion, sexual orientation, caste, descent, gender, age, disability, HIV status, migrant status or where they live.'

- Based upon the above characteristics, the above population groups in the Bangladeshi society **experience marginalization and social exclusion** in a variety of ways. Besides gender-based exclusions which is a cross-cutting issue, the RR found other important categories based on ethnicity and religion, extreme poverty, patron-client relationships, physical and mental disability, sexual orientation, and menial occupation.

- The **underlying causes for marginalization and social exclusion** include ethnicity, extreme poverty, caste-based social system and associated stigma, migration (e.g., rural to urban migration, landing in pavements or slums), weak and poorly-resourced and inefficient health systems failing to reach these populations, and lack of understanding and respect for human rights. The most extreme forms of social exclusion occur when unequal power relationship interact with socio-economic, cultural, and political dimensions of the society, operating at the level of individuals, communities, nation states and global regions.

- Like the underlying causes, **the process of margnalisation/social exclusion** is also varied. These may occur through the process of i) structural barriers to education, employment, and access to land and other resources; ii) patriarchal attitude and norms of the society towards women; iii) livelihood and life-styles associated with extreme poverty and destitution; iv) hazardous occupation for survival such as sweeping (also involves scavenging and medical waste handling); v) spatial remoteness e.g., living in hard-to-reach areas; suffering from diseases which have a social stigma e.g., TB, HIV/AIDS, Leprosy; having physical and/or mental disabilities; vi) differing sexual orientation and selling sex as a means of living; vii) migration, sudden influx or more subtle on-going phenomenon e.g., rural to urban.

- RR of the **existing policies** reveals that the various marginalized/excluded groups are touched upon in passing, but failed to go more in-depth into the problem and identify the needs and priorities, for informed design of specific interventions benefitting the marginalized and socially excluded. However women, children, people with disability, and ethnic minority people (tribal people) have specific policies/plans

- The current Social Safety Net programme of the government, consolidating hitherto existing multiple, fragmented, and small-scale safety-net programmes into its social development activities, are mostly provided by different agencies of the government and mainly target three types of people at risk: i) people who are in food insecurity due to seasonality, disaster or crisis ii) people who are living in structural poverty iii) people with special needs like elderly, widows and disabled. Due to nepotism, social and political pressure from the local elites and lack of integrity of those in charge, well-off people often get included in the program in exchange for under-the-table deals. Also, transfers made under the scheme, whether in cash or kind, is limited to meet the requirement of the beneficiaries under available market realities.

- Whilst there is political commitment from the highest level of the government for achieving UHC by 2030, the great proportion of the

above marginalized and socially excluded groups are not accessing the very basic/essential health care services from the formal system for various reasons, giving rise to large '**unmet health needs**'. Though Bangladesh is largely applauded for achieving health related MDGs at aggregate levels, these marginalized and socially excluded groups are miles behind the general population when the outcome are disaggregated with respect to wealth quintiles, gender and other socio-demographic variables. Shortage or absence or lack of qualified health care professional combined with socio-cultural and financial factors compels the population at the fringes to seek care from traditional, unqualified, and spiritual healers as a last resort.

- The **national databases, as well as some surveillance databases**, do not collect and present disaggregated data beyond some common variables, and beyond sub-districts. Thus, there is a large gap in data for taking evidence-based decision and policies and programmes to cover these populations scattered in specified pockets, on the journey towards UHC by 2030!

- A detailed, in-depth, and focused study covering the identified groups of marginalized populations is needed for properly articulating their needs and priorities, for designing and customizing an informed intervention to suit their specific requirements.

Chapter 1

BACKGROUND, OBJECTIVES AND METHODS

1.1 Background of the Bangladesh case study

Bangladesh made remarkable progress in socio-economic development in the recent decades, successfully achieving the MDGs which has been acclaimed globally (GoB, 2015). Presumably, at least 30 million marginalized people are living in Bangladesh with 'diverse categories, cultural identities, races and ethnicities who have historically been prone to exclusion that make them extremely vulnerable' (Manusher Jonno Foundation, 2016). From the limited data currently available, it is clear that the benefits of development are not evenly distributed (UN, 2016b). Reforming and restructuring the health system to address the needs and priorities of the marginalized/ vulnerable population is a key responsibility of any health system, failure of which leads to large coverage gaps with a fall in performance due to persistence disparities (ICS Center, 2015). However, data needed to identify and address the problems of the marginalized/vulnerable groups, based on felt needs, are often unavailable (UN, 2016b).

To address these data gaps and to identify, support, and empower marginalized and vulnerable groups worldwide in the context of SDG implementation, twelve International Civil Society Organizations (ICSOs) came up with an action project "Leave no one behind' in 2017 (ICS Center, 2015). These large organisations share a common knowledge base and have exceptional experiences in reaching out to the marginalized communities worldwide. The evidence generated through this project will be used for giving them 'a voice that will be heard' by the policy makers and programme implementers, facilitating alignment of the existing services with identified needs of these populations. The four countries under this pilot project include Bangladesh, Nepal, Vietnam and Kenya.

To ensure an inclusive health system in the spirit of the SDGs, detailed information on the marginalized populations is required to understand and properly contextualize their health care needs and priorities. However, disaggregated data needed for this are largely lacking in countries like Bangladesh. This study aimed to fill-in this knowledge gap for Bangladesh to inform relevant stakeholders at the policy and practice levels for designing an evidence-based, inclusive heath system for achieving the UHC targets by 2030.

Research questions
Who and how the different population groups in Bangladesh are marginalized/socially excluded, what are the data/knowledge gaps regarding 'availability, accessibility, affordability, acceptability and effective coverage' of health care services for the different marginalized /socially excluded' groups, and how to ensure their inclusion in the mainstream health system for achieving universal health coverage in Bangladesh by 2030?

1.2 Objectives

General
To identify the knowledge gaps regarding the 'marginalized/socially excluded' population groups, underlying processes and factors, and existing scenario regarding policies and programmes. Finally, informed by the above evidence, to propose a roadmap for the future towards contributing to the UHC 2030 journey.

Specific
- To define and identify the 'marginalised'socially excluded' groups of population in national context who are 'left behind'/whose health care needs are not equitably addressed
- To explore and understand the process and the factors, underlying their marginalisation/ social exclusion situation
- To explore the current policies and programmes for these populations, including their 'unmet health needs'
- To explore the national databases and surveillance systems for the availability of disaggregated data by margilanised/socially excluded population groups
- To recommend actions to better align policies and programmes for including/mainstreaming the 'marginalized' populations towards achieving UHC by 2030

1.3 The Study Protocol

Due to constraints in time and resources, the study adopted a Rapid Review (RR) approach to summarise evidences for policy and programmatic actions targeted towards the 'marginalized/ socially excluded' population groups in Bangladesh, (Tricco et al, 2017). According to the WHO, RR involves a type of knowledge synthesis in which systematic review process is accelerated and methods are streamlined to complete the review within a shorter span of time than is the case for typical systematic reviews (Andrea et al 2017).This method has emerged as a streamlined approach 'to synthesis evidence in a timely manner typically for the purpose of informing emergent decisions faced by decision makers in health care settings' (Sara et al 2012). The different steps followed in the RR method are detailed below (Table 1).

Table 1: Steps of the Rapid Review Process (Tricco et al, 2017)

Rapid Review Steps	Methods	Key considerations
Need assessment Topic selection	The broader project was generated from the need to share data and experiences, thus need assessment has already been covered. The topic was assigned under the broader research objective by the requester	Meeting & discussion held with the partners on 7/3/18 to ascertain intended purpose, scope, and timeline to ensure whether proposed approach fits the purpose.
Topic refinement	Discussion held with requester to obtain clarity on objective , study population, timeline and key research question	A preliminary literature search was done to discuss with the partners, mapped the mandate, setting timeline and deliverables.
Protocol development	Used WHO RRs guideline and reporting items for protocol development	A detailed review protocol was developed and shared with the partners for feedback. Protocol finalized with inclusion of feedback, feasible and relevant.
Literature search Screening and document selection Data extraction	Electronic databases were used primarily; grey literature and web sites searched through manual search. Applying inclusion, exclusion criteria screening and selection was done. The criteria's will be followed strictly and consistently	Search was done by reviewer 1 &2, under the guidance of PI Screening and selection was done by reviewer 1 & 2, under the guidance of the PI
Risk-of-bias assessment/Quality assessment	Data were extracted using the extraction templates prepared. Extraction was limited to the key concepts of the study.	Data extraction was done by reviewer 1&2, under the supervision of PI.

Rapid Review Steps	Methods	Key considerations
Knowledge synthesis	The review was strictly adhere to review protocol. Data was synthesized and analyzed following objectives applying a narrative summarizing approach.	Two reviewers were involved independently in the overall process, guided by the PI Narrative summaries were produced
Report writing	Report was developed, shared among the partners and finalized incorporating feedbacks	Report addressed the research questions and presented evidences related to the study objectives

Rapid review protocol

Initially, a number of brain-storming sessions were held with BRAC's ASC&T team to get conceptual clarity about their needs and requirements. Based upon these interactions, the study team drafted a rapid review protocol outlining the basic aspects of study including the methods. The 'PROGRESS Plus' (place of residence, race, occupation, gender/sex, religion, education, socio-economic status, social capital, plus other variables like disease status, disability) approach covering variables such as place of residence, race, occupation, gender, religion, education, socio-economic status, social capital was used to apply an 'equity lense' to the review (viewing unfair differences of the society & identify the interventions that can address the difference) (Dobbins, 2017). The draft specified the criteria for searching relevant literature, the key search terms to be used, and the search engines. The draft protocol was subjected to peer-review by the BRAC ASC&T and was finalized after incorporating their feedbacks (*Please see Annex 3 for the detailed RR Protocol*).

The process of selecting the articles/documents for inclusion in the final analysis is shown in Fig. 1.

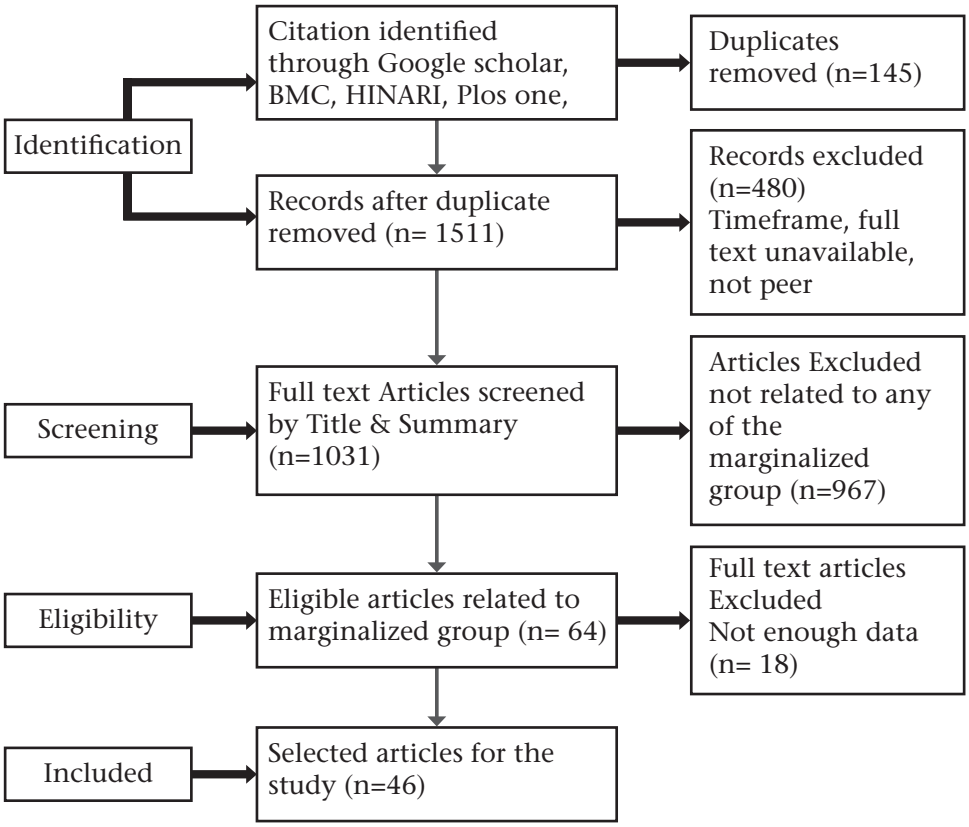

Figure 1: Selection of peer reviewed articles for exploring the health care scenario of the different groups of marginalized people

Data were extracted and synthesized in a pre-defined template prepared by the study team under the guidance of the Principal Investigator. Thematic analysis was done as per objectives of the study. Tables for different marginalized groups were prepared to demonstrate the data availability of different group, specific policy recommendation for the groups and how different projects and programs addressed their unmet needs.

