ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: BANGLADESH

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ACRONYMS

APC	Advancing Partners & Communities
CBHC	Community-Based Health Care
CG	community group
CHCP	community health care provider
CHS	community health system
CSG	community support group
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
ESP	essential service package
FP	family planning
FWA	family welfare assistant
FWV	female welfare visitor
HA	health assistant
IUD	intrauterine device
HPNSDP	Health, Population, and Nutrition Sector Development Program
HPNSSP	Health, Population & Nutrition Sector Strategic Plan 2011–2016, Third Draft
HPSP	Health and Population Sector Program
MCWC	maternal and child welfare center
MNCH	maternal, newborn, and child health
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
NGO	nongovernmental organization
SACMO	sub-assistant community medical officers
SWAp	sector-wide approach
TB	tuberculosis
UHC	upazila health complex
UHFWC	union health and family welfare center
UHMC	upazila health management committee
ULB	urban local body
UPHCP	Urban Primary Health-Care Project
USAID	Unites States Agency for International Development
WASH	water, sanitation, and hygiene

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

BANGLADESH COMMUNITY HEALTH OVERVIEW

Over the past two decades, Bangladesh has focused on harmonizing its community health system. Previously, the health system relied on individual programs that specialized in specific health areas or vertical programs, making it difficult to coordinate cross-cutting aspects of community health. In the late 1990s, the Ministry of Health and Family Welfare (MOHFW) responded with a sector-wide approach (SWAp) to align and coordinate health planning and implementation. The SWAp created opportunities for the government to provide leadership across all health programs by improving coordination and streamlining donor-funded projects and resources. This single program was initially known as the Health and Population Sector Program (HPSP).

Over time, the country revised the SWAp, and the HPSP gradually incorporated initiatives to improve community health, particularly in rural areas. The MOHFW launched a pilot initiative to revitalize community health care by introducing community clinics, the lowest service delivery point for primary health care. Community clinics are now in place nationwide and serve as a cornerstone of the community health system in rural settings. The current version of the HPSP is the Health, Population, and Nutrition Sector Development Program (HPNSDP), which began in 2011.

Table 1. Community Health Quick Stats

Main community health policies/strategies	*Health, Population & Nutrition Sector Strategic Plan 2011 –2016, Third Draft*	*National Urban Health Strategy*	*Operational Plan Community-Based Health Care July 2011–June 2016; Health, Population and Nutrition Sector Development Programme*	*Operational Plan Essential Service Delivery July 2011 –June 2016; Health, Population and Nutrition Sector Development Programme*
Last updated	2010	2011	2011	2011
Number of community health provider cadres	3 main cadres			
	Community health care provider (CHCP)	Family welfare assistant (FWA)	Health assistant (HA)	
Recommended number of community health providers	13,500 CHCPs	*Information not available*	*Information not available*	
Estimated number of community health providers	13,622 CHCPs[1]	23,500 FWAs[2]	19,279 HAs[2]	
Recommended ratio of community health providers to beneficiaries	1 CHCP : 1 community clinic, or approximately 6,000 people	1 FWA : 500 couples	*Information not available*	
Community-level data collection	Yes			
Levels of management of community-level service delivery	National, district, upazila, union, ward			
Key community health program(s)	Community Based Health Care (CBHC); Health, Population, and Nutrition Sector Development Program (HPNSDP); Urban Primary Health-Care Project (UPHCP); additional programs operated by NGOs			

[1] As of June 2016.
[2] As of 2012.

Currently, a number of policies and guidance documents developed by the MOHFW shape the community health system. The *Health, Population & Nutrition Sector Strategic Plan (HPNSSP) 2011–2016, Third Draft*, lays out a strategic framework, including broad goals for the HPNSDP and its health initiatives. Activities are elaborated upon in the *Health, Population and Nutrition Sector Development Program (2011–2016) Program Implementation Plan*. Additional guidance documents provide specifics on HPNSDP services at the community level, known as the ward. These documents include the *Operational Plan Community-Based Health Care July 2011–June 2016*, and *Operational Plan Essential Service Delivery July 2011–June 2016*, both developed in 2011. The *National Urban Health Strategy 2011* guides community health in urban settings.

