Universal Health Coverage in Bangladesh:

Activities, Challenges, Recommendations and Commitments

IN PARTNERSHIP WITH

Save the Children

BRAC JAMES P GRANT SCHOOL OF PUBLIC HEALTH

Centre of Excellence for Universal Health Coverage

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Reaching #EveryLastChild in Bangladesh

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

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ACRONYMS

ANC	Antenatal care
BCS	Bangladesh Civil Service
BDNA	Bangladesh Diploma Nurses Association
BMA	Bangladesh Medical Association
BNHA	Bangladesh National Health Accounts
CC	Community clinic
CSR	Corporate social responsibility
DSF	Demand side financing
EOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
ESP	Essential Service Package
GoB	Government of Bangladesh
HEU	Health Economics Unit
HFG	Health Financing and Governance
HPNSDP	Health, Population and Nutrition Sector Development Program
HPNSSP	Health, Population and Nutrition Sector Strategic Plan
HRH	Human resources for health
icddr,b	International Center for Diarrheal Disease Research, Bangladesh
ICT	Information and communication technology
IMCI	Integrated Management of Childhood Illness
KII	Key informant interview
MoHFW	Ministry of Health and Family Welfare
NGO	Non-governmental organization
NIPORT	National Institute of Population Research and Training
NSSS	National Social Security Strategy
OOP	Out of pocket
PHC	Primary Health Care
PIB	Press Institute of Bangladesh
QoC	Quality of care
SBCC	Social and behavioral change communication
SSK	Shasthyo Suroksha Karmasuchi
STI	Sexually transmitted infection
THE	Total health expenditure
UH&FPO	Upazila Health and Family Planning Officer
UHC	Universal Health Coverage
USAID	United States Assistance for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Globally, health care expenses push 25 million households each year towards abject poverty. It is estimated that in Bangladesh alone, catastrophic health expenditure results in 5.7 million Bangladeshis being forced into poverty. Bangladesh recognizes the right of all people to the highest attainable standard of physical and mental health under the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child. These fundamental human rights cannot be realized without Universal Health Coverage (UHC), which ensures that all people have access to the health services they need, without financial hardship. The Bangladeshi Constitution commits to address inequalities in access to health in rural areas and the country joined the global community in committing to achieve UHC by 2030 under the Sustainable Development Goals (SDG).

Initiatives by low- and middle-income countries like Bangladesh must focus on progressive expansion of UHC in terms of breadth of coverage (proportion of population enjoying health coverage), depth (range of essential services), and height (reducing cost through cost-sharing). Each country must decide its own path. Ninety percent of health needs can be met at the primary healthcare level. Strong primary healthcare systems enable early diagnosis, preventative, curative and palliative care across the life-course and are the first line of defense against communicable diseases and the biggest killers of pregnant women, mothers, children and adolescents. Primary healthcare providers are essential gatekeepers, guiding people through the health system and improving efficiency by directing patients to the most appropriate and affordable services. Strong primary healthcare systems are a critical foundation for UHC and should be a priority for all countries working to deliver SDG 3. This research examines Bangladesh's path to achieving UHC by 2030.

OBJECTIVES AND METHODOLOGY

The report was commissioned as part of a Save the Children's Global Report first steps: Strengthening Primary Healthcare for Universal at Health Coverage to promote primary healthcare as the first step toward UHC. The objectives of this research were to promote understanding of the health policy environment in Bangladesh, to explore ongoing work toward UHC, barriers, challenges, and commitments by different stakeholders. Researchers employed qualitative methods, including document reviews and key informant interviews with 15 respondents from the public sector, multilateral organizations and donors, non-governmental and implementing organizations, academia and the media.

KEY FINDINGS

- Inequalities in health outcomes and access to skilled healthcare between rural and urban areas, genders, different economic status, levels of education and geographical divisions highlight the need for expansion of services and financial protection to achieve UHC in Bangladesh.
- Total health expenditure in Bangladesh amounts to just $37 per capita each year. This falls far short of the $86 per capita or 5% of GDP that Chatham House recommends spending on primary healthcare although health expenditure as a proportion of total government expenditure is relatively high at 23% (decreasing from 37% in 1997).
- Reliance on out-of-pocket payments (OOPs) is major barrier to access for marginalized groups. Health costs account for 22% of economic shocks for households. Bangladesh has one of the highest OOP rates in the world with 67% of total health expenditure met by private households, more than triple the recommended maximum 20% that out-of-pocket payments should contribute to health expenditure.
- Policy requires free delivery of basic health services, yet 80% of Bangladeshis report making payments for healthcare.
- Bangladesh has a comprehensive set of guiding policies for working toward UHC, this includes a health financing strategy and staged recommendations for pooling of funds to create a national health insurance scheme and expand financial protection.
- Implementation and funding of policies has been the principle challenge but important progress is being made:
    - Bangladesh has defined an essential package of health services that all citizens are entitled to, covering primary healthcare services and some emergency obstetric care.
    - External donors have provided some support to expand access to primary healthcare services with a particular focus on children and hard-to-reach economically, geographically marginalized groups.
    - Health insurance is being piloted in three sub-districts.
    - Political commitment to achieving UHC is strong and supported by key stakeholders.
- Those working toward UHC also face systemic barriers including rigid public financing processes inherited from the colonial era, lack of human resources for health, political interference, poor monitoring and supervision to ensure quality of care.
- Demand for UHC is limited by religio-cultural beliefs that discourage health seeking behavior, historical distrust of the health system and lack of empowerment to seek services. Building a shared understanding of UHC among all stakeholders is key to increasing demand and improving policy development and implementation.

