POLICY BRIEF

Under Five Pneumonia: Early Recognition Saves Lives

Saving Our Newborns: High Time to Extend Quality Emergency Obstetric Care to Access Poor

My Children Free from Second-Hand Smoke Exposure: Campaign for Voluntary Smoke Free Home
Editor-in-Chief’s Note
Prof. Mamunar Rashid

Public Health Policy Forum is a unique initiative of the Institute of Epidemiology, Disease Control and Research (IEDCR) which is being implemented with the technical support of CHAMPS - “data to action”, Emory University and International Association of National Public Health Institutes (IANPHI) as part of the Data Impact Program (DIP).

The DIP is implemented to build capacity of researchers and policy makers to use data for making informed health related policy decisions. Capacity building on “Data to Policy” for developing policy briefs and sharing the briefs with the policymakers and stakeholders in Policy Forum created an opportunity for IEDCR as an epidemiological institute to translate epidemiological data to evidence-based policy through DIP.

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Under-five Pneumonia: Early Recognition Saves Lives

Dr. Tanzila Naureen, DMC; ANM Ehtesham Kabir, NNCHC, MNC&AH, DGHS; Kamal Ibne Amin Chowdhury, icddr,b; Julie Harris,CDC-USA
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Key messages
• Pneumonia is the leading cause of death among under-five children
• Approximately 18% of all under 5 deaths are caused by pneumonia in Bangladesh
• In Bangladesh, most under-five deaths from pneumonia occur due to delays in seeking appropriate healthcare

Problem statement
Pneumonia accounts for 18% of all deaths among under-five children, killing approximately 2 million children globally each year. It is currently the leading infectious cause of under-five mortality. Bangladesh has the fifth-highest rate of pneumonia in the world, with an estimated 6 million cases annually among under-five children. Delays in care-seeking lead to progression of mild and moderate pneumonia to severe pneumonia, which in turn is associated with increased mortality. In Bangladesh, 15% of all deaths among under-five children are due to severe pneumonia.

At least three factors are associated with delays in appropriate care-seeking for pneumonia. First, caregivers often fail to recognize danger signs and symptoms of pneumonia, and do not seek care until the disease is at a later, more serious stage. In addition, even when the disease is recognized, mothers frequently apply home remedies before seeking formal healthcare. When those fail, they usually consult informal healthcare providers, who cannot provide appropriate management for pneumonia. Beyond this, social norms reduce maternal autonomy in seeking formal healthcare, forcing mothers to wait until the decision maker of the family (e.g., mothers-in-law or husbands) give them permission.

Policy Option: Nation-wide Awareness Campaign
Union-level health centers are the first stop for mothers seeking formal healthcare for pneumonia. These centers can initiate treatment for mild and moderate pneumonia with antibiotics, but patients still require referral to higher-level facilities for standard management. However, many care-givers do not bring their children to union-level facilities until the child’s status is severe.

The Government of Bangladesh (GoB) has implemented several interventions to address this problem, including integrated

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management of childhood illness (IMCI) at all levels to facilitate effective referrals for children who need it, and the introduction of pneumococcal vaccine to address childhood pneumonia in 2015. Although the Government of Bangladesh currently employs approximately 60,000 community health workers (CHWs) to promote maternal and child health care, including essential newborn care, they are not trained to educate caregivers to recognize signs and symptoms of childhood pneumonia. As a result, the population is largely unaware that early intervention for pneumonia could substantially prevent child deaths.

There is a knowledge gap among caregivers regarding early signs and symptoms of pneumonia, as well as the benefits of early presentation. To improve under-five survival from pneumonia, we propose a nationwide campaign to increase the proportion of caregivers who recognize early pneumonia and seek appropriate, timely care.

