



UKPHS SCOPING ASSESSMENT REPORT

BANGLADESH

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TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS	2
Introduction.....	4
UK Partnerships for Health Systems programme (UKPHS).....	4
Purpose and objectives of the scoping assessment	4
Expected Outputs of the Scoping Assessment	5
Scoping Assessment Approach and Methodology	5
Desk review	5
Stakeholder consultation and engagement	5
Status of the Bangladesh health system: achievements, challenges and priorities.....	6
Introduction.....	6
Policy environment.....	7
Health outcomes and achievements	8
Ongoing health systems issues, challenges	8
Synthesis of Priorities across Stakeholders	9
Health Systems Priority Areas	9
Activity scoring across all stakeholders	10
Gender equality and social inclusion (GESI) prioritisation across all stakeholders	14
Feasibility of a HP to address the identified HS priorities	16
Health Systems Priorities identified by Stakeholders.....	18
Ministry of Health and Family Welfare	19
Health Education, Training and Research Institutions	20
Development Partners	24
National/International NGOs	25
Independent Consultants.....	28
Foreign, Commonwealth and Development Office (FCDO) perspectives	30
Priority areas in the Health Chapter, GOB Eighth Five Year Plan (2020-2025)	30
Review of priorities identified and potentially addressed through a HP.....	31
Final prioritisation	33
Health systems priorities to be addressed by HPs	33
National Oversight Mechanism (NOM) for the UKPHS programme.....	34
Theory of Change	35
Annex 1 Programme Overview – Bangladesh	37

Annex 2 Health System Priority Areas and Activities	52
Annex 3: Stakeholder Feedback Tool with Health Systems Priorities	65
Annex 4 Stakeholders consulted in Bangladesh.....	84
Annex 5 Documents Reviewed.....	85

ACRONYMS AND ABBREVIATIONS

AFHS	Adolescent Friendly Health Services
AMR	Antimicrobial Resistance
AMS	Antimicrobial Stewardship
ANC	Antenatal Care
BDHS	Bangladesh Demographic and Health Surveys
BEmONC	Basic Emergency Obstetric and Newborn Care
CBHC	Community Based Health Care
CC	Community Clinic
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CD	Country Director
CHW	Community Health Worker
CPD	Continuous Professional Development
CS	Caesarean Section
DFID	Department for International Development, UK
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHIS2	District Health Information Software version 2
ECD	Early Childhood Development
ESP	Essential Service Package
FCDO	Foreign, Commonwealth and Development Office
FP	Family Planning
GBV	Gender Based Violence
GESI	Gender Equality and Social Inclusion
GOB	Government of Bangladesh
HA	Health Assistant
HCW	Health Care Worker
HEU	Health Economics Unit
HW	Health Worker
HNP	Health, Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Programme
HPNSDP	Health, Population and Nutrition Sector Development Programme

HPNSP	Health, Population and Nutrition Sector Programme
HPSP	Health and Population Sector Programme
HRH	Human Resources for Health
HP	Health Partnership
HQA	Health Quality Assurance
HS	Health Systems
HSS	Health Systems Strengthening
LD	Line Director
LMICs	Low- and middle-income countries
LSTM	Liverpool School of Tropical Medicine
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation and Learning
MH	Mental Health
MNCAH	Maternal, Neonatal, Child and Adolescent Health
MNCH	Maternal Newborn and Child Health
MOLGRD&C	Ministry of Local Government, Rural Development and Cooperatives
MOHFW	Ministry of Health and Family Welfare
MIS	Management Information Systems
MTR	Mid Term Review
NCD	Non-Communicable Disease
NGO	Non-Government Organisation
NMES	Nursing and Midwifery Education and Services
NOM	National Oversight Mechanism
NTD	Neglected Tropical Disease
PHC	Primary Health Care
QI	Quality Improvement
RMNCAH	Reproductive, Maternal, Newborn Child and Adolescent Health
SBA	Skilled Birth Attendant
SCANU	Special Care Newborn Unit
SDG	Sustainable Development Goals
SSA	Sub-Saharan Africa
SSK	Shasthyo Shuroskha Karmasuchi
SWAp	Sector Wide Approach
TA	Technical Assistance
THET	Tropical Health and Education Trust
TOC	Theory of Change
UHC	Universal Health Coverage

UKPHS	UK Partnerships for Health Systems
USC	Union Sub Centre
UzHC	Upazila Health Complex
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

INTRODUCTION

This report aims to present to key stakeholders the findings of the UK Partnerships for Health Systems (UKPHS) Programme scoping assessment conducted between November and December 2020 in Bangladesh. It outlines the purpose, approach, and methodology of the scoping assessment, provides an overview of health system issues, achievements and challenges, presents priority health systems areas and activities, and the interventions identified by stakeholders that could be addressed and/or supported through a health partnership (HP). The programme overview for the scoping assessment is included in [Annex 1](#).

UK PARTNERSHIPS FOR HEALTH SYSTEMS PROGRAMME (UKPHS)

In 2019 the UK Department for International Development (DFID) contracted the Tropical Health and Education Trust (THET) and the Liverpool School of Tropical Medicine (LSTM) to manage and implement the UK Partnerships for Health Systems programme (UKPHS). This programme has a value of £30m and a time frame of December 2019 to March 2024.

UKPHS aims to improve health system performance in Low- and Middle-Income Countries (LMICs) through Health Partnerships (HPs) between health institutions in the LMIC and health institutions from the UK health system that address nationally identified priorities and enable progress towards Universal Health Coverage (UHC), especially for poor and vulnerable populations. The programme will achieve this by supporting the development of stronger health systems, including components such as leadership and management, information systems, quality of care and the health workforce.

THET will provide grants to Health Partnerships to deliver these activities. UKPHS will support large grants in ten countries namely, **Bangladesh**, Ethiopia, Ghana, Myanmar, Nepal, Sierra Leone, Somalia/Somaliland, Tanzania, Uganda, and Zambia. These grants will explicitly focus on supporting nationally identified priorities, complemented by smaller partnership grants that take on innovative approaches to address specific health system challenges. The UKPHS will promote HPs that are aligned to the health strategies of that country, focusing on quality and reaching the poorest and most vulnerable populations.

PURPOSE AND OBJECTIVES OF THE SCOPING ASSESSMENT

In order to understand the health system priorities that could be addressed through HPs under the UKPHS programme in Bangladesh, a scoping assessment team comprising THET UK and Bangladesh staff, and health systems and Gender Equity and Social Inclusion (GESI) specialists from LSTM, undertook a detailed scoping assessment in Bangladesh to examine and analyse health systems issues to inform the design of country specific grant calls for the UK Partnerships for Health Systems (UKPHS) programme, that are aligned with, and address national priorities.

The overall purpose of the scoping assessments was to introduce the UKPHS programme to key stakeholders, to collaboratively identify and validate national health systems priorities, and to determine how health partnerships could contribute to addressing the priorities identified and health systems strengthening.

The specific objectives are to:

- introduce the UKPHS programme to key in-country stakeholders
- identify, validate and/or get consensus on national health system strengthening (HSS) issues, gaps and priorities, while considering gender equity and social inclusion (GESI), across the six Health System (HS) building blocks with key stakeholders
- explore the feasibility of the health partnership (HP) model to address the identified HSS priorities

- identify interventions that could be implemented through HPs and address these HSS priorities, as well as support the country's progress towards UHC
- identify and understand the work of key actors supporting HSS in the country to ensure HPs build complementarity and synergies with these programmes and initiatives
- agree the way forward and national level mechanisms for ongoing programme oversight and monitoring.

EXPECTED OUTPUTS OF THE SCOPING ASSESSMENT

The team expected to validate health and identify health systems priorities that could be potentially addressed by a HP. In addition, a National Oversight Mechanism (NOM), comprising a small core group of key stakeholders from the MoH, the Foreign, Commonwealth and Development Office (FCDO) and other relevant organisations to provide ongoing oversight and coordination of the UKPHS in Bangladesh will be established.

SCOPING ASSESSMENT APPROACH AND METHODOLOGY

DESK REVIEW

Prior to the scoping assessment, the LSTM team undertook a desk review of available secondary data (the list of documents reviewed is in [Annex 5](#)) to identify and document key health systems priorities ([Annex 2](#) shows priorities identified under the six health systems components) in Bangladesh. These secondary documents included national and health policies and strategies, such as the Health, Population and Nutrition Chapter of the Government of Bangladesh's (GoB) Eighth Five Year Plan 2020 to 2025; the Programme Implementation Plan (PIP) for the 4th Health, Population and Nutrition Sector Programme (HPNSP), the Bangladesh Health Workforce Strategy, the National Strategy for Adolescent Health 2017-2030, the 2014 Gender Equity Strategy and the 2019 Community Health Worker Strategy.

Further, the team reviewed the Operational Plans for key thematic areas, related to the six health systems building blocks, namely reproductive, maternal, newborn, child and adolescent health and nutrition, communicable and non-communicable diseases, governance and stewardship, human resources management and development, nursing and midwifery education and services, financial and sector management, and pharmaceuticals and supply chain management.

The team also reviewed key surveys and evaluations, such as the Bangladesh Maternal Mortality and Health Care Survey 2016, the Bangladesh Health Facility Survey 2017, the Post Graduate Medical Education in Bangladesh: A Situation Analysis, and the Evaluation of Community Based Health Services in Bangladesh, as well as the Independent Review Team's 2020 of the Mid-Term Review (MTR) – the main and relevant thematic reports - of the 4th Health, Population and Nutrition Sector Program (HPNSP). The FCDO, who was briefed by the assessment team, prior to the commencement of the scoping assessment, made many of these documents available to the team.

The LSTM team used the WHO Health Systems Framework and its six building blocks as the key framework against which to identify and categorise the health systems priorities extracted from the documents and to develop a **Stakeholder Feedback Tool** ([Annex 3](#)). This tool was used to collect a mix of numerical and descriptive inputs and feedback from the identified stakeholders. The LSTM team also developed a range of cross cutting GESI priority areas, informed by documentation and information beyond the policy documents and reports reviewed by the team (RINGS, 2019). These were included under each of the health systems components in the Feedback Tool, with stakeholders asked to identify the GESI activities which they felt were most important and/or relevant in their contexts.

STAKEHOLDER CONSULTATION AND ENGAGEMENT

The scoping assessment team adopted a participatory stakeholder approach to the facilitation of meetings with stakeholders to identify health system strengthening priorities in Bangladesh that could best be addressed by a Health Partnership, under the UKPHS programme. Multidisciplinary and multi-sectoral stakeholder involvement were sought to enable a rich and comprehensive examination and analysis of health systems priorities and potential HP interventions to address these.

The THET Bangladesh Country Director (CD), who is very familiar with the Bangladesh context and its health systems and has well established relationships with key actors in the health sector, helped to facilitate the assessment. Prior to the assessment, the CD conducted a stakeholder analysis and identified approximately 25 stakeholders who play a key role in health systems strengthening within the health system, at national and sub-national levels, and that should be involved in the scoping assessment (See [Annex 4](#) for a list of stakeholders consulted). The stakeholders identified include representatives from the various directorates within the Ministry of Health and Family Welfare (MOHFW), as well as stakeholders from key Universities and Health Training Institutions, UN agencies, development partners, and international and national NGOs. The list of stakeholders selected to participate in the scoping assessment was made available to the FCDO Health Advisor and senior MOHFW officials for their review and validation.

A preliminary desk review report, prepared by the LSTM/THET team, was shared with the FCDO Health Advisor and senior MOHFW officials, to familiarise them with the approach and methodology to be used for the scoping assessment. These stakeholders were also invited to provide feedback on the documents reviewed and the Health Systems priorities identified. The FCDO responded by providing the assessment team with a copy of the Health, Population and Nutrition Chapter of the Government of Bangladesh's (GoB) Eighth Five Year Plan 2020 to 2025. The FCDO's comments on the Health Chapter was also made available, with those relevant to the scoping assessment represented in Section 5 below.

Prior to commencing the scoping assessment, the THET Bangladesh CD met with high level MOHFW officials on several occasions to share information on the purpose and objectives of the scoping assessment, as well as to provide an overview of the UKPHS programme, the HP model and examples of previous Health Partnerships in Bangladesh ([Annex 1](#)). The THET CD also sought the cooperation and endorsement of these leaders to schedule meetings with key MOHFW Line Directors and programme managers. In addition, the officials consulted were invited to identify what they considered to be the country's health systems priorities and, in particular, those that could be addressed by a HP.

The THET Bangladesh CD disseminated the Stakeholder Feedback Tool, along with other relevant information on the UKPHS programme to the 25 selected stakeholders with the aim of having them validate the identified HS priorities and to indicate priorities that could be best addressed by a HP. Respondents were asked to rank the six health systems components in order of priority and within each of these to score the priority areas and activities in order of importance. Respondents were also asked to respond to four key questions to get their agreement/disagreement with the priority areas and activities identified, to enable them to identify and add any activities omitted, and to identify the priorities that could be addressed by the health partnership model. The CD contacted each stakeholder, before and after the dissemination of the tool, to provide further information and/or clarifications.

A total of 18 respondents returned the completed stakeholder feedback tool. The LSTM team analysed the responses provided through the tool, and findings are presented and discussed in Section 4 of the report.

The scoping assessment team synthesized and summarised the findings from the analysis of the data provided through the Stakeholder Feedback Tool and presented the preliminary report, outlining the identified HS priorities and the proposed priority areas and activities that potentially could be addressed by a HP, to the FCDO Health Advisor for her review and validation. The HA's comments and feedback informed the focus of a final stakeholder consultation meeting with a core group of stakeholders, comprising senior MoHFW, the FCDO HA and other key stakeholders. The purpose of this meeting was to validate a final set of HS priority areas and activities that could potentially be addressed by a HP. Deliberations and conclusions are presented in Section 6 below.

In addition to the prioritisation of the HS areas and activities that could be potentially addressed by a HP, the functions and composition of a National Oversight Mechanism for the UKPHS programme were also discussed with the MoHFW and the FCDO HA.

The agreed set of priorities for which the HP model was deemed suitable and feasible are presented in the Theory of Change presented on page 35.

Bangladesh is one of the most densely populated countries in the world. Health and education levels are relatively low, although they have improved in recent years as poverty levels have decreased. Most Bangladeshis live by subsistence farming in rural villages.

POLICY ENVIRONMENT

The health system of Bangladesh is a pluralistic system with four key actors: government, private sector, non-governmental organisations (NGOs) and donor agencies. It has gone through a number of reforms in recent years and an extensive health infrastructure has been established in the public and private sectors.

Bangladesh has been following a Sector-Wide Approach (SWAp) in the health sector since 1998. Under the SWAp arrangement, Government, development partners (DPs) and other stakeholders within a single sector policy and expenditure program, and under Government leadership, adopt common approaches across the sector, and progress towards relying on Government procedures to disburse and account for all funds (GoB, 2020).

The Fourth Health, Population and Nutrition and Sector Program (4th HPNSP) covering the period from January 2017 to June 2022, is aligned with the sustainable development goals (SDGs) and takes a holistic approach, with its focus on (a) strengthening MoHFW's governance and stewardship roles in the HNP sector; (b) strengthening systems/ institutions for efficient service delivery; and (c) expanding HNP services and emphasizing service quality both in public and private sectors (GoB, 2020).

The planning and design of the current SWAp (4th HPNSP) has a pro-poor focus and is geared to tackling gender inequality and improving equity by improving access to and utilization of health. The 4th HPNSP aims to achieve this through two components. The first is improving health services, such as maternal and child health, family planning, reproductive health, adolescent health, communicable and non-communicable diseases, and supporting the service delivery system, including PHC. The second component focuses on strengthening health systems such as governance and human resources.

The GoB has focused a large share (approximately 45%) of resources at the upazila and below levels where majority of the population live to reduce inequity in health. Other initiatives aimed at improving equity include the pilot social health protection scheme, "Shasthyo Shuroksha Karmasuchi (SSK) which provides free hospital services to the poor; the Maternal Health Voucher Scheme (MHVS) for poor and vulnerable pregnant women; and conditional cash transfers (CCs), enabling women to access PHC services nearer to their homes.

The formulation and implementation of national health, nutrition and population policies along with maternal, neonatal and child health strategies, have contributed to improving service delivery in Bangladesh. The fiduciary capacity of the MoHFW has been strengthened and health management information systems (MIS) have improved through digitalization. Improvements in procurement, budget planning, sector coordination and management, fund absorption capacity, monitoring and supportive development of overall socio-economic conditions have reportedly contributed to improved outcomes in maternal, newborn, infant and under-5 mortality rates, the total fertility rate and malnutrition, and have increased life expectancy (GoB, 2020).

The GoB has also formulated a number of health workforce policies in recent years. An Action Plan of the Bangladesh Health Workforce Strategy was drafted in 2015, which reaffirms the GoB's commitment to the achievement of the SDGs:

The Government of Bangladesh (GoB) is obligated to ensure that all citizens enjoy a quality of life assured with basic healthcare and adequate nutrition as stated in the Article 15a of the Constitution. Vision 2021 of the Government aims to transform the country Bangladesh from a developing country into a middle-income country by 2021. The Government is also committed to achieving the globally accepted goals such as SDG to be achieved by 2030 (MoHFW/WHO, 2017).

A supplementary document to the National Health Workforce Strategy, a National Strategy for Community Health Workers (MoHFW/WHO, 2019), was prepared in 2019. This strategy affirms Bangladesh's commitment to the PHC approach, as spelt out in

Alma Ata and reiterated in the 2018 Astana Declaration, and outlines the key role envisaged for CHWs in the delivery of PHC services.

HEALTH OUTCOMES AND ACHIEVEMENTS

There have been significant improvements in a number of health indicators. The Maternal Mortality Ratio (MMR) decreased from 181 per 1,00,000 live births in 2015 to 165 in 2019; the under-five mortality rate declined from 36 per 1,000 live births in 2015 to 28 in 2019, while the neo-natal mortality rate (NMR) decreased to 15/1,000 live births in 2019 from 20 in 2015; achieving the 2025 SDG targets (GoB, 2020). Malnutrition is reducing, with rates of stunting (height-for-age), underweight and wasting of children decreasing. Immunization coverage, and the total fertility rate have also improved.

Prevalence of HIV/AIDS (all ages) is low in Bangladesh and the incidence rate of TB and malaria is declining. There is a high burden of neglected tropical diseases (NTDs), and non-communicable diseases (NCDs), including cardiovascular disease, cancer, diabetes, and chronic respiratory disease, which constitute a major share of the overall disease burden and mortality in the country. The revitalisation of community clinics and community-based health care service provision has helped to increase access of poor women to health services.

There have been improvements in the availability of medical educational institutions both in the public and private sectors, from 190 in 2009 to 786 in 2018. There have been significant improvements in strengthening nursing and midwifery education and services. The availability of key health cadres - doctors, nurses, midwives, and community-based cadres has also improved, with vacancy rates declining to around 15% in 2018 from above 20% in 2011.

ONGOING HEALTH SYSTEMS ISSUES, CHALLENGES

However, despite recent economic growth, poverty and income inequality remain persistent challenges for the country. Bangladesh faces a number of major challenges, including poverty, corruption, overpopulation and vulnerability to climate change (WHO, 2015). The health system continues to face challenges to achieving universal health coverage (UHC). These include a lack of coordination between the two ministries implementing primary health care (PHC); a critical shortage of trained health providers and skill-mix imbalances in the public sector; and inequitable access to health services between urban and rural areas (WHO, 2015).

Service delivery challenges highlighted in the literature reviews include assuring quality of care, addressing the demographic transition and the increasing demand for urban primary health care services; addressing the epidemiological transition and the double burden of communicable diseases and NCDs; ensuring skilled attendance at birth; improving the overall nutritional situation; improving the quality and safety of food and drugs; providing adequate health response to gender-based violence; improving mental health care, expanding services to hard-to-reach (HTR) areas, and addressing emerging health challenges (GoB, 2020).

The documentation reviewed highlights the need for increased efforts to address equity issues related to geographical location, ethnicity, gender, and different forms of marginalization. In general, women and children have less access to health care and their health status is relatively worse than their male counterparts.

Institutional issues such as strengthening governance, stewardship, and regulatory functions; 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. Rising out-of-pocket expenditure is creating greater hardships on lower income and poor people and is a barrier to achieving UHC. The need for increased domestic financing and investment, and more effective local accountability are also acknowledged as critical to improving the quality of health services.

The COVID-19 pandemic has highlighted the importance of human health for national development and welfare and exposed the need for strong and resilient health systems. As a result of the pandemic, the health system in Bangladesh has come under great

pressure and important gaps in health care on both the supply and demand sides have been exposed. Supply side constraints identified include weak capabilities, inadequate physical facilities, lack of emergency preparedness, shortage of human resources, critical supplies and materials, and unbalanced distribution of health care facilities across the country. On the demand side, the low capacity to pay for the poor and lower middle class for emergency health care needs has emerged as a major constraint (GoB, 2020).

SYNTHESIS OF PRIORITIES ACROSS STAKEHOLDERS

HEALTH SYSTEMS PRIORITY AREAS

The health systems priorities identified through the desk review were categorized under six health system components as shown below. The components ranked the highest priority across all respondents are: (1) Service Delivery; (2) Human Resources for Health; and (3) Governance and Leadership.

SUMMARY OF HEALTH SYSTEMS PRIORITY AREAS ACROSS STAKEHOLDERS

Rank	Health System Area	Lowest score = highest priority
1.	Service Delivery	35
2.	Human Resources for Health	36
3.	Governance and Leadership	39
4.	Health Information Systems	67
5.	Health Financing	56
6.	Medical Products and Technologies	84

SUMMARY OF HEALTH SYSTEMS PRIORITY AREAS BY NUMBER OF TIMES RANKED BY RESPONDENTS

The following results are highlighted:

- Service Delivery was ranked the number one priority by 9 out of the 18 respondents
- All respondents ranked Health Financing as one of their priorities
- Service Delivery, and Governance and Leadership were ranked in the top 3 priorities by 13 respondents, 12 respondents ranked HRH in the top 3, while 7 respondents ranked Health Financing in their top three priorities
- Two respondents ranked Health Information Systems in their top three priorities

Health Systems Component	1	2	3	4	5	6
Service Delivery	9	0	4	2	0	1
Human Resources for Health	2	7	3	1	1	0
Governance and Leadership	4	4	5	3	0	0

Health Information Systems	0	0	2	4	9	0
Health Financing	1	4	2	5	3	1
Medical Products and Technologies	0	1	0	0	2	12

ACTIVITY SCORING ACROSS ALL STAKEHOLDERS

Within the six health systems components respondents were asked to score the priority areas and activities in order of importance. The top three priority activities selected by all respondents across the six health systems components are consolidated and presented below. Those with lower scores are given more priority.

It should be noted that the results below are influenced by the number of stakeholders that ranked each health systems area. While stakeholders were only required to rank their top three HS components in order of priority, some ranked less than this, while others ranked all six, and therefore, the results should be interpreted accordingly. Regardless, the ranking gives an indication of which health systems activities within each of the health systems component stakeholders view as a priority.

