ASSESSMENT & PLAN OF ACTION

Scaling Innovation for Strong Upazila Health Systems

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BREAKING NEW GROUND

THINKWELL

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ACRONYMS

ANC	Ante-Natal Care
CC	Community Clinic
CCMG	Community Clinic Management Group
CHCP	Community Health Care Provider
CHV	Community Health Volunteer
CHW	Community Health Worker
CS	Civil Surgeon
DD	Deputy Director, Family Planning
DG	Director General
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHS	Demographic Health Survey
DSF	Demand Side Financing
EMOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Volunteer
GOB	Government of Bangladesh
HA	Health Assistant
HFWC	Health and Family Welfare Center
HMC	Hospital Management Committee
HPNSDP	Health Nutrition and Population Sector Development Plan
LGD	Local Government Division
LLP	Local Level Planning
MAMONI	Integrated Safe Motherhood, Newborn Care, and Family Planning Project
MCWC	Maternal and Child Welfare Center
MIS	Management Information Systems
MOHFW	Ministry of Health and Family Welfare
MOMCH	Medical Officer Maternal and Child Health
MP	Member of Parliament
NGO	Non-Governmental Organization
OP	Operational Plan
RMO	Residential Medical Officer
SACMO	Sub-Assistant Community Medical Officer
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UH&FPO	Upazila Health and Family Planning Officer
UHFWC	Union Health and Family Welfare Center
UHS	Upazila Health System
UHSS	Upazila Health Systems Strengthening
UNO	Upazila Nirbahi Officer
USC	Union Sub-Center
USAID	United States Agency for International Development

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1. BACKGROUND

1.1. Bangladesh has made impressive gains in health over the past decade. According to the DHS, between 1997 and 2007 Bangladesh has seen total fertility rate decline from 3.3 to 2.7, under-five mortality decline from 116 to 65, infant mortality decline from 82 to 52, children's vaccination rate increase from 54.1% to 81.9%, ANC use increase from 29 to 51.7, and percentage skilled deliveries increase from 8% to 18%. These are unprecedented gains that few countries globally have ever made in such a short period of time.

1.2. The Government of Bangladesh (GOB) has recognized that the key to sustaining and further improving on these gains is to strengthen the overall health system at the upazila level. Therefore, the GOB has made upazila health systems strengthening is a critical component of the HPNSDP 2011-2016.

1.3. The focus of this assessment is to assess critical systems constraints at the upazila level and identify local innovations that can be brought to scale. Much analysis has already been done over the years on identifying health systems bottlenecks, therefore this analysis was largely intended to take current stock of the situation, identify local scalable innovations, and develop an action plan to improve the Upazila Health System (UHS).

2. HEALTH SYSTEMS CONTEXT

2.1. The Bangladeshi health system is hierarchically structured and can be compared to a five-layer pyramid. First, at the base of the pyramid, there is the ward level health facility (CC), consisting of a health assistant, family welfare assistant, and CHCP. At the next level is the union health and family welfare center (HFWC) staffed by a medical assistant, one family welfare visitor, and one pharmacist, which concentrates on the provision of maternal and child health care and provides only limited curative care. Third, there is the Upazila Health Complex (UHC) with nine doctors, two medical assistants, one pharmacist and one radiographer and EPI technician. The UHC is responsible for inpatient and outpatient care, maternal and child health services and disease control. Operation theatre is also functioning in the UHCs especially in the 50 bedded UHCs. Fourth, the district hospital is the first layer of the health care pyramid to have theatre facilities, but some selected UHCs have been upgraded to have EOC facilities. Finally, the medical colleges and post-graduate institutes form the top of the health services pyramid offering a wide range of specialty services.

2.2. Bangladesh has an extensive health infrastructure throughout the country. The country has six administrative divisions and 64 districts while the districts are divided into upazilas (4824), and upazilas into unions (4,770). Each union consists of approximately 25,000 people and the unions are sub-divided into, in most cases, nine villages. There is a network of hospitals, health centers and dispensaries, thousands of staff, and extensive training centers. This network, now in its advanced stage of development, is comprised of 402 health complexes at the upazila level (UHCs), about 4000 health and family welfare centers (HFWCs) at the union level, and several thousand community clinics (13,500 anticipated) at the ward level. In addition, NGOs play an extensive role in service

delivery. For example, BRAC's own statistics state that their services reach more than 92 million people with 18,000 staff members and 68,095 all-female community health volunteers working in all 64 districts of Bangladesh. Many other NGOs, such as CARE and the Smiling Sun Franchise Network also play an important role.

2.3. The UHS is an important part of the overall health system in Bangladesh. According to the HPNDSP UHS consists of a three-tier system: (i) a Hospital (UHC with 31-50 beds), (ii) Health Centers (with or without beds), and (iii) Community Clinics (CC). GOB policy documents do not include NGO or private facilities into the definition of the UHS.

2.4. The revitalization of the community clinic program has built an important layer of the UHS. Initiated during the earlier tenure of the present government, the initiative is based on the principle of one community clinic for every 6,000 rural persons. Community clinics are intended to deliver one stop integrated health, population, and nutrition services to the respective communities and aim to be first point of contact of the rural community with the public sector health services. Progress in revitalization of the CC has been impressive -- 10,723 community clinics previously established community clinics have been renovated and another 2,777 are planned for construction. The community clinic management group (CCMG), comprising of members of the community, provide oversight of the CC.