CHAPTER 2

WHO ARE THE 'MARGINALIZED' POPULATIONS AND WHY THEY ARE LEFT BEHIND?

2.1 Definition, categories and characteristics

'Marginalisation' has been seen from different perspectives in the literature. For example, DfID defined it as comprising those peoples who are socially excluded on the basis of their 'age, race, ethnicity, gender, disability status, migration status and geographical location,' resulting in deprivation from receiving public services like health, education, and job including alienation from the mainstream of the society. (DFID, 2005). On the other hand, Marshall (1998) described marginalization as a 'process by which a group or individual is denied access to important positions and symbols of economic, religious or political power within any society' (Marshall, 1998). Daniel & Linder (2002) goes a little more deep into the matter and consider it 'to be distanced from power and resources' that is a pre-requisite for self-determination in economic, political, and social settings. Further, they termed the concept to be 'highly depending on the historical and socio-economical context of a society.'

Marginalization has also been seen from spatial perspectives such as a 'condition of socio-spatial structure and process in which components of society and space in a territorial unit are observed to lag behind an expected level of performance in economic, political and social well-being compared with average condition in the territory as a whole' (Sommers et al., 1999). And more recently as a "temporary state of having been put aside of living in relative isolation, at the edge of a system (cultural, social, political or economic), in mind, when one excludes certain domains or phenomena from one's thinking because they do not correspond to the mainstream philosophy' (International Geographical Union (IGU), 2003). From the above definitions, the following characteristics of 'marginalization' become apparent: this is a process, originating from lack of awareness or negative attitudes of the larger society, by which certain population groups are denied access to resources and services essential for living a decent life. For example, they are deprived from basic human rights like food, health, shelter, education etc.

2.2 Categories and characteristics

Marginalized populations (based on ethnicity, cast, descent, religion, sexual orientation, gender, age, disability, and region) in the Bangladeshi society experience social exclusion in a variety of ways. Besides gender-based

exclusions which is a cross-cutting issue, the RR found other important categories to be based on ethnicity and religion, SES including extreme poverty, patron-client relationships, physical and mental disability, sexual orientation, occupation etc. These are presented below with references (Please see Table 2). All of these groups are deprived from availing their basic health care rights and needs, due to their marginalization status. They are marginalized as they belongs to a particular group of the society and having different identity, imposed by the society.

Table 2: Marginalized/socially excluded groups in Bangladesh

Groups based on	**Population**	**References**
Ethnicity	Ethnic/indigenous people such as Hilly Adivasi /Local Ethnics- Chakma, Khyang (Rangamati), Khumi, BAWM (Bandarban), Marma, Tripura (Khagrachari) ii) Plain Land Adivasi (Local Ethnic)- Garo (Netrokona), Santal (Rajshahi), Oran (Rangpur)	Ahsania Mission, 2013; Arban 2017; Islam, 2011
Socio-economic status (SES)	**Ultra-poor/people living under extreme poverty:** Women headed household (widow, separated, divorced), people excluded from the NGO, education	Ahsania Mission 2013; Islam & Nath 2012, Islam, 2011
Religion/caste	**Cast based dalit:** Sweeper (Horizon-hindu, in Khulna), Dhulee (Traditional drum player), Kulu (Traditional oil crusher), Jhola (Traditional weaver), Cobbler, Barbar, Abdal (laborer, bone seller), Mahali (bamboo & cane work), Traditional fisher-folk- in Magura, Gopalganj and Pabna, Rissi- in Jessore Kaiputra- in Satkhira, Khulna Religious minorities- in Chittagong, Gopalgank, Jessore	Islam & Nath 2012, Manusher Jonno Foundation (MJF) 2016; Islam, 2011

Groups based on	Population	References
Migrant & mobile	**Cross border migrants**, internal migrants (rural-urban), refugee/displaces, river gypsi(bede), landless, street dwellers, street children	Ahsania Mission, 2013; Islam, 2011; GSDRC, 2008
Geographical	People living in **hard-to-rich, coastal, haor areas, Char, hill areas**	Ahsania Mission, 2013; Manusher Jonno Foundation (MJF) 2016; Islam, 2011
Disability Disease	**Persons with disabilities, mental retardation** Person with communicable diseases, **HIV&AIDS**, Leprosy, drug addict, clustered people with neglected tropical diseases(NTD) like Kalaazar (visceral leishmaniasis), filariasis	Ahsania Mission, 2013; Arban, 2017; Islam, 2011; GSDRC, 2008 Ahsania Mission, 2013; Islam, 2011; GSDRC, 2008
Occupation	**Tea plantation workers, sweepers** (pariah people), dom (person who deals with dead bodies), beggar, child labourer, unemployed, commercial sex workers	Ahsania Mission, 2013; Islam & Nath 2012; Islam, 2008
Sexual orientation/ diversity	**Women, transgender/third gender** (Hijra/,gay/lesbian (LGBT)	Ahsania Mission, 2013; Arban, 2015; Islam, 2011
Violence	Trafficked survivors, **acid survivors,** sexually violated, **raped victims**	Ahsania Mission, 2013; Islam, 2011
Age	Young people, **adolescents, elderly/senior citizens**	Exclusion and Marginalization, 2013; Arban, 2015,; Islam, 2011
Disasters	Victims of natural and man-made disaster	ADPC, 2015

2.3 Underlying causes and processes

Though anyone may be potentially at the risk of marginalization or social exclusion, certain characteristics or attributes increase the risk of marginalization which include but not limited to different factors such as physical and mental disabilities, income-earning status, health status, educational achievements, housing conditions, hierarchy of the political process, governance mechanisms etc. (GSDRC, 2008). These act through the process of unequal access to resources, unequal participation and denial of opportunities. Prevailing attitudes and practices in the society 'conscious or unconscious, intended or unintended, explicit or informal', may also contribute to the process of marginalization and ultimately, exclusion from health care-seeking from the mainstream health systems (Kabeer, 2010) (Please see table 3).

Table 3: Social practices leading to marginalization (Kabeer, 2010)

Social practices leading to marginalization	Explanation
Mobilization of social bias	This refers to a predominant set of values, beliefs, rituals and institutional procedures that operate systematically and consistently to the benefit of certain persons and groups at the expense of others.
Social closure	This refers to the social collectivities seek to maximize rewards by restricting access to resources and opportunities to a limited circle of eligible.
Unruly practices	This refers to the gaps between rules and their implementation. Institutions unofficially perpetuate exclusion when public sector workers reflect the prejudices of their society through their position
Power relation	This refers to who is being excluded and who is doing the excluding, and why.

In case of Bangladesh, the process of marginalization and social exclusion is approached in different ways by different authors. For example, Zohir et al (2008) conceptualized exclusion in terms of 'space' and 'attributes' or characteristics. Attributes are considered characteristics of individuals, households or communities that lead to exclusion in one or more spaces. Individuals may be born with or acquire these attributes, e.g. through religion, ethnicity or descent. Some of these attributes may be permanent

(such as ethnicity, disability) or temporary (such as descent, occupation). Education and health services, land rights, housing facilities, employment status, financial services, and access to markets are some of the spaces where exclusion is more prominently practiced. Others point to the limitations arising out of the country's poor socio-economic and cultural environment (e.g., lack of social trust, role played by local power structures, and negative role of religious leaders), including those created by the government and donor agencies (e.g., donor dependency, inaccessible market and lack of government initiative, and challenges of knowledge transfer) (Islam & Nath, 2012).

Entitlement and governance failures are important for the marginalization process in Bangladesh. Marginalized people are deprived of accessing resources and treated unfairly due to non-targeting nature of existing programs. For example, person with disabilities are unable to access formal health care due to inaccessible facilities, stigma, lack of awareness and existing informal care practice (Manusher Jonno Foundation, 2016). The different processes of marginalization and exclusion that occurs in the context of Bangladesh is shown below with references *(Please, see table 4)*.

Table 4: Processes leading to of marginalization in the context of Bangladesh

Dimensions/process leading to marginalization in Bangladesh	**Reference**
Structural(e. g; lack of education, employment, poor access to land, poor access to health care)	Wazed, 2012; Islam & Nath 2012
Concept of patriarchy concept, particularly in rural areas of Bangladesh as a reason behind excluding women especially in terms of seeking health care service	Islam & Sultana, 2006; Islam & Nath 2012
Socio-economic (SES) condition (ultra-poor, hardcore poor, poorest of the poor are unable to access formal health care)	Ali, 2013
Occupation (hazardous and risky occupation e.g., ship-breaking, medical waste handling- These peoples are at risk of developing disease, but, they are ignoring their health issues due to poor SES)	Manusher Jonno Foundation 2016; Islam & Nath 2012; Ali, 2013

Dimensions/process leading to marginalization in Bangladesh	Reference
Minority situation-religion, caste, or indigenous people (Unable to seek and access health care due to their cast based system)	Manusher Jonno Foundation, 2016; Islam & Nath 2012; Ali, 2013
Geographical (remote, hard-to-reach areas- Unable to seek formal health care due to distance and cost)	Manusher Jonno Foundation, 2016
Disease (with social stigma e.g., HIV/AIDS, TB, Leprosy- Not seeking health care due to stigma)	Manusher Jonno Foundation, 2016, Islam & Nath, 2012
Disabilities (physical and mental- Not seeking health care due to inaccessible health care facility & stigma)	Manusher Jonno Foundation, 2016; Ali, 2013
Sexual orientation (LGBT, transgender, CSWs- Not seeking health care due to existing social isolation)	Manusher Jonno Foundation, 2016
Migration (rural to urban; influx from neighbors e.g., Rohingyas- They are struggling to have their basic need and health is not the immediate priority)	Mrshall & Rahman, 2013; Unicef 2013
Urbanization (Slum and street dwellers- Not seeking health care due to poor SES, awareness)	Khan, 2009

2.4 Unmet Health needs of the different marginalized groups

Indigenous people

Bangladesh has been able to meet many targets related to the Millennium Development Goals (MDGs). However, the indigenous people remained largely outside this and their health conditions have not improved in the same way as of the rest of the general population (Tuhin & Ameen, 2015,). In three districts of Chittagong, 11 indigenous groups live where the health services are provided by both the public and private sector. Due to extreme geographical remoteness the government facilities are routinely in shortage of resource (both physical and human).There is limited provision of door step services such as ante- and post-natal care, and health promotion provided by the MoHFW and NGOs. The facilities are located 4.5 hour walking distance away which causes delay in seeking healthcare. As a result, they mostly seek health care from the traditional healer or, use home

remedy. Due to remoteness of the local context, they have difficulties in having basic sanitation and safe water, they use water from water fall, which became contaminated during rainy season and they got affected with diarrhea and other water borne diseases. Due to loss of land, they have difficulties in managing balanced diet, eating spoiled food causing gastric problems (Hussain et al, 2015).