SERVICE DELIVERY ACTIVITY SCORING

Health System Activity	Lowest score = highest priority
Health care Provision - Rural PHC and community health	26
Explore institutional reforms required within MOHFW to drive rural and urban PHC, e.g., establish new Directorate for Primary Health Care, with 2-line directors, and separate OPs, one each for rural and urban health.	31
Capacity strengthening of the new Community Clinic (CC) Trust status, including provision of Technical Assistance (TA) to finalise governance structures, operationalise Trust management and to build stewardship capacity of DGHS to fund, regulate and monitor community clinics.	37
Modify contracts and job descriptions for all community health personnel (Health Assistant, Family Welfare Assistant, Community Health Care Provider, Multipurpose Health Volunteer), avoiding impact on well performing programmes such as EPI	48
Health care Provision - Urban PHC	49
Map all urban health facilities and use information to set up integrated service delivery network for 6-10 wards around a government secondary/tertiary hospital.	44
Fine tune the 2020 Urban Health Strategy	57
Delineate the roles of MoHFW, MoLGRD&C and the LGIs for Urban Health	54
Health care Provision - Secondary and Tertiary	46
Establish structured referral system in high performing districts and develop guidelines	30
Make existing hospitals fully functional before starting new construction (needed staff, equipment and drugs)	37
Allocate budget to hospital managers for quality improvement initiatives and assessment of effectiveness	33
NCDs	55
Implement an NCD Behaviour Change Campaign to address underlying lifestyle determinants (exercise, diet, substance abuse)	42

Activate the coordination committees set up at district and upazila levels to implement multisectoral actions (under the multi sectoral action plan) for NCD prevention by different sectors	42
Increase budget allocation to NCD programme, including for management of hypertension and diabetes, for staff, drugs and supplies, and institute better patient tracking through dedicated patient records and HMIS/DHIS2	41
MNCAH including Reproductive Health	69
Revise the current maternal health action plan to include MTR recommendations and implement the plan, prioritizing high maternal and neonatal mortality geographical areas.	17
Rationalise availability of 24/7 normal delivery (selection of union level facilities) and BEmONC and NSU (selection of UzHC and MCWC) with adequate HR and midwifery led continuity of care	24
Improve access to 24/7 normal delivery facilities for slum populations and remote and difficult to access areas through innovative strategies such as ‘alongside midwifery-led care’ units and partnerships with private providers (slums) and maternity homes and introduce telemedicine for guiding emergency care	30
Mental Health	94
Secure approval of the Mental Health Strategy, and prioritise activities for implementation during remaining period of HPNSP	22
Include mental health indicator at RFW (Suicide rate) and OP level (Substance Use Disorder) aligning with the SDG results framework	34
Harmonize and standardise mental health training to be coordinated by NCDC	48
Communicable & Emerging Diseases	99
Fill all vacant Laboratory Technologist positions so that costly procured Gene Xpert machines are utilized properly	17
Ensure a smooth transition of support for the TB programme from decreasing donor funding to increased domestic funding.	21
Adolescent Health	100
Implement the finalised Adolescent Action Plan, including preconception care package in collaboration with Ministry of Education (schools programme) and Ministry of Women’s Children Affairs (early marriage and childbearing)	27
Capacity building of health personnel in strategic leadership positions to develop and manage services for adolescents;	25
Strengthen partnerships with all relevant actors at the highest level – both government and non-government – to deliver effective services which meet adolescent health needs;	30
Immunisation	114
Improve immunisation coverage in urban areas and remote and difficult to access areas and plan for the smooth transition of vaccine procurement	16
Nutrition	120
Speed up the progress on reducing stunting by investing in actions to improve Exclusive Breastfeeding (EBF), continued breastfeeding and MAD for children between 6 and 23 months	26
Intensify counselling during the entire first 1000 days of life on exclusive breast feeding and complimentary feeding, introduce Growth Monitoring and Promotion (GMP) near and in the community and introduction of CMAM. Link GMP services to EPI services in the CC and during outreach sessions	37
Prioritize the development and implementation of an Urban Nutrition Strategy that covers all forms of malnutrition taking into account the lifecycle approach; include adolescents.	46
Family Planning	148
Use post FP2020 Costed Implementation Plan (CIP) to revise FP related OPs and develop approaches to mobilize additional resources to address funding gap	34

Place responsibility for oversight of CIP implementation within the new Governance Stewardship, and Regulation Unit	49
Provide needed resources as per CIP to strengthen FP delivery in both DGHS and DGFP operated facilities, especially LARC and PMs.	50
Health security & emergency preparedness	147
MOHFW to endorse National Action Plan for Health Security and capacity built in compliance with International Health Regulations (IHR)	20
Strengthen the existing surveillance system for communicable and non-communicable diseases	32
Develop capacity at designated points of entry in compliance with IHR (2005), including setting up Emergency Operation Centres at all levels for emerging diseases	30
Eye Care For All	152
Fill vacant positions of ophthalmologists at district hospitals and provide more trained nurses to run the community vision centres at the UzHCs	14
Provide care for corneal disease	28
Incorporate Cataract Operation within the system, replacing the 'Eye Camp' modality and incorporate data from all facilities in the DHIS2	25
Environmental Health and Waste Management	165
Introduce in-house Medical Waste Management (MWM) (e.g. Autoclave Steam Sterilization) in all Public Medical College Hospitals, Specialized Hospitals and District Hospitals and selected UzHCs	13
Conduct final disposal of hazard waste in pits at all UzHCs (until there is assurance that disposal by city/municipal corporation is environmentally safe and scientific)	32
Explore PPP model for Medical Waste Management and engagement of private hospitals.	31

Human Resources for Health Activity Scoring

Health System Activity	Lowest score = Highest Priority
Human resources management & institutional arrangements	18
Endorse key HR documents (planning, policy) and tools, and use to generate plans to fill vacant positions against all categories of HWF (including administrative, allied, and supporting HR)	17
Finalise and implement Recruitment and Deployment Action Plan that maximises skill-mix across already sanctioned HR, and for the recruitment of additional HAs and FWAs to fill existing positions and respond to upcoming retirements	42
Update the Health Workforce Strategy 2015, addressing findings of the recently approved 'National CHW Strategy', especially with respect to urban CHW/Auxiliary CHW (definition, need, role of informal providers, etc), and the needs of hard to reach and remote areas like CHT, tea garden, hoar /char/islands	41
Medical Education and Regulation	22
Issue a revised SRO to allocate ME&FWD of MOHFW the required authority and responsibility for the stewardship of medical education and fully complete the transfer of business.	27
Undertake a comprehensive assessment of public and private medical colleges, dental colleges/units	25
Review and update all existing laws of the regulatory bodies (BMDC, BNMC, PCB, BHB and BBAUSM)	32

GOVERNANCE AND LEADERSHIP ACTIVITY SCORING

Health System Activity	Lowest score = Highest Priority
Sector Management, Stewardship and Regulation	15
Review and revise OPs based on the MTR 20202 findings and recommendations.	20
Review the architecture of health sector coordination, with its extensive range of committees and task groups, and rationalise working practices and act to ensure strong and sustained leadership of the sector.	39
Reduce number of OPs, clustered around major themes (PHC rural, PHC urban, secondary, and tertiary etc) with their own logframe, nested within the higher-level results frameworks, with clear indicators to track progress and contribution to higher level goals.	39
Create a Governance, Stewardship and Regulation Unit (GS&RU) in MOHFW to drive reforms related to resource mobilisation, delegation of authority with budget, local level planning, and strategic purchasing.	38
Drug Quality and Regulation	33
Qualified HR with proper training in the DGDA and NCL, including IT personnel.	21
Meet NRA standards, so the Bangladesh pharmaceutical industry can be WHO pre-qualified.	25
Working with DGDA and DGHS, expand Pharmacovigilance (PV) activities in hospitals and pharmaceutical companies, and review status of ADE reporting system, including awareness program among the stakeholders through allocation of sufficient budget to address this issue	27
Health Financing and Equity	28
Prepare advocacy materials (including newspaper articles) and advocate for the health budget increase from 0.4% of GDP to 1% of GDP, funded by general taxation, and earmarked taxes, (e.g. tobacco and sugar tax)	35
Health Economics Unit (HEU) to revisit and modify the Health Care Financing Strategy, taking on board UHC lessons from countries similar to Bangladesh (e.g., Indonesia).	21
Enact a Health Protection Act	33

HEALTH INFORMATION SYSTEMS ACTIVITY SCORING

Health System Activity	Lowest score = Highest Priority
Information Management & Data Quality	

Development of Health System Innovation and Incubation Unit (HSIIU) under MOHFW to perform research, innovation, incubation and validation for improving health system, service delivery, better patient care and address emerging health issues.	19
Conduct IT system audit to evaluate and identify the structure and limitations of DHIS2 and all existing system of DGHS, DGFP and other MIS (MNCAH, CBHC, HSM, RMNCAH, FP, NNS, etc.)	20
Implementation of digitalised service recording, tracking and referral system from household (MHV) to CC (CHCP) to distribute patient load and improve quality of services.	27

HEALTH FINANCING ACTIVITY SCORING

Health System Activity	Lowest score = Highest Priority
Financial Management & Audit	
Strengthen Internal Audit Function: set up an internal audit outfit in FMAU (HSD) and engage experts to help develop capacity of staff for conducting internal audit.	28
Expedite completion of the ongoing approval process of recruitment rules for FMAU (HSD) and recruit sanctioned staff to make it fully functional	33
Establish FM Unit at LDs of all major OPs and deploy staff with FM background	39

MEDICAL PRODUCTS AND TECHNOLOGIES ACTIVITY SCORING

Health System Activity	Lowest score = Highest Priority
Procurement and Supply Chain Management	14
Reform of procurement policy to allow prequalification and framework contracts.	19
Reform of financial flows to allow funding to be spared from one year to the next.	20
DGHS to expand LMIS for DGHS to 200 most common ESP items and roll it out to all Upazila and hospitals.	21
Infrastructure	12
Establish local steering committees for each construction project, with presence of local management of Upazila/hospital, HED/PWD, equipment procurement and personnel allocation.	20
DGHS to establish a Logistics and procurement Line Director within HS, responsible for LMIS and all centralized procurement on behalf of other line directors.	16
DGHS to establish long term procurement plans (three years) to the extent possible within the present rules and regulations while working on expanding the frame.	23

GENDER EQUALITY AND SOCIAL INCLUSION (GESI) PRIORITISATION ACROSS ALL STAKEHOLDERS

The GESI priority areas under each health systems component are different from the other priority areas in that they are: (1) cross-cutting; and (2) informed by documentation and information beyond the policy documents and reports reviewed by the LSTM team. The aim is for gender equality and social inclusion to be integrated and advanced in all HPs supported under the UKPHS programme.

The GESI priority areas, included in the Stakeholder Feedback Tool for Bangladesh, were to enable stakeholders identify which GESI activities they felt were most important and/or relevant for their context. In addition, relevant GESI activities under each of health systems component can sometimes be difficult to identify, which is why additional GESI related activities were included for stakeholders to consider.

As mentioned above regarding the scoring of the HS priorities, the scores below will be influenced by the number of health system components ranked by respondents. While stakeholders were only required to rank their top three, some ranked less, while others ranked all seven. Regardless, the numbers give an indication of which GESI activities within each health systems area stakeholders view as a priority. Those with higher scores are given more priority. GESI activities that received the highest scores are presented below.

The activities that are of the highest priority across all seven health systems areas included:

- The collection and use of data disaggregated by factors (such as sex, location, age, disability, etc.)
- Ensuring MoHFW policies, strategies, operational plans and other programmes adhere to the principles of gender equity and effective practice in line with the GoB commitment to equality
- Development of gender responsive budgets
- Increased representation of women and other key groups, including patients and communities, on relevant committees.

Gender equality and social inclusion (GESI) prioritisation across all Health System Activities

Health System Activity	Lowest score = Highest Priority
Integration of GESI approach into health <u>service delivery</u>	
Develop a strategy, including a plan of action, for prioritizing approaches for gender equity, gender-based voice and accountability, social inclusion and fair and respectable interaction with women and poor, in all tiers of PHC services;	22
Ensure equitable access to and utilisation of services by women, girls, boys and other socially excluded people within a rights-based approach.	36
PHC service provision targets women in garment factories, tea garden workers and slum populations	37
Integration of GESI approach into <u>HRH interventions</u>	
Disaggregation and analysis of data by sex and other social stratifiers (e.g., age, location, cadre)	28
Ensure gender-sensitive health care providers have appropriate skills development to deliver gender sensitive, non-discriminatory services.	22
Development and analysis of gender-sensitive HRH data	32
Integration of GESI approach into management of <u>governance and leadership</u>	
Ensure MOHFW policies, strategies, operational plans and other programmes adhere to the principles of gender equity and effective practice in line with the GOB commitment to equality	12
Mainstream gender in all programmes with MOHFW and other ministries and organisations through equitable planning, policymaking, and budgeting	23
Ensure all OPs are gender sensitive and budgets allocated are gender responsive	33
Integration of GESI approach into <u>health information systems</u>	
Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)	24
Develop information management approaches that focus on the role of quality data in providing knowledge about gender inequities, e.g., gender-sensitive health indicators to identify key differences between women and men in relation to health and social determinants of health, to support policy change	26
Establish positive practices in the systematic collection of gender disaggregated statistical data	29

Increase participation of patients and community in assessment and reviewing any disaggregated data to measure improvements in inequalities.	29
Integration of GESI approach into <u>health financial management</u>	
Development of gender responsive budgets	13
Advocate and support gender analyses of health financing and insurance proposals to ensure that they do not discriminate or disadvantage women and effectively address women’s health and family planning needs	29
Increase representation of women and other key groups on financial management committees.	34
Integration of GESI approach into management and use of <u>medical products and technologies</u>	
Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.	12
Development and analysis of gender-sensitive medicines and technologies management and use.	17
Increase representation of women and other key groups, including patients and communities, on relevant committees	14

FEASIBILITY OF A HP TO ADDRESS THE IDENTIFIED HS PRIORITIES

As described above, one of the key objectives of the scoping assessment was to, using the stakeholder feedback tool and face to face and remote meetings, elicit stakeholders’ perspectives on the national HS priorities, to enable them to validate the priorities identified through the document review, and to get their views and perceptions of the importance of these priorities across the six health system building blocks/components.

A second key objective was to facilitate further reflection by stakeholders on the identified HS priorities to determine which of these priorities could be best addressed by a Health Partnership. To enable stakeholders to make an informed selection and shortlist the priorities, the LSTM/THET team provided them with a range of informational materials on the UKPHS Programme, the Health Partnership modality and previous and ongoing HPs in Bangladesh and other countries (see [Annex 1](#)). To aid understanding, the THET CD followed up individual respondents, face to face and remotely to provide any additional guidance and information required.

Using this information and their understanding of the HP model, respondents were then asked to respond to the relevant open-ended question in the stakeholder feedback tool and to identify which of the priority HS areas and activities could be best addressed by a Health Partnership. In responding to this question, respondents were asked to consider several criteria against which to assess the feasibility of the HP model to address a particular HP intervention, as listed in the table below.

Assessment Criteria		Considerations
Feasibility – Will the intervention be able to achieve its objectives given the time and resources available?		To what extent are the identified priority activities to be addressed through a HP achievable given the timeframe and financial resources available?
Coherence – How well does the intervention fit?	Internal coherence addresses the synergies and interlinkages between the intervention and other interventions carried out by the same institution/ government	To what extent are the identified priority activities to be addressed through a HP aligned with national priorities? Consider how your intervention will: <ul style="list-style-type: none"> • Align with other HSS interventions • Support linkages and synergy with MoH • Support and comply with GESI goals
	External coherence considers the consistency of the intervention with other actors’ interventions in the same context.	

		<ul style="list-style-type: none"> • Have added value and avoid duplication
Relevance - Will the intervention do the right things?		<p>Consider how identified priorities:</p> <ul style="list-style-type: none"> • Are relevant to needs of beneficiaries, institution, or country, priorities • Will remain relevant • Are supportive of GESI needs and aims
Effectiveness – Will the intervention achieve its objectives?		<p>Consider how identified project activities:</p> <ul style="list-style-type: none"> • Are likely to achieve their objectives and results • May be affected by barriers and challenges • Might achieve their GESI related objectives
Efficiency - How well will resources be used?	Technical efficiency - producing the maximum possible output from a given set of inputs	<p>To what extent will the identified priority activities to be addressed through a HP deliver, or are likely to deliver, results in an economic and timely way?</p> <p>Think about:</p> <ul style="list-style-type: none"> • Whether inputs could be converted into outputs, outcomes, and impacts in the most cost-effective way • Will VFM be achieved? • Are HPs the most cost-effective model for achieving the objective?
	Allocative efficiency - allocating resources to the most cost-effective approaches and interventions	
Access – Will there be equal access to benefits?	Financial access – the extent to which people are able to pay for health services	<p>Consider the barriers to access that might exist:</p> <ul style="list-style-type: none"> • Will the HP promote equal access for all people and address economic, physical, cultural, or other barriers that people of all genders and those living with disabilities might face in using health services?
	Physical access – the extent to which health services are available and reachable	
Quality		<p>To what extent will the identified priority activities to be addressed through a HP improve the quality of care and meet the needs of people of all genders and those living with disabilities?</p>
Equity – will an equity focused approach be embedded?	Horizontal equity – equal treatment of equal need	<p>Think about whether the identified health priority activities can:</p> <ul style="list-style-type: none"> • Be effective in reaching poor and vulnerable groups • Promote horizontal and vertical equity
	Vertical equity - the extent to which individuals with different characteristics should be treated differently	

		<ul style="list-style-type: none"> Address axes of inequity
Impact – what difference will the intervention make?	Consider how the identified interventions might be able to:	<ul style="list-style-type: none"> Generate significant higher-level effects, such as contribution to SDGs Impact on health service performance Impact on health worker performance Achieve GESI related impact and outcomes
Sustainability – will the benefits last?	Consider if the benefits (including GESI) will continue beyond the life of the UKPHS programme	

For example, respondents were asked to consider the coherence and fit of a proposed HP intervention with other HSS interventions being supported in the health sector to ensure synergy and harmonised approaches, and to avoid duplication. Stakeholders were also asked to consider the time frame of the UKPHS programme and the financial resources available through the individual grants. Other considerations included the potential of the HP interventions to contribute to health systems strengthening effectively, efficiently, and sustainably, while ensuring equity and quality. Respondents views and perspectives on which HS priorities were best addressed by a HP, and where a HP could add most value, are presented and discussed in the following sections.

The ability of the Health Partnership community to respond to the identified HS priorities is dependent on the expertise available both in Bangladesh and in the UK. Throughout the scoping exercise, all stakeholders were asked to identify areas which they thought would be appropriate for Health Partnerships to respond to, as well as identifying areas where there were gaps in others responding. THET and LSTM will work to stimulate the supply of institutions which can respond to the identified priority areas and activities.

HEALTH SYSTEMS PRIORITIES IDENTIFIED BY STAKEHOLDERS

The 18 stakeholders who responded and provided feedback are clustered according to their organisational remit and key functions into five main groups as shown in the table below.

Stakeholder clusters

Stakeholder Group	Organisation/Institution
Ministry of Health and Family Welfare (3 respondents)	Directorate General of Medical Education (DGME)
	Management Information Systems (MIS), Directorate General of Health Services (DGHS)
	Bangladesh National Nutrition Council
Health Training & Research Institutions (8 respondents)	Bangabandhu Sheikh Mujib Medical University
	Bangladesh University of Health Sciences
	BRAC James P Grant School of Public Health, BRAC University
	Department of Economics, University of Dhaka
	Centre for Injury Prevention and Research, Bangladesh
Development Partners (2 respondents)	Interactive Research and Development, Bangladesh
	UNFPA
National/International NGOs (2 respondents)	Embassy of Sweden
	Partners in Health and Development (PHD)
Independent Consultants (3)	Orbis International
	Individual Consultant - Health Specialist

respondents)	Individual Consultant – MNCAH-FP Specialist
	Freelance Consultant - Health Economics Specialist

The key priority HS **components** identified by each of these 5 groups are presented below. Service Delivery, HRH, and Governance and Leadership were the top three priority components for four out of the five groups. Governance and Leadership was one of the top three priorities for all groups.

MINISTRY OF HEALTH AND FAMILY WELFARE

The THET CD consulted and met with a number of MoHFW stakeholders in the Directorate General of Medical Education and the Directorate General of Health Services. As shown in the table below, two MOHFW respondents provided feedback through the Stakeholder Feedback Tool and one referred the THET CD to another official for feedback.

MOHFW respondents

Ministry of Health and Family Welfare	1. Directorate General of Medical Education (DGME)
	2. Management Information Systems (MIS), Directorate General of Health Services (DGHS)
	3. Bangladesh National Nutrition Council

PRIORITY HS COMPONENTS

The table below shows the key priority HS components identified by the MOHFW. The components ranked the highest priority across this group of respondents are: (1) Human Resources for Health; (2) Service Delivery; and (3) Governance and Leadership and Health Financing.

SUMMARY OF HEALTH SYSTEMS PRIORITY COMPONENTS BY THE MINISTRY OF HEALTH AND FAMILY WELFARE

Health System Area	Lowest score = highest priority
Service Delivery	5
Human Resources for Health	3
Governance and Leadership	6
Health Information Systems	10
Health Financing	6
Medical Products and Technologies	12

VIEWS ON PRIORITY AREAS IDENTIFIED

Respondent acknowledged that all the key health policies and strategies, including the recent MTR Report, had been reviewed as part of the desk review, and all respondents in this cluster agreed with the priority areas and activities identified. They felt that the country's health challenges and priorities had been identified, especially those related to the availability of a skilled health workforce, logistics and incorporating supervision and monitoring in all major activities. They also acknowledged that most of the activities identified would have an impact on achieving SDGs goals and targets. They noted the need for evidence-based decision making and the importance of governance and policy decisions in running health institutions and hospitals.

PRIORITY AREAS/ACTIVITIES OMITTED

Respondents identified the following additional priority area:

- Initiatives to improve the functioning of existing health and family planning institutions

PRIORITY AREAS AND ACTIVITIES THAT CAN BE SUPPORTED BY THE HEALTH PARTNERSHIP MODEL

When asked which of the identified HS priorities could be addressed by a health partnership, they indicated that the following areas and activities could be considered:

- Emergency response and preparedness.
- Capacity development of existing HR.
- Improvement of health service delivery as a whole

HEALTH EDUCATION, TRAINING AND RESEARCH INSTITUTIONS

The THET CD consulted and met with a number of stakeholders from the health education, training and research area. As shown in the table below, 6 institutions and eight respondents provided feedback through the Stakeholder Feedback Tool.

Health education, training and research respondents

Health Training & Research Institutions	1. Bangabandhu Sheikh Mujib Medical University
	2. Bangladesh University of Health Sciences
	3. BRAC James P Grant School of Public Health, BRAC University
	4. DEPARTMENT OF ECONOMICS, UNIVERSITY OF DHAKA
	5. Centre for Injury Prevention and Research, Bangladesh
	6. Interactive Research and Development, Bangladesh

PRIORITY HS COMPONENTS

The table below shows the key priority components identified by respondents from the health education, training and research institutions. Human Resources for Health; Service Delivery; and Governance and Leadership were all ranked equally as the highest priorities across this group of respondents.

SUMMARY OF HEALTH SYSTEMS PRIORITY COMPONENTS BY THE HEALTH EDUCATION, TRAINING AND RESEARCH INSTITUTIONS

Health System Area	Lowest score = highest priority
Service Delivery	17
Human Resources for Health	17
Governance and Leadership	17
Health Information Systems	32
Health Financing	23
Medical Products and Technologies	41

..... VIEWS ON PRIORITY AREAS IDENTIFIED

The majority of respondents (7 out of the 8 respondents) in this cluster agreed with the priority **HS areas** identified. They noted that the tool followed the WHO’s building blocks, and that the literature review was “extensive’ and ‘very comprehensive’. They felt that the prioritisation had covered a number of programmes in the country, and considered environmental issues, waste management, mental health, and the inclusion of the primary health care directorate, among others. One of the respondents observed that the priority areas identified are critical for public health programming in Bangladesh and will foster progress towards universal health coverage and contribute to the health systems strengthening efforts of the Government of Bangladesh.

However, one respondent felt that the priorities identified only offered government and donor perspectives and that the reports and findings of research and academia should be examined, ‘to get a more critical and unbiased view of the Health System scenario’.

