Gap analysis in achieving health-related sustainable development goals in Bangladesh, 2023

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Abstract

The Sustainable Development Goals (SDGs) aim to end poverty, protect the planet, and ensure peace and prosperity for all people by 2030. It consists of 17 goals, 169 targets and 231 unique indicators. All the 17 SDG goals are integrated i.e. the action in one, will affect the outcome in others and eventually develop a social, economic, and environmental balance. The SDG goal 3, regarding "Good Health and Well-being" encompasses the majority of health indicators, but there are a few indicators which belong to other goals but also have significant effects on health.

We conducted a cross-sectional survey following the mixed method. Our primary data source was the focal persons responsible for health-related SDG from different organizations, ministries and divisions along with custodian/partner agencies. We collected data through key informant interviews (KIIs) and a series of consultancy workshops. For secondary data, national and global project documents, census/survey data from BBS and NIPORT, administrative data from DGHS and innovative data from a2i, General Economic Division (GED) were systemically reviewed. During desk review we derived data from SDG tracker, Metadata of respective indicators, and conducted mapping of Stakeholder engagement.

Previously Bangladesh has been one of the successful countries in achieving MDGs, and currently it is on its way towards achieving SDGs. However, despite the Government's initiatives, there are difficulties in multiple sectors towards SDGs goal achievement. SDG data generation is hampered due to infrequent survey conduction or report release on due time. Moreover, program activities were not aligned with SDGs indicators. This study confirms that there are notable data gaps impeding the achievement of health and health-related SDGs in Bangladesh and it is crucial to overcome these gaps in order to meet the targeted goals.

The implications of the findings are discussed, with a focus on the importance of data-driven decision-making to achieve SDG objectives and a need for greater investments in the collection and analysis of data in Bangladesh. It is concluded that multi-stakeholder engagements, along with increased government funding on routine surveys and improved coordination among existing services, are required to expedite progress and ensure that no one is left behind.

Introduction:

The Sustainable Development Goals (SDGs) emerged as a global call to action to eradicate poverty, safeguard the environment, and guarantee that everyone lives in peace and prosperity by 2030. In September 2015, 193 UN countries, including Bangladesh, agreed on a future agenda for sustainable development1. The SDGs are a set of 17 goals and 169 targets aimed at addressing the world's most serious issues, such as poverty, hunger, inequality, climate change, and environmental degradation. The 17 SDG goals are interconnected, recognizing that actions in one area will have an impact on outcomes in others and that development must strike a balance between social, economic, and environmental sustainability2. Countries have agreed to emphasize improvement for those who are the most disadvantaged as the primary motto of the 2030 Agenda for Sustainable Development is "Leave no one behind (LNOB)3."

Health and health-related SDGs (HHRSDGs)might play an important role in this context. Although health is only one of the 17 goals, other goals encompass a variety of health-related issues that, while not directly related to goal 3: "Good Health and Well-being," are no less significant4,5.

Data availability is a key component in accelerating the implementation of health and health related SDGs (HHRSDGs)5. The unavailability of data prevented the establishment of a common baseline for all the

indicators. The baseline is made up of indicators for which annual data are available for 2014–2015, on the other hand, the most recent survey data is used as the baseline if an indicator does not contain data for 2014–15. 127 indicators have a baseline data set, and 108 indicators are included in the M&E framework. For several of the indicators that are qualitative in character, milestones have yet to be established7.

The Government of Bangladesh has launched an online "SDG Tracker" that is run by SDG Cell, BBS providing IT support via the Aspire to Innovate (a2i) Program, and where all the data-generating ministries are connected to contribute data on the platform. This SDG Tracker aimed at creating a data repository for monitoring the implementation of SDGs, strengthening timely data collection, and improving situation analysis and performance monitoring of achieving the SDGs along with other national development goals8,9.

To ensure Sustainable Development Goals in Bangladesh by leaving no one behind in the most possible short time, a set of 39 indicators has been selected under the instruction of the SDG Working Committee of the Prime Minister's Office. The government has designated 40 (39+1) priority indicators: 39 indicators (with 11 national indicators) for the 17 goals deemed essential; and one extra (+1) local indicator to reflect the "leave no one behind (LNOB)" agenda7 Under these indicators, some of the indicators are selected from the global Sustainable Development Goals and some of the indicators are selected after modification on Bangladesh perspective. All relevant ministries are connected with this process8.

