NCDs POLICY BRIEF - BANGLADESH

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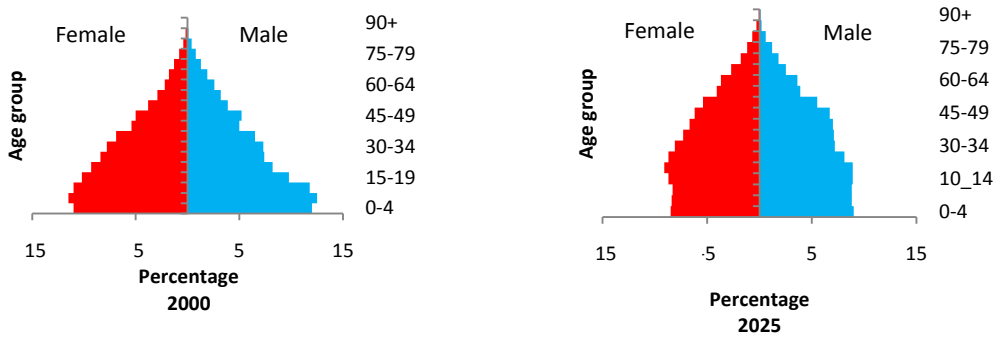
NON-COMMUNICABLE DISEASES (NCDS)[1] – BANGLADESH'S NEXT MAJOR HEALTH CHALLENGE

This policy brief is based on the World Bank's recent publication: Capitalizing on the Demographic Transition: Tackling Non-communicable Diseases in South Asia (2011). It assesses the NCD burden and develops policy options at both country and regional level.

✓ ***Population aging will increase in the future*** (Figure 1). The proportion of the population 65 years and older will move from 4.5 percent, in 2000, to 6.6 percent, in 2025. Older populations are more likely to be affected by NCDs. Thus, the health burden from NCDs will rise in parallel with aging.

Figure 1: Population structure in Bangladesh in 2000 and 2025



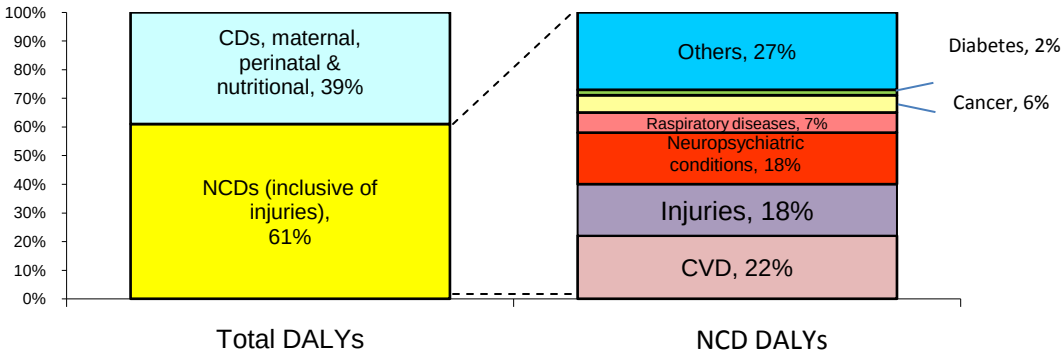
Source: U.S Census Bureau. www.census.gov/ipc accessed July 1, 2010.

✓ ***NCDs now impose the largest health burden in Bangladesh.*** In terms of the number of lives lost due to ill-health, disability, and early death (DALYs)[2], NCDs (inclusive of injuries) accounts for 61 percent of the total disease burden while 39 percent is from communicable diseases, maternal and child health, and nutrition, all combined (Figure 2).

✓ ***Cardiovascular diseases (CVD), injuries, mental health, cancer, chronic respiratory diseases, and diabetes are the major NCDs.*** (Figure 2). Among CVDs, ischemic heart disease (IHD) is the leading cause of death in the country. Among injuries, road traffic injuries are the most common cause of serious injuries among men (40–45 percent among urban men). Among children, drowning and road traffic injuries accounts for more than 70 percent of injury-related deaths. Indoor air pollution from burning solid fuels, used by nearly 90 percent of the population, is responsible, along with tobacco, for chronic respiratory diseases including asthma and chronic obstructive pulmonary disorder (COPD). Diabetes is more prevalent in rural areas.