Another respondent noted the importance of the inclusion of the review of the MBBS course as a priority. It was perceived that the Bangladesh health system is ‘extremely vulnerable and corrupted’, and to improve the overall health system, ‘lucid planning’ as well as ‘well-governed service delivery with skilled and adequate human resources should be ensured’.

Another indicated that the Bangladesh Health System is ‘suffering from three important faults’, including: i) poor health system management; ii) lack of coordinated workforce; and iii) insufficient service provision, including UHC, specially for vulnerable groups. This respondent emphasised the importance of prioritizing HS activities to ensure accessibility to good quality services for the population.

..... VIEWS ON PRIORITY ACTIVITIES IDENTIFIED

Respondents in this cluster indicated that the identified priority activities were ‘comprehensive’, and were ‘in line with the national priorities, as documented in different reviews, reports or discussed in policy dialogue’.

The majority of respondents (7 out of the 8 respondents) agreed with the priority **HS activities** identified and felt they were important to strengthen health systems and accelerate progress towards universal health coverage. One respondent felt that the priority areas and activities identified were not “evidence-based”. Another suggested that with such a wide range of priorities identified, prioritisation would have to be done ‘very carefully’.

..... PRIORITY AREAS/ACTIVITIES OMITTED

All but one respondent in this cluster identified additional HS priority areas and activities that should be considered, covering the governance and leadership, COVID 19 and emergency preparedness and prevention, service delivery, HRH, and GESI components.

A number of respondents highlighted health sector corruption as a key governance issue that needs to be addressed. One respondent referred to the findings of the FCDO funded Anti-Corruption Evidence (ACE) Project, led by the SOAS Consortium. The

study has identified chronic problems of corruption and weak governance in health, despite the establishment of an Anti-Corruption Commission and widespread anti-corruption efforts. As a result, it was felt that the governance and leadership component should have been given more 'weight' in the prioritisation. It was perceived that addressing these two issues 'properly', would help overcome many of the health system challenges in Bangladesh. Another respondent highlighted the need for good governance in hospitals, including supporting employees such as ward boys, as reportedly this cadre has been involved in corruption and bribery.

A majority of respondents in this cluster identified COVID 19 prevention and emergency preparedness as priority activities. One suggested that public health focused activities relevant to COVID-19 such as hand washing, sanitisation, use of mask should be included in the Behaviour Change Communication (BCC) plans. Another identified the need to develop an effective, structured emergency health care system, currently lacking in Bangladesh.

One respondent suggested that priority should be given to areas which are neglected but important. Nutrition, drowning as a cause of under 5 mortality, the integration of the management information system across DGHS and DGFP, and coordination with MOLGRD&C, were some of the neglected areas identified.

Another suggested that as NCDs are major causes of mortality and morbidity, these diseases, including mental health and nutrition should be prioritised, with a standard protocol on a digital platform developed for the management of NCDs to improve the monitoring of coverage and the follow-up of cases. Others suggested that additional HS activities could be included, for example multi drug resistant (MDR)-TB and childhood blindness prevention were identified as critical activities to consider.

Other service delivery priority area and activities identified by respondents in this cluster included the following:

- Antimicrobial resistance policy and programs (human, animal, and environment sectors)
- WASH
- Malaria in high burden districts (Hill track areas)
- HIV/AIDS and STIs
- Adolescent Friendly Health Services
- Allied health professionals development for eye care and other programs

Additional priority areas and activities related to the health workforce were also highlighted. One respondent felt that although midwifery was a priority considered under service delivery, this was an area that should receive more emphasis in terms of human resources. It was suggested that the Family Planning (FP) department should utilise the midwifery cadre to improve the provision of FP services, especially post-partum intrauterine device (PPIUD) services. In addition, one respondent felt that the recruitment and deployment of these midwives to private sector clinics would ultimately help to reduce the number of caesarean sections performed in these facilities.

Another respondent noted that the medical education system needs to be reviewed and curricula standardized. Another suggestion was that job descriptions within the DGHS and DGFP should be reviewed, and public health experts should be included in the health and local government ministries.

Regarding mental health services, it was also suggested that before recruiting and deploying the mental health workforce, the government needed to gather 'evidence from NGOs' that 'the mental health workforce plays a significant effect at the community level'.

It was suggested that addressing street children's issues is a priority and this would also promote equity as it is "not only a health service issue, it is a right for these children, in terms of GESI".

Other areas identified required more focus included health technology assessment, coordination with development partners and ministries, as well as the examination of decentralisation and local level planning practices and processes in a more holistic way.

Other omitted priority areas/activities identified by respondents are detailed in the table below.

Additional priority areas/activities

Health System Priority Areas	Activities under Health System Priority Area
Service delivery	
Health care Provision - Rural PHC and community health	Other: <ul style="list-style-type: none"> Waste management of all the hospitals is needed, including district hospitals, not only UHCs JDs of FWVs need to be reviewed as FWV-MW is coming into the system
Adolescent Health	Other: <ul style="list-style-type: none"> Establish active referral system for adolescents (male and female) from schools, community, and clubs to adolescent friendly health services
Immunisation	Other: <ul style="list-style-type: none"> Ensure cold chain to include COVID 19 vaccine storage and distribution related issues in near future
NCDs	Other: <ul style="list-style-type: none"> Implement digital technology-based health service management at primary care level to increase coverage and follow up
Communicable & Emerging Diseases	Other: <ul style="list-style-type: none"> Training is essential for Lab Technicians Ensure adequate lab equipment and its maintenance
Nutrition	Other: <ul style="list-style-type: none"> Include adolescent nutrition, especially iron and calcium Include adolescent's food habits and encourage balanced diet
Human Resources for Health	
Human resources management & institutional arrangements	Other: <ul style="list-style-type: none"> Include JDs for midwives and ensure their position in the health workforce.
Medical Education and Regulation	Other: <ul style="list-style-type: none"> Revisit and revise requirement for tuition in midwifery as well as nursing institutions to be in English Establish a regular quality assurance system for medical education and nursing education Include 'communication' as a subject in the MBBS and BDS curricula. The course should be revisited against international standards Include Gender in undergrad Medical, Dental and Nursing curriculum
Integration of GESI approach into HRH interventions	Other: <ul style="list-style-type: none"> Revisit the Medical Admission Criteria and analyse the effect of feminization of undergrad Medical Education Do the projection of need-based specialists for Bangladesh Population up to 2030 and estimate the male and female Physician Ratio Ensure all service providers in health facilities receive gender training, which should come from within, after the training
Governance and leadership	
Drug Quality and Regulation	Other:

	<ul style="list-style-type: none"> • Qualified HR with proper training in the DGDA and NCL, including IT personnel 'unlinked' to the Pharma industry • Introduce new policies and legislation for putting a cap on the retail price of all drugs
Health Information Systems	<p>Other:</p> <ul style="list-style-type: none"> • Include information on midwifery services • Develop a system of one source of data (integration of data of DGFP & DGHS)

PRIORITY AREAS AND ACTIVITIES THAT CAN BE SUPPORTED BY THE HEALTH PARTNERSHIP MODEL

Most respondents identified priority areas and activities related to service delivery, HRH, governance and GESI that could be addressed by a health partnership:

Several respondents felt that HPs could support the delivery of quality and equitable health services, improve access to and utilization of health care, and service integration. One respondent identified specific services, including rural PHC services, nutrition, and waste management. Another suggested that the provision of healthcare at rural PHC and community levels would be a suitable area to “deploy HPs”. This respondent noted that HPs, especially public-private partnerships (PPP), are becoming a popular way to execute health service delivery all over the world. Furthermore, the private sector is an attractive partner not only because of the financial power it possesses, but also because of the technical expertise, strong advocacy power, and lack of bureaucratic complexities that it is able to bring to the table. Moreover, a well-structured, ethically sound, trustworthy, locally communicated, and voluntary HP can be the best vehicle to ensure community health as well as primary healthcare in rural areas.

Another felt that HPs could have an equity focus and could contribute to improving the health status of urban slum dwellers, marginalized groups (Dalit, transgenders, indigenous population, people living in slums and remote areas), adolescents, women at reproductive health and the elderly.

A number of respondents suggested that a HP could be effective in health workforce development, particularly in the development of skills of lab technicians and paramedics to improve the quality of care, as well as skills development in planning and financial management.

Other areas that could be addressed by a HP included strengthening health sector governance to move the health system forward towards UHC; and strengthening health information systems, including monitoring, supervision, and record keeping.

However, one respondent cautioned that the short-term nature of such projects may not be the most effective approach, and to mitigate this it would be critical to consider and build sustainability into all HP projects. Another observed that multi-sectoral partnership, coordination and accountability across health systems and among government, NGOs, and private sectors are critical for the sustainability of health programmes and achieving lasting outcomes.

DEVELOPMENT PARTNERS

The THET CD consulted and met with a number of Development Partners. As shown in the table below, two respondents provided feedback through the Stakeholder Feedback Tool.

Development Partner respondents

Development Partners (2 respondents)	UNFPA
	Embassy of Sweden

PRIORITY HS COMPONENTS

The table below shows the key priority components identified by the Development Partners who provided feedback. Human Resources for Health and Governance and Leadership were ranked equally, while Health information Systems was the other priority component identified.

Summary of health systems priority components by Development Partners

Health System Area	Lowest score = highest priority
Service Delivery	6
Human Resources for Health	2
Governance and Leadership	2
Health Information Systems	5
Health Financing	6
Medical Products and Technologies	6

PRIORITIES IDENTIFIED

Respondents in this cluster acknowledged that the six pillars of the health system were covered in the review. They agreed with the priority areas and activities identified and observed that the priority activities were broadly in alignment with the findings of the different program reviews conducted and the priority actions identified by relevant stakeholders in recent years.

PRIORITY AREAS/ACTIVITIES OMITTED

Respondent identified the following additional priority areas and activities:

- Health Sector Reform, creating a purchaser-provider split
- Climate change and health
- Enhancing and addressing the voices of the poor and make health system accountable at all levels
- Strengthening the district health system
- Introduction of Health Technology Assessment (HTA)
- Addressing corruption in the Health Sector

PRIORITY AREAS AND ACTIVITIES THAT CAN BE SUPPORTED BY THE HEALTH PARTNERSHIP MODEL

One of the respondents in this cluster identified a number of areas that could be addressed by a health partnership, as follows:

- GP Model
- Health Technology Assessment (HTA)
- Health Sector Reform
- Voice and Accountability
- Climate Change and Health
- Disease Surveillance
- Health Financing
- Anti-corruption measures in the health sector
- Health Workforce
- Mental Health

NATIONAL/INTERNATIONAL NGOS

The THET CD consulted and met with a number of stakeholders from international and national NGOs. As shown in the table below, two respondents provided feedback through the Stakeholder Feedback tool.

National NGO respondents

National/International NGOs (2 respondents)	Partners in Health and Development (PHD)
	Orbis International

PRIORITY HS COMPONENTS

The table below shows the key priority components identified by the NGOs. The components ranked the highest priority by this group of respondents are: (1) Service Delivery.; (2) Human Resources for Health; and (3) Governance and Leadership.

Summary of health systems priority components by the Health Facilities

Health System Area	Lowest score = highest priority
Service Delivery	2
Human Resources for Health	4
Governance and Leadership	6
Health Information Systems	9
Health Financing	9
Medical Products and Technologies	12

PRIORITIES IDENTIFIED

Respondents in this cluster agreed with the priority areas and activities identified. One noted that all the activities ‘are needed’, however, emphasised that health services need to be accessible, and be of good quality so that all can benefit. It was felt that the priorities identified were evidence based, aligned with government priorities and relevant to the context.

One respondent stressed the need for functional health systems and integrated people-centred health services at all levels to achieve UHC and the SDGs. Robust governance systems and leadership capacity development and mentoring were perceived to be central to improving service quality, management competence, and motivation.

PRIORITY AREAS/ACTIVITIES OMITTED

One respondent suggested that Retinopathy of Prematurity (ROP) should be included as a priority area. ROP is a potentially blinding eye disease that affects premature babies and is the leading cause of blindness among children worldwide. Few hospitals in Bangladesh have the facilities, appropriate set-up, including skills and resources to prevent ROP and deliver quality care when needed. This respondent recommended that ROP should be prioritized as a cause of avoidable blindness in the National Eye Care plan, and other activities such as the assessment of Neonatal Intensive Care Units (NICUs) be undertaken to understand the infrastructure, processes and care available for premature infants at risk of ROP. In addition, hospital management and health care professionals at all levels should be trained to ensure early diagnosis and referral; and national screening and treatment guidelines for ROP should be developed.

Other areas suggested for inclusion as priority activities included:

- The mobilisation of the community to ensure appropriate self-care at home, psycho-social protection at community level, and care seeking behaviours.

- The reduction of access barriers among the underserved population in the rural hard-to-reach area to ensure equitable utilization of health services
- The promotion of accountability in the health system through functional client feedback mechanism

Other omitted priority areas/activities identified by respondents are detailed in the table below.

Additional priority areas/activities

Health System Priority Areas	Activities under Health System Priority Area
Service Delivery	
Health care Provision - Secondary and Tertiary	Other: <ul style="list-style-type: none"> • Establish effective emergency care system
Immunisation	Other: <ul style="list-style-type: none"> • Immunisation for emerging and re-emerging diseases
Mental Health	Other: <ul style="list-style-type: none"> • Prevention of smoking and drug addiction
Eye Care	Other: <ul style="list-style-type: none"> • Improved access to and utilization of essential eye health services particularly by the poor • Use of standardized essential eye health technology and medical products at all levels of eye care service • An appropriate and skilled eye health workforce available to meet population need • Strengthened capacity of eye health information system for policy, planning, monitoring and evaluation • Improved health financing capacities for eye health service • Improved governance and accountability for eye health • Improving access and quality of care • Evidence base for eye health policy advocacy and planning
Health security & emergency preparedness	Other: <ul style="list-style-type: none"> • Identify and mobilize resources for sustainable financing for IHR core capacity areas and reduce dependence on external funding • Develop an investment case, integrate the costed national action plan for health security into the national budget cycles, and get GoB commitment on increased funding • Streamline financial reporting format to reflect the government and DPA financing (i.e., budget inflows and spending) situation by each IHR (2005) core capacity areas • Use common platform for data reporting
Rohingya Humanitarian Response	Other: <ul style="list-style-type: none"> • Integrate primary eye care • Develop comprehensive model of service delivery for Rohingya and host community • Eye care program for Rohingya children • Conduct RARE

- Improved NCD services at camps.
- Strengthen health post by integrating primary eye care
- Improved Primary Eye Care Service Delivery
- Develop District Eye Care Plan
- Develop Minimum Standard for Primary Care Package
- Generate Evidence

PRIORITY AREAS AND ACTIVITIES THAT CAN BE SUPPORTED BY THE HEALTH PARTNERSHIP MODEL

Respondents suggested that HPs could consider programming around service delivery and the development of the health workforce particularly. It was also suggested that district-based strategies could be adopted for engaging and empowering communities.

Suggestions for activities to be supported under the **Service Delivery component** included the design and implementation of packages of services, service redesign, organisational strengthening, and other reforms that combine activities across the workforce, financing, governance, and other building blocks at macro-level and meso-level. It was felt the inclusion of demand generation components would increase the effectiveness of the interventions. As one respondent emphasised, strengthening primary care services and the implementation of effective strategies to reach underserved populations are central to health system strengthening, and as the evidence suggests, these have positive effects on access and coverage of services, and health outcomes.

Other suggestions for areas and activities that could be supported by a HP included the following:

- Community-based interventions for behavioural change and demand creation
- Interventions for improving access to MNCAH services among the underserved population in hard-to-reach areas
- Technical assistance interventions for Facility Management Committees and authorities of District Hospitals and UHCs to promote accountability and quality improvement through the use of functional client feedback mechanism.

INDEPENDENT CONSULTANTS

The THET CD consulted and met with a number of independent consultants who are specialist in specific HS areas. As shown in the table below, three respondents provided feedback through the Stakeholder Feedback Tool.

Independent Consultants (3 respondents)	Individual Consultant - Health Specialist
	Individual Consultant – MNCAH-FP
	Freelance Consultant - Health Economics Specialist

PRIORITY HS COMPONENTS

The table below shows the key priority components identified by the Independent Consultants. The components ranked the highest priority by this group of respondents are: (1) Service Delivery; (2) Governance and Leadership; and (3) Human Resources for Health.

Summary of health systems priority areas by the Independent Consultants.

Health System Area	Lowest score = highest priority
Service Delivery	5
Human Resources for Health	10
Governance and Leadership	8
Health Information Systems	11

Health Financing	12
Medical Products and Technologies	13

PRIORITIES IDENTIFIED

Respondent in this cluster agreed with the identified priority areas and activities. They acknowledged that the identified priority areas and activities addressed the main health, population, and nutrition (HPN) related problems and suggested evidence-based activities which were feasible and cost effective to address these problems, which would also strengthen the health system and ensure quality HPN services in Bangladesh. However, as one respondent noted, many of the priority activities are from the recently completed MTR of the 4th HPNSP, which was limited in scope and identified broad areas, not necessarily the specific details, and advised further exploration of appropriate activities.

PRIORITY AREAS/ACTIVITIES OMITTED

Respondents in this cluster identified the following additional priorities for consideration:

- Conducting research studies, strengthening monitoring systems, and empowering local authorities to identify gaps/problems, causes of the problems, and to identify reasonable solutions.
- Further exploration of the HS priority areas and activities is needed to identify the “real issues” and addressing these will help to achieve the project goals. For example, public financial management (PFM) issues are extremely important, however, what this means for the health sector, and what activities exactly need to be addressed, are missing and should be considered.
- The private sector makes a “major contribution” in the Bangladesh health sector and as such its involvement should be considered.

Other omitted priority areas/activities identified by respondents are detailed in the table below.

Additional priority areas/activities

Health System Priority Areas	Activities under Health System Priority Area
Service delivery	
Health care Provision - Rural PHC and community health	Other: <ul style="list-style-type: none"> • Emphasis on prevention of death from injury • Readiness of health centres for 24/7 clinical service
Health care Provision -Urban PHC	Other: <ul style="list-style-type: none"> • Urban health, involving private and NGO clinics
Health care Provision - Secondary and Tertiary	Other: <ul style="list-style-type: none"> • Subsidy for poor and ultra-poor
MNCAH	Other: <ul style="list-style-type: none"> • MNCAH, including Reproductive Health, with motivation of service providers and recipients
Family Planning	Other: <ul style="list-style-type: none"> • Family Planning with emphasis on unmet need and sustainable supply of commodities • Increase long acting and reversible permanent methods • Male involvement in the FP system
Nutrition	Other:

	<ul style="list-style-type: none"> • Mainstream nutrition in curative and preventive services
Integration of GESI approach into health service delivery	Other: <ul style="list-style-type: none"> • Community mobilization for Gender Based Violence

PRIORITY AREAS AND ACTIVITIES THAT CAN BE SUPPORTED BY THE HEALTH PARTNERSHIP MODEL

One respondent suggested that some components of health financing could be tested under a HP. This respondent gave examples such as framework contracts with pharmaceutical companies, diagnostic facilities, use of public health care facilities beyond regular “office hour”, etc. that could be addressed by a HP. Another proposed that service delivery and HRH would be the two main areas that could be best addressed by a health partnership. It was also suggested that the community should be involved in the i) planning of the programmes; ii) resource mobilization/contribution; and iii) self-assessment to review the progress of the programme and make changes to the strategy based on gaps in the ongoing programme.

FOREIGN, COMMONWEALTH AND DEVELOPMENT OFFICE (FCDO) PERSPECTIVES

PRIORITY AREAS IN THE HEALTH CHAPTER, GOB EIGHTH FIVE YEAR PLAN (2020-2025)

In its review and response to the Health Chapter of the GOB Eighth Five Year Plan 2020 to 2025, the FCDO highlighted several priority areas and gaps. Those relevant to HSS are presented below.

Regarding governance and leadership, the proposed multisectoral action and response through public, private and NGO partnerships is perceived as essential to address increasing and a wide range of health needs. Improved regulation of the rapidly increasing private sector needs further focus. It also emphasised that the role of the MOLGRD in terms of preserving the health of the people through WASH, vector control, etc. needs to be promoted, allowing the health ministry to focus its expertise and capacity on the provision of health services.

Regarding the provision of **MNCAH services**, it emphasized the need to address maternal mortality and the deaths of women of reproductive age not only in pregnancy but also from breast and cervical cancers. TB and NCDs are also identified as key **service delivery areas**, as well as the management of injuries through road traffic accidents. Mental health, safe blood transfusion, and organ donation are also highlighted as areas that need to be addressed. Addressing anti-microbial resistance (AMR) will be key for international health security. Ensuring that any expansion of community based PHC facilities is needs-based and is not done uniformly throughout the country, would also help to promote equity.

Other **health workforce issues** highlighted in the FCDO feedback was the need to focus on increased utilisation of nurses, midwives, and paramedics for the provision of PHC services, as this would free up doctors to focus on higher level service provision. This was deemed a critical intervention given the lengthy production pipeline for doctors, the current COVID-19 situation, and the staffing required for the planned expansion of medical universities, medical colleges, and intensive care units. Improving the availability of doctors in large upazila health complexes, district hospitals, and medical colleges to deal with increasing patient load was identified as another urgent issue.

In the areas of **nursing and midwifery**, it was felt there should be more focus on training and deploying more licensed diploma midwives, who receive 3 years education, to provide MNCAH services rather than the Community-based Skilled Birth Attendants (CSBAs), who are not sufficiently competent, nor a recognised professional cadre globally. The increased deployment and improved availability of licensed midwives would free up nurses to provide services in other critical areas.

The **COVID-19 pandemic** has also spotlighted the importance of the availability of adequate health technologists and the need to ensure lab technicians, radiographers, physiotherapists, and pharmacists are deployed to provide critical care.

A key factor in improving the quality of **health education** is ensuring the availability of teaching faculty and the FCDO recommends increasing the service length of medical faculty, continuing the contracting of retired doctors, and providing separate education and service streams in education to alleviate the loss of trained teachers.

Regarding medical products, it was noted that a major part of the out of pocket (OOP) health expenditure incurred by the population is drug prices, exacerbated by the practice of self-medication in Bangladesh, and as a result, plans to make essential drugs more affordable, including for NCDs, would be crucial.

REVIEW OF PRIORITIES IDENTIFIED AND POTENTIALLY ADDRESSED THROUGH A HP

The preliminary analysis and findings of the data collected through the Stakeholder Feedback Tool and through stakeholder consultations was shared with the Bangladesh FCDO Health Advisor (HA).

The HA reviewed the priorities identified by the 18 respondents, and the activities they had proposed that could be addressed by a HP. The HA was generally in agreement with the priorities highlighted. Under the service delivery component and noted that NCDs are major causes of mortality and morbidity, and should be prioritised, and added that the private sector, which is currently 'catering to most of the NCD patients', should be included in the planning and implementation of NCD interventions in the country. However, the HA felt that areas such as nutrition and MIS, that some respondents identified as neglected, are in fact being 'actively pursued'; the exception being drowning as a cause of under-5 mortality. She was also in agreement with the overall perception among the respondents that health sector corruption is a key governance issue, and that needs to be addressed at both policy and programme levels.

Within the priorities identified by respondents, she highlighted several important HS areas and activities that need more support and that could be addressed through a HP.

Under the **Service Delivery** component, the following issues, priority areas, and activities were highlighted:

Rural PHC and community health

Strengthening the quality of Community Clinics' service provision is a priority. In particular, there is a need to revisit policies related to the Community Health Care Provider (CHCP) cadre, a key health worker based in the Community Clinic, which is the lowest level of PHC delivery in the country. Recruitment and training policies to ensure that this cadre is available, equitably distributed and CHCPs have the required knowledge, skills and competencies to deliver quality services were key concerns. It was suggested that there are many "ex-NGO workers" in the country with experience in PHC that could be recruited for these posts.