3. PURPOSE AND METHODOLOGY OF ASSESSMENT

3.1. In February 2012, the MOHFW undertook this assessment of the upazila health system to observe the strengths, weaknesses, and innovations in the system. The principle objective of this assessment was to identify scalable innovations to improve the UHS. Key areas of examination included the structure and definition of the UHC, planning and management, human resources, governance, and local health financing. This assessment was not intended to deeply assess all sub-sectors of the health system. For example, pharmaceutical management was not examined in great depth as other assessments and initiatives are deeply engaged in this area. Similarly, a deep diagnosis of the HMIS was not undertaken for the same reasons. Additionally, this assessment is intended to compliment recent policy developments, such as the recently developed health financing policy. To maintain brevity, this assessment does not rehash information and analysis contained in those documents. Finally, this assessment was not intended to examine the widely-known root causes for UHS weaknesses, nor was it intended to form the basis of major health sector reforms. Instead, this assessment aimed to broadly examine the UHS as a whole, identify simple and effective local innovations, and propose an action plan to bring them to scale.

3.2. The MOHFW constituted a team comprised of 7 officials from DGHS, DGFP, and Planning Wing to undertake field visits and synthesis analysis and recommendations. The team conducted its evaluation between February and July 2012.

3.3. The team visited Upazilas in Sunamganj, Sylhet, Habiganj, Pabna, Jessore, Lakshmipur, and Noakhali. In each district, the team visited multiple upazilas. Upazilas were selected based on various criteria to ensure that a mix of hard-to-reach, EMOC, LLP, DSF, under-performing, and "model" upazilas were represented. Within each upazila, the team visited the entirety of the UHS, including the UHC, MCWC, USC/UHFWC, community clinics, private clinics, private pharmacies/clinics, and NGO clinics.

3.4. Semi-structured interviews undertaken with all concerned officials, including the CS, DDFP, District hospital directors, UH&FPO, SACMO, medical doctors at all levels, FWVs, HAs, FWAs, CHCP. The team also gathered patients and community members in each upazila to understand their perspectives. Finally, the team interviewed private and NGO facility managers. The interview guide was loosely based on the USAID health systems assessment tool, but significantly modified on an ad hoc basis to account for local context and interview circumstance.

3.5. Multiple stakeholder presentations were made to Planning Wing and PMMU throughout the assessment to gauge progress. In particular, Planning Wing officials provided extensive feedback throughout the assessment period to help steer the assessment in the appropriate direction and focus the team on key GOB priorities. The combination of these consultations along with the assessment team's internal deliberations has formed the basis for the highlighted findings and action plan.

4. ASSESSMENT FINDINGS

4.1. Structure and Definition of Upazila Health System

4.1.1. Concept and boundary of 'upazila health system' requires clarity and refinement at the district level and below. Our interviews with Dhaka-based line directors, district CS, DDFP, UH&FPOs, health workers in CCs, UHFWCs, and UHC staff revealed that there is significant variance in people's understanding on the definition and boundaries of the UHS. Some interviewees included only DG health facilities, others include all public and NGO, while others include all public, NGO, private and informal. The lack of definitional clarity has serious implications for the management and regulation of the system overall. A partial framework to describe the UHS has complicated efforts for functional integration across DGs, as well as the establishment of public-private partnerships. It also has impacted the development of a robust continuity of care model, as well as a functionally integrated referral system.

4.1.2. Many types of service providers exist beyond public providers at the district level and below. The team encountered a wide range of service providers, including NGO facilities, public/private physicians practicing in pharmacies or private chambers, and informal providers. At the district level, private providers were easy to find. At the upazila level, private provision was observed inside pharmacies or in private chambers. In one upazila, we observed private practice occurring inside the living quarters of upazila health workers. At the upazila and district levels, we also observed private diagnostic centers for tests. NGO providers exist across the system. For

instance, CARE and BRAC health workers visibly distributed at the community level.

4.1.3. Community Clinic program is fledgling and requires focused GOB attention. Every community clinic visited by the team was operational and serving large volumes of patients. In some cases, such as in Shantiya and Chaugacha, the community clinic was seeing more patients than the UHFWCs. Interviews with patients and community members in villages indicate that the CCs popularity is due to: 1) proximity to village; 2) ability to locate FWA & HA; 3) trust in FWA & HA; 4) ability to hold FWA & HA accountable.

The CC Revitalization program is progressing quickly, and the high demand for services means GOB must ensure very monitoring. CC remains under-stocked and under-resourced. For example, no community clinics visited had GOB-provided baby scales on site, which undermines the GOB mission of strong nutritional monitoring and regular growth monitoring. Functional integration by FWA and HA is still not evident in most community clinics. While the CHCP is intended to support functional integration, our interviews find that CHCPs are wary of playing this role and do not have the appropriate mandate/empowerment to ensure better coordination. Finally, since many CCs are built on donated land, we observed conflict between the landowners and the many parties who are involved in CC management. This tension will need to be resolved to ensure CC remains fully supported. Finally, the community clinic management group (CCMG) in most CCs visited were not fully functional, but hold tremendous potential to meaningfully involve communities into health systems management.

4.1.4. Improved coordination among health sector actors can result in major improvements in quality of service delivery. In Shantiya upazila, the CS and UH&FPO made a special effort to ensure strong coordination with the DDFP and other DGFP colleagues. Practical measures, such as joining patient files between DGs and producing joint HMIS reports, have led to strong coordination and functional integration between the two DGs. This exceptional result is not the product of an expensive or complicated technical intervention – it is simply based on the willingness and motivation of the leadership of Shantiya.