Studies indicate a broad compatibility of indicators, where progress in one indicator is associated with the fulfillment of another one in the same goal4, 5. For SDG 3 (Good Health and Well-being) a large fraction of synergies with various SDGs are also observed5.

This discussion reinforces the fact that data gap analysis involving only health Goal 3 will not have been tough to reach a significant conclusion, whereas a study on data gap analysis of other health related goals along with Goal 3 is required; which corresponds well with this study's objectives. Furthermore, this study will also indirectly help bring benefit to achieve all the 17 SDGs by the same logic of cohesiveness and interrelation among the SDGs. The aim of the study was to find out the data gap (analyze the challenges) in the achievement of Health and Health-related SDGs in Bangladesh and recommend ways to overcome them. This study also looked for new data sources for the HHRSDGs indicators having unavailable data, improve timely data flow mechanism for the indicators having HHRSDGs indicators having partially available data. However, the study also aimed to find out the challenges in achieving HHRSDGs in Bangladesh.

Study Objectives

- To find out the new data sources for the(HHRSDGs) having unavailable and partially available data.
- To find out the obstacles in data flow mechanism for the (HHRSDGs) having unavailable and partially available data.

Methodology

Study Design

This study was a cross-sectional survey following the mixed method. The research team followed a

combination of quantitative and qualitative data collection methods. First, started with a desk review following analysis of existing data (secondary data), and finally for primary data a series of consultancy workshops and key informant interviews (KII) with focal persons of organizations or/divisions/ministries on SDG were taken.

Quantitative Study

Study Population

Focal points Organization/Division/Ministries related to health SDGs were our target population for primary data. For secondary data our study population were officials from- Bangladesh Bureau of Statistics (BBS), Statistics and Informatics Division (SID), NIPORT, Health Service Division (HSD), MHEFWD, MoHFW, DGHS, Several Program Managers/DPMs, key persons from custodian/partner agencies and other relevant stockholders.

Study Period

The study was conducted during November 2022 to May 2023.

Stakeholder Mapping

Robust mapping of Stakeholders related to health-related SDG goals achievements, like Policymakers, Program Managers (Health, environment & others), civil society, development partners, academics, researchers, environment and climate change experts, and Non-Government Organizations (NGOs), were done.

Data collection procedure and instruments

Both qualitative and quantitative data were collected. Qualitative (Primary) data were collected through Key Informant Interviews(KII) and a series of (eight) consultation workshops. For secondary data, systematic desk review of existing national and global project documents, Survey/Census data from Bangladesh Bureau of Statistics (BBS), administrative data from MIS&IEDCR, of Directorate General of Health Services (DGHS), and innovative data from Big Data from available sources were collected. In addition, annual reports, annual performance agreements (APA), SDG Tracker, SDG Data Lab, budget allocation, current projects/programmes, and completed projects, UN & WHO official websites were accessed and analyzed.

A semi-structured questionnaire prepared by the research team and validated by the experts was used for KII among focal points of SDGs in different organizations/divisions/ministries.

An Excel spreadsheet were used for Health and Health-related SDGs Indicators (SDG-HHRI) to display visible data gaps among different official websites of relevant organizations/divisions/ministries. Those were displayed and reviewed during consultation workshops with key stakeholders.

Data Management and Statistical Analysis

Collected data were validated by experts from participants of consultation workshops. Primary/secondary data sources from divisions/ministries other than Directorate General of Health Services (DGHS)were validated from resources of respective ministries/divisions/agencies. Data were cross checked by custodian agencies/partner agencies/ data generating agencies.

The analysis procedure was carried out by mixed methods consisting of constant comparison and classical content analysis. The sequence of analysis was decoding, with theme preparation, selective coding, and synopsis. For quantitative data descriptive statistics such as frequency, and percentage, for categorical data and mean and standard deviation (SD) for numerical data was used primarily to summarize and describe the data. Continuous variables were expressed as means (standard deviations [SD]) or medians (interquartile ranges [IQR]).

