UKPHS BANGLADESH HEALTH SYSTEM PRIORITIES

BACKGROUND

Crucial to the success of the UKPHS programme is alignment with national plans and health system strengthening priorities. Between September and November 2020, a scoping assessment was conducted in Bangladesh to identify and validate national health system priorities that could be supported through Health Partnership (HP) activities. Due to the outbreak of COVID-19, several of the scoping activities were undertaken remotely.

DESK REVIEW AND SCOPING ASSESSMENT

A desk review and scoping exercise, involving the input of the Bangladesh Ministry of Health and Family Welfare (MoHFW) and other stakeholders from key universities and health training institutions, UN agencies, development partners, and international and national NGOs, was undertaken to identify health system strengthening priorities, and which of these could be best addressed by the HP model and be the focus of support from UKPHS in Bangladesh.

Health systems (HS) priorities in the Bangladesh health sector were identified from a review of key policy and strategy documents including the Health, Population and Nutrition Chapter of the Government of Bangladesh's Eighth Five Year Plan 2020 to 2025; Programme Implementation Plan for the 4th Health, Population and Nutrition Sector Programme; Bangladesh Health Workforce Strategy; National Strategy for Adolescent Health 2017-2030; 2014 Gender Equity Strategy; and 2019 Community Health Worker Strategy. The HS priorities identified and extracted from the documents were mapped across the six health systems building blocks (i.e., Service Delivery, Human Resources for Health, Governance and Leadership, Health Information Systems, Health Financing, and Medical Products and Technologies). A range of cross-cutting Gender Equality and Social Inclusion (GESI) priority areas were also identified under each of the six HS components to guide stakeholders in the identification of GESI activities relevant to the context.

Along with information on the UKPHS programme and the HP modality, the desk review findings were presented to 25 key stakeholders in the form of a self-administered questionnaire. Respondents were asked to identify and rank the most important HS areas and activities across the six health systems components, as well as to highlight any omitted priorities. Once the priority areas and activities had been identified, stakeholders were then asked to identify the priority activities that could be addressed by a HP. They were asked to consider a number of criteria to inform their selection, including, among others, the HP timeframe and resources, the coherence and fit with national priorities and other health systems strengthening (HSS) interventions in the country, the potential of the intervention to be effective and sustainable, promote GESI, and have an impact on HSS.

Stakeholder engagement and group and individual consultations were facilitated throughout the scoping assessment process. The summarised findings from the analysis of the data collected, including the identified HS priorities and the proposed priority areas and activities that potentially could be addressed by a HP, were presented to a core group of senior MoHFW and FCDO officials. The validated and endorsed set of HS priorities are presented below.

STATUS OF BANGLADESH HEALTH SYSTEM

Overall, there have been significant improvements in several health indicators in Bangladesh over the last decade. Maternal mortality rates, under-five mortality rates, neo-natal mortality rates and malnutrition have all decreased since 2015. Prevalence of HIV/AIDS is low, and the incidence rate of TB and malaria is declining. There have been improvements in the availability of medical educational institutions both in the public and private sectors, and in nursing and midwifery education and services, in particular. Despite these achievements, a number of challenges remain to be addressed. Though the country has seen as period of economic growth, poverty and income inequality remain persistent challenges for the country, along with overpopulation and vulnerability to climate change. There is a high burden of neglected tropical diseases (NTDs), and non-communicable diseases (NCDs), and rising out-of-pocket expenditure is creating greater hardships on lower income and poor people. Strengthening governance, stewardship, and regulatory functions of health institutions; accreditation and quality assurance of health care facilities, and ensuring the availability, equitable distribution and retention of a skilled and motivated health workforce also need greater attention. The COVID-19 pandemic has added to the pressures on the health system in Bangladesh and has exposed gaps in health care on both the supply and demand sides.