Non-communicable diseases (NCDs)

The area of NCDs was considered a 'promising area' for support. The FCDO is currently supporting NCDs through TA, but further support is needed to complement this ongoing work. The FCDO HA identified the potential areas of support could include strengthening government capacity, capacity development for service providers, development of protocols and further research studies. The private sector, including medicine sellers, is currently a key provider of NCD services and drugs in Bangladesh and should be considered in the design and implementation of HP interventions.

Mental health

FCDO is providing TA support in this area, but it was perceived that work is progressing 'very slowly'. It was felt that the capacity of the DGHS to provide mental health services could be improved.

Eye Care

It was perceived that a public health approach to eye care is lacking in Bangladesh, with the bulk of eye care services being provided by private health care providers. Ophthalmologists are produced for the public sector, but there is resistance to the production and development of a lower-level Optometrist cadre. Currently, nurses are being utilised to provide eye care services in the public sector, which takes this very scarce cadre away from their core roles and responsibilities. It was felt that the government should coordinate with private eyecare providers in the country when planning eye care strategies and interventions. 'High level influencing' and TA could help to address specific governance issues around the production and development of appropriately skilled allied health professionals and enhancing collaboration with the private sector.

Environmental Health and Waste Management

The area of environmental health and waste management was perceived to be 'very important' and is an area where there is currently 'not much support'. It was suggested that 'cost effective technology' appropriate for Bangladesh, is very much needed to support improvements in this area.

The FCDO HA reported that the following areas were currently well supported:

- **Health security and emergency preparedness:** the Fleming Fund is supporting the government in this area and FCDO is providing TA through WHO.
- **Nutrition:** there is reportedly a lot of enthusiasm and support from external partners and therefore where there has been good progress made in this area
- **MNCAH:** this is perceived to be a 'crowded area', receiving significant support from external partners, including UN agencies. However, one gap identified was the need to redesign the voucher scheme and align it with other government schemes.
- **Rohingya Humanitarian Response:** this is another area that is already "too crowded".

Under the Human Resources for Health component the following issues, priority areas and activities were highlighted:

Human resources management & institutional arrangements

It was reported that although WHO is providing support in this area, more support is needed, especially to address MoHFW 'capacity issues'. It was felt that TA, provided through ex-government officials could help address some of the challenges in this area. The integration of a Gender Equity and Social inclusion (GESI) approach in HRH interventions was also highlighted as a priority to be considered under this area, including the disaggregation and analysis of data by sex and other social stratifiers (e.g. age, location, cadre). The need to ensure that health care providers have the appropriate skills and competencies to deliver gender sensitive, non-discriminatory services was also perceived to be a key priority.

Medical Education and Regulation

FCDO is supporting this area through TA and the World Bank support will be coming on stream in the near future.

Under the Governance and Leadership component the following issues, priority areas and activities were highlighted:

Sector Management, Stewardship and Regulation

It was felt that across the MoHFW, governance and leadership capacity needed to be strengthened. The creation of a Governance, Stewardship and Regulation Unit (GS&RU) in the MOHFW, a recommendation of the MTR, was perceived to be a good suggestion. However, this would need 'political buy-in' and TA, which would be best provided through ex-government officials.

The FCDO HA reported that the area of **Drug Quality and Regulation** is already receiving significant support from development partners, with USAID in particular supporting Pharmacovigilance (PV) activities.

FINAL PRIORITISATION

HEALTH SYSTEMS PRIORITIES TO BE ADDRESSED BY HPS

The scoping assessment team presented the findings of the prioritisation exercise to a core group of stakeholders, comprising senior MoHFW officials, development partner, independent consultants, and the FCDO HA for further prioritisation. This was also an opportunity to facilitate the selection of a final set of priority areas and activities that could potentially be addressed through a HP.

Participants highlighted that addressing some areas and activities would require systemic change and/or policy reform which it was felt was not within the remit of a HP or project.

Participants highlighted the need for a structured referral system and the development of guidelines to support its operationalisation to strengthen **rural PHC and community health service provision**. The absence of a functioning referral system is perceived to be a barrier to the effective utilisation and take-up of PHC and community health services in rural areas. The bypassing of PHC facilities is also contributing to overcrowding and poor-quality service provision in higher level secondary and tertiary facilities.

The lack of coordination between PHC health care workers, including providers from family planning, health services and the Community Clinics, as well as community-based volunteers, and between these providers and the local government was also perceived to be problematic in the provision and take up of integrated and quality PHC services.

While the PHC delivery system, and in particular, the Community Clinic is 'popular' with the population, it does not always 'meet their expectations', due to, among other things, health workforce shortages and the unavailability of supplies. Participants also expressed concerns about the barriers experienced by "poor people" in accessing services at the PHC and sub-district levels. Various mechanisms (e.g., a 'card system') and schemes have been introduced to address socio-economic barriers and other supply and demand side barriers and to improve equitable access to quality services for these population groups.

It was suggested that a HP could support the design and piloting of interventions to address such barriers and improve equitable access to PHC services at the sub-district level for rural populations. Such interventions could also generate evidence for the scale up of high impact interventions. Participants also suggested that greater involvement of NGOs in the delivery of rural PHC services would help improve coverage, accessibility, and quality of care.

The provision of **urban health services**, including for slum dwellers, was another concern raised by participants. While there are multiple service providers in the urban areas, including the MoH, local government and the private sector, these are not well coordinated, and there continue to be gaps in PHC service provision, especially preventive services. It was noted that the Asian Development Bank is supporting an Urban PHC project, which is producing good lessons and evidence.

It was suggested that a HP could support the design and piloting of innovative models to improve PHC provision at the urban level and generate evidence for the scale up of high impact interventions. The FCDO HA reported that FCDO has been supporting the development of the 2020 Urban Health Strategy, which also considers the roles of MoHFW, MoLGRD&C, and the LGIs. The Urban Health Strategy is now nearing completion and the HA advised that any HP interventions in this area should be aligned with approaches and interventions proposed in the new Strategy.

Participants agreed that capacity development was needed in the areas of **NCDs, disability, and mental health service provision** particularly, and that a HP could support in these areas. The private sector currently plays a major role in the provision of such services, albeit with limited regulation, and design and implementation of interventions should consider its involvement.

As mentioned above, the FCDO HA was particularly interested in HP support for NCDs to complement the government's capacity to deliver NCD services. The HA suggested that FCDO would be interested to 'complement and/or jointly design' such interventions.

It was suggested that increased advocacy and improved governance are needed to promote a more public health approach to eye care, and it was felt that the development of an Optometrist cadre would enhance and expand the provision of eye care services in the public sector.

The availability of human resources remains a key barrier to improving the accessibility and quality of health services at all levels. Participants identified challenges with the training, availability, supervision, and quality of **human resources for health in the country**. The adequacy of the skills and competencies of the CHCP cadre to provide quality services in the Community Clinics was of particular concern. The duration of their training (currently 3 months), the training approaches used, and the overall quality of the training were perceived to be sub-optimal. The dwindling number of DGHS master trainers used to provide training for this cadre was also an issue. The overall view was that the institutionalisation of CHCP training would improve its overall quality, as well as the skills and competencies of this cadre. While it was felt that a HP could support areas of health workforce strengthening, some areas such as the institutionalisation of CHCP training, the availability and retention of teaching faculty to deliver the training, and the recruitment and deployment of CHCPs, are beyond the scope of a HP, and instead, would require government commitment and policy support.

A number of specific cadres requiring capacity strengthening interventions were identified, including eye care health professionals, and cadres involved in the provision of disability and NCDs services. It was felt that the capacity of the DGHS to coordinate and deliver mental health service was another area that required support. Developing leadership capacity across the MoHFW and strengthening the capacity of IT personnel were other areas identified for HP support.

Governance and leadership capacity strengthening across the health sector is critical for improving the coordination, delivery, and quality of health services at all levels and for enhancing multisectoral approaches and responses. It was suggested that a HP could be used to design and deliver a governance and leadership training course tailored to the needs of MOHFW officials.

The development and strengthening of IT capacity and **health information systems** was also a priority identified, especially to enhance and support the digitalisation process currently being rolled out across all hospitals in the country.

In the area of **health financing**, reducing the cost of health care is a key consideration and a number of partners are providing support in this area, including FCDO, IFC, and Abt Associates. There are ongoing initiatives and advocacy to make medicines, especially for chronic diseases such as diabetes and hypertension, more affordable. Public health facilities, such as the Medical College Hospitals, can offer services at a lower cost than the private sector, for example, low-cost dialysis units are being established in tertiary hospitals through public private partnerships, however, overcrowding and other factors affects the quality of the services these facilities offer.

Further research into health financing, particularly examining the effectiveness of the different approaches currently being used and tested to reduce costs (e.g., SSK, vouchers) in a more comprehensive way, as the current evidence is fragmented, could potentially be an area where a HP could add value.

The proposed NOM will play a key role in ensuring the programme has national oversight and meets nationally identified priorities. The CD has consulted with the FCDO HA and MOHFW officials and shared the Terms of Reference for the NOM, with a number of MOHFW officials expressing interest in being involved in the NOM. He has planned further discussions with relevant participants to finalise the composition and functions of the NOM in Bangladesh. It has been suggested that the NOM could be established specifically for the UKPHS programme or the function could be performed by an existing forum or structure within the MoHFW.

THEORY OF CHANGE

The overall focus of the UKPHS programme in Bangladesh and the key health systems priority activities that could potentially be addressed by a health partnership, and the expected outputs, outcomes and impact are presented below in an 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 CHCDs.
- 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 barriers to 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, CHCB, & 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 stratifiers.

- 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 stratifiers
- 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 stratifiers 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 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 stratifiers.
- 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 stratifiers.

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, refugees, 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 at all levels with digitalised health information.

Potential Impact

Improved health worker and health service performance, including for the poor and most vulnerable populations.

The UK Partnerships for Health Systems (UKPHS) Programme

Overview and identification of national priorities

The UK Partnerships for Health Systems Programme – an overview

In 2019 the Foreign, Commonwealth and Development Office (FCDO) contracted the Tropical Health and Education Trust (THET) and the Liverpool School of Tropical Medicine (LSTM) to manage and implement the UK Partnerships for Health Systems programme (UKPHS). This programme has a value of £28.5m and a time frame of December 2019 to March 2024.

UKPHS aims to improve health system performance in Low and Lower-Middle Income Countries (LMICs) through Health Partnerships (HPs) between health institutions in the LMIC and health institutions from the UK health system that address nationally identified priorities and enable progress towards Universal Health Coverage (UHC), especially for poor and vulnerable populations. The programme will achieve this by supporting the development of stronger health systems, including components such as leadership and management, information systems, quality of care and the health workforce.

THET will provide grants to Health Partnerships to deliver these activities. UKPHS will support large grants in ten countries:

Bangladesh	Sierra Leone
Ethiopia	Somalia/Somaliland
Ghana	Tanzania
Myanmar	Uganda
Nepal	Zambia

These grants will explicitly focus on supporting nationally identified priorities, complemented by smaller partnership grants that take on innovative approaches to address specific health system challenges.

The UKPHS will promote HPs that are aligned to the health strategies of that country, focusing on quality and reaching the poorest and most vulnerable populations.

Identification of National Priorities – Scoping Assessments

To understand the health system priorities that could be addressed through HPs, between January and November THET and LSTM undertook detailed scoping assessments in each of the 10 countries. These assessments aimed to gain a better understanding of the current status of, and challenges within, the health system, how effectively the needs of the population (including the most vulnerable) are being met, and how the health partnership model can respond to these. These scoping assessments were informed by the existing track record of HPs in the country and globally, and an assessment of what new HP activity might be possible.

Purpose of the Scoping Assessments

The purpose of the scoping assessments was to develop robust stakeholder - led analyses of the priorities which were used to inform the design of country specific grant calls for HP projects that are aligned with, and address, national priorities.

Approach and methodology

During the scoping assessment the team facilitated participatory stakeholder meetings with the Ministry of Health, FCDO and key health system stakeholders to identify health system strengthening priorities that can best be addressed by health partnerships working through the UKPHS.

Multidisciplinary and multi-stakeholder involvement to discuss the proposed HP interventions is critical, as is alignment with key stakeholders affected by the implementation of each intervention. Meetings and workshops were conducted with a range of stakeholders, including: policy-makers, representatives from the MoHD and other strategic sectors and line ministries, in-country FCDO teams, professional bodies and associations (including nursing), training institutions, NGOs, civil society, women's, disability and faith-based organisations, development/funding partners, UN agencies, and private sector organisations, including stakeholders from national and sub-national levels.

The scoping visit resulted in the validation by key national stakeholders of the findings and of the draft priorities for the country specific grant call.

A small core group of national stakeholders, including the MoHD and FCDO in-country will then be established to form an on-going National Oversight Mechanism, to ensure national ownership and alignment throughout the course of the programme.

Timing of programme activities in Bangladesh

The scoping assessment took place between September – November 2020. The grant call will be launched in December 2020. Once awarded, grant holder projects will run for up to 24 to 30 months.

UK Partnerships for Health Systems - Frequently Asked Questions

What is UK Partnerships for Health Systems?

The UK Partnerships for Health (UKPHS) programme was announced by the UK Department for International Development as the successor to the Health Partnership Scheme (2011-2019). Management of the programme was awarded to the Tropical Health and Education Trust with technical input from the Liverpool School of Tropical Medicine. The programme began on 2nd December 2019 and will run until March 2024.

The programme aims to help LMICs build stronger, and more resilient health systems, making progress towards universal health coverage through improved health service performance, particularly targeting poor and vulnerable populations. Some of the key aims are to:

- Support the development of stronger health systems through better governance, information, and management of health institutions
- Provide the health workforce with opportunities to improve skills and knowledge
- Build on institutional capacity to decrease any reliance on external support.

What kind of projects will be funded under the UKPHS?

UKPHS focuses on 10 strategic countries which were identified by FCDO – **Bangladesh**, Ethiopia, Ghana, Myanmar, Nepal, Sierra Leone, Somalia/Somaliland, Tanzania, Uganda, and Zambia. Grants must address pre-identified health priorities, as identified by stakeholders within the country.

All projects under this funding programme must be delivered by health partnerships and must address issues with the health workforce through activities such as training, leadership development, or protocol and curricula development., The funding cannot be used for infrastructure work, including equipment procurement or refurbishment.

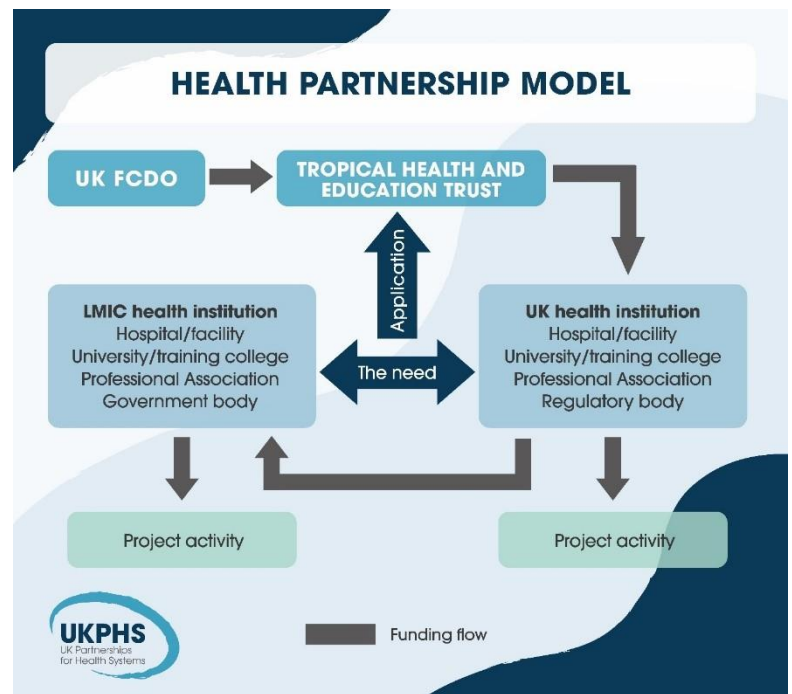
How much funding is available for work in Bangladesh through the UKPHS and how is it monitored?

There will be 4-8 grants of up to £350k available, running from July 2021 to December 2023. A total of up to £2m is available for Bangladesh. The number of grants will be decided based on the number and quality of applications. As a multi-country programme, the financing modality of this programme will be off-budget-off-treasury.

THET can transfer funds to either the UK partner or the Somaliland partner, and then that partner can transfer downstream funds accordingly. Grant holders will provide biannual narrative and financial reports to THET, and THET will conduct annual financial audits on the lead UK and Somaliland partners. THET will also conduct annual monitoring visits to the Somaliland institution to verify project progress, and the THET Country Director will be in regular communication with the grant holders.

What is the modality of the programme?

Grants will be awarded to health partnerships between UK and LMIC institutions. A health partnership is a long-term institutionalised relationship between a UK health institution, either a hospital, a trust, a professional association, or a health education facility such as a university, and their counterpart overseas. The aim of these partnerships is to deliver health systems strengthening through utilising the expertise of the UK partner. Staff from the UK volunteer their time in the overseas institution to train health workers and improve the systems within which they work. Partners co-develop programmes that address organisational and national priorities. The partnerships themselves are generally long term and sustainable, while the projects which they deliver are discrete and tailored to specific identified needs. The aim of all projects is sustainable impact and mutual benefit.



What are the main objectives and planned outcomes of the grants programme?

The entirety of the programme aims to contribute to SDG 3 – ensuring healthier lives and promotion of well-being for all at all ages, with a focus on Universal Health Coverage. A key outcome will be improved health worker and health service performance including for the poor and most vulnerable populations. This will be measured through monitoring the number of facilities supported by UK PHS projects demonstrating positive outcomes in health service performance, with a focus on health worker performance. Projects funded under this programme should take an approach which enhances gender equality and social inclusion, focusing on targeting poor and vulnerable groups.

What are the previous health partnership projects by THET, and what was their impact?

Historically THET was the grants manager for the Health Partnership Scheme – a 7-year, £32 million programme funded by the UK Department for International Development. This programme supported 210 projects in over 30 countries and trained over 93,000 health workers. Examples of previous projects are given in Annex 1.

What were the lessons learned from the Health Partnership Scheme?

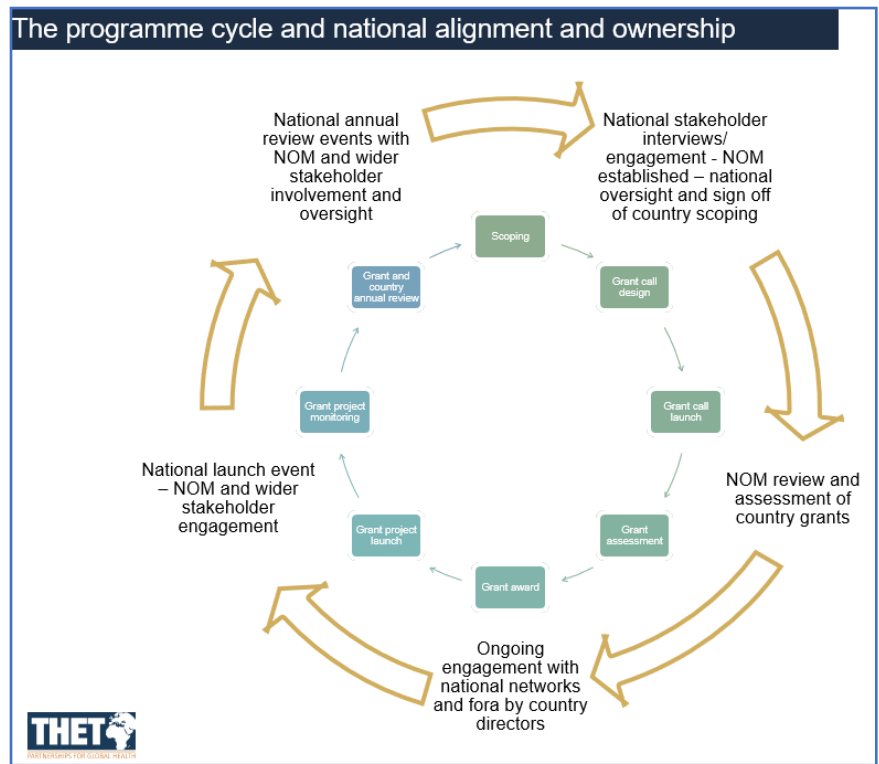
DFID commissioned an independent evaluation of the programme in 2016 which found that “Health Partnership Scheme projects have contributed to the health system strengthening by strengthening health worker capacity in terms of their skills, knowledge and confidence”. However, there were some lessons learned that THET will incorporate into the UKPHS, including:

- Partnerships had not all considered the broader system challenges that could occur and how their implemented change fed into the wider system. Wider health system constraints may have limited the chances for improving health worker capacity and health services.
 - For example, health workers could receive training but could be quickly rotated or not have the medicines to put their improved skills and knowledge into practice.
 - Without central MoH engagement and oversight, certain bottlenecks occurred, and sustainability is more difficult to maintain.
 - The UKPHS will therefore develop clear strategies of support to ensure health partnerships are aligned with national health plans and are facilitated and managed to most effectively deliver against these priorities (see below). Only through directly contributing to the national priorities partnerships can play a key role in Health System Development

- There were examples of female health worker empowerment, but gender and social inclusion approaches and analysis are not strong enough. GESI will be a key component of the new programme.
- There was very little collaboration between partnerships or with other aid programming in host countries. Other aid programmes will be reviewed during the scoping trip.
- Long-term partnerships are effective at designing and implementing approaches that contribute to health system strengthening. Sustainability of project outputs are supported by the strength and longevity of the partnership. While we will encourage new partnerships to apply, we may require an inception period before granting the full award.

How will national ownership and buy-in be ensured?

- It is crucial to the success of this programme and the sustainability of its outcomes that national stakeholders play a leading role in determining priorities. The key health priorities addressed by projects being implemented in strategic countries will be determined through a scoping visit undertaken specifically to engage with national stakeholders. Over the course of the scoping visit, national stakeholders will be asked to participate in workshops, focus groups and key informant interviews, aiming to draw out key priorities for those working in the health sector.
- The priorities raised during these meetings will then be agreed upon and used to develop a country specific Theory of Change, which will form the basis for all the project interventions. Relevant stakeholders will then be invited to join a National Oversight Mechanism (NOM), which will play a key role throughout the programme in ensuring that projects remain aligned with national priorities and feed into the relevant national plans. The NOM will be asked to review and assess applications during the selection phase of the programme and then play an ongoing role in providing oversight on projects as they progress and attending annual national review events.
- In addition to the NOM, THET’s Country Director will support funded health partnerships for the duration of the programme. They will be continuously engaging with national networks, the Ministry of Health and other relevant partners.



Who is THET?

THET – the Tropical Health and Education Trust - is a global health charity operating whose aim is to address the statistic that one in seven people globally will never visit a qualified health worker. We do this primarily through health workforce development. We train, support, and educate health workers across Africa and Asia, working in partnership with organisations and volunteers from across the UK, Africa and Asia. All the work which THET does works within the health partnership model framework. THET is the fund manager of the UK Partnerships for Health Systems.

Who is LSTM?

LSTM – the Liverpool School of Tropical Medicine – is a higher education institution with demonstrable and proven experience and expertise in HSS interventions, across several of the health system building blocks. These include governance and leadership, human resources for health, service delivery for maternal, newborn and child health, and information, co-producing and applying knowledge with policy makers, academics, practitioners, and communities to promote equitable access to quality health care. LSTM is the technical partner of THET in UKPHS, providing HSS and GESI expertise

Previous partnership projects supported by THET

THET has previously only funded one partnership in Bangladesh. This and other examples are detailed below.