An awareness campaign for caregivers and family members about early signs and symptoms of pneumonia and available community-level treatment facilities could address this problem. This policy option focuses on TV/radio documentaries, short drama, telefilms, and health discussions on childhood pneumonia. Posters, infographics, and leaflets will be distributed by CHWs at government-owned sub-district level health complexes, union-level healthcare centers, and community clinics.

Additionally, CHWs will be trained to motivate caregivers to identify early symptoms of pneumonia and bring their children for assessment and care. The CHWs will also be trained on providing initial management of pneumonia. This builds on existing infrastructure in Bangladesh with CHWs who already undergo a routine training program. Implementing this option would require only adding a half-day to their existing training program, which is carried out monthly.

Cost per child life saved
This policy option will save 2,592 child lives each year. The estimated program cost is US $315,000, estimating a cost of US $122/10358 Taka for each child life saved.

DELAY IN Reaching a Health Facility (যাত্রা বোধে গোষ্ঠীতে বিলম্ব)
DELAY IN Decision to Seek Care (চিকিৎসা নিকটে চিকিৎসা বিলম্ব)
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One-third of children with pneumonia-like symptoms do not seek appropriate care
(নিউমনোনিয়ার উপসর্গ দৃঢ় শিষ্যদের এক-একদিনের বিকাশ চিকিৎসা নিকটে বিলম্ব সৃষ্টি)

নিউমনোনিয়ার উপসর্গ দেখা দেখার পর দ্রুত যাত্রাকে তিন তিন নটিকা এবং চিকিৎসা দেহাত্মক হয় না। এটি উপসর্গ দেখা দেখার পর দ্রুত যাত্রাকে তিন তিন নটিকা এবং চিকিৎসা দেহাত্মক হয় না।
Feasibility
The proposed policy is operationally feasible. The GoB has previously initiated successful education campaigns to promote many different health messages. This option is also politically feasible as this will help to achieve the national goal in alignment with Sustainable Development Goal (SDG) which targets to reduce under-five mortality. Addressing child mortality from pneumonia will facilitate reaching this goal.

Recommendations and next steps
A media campaign can increase awareness among caregivers throughout the country about early signs and symptoms of childhood pneumonia, and where caregivers can go to receive appropriate healthcare. Additional training of CHWs within the existing system will enable them to motivate caregivers to identify early childhood pneumonia and bring their children for assessment and care. The government of Bangladesh should issue an official order to address childhood pneumonia during the routine monthly meetings of CHWs. We also recommend strengthening the current health system in terms of logistics, medical supplies and manpower. This policy option will help to prevent more than 2,500 child deaths due to pneumonia with minimum investment, and help to achieve the Sustainable Development Goal for reducing child mortality by 2030.

References
Simple Clinical Signs of Pneumonia (WHO)

- Fast breathing (tachypnea) (ফ্রাত ছাস দেওয়া (টাকিপনিয়া))
- Respiratory thresholds (ছাস-ছাসের সীমা)

<table>
<thead>
<tr>
<th>Age (বয়স)</th>
<th>Breaths/minute (ছাস / মিনিট)</th>
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<tr>
<td>&lt; 2 months (&lt; 2 মাস)</td>
<td>60 (৬০)</td>
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<tr>
<td>2 - 12 months (২-১২ মাস)</td>
<td>50 (৫০)</td>
</tr>
<tr>
<td>1 - 5 years (১-৫ বছর)</td>
<td>40 (৪০)</td>
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- Chest Indrawing (subcostal retraction) (রুক ডেহার দিকে দেবে যাওয়া)

Clinical Manifestations (রোগের প্রকাশ)

- Fever (ফেভার)
- Fast & Difficult Breathing (ফ্রাত এবং কষ্টকর ছাস)
- Cough (কাশি)
- Chest pain (রুকে ব্যথা)
- Abdominal pain (পেটে ব্যথা)
- Poor feeding (কম খাওয়া)
- Irritability (ষিটিষিটে)
Saving Our Newborns: Extend Quality Emergency Obstetric Care to Reach the Poor