In contrast, we found limited evidence of basic coordination between the health and family planning arms of the MOHFW in all other upazilas. In several upazilas, the CS and DDFP reported never having seen each other's annual plans, budgets, or statistics. Even within UHCs, the health and family planning wings of the complex appeared to be separate, without coordination between the two, sometimes even competing for patients. We also found almost no systematic coordination between the public and NGO sectors.

In every upazila visited, the CS and DDFPs reported that they were largely unaware of what NGOs and private providers are doing in their districts. Some commented that this was a major management gap, but was not easy to fix since most NGO and private providers were not willing to be 'coordinated' by public officials.

4.1.5. **In every upazila visited, strong systems of coordination exist for EPI services.** In all of our field visits, the EPI centers were well functioning. HAs and FWAs were well coordinated, sharing health and demographic information into a unified MIS, and working towards the common goal of providing immunizations. This high level of cooperation between staff of DGHS and DGFP was not witnessed in any other part of the health system. In Shantiya and Hobiganj, health managers are building from the success of the EPI centers by adding additional services to the model. In Shantiya, for example, sputum collection is also conducted at the EPI center, whereas in Hobiganj overall basic preventive care is provided.

4.2. Management of the Upazila Health System

4.2.1. **Local officials need empowerment to meaningfully engage in district-level planning.** As best summarized by the CS in Lakshimpur "Why should we plan? Everything is dictated from Dhaka". District leadership felt that budgets were developed in Dhaka and planning was done by health facilities. Those districts that were previously engaged in LLP commented that the exercise was a poor use of their time, as no feedback from Dhaka was given on the plans, no resources were attached to the plans, and no visible changes were evident. Most CSs felt that Dhaka line directors developed and implemented their OPs without much consultation from the field. The CSs also commented that even when serious resource needs arose and they appealed to line directors for help, rarely any meaningful action was taken. As a result, even in model upazilas, district-wide health planning was weak.

4.2.2. **District officials require further sensitization on the concept of overall district health systems management.** Our field visits to Lakshimpur, Hobiganj, and Sunamganj showed that the DDFP and CS did not embrace or fully understand the concept of overall management of the health system. Most CSs did not coordinate health information with DDFPs. In several districts, the CS and DDFP separately presented largely different district health statistics for the same indicators. In Shantiya and Chaugacha upazilas, the district CS appeared strongly motivated to take on greater management of the health system, but commented that they did not have the financial or political autonomy to do so.

4.2.3. **Health information system is often not providing comprehensive and meaningful health statistics.** In nearly every district we visited, UH&FPOs and CSs complained that the health information they have is largely inaccurate. They pointed to several reasons. First, the FWA and HAs often do not report correctly, often manufacturing data. Second, the information systems across DGHS and DGFP remain bifurcated in most upazilas, therefore not allowing for a complete picture of the health situation in the district. Third, there is no systematic mechanism to collect information from the NGO or private providers. The CS in several districts commented that many NGOs refused to provide service statistics.

4.2.4. **Third party management can greatly improve UHS referral system.** In most upazilas we visited, we did not observe any systematic referral program. If patients needed to be referred, they would rely on the goodwill of the

doctor to make arrangements. Otherwise, they were on their own to find transport, explain their diagnosis to the receiving facility, etc. We found that most referrals happened either within the public system or from the public system to the private system. We did not encounter any public health facilities that referred patients to NGO facilities.

The USAID MAMONI program has financed a dedicated person to manage referral together with a transport network. This person manages all aspects of referral, from arranging transport to pre-designated pick-up points to informing receiving facilities of emergency situations. Community health volunteers, which work under FWAs and HAs, identify serious cases and also facilitate referral to formal care. Receiving facilities are typically public sector clinics, but the project team reported that the referral coordinator is fully aware of all referral options and has also referred patients to private and NGO clinics when requested by the patient. Such a model, if brought to scale, holds tremendous potential for improving referral across the complex health landscape.

4.2.5. Emphasis on "customer service" has greatly improved patient satisfaction. Many innovations we witnessed in Hobiganj, Sylhet, Chaugacha, and Shantiya were simple in nature, such as increasing the number of registration intake staff, displaying a full map of the health facility, listing all drugs available in the health facility on a daily basis, prominently listing the name and room for every doctor, staffing an information booth in the front of the health facility, displaying the patient charter at the entrance to the health facility, and prominently displaying complaint boxes throughout the facility. These simple but effective actions had made the patient experience more pleasant, adding to increased overall satisfaction. In places that were less 'customer service' oriented, patient volume was low and the patients were less enthusiastic about the performance of the facility. Citizens in the surrounding villages of these facilities were also not enthusiastic about the performance of their UHC.

4.2.6. Community engagement initiatives have potential to resolve many local systems bottlenecks. One particularly impressive initiative is the USAID MAMONI microplanning initiative, in which CHVs, HAs, FWAs, NGO staff, and representative community members regularly meet to plan, monitor, and implement health systems improvements. We witnessed microplanning in Habiganj and Syhlet, and in both cases community members were fully engaged and creatively searching for solutions to local problems. Strong community ownership into the management of the UHS was evident, and local GOB involvement allowed for co-ownership of the issues and solutions. This initiative has managed to solve many basic local issues that, in other places, are relegated back to the CS and Dhaka to resolve.

4.3. Human Resources

4.3.1. Morale of public workers is low, but can be improved by recognizing strong performance. The low level salaries offered to the doctors and lack of promotion prospects with the DGHS and DGFP cadres has resulted in low motivation and inspiration to work. We met doctors who had not been promoted for decades. Doctors posted to union facilities were even more

demoralized, as their peers in other cadres were posted to more urban areas. Many doctors complained that GOB provided living quarters were of poor quality and more expensive than even higher standard living quarters in more urban areas. Doctors also complained that their families were forced to make great sacrifices, including lack of proper schooling, poor living standards, and separation from their home districts, and in return received no financial incentive for hardship postings is offered. Many doctors we interviewed used these arguments to justify absenteeism, informal fees, dual practice, and other irregularities.