RECOMMENDATIONS

Bangladesh must invest in addressing inequalities in access to health services and reducing reliance on OOP payments if it is to achieve UHC by 2030. Bangladesh's Heath Nutrition and Population Strategic Investment Plan 2016-2021 recognizes the importance of investing in a strong foundation for UHC through its commitment to delivering primary healthcare under the Essential Service Package as the first milestone on the road to universal coverage. To fulfill this policy, Save the Children recommends that Bangladesh:

1. **Increase government expenditure on primary healthcare as a priority for achieving UHC:** Public financing is the most reliable source of health financing. Bangladesh should increase government expenditure on primary healthcare to the levels recommended by national costings for the Essential Service Package ($8.5 per capita) to 5% of GDP or at least $86 per capita, per year in accordance with Chatham House's recommendations for achieving UHC.

2. **Invest to improve financial protection for households:** Bangladesh must reduce reliance on out-of-pocket payments to end catastrophic healthcare expenditure. This can be achieved by:
   - Ensuring user fees are not charged and policy directives to provide free basic healthcare are complied with.
   - Expanding piloted health insurance to reduce out-of-pocket payments through cross-subsidized pre-payments.
   - Increasing government investment in primary healthcare services to ensure quality services are available and patients are not forced to pay for private sector care.

3. **Address inequity in health outcomes and access to services:** Policy and investment should specifically address barriers to access faced by marginalized groups and those located in hard-to-reach areas. Attention should be given to ensuring sustainability of this work currently funded by external donors through government buy-in and transfer of responsibility.

4. **Increase fiscal space through health financing reform:** This should include:
   - Reduced inefficiencies through improved governance and regulation and improved health service management.
   - Financing reform to increase flexibility in use of funds and giving greater autonomy to sub-national health management for improved responsiveness in a decentralized system.

5. **Create greater demand for UHC and quality primary healthcare, including through support for civil society:** Improving quality of services is key to increasing trust and demand for services this could be achieved through the introduction and enforcement of a code of conduct for service providers, improved regulation, inter-sectoral collaboration and increased involvement of civil society in decision-making and community monitoring of service quality. Empowerment of people to improve health-seeking behavior through better health promotion and support, including capacity building, for civil society to engage in advocacy activities.

Section 1: Introduction

The Declaration of Alma Ata, in 1978 marked an important shift from the individualistic biomedical approach of physician-centered health policies towards community-centered care (Walt and Rifkin, 1990). The document clearly identified quality, affordable and accessible primary healthcare as key to realizing the right to health. The compassionate ideologies of 'equity' and 'social justice', championed by the then Secretary General of the World Health Organization (WHO), Dr. Halfdan Mahler, culminated in the Declaration's ambitious goal of 'Health for All' by the year 2000.

The world did not deliver Health for All by 2000 but the principles of the Alma Ata Declaration remain a powerful influence on the global health agenda. The former Director General of WHO, Dr. Margaret Chan, remarked in her introductory message of The World health report 2008: Primary Health Care Now More Than Ever, "While our global health context has changed remarkably over six decades, the values that lie at the core of the WHO Constitution and those that informed the Alma-Ata Declaration have been tested and remain true" (World Health Organization, 2008). The Sustainable Development Goals (SDGs) have given fresh momentum to calls for 'health for all', with a global commitment to achieve Universal Health Coverage (UHC) by 2030, as newly elected Director General of WHO, Dr. Tedros Adhanom Ghebreyesus, stated in his address to the World Health Assembly 2017:

> "All roads lead to Universal Health Coverage. This will be my central priority. At present, only about the half of world's people have access to healthcare without impoverishment. This needs to improve dramatically. The path forward is really clear. The Sustainable Development Goals give WHO an opportunity to dramatically increase access to healthcare."

Globally, health care expenses push 25 million households each year towards abject poverty (Carrin et al., 2008). It is estimated that in Bangladesh alone, catastrophic health expenditure results in 5.7 million Bangladeshis being forced into poverty (Bangladesh Health Watch, 2012). Bangladesh recognizes the right of all people to the highest attainable standard of physical and mental health under the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child (United Nations Human Rights Office of the High Commissioner, 1976, 1990). These fundamental human rights cannot be realized without UHC, which ensures that all people have access to the health services they need, without financial hardship.

The Bangladeshi Constitution commits to address inequalities in access to health in rural areas and the country joined the global community in committing to achieve UHC by 2030 under the SDGs (Government of Bangladesh, 1972). Initiatives by low- and middle-income countries (LMIC) like Bangladesh must focus on progressive expansion of UHC in terms of breadth of coverage (proportion of population enjoying health coverage), depth (range of essential services), and height (reducing cost through cost-sharing) – see Figure 1, below (World Health Organization, 2008).