Dr. Quazi Ahmed Zaki, IEDCR; Dr. Zahid Haider, DGHS; Dr. Md. Sazzad Hossain, IEDCR
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Key Messages
• Bangladesh ranks 8th globally for neonatal mortality, with 20 deaths /1000 live births
• Among all neonatal deaths, 66% are due to preventable asphyxia or sepsis
• Among all births, 37% are delivered at institutions and 55.46 % of Demand Side Financing (DSF) vouchers were utilized by pro poor in sub districts
• Increasing the number of trained staff at DSF sites can ensure 24/7 coverage of Emergency Obstetric Care (EOC) services
• Expanding the number of DSF service to EOC sites with additional staffing will reduce neonatal deaths by increasing facility deliveries

Problem Statement
Globally, 2.5 million neonates died in the first month of life in 2017 alone. Most of these deaths occurred in the first week of life, with about one million dying on the first day, and nearly the same number dying within the next six days. In 2018, Bangladesh ranked 8th worldwide in neonatal mortality with 56,341 neonatal deaths, for a neonatal mortality rate (NMR) of 20/1000 live births. Although the NMR steadily declined from 52/1000 to 20/1000 live births during 1989-2017, it is still not near the Sustainable Development Goal (SDG) target of 12/1000 live births.

Nearly all (91%) neonatal mortality in Bangladesh is due to birth complications that are treatable and preventable, including birth asphyxia and sepsis, which account for 66% of neonatal deaths. Fully-staffed, high-quality Emergency Obstetric Care-Demand Side Financing (EOC-DSF) facilities can care for such infants, but high rates of home births (63%) preclude their use. In 2018, only 55.5% of DSF enrolled mothers gave births at DSF facilities in Bangladesh.

Unavailability of care where needed, poor quality of services and cost of care are key drivers to low institutional deliveries. Facilities can be divided in to those that provide basic EOC care, those that provide comprehensive EOC care, and those that provide comprehensive EOC care and DSF service that provides cash incentives to both service recipients and providers to encourage attendance by the poor.

Currently, of the 433 sub-district hospitals, only 55 (12.6%) have comprehensive EOC care that could treat neonatal asphyxia or...
sepsis, as well as direct cash incentives to 35% of the pro-poor in the catchment area. An additional 132 (30.3%) provide comprehensive EOC care but no cash incentives, while the remainder provide only basic EOC care. Beyond this, there are inadequate numbers of EOC-trained staff at the facilities: only 34% of EOC-DSF facilities are fully-staffed to provide 24/7 EOC services. The total out-of-pocket expenditure for an institutional birth is BDT 5000-15000, compared to home delivery costs of approximately 2000 BDT.

Current Health Population and Nutrition Sector Program (HPNSP) program plans have already targeted extending the DSF in 10 sub-districts by 2021. In addition, the Bangladeshi government plans to train about 80 physicians each year to provide EOC services at designated sub-districts.

**Policy Options**

The following policy options proposed below are aimed at reducing neonatal mortality from complicated birth outcomes, including sepsis and asphyxia, in Bangladesh

1. **Increase the trained staff at existing DSF sites to ensure 24/7 service**

**What:** Increase the number of EOC-trained staffs for the existing 55 DSF, to ensure 24/7 comprehensive EOC services.

**Why:** Scaling-up of training for physicians and nurses and deployment at existing DSF sites will promote retention of service providers. DSF sites provide additional incentives of BDT 1100 to surgeons, BDT 600 for anesthetists, and BDT 500 for assistance for each C-section performed at the facility. For normal delivery, the service provider’s incentive is BDT 60-75. Additional financial benefits for providing EOC care ensures additional pay to service providers that can improve staff retention at EOC facilities.

**Feasibility:** High. This strategy will have a positive impact in health service provider’s care giving behavior. Additional pay for performance will attract the service providers to stay at facilities and thus 24/7 availability of EOC service can be accessed by mothers in rural Bangladesh. This will require timely disbursement of incentives to service recipients as well as the

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EOC skilled service providers at DSF sites.