Health partnership 1 – Bangladesh	
Project title	Bangladesh Child Cancer Project
Partners	Lead UK Partner: University College Hospitals London Lead Bangladeshi Partner: Bangabandhu Sheikh Mujib Medical University
Funding amount/time	£30,000 01/03/2013 – 28/02/2015
Basic Information and History of the Partnership	<p>Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka</p> <p>The BSMMU is the first public medical university in Bangladesh established in 1998. The Paediatric Haematology and Oncology department of BSMMU is the largest centre in Bangladesh for the treatment of child cancer. The BSMMU diagnoses and treats over 400 new cases of childhood cancer per year and survival rates are overall under 10% (compared to 75-80% of the UK). The unit works with 8 satellite centres across the country.</p> <p>The partnership had worked together for nine months prior to this project with World Child Cancer facilitating the partnership between BSMMU, University College Hospitals, and British Columbia Children’s Hospital and University of British Columbia.</p>
Grant Summary	<p>The project aims to address the problem of very poor survival rates for children with cancer by focusing on the development of a specialist centre in Dhaka and 8 satellite centres across the country. This specific project is one distinct element of a larger five-year project which will also provide funding for drugs to reduce abandonment of treatment and an awareness campaign to promote earlier diagnosis.</p> <p>A twinning partnership has been created between the BSMMU and University College Hospitals (London, UK) and BC Children’s Hospital/University of British Columbia (Vancouver, Canada) to create a two-way transfer of expertise and skills. World Child Cancer, who specialise in improving diagnosis, treatment and care for child cancer patients in LMICs, has facilitated the partnership and will take on a project management role. The focus is on training local healthcare professionals, specifically on disease recognition and speeding up diagnosis, and developing a child cancer registry. Sustainability elements include on-going mentoring for the project leader and senior doctors and the development of a national child cancer care policy plan.</p> <p>The cadres targeted were:</p> <ul style="list-style-type: none"> - Child cancer doctors. Received training in child cancer diagnosis, treatment, and care. - Trainee doctors. Benefitted from training workshops and expertise of the overseas volunteers - Nurses. Benefitted from training workshops and expertise of the overseas volunteers - Support staff including database managers. Received training in the collection and management of data.
Summary of Activities	<ol style="list-style-type: none"> 1. Establishment of a child cancer registry to record all cases and treatment plans including the training of local database management staff 2. Development of locally appropriate treatment protocols. 3. Provision of training for doctors at the BSMMU and the 8 satellite treatment centres in the diagnosis and treatment of children with cancer. The initial focus will be on disease recognition and speeding up diagnosis.

	<p>4. Provision of training for nurses at the BSMMU and the 8 satellite centres in the care and treatment of children with cancer.</p> <p>5. Provision of mentoring for the project leader by doctors from the twinning partners.</p> <p>6. Develop a national child cancer care policy plan.</p>
Health partnership 2 - Ethiopia	
Project title	Consolidating Patient Safety: Strengthening preventive capacity, improving infection prevention and control whilst maintaining and promoting the physical, mental, and social well-being of healthcare workers
Partners	<p>UK Lead Partner: University Hospitals of Leicester (UHL)</p> <p>LMIC Lead Partner: Gondar University Hospital (GUH)</p>
Background Information and History of Partnership	<p>University Hospitals of Leicester is one of the biggest and busiest NHS Trusts in Ethiopia, serving one million residents and are nationally and internationally recognised in cardio-respiratory diseases, ECMO (extracorporeal membrane oxygenation, outside of body respiratory life support), cancer, and renal disorders.</p> <p>Gondar University Hospital is the only referral hospital in the north west of Ethiopia, 800 km north of Addis Ababa, and serving a population of over 7 million. It is a government-run hospital working closely with Gondar University and has a staff of 1200.</p> <p>This partnership has worked together since 1997, with an impressive list of past projects:</p> <p>2013-2015 Multidisciplinary Educational Site Development</p> <p>2010-2014 Inaugural round of World Health Organisation (WHO) African Partnerships for Patient Safety (APPS) Programmes including Hand Hygiene, Infection Prevention and Control, Safe Surgery, Healthcare Worker Protection and Healthcare Waste Management. Capacity building and development of an audit clerk (Gondar) and implementation of “Train the Trainer” cascade training was critical for success.</p> <p>2011-2012 Establishment of Masters Degree in Advanced Nursing Practice</p> <p>2010-2014 Upgrade of Maternity Unit at Kolladiba Health Centre – Training for Midwives, Health Extension Workers and Traditional Birth Attendants</p> <p>2010-2011 New Masters Degree in Clinical Practice for leading Practitioners in Anaesthesia, Physiotherapy and Biomedical Science</p> <p>2009-2014 New Mental Health Nursing Programme</p> <p>2009-2015 Mental Health Training for Medical Students</p> <p>2008-2010 Improvement and upgrade of the Gondar Maternity Unit</p> <p>2001-2005 New integrated training programme for Specialist Surgeons</p> <p>2001-2003 Innovative new Masters Degree in Public Health</p>
Funding amount/time	<p>£50,000</p> <p>01/11/2015 – 31/03/2017</p>
Project goal	To improve hand hygiene and promote the physical, mental, and social well-being of healthcare workers to prevent occupational diseases and injuries including sharps safety, which should also improve patient safety.
Summary of activities	Activities revolved around establishing and training the Infection Prevention and Control (IPC) team, the Occupational Health (OH) team, and Senior Management to improve well-being and safety of healthcare workers and patients. This was done through establishing of committees, audits, workshops, and guidelines. The full breakdown of activities is as follows:

	<p>Provide leadership and support to run an initial workshop with the Infection Prevention and Control (IPC) team, the Occupational Health (OH) team and Senior Management of the Hospital and University to establish various roles in these teams; have an understanding of the IPC and OH programmes; Gain agreement on the time frames within the project and discuss monitoring and evaluation.</p> <p>Regular workshops between the IPC and OH teams to monitor progress to date and ensure that the programmes continue in a timely fashion</p> <p>Establish a fully functioning IPC Committee and team and an OH team which has regular meetings, which have an agenda, minutes taken, action plan reviews, new action plan with time frames and named responsibility.</p> <p>Work together to identify training needs of both IPC Lead and OH Lead with a view to increasing their knowledge through training visits, e learning, books, etc.</p> <p>Work together, and with Hospital management, to establish a fully functioning IPC and OH Offices.</p> <p>Work with the IPC and OH teams to update / produce relevant guidelines and policies deemed necessary to improve Patient Safety and to ensure consistency with national standards.</p> <p>Develop an audit programme together with the Audit clerk to ensure frequent monitoring of the project activities. Monthly audits with reports to be done as plan.</p> <p>Identify needs and develop training programmes for all staff to increase awareness of IPC and OH in order to improve Patient Safety. Deliver training as per plan and award certificates.</p> <p>Work with the IPC and OH team, and procurement and finance, to ensure Personal Protective Equipment (PPE) and Alcohol Based Hand rub (ABHR) is always available</p> <p>Undertake international visits by appropriate individuals to support all of the above.</p> <p>Explore ways to involve the community to support good practice in the Hospital as well as ensuring that patients and carers understand the reasons for IPC and OH and Safety.</p> <p>Hepatitis B vaccinations for all Clinical Staff</p> <p>Develop and carry out simple surveillance for recording Healthcare Associated Infections</p>			
Main achievements	<p>The hospital has overall become cleaner and more hygienic, with improved toilet facilities and access to hand washing facilities improved by sinks being repaired and new sinks installed. The IPC and OH teams also demonstrated marked improvements in their leadership and taking ownership. There are far more reminders about Hand Hygiene around the Hospital and 2 members of the team were invited to attend a Symposium in Tanzania where the project was presented.</p> <p>The breakdown of achievements are as follows:</p> <p>7 relevant staff attend at least 3-4 weekly Clean and Safer Hospitals (CASH) meetings (up from 0)</p> <p>7 Team members indicate awareness of good practice</p> <p>IPC and OH teams presented a plan with clear situational analysis, rationale, activities, timeline, responsibilities, and budget</p> <p>103 Nurses, 240 Interns, and 157 Janitors and Cleaners have had one day training in Infection Prevention and Control</p> <p>50 Hand Hygiene Champions trained who are responsible for improving and maintaining high standards in their clinical areas around the hospital.</p> <p>500 Staff members trained in IPS and OHS for a two-day training seminar</p> <p>272 ABHR available up from 143</p>			
Break-down of Health Workers Trained	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; text-align: center;">Cadre</td> <td style="width: 33%; text-align: center;">Female</td> <td style="width: 33%; text-align: center;">Male</td> </tr> </table>	Cadre	Female	Male
Cadre	Female	Male		

Interns	59	181
Janitors/Cleaners	105	52
Nurses	58	45

Health partnership 3 – Tanzania

Project title	Strengthening and sustaining clinical leadership capacity at Mirembe Hospital
Partners	UK Lead Partner: The Central and North West London NHS Foundation Trust (CNWL) Tanzanian Lead Partner: Mirembe Mental Health Hospital and School of Nursing
History of Partnership	<p>The CNWL – Mirembe Partnership has been in place since 2009. Mirembe is in Dodoma, the administrative capital of Tanzania in the heart of the country. Mirembe is the national referral psychiatric hospital with provision for general and forensic inpatients and a rehabilitation village.</p> <p>A previous THET grant between 2011 – 2014 that focused on training Mirembe staff in the Therapeutic Management of Violence and Aggression (TMVA), resulting in 170 Mirembe staff and 28 at 2 regional mental health units being trained. The project also changed the treatment milieu and interpersonal communication between staff and patients at Mirembe.</p> <p>Another THET grant lasted between 2014 – 2017 and focused on strengthening the existing substance misuse interventions through training of staff. This resulted in 44 staff being trained in the assessment and treatment of substance use and the recruitment of 14 staff Champions. The staff Champions can deliver substance use training for their colleagues and have taken on lead responsibilities for other elements of the programme, such as peer support and community engagement. They are now considered as key members of the senior management team.</p> <p>The project also established a Peer Support Worker (PSW) structure, that has allowed Mirembe to demonstrate that previously disadvantaged and unrecognised groups can be very effective in supporting fellow patients and the staff themselves. This has altered the relationship between staff and patients, with PSW being an effective positive contribution to the operational infrastructure of the hospital.</p> <p>Since the end of the project, the new Itega Substance Use unit has been opened.</p>
Funding amount/time	£46,298 01/12/2017 – 31/12/18
Project goal	<p>The overall goal of the project is to further strengthen and empower the mental health service providers at Mirembe Hospital.</p> <p>Deliver training in mental health and substance use to a cohort of 60 Nursing/Healthcare Assistant staff at Mirembe Hospital. Evaluate confidence of staff to utilise new skills and knowledge, and change in practice</p> <p>Deliver training in work skills assessment, work activity design, and Recovery Approach, to 60 Mirembe staff and 20 PSW's. Evaluate levels of confidence, change in practice and review use of the Annexe.</p> <p>Clearly agreed management and leadership development programme for future collaboration within the partnership, chiefly through ongoing support for Commonwealth Fellowship uptake by</p>

	<p>key people.</p> <p>Assess training needs of CHW's at Mirembe School of Nursing and feasibility regarding the development of a mental health and substance use module for the curriculum</p>								
<p>Summary of activities</p>	<p>Co-design of mental health and substance use training package</p> <p>Co-design of work skills and Recovery Approach training package</p> <p>Train Champions as trainers (training the trainers)</p> <p>Deliver mental health and substance use training to NA/HCAs</p> <p>Deliver work skills and Recovery Approach training</p> <p>Deliver management and leadership training</p> <p>Run an Occupational Therapy workshop for medical and nursing staff</p> <p>Run an Arts Therapies workshop for multidisciplinary staff</p> <p>Deliver Friendship Bench training</p>								
<p>Main achievements</p>	<p>Main achievements include:</p> <p>Trained 14 Community Mental Health Coordinators to become Champions</p> <p>63 Staff, 33 Peer Support Workers trainees, and 14 community volunteers have attended training and demonstrated improved understanding and knowledge in mental health and substance misuse</p> <p>65 Staff and 29 Peer Support Workers have attended training and demonstrated improved understanding and knowledge in work skills assessment and development activities</p> <p>14 Senior Management staff took part in leadership workshops</p> <p>Trainees that reported that they feel confident and are using the learned skills in their work with patients</p> <p style="padding-left: 40px;">Mental Health and Substance Use:</p> <p style="padding-left: 80px;">63 Staff, 33 PSWs, and 14 Community volunteers</p> <p style="padding-left: 40px;">Work Skills:</p> <p style="padding-left: 80px;">65 Staff and 29 PSWs</p> <p>Number of volunteer days dedicated to the project: 320 total, of these 274 were spent overseas</p> <p>Other achievements include:</p> <p>Include volunteers from other NGOs in Dodoma among the trainees, allowing additional resources to help post-discharge support provision for patients in the Dodoma area and reduce the burden of hospital (re-)admissions on Mirembe</p> <p>The development of the Community Support Desk as the mechanism for patients and relatives to get support without the need for hospital admission</p> <p>Trainees have reported that they have increased motivation and commitment to their jobs, and that they would like to get involved outside of their work to promote mental health in the community</p>								
<p>Break-down of Health Workers Trained</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td colspan="2" style="text-align: center;">Trained by local trainers</td> <td colspan="2" style="text-align: center;">Trained by UK Volunteers</td> </tr> <tr> <td style="text-align: center;">Female</td> <td style="text-align: center;">Male</td> <td style="text-align: center;">Female</td> <td style="text-align: center;">Male</td> </tr> </table>	Trained by local trainers		Trained by UK Volunteers		Female	Male	Female	Male
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Nurses	11	12		
Medical Attendants	76	25	37	10
Community Outreach Coordinator	1		1	
Community Outreach Worker	1		1	
Social Worker	3			
PSWs	7	26	5	8
Project Manager	1			

Challenges

Relying on paper records to capture complex data was challenging due to incomplete records. A new electronic patient case recording initiative has been set up

Difficult to guarantee that staff will be able to attend training due to Mirembe's limited staff resources. Those who have received incomplete training were identified for further training by the Champions

Health partnership 4 - Myanmar

Project Title

Working in partnership to improve the quality of hospital care for seriously sick/injured children and newborns in Myanmar through an ETAT+ package of training with ongoing support and mentorship, leading to sustained changes in clinical practice.

Partners

The Royal College of Paediatrics and Child Health (RCPCH);
The Myanmar Paediatric Society (MPS)

History of Partnership

The RCPCH partnership with the MPS began in 2012 with the development of an Advanced Paediatric Life Support Course (APLS) appropriate for healthcare professionals (doctors and nurses) working in Myanmar. This focused on critical thinking and developing teamwork between doctors and nurses. The first four APLS courses were conducted in February 2013 and were the first of their kind to be undertaken in Myanmar.

The RCPCH also supported a review and needs assessment of paediatric intensive care in Yangon Children's Hospital (YCH) and the development of a skills lab at YCH and Magway University Medical School. In 2014, the RCPCH and MPS signed a Memorandum of Understanding supporting the development of child healthcare in Myanmar including the provision of ETAT+.

The RCPCH has also been working with the Kenyan Paediatric Association (KPA) and have been

	able to partake in a unique South-South transfer of skills from East Africa to Myanmar by facilitating the KPA–MPS partnership.
Funding amount/time	£245,352 1 st March 2015 – 28 th February 2017
Project goal	<p>Through skills transfer, capacity development, and health systems strengthening, the project aims to improve the quality of hospital care for seriously sick newborns and children in three district hospitals and clinics in Myanmar.</p> <p>It aims to reduce neonatal and under-five morbidity and mortality through an integrated package that expands considerably on the WHO Emergency, Triage, Assessment, and Treatment (ETAT) intervention and includes care for newborns, admission care in hospital, support for the development guidelines and job aides, and ongoing mentorship (ETAT+). Key to the programme is ongoing support and supervision leading to sustainable changes in clinical practice, together with strategies to overcome institutional constraints. Over two years the programme aims to directly benefit approximately 30,00 sick newborns and children.</p> <p>The provision of training for ETAT+ instructors, and more widely teaching skills, curriculum development and audit, will strengthen the educational skills in the MPS and the district teams. The programme will also produce a group of highly skilled trainers and mentors ideally positioned to roll-out the programme to other hospitals throughout Myanmar.</p>
Interaction with Ministries/National Strategy	The RCPCH met with the MoHS who together discussed the priorities and endorsed the partnership between the RCPCH and MPS, ensuring that the ETAT+ programme is relevant, appropriate and in line with the national healthcare plan.
Summary of activities	<p>Delivering EPCP Courses to 3 hospitals</p> <p>Drafted EPCP implementation plan for each facility, such as accounting for layout, equipment needs, and timetable for improvement</p>
Main achievements (inc. data)	<p>The partnership was able to gain permission for the placing of foreign health workers in Myanmar (from the KPA) and despite the bureaucracy, meaningful engagement was possible.</p> <p>71 New instructors recruited (far exceeding original target of 24-32)</p> <p>339 Participants completing the ETAT+ training with an 83% pass rate</p> <p>48 ETAT+ instructors trained, who can provide ongoing training to others</p> <p>The project recorded a total of 382 days from UK volunteers, 199 of those were spent in Myanmar</p>
Challenges	The main challenge was the hierarchical nature of healthcare systems in Myanmar, meaning that senior clinician engagement and support is essential. This was only identified late in the project, but two courses were run in Yangon and Mandalay for senior clinicians in order to gain their support, which were largely successful.
Health partnership 5 – Ghana	
Project title	Scaling up multi-disciplinary stroke training in Ghana

Partners	UK Lead: Wessex Ghana Stroke Partnership, Southern Health Foundation Trust Ghana Lead: Korle Bu Teaching Hospital
Basic Information and History of Partnership	<p>Korle Bu Teaching Hospital is located central Accra. With a bed capacity of 2000 and 17 clinical and diagnostic departments/units, it is the third largest hospital in Africa and the leading national referral centre in Ghana. It has an average daily attendance of 1500 patients and about 250 patient admissions. Clinical and diagnostic departments of the Hospital include Medicine, Child Health, Obstetrics and Gynaecology, Pathology, Laboratories, Radiology, Anaesthesia, Surgery, Polyclinic, Accident Centre and the Surgical/Medical Emergency as well as Pharmacy.</p> <p>In 2009, a multidisciplinary team of health professionals working in stroke care across Wessex join with the Korle Bu Teaching Hospital (KBTH) to form an international health partnership with the aim of sharing knowledge of stroke management. The partnership work has been pivotal in increasing awareness of the benefits of multidisciplinary stroke care. Progress and enthusiasm for the partnership has helped to secure the opening of a Stroke Unit at KBTH in January 2014.</p> <p>A previous THET grant titled <i>“To sustain and develop the delivery of safe and effective stroke care on the Stroke Unit at KBTH”</i> was highly successful in developing the Stroke Unit. Main achievements of the project include:</p> <ul style="list-style-type: none"> 17 Clinical staff members completing a set of knowledge and skill competencies relevant to their role 7 Stroke leads have been involved in quality improvement project skills 18 Stroke unit clinical staff trained and demonstrating appropriate behaviours relating to the effective delivery of multidisciplinary stroke care 94% (34 of 36 patients) admitted to the Stroke Unit received high quality relevant assessment against agreed benchmarks, including discharge management <p>Established the Stroke Unit as an important part of training rotations for staff, signifying recognition of the unit as a site of quality care and an example of robust MDT working.</p>
Funding amount/time	£28,039 01/12/2017 – 31/12/2018
Project goal	<p>To sustain and increase capacity for the appropriate care of patients with stroke in Greater Accra</p> <p>To spread the training and knowledge of multidisciplinary stroke care to other hospitals, namely La General Hospital and Ridge Hospital.</p>
Summary of activities	<p>Appointment of key staff in Ghana and UK for project delivery (project management and administration)</p> <p>Ghanaian leads identify link professionals at hospitals where training will be delivered.</p> <p>Review current stroke care (including training, education and equipment needs) and patient cohort in receiving institutions (Ghanaian teams with support of UK team)</p> <p>UK team visit to Ghana to support the initial review of hospitals and training plans.</p> <p>Order/purchase relevant equipment for local sites.</p> <p>UK team visit to Ghana to support the agreement and development of training plan and educational resources (videos and other materials)</p> <p>Development and editing of video resources</p> <p>Review data on referrals from other hospitals and maintain data collection (including gender and disability)</p> <p>Training delivered to visiting institution professionals at KBTH (UK Team to support virtually</p>

	<p>through Skype, telephone and WhatsApp)</p> <p>Set up of meeting of key stakeholders for clinical stroke education (Ghana leads with support of project manager in Ghana and UK group)</p> <p>Hold first Ghanaian Clinical Stroke Education Stakeholder and Network meeting</p> <p>Education videos – pilot with patients and families as a continuing reference tool for once the patient is discharged</p> <p>UK team to visit to support Ghanaian Clinical Stroke Education Network meeting, review overall progress and agree next steps</p> <p>Planning for UK Health Partnerships in Stroke – Sharing Forum</p> <p>UK Health Partnerships in Stroke – Sharing Forum</p>														
Main Achievements	<p>Trained 8 (6 at La General Hospital and 2 at Ridge Hospital) professional leads who achieved competence in stroke core skills, and demonstrated ability to deliver the training in their hospitals. Leads in LGH are: 1 doctor (female), 4 nurses (3 female and 1 male), and 1 physio (female); leads in RH are: 1 doctor (male) and 1 endocrinologist.</p> <p>72 patients have been assessed at LGH by staff trained in stroke care. Ridge Hospital have had staffing turnovers and have not used checklists consistently, not allowing for consistent data gathering</p> <p>UK sharing event in Winchester and a follow-up event in Telford have provided the basis for a peer support network of UK based stroke groups. Through this, new links have been made including with the King’s Sierra Leone Partnership. The links have provided peer support and comparison.</p> <p>In October 2018, the Ghanaian team were involved in a number of local and national opportunities to raise awareness of stroke and stroke care. This included numerous television, radio, and newspaper interviews tied in with World Stroke Day.</p>														
Break down of health workers trained	<table border="1" data-bbox="521 1052 1268 1682"> <thead> <tr> <th data-bbox="521 1052 857 1207">Cadre</th> <th data-bbox="857 1052 1268 1207">Total number of training days provided (no. of trainees multiplied by training days)</th> </tr> </thead> <tbody> <tr> <td data-bbox="521 1207 857 1285">Nurses</td> <td data-bbox="857 1207 1268 1285">97 days</td> </tr> <tr> <td data-bbox="521 1285 857 1362">Doctors</td> <td data-bbox="857 1285 1268 1362">12 days</td> </tr> <tr> <td data-bbox="521 1362 857 1440">Physiotherapists</td> <td data-bbox="857 1362 1268 1440">7 days</td> </tr> <tr> <td data-bbox="521 1440 857 1518">Midwife</td> <td data-bbox="857 1440 1268 1518">1 day</td> </tr> <tr> <td data-bbox="521 1518 857 1596">Nutritionist</td> <td data-bbox="857 1518 1268 1596">1 day</td> </tr> <tr> <td data-bbox="521 1596 857 1682">Physician’s Assistants</td> <td data-bbox="857 1596 1268 1682">5 days</td> </tr> </tbody> </table> <p data-bbox="475 1740 1317 1772">Total number of volunteering days: 64 days, of those, 36 were spent in Ghana</p>	Cadre	Total number of training days provided (no. of trainees multiplied by training days)	Nurses	97 days	Doctors	12 days	Physiotherapists	7 days	Midwife	1 day	Nutritionist	1 day	Physician’s Assistants	5 days
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Health partnership 5 - Uganda															
Partners	Global Health Academy University of Edinburgh, Makerere and Mulago Palliative Care Unit														