That said, we met health workers working in dire conditions who were enthusiastic and highly committed to their jobs. These workers include the FWV in Gopalpur UFWC, the staff in Chaugacha UHC, the FWA in Shantiya community clinic (who performed Bangladesh's first normal delivery in a community clinic), and health staff in Shantiya UHC. These facilities had all won national or local awards for excellence in health care, which has been a tremendously powerful motivating factor despite the difficult work conditions they face.

4.3.2. Dual-practice is common and often detracts from public practice. In every upazila visited, dual practice was rampant. Private practice was observed in the physician's quarters, private pharmacies, private chambers, and inside the upazila health complex itself. Though private practice during off-hours is legal, our interviews suggested that public doctors were often practicing privately during normal business hours. Moreover, we heard that doctors often refuse to provide care in public facilities and refer cases to their private chambers instead. In some upazilas and district hospitals, we heard that doctors would see patients faster for paying fees directly to the doctor above and beyond the standard 'ticket' fee.

4.3.3. Absenteeism can be reduced with strong management. With the exception of Shantiya and Chaugacha, the team found that significant absenteeism existed within the system. In some cases, the team was informed that absenteeism was even sanctioned by supervising authorities. Absenteeism and dysfunctionality was clear in the Jaganathpur UHC in Sunamganj – the facility appeared nearly abandoned, the upgraded wing was under lock and key, and officials openly spoke of private practice dominating health workers' time. In contrast, UH&FPOs in Shantiya and Chaugacha commented that absenteeism in their facilities was low due to strong and diligent management. They also commented that the heavy volume of patients fostered a sense of importance among doctors, which motivated them to attend regularly. Finally, they also commented that the UHC's proximity to good schools and decent living conditions reduced the incentive for doctors to live far from work.

4.3.4. Innovative solutions to post vacancies have improved UHC performance. The team observed the widely known and discussed issue of vacant postings in every facility visited, at all levels. For example, in Jaganathpur Upazila, only 62 out of the 94 sanctioned posts were filled. Some posts have been vacant for many years. For example, the SACMO post in the FWC in Sunamgonj Shadur had been vacant for 17 years. The CS, DD, and UH&FPOs

consistently complained that vacancies were the single most debilitating factor facing the health system. In Habiganj, staff vacancies were ameliorated by the hiring temporary health workers through the USAID MAMONI project. In Chaugacha and Shantiya, locally generated funds were used to hire temporary health workers. By contracting staff, these UHCs were able to see high volumes of patients. Locally contracted staff were directly accountable for performance to those who privately financed them, therefore absenteeism was not an issue.

4.3.5. Harmonization of health worker training across public and NGO sectors will improve quality of care. The team observed a range of community health workers from the public and NGO sector, all of which had different types and durations of training. For instance, the team witnessed a CARE training of CHWs in Sunamganj in which 29 community members from 6 unions were sequestered for 21 days for intensive basic health training. It was unclear how this program fit together with the GOB FWAs and HAs or if there is any correlation to the various trainings offered by GOB. The BRAC system has deployed tens of thousands of CHVs (Shastya Shebikas), which provide essential health services, medicines, and referral. Community members commented to us that they did not know who was qualified to do what and how the various community health workers were working together.

4.4. Oversight and Governance

4.4.1. When leaders are motivated and engaged, health system performance is strong. In Shantiya and Chaugacha, the CS, upazila parishad, UNH&FPO and other leadership were dynamic, motivated, and fully engaged. Their extensive involvement has led to these facilities developing simple local innovations to cut across broader constraints. Their demonstrated commitment was evident to the community, leading to private donations to improve service delivery even further. They worked hard to combat systemic issues related to absenteeism, corruption, vacancies, and resource constraints. The important lesson in governance is that intrinsic motivation is the key to strengthening the health system. Such motivation is must be recognized at the national scale.

4.4.2. Critical oversight committees require revitalization. The UHC is run entirely under the administrative authority of UH&FPPO, it has a Hospital Management Committee (HMC) which includes the Member of Parliament (MP), Upazila Chairman (Local Government Leader), UH&FPO, Upazila Nirbahi Officer (UNO, the administrative head of the Upazila) and other government high officials at the upazila level. But there is no direct linkage between the community and the HMC except for the involvement of the MP and the Upazila Chairman. These public representatives are not formally linked with the community in terms health issues unless an individual approaches them of his/her own. Secondly, these members are not empowered by the state formally regarding their administrative domain of involvements and roles and responsibilities. In all upazilas visited, except for Shantiya, MP led HMC meetings were non-functional. Even in Chaugacha, a model upazila, the HMC meeting hadn't taken place since early 2010. Finally,

the CCMG for the community clinics was not observed to be functional in any of the upazilas visited.

4.4.3. Local government holds tremendous potential but, without proper governance arrangements, also poses a threat. Local government can help bring in additional resources, resolve local conflicts, and provide critical oversight to ensure service delivery is of high quality. In Shantiya, local government was deeply involved in overseeing the health system, which allowed many resource constraints to be resolved. The union & upazila parishads had donated many necessary items, including baby scales, EMOC equipment, and replacement parts for diagnostic machines. In Shantiya and Chaugacha, local government worked to mobilize private financing to support the public facilities. This advocacy and support by local government has been fundamental in the success of these two upazilas.