Qualitative Study

Sampling and Enrollment

We followed purposive sampling technique for enrolling the study participants. We selected twenty-three participants purposively. Before going to conduct KII interview, we communicated physically and/or the over phone with the participants to select their convenient date and time for the interview session. By this way, we built rapport with the participants and rapport building in qualitative research interviews lays the foundation for a respectful and productive relationship between the researchers and participants, leading to a deeper understanding of participants' experiences and generating high-quality data for analysis.

Data Collection

Training and Field Test for Data Collection

Data collectors were trained through lectures, classroom practices, group discussions, role playing (among the interviewers) for two days. The training was designed to prepare the interviewers, and quality of data, and rapport building with the study participants by a thorough explanation of all questions, definitions and explanation to SDG related terms, and in-depth discussion on interview guidelines/checklists, and how to record the data. In training session,

training was also given on ethical principles and guidelines for research involving human subjects. During the two days training, we conducted field test and feedback sessions. The PI, Co-PI, Co-I and qualitative analysist provided trainings to the data collectors.

Data collection tools

Key Informant Interview guidelines or checklists had been developed from the experience of the investigators and related literature reviews and interviews were recorded in voice recorder.

Data Collection and Data Quality Assurance

Data collection was carried out by three data collectors trained in qualitative data collection, However, one Co-Investigator and Co-Principal Investigator also collected data by conducting interviews in the fields (during pre-testing). For ensuring the quality and accuracy of the collected data, the Co-investigators also visited field and observed data collection and provided instant feedback to data collectors.

Data Analysis

For the Key Informant Interviews, recorded audio were carefully transcribed into Bangla. The qualitative data analysist read the text of interviews again and again. Then it was developed thematic codes using content analysis method. After that the codes have been prepared by thorough discussion with each member of the team including Principal Investigator, Co- Investigators, especially with data collectors and Co-Principal Investigator, and entered the data through Atlas-Ti program for analysis.

Ethical consideration

This study was performed after getting official clearance for the protocol from the Institutional Review Board (IRB) of IEDCR. Informed consent was taken before starting the interview through a consent form. It contained details about the aim and objectives of the study, study procedure, benefits and risks of the study, confidential handling of data, and the responsible principal investigator's identity. We also described the details of the consent form for a better understanding of it Anonymity and confidentiality were maintained by ensuring that all data was coded and stored in a locked cabinet, and only research-related personnel was permitted to access the data. Collected information was used only for research purposes, not otherwise. This study neither involved any physical or social risk nor used any invasive procedure. Moreover, regular reports including mid-term progress reports and final reports were submitted to the Planning, Monitoring and Research (PMR) OP of the DGHS for regular review of the study quality. Any recommendations or review given, they were maintained to keep a high standard of the quality of this study.

Result

We identified forty indicators as Health and Health related indicators (SDG-HHRIs). Among 40 indicators, 4 indicators had no data available, 10 indicators showed partially available data, and the rest 26 indicators showed readily available data. Not available data Indicators were 1) 3.7.2, Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group 2) 3.9.2 Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene WASH) 3) 3.b.3 Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis 4) 3.d.2 Percentage of bloodstream infections due to Selected antimicrobial resistant organisms.

SDG-HHRIs having partially available data were

1) 3.3.1 Number of new HIV infections per 1,000 uninfected populations, by sex, age and key populations.
2) 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income
3) 3.9.1 Mortality rate attributed to household and ambient air pollution
4) 3.a.1 Age-standardized prevalence of current tobacco use among persons aged 15 years and older
5) 3.b.1 Proportion of the target population covered by all vaccines included in their national program
6) 3.b.2 Total net official development assistance to medical research and basic health sectors
7) 2.1.1 Prevalence of undernourishment
8) 2.2.3 Prevalence of anemia in women aged 15 to 49 years, by pregnancy status (percentage)
9) 11.5.1 Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population
10) 16.1.3 Proportion of population subjected to (a) physical violence, (b) psychological violence and (c) sexual violence in the previous 12 months

SDG-HHRIs having readily available data (26 indicators)

After analyzing the status of indicators, we started with indicators having unavailable data. We went through extensive research over those indicators and tried to find out the root cause of why they are not available. To do so we started reviewing all those targets and their indicators, whether the indicators are

suitable to meet the target needs. Moreover, we went through the metadata findings, indicator wise data generating source, and many more. After come to the end of our study we leave some recommendation for each indicators.