2. **Extension and strengthening as an equal priority from existing 55 (12.7%) to 187 (43%) sub-district hospitals**

*What:* Increase the number of fully equipped and functional EOC sites with DSF programs to increase coverage of comprehensive services.

*Why:* Extension of EOC-DSF service facilities will change the maternal and neonatal healthcare-seeking behavior among pro-poor mothers in sub-districts. A reduction in out of pocket costs through a DSF program will promote both higher utilization of DSF/comprehensive EOC services and institutional deliveries, reducing neonatal mortality due to birth complications.
Feasibility: High. This strategy will have positive impact in health seeking behavior and increase utilization of EOC service in rural Bangladesh. This will require inclusion of a DSF program to all comprehensive EOC facilities proposed for extension initiatives.

Economic and Public Health Impact
By doubling the numbers of staff to extend service hours to 24/7, we project that 74% deliveries will happen in the health facilities. That translates to 118,320 more institutional deliveries in the existing DSF sites. Proposed extension/scaling up of the DSF sites from existing 55 to proposed 187 will increase the institutional deliveries from an existing 37% to 67%. This means additional 5,94,699 more deliveries will happen at the extended DSF facilities. Doubling the EOC trained staffs in existing 55 DSF sites will require 13.75 million taka. Each DSF sites will require 25 million taka annually to operate. Thus, a total of 3360 million taka will be required to scale up the facilities. Expected increase in neonatal survival will be 2,02,291 (30%) with extension of DSF sites and an additional 77,578 by increased staff training.

Recommendations and next steps
• Increasing the number of trained staffs and deploying in DSF facilities will ensure 24/7 availability of EOC-service for higher utilization of safe institutional delivery
• Extension of DSF facilities with equal priority to quality will increase access and utilization of institutional delivery to address the neonatal mortality

References/Resources
1. Bangladesh Demographic and health survey 2014
3. Demographic and health survey2014
4. Health Population Nutrition Sector Development Program (HPNSDP) 2011-16
5. Online database UNICEF
6. SDG profile Bangladesh, WHO
Key message

- The dangers of secondhand smoke (SHS), especially for children, are unrecognized and unaddressed in Bangladesh.
- An estimated 23% of acute asthma, 35% of lower respiratory tract infections, and 39% of ear infections in Bangladeshi children are attributable to SHS.
- More than 40% of children in Bangladesh are regularly exposed to SHS at home.
- Lack of awareness about the dangers of SHS contributes to exposure at home.
- Campaign for a “voluntary smoke-free home” by empowering children as change agents can reduce SHS exposure at home.

Problem statement

The effects of Secondhand Smoke (SHS) exposure are often overlooked compared to the much-discussed direct effects of smoking. The World Health Organization (WHO) Report on the Global Tobacco Epidemic (2009) stated that “Second-hand smoke accounts for one in 10 tobacco-related deaths. People who smoke not only harm themselves, but also harm others around them, especially children, who are more vulnerable to the harmful effects of SHS than adults.”

Major health impacts of SHS among children include ear infections, more frequent and severe asthma attacks, and lower respiratory tract infections. Beyond this, children exposed to SHS are more likely to develop respiratory problems, metabolic diseases, and infertility, and have an increased likelihood of becoming a smoker as an adult.

WHO estimates that 60% of the DALYs lost due to SHS exposure globally are in children. Of the 600,000 deaths attributed to SHS exposure per year, most are in South East Asia, and 28% are in children. According to The Union (theunion.org), 42% of children aged 13-15 years are exposed to SHS at home in Bangladesh.