On the other hand, health care providers pointed out many incidences of misuse of local power by the local government leaders and their accomplices. For example, in Hobiganj, doctors complained about politically connected individuals demanding grievous hurt certificates even when medically unjustified. Doctors we interviewed explained that they usually comply in fear of being arrested, beaten, or harassed, often with full support of local government authorities. Doctors also expressed concern that victims of physical assault, many of whom have conflicting interests with local leaders, would be victimized if local leaders were to assume full control of the UHC.

4.4.4. Forums that allow general citizens to collectively voice their concerns to officials can improve UHS performance. We did not find any standardized formal forums that allowed for citizen dialog. However, in MAMONI's microplanning initiative, which we observed, citizens and officials were planning their basic needs together. Throughout the microplanning exercise, citizens were expressing their satisfaction levels on different aspects of the UHS. This dialog also helped health managers identify and target areas to improve.

4.4.5. Citizen charter for health is an impressive step forward but must be taken further for meaningful patient empowerment. In two upazilas we visited, the citizen charter was prominently displayed in the front of the facility. Near the citizen charter was a complaint box allowing patients to voice their concerns. According to the UH&FPO of both upazilas, UHC staff were aware of the charter and were afraid about patient complaints, thus worked hard to ensure patients were treated respectfully. Consequently, patients very rarely complained of being denied their rights. In the remaining upazilas, the citizen charter was not displayed and the UH&FPOs did not know what the citizen charter was. In none of the upazilas visited was the patient charter used as a basis for annual performance evaluation by any management committees.

4.4.6. Private practice appears to be largely unregulated. While extensive private practice was observed in every upazila we visited, it was also observed that private providers had almost no regulatory interactions with GOB. No single-practice private providers interviewed reported being visited by GOB

officials for regulatory or inspection purposes. Private practitioners reported following good medical practices based on their professional knowledge, but were not aware of any GOB standards or treatment protocols. They also commented that public officials rarely informed them of GOB policy directives or changes.

4.5. Health Financing

4.5.1. Local government allocation for health not available in most places. According to the Local Government Division's *Upazila Parishad Development Fund Utilisation Directive* (Dhaka, 10 April 2010), the upazila parishad should allocate between 10% (min) and 15% (max) of its annual grant to health and social welfare. Neither the CS nor DD were aware of any local allocation towards health in all upazilas we visited except for Shantiya. In Shantiya, strong engagement by the upazila parishad and MP in health resulted in a 7% local government allocation for health, which was used mostly to buy equipment for the UHC and CC.

4.5.2. Local private funds have allowed motivated upazilas to greatly improve performance. In Chaugacha, private donations allowed the UHC to hire 16 staff, medical equipment, repair parts, and other critical items. In Shantiya, 4.2 lakhs taka of local funds were generated last fiscal year. These local funds have enabled the UHC to self-upgrade itself into an EMOC facility where C-sections are now regular practice. To date, this facility is still not designated and resourced as an official GOB EMOC center. Items purchased include an ultrasound machine, operation light, hydrolic OT table, and laboratory equipment. Shantiya UHC is a 50 bedded hospital that receives GOB resources for only 31 beds, but bed occupancy is consistently over 200% based on a 50 bedded denominator. The resources to finance the operations at such high occupancy are largely financed from private donations.

Local Funds Strengthen UHS in Shantiya

Civil Society Contributions

- Laptop
- E.C.G. machine
- Multimedia projector
- Grass cutting machine
- Digital camera
- Scanner and photocopy machine
- Build canteen
- Build stand of Honda/Cycle

Union Parishad Contributions:

- Ultra sonogram machine
- Dental set with dental chair
- Operation light
- Hydrolic O.T. table
- Colorimeter
- Bio-chemical reagents
- Medicines for CC and pregnant
- Laboratory upgrade

4.5.3. Budget allocation from Dhaka not rational. As well documented in other assessments, public resource allocation is based on historical norms for facilities rather than need. Most often, CS and DDFP are not consulted in allocative decisions by line directors in Dhaka. Many UH&FPOs expressed frustration about the lack of resources commensurate with their facility's volume of patients. For instance, Jaganath UHFWC is a 50 bedded hospital with 24% bed occupancy, and receives greater resource allocation than the 50 bedded UHFWC in Shantiya, which has 208% bed occupancy.

4.5.4. Discretionary public budget for health not existent. In several upazilas, the CS commented that the lack of budget authority and limited responsiveness from Dhaka hinders their ability to provide support to the UHS. For instance,

in the CS in Habiganj mentioned that the amplifying mechanism for the x-ray machine had needed replacement for several years, but despite many requests to Dhaka, they still had not received the parts. He commented that this problem could be easily solved if the CS had greater discretionary budget authority. Other CSs had similar thoughts – one suggested creating a local referral transportation system with discretionary budgets, while another discussed making basic upgrades to community clinics.

Upazila parishads are even more constrained, in that they must relay all requests to the CS, which eventually are fed up to Dhaka. Many upazila parishad members commented that they are under great pressure from their constituents to make improvements, but lack the resources to do so.

4.5.5. Unofficial fees are likely charged in some facilities. In many of the upazilas visited, we were told by patients, NGO staff, and even union parishad officials that illegal fees were an open secret in the public health system. If patients wanted to bypass queues, they could directly pay the doctor an additional fee on top of the registration ticket paid to the UHC. No doctors or UHC management admitted to this when asked, but one UHC manager affirmed that, in general, "many irregularities are persistent" in the Bangladeshi health system. When asked, one CS commented these issues were known to him and were a major concern, but that he lacked the enforcement mechanisms to eliminate this practice.