After that our next work destination was those indicators having partially available data. After went through those indicators we try to find out the data flow mechanism of those indicators according to our methodology. Furthermore, we did all those researches that had been done for not available data indicators, which helped to take decision regarding recommendation.

To meet the aim of our study it is necessary to evaluate our continuous improvement of health and health-related indicators of SDG. So that we assess where we need to focus more and can take necessary action. To do so we made a comparison table that can show us from where we started and where to end. We put baseline study status, our present status and our future target of 2025 and 2030.
* Present data status is taken during our study period that's why recent present data status couldn't be matched regarding some indicators.
Challenges found in achieving Health and Health-related SDGs in Bangladesh- KII findings
Bangladesh faces challenges in creating an SDG database, identified through key informant interviews (KIIs). Issues include stakeholder coordination, data collection, quality enhancement, funding sustainability, and handling frequent personnel transfers impacting SDG continuity.
Coordination among Inter-agencies and Intra-agencies of SDG Stakeholders
Effective coordination among stakeholders, including government agencies, NGOs, and international partners, is crucial for successful SDG database development. Clear roles, responsibilities, and collaboration mechanisms streamline efforts. Reliable data is vital for SDG progress tracking and decision-making. However, a challenge arises from the lack of data integration across sectors in the SDG database. Management Information Systems (MIS) in health and family planning collect grassroots data, but inter-agency and intra-agency coordination hurdles slow data flow, leading to data gaps.
The liminality of Respective Employee of SDG Creates Data Gap
Frequent transfers of SDG employees disrupt continuity and memory. Addressing this requires clear job roles, training, and retaining experienced personnel. Key informants note this challenge affects data submission, causing missed deadlines and hindering data-driven decisions and progress. Personnel transfers disrupt data continuity. Newcomers need time to understand data processes, leading to missed deadlines. Delayed data hampers decisions, resource allocation, and SDG progress, impacting informed planning and achievement.
"When someone thinks that she or he has to provide data at that time, she or he has been transferred. A new person comes and he or she takes time to understand the process and importance of data. In the meantime, the expected dateline is finished for data providing." [One Focal Person of SDG]
Diverse Data Sources and Distinct Data within the SDG Database
The SDG database faces challenges from diverse data sources and varied information. This affects compatibility and harmonization. Key informants question data source acceptability, posing a challenge for researchers and health programmers. Admin data isn't directly used in SDG parameters. Reliable data demands robust collection mechanisms: surveys, censuses, etc. Challenges include technical expertise, infrastructure, and coordinating efforts among agencies, causing delays in data availability for the SDG tracker.

Increase Coverage of Data for SDG Database

Expanding data coverage is crucial for precise SDG progress monitoring. Investment in collector training, including all regions and groups, is essential to avoid biases and inaccuracies, incorporating both public and private health facilities.

Lacking Adequate Funds for Running SDG Tracker

Insufficient funds impact SDG database sustainability, including robust data management systems and infrastructure. Adequate financial resources for collection, capacity building, and tech upgrades are vital. Long-term funding from domestic and international sources ensures accurate data for tracking progress towards SDGs. Investing in database sustainability is an investment in a sustainable future.

Alignment Health program with SDG

Aligning health programs with SDGs enhances healthcare, equity, and development. Integration leverages synergies, collaboration, and resource mobilization. Challenges like resource limits, policy coherence, and data monitoring need addressing. Global effort can drive health sector progress through SDG alignment.

Discussion

Bangladesh achieved country ranking 104th place in SDG index out of 163 countries globally15 which indicate country progress gradually towards SDG goal achievement. One important aspect of achieving these goals is the availability and quality of data to measure progress and inform policy decisions. In this study, gap analysis measures progress towards SDGs landmarks (milestone and target) years. It helps identify the specific areas where additional resources, investments, and collaborations are needed to improve data availability, quality, and usability for effective decision-making and policy formulation. In this document we describe indicators based on data availability: start with not available data than, partially available data and finally radially available data.