Despite the efforts to harmonize the health system through the SWAp, challenges remain. Implementation of the HPNSDP initiatives is split between two MOHFW directorates at the national level, the Directorate General of Health Services (DGHS), and Directorate General of Family Planning (DGFP), each with a separate health management information system. The *HPNSSP* suggests ways to manage the difficulties that arise from the split MOHFW structure in future iterations of the SWAp, but it does not provide specific plans or guidance for the immediate future. In addition, urban areas operate under a separate health system from rural areas. While still managed by the MOHFW, the urban health system is overseen jointly with the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC).

Gender is integrated into Bangladesh's strategy and guidance documents. For example, the *HPNSDP 2011–2016, Third Draft* prioritizes gender inequities in the health sector and gender-based violence.

Bangladesh's policies list civil society organizations and community groups as partners for ward-level service provision. The community clinic pilot initiative established community groups (CGs) to manage each community clinic, comprising 13–17 community members, one-third of whom are required to be women. CGs manage and oversee implementation of the HPNSDP at the ward level, and support community health providers to mobilize communities and raise funds. Community support groups (CSGs), made up of 10–15 local members, are groups that support the CGs oversee community clinics and conduct outreach to improve demand and uptake of services.

Table 2. Key Health Indicators, Bangladesh

Total population[1]	162.9 m
Rural population[1]	66%
Total expenditure on health per capita (current US$)[2]	$31
Total fertility rate[3]	2.3
Unmet need for contraception[3]	12%
Contraceptive prevalence rate (modern methods for married women 10-49 years)[3*]	54.1%
Maternal mortality ratio[4]	176
Neonatal, infant, and under 5 mortality rates[3]	28 / 38 / 46
Percentage of births delivered by a skilled provider[3]	43%
Percentage of children under 5 years moderately or severely stunted[3]	36%
HIV prevalence rate[5]	<0.1%

[1]PRB 2016; [2]World Bank 2016; [3]National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International 2016; [4]World Health Organization 2015; [5]UNAIDS 2015.
*The age range used to determine contraceptive prevalence rate in Bangladesh is 10–49, as opposed to 15–49.

Three cadres of community health providers are employed by the MOHFW at community clinics at the ward level: community health care providers (CHCPs), family welfare assistants (FWAs), and health assistants (HAs). Together, they provide the full range of services that are part of the HPNSDP, including health promotion, community mobilization, maternal, newborn, and child health (MNCH), immunization, FP, nutrition, tuberculosis (TB), and malaria. Other cadres of community health providers are supported by nongovernmental organizations (NGOs) to implement vertical health programs in Bangladesh. In addition, there are a number of types of informal providers including traditional birth attendants, traditional medicine and faith healers, and drug shop/pharmacy operators.

The HPNSDP is the main community health program in Bangladesh, providing health services for MNCH including immunization, FP, nutrition, neglected tropical diseases, non-communicable diseases, and communicable diseases including TB, HIV and AIDS, and malaria. Additional initiatives within the HPNSDP include the Community Based Health Care (CBHC) initiative, which is responsible for the community clinics. The health system in urban settings is managed by a separate program entirely, the Urban Primary Health-Care Project (UPHCP).

Over 4,000 NGOs operate in the health sector in Bangladesh. BRAC works in both urban and rural settings operating multi-sectoral programs in a variety of areas including family planning, nutrition, education, and urban development.

NGOs provide support at all levels of the health system and implement their own programs in coordination with the MOHFW. There are more than 4,000 NGOs working in the health sector in Bangladesh. Due to the breadth of NGOs and large number of programs they implement, this country profile focuses on government programs and cadres of community health providers.

LEADERSHIP AND GOVERNANCE

Community-level service delivery in Bangladesh is managed and coordinated across the national, district, upazila, union, and ward levels. Each administrative level has a distinct role in supporting community policy and program efforts. NGOs are heavily involved at all levels of the health system; they support management bodies and directly provide health services in urban and rural areas.