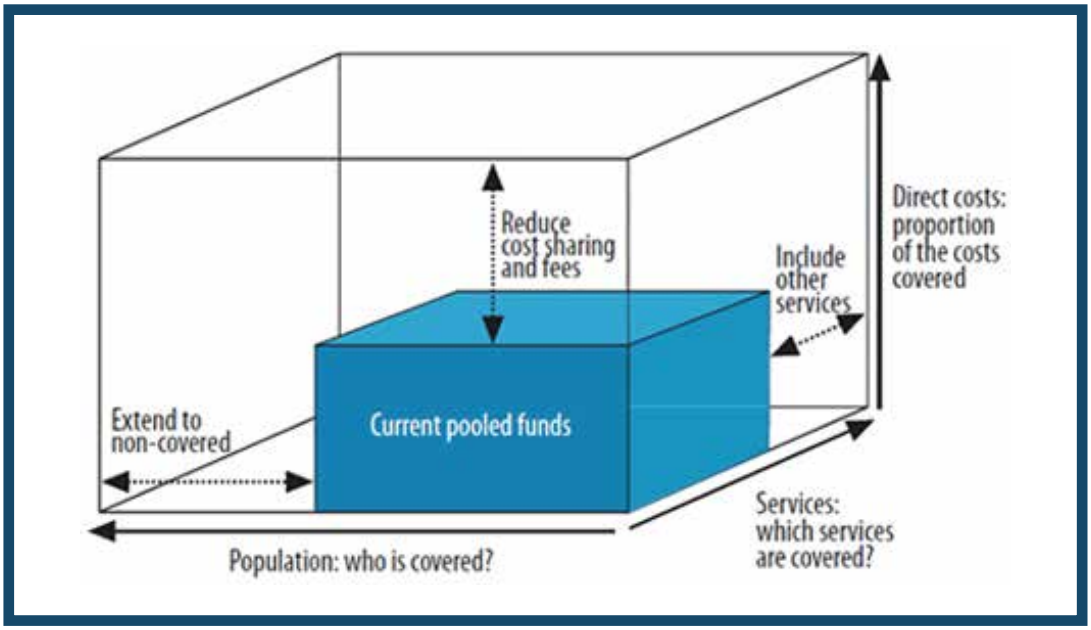


Figure 1

There is no single route or 'magic bullet' to achieve UHC – it will not be achieved overnight, especially in LMICs. Initiatives must manage progressive expansion of UHC in terms of:

- Coverage of essential health services including reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases
- Service capacity and access, among the general and the most disadvantaged populations
- The number of people covered by health insurance or a public health system.

Money will remain a key challenge in resource-poor countries but money alone cannot ensure UHC (Garrett *et al.* (2009)) – effective investment is critical.

While each country must decide its own path toward UHC based on country contexts, all should draw on existing evidence and shared experience. Ninety percent of health needs can be met at the primary healthcare level. Strong primary healthcare systems enable early diagnosis, preventative, curative and palliative care across the life-course and are the first line of defense against communicable diseases and the biggest killers of pregnant women, mothers, children and adolescents. Primary healthcare providers are essential gatekeepers, guiding people through the health system and improving efficiency by directing patients to the most appropriate and affordable services. Strong primary healthcare systems are a critical foundation for UHC and should be a priority for all countries working to deliver SDG 3.

This research examines Bangladesh's path to achieving UHC by 2030. It seeks to understand the existing health policy environment and current activities to further the progress towards UHC and the barriers or challenges faced in these endeavors. It concludes with policy recommendations and an examination of commitments made by different stakeholders to realization of UHC.

Section 2: Methodology

This report is based on a small qualitative study conducted between May and June 2017. This involved document reviews and key informant interviews (KII). Save the Children in Bangladesh provided financial as well as logistic support in preparing the report. The details of the methodologies followed are mentioned below.

DOCUMENT REVIEW

Document review included published reports, guidelines, strategic documents, and policy documents. An initial list was prepared first, which was later supplemented by the information and suggestions from the informants of the KIIs. Reference tracking of published articles, consulted during the literature review, also contributed to the list. The review included 22 documents and the Lancet Bangladesh Series articles pertaining to UHC. Among 22 documents, majority (n = 16) were published by different organs of the Government of Bangladesh (GoB), especially Ministry of Health and Family Welfare (MoHFW). The rest were published by multilateral international organizations, civil society consortium, and private academic and research organizations. The complete list of reviewed documents is available in Table 2.

KEY INFORMANT INTERVIEW

KIIs were conducted using semi-structured guidelines, supplemented by qualitative probing techniques. A tentative list of potential key informants was developed in consultation between the consultant (a health systems researcher with experience in UHC related academic activities in Bangladesh) and Save the Children's leadership (with significant experience of program implementation and advocacy around UHC in Bangladesh) in Bangladesh office. The list was supplemented by snowball recruitment techniques as the interviews progressed.

Key informants were sampled purposively, aiming for maximum variation (Ritchie *et al.*, 2003) in terms of their sectoral alignment. In total, 15 respondents were interviewed from different sectors, broadly categorized as:

1. Public sector (central level): 1
2. Public sector (local level, Sylhet): 5
3. Multilateral organization/ donor: 2
4. NGO/ implementation organization: 4
5. Academia/ research: 2
6. Health journalist: 1

A complete list of key informants is provided in Annex 1.

Most of the interviews were conducted in Bengali, as the first language of most of the respondents was Bengali and they preferred speaking in this language. However, two key informants preferred to speak in English and the interviews were taken according to their language preference. Interviews were conducted by two public health experts (one male and one female), both of whom had adequate command over both Bengali and English. The key informants were assured of strict anonymity regarding the content of their interviews. Quotations, where their names or designations were mentions, were used in this report only after getting approval from the key informants. All the interviews were digitally recorded (using mobile phone recorders); however, they were provided the option of speaking 'off the record', should they preferred. Manual note taking was also employed for all interviews in order to prevent the risk of data loss due to technical issues.

Although a key informant guideline was used for data generation, adequate probing was used to clarify the views expressed by the respondents. Follow up questions were asked to ensure maximum and in-depth information. Each interview lasted between 25 and 45 minutes.

Verbatim transcriptions were done by professional transcribers once the interviews had been finished. After transcription, the transcripts were read carefully and matched with the records, to check if any information was missing. The thematic analysis of texts was done using manual coding. Texts were organized across four main themes: 1. Activities around UHC, 2. Barriers to implement UHC, 3. Recommendations to progress towards UHC, and 4. Commitments of stakeholders towards UHC. Appropriate quotations were extracted to substantiate the thematic analysis. Finally, member checking was done with the key informants, before finalizing the report.