For not available data Indicators were 3.7.2, 3.9.2, 3.b.3 and 3.d.2. Indicator 3.7.2 (Adolescent birth rate) has two age groups (10-14) and (15-19). According to indicator 5.3.1 first married by the age of 18 years old decreased from 73.3 percent in 1994 to 58.6 percent in 2014 (World Bank, 2019), Similar progress was also recorded for the first marriage of women by the age of 15 years old decreased from 47.2 percent in 1994 to 22.4 percent in 2014 (World Bank, 2019). So, evidence proved, in both groups of (10-14) years and (15-19) years, marriage rate decreased substantially. It indicates adolescent birth rate among (10- 14) age group is difficult to find.

Target 3.9 is by 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination, where 3.9.1 indicator has data in progress status and 3.9.2 has no data status. After analyzing metadata methodology, research team revealed for these two indicators few diseases are duplicated with indicator 3.4.1. For indicator 3.9.1 diseases are: Acute respiratory infections (estimated in all age groups); - Cerebrovascular diseases (stroke) in adults (estimated above 25 years); Ischemic heart diseases (IHD) in adults (estimated above 25 years); - Chronic obstructive pulmonary disease (COPD) in adults (estimated above 25 years); and - Lung cancer in adults (estimated above 25 years), For 3.9.2; included diseases are diarrhea (GHE code 110), acute respiratory infections (GHE code 380) intestinal nematode infections and protein-energy malnutrition. For 3.4.1 diseases are cardiovascular disease, cancer, diabetes, or chronic respiratory diseases. All of them have common diseases like acute and chronic respiratory diseases, cardiovascular diseases, and cancer.

Regarding those indicators present data sources are (SVRS) (HMSS) BBS, WHO, SID, MIS, NCDC-DGHS. However, Medical Certificate of Cause of death (MCCOD) is an established system where all government hospitals submit mortality-related information, where mortality information is aligned with ICD 10 code. Moreover for community and non-institutional death verbal autopsy aligned with ICD 10 code could be a new source. To achieve this target expand MCCOD to private hospitals by ICD code 10 trained physicians and community level by ICD code 10 trained physicians. Moreover for urban areas to get community data might need city corporations or municipalities support for better coordination. 3.b.3 (Proportion of health facilities that have essential medicines available and affordable) which data sources are NIPORT (BHFS) Bangladesh Health Facility Survey, Medical Education and Family Welfare Division (MEFWD). In DHIs2, government health facilities have to update their essential medicine availability status daily basis, but there is not enough monitoring regarding the regular updating, moreover, it needs to modify the medicine list for its optimum use. Private hospitals also have to be enlisted under DHIS2 and make them sensitized about its importance. MEFWD/HSD could be empowered to conduct surveys on health facilities (pharmacies, hospitals, clinics, primary care centers, public/private, etc.) Need to conduct BHFS routinely. 3. D.2 (Percentage of bloodstream infections due to selected antimicrobial-resistant organisms). Regarding this indicator data sources DGHS, HSD, and IEDCR could be a new data-generating source against this indicator, as they have: the National AMR surveillance system. Need to expand over private hospitals too.

SDG-HHRIs of having partially available data were ten in numbers. Indicator 2.1.1 (Prevalence of undernourishment) was revised in accordance with metadata9. Multiple data sources such as BBS (HIES) and FAO; but baseline data was taken from FAO: 15.2% (FAO, 2016). The last updated on SDG tracker was in 2018- 11.4% (FAO 2020). For the successful data collection of this indicator, new methodology should be adapted and implemented. According to expert opinion, HSD, Ministry of Agriculture, BNNC, and NNS should contribute in this regard. Indicator 2.2.1 Prevalence of stunting among children under 5 years of age is defined as “Prevalence of stunting (height-for-age <-2 standard deviation from the median of the World. Health Organization (WHO) Child Growth Standards) among children under 5 years of age.” National Priority Target (NPT) 3 is aligned with this SDG indicator8. The only data source is BBS (MICS). The baseline was revised in accordance with metadata which is set at 42% from MICS 2012-2013, BBS9. Data is updated up to 2019 in SDG tracker, Bangladesh (BD). Latest score is 28% (Slightly more in rural areas 28.4%14 than urban areas 26.3%) in 2019 according to SDG tracker BD16. According to SDG index dashboard country profile, this indicator has a stagnating trend13. Indicator 2.2.3 Prevalence of anemia in women aged 15 to 49 years, by pregnancy status (percentage). There has been no update on this indicator since the 2012 baseline data. This indicator requires a multidisciplinary approach. The prevalence of anemia cannot be obtained from a survey, as lab support and health workers are needed for this. As per our expert opinion, NNS should contribute to this. Indicator 3.3.1 (Number of new HIV infections per 1,000 uninfected populations, by sex, age, and key populations). The SDG tracker's most recent data update was in 2018 and it needs to be updated. One of the data sources for this indicator is IEDCR but there is no such surveillance or project through which IEDCR can accumulate the data. Thus, IEDCR’s name could be excluded and another reliable source could be added as a data provider. Also according to the expert opinion from the consultation workshops, a national team should be designated for this purpose, which at the moment is not available. Indicator 3.8.2 Proportion of the population with large household expenditures on health as a share of total household expenditure or income. There has