- At the **national level**, the MOHFW is responsible for the implementation, management, coordination and regulation of health-related policies, programs, and activities. Its core functions are policy and strategy planning, monitoring, and management of budgets, information, reform, and funding. The DGHS and DGFP are executive agencies within the MOHFW that develop and implement health programs, including the HPNSDP. The MOLGRDC and the MOHFW develop and implement health programs in urban areas. The national bodies also manage the appointment, transfer, posting, and salary of community health providers.
- A health administrator at the **district level** provides management and monitoring oversight for the upazila level and serves as a link between the upazila and national levels.
- At the **upazila** level, the upazila health management committees (UHMCs) oversee planning, budgeting, priority setting, implementation, supervision and reporting of community health services. Upazilas are equivalent to a sub-district, and vary in population and geographic size.
- Medical officers, sub-assistant community medical officers (SACMOs), and female welfare visitors (FWVs) based at union health and family welfare centers (UHFWCs) at the **union level** visit and support community clinics at the ward level. Unions are the smallest administrative unit in rural settings. Each union includes nine wards.
- At the **ward level**, CGs[1] are responsible for running community clinics, including maintenance, security, fundraising, and community mobilization. CSGs support the CGs to oversee community clinics and ensure that the level of services provided is acceptable. CHCPs, FWAs, and HAs based at each community clinic also provide services within the community.

As noted, the health system operates differently in urban and rural areas. Urban local bodies (ULBs) in large and small cities oversee primary health care through the UPHCP. The UPHCP operates as a public-private partnership between the government and NGOs, which implement and provide co-funding. Services are delivered at hospitals, urban clinics and dispensaries by trained medical staff. In addition to the UPHCP, clients in urban settings can access services at privately run health facilities, including clinics, diagnostic centers, and hospitals, and from community health providers working for NGO programs.

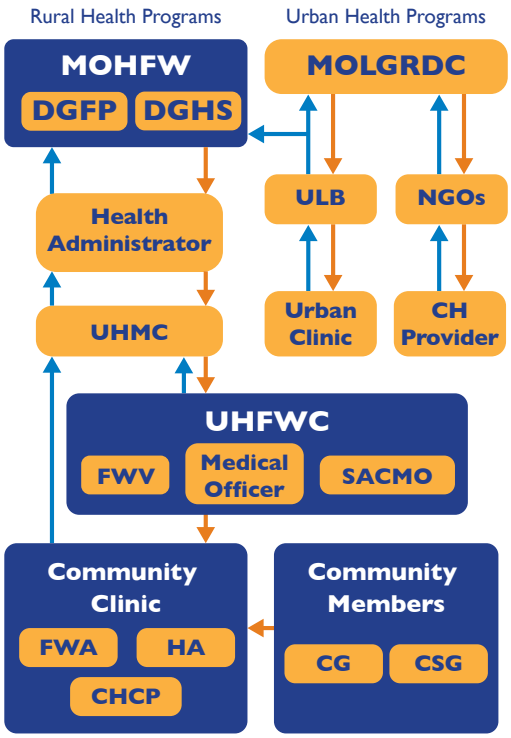
The health system differs between urban and rural settings in Bangladesh. In cities, the Urban Primary Health Care Project works to expand the availability of primary health care services, particularly for the urban poor. Clients access care at hospitals, urban clinics and dispensaries, as well as privately run health facilities.

Figure 1 summarizes Bangladesh's health structure, including service delivery points, key actors, and managing bodies at each level.

1 Community groups are sometimes referred to as community clinic management groups or community clinic management committees.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships*
National	MOHFW DGFP DGHS MOLGRDC	Specialized Hospital General Hospital	
District	Health Administrator	District Hospital Maternal and Child Welfare Center	
Upazila	UHMC	Upazila Health Complex	
Union	FWV Medical Officer SACMO	Union Health and Family Welfare Center	
Ward	CG CSG	Community Clinic CHCP, FWA, HA	



*NGOs provide support at all levels and work in close collaboration with the government in community health planning and implementation.