	Makerere University
History of Partnership	<p>The partnership between UoE and Makerere University Palliative Care Unit (MPCU) in Kampala has been ongoing since 2009 with a focus on education and research activities.</p> <p>MPCU in partnership with the University of Edinburgh, with support from Cairdeas IPCT, has been a partner on three previous successful THET grants projects:</p> <p>Integrating Palliative Care into the health systems of 4 African countries (Kenya, Uganda, Zambia, and Rwanda)</p> <p>Integrating Palliative Care through Nurse Leadership Development in Uganda</p> <p>Integrating Palliative Care into the health system of Rwanda</p> <p>This project builds on the successes of Nurse Leadership Development project, with previous nurse leadership fellows being closely involved in the training and mentoring of new specialist palliative care health professionals.</p>
Project title	Development of Palliative Care Leaders in Uganda
Funding amount/time	£119,910 01/12/2017 – 01/12/2018
Project goal	<p>To train specialist palliative care health professionals and enable them to work effectively as leaders within the health system in Uganda, mentored and supported by previous nurse leadership fellows.</p> <p>The project took place at Mulago National Referral Hospital, located northern part of Kampala and is the largest public hospital in Uganda.</p>
Interaction with Ministry/National Strategy	MoH are committed to the ongoing development of palliative care, as demonstrated by the passing of a national palliative care policy in 2017
Summary of activities	<p>The development of palliative care leaders through a leadership programme</p> <p>Conducting face-to-face leadership development module</p> <p>Provision of mentorship by former nurse leadership fellows</p> <p>Clinical and organisational modelling of leaders by palliative care specialist from the UK, along with mentoring previous nurse leaders to be mentors</p> <p>UK volunteers provided remote face-to-face mentorship for palliative care leaders, along with mentoring some of the nurse leadership in mentorship.</p> <p>Report writing and recommendations for ongoing support provided.</p> <p>Review of the outcomes and impact of the mentorship programme</p> <p>Expansion of palliative care knowledge in order to increase sustainability of palliative care service provision</p> <p>Printing and dissemination of clinical guidelines for the participating organisations.</p> <p>Undertaking integrated palliative care implementation plan, such as link professional training, children's palliative care training, flip-classroom training, etc.</p> <p>Provide follow-up supervision to the 20 previously trained nurse leaders to support the ongoing sustainability of activities implemented and leadership development</p> <p>Follow-up workshop in Kampala for the nurse leaders trained under the original nurse leadership programme.</p> <p>Identification of nurse leaders to provide virtual and face-to-face mentorship to the new cohort of palliative care nurse leaders, linking them with a UK based mentor for support and mentorship.</p> <p>Mentoring new palliative care leaders.</p>

	Follow-up workshop in Kampala to review, discuss mentorship, facilitation, and develop on-going action plans.
Main achievements (inc. data)	<p>The project overall was a success, with almost all of the quantitative and qualitative indicators satisfied, especially in terms of the development of nurse leaders.</p> <p>The project had 15 nurses from the previous cohort acting as mentors, rather than the estimated 10.</p> <p>33 Days spent volunteering in the UK</p> <p>112 Days spent volunteering in Uganda</p> <p>15 Days spent in the UK by overseas partners</p>
Challenges	<p>Difficult for the first cohort of nurse leaders to support the new group, as it was hard for them to get time from work to visit their mentees.</p> <p>Getting ethical approval for the projects took longer than planned.</p>

ANNEX 2 HEALTH SYSTEM PRIORITY AREAS AND ACTIVITIES

The following priorities were identified and mapped against each of the HS building blocks.

Service Delivery

Health System Priority Areas	Activities under Health System Priority Area
Health care Provision - Rural PHC and community health	Explore Institutional reforms required within MOHFW to drive rural and urban PHC, e.g., establish new Directorate for Primary Health Care, with 2-line directors, and separate Ops, one each for rural and urban health
	Capacity strengthening of the new Community Clinic (CC) Trust status, including provision of Technical Assistance (TA) to finalise governance structures, operationalise Trust management and to build stewardship capacity of DGHS to fund, regulate and monitor community clinics
	Modify contracts and job descriptions for all community health personnel (Health Assistant (HA), Family Welfare Assistant (FWA), Community Health Care Provider (CHCP), Multipurpose Health Volunteer (MPHV), avoiding impact on well performing programmes such as EPI
	Bolster capacity of the MultiPurpose Health Volunteers (MPHV) to provide domiciliary services, support mHealth (HMIS and test innovative apps, such as blood sugar test)
	Finalise the design of the GP model for strengthened PHC delivery in rural areas, pilot and scale in a phased manner, taking on board evidence and learnings generated, and introduce a gate keeping role for access to higher level care
	Introduce contracting of community clinic services, in a phased manner, with strong monitoring and oversight
	Develop strategic partnership with NGOs, CBOs, LGIs and community at each tier of PHC system with supportive ToR ¹
	Strengthen quality of care and waste management in UHCs ¹ through skilled supportive supervision and community monitoring
	Other:
Health care Provision - Urban PHC	Urban Health Committee and Working Group meeting on quarterly basis
	Map all urban health facilities - MOHFW, other government departments, city corporation, NGOs and private sectors, and use information to set up integrated service delivery network for 6-10 wards (or roughly 10,000 people per unit) around a government secondary/tertiary hospital
	Design and start pilot of urban GP model (along the lines of the Mohalla clinics operating in New Delhi) and empanel private diagnostic centres and private clinics (providing specialised outpatient care) and scale up in a phased manner taking on board evidence and learnings generated
	Improve underlying determinants of poor environmental health (medical waste management, sanitation, clean water, and clean air)
	Expand opportunities available through social marketing (such as SMC) etc. to bring retail pharmacies within the integrated service delivery network
	Assess the capacity of LGIs to take up the responsibility of urban health as per Local Government (Pourashava/ City Corporation) Act 2009
	Fine tune the 2020 Urban Health Strategy
	Delineate the roles of MoHFW, MoLGRD&C and the LGIs for Urban Health
	Develop capacity of LGIs by providing orientation, training, personnel, and logistics to lead urban health
	Strengthen infectious disease surveillance, prevention, and rapid response
	Continue to address the underlying determinants of poor environmental health
	Pilot digital technologies, such app-based GP access
	Other:

Health care Provision - Secondary and Tertiary	Establish structured referral system in high performing districts and develop Structured Referral System Guidelines
	Make existing hospitals fully functional before starting new construction (needed staff, equipment, and drugs)
	Improve antibiotic prescribing and dispensing
	Allocate budget to hospital managers for quality improvement initiatives and assessment of effectiveness
	Establish effective referral system across all levels of care, including relationship with Maternal and Child Welfare Centres (MCWC), and pilot gatekeeping at union level in the GP pilot
	Secure approval of the Accreditation Act, and initiate accreditation of public and private hospitals
	Procure the services of at least one private hospital in the scale up Shasthya Surokkha Karmosuchi (SSK), and introduce a similar social protection scheme with private hospitals for the urban poor
	Continue expansion of service offerings from secondary and tertiary hospitals. (e.g., mental health, geriatric and palliative care, thalassemia care, emergency department, child development centre, reconstructive surgery for club foot, cleft palate, ICU/CCU, dialysis etc.
	Roll out of (R)MN(CA)H quality standards to all District Hospitals DH and MCWC's
	Install digital hospital management Information Systems (MIS)
	Support tertiary specialised hospitals to become centres of excellence and provide technical leadership
	Continue strengthening lower-level facilities and introduce gatekeeping function in order to streamline use of secondary and tertiary hospitals
	Establish Observation Ward and Day Care Centre in hospitals to reduce inpatient admissions
	Award hospitals greater autonomy to raise finance, manage, and procure the services they need
	Provide incentives to hospitals for efficient care (including preventive measures) and refer uncomplicated cases to primary care level
	Introduce structured death audit in hospitals as a tool to improve patient management effectiveness, for learning purposes, without blaming and shaming, with actions to resolve the problems identified
Ensure coordinated plan on facility construction, staffing, and equipping before starting construction work	
Other:	
MNCAH including Reproductive Health	Revise the current maternal health action plan to include MTR recommendations and implement the plan, prioritizing high maternal and neonatal mortality geographical areas.
	Rationalise availability of 24/7 normal delivery (selection of union level facilities) and BEmONC and NSU (selection of UzHC and MCWC) with adequate HR and midwifery led continuity of care
	Improve access to 24/7 normal delivery facilities for slum populations and remote and difficult to access areas through innovative strategies such as 'alongside midwifery-led care' units and partnerships with private providers (slums) and maternity homes and introduce telemedicine for guiding emergency care
	Develop a plan for prevention and management of stillbirths, including stillbirth surveillance in institutions under the expansion and improvement of quality of MPDSR response
	Improve and expand access to Special Care Newborn Unit (SCANUs) based on the findings of the SCANU assessment
	Incorporate the PPH and Eclampsia plan into the overall BEmONC improvement plan based on the technical review of the plan
	Establish a system for auditing caesarean sections
	Introduce preconception care package to contribute to reduction in maternal and newborn mortality and stillbirth
	Modify the maternal health voucher scheme - Demand Side Financing (DSF), including the benefit package and disincentivise the over-provision of caesarean sections in the private sector.
	Undertake a critical review of the incentives for providers with regard to accountability and quality

	Review and rationalise maternal, newborn, child, adolescent health indicators under 4 th HNPSR results framework and operational plans to better align at goal, output and input levels
	Revise DLR indicators to include quality elements and measure population coverage instead of just numbers
	Other:
Adolescent Health	Implement the finalised Adolescent Action Plan, including preconception care package in collaboration with Ministry of Education (schools programme) and Ministry of Women's Children Affairs (early marriage and childbearing)
	Capacity building of health personnel in strategic leadership positions to develop and manage services for adolescents
	Strengthen partnerships with all relevant actors at the highest level – both government and non-government – to deliver effective services which meet adolescent health needs
	Provide leadership in mainstreaming adolescent SRH services at all levels of service provision according to the ESP
	Capacity building of health providers to be sensitive to the needs of all adolescents, including those who are unmarried, through pre-service, in service and on the job training
	Provide health service personnel with training on counselling for adolescents and capacitate them to adopt non-judgemental attitudes when working with adolescents
	Strengthen quality assurance and monitoring mechanisms to ensure consistent quality in the delivery of services
	Strengthen the Health Management Information System (HMIS) to collect age and gender disaggregated data on issues which pertain to adolescents
	Ensure availability and facilitate equitable access to all essential medicines and medical technology by putting in place systems to meet the needs of the most vulnerable adolescents
	Other:
Immunisation	Improve immunisation coverage in urban areas and remote and difficult to access areas and plan for the smooth transition of vaccine procurement
	Other
Family Planning	Use post FP2020 Costed Implementation Plan (CIP) to revise FP related OPs and develop approaches to mobilize additional resources to address funding gap
	Place responsibility for oversight of CIP implementation within the new Governance Stewardship, and Regulation Unit (GS&R Unit)
	Provide needed resources as per CIP to strengthen FP delivery in both DGHS and DGFP operated facilities, especially LARC and PMs
	Recruit volunteers to fill vacant fieldworker positions with uniform criteria and package for all directorates and OPs
	Initiate an assessment of all operational FPCST-QIT in the entire country to observe its effectiveness to improve quality of FP services, including addressing structural gaps such as filling vacant MO (MCH-FP) positions
	DGFP/GS&RU operationalise and use the newly developed national dashboard to monitor and improve quality of FP, especially LARC/PM
	Review and scale up FP interventions with the private sector (such as SMC Pink Star Providers Network for PFP, and SMC's social marketing of Sayana Press)
	Introduce BCC campaigns to address specific non-use concerns of women with unmet FP needs (e.g. side effects or health risks, infrequent or no sex, opposition from persons close to them, etc)
	Implement geographically targeted service package (including BCC campaigns and contraceptives delivery) at low performing upazilas within low performing region, chars and coastal areas
	Agree a mechanism to strengthen the modalities of FP service delivery at urban areas particularly for the slum dwellers, the floating and poor people in the city corporation areas, including through the GP system and other

	<p>public-private partnerships</p> <p>Conduct in-depth review of existing satellite clinics conducted at different locations by different type of providers to rearrange/re-design the program based as per clients need</p> <p>Initiate programs to popularize injectables (including newer technologies) through intensive motivation and follow up involving public and private sector</p> <p>Other:</p>
NCDs	<p>Implement an NCD Behaviour Change Campaign to address underlying life style determinants (exercise, diet, substance abuse etc.)</p> <p>Activate the coordination committees set up at district and upazila levels to implement multisectoral actions (under the multi sectoral action plan) for NCD prevention by different sectors</p> <p>Increase budget allocation to NCD programme, including for management of hypertension and diabetes, for staff, drugs and supplies, and institute better patient tracking through dedicated patient records and HMIS/DHIS2</p> <p>Allow lower levels of the health system to “refill” drugs for patients diagnosed with hypertension and diabetes</p> <p>Expand NCD programme to manage more conditions, including COPD, asthma, disability, cancer, and road traffic injuries and ensure these are addressed at PHC level</p> <p>Ensure NCD prevention and management is appropriately incorporated into Essential Service Package (ESP) delivery in urban areas, including partnerships with the NGOs, City Corporation facilities, private facilities, and hospitals</p> <p>Emphasise primary prevention of NCDs through promotion of lifestyle change, and policy/regulation of food industry</p> <p>Incorporation of NCD treatment into social protection/health insurance schemes, which entitle the poor (including urban poor) access to specialised services in both public and private sectors</p> <p>Other:</p>
Mental Health	<p>Secure approval of the Mental Health Strategy, and prioritise activities for implementation during remaining period of HPNSP</p> <p>Include mental health indicator at RFW (Suicide rate) and OP level (Substance Use Disorder) aligning with the SDG results framework</p> <p>Harmonize and standardise mental health training to be coordinated by NCDC</p> <p>Ensure the 4 government medical college hospitals that currently lack indoor mental health services add this service as a priority</p> <p>Ensure adequate budget and required institutional capacity is allocated to mental health</p> <p>Recruit and deploy needed mental health workforce at all levels to realise approved mental health strategic plan</p> <p>Introduce mental health in the undergraduate MBBS curricula</p> <p>Introduction of certificate courses of three to six-months duration, with medical and psychosocial modules for doctors and other allied professionals</p> <p>Develop an action plan to prevent and address substance abuse, and work collaboratively with DNC and MOHA</p> <p>Other:</p>
Eye Care	<p>Fill vacant positions of ophthalmologists at district hospitals and provide more trained nurses to run the community vision centres at the UzHCs</p> <p>Provide care for corneal disease</p> <p>Incorporate Cataract Operation within the system, replacing the ‘Eye Camp’ modality and incorporate data from all facilities in the DHIS2</p> <p>Retinopathy, MNCA&H Program to capture ‘Retinopathy of Prematurity’ and IMCI program to capture certain eye diseases /conditions to prevent childhood blindness</p> <p>Distribution of DSF for cataract operation through the main system to attract the vulnerable and capture</p>

	availability of services data in DHIS2
	Other:
Communicable & Emerging Diseases	Fill all vacant Laboratory Technologist positions so that costly procured Gene Xpert machines are utilized properly
	Ensure a smooth transition of support for the TB programme from decreasing donor funding (Global Fund) to increased domestic funding
	Other:
Health Security & emergency preparedness	MOHFW to endorse National Action Plan for Health Security (NAPHS) and capacity built in compliance with International Health Regulations (IHR)
	Strengthen the existing surveillance system for communicable and non-communicable diseases
	Develop capacity at designated points of entry in compliance with IHR (2005), including setting up Emergency Operation Centres at all levels for emerging diseases
	Allocate more resources to build capacity of hospitals to meet medical emergencies
	Strengthen emergency services as per competency at each PHC tier with all necessary logistics, skill, and gender mix
	Other:
Environmental Health and Waste Management	Introduce in-house Medical Waste Management (MWM) (E.g. Autoclave Steam Sterilization) in all Public Medical College Hospitals, Specialized Hospitals and District Hospitals and selected UzHCs
	Conduct final disposal of hazard waste in pits at all UzHCs (until there is assurance that disposal by city/municipal corporation is environmentally safe and scientific)
	Explore PPP model for Medical Waste Management and engagement of private hospitals.
	Ensure all public and private health facilities have standard MWM system
	Other:
Nutrition	Speed up the progress on stunting by investing in actions to improve Exclusive Breastfeeding (EBF), continued breastfeeding and MAD for children between 6 and 23 months in order to increase the health sector contribution to stunting reduction
	Intensify counselling during the entire first 1000 days of life on exclusive breast feeding and complimentary feeding, introduce Growth Monitoring and Promotion (GMP) near and in the community and introduction of CMAM. Link GMP services to EPI services in the CC and during outreach sessions
	Enable mothers to practice EBF up to 6 months, and continued breastfeeding up to 2 years, by ensuring a supportive environment at the home and workplace, at services and provision of a regulatory safety net
	Prioritize the development and implementation of an Urban Nutrition Strategy that covers all forms of malnutrition taking into account the lifecycle approach; include adolescents
	Develop tailor-made approaches for nutrition services in slums
	Strengthen monitoring of the implementation of the BMS code (adopt the WHO Netcode approach)
	Work towards a sustainable and effective Bangladesh National Nutrition Council (BNNC) by housing it in an overarching ministry (Prime Minister's Office or Ministry of Planning) that allows them to play an overarching role for all stakeholders and to become less DP dependent
	Introduce task shifting for nutrition counselling as done in the Urban PHC Delivery Project in Barisal and use general counsellors, e.g., the multipurpose volunteers for intensive counselling of women at ANC and on IYCF instead of overloaded nurses
	Develop, in strong coordination with NCD OP and HLE OP, a plan to address overweight and obesity
	Other:
Rohingya Humanitarian Response	Strengthen coordination, supervision and monitoring of the FDMN health operation
	Interoperability of the early warning system and DHIS2
	Improved healthcare waste management

	Coordination with other actors to improve camp conditions affecting health and nutrition of FDMN
	Mainstream prevention of gender-based violence (GBV)
	Other:
Integration of GESI approach into health service delivery.	Develop a strategy including a plan of action for prioritizing approaches for gender equity, gender-based voice and accountability, social inclusion and fair and respectable interaction with women and poor, in all tiers of PHC services
	Equitable access to and utilisation of services by women, girls, boys and other socially excluded people within a rights-based approach
	Health, family planning, and nursing and midwifery departments should emphasize on reducing child marriage through their personnel at upazila health complex and below
	PHC service provision should target women in garment factories, tea garden workers and slum population and reach them through NGOs
	At PHC level in rural areas, DSF and SSK could be merged
	HMIS should emphasize on child deliveries by type at public, private and NGO health facilities for facilitating monitoring and for taking measures by UHFPO and CS at their levels accordingly to control undue C-sections;
	Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
	Gender analysis of barriers to health service access and use
	Development and implementation of gender sensitive health services
	Development of screening and referral for gender-based violence
	Increase stakeholder involvement in planning, delivery and review of services, including with representation of women and most vulnerable communities
	Increase intersectoral collaboration to address social determinants of health
	Other:

Human Resources for Health

Health System Priority Areas	Activities under Health System Priority Area
Human resource management and institutional arrangements	Endorse key HR documents (planning, policy) and tools, and use to generate plans to fill vacant positions against all categories of HWF (including administrative, allied, and supporting HR)
	Finalise and implement Recruitment and Deployment Action Plan that maximises skill-mix across already sanctioned HR, and for the recruitment of additional HAs and FWAs to fill existing positions and respond to upcoming retirements
	Develop a coordinated Training Plan for all the OPs and make provision to evaluate the impact of the training.
	Update the Health Workforce Strategy 2015, addressing findings of the recently approved 'National CHW Strategy', especially with respect to urban CHW/Auxiliary CHW (definition, need, role of informal providers, etc), and the needs of hard to reach and remote areas like CHT, Tea garden, hoar /char/islands
	Finalise, approve and implement a costed Action Plan following the short, medium, and long-term recommendations of the Health Workforce Strategy, with added focus on the involvement of the private sector
	Recruit and deploy adequate HFW (through objectively assessed HR requirement) in every category at all levels of health care with facility-wise standardization of service
	Finalise Health Labour Market Analysis (HLMA)
	Address other vital HR issues like skill-mix & task shifting, alignment with HR production, quality improvement & accreditation, motivation, incentives-disincentives, retention, job description, performance evaluation & accountability, and integrated MIS
	Pilot various options (alone or in combination) of healthcare and HR generation (e.g., Referral System, GP system, Digital Health and PPP) with special focus on urban health strategies
	Rationalise the HR issues across all the Operational Plans (Ops) through coordinated HR planning and professional capacity development with one dedicated umbrella HR OP to deal with HR planning and training related activities
	Conduct an organisational review of NIPORT, and explore various options including making it an autonomous institution (with possible linkage to a Medical University)
	Have 2 HRD OPs (one each for the 2 Divisions) with responsibility for coordinating all training
	Delegate HRD OP responsibility for maintaining a database for all training
	Bring the Alternative Medical Care (AMC) (homeopathy, ayurvedic and unani) professionals into mainstream by abolishing the AMC OP and, with appropriate legislative and regulatory frameworks, its activities rationally distributed to other relevant OPs like ME&HMD, HSM, and HRD
	Strengthen the HRD Unit of MoHFW to conduct HR planning, training, and coordination, and provide high level oversight to ensure the Unit performs well and delivers
	Devolve some powers for local HR planning, and decision making for recruitment and retention
	Enact the Bangladesh Allied Health Professional Education Board Law 2019, to provide a legal base of the SMF and other regulatory bodies
	Enhance capacities of regulatory bodies for proper compliance of laws
	Undertake innovative approaches to ensure availability of specialist health services (Surgery, Medicine, anaesthetists, Obs/Gyn, Paediatrics specialists) at district level hospital, including partnerships with the private sector
	Initiate process of revising the curricula for MATS and diploma courses in Institute of Health Technology (IHT)
Initiate process of bringing AMC graduate course under Medical Faculty, from Pharmacy Faculty of Dhaka University	
Other:	

Medical Education and Regulation	Issue a revised SRO to allocate ME&FWD of MOHFW the required authority and responsibility for the stewardship of medical education and fully complete the transfer of business
	Undertake a comprehensive assessment of medical colleges, dental colleges/units of both public and private sectors
	Delay set-up of any new medical colleges until all established medical colleges have needed infrastructure and faculty
	Revisit and revise requirement for tuition in nursing institutions to be in English
	Review and update all existing laws of the regulatory bodies (BMDC, BNMC, PCB, BHB and BBAUSM)
	Secure approval of the Bangladesh Medical Education Accreditation Law 2019
	Revise the organogram of DGME, adding in required posts, and get revised organogram approved
	DGME and DGNM to ensure all the non-government educational institutions under their purview have required physical infrastructure, faculty, and support staff, through regular supervision and monitoring
	DGME to establish operations at least at divisional levels
	Establish dedicated midwifery institutions with required physical facilities, staff, skills laboratories, and other required amenities
	Undertake comprehensive assessment of nursing colleges and institutes of both public and private sectors
	Initiate process of revising MBBS and BDS curricula
	Introduce aptitude test/viva in the MBBS and BDS admission tests
	Other:
Integration of GESI approach into HRH interventions.	Disaggregation and analysis of data by sex and other social stratifiers (e.g., age, location, cadre)
	Gender-sensitive human resources (service providers) in the health sector with appropriate skills development for health service providers to deliver gender sensitive, non-discriminatory services
	Development and analysis of gender-sensitive HRH data
	Participation of key stakeholders, including female health care providers, in the design of human resource reforms
	Increase women's representation in HRH leadership positions
	Development and implementation of gender-sensitive HRH policies and strategies
	Other:

Governance and Leadership

Health System Priority Areas	Activities under Health System Priority Area
Sector Management, Stewardship and Regulation	Review and revise OPs based on the MTR 20202 findings and recommendations
	Initiate strategic purchasing pilots under Shasthyo Shuroksha Karmasuchi (SSK) for universal coverage
	Review the architecture of health sector coordination, with its extensive range of committees and task groups, and rationalise working practices and act to ensure strong and sustained leadership of the sector
	Reduce number of OPs, clustered around major themes (PHC rural, PHC urban, secondary, and tertiary etc) with their own logframe, nested within the higher-level results frameworks, with clear indicators to track progress and contribution to higher level goals
	Create a Governance, Stewardship and Regulation Unit (GS&RU) in MOHFW to drive reforms related to resource mobilisation, delegation of authority with budget, local level planning, and strategic purchasing
	Start strategic purchasing of PHC (rural and urban) and inpatient care from accredited/empanelled public and private providers
	Establish pooled technical assistance from Development Partners to drive critical areas (GP model, risk pooling, urban health etc) for achievement of UHC
	Other:
Drug Quality and Regulation	Qualified HR with proper training in the DGDA and NCL, including IT personnel
	Introduce new policies and legislation for putting a cap on the retail price of essential drugs
	Meet NRA standards, so the Bangladesh pharmaceutical industry can be WHO pre-qualified
	Working with DGDA and DGHS, expand Pharmacovigilance (PV) activities in hospitals and pharmaceutical companies, and review status of ADE reporting system, including awareness program among the stakeholders through allocation of sufficient budget to address this issue
	Enforcement and monitoring of antibiotic prescribing, including among informal unskilled practitioners to prevent antimicrobial resistance (AMR)
	Appointment of graduate Pharmacist in healthcare system to improve drug monitoring and patients' safety through Good Dispensing Practice to reduce out-of-pocket (OOP) expenditure
	Construction of dedicated Medicine Store, with required facilities and logistics at district and Upazila levels
	Other:
Health Financing and Equity	Prepare advocacy materials (including newspaper articles) and advocate for the health budget increase from 0.4% of GDP to 1% of GDP, funded by general taxation, and earmarked taxes, (e.g., tobacco and sugar tax)
	Health Economics Unit (HEU) to revisit and modify the Health Care Financing Strategy, taking on board UHC lessons from countries similar to Bangladesh (e.g., Indonesia).
	Continue provision of timely National Health Accounts and Public Expenditures Reviews
	Modify design of SSK and MHVS in context of UHC (universal and broader benefit package) and scale up to more sites
	Expand cover for SSK to include access to care in private facilities
	Enact a Health Protection Act
	Improve Public Financial Management
	Establish a NHSO, and drive UHC through one risk pool, strategic purchasing of PHC and higher-level care (for all), with a strong gate keeping function
	Sustain increased resource mobilisation for health - explore scope for introduction of mandatory payroll tax
	Continue measures to improve fund absorption capacity of MOHFW

	Other:
Integration of GESI approach into management of governance and leadership.	MOHFW policies, strategies, operational plans, and other programmes adhere to the principles of gender equity and effective practice in line with the GOB commitment to equality
	Gender mainstreamed in all programmes with MOHFW and other ministries and organisations through equitable planning, policymaking, and budgeting
	Foster meaningful dialogue with representatives of civil society and other stakeholders, particularly women, girls and other socially excluded communities, on planning, implementing and reviewing health and family welfare services and gender equity strategy
	Ensure that all district and community consultations include equal representation of men and women
	All OPs are gender sensitive and budgets allocated are gender responsive
	Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
	Gender analysis of health systems reform and implementation
	Development and implementation of gender sensitive policies
	Increase representation of women and other key groups into decision-making bodies
	Increase citizens' participation, civil society dialogue and interaction with governments including parliamentarians, finance ministers, and heads of states
	Other:

Health Information Systems

Health System Priority Areas	Activities under Health System Priority Area
Information Management & Data Quality	Development of Health System Innovation and Incubation Unit (HSIIU) under MOHFW to perform research, innovation, incubation, and validation for improving health system, service delivery, better patient care and address emerging health issues
	Conduct IT system audit to evaluate and identify the structure and limitations of DHIS2 and all existing system of DGHS, DGFP and other MIS (MNCAH, CBHC, HSM, RMNCAH, FP, NNS, etc.)
	Implementation of digitalised service recording, tracking and referral system from household (MHV) to CC (CHCP) to distribute patient load and improve quality of services
	Digitalise CCs, with all activities of CC/HA performed using mobile application, to reduce cost and enhance monitoring and supervision for CBHC or CC Trust and improve efficiency and accountability. Integrate NCDC, EPI, Maternal Health etc. program activities with Digital CC to reduce workload and prevent data duplication
	Creation of citizen's health account (allowing age, sex, disability disaggregation) connecting with NID/Birth ID for primary healthcare
	NCD program to utilize digital system (mobile app and smart screening tools) to screen, provide interventions and follow up as well as medicine distribution for diabetes and hypertension.
	Adaptation of software-based Cancer Registry to track situation of cancer in Bangladesh
	Interoperable digital health platform to support the rural and urban GP models
	Integrated national digital systems for real-time disease surveillance to inform risk predication and evidence-based timely response during an epidemic/pandemic
	Continued implementation of the national digital health strategy
	Improvement of LIMS (Smart AMS solution) by utilizing advanced technologies (IoT and AI), integrating with operators (HR) and service delivery
	Strengthening (both HR and capacity) of MIS of MOHFW in collaboration with HSIIU
	Inclusion of skilled ICT manpower from Upazila and above to ensure stable IT systems (Software, Hardware, Network and Maintenance), operations and sustainability
	Digital system for Accreditation of Hospitals for tracking service quality in public and private hospitals
	Medical education and HR development system oriented with digital technologies and tools like AR, VR, AI and IoT used in education, learning, training, patient care and healthcare service delivery
Other:	
Integration of GESI approach into health information systems	Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
	Development and analysis of gender-sensitive data: Develop information management approaches that focus on the role of quality data in providing knowledge about gender inequities, e.g., gender-sensitive health indicators to identify key differences between women and men in relation to health and in the social determinants of health, to support policy change
	Establish positive practices in the systematic collecting of gender disaggregated statistical data
	Education and training for application of the methodologies for collecting data
	Data used in planning and developing baselines on gender sensitive performance indicators
	Increase participation of patients and community in assessment and reviewing any disaggregated data to measure improvements in inequalities
	Increase women's representation on data collection and analysis teams
	Other:

Health Financing

Health System Priority Areas	Activities under Health System Priority Area
Financial Management & Audit	Strengthen Internal Audit Function: set up an internal audit outfit in FMAU (HSD) and engage experts to help develop capacity of staff for conducting internal audit
	Expedite completion of the ongoing approval process of recruitment rules for FMAU (HSD) and recruit sanctioned staff to make it fully functional
	Start monitoring (by FMAU) of expenditure incurred by LDs using iBAS++
	Develop and implement an action plan for restructuring of FMAU of ME&FW Division to enable the unit to perform all its assigned functions with all the required HR in place
	Establish FM Unit at LDs of all major OPs and deploy staff with FM background
	Ensure timely preparation and approval of work plans, procurement plans, and training plans by LDs to improve the timely implementation and utilization of funds
	Streamline the monitoring of DLR achievements to ensure timely reporting by LDs and expedite verification by IMED
	Revitalize the functioning of the Audit Committee in the HSD and ME&FWD
	Establish an OP for Improved Financial Management for ME&FWD
	Review and strengthen the accountability framework and process for resolution of pending audit observations
	Take administrative and legal actions against officials responsible for financial irregularities reported by Audit
	Other:
Integration of GESI approach into health financing management and delivery.	Development of gender responsive budgets
	Advocate and support gender analyses of health financing and insurance proposals to ensure that they do not discriminate or disadvantage women and effectively address women’s health and family planning needs
	Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
	Development and analysis of gender-sensitive health financing schemes
	Increase representation of women and other key groups on financial management committees
	Increase participation of patients and community in financial management committees
	Other:

Medical Products and Technologies

Health System Priority Areas	Activities under Health System Priority Area
Procurement and Supply Chain Management	Reform of procurement policy to allow prequalification and framework contracts
	Reform of financial flows to allow funding to be spared from one year to the next
	Allocate budgets for both procurement of medicines and contracting of equipment maintenance to Upazila /hospital level
	DGHS to expand LMIS for DGHS to 200 most common ESP items and roll it out to all Upazila and hospitals
	DGHS to allocate a budget for maintenance of equipment to all Upazila and hospitals
	DGHS to ensure finalization of ability to do ICB procurement in e-GP
	DGHS to issue Standard Operating Procedure (SOP) on physical stock management and procurement and include the monitoring of product management in the external work of DGDA to inspect warehousing of pharmaceuticals
	DGFP to revise method for distribution to Union level from kit distribution to informed push
	DGFP to train 5 central logistics personnel on advanced supply chain management from certified institute
	DGFP to recruit two pharmacists and train them on quality assurance of key products under central procurement
	DGFP to adjust LMIS system to do forecasting and to include dashboard functionality for all items in the LMIS
	DGFP to revise focus on stock availability for all items
	Other:
infrastructure	Establish local steering committees for each construction project, with presence of local management of Upazila/hospital, HED/PWD, equipment procurement and personnel allocation
	Prioritise rehabilitation of existing facilities to ensure they are functional
	DGHS to establish a Logistics and procurement Line Director within HS, responsible for LMIS and all centralized procurement on behalf of other line directors
	DGHS to establish long term procurement plans (three years) to the extent possible within the present rules and regulations while working on expanding the frame
	DGHS to establish framework contracts as a procurement tool within health
	DGHS to reform CMSD and have the full administration on an ERP system
	DGHS to build, recruit and deploy cadre of pharmacists (minimum 200 pharmacists) specialized in stock management and procurement to hospitals and Upazila
	DGFP to establish a Logistics and Procurement Line Director within FW
	DGFP to implement framework contracts for central procurement
	DGFP to get ICB procurement into e-GP
	Separate the organizations responsible for tendering out of construction from the organization responsible for monitoring the actual construction
	Other:
Integration of GESI approach into management and use of medical products and technologies	Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
	Development and analysis of gender-sensitive medicines and technologies management and use
	Increase representation of women and other key groups, including patients and communities, on relevant committees
	Other:

Health Systems Prioritization for UKPHS

Stakeholder Feedback Tool

Bangladesh

Name: _____

Organization: _____

Date: _____

Policy Documents Reviewed

The following health system priority areas and activities have been identified from a review of the available key documents for **Bangladesh**.

The main documents reviewed to identify priority areas are included in the table below.

Documents Reviewed
Independent Review Team (2020) 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020. Main Report., May 2020
Independent Review Team (2020) 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020 Thematic Report: FP under MNCAH & FP
Independent Review Team (2020) 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020 Thematic Report: Primary Health Care (Rural and Urban)
Independent Review Team (2020) 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020 Thematic Report: Financial Management and Audit
Independent Review Team (2020) 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020 Thematic Report: Noncommunicable Disease and Mental Health
Independent Review Team (2020) 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR)

2020 Thematic Report: Procurement and Supply Management
Independent Review Team (2020) 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020 Thematic Report: Communicable and Emerging Diseases, Environmental Health, including Waste Management
Independent Review Team (2020) 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020 Thematic Report: Secondary and Tertiary Health Care Provision
Meeting of Human Resources & Medical Education (HR-ME) Task Group. Medical Education and Regulation Thematic Area. PowerPoint Presentation, 04 March 2020
Findings and Recommendations: Thematic Area: Medical Education and Regulation. PowerPoint Presentation
Meeting of Human Resources & Medical Education (HR-ME) Task Group. Human Resource Management and Institutional Arrangements Thematic Area. PowerPoint Presentation, 04 March 2020
Joint Meeting of Governance & Stewardship and Sector Management, Monitoring and Evaluation Task Groups. Sector Management, Stewardship and Regulation Thematic Area. PowerPoint Presentation, 01 March 2020
MoHFW (2012) Expanding Social Protection for Health Towards Universal Coverage Health Care Financing Strategy 2012-2032. Health Economics Unit
Annual Programme Review (APR) 2018 (January 2017- June 2018). Report of the Independent Review Team. 24 February 2019
MoHFW (2014) Gender Equity Strategy
4th Health, Population and Nutrition Sector Program (HPNSP) 2017-2022 Mid-Term Review (MTR) 2020. Thematic Reports
WHO (2015) Bangladesh Health System Review. Health Systems in Transition Vol. 5 No. 3 2015
Centre for Medical Education (2016) Post Graduate Medical Education in Bangladesh: A Situation Analysis
Centre for Medical Education (2017) Technical Brief: Assessing Implementation of National Quality Assurance Scheme in Different Medical Colleges in Bangladesh. January -October 2017.
Centre for Medical Education & Directorate General of Health Services (2012) National Guidelines and Tools for Quality Assurance Scheme (QAS) for Medical Colleges in Bangladesh
DGNM (2018) Human Resources Report, December 2017, July 2017 and June 2018
DGNM (2018) Recommendations from the National Task Force on Future of Nursing in Bangladesh
Experience with Accreditation of Health Professionals' Education in the South-East Asia Region: Expert workshop. Summary Report 14-15 February 2018, Bangkok, Thailand http://www.dghs.gov.bd/images/docs/Publicaations/Health_Workforce_Situation_in_Bangladesh_Preprint_zero_draft_version_31.12.18.pdf
MIS /WHO (2018) Technical Brief on Health Systems Strengthening Initiative. Health Minister's National Award 2017. February 15, 2018
MoHFW (2015) Bangladesh Health Workforce Strategy
MoHFW (2016) Plan Projection and Career Development (HRPP&CD). Draft Report 8.8.16
MoHFW (2017) Action Plan of Bangladesh Health Workforce Strategy 2015. Final Draft March 2017
MoHFW (2019) National Strategy for Community health Workers
MoHFW and WHO (2019) Independent evaluation of community-based health services in Bangladesh
MoHFW (2018) Workload Indicators of Staffing Need (WISN). Application at Public Sector Health Facilities in Bangladesh. Technical Brief
MoHFW/WHO (2018) Conducting Health Labour Market Analysis in Bangladesh. Concept Note. Final Draft. August 2018
MOHFW/WHO (2018) Mapping of Health Professional Education Institutions in Bangladesh
NIPORT (2016) Bangladesh Maternal Mortality and Health Care Survey 2016. Preliminary Report
NIPORT (2018) Bangladesh Health Facility Survey 2017. Preliminary Report, November 2018.
WHO (2018) Decade for health workforce strengthening in the South-East Asia Region 2015–2024; Second review of progress, 2018
WHO & BRAC James P. Grant School of Public Health (2018) Assessment of Staffing Need through Workload Analysis at Public Sector

Health Systems Components Priority Ranking

Instructions:

- Rank the following six health systems areas in order of priority.
- For the top three priorities, please review the associated health system component table and rank the priority areas and activities (including any additional ones you have identified above) underneath each area, with one 1 being the highest ranked priority.

Priority Ranking	Health System Component
	<u>Service Delivery</u>
	<u>Human Resources for Health</u>
	<u>Governance and Leadership</u>
	<u>Health Information Systems</u>
	<u>Health Financing</u>
	<u>Medical Products and Technologies</u>

Priority Ranking Per Health Systems Area

Service Delivery

Instructions:

1. Rank the health system priority areas using the column labelled: Priority Ranking of HS Areas, with 1 being the highest priority.
2. Rank the of activities under each health systems area using the column labelled: Priority Ranking Activities under HS Area, with 1 being the highest priority.

Priority Ranking of HS Areas (1=highest priority)	Health System Priority Areas	Priority Ranking of Activities under HS Area (1=highest priority)	Activities under Health System Priority Area
	Health care Provision -Rural PHC		Explore Institutional reforms required within MOHFW to drive rural and urban PHC, e.g., establish new Directorate for Primary Health Care, with 2-line directors, and separate Ops, one each for rural and urban health.
			Capacity strengthening of the new community clinic trust status, including provision of TA to finalise governance structures and operationalise Trust management and to build stewardship capacity of DGHS to fund, regulate and monitor community clinics.
			Modify contracts and job descriptions for all community health personnel (HA, FWA, CPHC, MPHV), avoiding impact on well performing programmes such as EPI
			Bolster capacity of the Multipurpose Health Volunteers (MHVS) to provide domiciliary services, support mHealth (HMIS and test innovative apps, such as blood sugar test)
			Continue to investigate the feasibility of introducing a GP system for strengthened PHC delivery in rural areas and finalise design of a pilot
			Introduce contracting of community clinic services, In a phased manner, with strong monitoring and oversight
			Finalise the design of the GP model for strengthened PHC delivery in rural areas, pilot and scale in a phased manner, taking on board evidence and learnings generated, and introduce a gate keeping role for access to higher level care.
			Other:
	Health care Provision -Urban PHC		Urban Health Committee and Working Group meeting on quarterly basis
			Map all health facilities - MOHFW, other government departments, city corporation, NGOs and private sectors, and use information to set up integrated service delivery network for 6 -10 wards (or roughly 10,000 people per unit) around a government secondary/tertiary hospital.
			Design and start pilot of urban GP model along the lines of the Mohalla clinics operating in New Delhi, and empanel private diagnostic centres and private clinics (providing specialised outpatient care) and scale up in a phased manner taking on board evidence and learnings generated.
			Improve underlying determinants of poor environmental health (medical waste management, sanitation, clean water, and clean air).

		Expand opportunities available through social marketing (such as SMC) etc. to bring retail pharmacies within the integrated service delivery network.	
		Strengthen infectious disease surveillance, prevention and rapid response	
		Continue to address the underlying determinants of poor environmental health	
		Pilot digital technologies, such app-based GP access	
		Other:	
Health care Provision - Secondary and Tertiary		Establish structured referral system in high performing districts and develop Structured Referral System Guidelines	
		Make existing hospitals fully functional before starting new construction (needed staff, equipment and drugs).	
		Improve antibiotic prescribing and dispensing	
		Allocate budget to hospital managers for quality improvement initiatives and assessment of effectiveness	
		Establish effective referral system across all levels of care, including relationship with Maternal and Child Welfare Centres (MCWC), and pilot gatekeeping at union level in the GP pilot	
		Secure approval of the Accreditation Act, and initiate accreditation of public and private hospitals	
		Procure the services of at least one private hospital in the scale up Shasthya Surokkha Karmosuchi (SSK), and introduce a similar social protection scheme with private hospitals for the urban poor	
		Continue expansion of service offerings from secondary and tertiary hospitals. (e.g., mental health, geriatric and palliative care, thalassemia care, emergency department, child development centre, reconstructive surgery for club foot, cleft palate, ICU/CCU, dialysis etc.	
		Roll out of (R)MN(CA)H quality standards to all District Hospitals DH and MCWC's	
		Install digital hospital management Information Systems (MIS)	
		Support tertiary specialised hospitals to become centres of excellence and provide technical leadership	
		Continue strengthening lower level facilities and introduce gatekeeping function in order to streamline use of secondary and tertiary hospitals	
		Establish Observation Ward and Day Care Centre in hospitals to reduce inpatient admissions	
		Award hospitals greater autonomy to raise finance, manage, and procure the services they need	
		Provide incentives to hospitals for efficient care (including preventive measures) and refer uncomplicated cases to primary care level	
	MNCAH including Reproductive Health		Introduce structured death audit in hospitals as a tool to improve patient management effectiveness, for learning purposes, without blaming and shaming, with actions to resolve the problems identified
			Ensure coordinated plan on facility construction, staffing, and equipping before starting construction work
		Other:	
		Revise the current maternal health action plan to include MTR recommendations and implement the plan, prioritizing high maternal and neonatal mortality geographical areas.	

			Rationalise availability of 24/7 normal delivery (selection of union level facilities) and BEmONC and NSU (selection of UzHC and MCWC) with adequate HR and midwifery led continuity of care
			Improve access to 24/7 normal delivery facilities for slum populations and remote and difficult to access areas through innovative strategies such as ‘alongside midwifery-led care’ units and partnerships with private providers (slums) and maternity homes and introduce telemedicine for guiding emergency care
			Develop a plan for prevention and management of stillbirths, including stillbirth surveillance in institutions under the expansion and improvement of quality of MPDSR response
			Improve and expand access to Special Care Newborn Unit (SCANUs) based on the findings of the SCANU assessment
			Incorporate the PPH and Eclampsia plan into the overall BEmONC improvement plan based on the technical review of the plan
			Establish a system for auditing caesarean sections
			Introduce preconception care package to contribute to reduction in maternal and newborn mortality and stillbirth
			Modify the maternal health voucher scheme - Demand Side Financing (DSF), including the benefit package and disincentivise the over-provision of caesarean sections in the private sector.
			Undertake a critical review of the incentives for providers with regard to accountability and quality
			Review and rationalise maternal, newborn, child, adolescent health indicators under 4 th HNPSP results framework and operational plans to better align at goal, output and input levels.
			Revise DLR indicators to include quality elements and measure population coverage instead of just numbers.
			Other:
	Adolescent Health		Implement the finalised Adolescent Action Plan, including preconception care package in collaboration with Ministry of Education (schools programme) and Ministry of Women’s Children Affairs (early marriage and childbearing)
	Immunisation		Improve immunisation coverage in urban areas and remote and difficult to access areas and plan for the smooth transition of vaccine procurement
	Family Planning		Use post FP2020 Costed Implementation Plan (CIP) to revise FP related OPs and develop approaches to mobilize additional resources to address funding gap
			Place responsibility for oversight of CIP implementation within the new Governance Stewardship, and Regulation Unit (GS&R Unit)
			Provide needed resources as per CIP to strengthen FP delivery in both DGHS and DGFP operated facilities, especially LARC and PMs.
			Recruit volunteers to fill vacant fieldworker positions with uniform criteria and package for all directorates and OPs.
			Initiate an assessment of all operational FPCST-QIT in the entire country to observe its effectiveness to improve quality of FP services, including addressing structural gaps such as filling vacant MO (MCH-FP) positions.
			DGFP/GS&RU operationalise and use the newly developed national dashboard to monitor and improve quality of FP, especially LARC/PM
			Review and scale up FP interventions with the private sector (such as SMC Pink Star Providers Network for PFP, and SMC’s social marketing of Sayana Press)

		<p>Introduce BCC campaigns to address specific non-use concerns of women with unmet FP needs (e.g. side effects or health risks, infrequent or no sex, opposition from persons close to them, etc)</p> <p>Implement geographically targeted service package (including BCC campaigns and contraceptives delivery) at low performing upazilas within low performing region, chars and coastal areas.</p> <p>Agree a mechanism to strengthen the modalities of FP service delivery at urban areas particularly for the slum dwellers, the floating and poor people in the city corporation areas, including through the GP system and other public-private partnerships.</p> <p>Conduct in-depth review of existing satellite clinics conducted at different locations by different type of providers to rearrange/re-design the program based as per clients need.</p> <p>Initiate programs to popularize injectables (including newer technologies) through intensive motivation and follow up involving public and private sector.</p> <p>Other:</p>
	NCDs	<p>Implement an NCD Behaviour Change Campaign to address underlying life style determinants (exercise, diet, substance abuse etc.)</p> <p>Activate the coordination committees set up at district and upazila levels to implement multisectoral actions (under the multi sectoral action plan) for NCD prevention by different sectors</p> <p>Increase budget allocation to NCD programme, including for management of hypertension and diabetes, for staff, drugs and supplies, and institute better patient tracking through dedicated patient records and HMIS/DHIS2</p> <p>Allow lower levels of the health system to “refill” drugs for patients diagnosed with hypertension and diabetes.</p> <p>Expand NCD programme to manage more conditions, including COPD, asthma, disability, cancer, and road traffic injuries and ensure these are addressed at PHC level</p> <p>Ensure NCD prevention and management is appropriately incorporated into Essential Service Package (ESP) delivery in urban areas, including partnerships with the NGOs, City Corporation facilities, private facilities and hospitals</p> <p>Emphasise primary prevention of NCDs through promotion of lifestyle change, and policy/regulation of food industry</p> <p>Incorporation of NCD treatment into social protection/health insurance schemes, which entitle the poor (including urban poor) access to specialised services in both public and private sectors</p> <p>Other:</p>
	Mental Health	<p>Secure approval of the Mental Health Strategy, and prioritise activities for implementation during remaining period of HPNSP</p> <p>Include mental health indicator at RFW (Suicide rate) and OP level (Substance Use Disorder) aligning with the SDG results framework</p> <p>Harmonize and standardise mental health training to be coordinated by NCDC</p> <p>Ensure the 4 government medical college hospitals that currently lack indoor mental health services add this service as a priority</p>