"Self-care" is found to be common among the ethnic minorities and treatment-seeking from traditional healers such as Baiddya, homeopathic practitioners, and traditional birth attendants (TBAs) is common (Ahmed et al 2001). They receive payment in kind or in cash in installments. Despite having problems of finding a qualified health care provider from whom to seek treatment, the tribal peoples are not interested to seek services from the public health facilities due to unwelcome behavior of staff, lack of respect, and the seriousness displayed while treating patients. The services are supposed to be free, but, they have to make informal payment to get services. Besides, age, perception about health problems and gender played important roles in treatment-seeking as well. There is an unmet need for reproductive health care services including pregnancy care (Rahman et al, 2012).

Groups	**Unmet health needs**	**Underlying reasons**
Indigenous people	Malnutrition, waterborne diseases, diarrhoea fever, gastrointestinal problems, malaria, adolescent healthcare	Geographical remoteness, shortage of resources, unfriendly behavioural approach of the providers, cost of care
Poor/Ultra poor	Cold, fever, musculoskeletal disease, gastro-intestinal disease, neurological disease, RTI, gastrointestinal disorders such as diarrhea and dysentery, aches and pain, essential lifesaving medicines	Catastrophic expenditure, distance to access
Elderly	Chronic Obstructive Pulmonary Disorder (COPD), stroke and other diseases, arthritis, gastric, blood pressure, diabetes, asthma, malnutrition, eye problems, hearing problems	Cost of care, economic dependency

Groups	Unmet health needs	Underlying reasons
Women	Reproductive and maternal health care services, skill birth attended	Wealth disparities, cost of care, unfriendly behavioral approach of the providers, lack of awareness
Adolescent	Pregnancy, anemia, gender based violence	Neglected in family
Children	Malnutrition, stunting	Poverty
Disable persons	Physical and mental stress	Socio-economic status, poor access, resource constrain
Street dwellers	Respiratory system diseases (cold/cough/fever/asthma), digestive system diseases (gastric, diarrhea), severe pain (headache/chest), reproductive health problems like vaginal discharge, lower abdominal pain, genital itching/burning, and others, such as mass in the lower abdomen/irregular period/prolapses	Lack of awareness of available services
Sex workers	Sexual and reproductive health needs like contraceptive, abortion, menstrual regulation, maternal health care and STI, treatment of physical abuse	Lack of awareness, financial problems, social stigma, ashamed of seeking care, attitude and behavior of the providers, distance of the healthcare facilities.

Table 5: Unmet health care needs of different marginalized groups in Bangladesh

Poor/ultra-poor

A study conducted in Chakaria, Coxs Bazar reveals that 51% of the respondents did not seek any formal health care and the village doctors were the primary contact for seeking services (67%) (Mahmood et al, 2010). Only 12% from the lowest quintile sought formal medical health care. Cost of treatment and distance of health facility were major barriers for many people to access the health care service. Another study from Matlab reported higher

prevalence of illness is 14% among poor women compared to 13% non-poor man and women (Ahmed et al, 2003). Fever was the most commonly reported illness followed by gastrointestinal disorders such as diarrhea and dysentery, aches and pain. A pervasive decline in the use of formal medical care was noticeable from the study findings.

A review of health care expenditure of households found that at least 10% spent more than 1/4th of their household resources for illness and 18% households were pushed into poverty (HEU, 2012). Poor households were found to be four-times more vulnerable for catastrophic expenditure compared to better-off households (Rahman et al, 2013). To avail free-of-cost or nominal cost govt. services, people have to make informal payments. Likewise, essential medicine and family planning commodities were available for free distribution, but, sometimes it is sold to the vendor and poor people are deprived of essential lifesaving medicine. They are forced to buy the 'free medicine' from the local market (Islam & Biswas, 2014). Interestingly, 30% health care subsidy is received by the richest quintile HEU, 2012-2032). Unavailability of health professionals, their unfriendly and unapproachable behavior, and charge of unofficial fees and lack of accountability are also setting barriers towards meeting health need of people in general and these marginalized groups (Hamid et al, 2011).

Elderly

A study conducted to assess the health care needs of the elderly people in rural areas of Bangladesh found that the health insurance coverage among elderly people was 14% and they were 1.2 times more likely to seek health care compared to other groups. The females were 1.5 times more likely to seek health care compared to men. Death from Chronic Obstructive Pulmonary Diseases (COPD), stroke and other diseases was 42% among the elderly people; of these, 27% did not seek any health care for their problems (Monowar & Begum, 2003). According to another study conducted in rural Naogaon of Bangladesh, elderly women who were 60-69 years old were socially and economically more vulnerable compared to elder men due to their economic dependency, illiteracy, living with their married children and unhealthy status (Munsur et al, 2010). When their widow status compounded with disability and ill health, they became even more vulnerable. They are prone to different lifestyle and chronic diseases like arthritis, gastric, blood pressure, diabetes, asthma etc. Widow women are more prone to be unhealthy compared to their married counterparts. Prevalence of malnutrition, eye problems, hearing problems is noticeable among them. They are not receiving proper health care for the mentioned problems from the available formal public health facilities. This study indicates 41.9% of them are seeking care from the nearby informal village doctors.

Women (maternal and reproductive healthcare)

The pro-wealth disparity in accessing reproductive and maternal health care services is well documented in Bangladesh (Zere et al, 2013). . The use of 4 antenatal care is significantly low among women of low wealth quintile. Women from the richest 10% household seek 8 times more antenatal care and use ultrasonography compared to the women from the poorest 10% household. At the same time, women from the richest quintile consulted doctors in their ante-natal care, while, women from poor quintile consulted nurse and midwifes. Similarly, there is a higher rate of facility birth among women from richest quintile in a study from Kurigram & Gaibandha on maternal care practices in ultra-poor households (Choudhury & Ahmed 2011). The authors found that the ultra-poor women were not willing to take services from the health care workers due to their harsh attitude and low tolerance level, and also, their lack of awareness. In a study of trend analysis on the utilization of maternal care among women from wealthy and poor households, wealth related inequality was found to have a greater impact on maternal care seeking and delivery practices (Hajizadeh et al, 2014). Relative index of inequality (RII) and slope index of inequality (SII) used in this study show that women from wealthy households are preferred by the health system when they sought and received care. The main reason for not seeking delivery care at hospital or clinic is poverty: poor people are unable to afford cost of delivery, medicine, hospital facility and transport. Thus, they prefer traditional birth attendants (TBA) for completing the delivery at a low price in exchange of non-monetary gifts or sometimes free of cost (Sarker et al, 2016). There is unmet need of delivery care among ultra-poor women and they required high level of awareness to seek the care. It is really important to include them in the target group to have greater coverage and achievement (Rahman et al, 2016).

Child, adolescent & youths

Child health care is a major problem in Bangladesh, particularly in rural areas. The prevalence of stunting among 0-59 months old is 43% in Bangladesh. This rate is higher among children whose mothers didn't receive any ANC and didn't have facility delivery (Hong et al, 2006). Government has taken many initiatives to improve access of the poor and rural people to health facilities. Still, their utilization rate of health care facilities is low compared to other groups. Most of the people seek health care from the informal care providers like traditional healers or, unqualified village doctors. They are less likely to report their illness and seek care from the qualified medical care providers. The prevalence of illness is higher among rural children (19.9%) compared to the urban children (16.8%), but, the care seeking practice from health facility and facility utilization is low among them (Huq & Tasneem, 2008). Girls of all ages are neglected and are seeking

and receiving minimal health care for most health problems (Fikree & Pasha, 2004).
According to Bangladesh National Youth Policy, 18-35 years people classified as youth and their estimated number is around 45 million. Only, 10% of them have the good employment with 250 USD and option for standard living in the country (Biswas et al, 2017). This have huge impact on their health. Besides, this group is at risk of health issues, particularly, in the area of reproductive health due to lack of information and access to the service provided (Barakat & Majid, 2003). The first national survey of mental health disorders revealed that 16.1% adult populations are suffering from mental health problems (depression, anxiety, bipolar mood disorders) and more than half of them are from youth group (NIMH, 2007). Unfortunately, mental health services are available in the big tertiary care hospitals, not in the primary care facility (Hossain et al., 2014). So, this is an unmet need which required attention immediately.

Persons with Disability

Person with disability are the most disadvantaged in our society. We have 140 million people living with different forms of disability in our country, which represent 10% of our total population (World Bank, 2004). Unfortunately, more than half of this population heavily rely on the informal care provider due to their poor SES, gender and stigma relevant to disability. Unfortunately, the existing public health care system doesn't have medical rehabilitation facilities for person and children with disabilities and less than 5% peoples are receiving rehabilitation service from private sector (World Bank, 2004). As a result, we are missing a large workforce (LWF), who can contribute to improve our economy. So, arrangement of proper medical rehabilitation services including assistive device (AFO, modified spoon, artificial limb, dynamic splint etc) is urgent medical need for persons with disabilities.

The prevalence of children with disability is high in Bangladesh (Mobarak et al, 2000). There are few centers available in Bangladesh to provide them rehabilitation services, but even then, mothers of children with disabilities are unable to access services due to lack of awareness about availability of services, socio-economic barriers. Stress level of mothers of children with disabilities is high, especially among rural women compared to urban women, due to difference in SES arising from resource constraints and poor access to appropriate services (Mobarak et al, 2000).

Street dwellers

Street dwellers living in unhygienic conditions like open spaces, railway terminal, bus station and parks in large number is creating a public health

problem in big cities (Uddin et al, 2009). They face difficulty to seek and access health care, especially women seeking reproductive health and family planning services. The study revealed that 45% female and 37% male didn't seek any health care while they were sick and 55% female and 67% male took medicine from the nearest pharmacy. Only 11% of male and female went to government health facilities for seeking medical care (Uddin et al, 2009).

Sex workers

For the adolescent sex workers, sexual and reproductive health care needs like contraceptives, abortion, menstrual regulation, maternal health care and STI remain unmet due to inadequacy of services. The unmet contraceptive need is high among both street based (25%) and hotel based (36%) sex workers as they at risk of getting pregnant and having STI due to poor negotiation power with client for using condom, and also, high number of clients (Katz et al, 2015). Gender based violence (GBV) is another common dimension of their life (Katz et al, 2015). They mainly receive services from NGOs (15%), pharmacies (16.8%) and unqualified health care providers (16.8%) (Wahed et al, 2017a). For example, providers are unable to diagnose and check the recovery of STI due to unavailability of pathology service (Wahed et al, 2017b). Financial problems, lack of knowledge and hateful manner of service provision of the providers restrict them to seek external health care (Wahed et al, 2017). Many of sex workers are not seeking health care, 51% of them are facing difficulty while seeking health care from the formal health care facilities The main reasons for not seeking health care are financial problems (72%), ashamed of seeking care (52.3%), attitude and behavior of the providers (24.4%) and distance (16.9%) of the healthcare facilities.