Supervision
Flow of community-level data

HUMAN RESOURCES FOR HEALTH

Three cadres of community service providers in Bangladesh—CHCPs, FWAs, and HAs—are stationed at community clinics. Employed by the government, they are the first line primary health care service providers. FWAs and HAs have existed within the health system for some time, while CHCPs were introduced in 2011 to help meet the increased demand for services created by the introduction of community clinics. The services each cadre provides vary slightly, but they have significant overlap. All three cadres provide basic curative and preventive care in a range of health areas including FP, MNCH, nutrition, and infectious diseases. FWAs and HAs are also trained as skilled birth attendants, and FWAs can provide emergency obstetric care. They spend the majority of their time based at the community clinic, but also conduct home visits and outreach clinics as needed, rotating visits so that the clinic is always staffed.

All three cadres receive support from and work closely with CGs and CSGs to ensure high-quality services, and increase demand for services. Additional types of community health providers—informal providers and providers who deliver services as part of NGO programs— operate in Bangladesh

Table 3 provides an overview of CHCPs, FWAs, and HAs.

Table 3. Community Health Provider Overview

	CHCP	FWA	HA
Number in country	13,622[1]	23,500[2]	19,279[2]
Target number	13,500	*Information not available*	*Information not available*
Coverage ratios and areas	1 CHCP : 1 community clinic or approximately 6,000 people Operate in rural areas.	1 FWA : 500 couples Operate in rural areas.	*Information not available* Operate in rural areas.
Health system linkage	CHCPs are employed by the MOHFW and provide services at government-run community clinics.	FWAs are employed by the MOHFW and provide services at government-run community clinics.	HAs are employed by the MOHFW and provide services at government-run community clinics.
Supervision	The CG and CSG oversee the management of the community clinic and the CHCPs who work there. A medical officer, SACMO, and FWV visit the community clinic on a monthly to weekly basis to ensure services are provided at the required standard.	The CG and CSG oversee the management of the community clinic and the FWAs who work there. A medical officer, SACMO, and FWV visit the community clinic on a monthly to weekly basis to ensure services are provided at the required standard.	The CG and CSG oversee the management of the community clinic and the HAs who work there. A medical officer, SACMO, and FWV visit the community clinic on a monthly to weekly basis to ensure services are provided at the required standard.
Accessing clients	On foot Bicycle Clients travel to them	On foot Bicycle Clients travel to them	On foot Bicycle Clients travel to them
Selection criteria	*Information not available*	*Information not available*	*Information not available*
Selection process	Recruitment is done at the national level. Some selection is done at the district level. Policy does not provide further information.	Recruitment is done at the national level. Some selection is done at the district level. Policy does not provide further information.	Recruitment is done at the national level. Some selection is done at the district level. Policy does not provide further information.

Table 3. Community Health Provider Overview

	CHCP	FWA	HA
Training	CHCPs undergo basic initial training for 12 weeks (6 weeks theoretical and 6 weeks practical). Refresher trainings are conducted as needed.	Policy is contradictory on the amount of training an FWA requires. A 2-month initial basic training on FP, nutrition, and common health issues is required, as are regular 5–6 day refresher trainings. The following are indicated in various policies: 6-month skilled birth attendant training 21-day essential services package (ESP) training Emergency obstetric care training	Policy is contradictory on the amount of training a HA requires. An initial basic training of undetermined length on FP, nutrition and common health issues is required, as are regular 5–6 day refresher trainings. The following are indicated in various policies: 6-month skilled birth attendant training for female HAs 21-day ESP training
Curriculum	*CHCP Training Manual, year unknown.*	*Information not available*	*Information not available*
Incentives and remuneration	CHCPs are paid salaries by the MOHFW. They may receive additional non-financial incentives as determined by the CG and CSG.	FWAs are paid salaries by the MOHFW. They may receive additional non-financial incentives as determined by the CG and CSG.	HAs are paid salaries by the MOHFW. They may receive additional non-financial incentives as determined by the CG and CSG.