CONCLUSIONS AND PRIORITIES FOR UKPHS

Based on a detailed analysis of the key priorities, a review of current gaps in support, and an assessment of where the health partnership model could add most value, the stakeholders consulted agreed that the overall focus of the UKPHS programme in Bangladesh should be:

The health system building blocks were ranked in the following order by the respondents:

1. Service Delivery
2. Human Resources for Health
3. Governance and Leadership
4. Health Financing
5. Health Information Systems
6. Medical Products and Technologies

SERVICE DELIVERY

- Rural primary health care and community health care provision
- Urban primary health care provision
- Non-communicable diseases (NCDs) services
- Disability services
- Mental Health services
- Eye care services

HUMAN RESOURCES FOR HEALTH

- Health workforce governance and institutional arrangements within MOHFW
- Capacity of health workforce to deliver quality services
- Supervision and performance monitoring of the health workforce
- Gender-sensitive HRH policies, strategies and services

GOVERNANCE AND LEADERSHIP

- Governance and leadership capacity across the sector
- Governance, Stewardship and Regulation systems and structures within the MOHFW
- Gender sensitive and responsive MOHFW policies, strategies, operational plans (OPs) and budgets

HEALTH FINANCING

- Health financing research to assess the effectiveness of approaches and schemes to reduce costs and catastrophic health expenditure among the poorest populations
- Gender responsive budgeting

HEALTH INFORMATION SYSTEMS

- Strengthening IT capacity and health information systems management to support the digitalization process across all hospitals
- Collection and reporting of data disaggregated by sex, age, and other relevant social stratifiers

THEORY OF CHANGE

The final set of priority activities that could potentially be addressed by a HP, and the related indicative outputs, outcomes and impact towards which HP projects in Bangladesh will be expected to contribute to, are presented in the following Theory of Change. The success of all activities under the Theory of Change (ToC) will be dependent upon the expertise available both in Bangladesh and the UK. To view an enlarged version of the ToC, please click here.