Chapter 3

CURRENT POLICIES AND PROGRAMMES FOR THE MARGINALIZED POPULATIONS

3.1 Current policy documents addressing marginailtion

There have been a number of key policy documents since independence in 1971 covering covered different marginalized groups and different aspects of their problems. Most of these policies like National health policy, National drug policy, National Health sector plan, Disability Act, Tribal People Plan etc. addressed the health needs of the marginalized people, stressing the importance of providing health care service for all who is in need. Unfortunately, there is a big gap exists between the national level policy document and its reflection in real life.

An inventory of these documents and the issues covered in the documents are presented below (Please see Table 6 and Table 7 respectively).

Table 6: Marginalised groups in Bangladesh covered by different policy/policies

Groups	Policies
Poor living below poverty line, ultra-poor and likes	Health and population Sector program 1998-2003; Seventh Five Year Plan 2016-2020; National Social Security Strategy; National Health Protection Act 2014; Expanding social protection for health: towards universal health coverage 2012-2032; National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016; Framework for monitoring progress towards Universal Health Coverage in Bangladesh; Prospective Plan of Bangladesh 2010-2021: Making Vision 2021 a reality; The Constitution of Peoples Republic of Bangladesh
Vulnerable people, Deprived, marginalised	Seventh Five Year Plan 2016-2020; National Health Protection Act, 2014; National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016; Health, population, nutrition sector program implementation plan 2011-2016, Framework towards Universal Health Coverage in Bangladesh; Prospective Plan of Bangladesh 2010-2021: Making Vision 2021 a reality; The Constitution of Peoples Republic of Bangladesh

Groups	Policies
Urban slum dwellers	National Health Protection Act, 2014;National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016, Framework for monitoring progress towards Universal Health Coverage in Bangladesh
Rural people	Seventh Five Year Plan 2016-2020, National Health Protection Act 2014; National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016; Framework for monitoring progress Universal Health Coverage in Bangladesh
Elderly people	Seventh Five Year Plan 2016-2020; National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016
Physically and mentally disabled	National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016; Health, population, nutrition sector program implementation plan 2011-2016; Persons with Disabilities' Rights and the Protection Act 2013; National Children Policy 2011; The Constitution of Peoples Republic of Bangladesh; The Right to Information Act, 2009; The National ICT Policy, 2009
Women	Eradicating poverty and promoting prosperity in a changing world, Voluntary National Review (VNR), 2017; Seventh Five Year Plan 2016-2020; National Drug policy 2016; Comprehensive social & behavioral change communication strategy 2016; Health and population Sector program 1998-2003, National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016; Gender Equity Strategy of LGED, 2014; Gender Policy 2016, MoE; National Women Development Policy 2011, Ministry of Women and Children's Affair; Domestic Violence Protection Act 2010; The Constitution of Peoples Republic of Bangladesh; The Suppression of Violence against Women and Children Act 2000

Groups	Policies
Children	Seventh Five Year Plan 2016-2020; National Drug policy 2016; Comprehensive social & behavioral change communication strategy 2016; Health and population Sector program 1998-2003; National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016; Domestic violence protection Act 2010; National Children Policy 2011; The Constitution of Peoples Republic of Bangladesh; The Suppression of Violence against Women and Children Act 2000; Child Marriage Restraint Act 2017
Adolescent	Seventh Five Year Plan 2016-2020; Comprehensive social & behavioral change communication strategy 2016; Strategic plan for health, population, nutrition sector development plan 2011-2016; National Children Policy 2011; Child Marriage Restraint Act 2017
Tribal/ethnic minorities	Eradicating poverty and promoting prosperity in a changing world, Voluntary National Review (VNR), 2017; Seventh Five Year Plan 2016-2020; The tribal people plan 2015; National Health Policy 2011; Strategic plan for health, population, nutrition sector development plan 2011-2016; Health, population, nutrition sector program implementation plan 2011-201; Framework for monitoring progress towards Universal Health Coverage in Bangladesh; National Children Policy; The Constitution of Peoples Republic of Bangladesh
People with communicable/infectious diseases (RTI/STI/NIPA/SARD/Kala-azar/HIV/AIDS)	National Drug Policy 2016; Comprehensive social & behavioral change communication strategy 2016; ; Health and population Sector program 1998-2003; Strategic plan for health, population, nutrition sector development plan 2011-2016; Health, population, nutrition sector program implementation plan 2011-2016; National Children Policy 2011

Groups	Policies
People with non-communicable diseases	Comprehensive social & behavioral change communication strategy 2016; Strategic plan for health, population, nutrition sector development plan 2011-2016; Health, population, nutrition sector program implementation plan 2011-2016; National Communication Strategy and Action Plan for Reduction of NCD High Risk Behaviors in Bangladesh 2014-2016
Orphan	National Health Protection Act 2014; National Children Policy 2011
Religious groups other than Muslims	Strategic plan for health, population, nutrition sector development plan 2011-2016; The Constitution of Peoples Republic of Bangladesh
Widow	National Women Development Policy 2011
Children of special need- autism	Seventh Five Year Plan 2016-2020; Persons with Disabilities' Rights and the Protection Act 2013; National Children Policy 2011, National strategic plan for Neuro-developmental disorder 2016-2021

Table 7: Key issues addressed in the policy documents

Types of documents	Issues addressed	References
Constitution	No discriminate against any citizen on grounds religion, race, caste, sex, place of birth and disability; Gender equality	The Constitution of the People's Republic of Bangladesh
National health sector programs /plans/strategies	Primary healthcare; Reproductive, Neonate, Child, Adolescent healthcare; Communicable/Non-communicable disease care; Limited curative care; BCC; Gender equity; Geographical remoteness; Equity in health; Universal health	Health and population Sector program 1998-2003; Strategic plan for health, population, nutrition sector development plan 2011-2016; Health, population, nutrition sector program implementation plan 2011-2016; Expanding social protection for

Types of documents	Issues addressed	References
	coverage; Food safety; Occupational health; Climate change; Water and sanitation; Sectoral collaboration; Use of technology; Social health protection scheme; Access to services; Financial risk protection, Quality of care; Disaster management ; Health education; Community empowerment; User friendly service; Leave no one behind; Whole of a society; Data gap analysis	health: towards universal health coverage 2012-2032; Prospective Plan of Bangladesh 2010-2021: Making Vision 2021 a reality; Framework for monitoring progress towards Universal Health Coverage in Bangladesh, 2014, HEU, MoHFW; National Social Security Strategy 2015; Comprehensive social & behavioral change communication strategy 2016; Seventh Five Year Plan 2016-2020; Eradicating poverty and promoting prosperity in a changing world, Voluntary National Review (VNR), 2017
Specific policies		
Health policy/Act	Health as a human right; equitable distribution of resources, marginalized groups health issues; Financial protection; Health Card	National Health Policy 2011; National Health Protection Act 2014
Drug Policy	Drug quality, price, rational use, ethical promotion, export, good manufacturing practice, pharmacovigilance, dispensing practice, adverse drug reaction, research & development of drugs	National Drug Policy 2016
Women policy	Women empowerment; Equity; Health; Nutrition; Safety; Occupation	National Women's Policy 2011

Types of documents	Issues addressed	References
Child Policy	Poverty elimination; elimination of child abuse, Health, Nutrition; Child labour; Girl child; Ethnic child; Increasing punishment for child marriage	National Children's Policy 2011; Child Marriage Restraint Act 2017
Population policy	Reproductive health; Child health; Malnutrition; RTI/STI, HIV/AIDs; elderly health; Gender equity; disability	National Population Policy 2012
Disability Act	Autism, physical, psychological, speech, hearing intellectual disability, visual impaired, cerebral palsy, down syndrome and multiple disabilities.	Persons with Disabilities' Rights and the Protection Act 2013, National strategic plan for neuro-developmental disorder 2016-2021
Gender strategy /policy	Gender empowerment; Women friendly infrastructure; Gender disaggregated data; Understanding gender dimensions in community	Gender equity strategy of the LGED, 2014; Gender Policy 2016,MoE
Tribal People Plan	Social safeguard issues; improve health services	The Tribal People Plan 2015
Violence protection	Protecting women, children from domestic and social violence	Domestic Violence (Prevention and Protection) Act, 2010; The Suppression of Violence against Women and Children Act 2000
Information Act	Disability friendly provisions of information	Right to Information Act, 2009
ICT Policy	Access to technologies	National ICT Policy 2009

3.2 Current programmes addressing marginalization/social exclusion

Currently, quite a number of programmes are being operational for different categories of the marginalized popylations, both in the public and the non-state sectors, albeit, with a wide gap between demand and supply. These are presented in a tabular form *(see table 7 and table 8 for GoB and non-GoB programmes respectively)*, including brief descriptions of the major programmes.

Table 8: Major safety net programmes in the public sector

Program Allowance program (old age, FFs)	**Ministry** MoWCA, MoSW, MoPME	**Coverage** Widow, deserted, destitute children, freedom fighters, orphans, Elderly, acid burn victim, disabled (adult & children), non-banglaees, lactating mothers	**Benefit Package** Fixed amount of allowance for each group
Food security & disaster assistance (VGF, OMS, TR, VGD)	MoPME/MoE, Disaster management & relief (MoDMR)	CHT people, vulnerable group	Relief for buying food, construction of housing, income generation, Ultra poor of northern area
Employment generation (EFW, EGPP)	Line ministries, LGD, FD, MoLE	Char people, ultra-poor	Food for work, skill development training, employed in different institutions
Human development & social empowerment (primary & secondary stipend)	Line ministries, LGD, FD	Teenagers, drop out students, pregnant mother, ultra-poor women, vulnerable women 19-59 years	Stipend for primary & secondary students, maternal voucher scheme, school feeding program, Children less than 1-18
Urban poverty reduction	LGD, FD	Working children	Provide basic education
Pension for government employees	MoSW, bank & financial institutions, divisions	Provide pension scheme money after retirement	Elderly & retired person

3.2.1 GoB's Social safety net programmes (PPRC-UNDP 2012)

With the change in concept regarding post-disaster relief and food rations and development over time, all different safety net programmes previously undertaken by the GoB (see Table7) are now mainstreamed under its social development activities and mostly provided by different agencies of the government (UNDP & PPRC, 2012). These programmes mainly target three types of people who are at risk- 1) people who are in food insecurity due to seasonality, disaster or, crisis 2) people who are living in structural poverty 3) people with special needs like elderly, widows and disabled (Please see table 8). These social safety net programmes are not fool-proof with respect to selecting beneficiaries in a transparent manner due to nepotism, social and political influences from local elites, and personal lack of integrity of those in charge. Also, the transfers made under the scheme, whether in cash or kind, is too little to meet the requirements of the beneficiaries under available market realities. (DCGCI, 2011).

3.2.2 Programmes by national & international NGOs

Some non-government organisations such as CBM and its partners e.g., DRRA, Work for Life, Sightsavers International, and Unicef are contributing to inclusive health and rehabilitation of persons with disabilities in the light of existing government policy. In line with the Government 7th 5 year plan and Neurodevelopmental disability Act 2013, the Incheon Strategy taken by ESCAP and its action plan would provide link how government has taken those in consideration in the SDG planning.