[1] As of June 2016.
[2] As of 2012.

HEALTH INFORMATION SYSTEMS

Each directorate at the national level has its own health information system, including the DGHS and DGFP. In addition, the UPHCP submits data directly to the MOHFW and MOLGRDC. Each directorate reviews data submitted by the upazila and district levels and NGOs. The Monitoring & Evaluation Unit of the MOHFW is in the process of establishing a data management information system that will gather data from all of the directorates into one database, allowing for integration of information and joint planning and policy development.

CHCPs, FWAs, and HAs routinely collect and submit data on their service provision activities. Data are combined at each community clinic into a progress report that is submitted to the UHMC, which enters the data into the appropriate health information system. Specific forms that community service providers use are not mentioned in policy, other than the FWA register that is used to record FP services provided to couples.

The blue arrows in Figure 1 depict the flow of information through Bangladesh's health system.

HEALTH SUPPLY MANAGEMENT

CHCPs, FWAs, and HAs receive the supplies and products they need from the community clinic at which they are located. Each community health provider tracks his/her supply and product use, which is compiled into a larger register for the community clinic. When the community clinic needs supplies, a resupply request is submitted to the national level. All service delivery points at every level of the health system follow this process.

Policy does not specify a process for obtaining emergency supplies in case of stockouts. In practice, community health providers obtain emergency supplies from neighboring community clinics, UHFWCs, upazila health complexes (UHCs), and maternal and child welfare centers (MCWCs).

Table 4. Selected Medicines and Products Included in Bangladesh's *National Drug Policy with Essential Drug List and OTC List*, 2016

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☑	Calcium supplements
	☑	Iron/folate
	☐	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

Policy also does not specify where and how community health providers should dispose of medical waste.

The full list of commodities that CHCPs, FWAs, and HAs provide is not available, but information about selected medicines and products on the list of essential drugs in Bangladesh's *National Drug Policy with Essential Drug List and OTC List* (2016) is provided in Table 4.

SERVICE DELIVERY

Bangladesh's main service delivery package is the essential health service package (ESP), which was most recently updated in 2016. It includes maternal, newborn, child, and adolescent health, with sub-categories of maternal and newborn care, child health and immunization, and adolescent-friendly health services; FP; nutrition; and communicable diseases. The ESP specifies which services within those health topics should be provided at community clinics, as well as additional services to be provided at clients' homes and during outreach clinics.

Policy and training guide CHCPs, FWAs, and HAs to refer cases that are beyond their ability to treat to higher-level health facilities. Staff at health facilities typically counter-refer clients to CHCPs, FWAs, or HAs for follow-up.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Health posts or other facilities
	Periodic outreach at fixed points
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
Community mobilization	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

Using FP as an example, CHCPs, FWAs, and HAs can provide clients with condoms and oral contraceptive pills, and can provide injectable contraceptives to non-first time users. They can refer clients to:

- **UHFWCs** for methods provided by community health providers, as well as first doses of injectable contraceptives, implants, and intrauterine devices (IUDs).
- **UHCs and MCWCs** for methods provided at UHFWCs and permanent methods.