BANGLADESH PRIORITIES | INITIAL THEORY OF CHANGE

	Service Delivery	Human Resources For Health	Leadership & Governance	Health Financing	Health Information Systems
Indicative Activities	• Improve quality of Community Clinic services & availability & capacity of CHCPs. • Develop & test QI initiatives at all levels. • Conduct a gender analysis of barriers to health service access & use. • Design & test interventions to address identified supply & demand side barriersto the delivery and take up of services and improve equitable access to quality PHC services for rural populations. • Design & deliver NCD strengthening interventions, including capacity development, training, guidelines & research studies. • Design & pilot innovative model and strategies aligned with the Urban Health Strategy (under development). • Develop capacity of health care providers to provide quality mental health & disability services at all levels. • Develop capacity of health care providers to provide quality government eye care services. • Design cost effective environmental health and waste management technology appropriate to the context to improve medical waste management in hospitals at all levels. • Increase stakeholder involvement in planning, delivery and review of services, with representation of women and vulnerable communities. • Develop and implement gender sensitive health services. • Collect and report data disaggregated by sex, age, and other relevant social stratifiers.	• Strengthen systems & capacity of MOHFW to plan, manage & develop health workforce. • Review job descriptions for PHC and community-based cadres, including the HA, FWV, FWA, CHCP, & the MPHV & Midwife, & develop associated guidelines. • Review job descriptions for the licensed diploma midwife cadre & improve their utilisation in the provision of RMNCH services, including family planning. • Build capacity of health workforce to deliver quality NCD, disability, mental health & eye care services in the public health sector. • Strengthen the supervision & performance monitoring of the health workforce. • Develop & implement gender-sensitive HRH policies and strategies. • Ensure service providers have appropriate skill and competencies to deliver gender sensitive and non-discriminatory services. • Increase women's representation in HRH leadership positions. • Collect and analyse gender-sensitive HRH data disaggregated by sex and other social stratifiers (e.g., age, location, cadre).	• Strengthen governance and leadership capacity at all levels to address and mitigate health sector corruption. • Advise on the creation of a Governance, Stewardship and Regulation Unit in the MoHFW • Build capacity of HR and IT personnel within the Directorate General of Drug Administration and National Control Laboratory. • Develop gender sensitive and responsive MOHFW policies, strategies, operational plans (OPs) and budgets and/or mainstream gender equality and social inclusion in all programs across the health sector. • Increase citizens' participation, civil society dialogue and interaction with governments including parliamentarians, finance ministers, and heads of states, with representation of women and most vulnerable communities. • Increase representation of women and other key groups into decision-making bodies. • Collect and report data disaggregated by sex, age, and other relevant social stratifiers.	• Support research studies into health financing, including examining the effectiveness of existing approaches and schemes to reduce costs and catastrophic health expenditure among the poorest populations. • Develop and implement gender-sensitive financial plans and strategies which consider the unique needs of women and men. • Collect and report data disaggregated by sex, age, and other relevant social stratifiers. • Increase representation of women and other marginalized groups, as well as patients and communities, on financial management committees.	• Develop and strengthen IT capacity and health information systems management to enhance and support the digitalisation process across all hospitals. • Collect and report data disaggregated by sex, age, and other relevant social stratifiers.
Indicative Outputs	• Enhanced capacity of Community Clinics to deliver quality services. • Evidence generated to inform scale up of interventions to improve equitable access to quality PHC services for rural populations. Government health facilities and health workers have improved systems, capacity and processes to ensure quality NCDs services are available to all population groups. • Improved health worker knowledge, skills and competencies to provide quality mental health, disability and eye care services at all levels. • Improved evidence for innovative high impact model and strategies aligned with the Urban Health Strategy (under development) to inform scale up. • Cost effective appropriate environmental health and waste management technology designed. • Stakeholders, with representation of women and vulnerable communities, meaningfully involved in planning, delivery and review of services. • Health facilities have gender-sensitive services. • Data systems collect and report data disaggregated by sex, age, and other relevant social statifiers.	• Improved MOHFW systems and capacity to plan, manage and develop the health workforce • Job descriptions for PHC and community-based cadres reviewed and revised and associated guidelines developed and approved • Capacity development • interventions delivered, and health care providers equipped with knowledge, skills and competencies to provide quality, gender sensitive NCD, disability, mental health and eye care services. • Supervision and health workforce performance monitoring systems and processes enhanced • Quality and gender sensitive health workforce data available for decision making for HR planning management and development • HRH data systems collect, and report data disaggregated by sex, age, and other relevant social statifiers • Women represented in leadership positions. • Gender-sensitive HRH policies and strategies implemented.	• Health sector coordination and governance structures, systems and capacity improved and driving reforms. • Strengthened governance and leadership capacity improves resource mobilisation, delegation of authority with budget, local level planning, and strategic purchasing. • HR and IT staff personnel within the Directorate General of Drug Administration and National Control Laboratory have improved knowledge, skills and competencies. • Citizens and civil society organizations participating in meaningful dialogue and interaction with governments, including parliamentarians, finance ministers, and heads of states, with representation of women and most vulnerable communities. • Women represented in MOHFW leadership positions. • Data systems collect and report data disaggregated by sex, age, and other relevant social statifiers increases. • Gender sensitive and responsive MOHFW policies, OPs and budgets and/or policies and programmes that mainstream GESI in place and in use.	• Research studies generate evidence for scale up of effective approaches and schemes to reduce health costs and and catastrophic health expenditure among the poorest populations. • Gender responsive budgets developed. • Financial information systems collect and report data disaggregated by sex, age, and other relevant social statifiers. • Increased engagement of women and marginalized groups, as well as patients and communities, on financial management committees.	• Improved IT and health information capacity of relevant institutions and workers. • Data information systems collect and report data disaggregated by sex, age, and other relevant social statifiers.
Indicative Outcomes	•Quality health services, including NCDs, mental health and disability care and eye care available, accessible, acceptable at rural and urban PHC level for all population groups •Improved hospital environmental health and medical waste management systems and processes •Increased number of marginalised and underserved populations (women, children, nomadic people, migrants, refuges, and other vulnerable groups) accessing and receiving quality, equitable, affordable and acceptable services.	• Skilled and competent health workers available, accessible and acceptable providing quality services that meet the needs of all population groups. • Strengthened MOHFW institutional arrangements and HR governance capacity. • Improved health worker performance, motivation and retention.	• Improved leadership and governance of health systems and the health sector, assuring quality, access, equity and social inclusion. • Enhanced health sector management, stewardship and regulation. • Improved drug quality and regulation. • Increased community participation and empowerment in health.	• Equitable health financing strategies in place.	• Improved decision making and planning at health facilities al all levels with digitalised health information.
Potential Impact	**Improved health worker and health service performance, including for the poor and most vulnerable populations.**				