Section 3: Inequity in Bangladesh

Equity in health is one of the central pillars in promoting social justice and improved health of the population. According to the International Society for Equity in Health, "Equity is the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically" (Starfield, 2002). Equality in health services is based on the principle that everyone has an equal right to access health services. Equity takes it one step further and addresses the fact that some groups within each society have less access to health services than others, and that steps should be taken to address this differential. Achieving equity in a health program means successfully reaching those people that are otherwise marginalized and less able than others to access those health services (an example of such a project that aimed to achieve health equity is provided in Annex 2).

Out of pocket (OOP) payments are one of the most inequitable sources of healthcare financing. Only 23% of the total health expenditure comes from the Government. Total per capita expenditure on health is only $37 and this figure includes government, donor and household contributions. OOP contributions to health expenditure in Bangladesh are among the highest in the world with 67% of health expenditure coming from households (Government of Bangladesh, 2017). Health expenditure in private health facilities is almost exclusively from OOP payments (93%). At the secondary care level, 74% of people are at risk of catastrophic expenditures for surgical care and 79% are at risk of impoverishment due to surgical expenditure (The World Bank, 2014). Health shock is the most common shock to Bangladeshi population, accounting for 22% of all economic shocks (Bangladesh Health Watch, 2012). Despite the public sector healthcare being formally free or highly subsidized, 80% of the respondents in Bangladesh Health Service Delivery Survey 2003 reported paying for different services in the public sector. Twenty percent reported being charged by and paying service providers directly.

Quality of care is highly questionable in the public sector. This encourages people to resort to private sector healthcare, which is more expensive. As a result, those who cannot afford private healthcare may either risk catastrophic health expenditure or must go without quality healthcare. The review of Bangladesh's Demographic and Health Survey 2014 revealed inequity in most of the health indicators in terms of economic status, level of education, gender, location (urban vs. rural), and geography (Divisions) (National Institute of Population Research and Training (NIPORT) et al., 2015). Among fertility and family planning indicators, for example, marital age of first marriage is only 15.3 years in the lowest income quintile versus 17.6 years in the highest (national average 16.1 years). The median age of first sexual intercourse among women of 20-49 years is 15.9 years in rural areas versus 17.0 years in urban (national average 16.2 years). Total fertility rate among 15-49 years women is 2.9 in Sylhet Division versus only 1.9 in Khulna and Rangpur (national average 2.3). Mean ideal number of children is 2.4 among women with no education versus 2.0 among those with secondary or higher level of education (national average 2.2). Contraceptive prevalence rate (any method) is only 47.8% in Sylhet Division versus 69.8% in Rangpur (national average 62.4%). Percentage of unmet needs for family

planning is 17.7 in the Sylhet Division versus 6.7 in Rangpur (national average 12.0).

Similar trends of inequity are observed in maternal and child health and nutrition indicators as well. For example, infant mortality rate is 35 per 1000 live births among the people of lowest income quintile, compared to only 14 among the highest income group. Antenatal care (ANC) coverage rate is highly inequitable in terms of all types of stratification (Table 1).

Table 1 Percent distribution of women age 15-49 who had a live birth in the three years preceding the survey, who received any number of ANC from any provider for the most recent birth, by background characteristics, Bangladesh 2014 (only the lowest and highest values are shown)

Background characteristics	Any ANC
Residence	
Rural	74.6
Urban	89.3
Division	
Sylhet	62.4
Khulna	88.1
Educational attainment	
No education	57.0
Secondary complete or higher	94.6
Wealth quintile	
Lowest (poorest)	57.4
Highest (richest)	95.2
Total	**78.4**

Distribution of home delivery is also the highest among subjects from rural areas (69.1 vs. 42.3 in urban), Sylhet Division (76.6 vs. 45.0 in Khulna), among those with no education (83.8 vs. 31.3 in secondary education or higher), and those in the lowest income quintile (84.8 vs. 28.8 in highest quintile). National average for home delivery is 62.2%. Percentage of children 12-23 months receiving all basic vaccinations is only 61.1 in Sylhet Division, as opposed to 90.0 in Rangpur. Among under-5 children, percentage of stunting is the highest in Sylhet Division (49.6 vs. 28.1 in Khulna), that of wasting in Barisal and Rangpur Divisions (17.7 vs. 11.9 in Dhaka), and percentage of underweight infants in lowest income quintile (45.1 vs. 17.4 in the highest).

Section 4: Policy Scan

In order to address inequities and foster UHC, the GoB has taken several policy initiatives. Besides, various multilateral organizations, civil society consortia, and academic and research organizations based in Bangladesh developed documents with policy directives for UHC in Bangladesh. We classified the GoB policy documents as follows: 1. Overarching documents, not specific to the health sector; 2. Overarching documents specific to the health sector, but not specific to health financing; 3. Documents specifically related to health financing; and 4. Documents not directly related to, but with implications for UHC. Findings from these documents, along with those not published by GoB, and the articles published in the Lancet Bangladesh Series are summarized in Annex III.

The most important policy document, specifically focusing on UHC in Bangladesh, is the 'Health Care Financing Strategy 2012-2032: Expanding Social Protection for Health towards Universal Coverage'; published in September 2012 by Health Economics Unit, MoHFW, GoB. Aligned with other important policy documents (e.g., National Health Policy, Health Population and Nutrition Sector Development Program, etc.), this strategy document acknowledged the importance of bringing more funds to the health sector and pooling the resources effectively. It summarized challenges of health financing in Bangladesh as: 1. Inadequate health financing; 2. Inequity in health financing and utilization; and 3. Inefficient use of existing resources. Designed to address the health financing issues for the next 20 years, this document also proposed ways to combine funds from tax-based budgets with proposed social health protection schemes (including for the poor and the formal sector), existing community based and other pre-payment schemes and donor funding to ensure financial protection against health expenditures for all segments of the population, starting with the poorest. It recognized the importance of and proposed collaboration with the for-profit and not-for-profit private sector, development partners, and the community people; to resolve the health financing challenges. It proposed a gradual process to achieve universal coverage, starting from the poor and the formal sector (public, for-profit private, and not-for-profit private), progressively to remaining segments of the population by 2032. It proposed three strategic objectives: 1. Generate more resources for effective health services; 2. Improve equity and increase healthcare access, especially for the poor and the vulnerable; and 3. Enhance efficiency in resource allocation and utilization. It proposed three strategic interventions and supportive actions: 1. Design and implement a Social Health Protection Scheme; 2. Strengthen financing and provision of public healthcare services; and 3. Strengthen national capacity.