My Children Free from Second-Hand Smoke Exposure: Campaign for a Voluntary Smoke-Free Home

Dr. Samsad Rabbani Khan, IEDCR; Dr. Mohammad Sohel Samad, IEDCR; Dr. Anupam Sarker, IEDCR

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comparison, in neighboring India, only 27% of children in the same age group are exposed to SHS at home.

A recent school-based study of SHS exposure in Dhaka found 43% of grade-5 students living with at least one smoker at home. Measurements of salivary cotinine levels showed that 95% of those students (40% of all students) had cotinine levels (a blood biomarker) indicative of SHS exposure. The frequent exposure of children to SHS mainly due to the lack of awareness of parents and caregivers about the harmful effects of SHS. Studies of Bangladeshi adults have demonstrated a major knowledge gap about the ways that secondhand smoke can harm others in the household.

Despite a decrease in overall tobacco consumption in Bangladesh, smoking is still very common (37% among males). This is partially attributable to the low price of cigarettes. Cigarette prices in Bangladesh are among the lowest in the world, and nearly everyone can afford cigarettes and locally-made ‘biris’.

Policy options

Policy options aimed at reducing SHS exposure to children at home include a nationwide school-based awareness campaign, a media campaign, and raising cigarette prices through raising tobacco tax.

A. “Voluntary Smoke-Free Home” by empowering children as change agents:

1a. School-based campaign empowering children as change agents to reduce

- Worldwide, more than 5 million deaths occur due to direct tobacco use, while more than 600,000 are the result of nonsmokers being exposed to second-hand smoke.

- SHS exposure increases risk of heart attack, stroke, asthma and depression.

- Children of smokers are 1.5-2 times more likely to become smokers themselves.

Bangladesh has demonstrated a major knowledge gap about the ways that secondhand smoke can harm others in the household. Despite a decrease in overall tobacco consumption in Bangladesh, smoking is still very common (37% among males). This is partially attributable to the low price of cigarettes. Cigarette prices in Bangladesh are among the lowest in the world, and nearly everyone can afford cigarettes and locally-made ‘biris’.

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A. “Voluntary Smoke-Free Home” by empowering children as change agents:

1a. School-based campaign empowering children as change agents to reduce
their parents’ smoking. Trained teachers in each upazila will utilize a training module, including video clips and Information, Education, and Communication (IEC) materials, to teach students about the harmful effects of SHS and empower them to become change agents as they convey these messages at home. School textbooks will include chapters about the harmful effects of SHS. A school-based study in Dhaka demonstrated that similar interventions increased the number of smoke-free homes by 19%. A school based health education campaign conducted in Tamil Nadu, India obtained similar effectiveness.

1b. Education of parents of schoolchildren about dangers of SHS. Teachers will also conduct awareness programs for parents about SHS and health hazards. Every three months, school teachers will arrange sessions to educate parents about the harmful effects of SHS on children. Training and communication materials will be provided to the parents during these sessions.

B. Media Campaign:
Airing of anti-smoking infomercials and Graphic Health Warnings (GHWs) emphasizing the hazards of SHS exposure to children. These will be broadcast across all Radio and TV channels at least three times a day and at the beginning of all movies in all cinema halls and multiplexes. Advertisements with the same messages will be published in main daily newspapers and on billboards for one year.

C. Raise cigarette price by raising tobacco tax and reforming taxation policy:
The aim of raising tobacco tax and reforming the existing taxation policy would affect the base price of all cigarettes and bidis. Raising the tobacco tax is well-documented as one of the most effective ways to reduce the overall smoking rate, which in turn can reduce the SHS exposure to children at home. Raising the base price of cheaper brands will prevent switching of brands by the consumers. Increasing the price of cigarettes and bidis by 33% is estimated to decrease use rate by 14% and 9% in short and long-run, respectively, and avert 800,000 premature deaths over the next 40 years.