CBM has been supporting its partner DRRA (Disability Research and Rehabilitation Association) to work directly with the government of Bangladesh on a tripatriate MOU to strengthen capacity of the government's Community Based Health Care (CBHC), Directorate General of Health Services (DGHS) of the Ministry of Health and Family Welfare (MoH&FW) from June 2017 to December 2019 for inclusion of persons with disabilities in the health services.

Table 9: Programmes by national & international NGOs

No.	Name of organization	Coverage	Benefit package
	Program Areas		
1	Grameen Bank www.grameen.com	Poorest poor/ultra-poor	Community micro health insurance scheme, Curative, maternity and child health care
2	Manusher Jonno Foundation (MJF) http://www.manusherjonno.org	Women, children, adolescent, ethnic, minorities, disable	Ensuring rights of the marginalized population, Health care services, education, skill development training and income generating activities.
3	BRAC www.brac.net	Extreme poor/ultra-poor	Microfinance, health, nutrition, WASH, gender equity, integrated intervention to improve access to information and services, human rights, legal aids
4	Gono shastho Kendra (GK) http://www.gonoshasthayakendra.com	Rural poor/ultra-poor	Micro health insurance, health service information, participatory/community based health service delivery
5	Acid Survivors Foundation http://www.acidsurvivors.org	Women	Medical support, physical and psychological rehabilitation for Acid violence victims
6	ADD International http://www.acidsurvivors.org	Women, disable, distresses, poor,	Disability rights, economic empowerment, gender based violence, mental health, inclusive education, mental health and WASH
7	Activities for reformation of basic needs (ARBAN) http://www.arban.org.bd	Poor people	Agriculture, education, computer training, disaster preparedness and management, handicraft, arsenic and WASH

No.	Name of organization	Coverage	Benefit package
	Program Areas		
8	Bangladesh Protibondhi Kalyan Samity (BPKS) bpksbd.org	Children	General health camp, rehabilitation services, educational support, providers support and training, capacity building and income generating activities.
9	D-Net dnet.org.bd	Marginalised and disadvantaged	Incorporate the information of all the available health facilities, livelihood, entrepreneurship program and capacity development program
10	Development Organization for the Rural Poor (DORP) www.dorpbd.org	Rural people, poor, women, ethnic, disable, adolescent	Health, Water & Sanitation, Education, Micro credit, HIV-AIDS Prevention, Resettlement & rehabilitation, Agriculture, Afforestation, Gender issue, Environment, Human rights and rights
11	Ethnic Community Development Organization (ECDO) www.ecdo-bd.org	Ethnic people	Provide access to primary health service facilities
12	Hope Foundation www.hopeforbangladesh.org/	Mother and children	Health camps, fistula care, burn care, birthing centers and cleft lip palate clinic etc. services
13	Partners in Health & Development (PHD) www.phd-bd.com	Less privileged and marginalized group of the community; Women, Children	Health and nutrition, maternal & child healthcare
14	Bangladesh Legal Aid and Services Trust www.blast.org.bd	Poor, marginalized, women, children	Legal aid (advice, referral, mediation, litigation and community awareness)

No.	Name of organization	Coverage	Benefit package
	Program Areas		
15	National Council of disable women www.ncdwbd.org	Women, disable	Develop strong network
16	National Grass Roots Disable Organization (NGDO) www.ngdobd.org	Disable	Strengthen capacity, enhance access to healthcare facilities
17	Sex Workers Network (SWN), Bangladesh http://tbinternet.ohchr.org	Sex Workers	Networking, situation analysis
18	Centre for Disability Development in Bangladesh www.cdd.org.bd	Disable	Skill development
19	ASHIQ http://ashic.org/en	Children	Medical, physical, family support for childhood cancer
20	Adivasi Unnayan Shongshta https://sagarika-bd.org	Ethnic people	Ensuring Rights of the Marginalized Population; Combating Violence Against Women; Protection of Working Children and Vulnerable Workers
21	Ain-o-Shalis Kendra www.askbd.org	Women, refugee, ethnic, religious minorities, political victims,	Legal support, advocacy, documentation, awareness
22	Association for prevention of septic abortion http://bapsa-bd.org	Women	Quality reproductive health
23	Association for women empowerment and child right www.srizonybd.org/women	Women, children	Health, HIV/AIDs, disability

No.	Name of organization	Coverage	Benefit package
	Program Areas		
24	Bangladesh Rehabilitation Centre for Trauma Victims www.brct.org	Trauma victims	Medical care, counselling, therapy
25	CARITAS http://caritasbd.org	Extreme poor, vulnerable people, HIV/AIDs, STI, TB Leprosy Plus people, women	Health education, primary health care, family planning, HIV/AIDs, STI, TB Leprosy, WASH
26	Dhaka Ahsania Mission www.ahsaniamission.org.bd	Women, children, adolescent, HIV, TB, cancer patients, mentally distressed people, road traffic accident victims	Primary healthcare, WASH, Treatment and rehabilitation of drug users, ESP delivery, HIV prevention, family planning, nutrition, TB control, mental health, road traffic accident prevention, cancer
27	Faith Bangladesh www.faithbangladesh.org	Children	Autism, disability
28	Sushilan http://shushilan.org	Youth	Health, WASH, nutrition
29	Society for under privileged families www.sufbd.org	Poor, day labour	ANC, PNC services, health camp, eye, diabetic, dental, blood group campaign
30	Centre for the Rehabilitation of the Paralyzed (CRP) www.crp-bangladesh.org	Disable people	Medical care, therapy, rehabilitation, vocational training, special school
	International Organization		

No.	Name of organization	Coverage	Benefit package
	Program Areas		
1	CARE, Bangladesh www.carebangladesh.org	Mothers, neonates, children; urban poor, HIV patients, female garments workers	Improve coverage of services, HIV prevention, improving maternal and infant health, workers health; To recover from shock and stress, empowering, Community based intervention; building resilience
2	Help Age, Bangladesh http://www.helpage.org/tags/bangladesh	Elderly	Support in emergency situation, action campaign
3	International Labour Organization (ILO) http://www.ilo.org/dhaka/lang--en/index.htm	Women, children, HIV plus, Ethnic, poor	Health, safety at work, discouraging child labour, disability, gender equity, maternity protection, social protection
4	UNAIDS http://www.unaids.org/en	HIV/AIDs patient, adolescent	HIV/AIDS education and prevention programmes
5	UN World Food Programme (WFP) https://www.wfp.org/content/wfp-bangladesh	Mother, children, ethnic	Nutrition
6	World Health Organization (WHO) http://www.who.int/country/bgd/en	Women, children, HIV patients	Maternal& child health, Tuberculosis, EPI, Non-communicable diseases
7	The United Nations Population Fund (UNFPA) http://bangladesh.unfpa.org/en	Women, children	Maternal and child health
8	United Nation Education, Scientific and Cultural Organization (UNESCO)	Children, refuge children	Education
	www.unesco.org/new/dhaka		

No.	Name of organization	Coverage	Benefit package
	Program Areas		
9	United Nations Refugee Agency (UNHCR) www.unhcr.org/en-us/bangladesh.html	Refugee	Counselling, education, support on health and other issues
10	United Nations Development Programme (UNDP) www.bd.undp.org	Poor, women, ethnic	Strengthening women, Social protection policy support, CTH development, poverty reduction
11	World Bank www.worldbank.org/en/country/bangladesh	Poor, marginalized	Support in sector wide approach, Health, HIV/AIDs, education
12	Action Aid Bangladesh www.actionaid.org/bangladesh	Poor, women, children, urban slum dwellers, drug addicts, sex workers, labours	Disability, health hazards, water-sanitation, hygiene, common diseases, health safety, sexual violence, malnutrition, safety net
13	Handicap International www.hi-us.org/bangladesh	Disable people, refugee	Disability rehabilitation, economic inclusion
14	Population Council www.popcouncil.org/research/bangladesh	Women, children, adolescent	Improve access to healthcare, maternal, child and adolescent healthcare services, preventive healthcare, reduce sexual violence
15	FHI 360 www.fhi360.org/countries/bangladesh	Women, neonate, children, sex workers	Reproductive health, malnutrition, HIV/AIDs
16	Friendship https://friendship.ngo/about-us	Ultra-poor, people living in hard-to-reach areas	Satellite clinic, mobile based diagnosis, floating hospital in ship, community based service

No.	Name of organization	Coverage	Benefit package
	Program Areas		
17	HEED Bangladesh www.heed-bangladesh.com	Marginalised, under privileged, women , children	Tuberculosis, Malaria, Arsenic control programme, nutrition programme, HIV/AIDs, WASH, hygiene, arsenic
18	Helen keller Bangladesh www.hki.org/	Ethnic, extreme poor, women, children	Improve health
19	Marie Stopes Bangladesh https://mariestopes.org/where-we-work/bangladesh/	Women	Reproductive health care
20	Save the children, Bangladesh https://bangladesh.savethechildren.net	Children, women	Health, nutrition, HIV/AIDs
21	SOS Children's Village www.sos-childrensvillages.org/where-we-help/asia/bangladesh/dhaka	Children without families	Advocating, family based care
22	Water Aid www.wateraid.org/bd	People lacking basic drinking water and sanitation	WASH

Chapter 4

WHERE IS THE EVIDENCE FOR ACTION?

The existing national and sub-national databases including surveillance databases lacks the levels disaggregation needed to focus the situations of the particular marginalized groups which in some cases may be very small.

4.1 National databases by the Bangladesh Bureau of Statistics (BBS)

A review of national databases maintained by the BBS, GoB, was conducted to explore the depth of data available i.e., availability of data to the lowest level of the geographical entity (Please see Table 10), and level of segregation of data by socioeconomic and demographic characteristics. The datasets and reports were downloaded from the BBS website and checked for data segregation level. As can be seen, Most of these datasets have data up to divisional level, with the exception of National Micro-nutrient Survey 2012. Only three had data up to district level, and two up to sub-district (upazilla level), and none at the union level. On the other hand, most of these databases disaggregated data by common socio-demographic characteristics e.g., age, sex, education, wealth, and marital status. None of these national datasets disaggregated data by any of the marginalized population groups identified in this review except for ethnicity in Household micro-nutrient survey 2012.