Apart from this crucial document, other few important policy documents provided important policy directions for UHC in Bangladesh. For example, the 'Seventh Five-Year Plan Fiscal Year 2016-2020: Accelerating Growth, Empowering Citizens' expressed commitment to ensure that the poor and the marginalized people are able to access and utilize health services. Acknowledging the existing deficiency in per capita health expenditure, share of the national budget for health, quality of care and high OOP, it proposed a health financing reform to address these issues. In light of these propositions, the 'National Social Security Strategy of Bangladesh'

suggested some specific reforms and action plans, and listed relevant ministries to collaborate with. It expressed the commitment of the GoB to introduce a national health insurance scheme. These reform requires budgetary allocation, the insufficiency of which has been recognized by the 'National Health Policy'.

It not only recommended increasing the allocation, but also proposed ensuring equitable care for the disadvantaged, poor, marginalized, elderly, and the disabled population. In alignment with National Health Policy's recommendations, the 'Health Population and Nutrition Sector Strategic Plan 2011 – 2016' dedicated a chapter on 'health sector financing', where it proposed a health-financing framework, advocated demand-side financing, and proposed a resource allocation formula. The 'Health Nutrition and Population Strategic Investment Plan 2016-2021' identified 10 driving forces, the final one of which suggested greater investment in health, ensuring a focus on managing demand, increasing efficiency, and developing the evidence base for future health funding. This document proposed eight strategic objectives; the third of which was "To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage." This strategic objective, envisioned to achieve three outputs: 1. Increase overall financial resources in the health sector; 2. Achieve equitable access to services and financial protection, especially for people in the bottom 40 percent; and 3. Enhance efficiency in financial resource allocation and use. Going one step further, outlined priority activities in order to achieve the proposed outputs. It also identified Essential Service Package (ESP) as the first milestone on the road to UHC. It also outlined three guiding principles for attaining UHC: quality, equity, and efficiency across health services. Apart from these government documents, many non-government ones, such as 'Bangladesh Health Watch Report 2011: Moving Towards Universal Health Coverage', and 'The Path to Universal Health Care in Bangladesh: Bridging the Gap of Human Resources for Health', advocated for creating greater demand for UHC and quality primary healthcare among the community through support from the civil society.

The most important of all policy implications for UHC is the commitment from the highest political level of Bangladesh. GoB's commitment to UHC is evident from their remarks at the G7 Summit held in Japan, in 2016; the 70th United Nations General Assembly, in 2015; and the 64th World Health Assembly, in 2011. The Prime Minister Sheikh Hasina in her inaugural address at the 64th World Health Assembly in Geneva in May 2011 maintained; "In Bangladesh, we have planned universal health coverage for all citizens… Let us renew our commitment to 'Health for All' as an essential precondition to transforming people as human assets. Only then will we be able to promote human dignity and enhance their quality of life."

Section 5: Theme 1: Activities

PUBLIC SECTOR

ESP has been selected as the basis for UHC activities in public sector of Bangladesh. ESP is currently in the process of implementation, even at the lowest unit of health service delivery facility, the Community Clinic (CC) level. A pilot health-financing scheme, Shasthyo Suroksha Karmasuchi (SSK), has been introduced by Health Economics Unit (HEU) of MoHFW in three upazilas (Kalihati, Ghatail, Modhupur) of the Tangail district. Initially, the below-poverty population has been included in the scheme with the government paying for their premium; but the above-poverty population is also intended for gradual inclusion.

At the local or implementation level, information and communication technologies (ICT) are used extensively to improve population coverage. Services are delivered through health centers as well as household visits. Social and behavioral change communications (SBCC), and Expanded Program on Immunization (EPI) activities are carried out as a preventive measure. Curative programs include Integrated Management of Childhood Illnesses (IMCI), maternal and neonatal health activities, demand side programs (DSF) with vouchers, Emergency Obstetric Care (EOC), indoor and outdoor services, etc., in many areas, if not all. The family planning wing of the MoHFW is also engaged in women, children, adolescent, and reproductive health, in addition to their role in family planning. The government has started shifting focus from just quantity to the quality of services as well. Medicines are given free of cost from health centers, which reduces the financial burden of the patients to some extent.

NGO SECTOR

NGOs, such as Save the Children, are mainly engaged in increasing service coverage, and that with service quality. In terms of service coverage, their emphasis is on newborn health, maternal health, nutrition, health system strengthening, and HIV/AIDS. They are trying to improve the quality of services at the PHC level. In terms of population coverage, their main focus is towards the hard-to-reach areas and the population therein. For example, a great deal of attention is paid to the char areas, hill tracts, tea gardens, coastal areas, minority groups, and economically vulnerable groups, especially the children. They are doing SBCC activities, which may go a long way to demand generation among the population for UHC; and also decrease the financial burden for curative care. A respondent clarified this concept:

"If we strengthen the preventive care, if we strengthen the SBCC components, that actually is the best way to bring down the cost of treatment in future." – Dr. Ishtiaq Mannan, Save the Children in Bangladesh

They expressed their acknowledgement to the ESP as a basis for UHC, and expressed their commitment to align their activities in this regard. They also advocate with the government for modifying policies, many of which directly or indirectly contribute to the UHC journey. They are actively involved not only at the grass-roots implementation level, but also the policy and decision level, such as the Quality Improvement Cell of HEU under MoHFW.