5. ACTION PLAN

5.1. Vision

The vision of this action plan is to catalyze the growth of a strong upazila health system that is well governed, rigorously managed, accountable to citizens, and well resourced. Implicit in this vision is the availability of highly motivated health staff, a customer-oriented service delivery model, and a supportive policy environment. Service delivery is the most effective when the citizen is at the center, therefore the vision of this action plan is to empower the citizenry to become active in the governance and management of the UHS.

5.2. Principles of Action

5.2.1. Intervene selectively. The focus of this action plan should be to alleviate critical bottlenecks to strong health systems performance at the upazila level. While many bottlenecks exist, this action plan will focus selectively on improvements that will have the highest impact. Therefore, this action plan is by no means comprehensive, and can be symbiotic with other initiatives not discussed (such as improved pharmaceutical management) that are ongoing.

5.2.2. Bring existing innovations to scale. This assessment demonstrates that many local innovations have emerged to alleviate complex health systems bottlenecks. This action plan emphasizes the scale up of those interventions.

5.2.3. Emphasize catalytic improvements in Dhaka and implementation in the upazila. The main focus in Dhaka should be on creating an enabling

environment to catalyze improvements in the field. This action plan will therefore not focus on strengthening the MOHFW systems, attempting major reforms, or engaging in complicated processes at the central level. At the upazila level, this action plan aims to cut through complicated bureaucracy and instead focuses on clear, direct actions that will have visible impact.

5.2.4. **Keep it simple.** We found that many successful interventions were not complex or expensive, but required positive engagement as the essential ingredient. Most of the innovations observed in the field were simple management approaches practically designed to improve UHS performance. These approaches were not expensive nor did they require major TA inputs. This action plan will emphasize those types of interventions.

5.2.5. **Begin with pilot upazilas where possible and appropriate.** Where possible, GOB should take a phased approach in which interventions are concentrated in several upazilas to demonstrate success and then scaled gradually. Pilot upazilas should be selected based on potential for success, which includes characteristics such as motivation of key actors including CS, DDFP, UH&FPO, upazila parishad, and MPs.

5.3. Objectives and Activities

Objective 1. Strengthen overall management of upazila health system.

The key to a well-functioning upazila is strong and engaged management. This objective focuses on strengthening management of core aspects of the upazila, such as referral systems, health facility management, and overall systems management. Activities are aimed at multiple levels, including the district level, facility level, and community level.

Sub-Objective 1. Strengthen facility management of the UHS

a. **Build on EPI center model to create greater functional integration across DGs.** Initiatives for functional integration from the top down has been complex and elusive. This activity will build on the successful functional integration that already exists at the EPI center level. As successfully demonstrated in Shantiya and Hobiganj, other primary care services can be built on top of the EPI model which are functionally integrated across DGs.

b. **Develop UHC management guide.** Many successful innovations have been developed across the country. In particular, Chaugacha and Shantiya have been role models for Bangladesh. This activity will build an upazila health manager's guide that accounts for all of the successful innovations, so that other upazilas institutionalize best practice and benefit from the knowledge of the role models.

c. **Pilot outsourced model of referral management.** As we have seen in most upazilas, public sector staff are stretched and vacancies are abundant. Therefore, it is difficult to standardize and institutionalize the role of referral management into a single position. This activity will replicate MAMONI's successful demonstration of hiring a contract staff to coordinate the referral

system. This staff will coordinate with HAs, FWAs, CCs, transportation providers, and receiving facilities to ensure smooth referral.

d. **Improve 'customer service' orientation of UHS.** This activity will scale up the many 'customer service' oriented initiatives, including the ones witnessed by the assessment team. First, guidelines on how to have a customer-friendly UHS will be developed, based on the innovations already in place. These guidelines will then be rolled out to pilot upazilas. Examples of activities include increasing the number of registration intake staff, displaying a full map of the health facility, listing all drugs available in the health facility on a daily basis, prominently listing the name and room for every doctor, staffing an information booth in the front of the health facility, displaying the patient charter at the entrance to the health facility, and prominently displaying complaint boxes throughout the facility.

e. **Implement accreditation standards.** GOB is already engaged in the development of accreditation standards. The implementation of these standards will greatly improve the quality and management of health service delivery. This long-term activity will bring together clinical accreditation with previous activities such as the management guide and customer service guidelines to form a total package for optimal UHS management.

Sub-Objective 2. Strengthen district and community management of UHS to ensure.

a. **Scale microplanning initiative to foster greater community engagement.** The microplanning initiative was seen as an outstanding mechanism for engaging community into health sector planning and management. This activity will build on the successful models built by MAMONI and others, and scale microplanning into more districts.

b. **Re-invigorate health management committees.** In most districts, these committees are not working, largely due to the limited availability of the MP who chairs the committee. This activity will work to reinvigorate the management committee and support its functioning in the absence of the MP, but still under his/her authority.

Objective 2. Increase available resources for to the upazila health system.

Increased resources are critical to strengthening the UHS. Resources include finance, human resources, and critical commodities. The root causes for resource constraints are complex, require structural reforms, and are beyond the scope of this action plan. The activities proposed offer solutions that attempt to circumvent the root issues.