		Ensure adequate budget and required institutional capacity is allocated to mental health
		Recruit and deploy needed mental health workforce at all levels to realise approved mental health strategic plan
		Introduce mental health in the undergraduate MBBS curricula
		Introduction of certificate courses of three to six-months duration, with medical and psychosocial modules for doctors and other allied professionals.
		Develop an action plan to prevent and address substance abuse, and work collaboratively with DNC and MOHA
		Other:
	Eye Care	Fill vacant positions of ophthalmologists at district hospitals and provide more trained nurses to run the community vision centres at the UzHCs
		Provide care for corneal disease
		Incorporate Cataract Operation within the system, replacing the 'Eye Camp' modality and incorporate data from all facilities in the DHIS2
		Retinopathy, MNCA&H Program to capture 'Retinopathy of Prematurity' and IMCI program to capture certain eye diseases /conditions to prevent childhood blindness
		Distribution of DSF for cataract operation through the main system to attract the vulnerable and capture availability of services data in DHIS2
		Other:
	Communicable & Emerging Diseases	Fill all vacant Laboratory Technologist positions so that costly procured Gene Xpert machines are utilized properly
		Ensure a smooth transition of support for the TB programme from decreasing donor funding (Global Fund) to increased domestic funding.
		Other:
	Health Security	MOHFW to endorse National Action Plan for Health Security (NAPHS) and capacity built in compliance with International Health Regulations (IHR) (2005)
		Strengthen the existing surveillance system for communicable and non-communicable diseases
		Develop capacity at designated points of entry in compliance with IHR (2005), including setting up Emergency Operation Centres at all levels for emerging diseases
		Allocate more resources to build capacity of hospitals to meet medical emergencies
	Environmental Health and Waste Management	Introduce in-house Medical Waste Management (MWM) (e.g. Autoclave Steam Sterilization) in all Public Medical College Hospitals, Specialized Hospitals and District Hospitals and selected UzHCs
		Conduct final disposal of hazard waste in pits at all UzHCs (until there is assurance that disposal by city/municipal corporation is environmentally safe and scientific)
		Explore PPP model for Medical Waste Management and engagement of private hospitals.
		Ensure all public and private health facilities have standard MWM system
	Nutrition	Speed up the progress on stunting by investing in actions to improve Exclusive Breastfeeding (EBF), continued breastfeeding and MAD for children between 6 and 23 months in order to increase the health sector contribution to stunting

		reduction.
		Intensify counselling during the entire first 1000 days of life on exclusive breast feeding and complimentary feeding, introduce Growth Monitoring and Promotion (GMP) near and in the community and introduction of CMAM. Link GMP services to EPI services in the CC and during outreach sessions
		Enable mothers to practice EBF up to 6 months, and continued breastfeeding up to 2 years, by ensuring a supportive environment at the home and workplace, at services and provision of a regulatory safety net
		Prioritize the development and implementation of an Urban Nutrition Strategy that covers all forms of malnutrition taking into account the lifecycle approach; include adolescents.
		Develop tailor-made approaches for nutrition services in slums.
		Strengthen monitoring of the implementation of the BMS code (adopt the WHO Netcode approach).
		Work towards a sustainable and effective Bangladesh National Nutrition Council (BNNC) by housing it in an overarching ministry (Prime Minister's Office or Ministry of Planning) that allows them to play an overarching role for all stakeholders and to become less DP dependent.
		Introduce task shifting for nutrition counselling as done in the Urban PHC Delivery Project in Barisal and use general counsellors, e.g. the multipurpose volunteers for intensive counselling of women at ANC and on IYCF instead of overloaded nurses.
		Develop, in strong coordination with NCD OP and HLE OP, a plan to address overweight and obesity
		Other:
	Rohingya Humanitarian Response	Strengthen coordination, supervision, and monitoring of the FDMN health operation
		Interoperability of the early warning system and DHIS2
		Improved healthcare waste management
		Coordination with other actors to improve camp conditions affecting health and nutrition of the FDMN
		Mainstream prevention of gender-based violence
		Other:
	Integration of GESI approach into health service delivery.	Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
		Gender analysis of barriers to health service access and use.
		Development and implementation of gender sensitive health services.
		Development of screening and referral for gender-based violence.
		Increase stakeholder involvement in planning, delivery and review of services, including with representation of women and most vulnerable communities.
		Increase intersectoral collaboration to address social determinants of health.
		Other:

Human Resources for Health

Instructions:

1. Rank the health system priority areas using the column labelled: Priority Ranking of HS Areas, with 1 being the highest priority.
2. Rank the of activities under each health systems area using the column labelled: Priority Ranking Activities under HS Area, with 1 being the highest priority.

Priority Ranking of HS Areas (1=highest priority)	Health System Priority Areas	Priority Ranking of Activities under HS Area (1=highest priority)	Activities under Health System Priority Area
	Human resource management and institutional arrangements		Endorse key HR documents (planning, policy) and tools, and use to generate plans to fill vacant positions against all categories of HWF (including administrative, allied and supporting HR)
			Finalise and implement Recruitment and Deployment Action Plan that maximises skill-mix across already sanctioned HR, and for the recruitment of additional HAs and FWAs to fill existing positions and respond to upcoming retirements
			Develop a coordinated Training Plan for all the OPs, and make provision to evaluate the impact of the training.
			Update the Health Workforce Strategy 2015, addressing findings of the recently approved 'National CHW Strategy, especially with respect to urban CHW/Auxiliary CHW (definition, need, role of informal providers, etc), and the needs of hard to reach and remote areas like CHT, Tea garden, hoar /char/islands
			Finalise, approve, and implement a costed Action Plan following the short, medium, and long-term recommendations of the Health Workforce Strategy, with added focus on the involvement of the private sector.
			Recruit and deploy adequate HFW (through objectively assessed HR requirement) in every category at all levels of health care with facility-wise standardization of service.
			Finalise Health Labour Market Analysis (HLMA)
			Address other vital HR issues like skill-mix & task shifting, alignment with HR production, quality improvement & accreditation, motivation, incentives-disincentives, retention, job description, performance evaluation & accountability, and integrated MIS
			Pilot various options (alone or in combination) of healthcare and HR generation (e.g. Referral System, GP system, Digital Health and PPP) with special focus on urban health strategies
			Rationalise the HR issues across all the Operational Plans (Ops) through coordinated HR planning and professional capacity development with one dedicated umbrella HR OP to deal with HR planning and training related activities
			Conduct an organisational review of NIPORT, and explore various options including making it an autonomous institution (with possible linkage to a Medical University)
			Have 2 HRD OPs (one each for the 2 Divisions) with responsibility for coordinating all training

		Delegate HRD OP responsibility for maintaining a database for all training
		Bring the Alternative Medical Care (AMC) (homeopathy, ayurvedic and unani) professionals into mainstream by abolishing the AMC OP and, with appropriate legislative and regulatory frameworks, its activities rationally distributed to other relevant OPs like ME&HMD, HSM, and HRD
		Strengthen the HRD Unit of MoHFW to conduct HR planning, training and coordination, and provide high level oversight to ensure the Unit performs well and delivers
		Devolve some powers for local HR planning, and decision making for recruitment and retention
		Enact the Bangladesh Allied Health Professional Education Board Law 2019, to provide a legal base of the SMF and other regulatory bodies
		Enhance capacities of regulatory bodies for proper compliance of laws
		Undertake innovative approaches to ensure availability of specialist health services (Surgery, Medicine, anaesthetists, Obs/Gyn, Paediatrics specialists) at district level hospital, including partnerships with the private sector
		Initiate process of revising the curricula for MATS and diploma courses in Institute of Health Technology (IHT)
		Initiate process of bringing AMC graduate course under Medical Faculty, from Pharmacy Faculty of Dhaka University
		Other:
	Medical Education and Regulation	Issue a revised SRO to allocate ME&FWD of MOHFW the required authority and responsibility for the stewardship of medical education and fully complete the transfer of business
		Undertake a comprehensive assessment of medical colleges, dental colleges/units of both public and private sectors
		Delay set-up of any new medical colleges until all established medical colleges have needed infrastructure and faculty
		Revisit and revise requirement for tuition in nursing institutions to be in English.
		Review and update all existing laws of the regulatory bodies (BMDC, BNMC, PCB, BHB and BBAUSM)
		Secure approval of the Bangladesh Medical Education Accreditation Law 2019
		Revise the organogram of DGME, adding in required posts, and get revised organogram approved
		DGME and DGNM to ensure all the non-government educational institutions under their purview have required physical infrastructure, faculty, and support staff, through regular supervision and monitoring
		DGME to establish operations at least at divisional levels
		Establish dedicated midwifery institutions with required physical facilities, staff, skills laboratories, and other required amenities
		Undertake comprehensive assessment of nursing colleges and institutes of both public and private sectors
		Initiate process of revising MBBS and BDS curricula
		Introduce aptitude test/viva in the MBBS and BDS admission tests
		Other:
	Integration of GESI approach	Disaggregation and analysis of data by sex and other social stratifiers (e.g. age, location, cadre)

	into HRH interventions.		Development and analysis of gender-sensitive HRH data
			Participation of key stakeholders, including female health care providers, in the design of human resource reforms
			Increase women’s representation in HRH leadership positions
			Development and implementation of gender-sensitive HRH policies and strategies
			Other:

Governance and Leadership

Instructions:

1. Rank the health system priority areas using the column labelled: Priority Ranking of HS Areas, with 1 being the highest priority.
2. Rank the of activities under each health systems area using the column labelled: Priority Ranking Activities under HS Area, with 1 being the highest priority.

Priority Ranking of HS Areas (1=highest priority)	Health System Priority Areas	Priority Ranking of Activities under HS Area (1=highest priority)	Activities under Health System Priority Area
	Sector Management, Stewardship and Regulation		Review and revise OPs based on the MTR 20202 findings and recommendations.
			Initiate strategic purchasing pilots under Shasthyo Shuroksha Karmasuchi (SSK) for universal coverage
			Review the architecture of health sector coordination, with its extensive range of committees and task groups, and rationalise working practices and act to ensure strong and sustained leadership of the sector.
			Reduce number of OPs, clustered around major themes (PHC rural, PHC urban, secondary, and tertiary etc) with their own logframe, nested within the higher-level results frameworks, with clear indicators to track progress and contribution to higher level goals
			Create a Governance, Stewardship and Regulation Unit (GS&RU) in MOHFW to drive reforms related to resource mobilisation, delegation of authority with budget, local level planning, and strategic purchasing
			Start strategic purchasing of PHC (rural and urban) and inpatient care from accredited/empanelled public and private providers
			Establish pooled technical assistance from Development Partners to drive critical areas (GP model, risk pooling, urban health etc) for achievement of UHC.
			Other:
	Drug Quality and Regulation		Qualified HR with proper training in the DGDA and NCL, including IT personnel
			Introduce new policies and legislation for putting a cap on the retail price of essential drugs
			Meet NRA standards, so the Bangladesh pharmaceutical industry can be WHO pre-qualified
			Working with DGDA and DGHS, expand Pharmacovigilance (PV) activities in hospitals and pharmaceutical companies, and review status of ADE reporting system, including awareness program among the stakeholders through allocation of sufficient budget to address this issue
			Enforcement and monitoring of antibiotic prescribing, including among informal unskilled practitioners to prevent antimicrobial resistance (AMR)
			Appointment of graduate Pharmacist in healthcare system to improve drug monitoring and patients' safety through Good Dispensing Practice to reduce

		out-of-pocket (OOP) expenditure
		Construction of dedicated Medicine Store, with required facilities and logistics at district and Upazila levels
		Other:
Health Financing and Equity		Prepare advocacy materials (including newspaper articles) and advocate for the health budget increase from 0.4% of GDP to 1% of GDP, funded by general taxation, and earmarked taxes, (e.g. tobacco and sugar tax)
		Health Economics Unit (HEU) to revisit and modify the Health Care Financing Strategy, taking on board UHC lessons from countries similar to Bangladesh (e.g., Indonesia)
		Continue provision of timely National Health Accounts and Public Expenditures Reviews
		Modify design of SSK and MHVS in context of UHC (universal and broader benefit package) and scale up to more sites
		Expand cover for SSK to include access to care in private facilities
		Enact a Health Protection Act
		Improve Public Financial Management
		Establish a NHSO, and drive UHC through one risk pool, strategic purchasing of PHC and higher-level care (for all), with a strong gate keeping function
		Sustain increased resource mobilisation for health - explore scope for introduction of mandatory payroll tax
		Continue measures to improve fund absorption capacity of MOHFW
		Other:
	Integration of GESI approach into management of governance and leadership.	
		Gender analysis of health systems reform and implementation
		Development and implementation of gender sensitive policies
		Increase representation of women and other key groups into decision-making bodies
		Increase citizens' participation, civil society dialogue and interaction with governments including parliamentarians, finance ministers, and heads of states
		Other:

Health Information Systems

Instructions:

1. Rank the following six health systems area in order of priority.
2. For the top three priorities, please review the associated health system component table and rank the priority areas and activities (including any additional ones you have identified above) underneath each area, with one 1 being the highest ranked priority.

Priority Ranking of HS Areas (1=highest priority)	Health System Priority Areas	Priority Ranking of Activities under HS Area (1=highest priority)	Activities under Health System Priority Area
	Information Management & Data Quality		Development of Health System Innovation and Incubation Unit (HSIIU) under MOHFW to perform research, innovation, incubation, and validation for improving health system, service delivery, better patient care and address emerging health issues
			Conduct IT system audit to evaluate and identify the structure and limitations of DHIS2 and all existing system of DGHS, DGFP and other MIS (MNCAH, CBHC, HSM, RMNCAH, FP, NNS, etc.)
			Implementation of digitalised service recording, tracking and referral system from household (MHV) to CC (CHCP) to distribute patient load and improve quality of services
			Digitalise CCs, with all activities of CC/HA performed using mobile application, to reduce cost and enhance monitoring and supervision for CBHC or CC Trust and improve efficiency and accountability. Integrate NCDC, EPI, Maternal Health etc. program activities with Digital CC to reduce workload and prevent data duplication
			Creation of citizen's health account (allowing age, sex, disability disaggregation) connecting with NID/Birth ID for primary healthcare
			NCD program to utilize digital system (mobile app and smart screening tools) to screen, provide interventions and follow up as well as medicine distribution for diabetes and hypertension
			Adaptation of software-based Cancer Registry to track situation of cancer in Bangladesh
			Interoperable digital health platform to support the rural and urban GP models
			Integrated national digital systems for real-time disease surveillance to inform risk predication and evidence-based timely response during an epidemic/pandemic
			Continued implementation of the national digital health strategy
			Improvement of LIMS (Smart AMS solution) by utilizing advanced technologies (IoT and AI), integrating with operators (HR) and service delivery
			Strengthening (both HR and capacity) of MIS of MOHFW in collaboration with HSIIU.
			Inclusion of skilled ICT manpower from Upazila and above to ensure stable IT systems (Software, Hardware, Network and Maintenance), operations and sustainability
			Digital system for Accreditation of Hospitals for tracking service quality in public and private hospitals

			Medical education and HR development system oriented with digital technologies and tools like AR, VR, AI and IoT used in education, learning, training, patient care and healthcare service delivery
			Other:
	Integration of GESI approach into health information systems		Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
			Development and analysis of gender-sensitive data
			Increase participation of patients and community in assessment and reviewing any disaggregated data to measure improvements in inequalities
			Increase women’s representation on data collection and analysis teams
			Other:

Health Financing

Instructions:

1. Rank the health system priority areas using the column labelled: Priority Ranking of HS Areas, with 1 being the highest priority.
2. Rank the of activities under each health systems area using the column labelled: Priority Ranking Activities under HS Area, with 1 being the highest priority.

Priority Ranking of HS Areas (1=highest priority)	Health System Priority Areas	Priority Ranking of Activities under HS Area (1=highest priority)	Activities under Health System Priority Area
	Financial Management & Audit		Strengthen Internal Audit Function: set up an internal audit outfit in FMAU (HSD) and engage experts to help develop capacity of staff for conducting internal audit
			Expedite completion of the ongoing approval process of recruitment rules for FMAU (HSD) and recruit sanctioned staff to make it fully functional
			Start monitoring (by FMAU) of expenditure incurred by LDs using iBAS++
			Develop and implement an action plan for restructuring of FMAU of ME&FW Division to enable the unit to perform all its assigned functions with all the required HR in place
			Establish FM Unit at LDs of all major OPs and deploy staff with FM background
			Ensure timely preparation and approval of work plans, procurement plans, and training plans by LDs to improve the timely implementation and utilization of funds
			Streamline the monitoring of DLR achievements to ensure timely reporting by LDs and expedite verification by IMED
			Revitalize the functioning of the Audit Committee in the HSD and ME&FWD
			Establish an OP for Improved Financial Management for ME&FWD
			Review and strengthen the accountability framework and process for resolution of pending audit observations
			Take administrative and legal actions against officials responsible for financial irregularities reported by Audit
			Other:
	Integration of GESI approach into health financing management and delivery.		Development of gender responsive budgets
			Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
			Development and analysis of gender-sensitive health financing schemes
			Increase representation of women and other key groups on financial management committees
			Increase participation of patients and community in financial management committees
			Other:

Medical Products and Technologies

Instructions:

1. Rank the health system priority areas using the column labelled: Priority Ranking of HS Areas, with 1 being the highest priority.
2. Rank the of activities under each health systems area using the column labelled: Priority Ranking Activities under HS Area, with 1 being the highest priority.

Priority Ranking of HS Areas (1=highest priority)	Health System Priority Areas	Priority Ranking of Activities under HS Area (1=highest priority)	Activities under Health System Priority Area
	Procurement and Supply Chain Management		Reform of procurement policy to allow prequalification and framework contracts
			Reform of financial flows to allow funding to be spared from one year to the next
			Allocate budgets for both procurement of medicines and contracting of equipment maintenance to Upazila / hospital level
			DGHS to expand LMIS for DGHS to 200 most common ESP items and roll it out to all Upazila and hospitals
			DGHS to allocate a budget for maintenance of equipment to all Upazila and hospitals
			DGHS to ensure finalization of ability to do ICB procurement in e-GP
			DGHS to issue Standard Operating Procedure (SOP) on physical stock management and procurement, and include the monitoring of product management in the external work of DGDA to inspect warehousing of pharmaceuticals
			DGFP to revise method for distribution to Union level from kit distribution to informed push
			DGFP to train 5 central logistics personnel on advanced supply chain management from certified institute
			DGFP to recruit two pharmacists and train them on quality assurance of key products under central procurement
			DGFP to adjust LMIS system to do forecasting and to include dashboard functionality for all items in the LMIS
			DGFP to revise focus on stock availability for all items
			Other:
	infrastructure		Establish local steering committees for each construction project, with presence of local management of Upazila/hospital, HED/PWD, equipment procurement and personnel allocation
			Prioritise rehabilitation of existing facilities to ensure they are functional
			DGHS to establish a Logistics and procurement Line Director within HS, responsible for LMIS and all centralized procurement on behalf of other line directors
			DGHS to establish long term procurement plans (three years) to the extent possible within the present rules and regulations while working on expanding the frame
			DGHS to establish framework contracts as a procurement tool within health

		DGHS to reform CMSD and have the full administration on an ERP system
		DGHS to build, recruit and deploy cadre of pharmacists (minimum 200 pharmacists) specialized in stock management and procurement to hospitals and Upazila
		DGFP to establish a Logistics and Procurement Line Director within FW
		DGFP to implement framework contracts for central procurement
		DGFP to get ICB procurement into e-GP
		Separate the organizations responsible for tendering out of construction from the organization responsible for monitoring the actual construction
		Other:
	Integration of GESI approach into management and use of medical products and technologies	Collection and use of data disaggregated by factors such as sex, location, age, disability, etc.)
		Development and analysis of gender-sensitive medicines and technologies management and use
		Increase representation of women and other key groups, including patients and communities, on relevant committees
		Other:

Open-Ended Questions

After having reviewed and ranked the priority areas and activities, please answer the following questions:

1. Do you agree with the priority areas identified? Yes/No
 - a. Please explain why or why not.

2. Do you agree with the priority activities identified? Yes/No
 - a. Please explain why or why not.

3. Are there any priority areas or priority activities that have been omitted and should be included? Please list and rank these here.

4. Which of the identified HSS priorities do you think could be addressed by the health partnership (HP) model? Consider *how HP projects could improve health service performance in terms of equity, efficiency, access, quality, and sustainability, and ultimately help the country to achieve UHC?*

ANNEX 4 STAKEHOLDERS CONSULTED IN BANGLADESH

No.	Name	Organisation/Institution
1.	Professor Dr. Meerjady Sabrina Flora	Additional Director General, Directorate General of Health Services
2.	Professor Dr AHM Enayet Hussain	Director General, Directorate General of Medical Education
3.	Dr Mizanur Rahman Arif	Program Manager, Directorate General of Medical Education
4.	Md Helal Uddin	Additional Secretary and Chief of Planning Division, Ministry of Health & Family Welfare
5.	Dr Md Nurul Amin	Director General, Health Economics Unit
6.	Dr. Md. Habibur Rahman	Director, Management Information Systems (MIS), Directorate General of Health Services
7.	Dr Md Khalilur Rahman	Director General, National Nutrition Council
8.	Dr Tanveer Ahmed Chowdhury	Director, Institute of Public Health (IPH), Directorate General of Health Services
9.	Dr Shehlina Ahmed	Health Advisor, FCDO
10.	Dr. M. Atiqul Haque	Bangabandhu Sheikh Mujib Medical University
11.	Dr Fariha Hassen	Bangabandhu Sheikh Mujib Medical University
12.	Prof. Saidur Rahman Mashreky	Bangladesh University of Health Sciences
13.	Dr Selina Amin	James P Grant School of Public Health, BRAC University
14.	Prof. Syed Masud Ahmed	Centre of Excellence for Health Systems and Universal Health Coverage, BRAC University
15.	Prof. Dr Rumana Huque	Department of Economics, University of Dhaka
16.	Prof. Dr. AKM Fazlur Rahman	Centre for Injury Prevention and Research, Bangladesh
17.	Dr Dewan Md Emdadul Hoque	UNFPA
18.	Dr. Mohammad Zahirul Islam	Embassy of Sweden
19.	Dr Momena Khatun	CIDA, Bangladesh
20.	Dr Sangay Wangmo	WHO
21.	Md Abdus Salam	Partners in Health and Development (PHD)
22.	Mohammed Alauddin	Orbis International
23.	Dr Tapash Roy	Interactive Research and Development Bangladesh
24.	Dr Md Abdur Rahman Khan	Individual Consultant (Ex-DG, DGHS)
25.	Dr Md. Saikhul Islam Helal	Individual Consultant
26.	Atia Hossain	Freelance Consultant (Health Economics)

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