MULTILATERALS AND DONORS

Multilateral organizations, such as WHO, are more into generating a common understanding on UHC among the stakeholders. They are also providing technical support to the government in implementing UHC. Generating information and strengthening the health system as a whole are their larger approach to contribute to UHC activities. Highlighting importance of multi-sectoral action for UHC, a representative of a multilateral organization remarked,

"UHC is critically important and our organization works closely with governments and other stakeholders to make improvements. We engage with concerned ministries and government entities, often through consultations and policy dialogues towards the advancement of UHC by prioritizing primary health care and the implementation of the ESP at district level and below." – Dr. Valeria Oliveira de Cruz, WHO, Bangladesh

Donors supported the HEU in developing the Health Care Financing Strategy 2012-2032, and also its implementation. Raising awareness and a common understanding on UHC has also been a main focus of United States Assistance for International Development (USAID). They organized sessions with stakeholders both at the national and sub-national levels. Since ESP is the basis of UHC, they supported the government in its costing analysis (costed at $8.5 per capita). A representative of the Health Financing and Governance (HFG) Project of USAID mentioned:

"HFG Project is providing technical assistance in costing the ESP, which will then allow the government to make decisions about how much resources are needed to provide essential services to the whole population. That information will support in improving service coverage, population coverage, and financial risk protection; in terms of advocating for additional resources for health." – Dr. Mursaleena Islam, HFG, USAID, Bangladesh

ACADEMIA AND RESEARCH

Academia and research organizations are there for familiarizing the concept of UHC to the relevant stakeholders. A Professor and the Director of Center of Excellence for UHC, based in BRAC School of Public Health remarked:

"We are trying to bring them (stakeholders) to the consensus, so that they are clear about what this (UHC) is, why is it necessary, what to do in order to achieve it, and how they all can contribute to this cause." – Professor Syed Masud Ahmed, BRAC School of Public Health, Bangladesh

They are organizing short courses to develop capacity, conducting research work on UHC related issues, and doing policy advocacy through roundtable discussions, TV talk shows, etc. Another leading research institute, International Center for Diarrheal Disease Research, Bangladesh (icddr,b) is involved in planning, monitoring, and evaluation of the SSK. They are also collaborating with the government in ensuring quality of care in the for-profit private sector. Their contribution to the development of asset quintile method stays as a hallmark for health equity analysis and UHC research.

Media

The media is also involved, as expected, in awareness building about UHC, especially among the common mass. Media has been involved since the beginning of the UHC agenda in Bangladesh, starting from a grant from Rockefeller Foundation made to the quasi-governmental autonomous organization, Press Institute of Bangladesh (PIB). Journalists received training on UHC, are writing extensively on different aspects of UHC, and visited the SSK project. Some journalists even went to other countries (e.g., Thailand, Nepal, Bhutan, Philippines) on an exposure tour. A senior health journalist said:

> "These exposure tours helped me develop an idea about what other countries are doing in terms of UHC. All I have been writing in newspapers, and what I am telling you now, are in light of these visits." – Toufik Maruf, The Daily Kaler Kantho

PIB is regularly organizing training and orientation sessions for journalists, and organizing TV talk shows on different aspects of the UHC agenda.

Section 6: Theme 2: Barriers

The barriers to progress towards UHC can be felt at different levels. We categorized the barriers in three levels, which are again crosscut by one important barrier, the lack of a shared understanding on UHC. The three levels are: 1. Larger policy-level barriers, often beyond the jurisdiction of health sector alone; 2. Implementation barriers in health sector; and 3. Demand-side barriers (Figure 2)

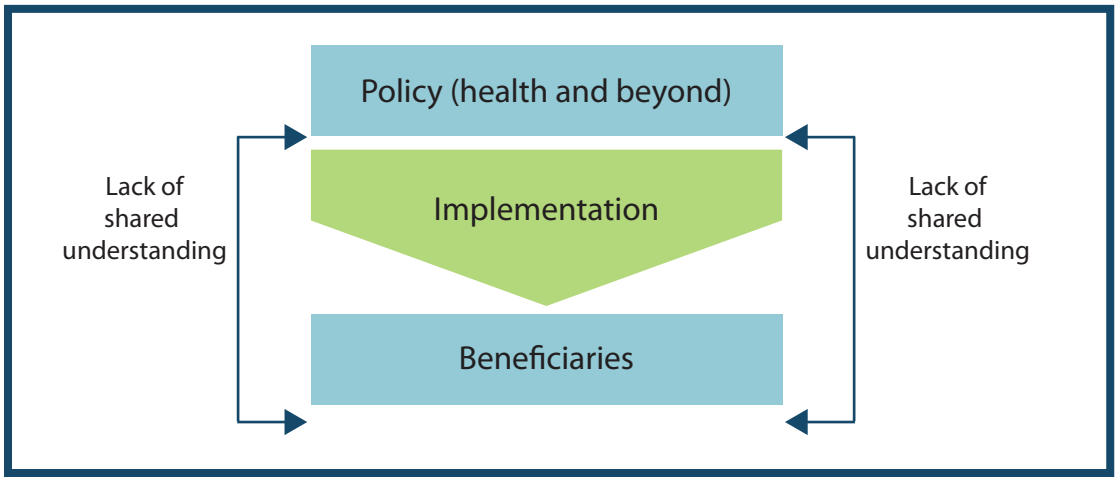


Figure 2 Barriers of implementing UHC in Bangladesh

LARGER POLICY-LEVEL BARRIERS (HEALTH SECTOR AND BEYOND)