Table 10: Availability of data to the lowest level of geographical entity in national databases by the BBS

National Survey	Data availability by geographical entity					
	Residence		Division	District	Upazilla	Union
	Urban	Rural				
Bangladesh Demographic and Health Survey (BDHS) 2014	√	√	√	X	X	X
Bangladesh Sample Vital Statistics 2016	√	√	√	√	√	X
Bangladesh Maternal Mortality & Health care Survey 2016	√	√	√	X	X	X
Household Income Expenditure Survey 2016	√	√	√	X	X	X

National Survey	Data availability by geographical entity					
	Residence		Division	District	Upazilla	Union
	Urban	Rural				
Statistical Pocket Book 2016	√	√	√	√	√	X
Multiple Indicator Cluster Survey 2012-13	√	√	√	X	X	X
National Micro-nutrient Survey 2012	√	√	X	X	X	X
Health & Morbidity Survey 2012	√	√	√	X	X	X
Child and Mother Nutrition Survey 2012	√	√	√	X	X	X
Bangladesh Urban Health Survey 2013	√	X	√	X	X	X
Disability in Bangladesh 2015	√	√	√	√	X	X

Table 11: Data disaggregation by socio-demographic characteristics in national data bases by the BBS

Socio-demographic characteristics >	Age	Sex	Religion	Ethnicity	Marital status	Educ	Occup	Wealth
Bangladesh Demographic and Health Survey (BDHS) 2014	√	√	√		√	√	√	√
Bangladesh Sample Vital Statistics 2016	√	√	√		√	√	√	√
Bangladesh Maternal Mortality & Health care Survey 2016	√	√	√		√	√	X	√
Household Income Expenditure Survey 2016	√	√	√		√	√	X	X

Socio-demographic characteristics >	**Age**	**Sex**	**Religion**	**Ethnicity**	**Marital status**	**Educ**	**Occup**	**Wealth**
Statistical Pocket Book 2016	√	√	√		√	√	X	√
Multiple Indicator Cluster Survey 2012-13	√	√	X		√	√	√	√
National Micro-nutrient Survey 2012	√	√	√	√	X	√	X	√
Health & Morbidity Survey 2012	√	√	X		√	√	X	X
Child and Mother Nutrition Survey 2012	√	√	X		√	√	√	√
Bangladesh Urban Health Survey 2013	√	√	√		√	√	√	√
Disability in Bangladesh 2015	√	√	√		√	√	√	X

Only National micro-nutrient survey 2012 disaggregated data by the different ethnic groups while Disability in Bangladesh 2015 survey went beyond the common socio-demographic characteristics (Please see Table 11).

Table 12: Data on disability disaggregated by socioeconomic and demographic characteristics

Prevalence of disability (%) by demographic characteristics	
Age	0 to 80+
Sex	Male, female
Ethnicity	X
Religion	Hindu, Muslin, Buddhist, Christin, Others
Geographical region	Urban, rural, division
Household characteristics	Type of house, source of drinking water, toilet facility, electricity
Distribution of disability by type	Physical, mental, autistic, vision, speech, hearing
Distribution of disabled by type of disability and marital status	Unmarried, married, widowed, divorced, separated
Access to education of the disabled aged 5-18 years compared to normal people of the same age group	Student, non-student
Access to income-generating activities among the disabled aged 14+ years compared to normal people of the same age group	Employed, looking for job, household, do not work
Disability by intensity of difficulty	Eyesight, hearing, walking, climbing, self-care, communication, speaking
Accessibility of disabled with age 5+ years to receiving benefit from social safety programme compared to normal people	Has/has not benefited from social safety programme in the last 12 months
Prevalence and pattern of disability by district	District, disability, speech, vision, hearing, physical, mental, autistic

***Source- BBS, 2016*

4.2 SDG Data Gaps: not addressed disaggregation to cover the marginalized populations

The Agenda 2030 for Sustainable Development encompasses 17 SDGs with 169 targets, which will be measured through a set of 230 indicators at local, national, regional, and global levels (GED, 2017b). Bangladesh is an 'early starter' in the implementation process of the SDGs as the goals, targets and indicators of the SDGs are included in its 7th 5 year plan (2016 – '21). A format for Data Gap Analysis was primarily developed by the Poverty Analysis and Monitoring (PA&M) Wing of the General Economics Division (GED) following a uniform format for the Ministries/Divisions/Agencies (Please see Table 12/AppxI and Table 13/appx II). Interestingly, none of these indicators was presumed to be disaggregated to cover most of the marginalized population groups discussed above.

Finally, the databases were explored to examine whether these addressed either of the three dimensions of Universal Health Coverage (UHC) e.g., population covered, services provided, and financial protection by the global indicators fixed for this purpose.

4.3 Real Time Data

The DGHS of the MoHFW has created a dashboard and DHIS2 online central database system to collect and monitor real time data from the field (DGHS, 2018). The system shows following data menus:

Dash Board Menu for Real Time Data-

- Primary Healthcare (PHC) Dashboard- Activity related data
- MNCH e-LMIS Dashboard- Data on district wise monthly facility level reporting (registered, reported, non-reported facilities) up to community clinics shows reporting and monthly medicine consumption rate by facility.
- MIS Line Director Dashboard shows-attendance system, training calendar, complaint, suggestion boxes, support ticket etc.
- PMR Line Director Dashboard shows- Training related data
- Health Work Force (HWF) Dashboard shows- Upazilla wise physicians distribution
- DGHS Logistic Status
- Healthcare Facility Register- Primary, Secondary, Tertiary, Daycare health facilities registered
- Health System Performance measurement Dashboard shows- Rank of all level healthcare facilities up to upazila health complex including community health services.
- Local Health Bulletin- Shows healthcare facilities reported/not reported for local health bulletin
- Health Indicators Dashboard shows- real time data available on UHC,

SDG indicators.

DHIS2 Online Database-

- DHIS2 Online Database- Have central database from upazila level to above and DHIS2 from union level to below facilities including community field workers for reporting

Bangladesh Health Observatory

- Health situation & interventions in Rohingyas at Cox's bazar. Data on forcibly displaced Myanmar national to Bangladesh includes data on settlement information, vulnerable, population distribution and distribution of diseases status (DGHS, 2018).

4.4 Surveillance databases

Besides, the BBS databases of the GoB, there are some NGOs, Government institutes and research organizations, who have their own surveillance system in the country to monitor their project and program data. These organizations are keeping their data on specific areas of health such as infectious disease, maternal & child health, HIV/AIDS, Neglected Tropical Disease (NTDs) etc. Though the country is shifted from communicable disease to a mix of communicable and non-communicable diseases, there is no recognized national level surveillance system for monitoring the trend of non-communicable diseases.

Institute of Epidemiology, Disease Control and Research (IEDCR)

IEDCR or the Institute for Epidemiological and Communicable disease Research under the MoHFW, conducts surveillance as well as functioning of disease control programs mainly in the form of parasitic and entomological containment of vector borne diseases through application of epidemiological principles (IEDCR, 2012).

Table 13: Surveillance data on specific groups and areas

Groups addressed	Service area
Children	• Child Health and Mortality Prevention Surveillance (CHAMPS) Cholera
Young Children	Acute Pesticide Poisoning
HIV Patient	HIV Surveillance in Bangladesh
Rohingya refugees	Diseases in Rohingya migrnats, Diphtheria
Infectious disease patients	Tuberculosis, Hepatitis, Influenza, Kala-zar,Chikungunya, Measles Zoonotic Disease-Japanese Encephalitis and Nipah, Cutaneous Anthrax, Gonorrhoea,, Swine Flue
All	Cholera diarrhoea, jaundice and febrile illness Dengue, Non-communicable diseases

***Source-IEDCR, 2012, http://www.iedcr.gov.bd/index.php/surveillance*

Health and Demographic Surveillance System (HDSS) of the icddr,b in Matlab, Bangladesh

International Centre for Diarrheal Disease Research, Bangladesh, (icddr, b, former Pakistan SEATO Cholera Research Laboratory) set up a field diarrhea hospital in Matlab in December 1963 for evaluating acceptability, safety and efficacy of cholera vaccines, including oral rehydration therapy, and studying the epidemiology, prevention and treatment of diarrheal diseases and other public health interventions (Alam et al, 2017). A quasi-experimental maternal and child health and family planning (MCH-FP) programme in one half of the surveillance area, keeping the other half as comparison receiving usual government health services, covering 149 villages and a population of 172000 with the aim to estimate the programme effects on fertility and mortality reductions, using HDSS data. Vital events, migrations and maternal and child health information in each calendar year are processed to compute and compare health and demographic indices for preparing HDSS annual reports, with soft copies in web pages. From the HDSS routine annual reports, demographic trends in terms of change in fertility, age at marriage, population structure, mortality, cause of death, and life expectancy at birth, population movement etc. can be monitored and used as a reference for health service planning and delivery (Alam et al, 2017).

HDSS addressed following marginalized groups *(Please see Table 14)*-

Table 14: Targeted population and services provided

Groups addressed	Services provided
Women	Maternal health services
Newborn, Children	Child health services-especially diarrhoeal diseases
Community people	Diarrhoeal diseases

***Source- Alam et al, 2017*

Center for Disease Control and Prevention (CDC), Bangladesh

CDC, US has been collaborating with Bangladesh for the past 40 years—most recently to strengthen the country's capacity to detect emerging infectious diseases and to provide training and other interventions to partners (CDC, 2014). In 2012, CDC designated Bangladesh as a CDC Global Disease Detection Center for enhancing global health security for rapid detection and response to infectious diseases. A strong collaboration between CDC and the Institute of Epidemiology Disease Control and Research (IEDCR) within the Bangladesh Ministry of Health and Family Welfare (MOHFW) has further strengthened the country's ability to detect and respond to disease threats. Emerging infectious diseases, tuberculosis and zoonotic diseases are the areas they work on (CDC, 2014).

World Health Organization (WHO) Bangladesh
WHO Bangladesh provides technical support in strengthening national capacity for effective management of major communicable diseases (WHO, 2018b). WHO supports are targeted to the policy, institutional and operational level, and focused on capacity development measures, introduction of new and appropriate technologies, operations research on cost-effective and community-based horizontally integrated service delivery models, and improved epidemiological surveillance (WHO, 2018b). There area of work for strengthening surveillance system are as below (Please see Table 15)

The Centre for Injury Prevention and Research, Bangladesh (CIPRB)
The Centre for Injury Prevention and Research, Bangladesh (CIPRB) is a world leading injury prevention organization based in Bangladesh (CIPRB, 2014). Since CIPRB's inception it had been conducting injury surveillance from 2005 to 2010 in five (05) unions namely Dhubil, Ghurka, Brammagachha, Chandaikona and Dhangara at Raiganj upazila of Sirajganj district covering 43,729 households under Prevention of Child Injuries through Social-intervention and Education (PRECISE) project (CIPRB, 2014).

Table 15: Surveillance areas supported by WHO

Diseases	**Area of work**
Communicable disease	Avian and pandemic Influenza (API), Influenza Like Illness (ILI), Severe Acute Respiratory Illness (SARI) and Pneumonia RI, Nipah virus, Mycobacterial disease (Tuberculosis and Leprosy)
HIV/AIDs, STIs	Most vulnerable groups - Injecting Drug Users (IDU), female and male sex workers (FSW and MSW), men who have sex with men (MSM), and some of the bridge population.
Neglected Tropical Diseases	Malaria, Kala-zar Lymphatic Filariasis Dengue/

***Source- WHO, (2018d)*

Chapter 5

A WAY FORWARD FOR "ACHIEVING UHC BY 2030," LEAVING NO ONE BEHIND!

5.1 Summary of findings and conclusions

The concept of 'marginalization' and 'social exclusion' is 'highly depending on the historical and socio-economical context of a society.' No formal/standard/legal/universally agreed definition or benchmark has been found across ministries/sectors/agencies in Bangladesh and identify the 'population left behind.' The least that came out of the RR is that 'marginalizaion' is 'a process, originating from lack of awareness or negative attitudes of the larger society, by which certain population groups are denied access to resources and services essential for living a decent life' and 'social exclusion' is 'a process that involves the systematic denial of entitlements to resources and services...on the basis of ethnicity, race, religion, sexual orientation, caste, descent, gender, age, disability, HIV status, migrant status or where they live.'