✓ ***Prevalence of adult smoking is higher than other South Asian countries.*** The prevalence is 47 percent for males and 4 percent for females. Smoking among youth is also relatively high.

Figure 2: Pattern of overall DALYs (age standardized) and NCD related DALYs in Bangladesh, 2004



Source: World Health Organization, Global Burden of Diseases http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html

BANGLADESH'S RESPONSE TO NCDS

POLICY

Bangladesh recognizes NCDs as a major health threat and much progress has been made in policy development. However, implementation has been slow. A comprehensive national NCD plan, the ***Strategic Plan for Surveillance and Prevention of Non-communicable Diseases in Bangladesh, 2007–2010***, has been adopted. However, implementation has been stalled by several issues including lack of clear lines of responsibility, absence of dedicated financing, and competing priorities. The ***Health Nutrition and Population Sector Program***, Bangladesh's five-year plan for health, identifies three NCDs—cancer, CVD, and diabetes—as major public health problems. The current Strategic Investment Plan is notable for including prevention and control of major NCDs. The plan recommends that (i) the public sector focuses on prevention and (ii) investment in intensive care units and tertiary care services be left to the private sector. The plan proposes publicly financed insurance and health vouchers to protect the poor against the costs of emergency care and catastrophic illnesses. However, efforts towards NCDs prevention and treatment have been lower priority in light of the current focus on the MDGs.

Several NCD preventive health policies have also been adopted. Bangladesh has ratified the Framework Convention on Tobacco Control (FCTC) and the ***Smoking and Tobacco Product Usage (Control) Act 2005*** which restricts smoking in public places and advertizing. In parallel, a ***National Strategic Plan of Action for Tobacco Control, 2007–2010***, has been adopted. For cancer control, the ***National Cancer Control Strategy and Plan of Action 2009–2015*** has been adopted.

HEALTH SERVICE DELIVERY

Health workers are not trained in NCD treatment in the primary health care system. Currently, NCD treatment comes mostly from the tertiary level. Bangladesh has a long tradition of specialty hospital and foundations in both public and private/NGO sectors that provide individual-based clinical care for NCDs and focus less on preventive care. NCD prevention and treatment services are not included in the essential services package in the public sector primary care system. Most, including the poor, use private practitioners for first-line clinical care. Clinical treatment is also sought from the informal sector and through pharmacies, both licensed and unlicensed. Diabetes, stroke, heart diseases, and their symptoms are routinely considered appropriate for treatment outside the formal health care system.

Bangladesh has a national essential drugs policy and a list of essential drugs to be procured and used in the public health services system. Most of the essential drugs are generics. However, **drugs for treating NCDs are not included in the essential drug list.**

PROGRAM

NGOs are actively involved in NCD-related programs. There is a low supply of health worker and few are trained in NCD prevention and management. The ***Diabetic Association of Bangladesh*** and ***the Bangladesh Institute of Research and Rehabilitation for Diabetes, Endocrine and Metabolic Disorders (BIRDEM)*** opened the Bangladesh Institute for Health Sciences Academy to produce adequate qualified human resources for all medical institutions in the country. Also, the National Institute of Cardiovascular Disease offers postgraduate courses for cardiology and training in CVD for nurses and paramedics. The National Institute for Diseases of the Chest & Hospital offers postgraduate training on chest disease (medical and surgical).

A public–private Health Care Development Project is being undertaken by the Diabetic Association of Bangladesh to test a model of integrated care service delivery for NCDs in urban and rural areas. Integrated care in this project includes a spectrum of services—not

just diabetes care—and includes primary, secondary and, through referrals, tertiary care.