Public finance management has been designed such that, only health sector finance is very difficult to alter separately. Ministry of Finance needs to change all its mechanisms and rules of procedures for all other ministries, if it wants to do something for one particular ministry. Bangladesh has traditionally been practicing supply-side budgeting; changing which is complicated, has crosscutting ramifications, and therefore, demands much broader or revolutionary commitment for whole system change. One key informant said:

> "This is the legacy of British colonial bureaucracy, which no one dares changing, despite how much they want." – Dr. Ishtiaq Mannan, Save the Children in Bangladesh

In tandem with the increase in economic activities in people's lives, the size of the economy is increasing. Since the purchasing power of people are increasing, their health seeking behavior is changing consequently, culminating in higher healthcare cost. A government high official said:

> "People nowadays go quickly to the doctor, demands quick diagnostic tests, want to get cured soon. They are much more aware. Some of this is informed awareness, which is good. However, there are some ill-informed care-seeking, which are increasing the cost of care unduly." – Mr. Ashadul Islam, HEU, MOHFW,GoB

As a result of all of these, the overall healthcare expenditure is increasing, which requires more funding to address. Eventually, implementation of UHC is becoming progressively expensive. This is happening in the context of a country that chronically allocates least share of its national budget for health. On top of all these, health insurance, if we consider as a means to UHC, itself is resource intensive.

Apart from the financial issues, there is deficiency in health systems governance and stewardship. Accountability and transparency is difficult to ensure in public sector, especially in the presence of a highly centralized system. One key informant said,

> "Due to the very centralized nature of public administration in Bangladesh, it is difficult for managers to be able to act based on local information. So, they do not always make decisions for their communities or for their catchment area that is based on local evidence."
> – Dr. Valeria Oliveira de Cruz, WHO, Bangladesh

Even in the private sector, a proper regulatory mechanism is missing. There is currently no such structure for functional mediatory mechanism, to resolve or mediate the complaints of the service seekers. Unqualified providers often continue harmful medical practices, capitalizing loopholes in the regulatory framework and its implementation.

IMPLEMENTATION BARRIERS IN HEALTH SECTOR

Poor human resource management, including shortages, deficient training, low motivation, failure in retention, skill-mix imbalance, quality service provision, etc. are staggering. Recruitment mechanisms by Bangladesh Civil Service (BCS) are also criticized for taking too long to deploy physicians to the vacant posts in time. Political interference is often adding insult to injury, as recruitment, retention, and disciplinary measures become difficult for the managers to exercise. One local level government health official said:

> "There are some bad areas near Hobiganj, where I cannot retain any physician. As soon as I deploy someone, phones keep coming from the honorable minister, secretary, political leaders, Awami League (ruling party) secretary, petit leaders, so-and-so, requesting not to keep his doctor there." – Dr. Ismail Faruk, Divisional Director of Sylhet, MOHFW, GoB.

The same bureaucrat also reflected on difficulties of disciplinary actions against his employees:

> "Yesterday, going to an Upazila Health Complex I discovered, the physician had not come to his duty on time. I asked him to show the causes of his absence. Since evening I had received at least 10 phone calls, vouching for him that he had genuine reasons to remain absent that day. If I tend to take disciplinary actions, they would say, 'why are you making too much of it'"? – Dr. Ismail Faruk, Divisional Director of Sylhet, MOHFW, GoB

Deficient monitoring mechanisms often exacerbate the shortage of human resources, as the existing service providers cannot be ensured to stay in their posted positions. There is no agreed-upon protocol for treatment, referral, follow-up, and even general service management. As a result, uniform care with sufficient quality is difficult to provide. Lack of proper training of service providers results in lack of quality of care and responsiveness towards the service seekers. Since the service providers are trained in a certain way, convincing them to do it differently overnight is challenging. Implementers of SSK in three upazilas faced this problem, as reported by a key informant:

"They (service providers in SSK facilities) are trained in a certain way. When we are giving direction to do something differently for the sake of the project, they are saying, 'why should I do it like this?' Now, no one is willing to go to those centers, despite those being close to Dhaka. Someone even told me, if he has to stay there, he would rather leave the job."
– Mr. Ashadul Islam, HEU, MOHFW, GoB

Identifying and reaching the hard-to-reach areas and population is another challenge to achieve UHC. Bangladesh has several difficult geographical regions, e.g., char or newly emerged land-strip in the bank of rivers, coastal areas, hill tracts, tea garden, etc. There are minority population groups, in terms of religion, ethnicity, etc. Also, the socially excluded and economically marginalized population needs special attention. Due to persistent lack of flexible budgeting and local level planning, these population groups never get due attention. One key informant from an international NGO said:

"Government's system is that, they always do flat budgeting. They allocate the same budget for hilly tea gardens of Sylhet, as they do for flat areas of Rangpur." – Dr. Shamim Jahan, Save the Children in Bangladesh

Apart from the above-mentioned barriers, some key informants pointed to the donor dependency and consequent compromise in autonomy of priority setting, lack of sufficient infrastructure, management shortfall, elusive collaboration and coordination mechanism, to name a few.

DEMAND-SIDE BARRIERS

There is a pervasive cultural and religious barrier against insurance. People allegedly consider health insurance against religious (Muslim) disposition.

Several key informants mentioned there is overall deficiency of trust in the society, due to historical and socio-cultural reasons. According to one key informant:

"Let alone trusting health insurance agency, we don't even trust our relatives, when it comes to financial transactions." – Mr. Ashadul Islam, HEU, MOHFW, GoB

Due to the pervasive lack of societal trust, coupled with lack of historical precedence to insurance mechanisms, it is difficult to convince people to give their money to a pooled fund.
Another historically established perception among the people is that, the government is solely responsible for health, and that must be free of cost. People are not receptive to the idea of paying for government healthcare, be it in the form of prepayment or otherwise.