The underlying causes for marginalization and social exclusion include ethnicity, extreme poverty, caste-based social system and associated stigma, migration (e.g., rural to urban migration, landing in pavements or slums), weak and poorly-resourced and inefficient health systems failing to reach these populations, and lack of understanding and respect for human rights. Like the underlying causes, the process of margnalisation/social exclusion is also varied. The process involve structural barriers to education, employment, and land and other resources; patriarchal attitude and norms of the society; life-styles associated with extreme poverty and destitution; hazardous occupation for survival such as scavenging, ship-breaking, medical waste handling; spatial remoteness; suffering from disease(s) with a social stigma e.g., TB, HIV/AIDS, Leprosy; having physical and/or mental disabilities; differing sexual orientation including sex trading; and consequences of migration.

Existing policies failed to go more in-depth into the problem and identify the needs and priorities of these populations. The current Social Safety Net programme of the government, consolidating hitherto existing multiple, fragmented, and small-scale safety-net programmes into its social development activities, are not comprehensive and inclusive and fraught with abuse and misuse. The great proportion of the marginalized and socially excluded groups are deprived from the very basic/essential health care services from the formal system, giving rise to large 'unmet health needs'. The national databases, as well as some surveillance databases, do not collect and present disaggregated data beyond some common variables, and

beyond sub-district level. Thus, there is a large gap in data for taking evidence-based decision and policies and programmes to cover these populations, on the journey towards UHC by 2030!

5.2 Recommendations

Based on the findings above, the following **recommendations** are made:

- There is an urgent need for developing a **consensus regarding the concept** of 'marginalisation and social exclusion' at the policy and practice levels (across ministries, sectors and agencies), for bringing relevant stakeholders on board and developing an integrated, comprehensive and customized intervention for the above population groups.

- For developing evidence-based and targeted interventions for implementing UHC for these groups, the **current data gaps need to be urgently addressed**. For example, concerted and concentrated advocacy will be needed to include the information of these groups in the coming rounds of survey of the national databases e.g., BDHS, HIES, FSNSP, BBS SRS, MICS, BD UHS etc. (based on ethnicity, caste, sexual orientation, sex work, spatial location, disability etc. as discussed in the report). Besides, the current surveillance systems in public and non-state sectors also need to be updated along this line.

- As these populations are sometimes concentrated in specific pockets of the country, these should be included as special statistical entities so that data depths are not lost. We need to go beyond currently used geographical levels of data collection e.g., the PSUs in the BBS surveys.

- In the short term, a nationwide sample survey on the marginalized and socially-excluded groups, using cluster sampling method, can be done to feed the policy makers and the programme developers. This will help **immediate actions to accelerate their journey towards UHC by 2030**, along with the mainstream population.

- These customized and specific **interventions should be culture and context sensitive** to succeed. Implementation research may be needed to understand their perspectives about illnesses and diseases (Emic and etic perspectives), needs and priorities regarding their health care needs and expectations.

- A supra ministerial **coordination mechanism** including the NGO and other non-actor sectors
(backed by PM's office and other centres of power in the current political context) will be needed to see that the policies and programmes are translated into real-life actions, and not drowned under bureaucratic 'in-action,' keeping in mind UHC 2030 commitment of the government and 'leaving no one behind.'

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Annex 1

Availability of data to monitor SDG indicators

SDG Goals	Availability of data to monitor SDG Indicators					
	Readily Available		Partially Available		Not Available	
	No.	%	No.	%	No.	%
1-No poverty	5	42	6	50	1	8
2-Zero hunger	5	36	9	64	0	0
3-Good health & well being	12	46	10	38	4	15
4-Quality education	2	18	6	55	3	27
5- Gender equity	8	57	4	29	2	14
6-Clean water & sanitation	2	18	4	36	5	45
7-Affordable energy	1	17	4	67	1	17
8-Work& economic growth	5	29	9	53	3	18
9-Industry, infrastructure	5	42	6	50	1	8
10- Reduced inequalities	7	64	1	9	3	27
11-Sustainable communities	2	13	8	53	5	33
12-Responsive production	0	0	4	31	9	69
13-Climate action	1	14	2	29	4	57
14-Life below water	1	10	3	30	6	60
15-Life on land	3	21	6	43	5	36
16-Peace, justice	4	17	10	43	9	49
17-Partnership	7	28	16	64	2	8
	70	29	108	45	63	26

**Source-GED, 2017b

Annex 2

Tracking SDG 3: Good Health and well-Being

Sustainable Development Goals 3/ Targets	Proposed Global Indicators for Performance Measurement	Status of Data Availability	Baseline figure with sources	Milestone by 2030	Relevant Ministry/ Division/ Agency to Generate/ Provide Data
3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births	3.1.1 Maternal mortality ratio	Readily Available	181 (SVRS, 2015); 176 (MMEIG2015)	70	a) BBS (SVRS), SID b) NIPORT (BMMS), MoHFW
	3.1.2 Proportion of births attended by skilled health personnel	Readily Available	42.1 (BDHS, 2014) 43.5 (MICS, 2012- 13);	80	a) BBS (MICS), SID b) NIPORT (BDHS), MoHFW c) NIPORT (UESD), MoHFW
3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under 5 mortality to at least as low as 25 per 1,000 live births	3.2.1 Under-five mortality rate	Readily Available	36 (SVRS, 2015); 37.6 (UNIAGCME2015); 46 (BDHS, 2014)	25	a) BBS (SVRS), SID b) NIPORT (BDHS), MoHFW
	3.2.2 Neonatal mortality rate	Readily Available	20 (SVRS-2015); 23.3 (UNIAGCME2015); 28 (BDHS-2014);	12	a) BBS (SVRS), SID b) NIPORT (BDHS), MoHFW

Sustainable Development Goals 3/ Targets	Proposed Global Indicators for Performance Measurement	Status of Data Availability	Baseline figure with sources	Milestone by 2030	Relevant Ministry/ Division/ Agency to Generate/ Provide Data
3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations	Readily Available	0.004 (2016); <0.01(2015) (UNAIDS, 2016)	0.001	a) DGHS (NASP), MoHFW b) IEDCR, MoHFW c) NIPORT, MoHFW
	3.3.2 Tuberculosis incidence per 1,000 population	Readily Available	2.27 (2014) (WHO, 2016); 4.04 per 1,000 (2015)	1.5	a) BBS (HMSS), SID b) NTP, DGHS, MoHFW c) NIPORT, MoHFW
	3.3.3 Malaria incidence per 1,000 population	Readily Available	4.3 (2014) (MCP, 2015);	0	a) BBS (HMSS), SID b) MCP, DGHS, MoHFW c) NIPORT, MoHFW
	3.3.4 Hepatitis B incidence per 100,000 population	Readily Available	546 (2014)	250	
	3.3.5 Number of people requiring interventions against neglected tropical diseases	Readily Available	49,873,889 (2014) (WHO2016)	35,000,000	a) CDC Unit, DGHS, MoHFW b) NIPORT, MoHFW

Sustainable Development Goals 3/ Targets	Proposed Global Indicators for Performance Measurement	Status of Data Availability	Baseline figure with sources	Milestone by 2030	Relevant Ministry/ Division/ Agency to Generate/ Provide Data
3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being	3.4.1 Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	Partially Available	17.5% (2012) (WHO 2016);	5.84	a) NCDC Unit, DGHS, MoHFW b) MIS, DGHS, MoHFW c) BBS (SVRS), SID
	3.4.2 Suicide mortality rate	Partially Available	6.57 (2012) (WHO-2015);	2.9	a) BP, MoHA b) NIPORT, MoHFW
3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	3.5.1 Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	Partially Available			a) Dept. of Narcotics Control, MoHA b) MIS, DGHS, MoHFW
	3.5.2 Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	Not Available	0.2 (2015) (WHO-2016)	0.1	

Sustainable Development Goals 3/ Targets	Proposed Global Indicators for Performance Measurement	Status of Data Availability	Baseline figure with sources	Milestone by 2030	Relevant Ministry/ Division/ Agency to Generate/ Provide Data
3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents	3.6.1 Death rate due to road traffic injuries	Partially Available	1.49 (BP, 2015) 13.6 (2013) (WHO-2016)	1.0	a) BP, MoHA b) MIS, DGHS, MoHFW c) BRTA, RTHD
3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	Readily Available	72.6% (2014) (BDHS-2014)	100%	a) BBS (SVRS), SID b) NIPORT (BDHS), MoHFW c) BBS (MICS), SID d) MIS, DGFP, MoHFW
	3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	Readily Available	75 (SVRS, 2015); 83 (MICS 2012- 13); 113 (BDHS 2014)	40	a) BBS (SVRS), SID b) NIPORT (BDHS), MoHFW
3.8 Achieve universal health coverage, including financial risk protection, access to quality essential	3.8.1 Coverage of essential health services (defined as the average coverage of essential services based	Partially Available			a) DGHS, MoHFW b) NIPORT (BDHS), MoHFW c) HEU, MoHFW

Sustainable Development Goals 3/ Targets	Proposed Global Indicators for Performance Measurement	Status of Data Availability	Baseline figure with sources	Milestone by 2030	Relevant Ministry/ Division/ Agency to Generate/ Provide Data
health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	on tracer interventions that include reproductive, maternal, new-born and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)				
	3.8.2 Number of people covered by health insurance or a public health system per 1,000 population	Partially Available			HEU, MoHFW
3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination	3.9.1 Mortality rate attributed to household and ambient air pollution	Not Available	68.2 (2012) WHO		a) DGHS, MoHFW b) Inspection for Factories and Establishments, MoLE c) NIPORT, MoHFW

Sustainable Development Goals 3/ Targets	Proposed Global Indicators for Performance Measurement	Status of Data Availability	Baseline figure with sources	Milestone by 2030	Relevant Ministry/ Division/ Agency to Generate/ Provide Data
	3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	Not Available	5.96 (WHO 2016) 5.72 (WHO 2016)	4.5	a) DGHS, MoHFW b) NIPORT, MoHFW
	3.9.3 Mortality rate attributed to unintentional poisoning	Not Available	68.2 (2012) WHO	4.0	a) DGHS, MoHFW b) NIPORT, MoHFW
3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate	3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older 3	Partially Available	43.3% (2009) Female: 29, Male: 58 (WHO, 2015)	25%	MoHFW
3.b Support the research and development of vaccines and medicines for the communicable and	3.b.1 Proportion of the population with access to affordable medicines and vaccines on a sustainable basis	Partially Available	All vaccines coverage: 78% (BDHS 2014)	100%	a) ERD b) MoHFW

Sustainable Development Goals 3/ Targets	Proposed Global Indicators for Performance Measurement	Status of Data Availability	Baseline figure with sources	Milestone by 2030	Relevant Ministry/ Division/ Agency to Generate/ Provide Data
non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all					

** Source- Data Gap Analysis of Sustainable Development Goals (SDGs): Bangladesh Perspective, Planning Commission, GED, 2017, Eradicating Poverty and Promoting Prosperity in a Changing World: Voluntary National Review (VNR), 2017)

Annex 3

RR PROTOCOL

Background of Rapid Review

Healthcare decision makers are increasingly in need of evidence-based reports in limited timeframes to support informed decisions [1]. Despite increasing demands to produce timely and relevant research findings, our traditional research process remains painstakingly slow [2]. This has led to the evolution of '**Rapid Reviews' (RRs)**, with no common description of their purpose, methods, and format as they vary in time to completion, report format, literature search strategies, and methods used for evidence synthesis [3]. The RRs method has emerged as a streamlined approach to synthesis evidence in a timely manner typically for the purpose of informing emergent decisions faced by decision makers in health care settings [4]. WHO defines RRs as a type of knowledge synthesis in which systematic review process are accelerated and methods are streamlined to complete the review more quickly than is the case for typical systematic reviews [5]. Although the definition of RRs can vary, typically they are characterized by a strong focus on the specific needs of decision makers and by methodological shortcuts [6]. Watt et al. stated that RRs are instrumental in answering specific policy questions. Further, RRs should not be viewed as inherently inferior to full systematic reviews. Watt et al found that the overall conclusions did not differ much between RRs and traditional SRs [3].