Sub-objective 1. Increase human resources availability

a. **Create Stop Gap fund to hire temporary health workers.** To provide relief to the well-known issue of vacancies and GOB staff shortages, a "stop gap" fund should be initiated to contract temporary providers from outside the cadre system. These temporary providers could also come from partnerships with private and NGO providers systems. This activity should begin with a scoping exercise to develop options for the governance and management of the stop gap fund. The fund must be carefully designed to ensure that the fund will be

insulated the fund from political pressures and empower health facilities to make staffing decisions.

b. **Single practice bonus to dissuade dual-practice.** Some Asian countries have combatted dual practice by offering financial incentives to providers who choose to forgo their private practice. This activity will assess the feasibility and likelihood for success of such an initiative in Bangladesh in the long term.

c. **Rural posting incentives to attract qualified doctors.** Currently, there is no compelling reason for staff to fill rural posts. The GOB should look to innovative models to incentivize rural service. These models could include a privately generated incentive program for service in rural areas.

d. **Conceptualize in-sourcing model to supplement public facilities.** In areas where public vacancies are high and governance/management capacity is low, one option that should receive examination is an 'in-sourcing' pilot program. In several south Asian countries, in-sourcing services to private providers has resulted in major improvements in service delivery performance. This activity is controversial and complex, and therefore will begin with a benign feasibility assessment. If found to be feasible and to have enough support, a pilot could be done in the long run.

Sub-objective 2. Increase availability of financial and medical resources

a. **Enforce LGD directive on upazila parishad development fund.** Only few upazilas are following the LGD directive for health and social welfare, which is depriving the UHS of sorely needed resources. This activity will work with the CS and LGD to monitor and ensure that upazila parishads are complying with the LGD directive.

b. **Expand user fee retention pilots**. These pilots have shown that, if effective governance standards are in place, many bottlenecks can be quickly resolved. Experience in Chaugacha and Shatiya also demonstrate that locally retained funds can be effectively used. This activity will carefully expand user fee retention pilots, ensuring that proper governance arrangements are in place with each expansion.

c. **Accelerate implementation of resource allocation formula.** Much has been written about the resource allocation formula. Detailed plans have been conceived for years, but progress has been limited. This activity calls again for the implementation of the resource allocation formula in LLP districts.

Objective 3. Improve governance and accountability of the upazila health system.

Improved governance is the single most important element to strong UHS performance. When districts have strong oversight, engaged officials, and involved civil society, many of the perceived bottlenecks to improved services disappear. Social accountability, in particular, has shown to been a powerful mechanism for improving public services in South Asia. The activities in this section represent the key priorities to improving overall UHS governance.

Sub-objective 1. Strengthen GOB stewardship of UHS

a. **Constitute National Steering committee to oversee UHS development.** The UHS requires an integrated approach that involves many constituencies from

the MOHFW. Focused attention from a senior-level national steering committee can help ensure that GOB policies and practices are on track to support UHS development.

b. **Align operational plans with UHS development.** In many of the 32 operational plans, there are elements of upazila health systems strengthening. Extracting these elements into a single strategic plan for upazila health systems strengthening will allow for better management of resources and progress towards UHSS.

c. **Provide CS office and upazila parishad resources to undertake strong monitoring.** The CS and upazila parishad often complained about the lack of financial resources to conduct meaningful field monitoring. In select pilot upazilas, this activity will provide those offices with a monitoring toolkit and financial resources to conduct quarterly rigorous monitoring.

Sub-objective 2. Increase social accountability of the UHS

a. **Establish community scorecard/social audit approach based on citizen charter in select upazilas.** The institutionalization of the citizen charter represents a unique opportunity to allow citizens/patients to hold health facilities accountable for performance. In pilot upazilas, GOB could support a community scorecard approach, in which UHS would have three levels of evaluation: 1) input/resource tracking; 2) community-generated performance (based on citizen charter); 3) self-evaluation by providers. This approach could be built into annual program review of the health sector at the sub-district level. In the short-term, a design process should be initiated, which will take into account successful South Asian practices in Andhra Pradesh, Maharashtra, and Sri Lanka. In the medium term, this can be piloted in select upazilas.

b. **Establish system of public hearings in select upazilas.** This activity compliments the community scorecard approach in that it offers the opportunity for civil society to directly interface and provide feedback to public officials. Public hearings can be centered around the community scorecard or could be expanded to semi-annual events to allow for increased dialog between the community and GOB. Like the previous activity, an initial scoping/design phase should be commenced in the short term, with piloting in select upazilas the medium term.

c. **Strengthen key community oversight committees.** Key oversight committees, such as the CCMG, HMC, and others, are largely non-functional, even in model upazilas. This activity will work to revitalize these key committees by assessing the reasons for dysfunction and proposing a restructured mechanism to improve their operations. Such mechanisms could include regular support/feedback from Dhaka, increased monitoring by the CC, or working with locally elected officials to support activation of local committees.

Objective 4. Create enabling environment for strong UHS performance.

Reducing critical policy bottlenecks and improving regulatory capacity will promote strong performance of the UHS. In addition, a formal national program to identify, promote, recognize, and reward local innovation will positively reinforce good

performance and serve to counter the negative incentives in the system. The Chaugacha and Shantiya model upazilas provide clear evidence that such an approach can work.