Recommendation and way forward
• School-based awareness campaign about the dangers of SHS is the best option to reduce SHS exposure at home, reducing the number of children exposed to SHS by >2 million at a cost of 32 taka per child no longer exposed
• Although raising tobacco tax is more
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<tr>
<th><strong>Programmatic (প্রোগ্রামাটিক)</strong></th>
<th><strong>Option A</strong> (অপশন ক) (Campaign for a Voluntary Smoke-Free Home)</th>
<th><strong>Option B</strong> (অপশন ধ) (Media Campaign)</th>
<th><strong>Option C</strong> (অপশন গ) (Raising taxes &amp; reforming tobacco taxation policy)</th>
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<td>• Comprehensive to capture the mindset for behavior change (আচরণের পরিবর্তনের জন্য মানসিক গঠন বুঝতে বিদ্যমান কর্মক্রম গঠন)</td>
<td>• Govt. has experience with similar campaigns (একই ধরনের ধারণাগত অভিজ্ঞতা সরকারের রয়েছে)</td>
<td>• Raising the tax and changing the taxation policy is a long and complex process and may not generate immediate and tangible effects (কর বৃদ্ধি ও করনীতির সংস্থার একটি নীতিমালার পাত্তন যা থেকে খুব প্রভাবিত কর্মক্রম ফলাফল পাওয়া যাবে না)</td>
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<td>• Has programmatic &amp; health benefits for children, parents, &amp; others who smoke (শিশুর পিতা মাতা ও যারা ধূমপান করেন তাদের যা সুবিধার অন্তর্ভুক্ত)</td>
<td>• A media campaign can reach a larger audience, but may have a limited effect on them (পদ্ধতিতে প্রচার অনেকে বেশি সংখ্যক মানুষের কাছে পৌঁছে তাদের ওপর ভাব ফেলতে পারে কম)</td>
<td>• Privately-owned media platforms may be reluctant to air messaging during their prime-time (ব্যক্তিগত মিডিয়া উপকরণের বিজ্ঞাপন সময়ে এসব সম্প্রচারে অনিচ্ছুক থাকতে পারে)</td>
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<td>• Primary school enrollment exceeds 90%, allowing for good reach (সর্বোচ্চ সাংঘাতিক মানুষের কাছে যাতে পৌঁছে টেক্স এগ্রিকুলার সময়ের বেশি সংখ্যক)</td>
<td>• Privately-owned media platforms may be reluctant to air messaging during their prime-time (ব্যক্তিগত মিডিয়া উপকরণের বিজ্ঞাপন সময়ে এসব সম্প্রচারে অনিচ্ছুক থাকতে পারে)</td>
<td>• Monitoring in cinemas will be challenging (মিডিয়ার ক্ষেত্রে নজরদারি করাটি বেশ কঠিন)</td>
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<td>• Strong upazila health structure will facilitate teacher training (উপজেলায় শিক্ষকীয় ধারণা কাঠামো স্থ্যক্ষরের সহায়তা করবে)</td>
<td>• Monitoring in cinemas will be challenging (মিডিয়ার ক্ষেত্রে নজরদারি করাটি বেশ কঠিন)</td>
<td>• Will generate govt. revenue, but may have major negative effect on tobacco industry (সরকারি রাজস্থান বৃদ্ধি হলেও তথ্যকী নীতিবাদক প্রভাব পড়তে পারে)</td>
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<tr>
<th><strong>Strategic (স্ট্র্যাটেজিক)</strong></th>
<th><strong>Option A</strong> (অপশন ক) (Campaign for a Voluntary Smoke-Free Home)</th>
<th><strong>Option B</strong> (অপশন ধ) (Media Campaign)</th>
<th><strong>Option C</strong> (অপশন গ) (Raising taxes &amp; reforming tobacco taxation policy)</th>
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</thead>
<tbody>
<tr>
<td>• More acceptable and appealing to parents and community stakeholders (পিতামাতাকে এবং সমাজের অধিনীষ্টতারকারীর ওপর প্রভাব ফেলতে পারে)</td>
<td>• May require multiple media information strategies to reach audiences diverse in education, culture, behaviors, economic &amp; social status (বিভিন্ন শিক্ষার পদ্ধতিতে গঠন, আচরণ, আর্থ-সামাজিক ভিত্তির কারণে পদ্ধতিতে ধারণার ফেলে বহুমূলক তথ্য সরবরাহের প্রয়োজন হতে পারে)</td>
<td>• Govt. may face political pressure against this (lobbying from tobacco companies, etc.) (তথ্যকী নীতিবাদক প্রভাব পড়তে পারে)</td>
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<td>• May reduce future smoking in children (ভক্তিবদ্ধের শিশুদের মাথা ধূমপান ক্রান্তি করতে পারে)</td>
<td>• May reduce future smoking in children (ভক্তিবদ্ধের শিশুদের মাথা ধূমপান ক্রান্তি করতে পারে)</td>
<td>• Govt. would need to rehabilitate existing tobacco workforce in shrinking industry (সরকারকে সংক্ষিপ্ত করতে হারে তথ্যকী শিক্ষকীয় শ্রমিকদের পুনর্বাসনের যাবজ্জীবন করতে হতে পারে)</td>
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<tr>
<td>• Political commitment likely favorable (রাজনৈতিক প্রতিকৃতি আরো অনুগমন পরিবেশ তৈরি করবে)</td>
<td>• May reduce future smoking in children (ভক্তিবদ্ধের শিশুদের মাথা ধূমপান ক্রান্তি করতে পারে)</td>
<td>• Might curtail healthy spending (food, clothes, children school tiffin) to continue smoking (ধূমপান চলায়ে যেতে যাচায় তাদের খাদ্য, পোশাক, বাচ্চাদের শিক্ষার বিভিন্ন কাঠামো থেকে কাটছে করতে হতে পারে)</td>
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Cost-effectiveness of policy options