been no update on this indicator since the 2016 baseline data. From our country's perspective, this indicator's correct projection cannot be obtained without establishing a strong surveillance system. Currently, the data is collected from the HIES survey from BBS, which was last published in 2022, but it is not updated in the SDG tracker. Following the expert opinion statement, a newly updated methodology needs to be obtained to get data from an established surveillance or survey. A further decision could be made on the feasibility of the availability of our resources. Indicator 3.9.1 Mortality rate attributed to household and ambient air pollution. The methodology for this indicator is complicated and it is difficult to find out the actual target people with exposure. For countries with resource constraints like us, the methodology needs to be more adaptable.

According to our expert opinion, death due to household and ambient air pollution can be included as NCD, as this is already incorporated in several international conferences. In that case, new potential data sources could be NCD DGHS. For that, strong collaboration is needed between the Department of Environment and HSD. A new framework for surveys should be adapted and implemented. Also, MCCOD for institutional death and verbal autopsy for community death could be new sources of data. For Indicator 3.a.1 (Age-standardized prevalence of current tobacco use among persons aged 15 years and older) the most recent data in the SDG tracker is from 2017 and it needs to be updated. The data source is GAT (Global Adult Tobacco) survey, which was last done in 2017. The survey needs to be more frequently conducted. National tobacco program prevalence can be started and act as a good data source. According to expert opinion, Tobacco Cell should contribute in this

Indicator 3.b.1 Proportion of the target population covered by all vaccines included in their national program. In accordance with EPI Coverage Evaluation Survey, DGHS, and HSD, from both vaccination cards and mother's reports, 86 percent of all children were fully vaccinated in 2018. The target is to increase the coverage to 98 percent by 2025. But there are some other vaccines that are not included in the EPI schedule. According to our expert opinion, all new vaccines can be included in EPI or under the national program. Only then a complete proportion of the population can be calculated. Indicator 11.5.1 Number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population The current data source for this indicator is the BDHRS survey of BBS, which does not provide complete data. Need to find out another data source related to the numerator for the computation. Indicator 16.1.3 Proportion of population subjected to (a) physical violence, (b) psychological violence, and (c) sexual violence in the previous 12 months. There has been no update on this indicator since the 2015 baseline data. The current data source of this indicator is VAW (violence against women) survey. But the survey is irregular and needs to be conducted regularly. Also, another data source should be determined to include the male population to ascertain the total population. Gender Violence Survey could be a good option but the framework needs to be revised.

Conclusion:

This study come up with new data sources for Heath and health related (HHRSDGs) indicators who have no available data as well as having partially available data for few indicators. To improve the data flow mechanism for the indicators who have partially available data, the study finding suggested to enhance the active participation of all the SDG focal persons in all the relevant important steps, like as; to appoint fixed focal persons for SDG activities. Moreover, for the personnel involved with SDG data reporting, for

them, refresher training along with fixed schedule meeting with relevant stakeholders is essential. To ensure proper data flow of administrative data, monitoring from divisional and central level by monitoring cell need to be established. For readily available data, the research revealed infrequent and delayed survey reports (by respective organizations/agencies) are hampering sustainable data generation. Therefore, timely survey should be ensured by respective organizations with the help of government or development partners fund. Finally, successful alignment of health programs (of DGHS) with the SDGs is a must to accelerate data driven policy in order to harness the best use of resources and improve the country's overall health. This will ultimately contribute to the effective achievement of health-related SDG targets, improved healthcare outcomes, and the promotion of sustainable development.

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