Sub-Objective 1. Initiate policy adjustments to support UHS

a. **Redefine upazila health system to include all formal actors: public, private, and NGO.** A robust formal health infrastructure in Bangladesh exists beyond the public sector. This activity will engage a stakeholder consultation to redefine the UHS such that it includes non-public health providers. This consultation will consider the responsibilities of non-public providers were they to be included in the overall UHS model. Invariably, the question of regulatory framework for non-state actors will need to be discussed. The end product of this activity will be a commonly agreed upon definition for the upazila health system that accounts for the diversity of providers and a framework outlining the responsibilities for all non-state actors included into the UHS model. Once an agreed definition and framework is in place, UHS sensitization workshops will be carried out across the country to ensure that districts and upazilas have definitional clarity on UHS.

b. **Harmonize training curriculum for CHWs through national CHW training policy.** This activity will set national minimum standards on the training of all levels of community health workers, including FWAs, HAs, NGO CHWs, CHVs, Shastya Shebikas, and any other community level health worker. This will reduce confusion in the field about CHW capabilities and improve overall quality of care at the community level. It will ensure that clear grades of CHWs exist, regardless of whether they are public or private.

c. **Develop regulatory framework for private and NGO health practitioners.** The regulatory policy framework will ascribe minimum standards, ensure compliance with reporting, and help ensure all providers are compliant with GOB policy standards. It will serve as a tool to hold private and NGO providers accountable for quality services. Several successful examples of regulatory frameworks exist in South Asia, which can be used as a starting point for development.

Sub-objective 2. Develop National System to identify, reward, and scale-up innovation

a. **Undertake comprehensive initiative to regularly monitor and identify local innovations.** As discovered by our assessment team and by many others who visit the field regularly, local innovations are widely prevalent in Bangladesh. However, most often, these innovations are discovered by chance. This initiative will proactively identify local innovations in UHS management by regularly polling CSs, DDFPs, UH&FPOs, and other key staff. This polling will occur during routine interactions, so no new resources are required to enable this activity.

b. **Support peer learning across upazilas to scale up local innovation.** Many local innovations exist in Bangladesh, but typically they remain localized. This activity will support peer-learning across upazilas through face-to-face forums twice per year. The peer-learning meetings will serve to motivate staff to

develop innovations, enlighten staff as to other innovations from their peers, and support the national institutionalization of local best practice.

c. **Reward top performing upazilas with performance bonuses.** Many local best practices go unrecognized and unrewarded. National recognition can lead to greater motivation and enthusiasm, which in turn can lead to better performance. Meetings with recipients of national awards, such as the first FWV to do normal delivery in a CC, emphasize the strong sense of empowerment and pride that can be generated by national recognition. This can serve to combat negative incentives in the system. This activity will focus on identifying innovative practices and their champions, and provide them with national recognition. National recognition can come from the Minister, Prime Minister, or medial spotlight. If feasible, financial bonuses can also be given.

d. **Implement Upazila Report Card to recognize good and bad performing upazilas.** A simple set of performance measures that include patient satisfaction, patient volume, absenteeism, quality of care, and health outputs should be developed to hold health facilities accountable for performance. The top performing UHCs should receive national recognition, which can be expanded to include financial incentives. If it is deemed appropriate and politically feasible, the poorest performing UHCs can also be recognized.

e. **Reward districts that take proactive measures for functional integration.** As we observed in Shantiya, the DGFP and DGHS officials took it upon themselves to produce joint HMIS reports, join patient files, and allocate local resources jointly. Such initiatives of successful functional integration should be nationally recognized, promoted, and rewarded. An initiative that rewards meaningful functional integration at the district and upazila level with block grants and/or national recognition could help achieve national health systems coordination goals without delving into the political complexities at the central level.

6. ACTION PLAN MATRIX

UPAZILA HEALTH SYSTEMS STRENGTHENING ACTION PLAN

	Short-Term	Medium-Term	Long-Term
Strategic Objective 1: Improve governance and accountability of UHS			
Sub-Objective 1. Strengthen GOB stewardship of UHS	• Constitute national steering committee to oversee UHS development	• Align operational plans with UHS development	
Sub-Objective 2. Increase social accountability of the UHS	• Strengthen key community oversight committees	• Establish system of public hearings • Establish community scorecard/social audit approach based on citizen charter in select upazilas	
Strategic Objective 2: Strengthen overall management of UHS			
Sub-Objective 1. Strengthen health facility management		• Develop upazila health complex management guide • Pilot outsourced model of referral management • Build on EPI center model to create greater functional integration across DGs	• Implement accreditation standards
Sub-Objective 2. Strengthen District-level management	• Fortify Health Management committee • Scale microplanning initiative to foster greater community engagement	• Build on existing DGHS monitoring system to include in-person, third-party random monitoring.	

Strategic Objective 3: Increase available resources for UHS			
Sub-Objective 1. Ensure adequate human resources	• Scoping exercise to create stop-gap fund to reduce HR vacancies	• Implementation of stop-gap fund to allow for short-term hires on contract basis	• Develop in-source PPP model with private/NGO providers • Pilot single practice bonus to dissuade dual-practice • Rural posting incentives to attract qualified doctors
Sub-Objective 2. Increase availability of local-level finance for health	• Continue and expand user fee retention pilots • Expand DSF	• Work with LGD to enforce upazila parishad development fund directive. • Accelerate resource allocation formula	
Strategic Objective 4. Create enabling environment for strong UHS performance			
Sub-Objective 1. Initiate policy adjustments to support UHS	• Redefine upazila health system to include all formal actors • Begin policy dialog with DGHS and DGFP on integration of HMIS	• Harmonize training curriculum for CHWs through national CHW training policy • Develop regulatory framework for private and NGO health practitioners	• Develop enforcement mechanisms for regulatory framework for private and NGO health practitioners
Sub-Objective 2. Develop National System to identify, reward, and scale-up innovation	• Support peer learning across upazilas to scale up local innovation • Actively identify local innovations • Develop indicators to measure overall UHS performance	• Implement Upazila Report Card to recognize good and bad performing upazilas	• Reward top performing upazilas with performance bonuses