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<tr>
<th>Metric (মাপকারী)</th>
<th>School education (বিদ্যালয় শিক্ষা)</th>
<th>Media campaign (পাবলিক শিক্ষা)</th>
<th>Raising tobacco tax (কর বৃদ্ধি)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children no longer exposed to SHS (% reduction) (শিশুরা আর পারাক্ষ মুখশিয়ার মুখূর্তী হবে না)</td>
<td>2,096,635 (15%) (2,096,635 (15%))</td>
<td>89,659 (&lt;1%) (89,659 (&lt;1%))</td>
<td>2,896,667 (21%) (2,896,667 (21%))</td>
</tr>
<tr>
<td>Estimated cost (BDT) (বাবার মান)</td>
<td>674,070.80 (৬৭৪,০৭০.৮০)</td>
<td>12,700,250 (১২,৭০০,২৫০)</td>
<td>4,956,270* (৪,৯৫৬,২৭০)</td>
</tr>
<tr>
<td>Cost/Child no longer exposed to SHS (BDT) (বাবার /শিশুরা আর পারাক্ষ মুখশিয়ার মুখূর্তী হবে না)</td>
<td>32.15 (৩২.১৫)</td>
<td>141.65 (১৪১.৬৫)</td>
<td>1.71 (১.৭১)</td>
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</table>

Feasibility of policy options

<table>
<thead>
<tr>
<th>Political Feasibility (রাজনৈতিক সম্ভাব্যতা)</th>
<th>Operational Feasibility (কার্যক্রম চিত্রিত সম্ভাব্যতা)</th>
</tr>
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<tbody>
<tr>
<td>Highly Feasible (যুব ভালো ভাবেই সম্ভব)</td>
<td>Somewhat Feasible (কিছু পরিমাণে সম্ভব)</td>
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A call for action

- Engage relevant Ministry and stakeholders in action-oriented dialogue to influence and support this policy
- Sensitize and persuade focal person in relevant Ministries such as MOHFW, Finance and Education to support and take forward this policy endeavor

References

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