SURVEILLANCE

Currently there is no surveillance of NCD-related morbidity and mortality or a cancer registry. ***The Bangladesh Network for Non-Communicable Disease Surveillance and Prevention (BanNet)*** data network has been created, involving government and private clinical institutions. The ***Alliance for Community Based Surveillance (ACSNet)*** is also promoting periodic population-based surveys of NCDs and their risk factors. The ***Matlab Health Research Center***, in rural Bangladesh, monitors population and health indicators for approximately 225,000 residents. At present it routinely collects some NCD-related risk factors, morbidity, and mortality data. A ***national risk factor survey*** is planned for completion in 2010. The ***2006 Bangladesh Urban Health Survey*** included NCD-related items in slum and non-slum areas of the six largest city corporations in the country. The ***2003 Bangladesh Health and Injury Survey (BHIS)*** was the largest injury survey conducted in a developing country. ***The new Center for Control of Chronic Diseases in Bangladesh (C3D)*** aims to bring scientific rigor to the study of the NCD burden; develop community-based prevention and management programs; evaluate the link between NCDs and poverty in the country; and characterize the health systems' response to NCDs.

FINANCE

In 2008, total expenditures on health amounted only to 3.5 percent of GDP, the second lowest in the region. **Household out-of-pocket expenditures at drug outlets account for nearly half (46 %) of total health sector's expenditures**, making household over-the-counter purchases of drugs by far the single largest expenditure item within the sector.

POLICY OPTIONS FOR BANGLADESH

The World Bank's recent publication: Capitalizing on the Demographic Transition: Tackling Non-communicable Diseases in South Asia (2010) introduces a policy framework for identifying NCD-related policy options. The options below follow this framework.

RETOOL HEALTH SERVICES DELIVERY FOR NCDS

Some efforts have been made to train health work force in NCDs. Still, the physician and non-physician workforce need treatment guidelines, knowledge, and skills to diagnose and treat NCD within the primary care system. Pilots to understand best practices, and those appropriate for the Bangladesh context, are needed. In addition adequate supply and access to the essential medications is keenly needed especially for the poor. Finally, sensitization of the population to the use of allopathic medicine and its benefits are needed.

STRENGTHEN TOBACCO CONTROL POLICIES

Some progress has been made with a national tobacco policy. However, tobacco use remains high among both adults (mostly men) and children. Expanding on the core FCTC activities is needed.

STRENGTHEN INJURY CONTROL POLICIES

Road traffic and childhood injuries have important preventable fractions, yet little policy attention has been directed towards their prevention.

DEVELOP A NATIONAL NCD SURVEILLANCE SYSTEM

Much has been done towards a national system. The national risk factor survey underway needs to be institutionalized and a strategy for injury surveillance is needed. Public and private institutions must be tapped and coordinated in support of NCD surveillance effort. In addition enhanced morbidity and mortality surveillance in subpopulations such as Matlab and BanNet are critical.

STRENGTHEN EVALUATE CAPACITY

Policies now in place, pilot studies, and intervention tested will all need solid evaluation. This will be especially the case for tobacco and injury policies.

PARTICIPATING IN REGIONAL COLLABORATION

Regional collaboration can be very effective for preventing and controlling NCDs. Several promising areas for regional cooperation have been identified. Actively participating in regional collaboration on NCDs prevention and control will synergize and possibly country efforts. Activities and opportunities include:

- Expanding and harmonizing tobacco advertising band to reduce demand
- Increasing and harmonizing tobacco taxation to reduce consumption
- Harmonizing tobacco taxes and strengthening anti-smuggling measures
- Standardizing and mandating food labeling policy to improve knowledge and awareness of food composition
- Collaborating on group purchasing of essential medications to increase their access and affordability
- Establishing a regional health technology assessment institution to improve the comparative effectiveness of interventions for NCDs and other conditions
- Using regional education and training capacity to complement the national needs for human resources in order to improve both staffing and skill levels
- Establishing a regional network of surveillance and burden assessment to improve national capacity through knowledge sharing and experience exchange

Reference

[1] Non-communicable Diseases (NCDs) are defined by World Health Organization to include chronic diseases, principally cardiovascular disease, diabetes, cancer, and asthma/chronic pulmonary disease (COPD), in addition to injuries and mental illness.

[2] Disability Adjusted Life Years (DALYs) are defined by World Health Organization as “the sum of years of potential life lost due to premature mortality and the years of productive life lost due to disability.”