Table 6 provides details about selected interventions delivered by CHCPs, FWAs, and HAs in the following health areas: FP, maternal health, newborn care, child health and nutrition, TB, HIV and AIDS, malaria, and WASH.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP	Condoms	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
	CycleBeads®	Unspecified	Unspecified	Unspecified	Unspecified
	Emergency contraceptive pills	Unspecified	Unspecified	Unspecified	Unspecified
	Implants	Unspecified	No	CHCP, FWA, HA	Unspecified
	Injectable contraceptives	CHCP, FWA, HA	CHCP, FWA, HA[1]	CHCP, FWA, HA	CHCP, FWA, HA
	IUDs	Unspecified	No	CHCP, FWA, HA	Unspecified
	Lactational amenorrhea method	Unspecified		Unspecified	Unspecified
	Oral contraceptive pills	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
	Other fertility awareness methods	Unspecified		Unspecified	Unspecified
	Permanent methods	Unspecified	No	CHCP, FWA, HA	Unspecified
	Standard Days Method	Unspecified		Unspecified	Unspecified
Maternal health	Birth preparedness plan	FWA	FWA	FWA	FWA
	Iron/folate for pregnant women[2]	CHCP, FWA, HA	CHCP, FWA, HA	Unspecified	CHCP, FWA, HA
	Nutrition/dietary practices during pregnancy	CHCP, FWA, HA		Unspecified	CHCP, FWA, HA
	Oxytocin or misoprostol for postpartum hemorrhage	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
	Recognition of danger signs during pregnancy	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
	Recognition of danger signs in mothers during postnatal period	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
Newborn care	Care seeking based on signs of illness	CHCP, FWA, HA			CHCP, FWA, HA
	Chlorhexidine use	FWA	FWA	Unspecified	FWA
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	CHCP, FWA, HA		CHCP, FWA, HA	CHCP, FWA, HA
	Nutrition/dietary practices during lactation	CHCP, FWA, HA		Unspecified	CHCP, FWA, HA
	Postnatal care	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
	Recognition of danger signs in newborns	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	CHCP, FWA, HA	CHCP, FWA, HA	Unspecified	CHCP, FWA, HA
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years[3]	CHCP, FWA, HA	CHCP, FWA, HA	Unspecified	CHCP, FWA, HA
	Exclusive breastfeeding for first 6 months	CHCP, FWA, HA		Unspecified	CHCP, FWA, HA
	Immunization of children[4]	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
	Vitamin A supplementation for children 6–59 months	CHCP, FWA, HA	CHCP, FWA, HA	Unspecified	CHCP, FWA, HA
HIV and TB	Community treatment adherence support, including directly observed therapy	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
	Contact tracing of people suspected of being exposed to TB	No	No	No	No
	HIV testing	CHCP, FWA, HA	No	CHCP, FWA, HA	Unspecified
	HIV treatment support	CHCP, FWA, HA	No	CHCP, FWA, HA	Unspecified
Malaria	Artemisinin combination therapy	CHCP, FWA, HA	CHCP, FWA, HA[5]	CHCP, FWA, HA	CHCP, FWA, HA
	Long-lasting insecticide-treated nets	CHCP, FWA, HA	CHCP, FWA, HA	Unspecified	CHCP, FWA, HA
	Rapid diagnostic testing for malaria	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA	CHCP, FWA, HA
WASH	Community-led total sanitation	Unspecified	Unspecified		
	Hand washing with soap	CHCP, FWA, HA			
	Household point-of-use water treatment	Unspecified			
	Oral rehydration salts[5]	CHCP, FWA, HA	CHCP, FWA, HA	Unspecified	Unspecified

[1] CHCPs, FWAs and HAs can only provide injectable contraceptives to non-first time users.
[2] CHCPs, FWAs and HAs can also provide iron/folate to non-pregnant women and adolescent girls.
[3] CHCPs, FWAs and HAs can also provide de-worming medication to those other than children under 5 years.
[4] Immunizations provided for newborns include BCG, Penta, OPV, PCV, and IPV. Immunizations provided for children include BCG, Penta, OPV, PCV, IPV, and MR.
[5] CHCPs, FWAs and HAs can only provide artemisinin combination therapy for uncomplicated cases of malaria.

KEY POLICIES AND STRATEGIES

Ministry of Health and Family Welfare, Directorate General of Drug Administration, Government of the People's Republic of Bangladesh. 2016. *National Drug Policy 2016 with Essential Drug List and OTC List*. Available at: http://www.dgda.gov.bd/index.php/2013-03-31-05-16-29/guidance-documents/205-national-drug-policy-2017-with-essential-drug-list-and-otc-list (accessed June 2017).

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