Rational of choosing Rapid Review as Study Method:

On the above mentioned background, we will conduct the study entitled '***Leave No One Behind: Putting marginalized people into the center for achieving Universal Health Coverage in Bangladesh***' applying a RRs method due to time and resource constrains for summarizing evidences for policy and programmatic actions on 'marginalised population' in national context.

Research Question

What are the data/knowledge gaps regarding 'availability, accessibility, affordability, acceptability and effective coverage' of health care services for different 'marginalized' groups, how to ensure their inclusion in the mainstream health system, and what needs to be done at the policy and programme levels for achieving universal health coverage in Bangladesh by 2030?

Research Objective

To identify the knowledge gaps regarding health care needs and services for the marginalized populations, process and underlying factors for their exclusion, and how these can be addressed/what needs to be done to overcome this in the policy and practice levels for achieving an inclusive and 'universal' health coverage by 2030.

Specific objectives

- To define and identify the 'marginalized' groups of population in national context who are 'left behind' /health care needs not adequately addressed due to 'social exclusion' problems
- To 'capture the factors' leading to marginalization in the national context
- To explore the existing databases (both public and non-state sectors) for the availability of segregated data by identified categories of 'marginalized' populations
- To explore the 'unmet health needs' of the 'marginalized' populations in the context of universal health coverage
- To explore the knowledge gaps and ways to better align policies and programmes for including/mainstreaming 'marginalised' populations

Rapid Reviews Method

Definition and background of RRs has already been described in the first section of this document. We will conduct the RR following the WHO outlined standardize steps [5] for RRs (Please see Table 1 for summarized steps & Table 2 for details of the steps).

Table 1: Rapid Review Process- Summarised steps

Review stage	Number of reviewers	Timeline (Weeks)
All levels of data screening	3	1
Data extraction	3	1
Data review	3	1
Data synthesis& analysis	4	1
Narrative reporting	4	4

Table 2: Rapid Review Process- Details of Steps

Rapid Review Steps	Methods	Key considerations
Need assessment	The broader project was generated from the need to share data and experiences, thus need assessment has already been covered.	Discussion held with requester to ascertain intended purpose, scope, timeline and ensure proposed approach fits the interned purpose.
Topic selection Topic refinement	The topic was assigned under the broader research objective by the requester Discussion held with requester to obtain clarity on objective , study population, timeline and key research question	A preliminary literature search was done to inform conversation with requester and to scope the review. Mapped the mandate to timeline and deliverables.
Protocol development	Used WHO RRs guideline and reporting items for protocol development	This protocol has been developed to serve as point of reference to avoid deviations
Literature search	Search will use electronic database, grey literature and hand search of web sites.	Search will be done by reviewer 1 &2, verified by reviewer 3, under guidance of PI
Screening and document selection	Applying inclusion, exclusion criteria screening and selection will be done. The criteria's will be followed strictly consistently	Screening and selection will be done by reviewer 1&2, verified by reviewer 3, under guidance of PI
Data extraction	Data will be extracted using the extraction templates. Extraction will be limited key concepts of the study	Data extraction will be done by reviewer 1&2. Reviewer 3 will randomly check the data accuracy
Risk-of-bias assessment/Quality assessment	Will strictly adhere to review protocol.	More than two reviewers will be involved in the overall process with verification by the third one under guidance of PI

Rapid Review Steps	Methods	Key considerations
Knowledge synthesis	Data will be synthesized and analysed into themes-subthemes. Framework analysis approached will be used to analyse data.	Narrative summarises will be produced
Report writing	Report template will be developed, shared among the partners and finalised incorporating feedbacks	Report will address the research question and present evidence in regard to the study objective

Scope:

The Rapid Review will be conducted using electronic databases, grey literatures and hand search of relevant documents to explore the scenario of 'marginalized' population, their health need in the country and how this health care need is addressed in practice and policy context. The scope includes-

- Scenario of 'marginalized' population in terms of health care needs
- Availability of segregated data on 'marginalized' population
- Knowledge gaps in terms of 'marginalized' population healthcare needs
- Current access to health care scenario of 'marginalized' population in Bangladesh
- Aligning health care need of 'marginalized' population through policy and practice of health system in the context of Bangladesh

Key concepts

Marginalized populations: Are those excluded from mainstream social, economic, cultural, or political life [7].

Vulnerability: It means 'capable of being physically wound', 'open to attack or, damage'. The concept of vulnerability lead to need, risk, susceptibility to harm or, neglect and lack of durability and capability among people by sex, race, age and ethnicity within family structure, marital status, social networks and access to neighborhood resources like school, colleges, hospitals etc. [8].

Health system: The combination of resources, organization, financing and management that culminate in the delivery of health services to the population [9].

Healthcare sector: An economic and social sector concerned with the provision, distribution and consumption of healthcare services and related products [10].

Universal Health Coverage (UHC): Universal health coverage is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services [11].

The goal of universal health coverage is to ensure that all people obtain the health services they need without suffering financial hardship when paying for them [12].

Eligibility criteria

Inclusion criteria: 'marginalized' population related documents focusing on health sector (Peer-reviewed, full-text articles, all methods, all design, published and unpublished)
Exclusion criteria: Documents that do not focus on 'marginalized' population (Published and unpublished)

Time period: From 2000 to 2018 (better not go beyond year 2000 unless absolutely necessary)
Language restriction: English only
Country to cover: Bangladesh
Information Sources:
Databases to be searched for published journal articles-

- Google, Google Scholar, PubMed

Sources of grey literatures-

- Books/Book chapters/Monograph/Dissertations/Workshop presentations/conference proceedings (print and on-line)
- Blogs ('Marginalization' & 'health care' related blogs in English)
- Online platforms such as Academia.edu, www.businessdictionary.com/definition/marginalization.html, http://counselingcenter.syr.edu/social-justice/impact-of-marginalization.html etc.

Sources of hand searches-

- Websites of Government Directorate like DGHS, DGFP, DGDA, DGNM etc.
- Website of National level organizations which are working for 'marginalized' population in Bangladesh like CARE, Manusher Jonno Foundation, CDD, HI, IOM etc.
- Website of National level organizations which are working to achieve universal health coverage in Bangladesh like icddr,b, Unicef etc.

- Journal (s) databases (e.g. PLoS ONE, Health Policy and Planning, Scientific Reports, Journals on Administration and Governance etc.)

Key search terms

Following identified key terms along with its different forms will be used to search the relevant documents (*Please see Table 3 for key search terms)*

Table 3: Key search terms to be used

Key terms to be used	Different forms of the selected key terms to be used
Marginalization	Marginality, Marginal, Marginalized, Vulnerable, Vulnerability, Minority
Marginalized groups/population	Ethnic, Ultra-poor, Migrants, Disable, Elderly, Adolescent, Victims, Transgender, LGBT, Occupational
Health care	Healthcare services, Health system, Healthcare facilities, health care policy, Healthcare programmes, Healthcare provider
Universal Health Coverage	Universal Health Coverage concept, Progress towards Universal Health Coverage, Indicators of universal health coverage, Implementation of universal health coverage, Monitoring of universal health coverage
Country	Bangladesh

Boolean Operators

1. ((“Marginalized” OR “marginality” OR “marginalization” OR “marginal” OR “vulnerable” OR “vulnerability” OR “minority” OR “ethnic” OR “ultra-poor” OR “migrants” OR “disabled” OR “elderly” OR “adolescents” OR “transgender” OR “ occupational marginalized”) AND (“Bangladesh”))

2. ((“Types of marginality” OR “Forms of marginalization” OR “types of marginal” OR “types of vulnerability” OR “ types of vulnerability” OR “types of vulnerable population” OR “forms of minority” OR “types of ethnic” OR “ultra-poor” OR “migrants” OR “types of disability” OR “elderly” OR “adolescents” OR “transgender” OR “types of occupational marginalized”) AND (“Impact of marginalization” OR “impact of vulnerability” OR “ impact of minority” OR “Effect on marginalized population” OR “ effect on vulnerable population” OR “effect on

minority" OR "Factor triggering marginalization" OR "factors triggering vulnerability" OR "factors triggering minority" OR "conditions creating vulnerability" OR "conditions creating minority" OR" Conditions creating marginalization") AND ("Bangladesh"))

3. (("Marginalized" OR "marginality" OR "marginal" OR "marginalization" OR "vulnerability" OR "vulnerable" OR "minority" OR "minority" OR "ethnic" OR "ultra-poor" OR "migrants" OR "disabled" OR "elderly" OR "adolescents" OR "transgender" OR " occupational marginalized") AND ("Health sector" OR "Hospital" OR "healthcare center" OR "health facilities" OR "health service" OR "health System" OR " health service provider") AND ("health worker" OR "service provider" OR "health care policy") AND ("Bangladesh"))

4. (("Types of marginalized OR "Forms of marginalization" OR "marginal" OR "behavior of marginalized population" OR "types of minority" OR " types of vulnerability" OR "types of vulnerable population" OR "forms of minority" OR "types of ethnic" OR "ultra-poor" OR "migrants" OR "types of disability" OR "elderly" OR "adolescents" OR "transgender" OR "types of occupational marginalized") AND ("impact of marginalization" OR "effect on marginalized population" OR "impact of vulnerability" OR " effect on vulnerable population" OR "factor triggering marginalization" OR "Conditions creating marginalization" OR "factors triggering vulnerability" OR "factors creating minority population") AND ("health sector" OR "hospital" OR "healthcare center" OR "health facilities" OR "health service" OR "health care policy") AND ("health worker" OR "health service provider") AND ("Bangladesh"))

5. (("Universal health coverage" OR "progress towards universal health coverage" OR" indicators of universal health coverage" OR " implementation of universal health coverage" OR "monitoring of universal health coverage") AND ("Bangladesh"))

6. (("Universal health coverage" OR "progress towards universal health coverage" OR" indicators of universal health coverage" OR " implementation of universal health coverage" OR "monitoring of universal health coverage" OR "marginalized" OR "vulnerable" OR " vulnerability" OR "marginal" OR "marginality" OR "marginalization" OR "vulnerable" OR "vulnerability" OR "minority" OR "ethnic" OR "ultra-poor" OR "migrants" OR "disabled" OR "elderly" OR "adolescents" OR "transgender" OR " occupational marginalized" OR "health seeking behavior" OR "health care" OR "health system" "Health sector" OR "Hospital" OR "Healthcare center" OR "Health facilities" OR "Health service" OR "Health System" OR " Health service provider") AND ("Bangladesh"))

Ensuring standard reporting items

As per WHO guideline, the proposed RRs protocol has addressed the suggested reporting items as below (Please see table 4 for standard reporting items)

Table 4: Standard Reporting Items

Category	Items Considered
Research question, objective	√
Scope	√
Comprehensiveness	√
Rigour and quality control	√