Lack of information on the available services is another demand side barrier to UHC. Communities also lack awareness regarding their own entitlements. They are not empowered enough to hold the decision makers and services providers responsible for providing UHC.

CROSSCUTTING BARRIERS

A lack of common understanding among different stakeholders, both supply and demand side, has been identified by several key informants as an overarching barrier to UHC. According to key informants, different people perceive UHC differently; for example, some think UHC is just

about insurance (including commercial health insurance), some think this is just a variant of the PHC movement, while some others consider any activity pertaining to health as UHC. One key informant said:

> "If you ask a government officer, he would say, 'we already have UHC'; healthcare has been free in Upazila Health Complexes since ages. We provide all health types of health service; we don't need a new UHC." – Professor Syed Masud Ahmed, BRAC School of Public Health, Bangladesh

Key informants suggested that, if stakeholders lack a shared understanding, and are not sufficiently motivated as a result, it would be difficult to take the UHC movement forward.

Section 7: Theme 3: Recommendations

The recommendations are drawn from the respondents and have been presented aligned with the barriers to UHC from the previous section. Bangladesh must invest in addressing inequalities in access to health services and reducing reliance on OOP payments if it is to achieve UHC by 2030. Bangladesh's Heath Nutrition and Population Strategic Investment Plan 2016-2021 recognizes the importance of investing in a strong foundation for UHC through its commitment to delivering primary healthcare under the ESP as the first milestone on the road to universal coverage. To fulfill this policy, Save the Children recommends that Bangladesh:

RECOMMENDATIONS TO ADDRESS LARGER POLICY LEVEL BARRIERS

1. Redesign the public finance: In order to accommodate the flexibility in financing options, required for UHC, redesigning the traditional public financing mechanism is recommended. It should be rearranged in a way to accommodate demand-side financing, projects like SSK, local level planning, and local authority for spending.

2. Improve governance and regulatory mechanism: It should be done with the aim of decreasing the cost of medicine and healthcare as a whole. Policy makers need not only to develop protocols, but also to ensure compliance to these. Private sector should be regulated for better management, improved quality, and reduced cost. Regulation and its implementation should make sure that there is no overcharging, exploitation of any form, unnecessary procedures and tests, and irrational use of antibiotics. There should be an oversight board, or a private sector coordination board, and/or a functioning mediatory body. Reflecting on the high cost of medicine, a key informant said:

> "They (pharmaceuticals) justify their high cost by saying, 'Show me which country is giving medicine in lower price? Even you go to neighboring India, the price is higher there too'. But they never say that we can give medicines with much less price." – Mr. Ashadul Islam, HEU, MOHFW, GoB

3. Code of conduct for service providers: There should be code of conduct for service providers, like physicians and nurses. These need to be developed in consultation with relevant stakeholders, including professional bodies of the respective professional groups, i.e., Bangladesh Medical Association (BMA), Bangladesh Diploma Nurses Association (BDNA), etc.

4. Health insurance and health financing reform: The government should consider introducing a national single payer system and increase coverage gradually to different population segments; starting with the formal sector as they are more informed, and more empowered to reclaim their right. Bangladesh needs its own model for health financing, which warrants further research and experiments. Creation of a purchasing body and separation of providers from purchaser authority is needed. Innovative financing mechanisms, such as, bringing corporate

social responsibility (CSR) money, zakat money, sin tax money, etc. into UHC should be considered. A senior health journalist suggested:

"There is no such corporate house which doesn't do CSR. They can give this fund for UHC; only government needs to take the initiative. …Zakat is also similar to CSR. If the government makes a law that people should contribute their zakat fund to UHC, that's enough. It's easy to convince people that 'you are rich, but someone among your poor neighbors is deprived of treatment and dying just due to shortage of money'. …The government makes arrangement with the tobacco industry that, their money is going to different sectors; this must be earmarked for health sector only."
– Toufik Maruf, The Daily Kaler Kantho

5. Inter-sectoral collaboration: Civil society needs to be consulted for optimization of UHC endeavor. A key informant from the leadership of an international NGO said:

"There should be a civil society and government collaboration, where we (civil society) will monitor our (national) progress, keep a watch, engage in dialogues, and raise our voice from time to time. This is needed so that the government, or whoever is working (on UHC), stays on right track." – Dr. Ishtiaq Mannan, Save the Children in Bangladesh

There needs to be an institutional body or a coordinating body, which will involve all relevant ministries or sectors and pave a common pathway towards UCH. It is important to include non-state actors in the UHC movement, in order to get their data and insights. NGOs should come forward to support the government with technical expertise they have. A key informant from an international NGO said:

"Role of organizations like ours is the raise the technical voice for UHC, and give courage to the government, stay with the government. We are not here to make them (government) look bad, rather we are trying to make their achievements more sustainable." – Dr. Ishtiaq Mannan, Save the Children in Bangladesh

Professional associations of service providers, and the media should also be collaborated with. Collaborations should be addressed in the policy explicitly. There should be a clear guideline regarding inter-sectoral collaboration.

6. Decentralization: A policy reform for decentralization is needed. A key informant from and international NGO said:

"Wherever we engaged local government, we were met with success. It is true for service utilization, reaching the hard to reach, inclusion of poor people – in all of these areas local government was very instrumental." - Dr. Ishtiaq Mannan, Save the Children in Bangladesh

7. Special attention to hard-to-reach areas and marginalized populations: Special attention should be paid to hard-to-reach areas and the marginalized population. A key informant from the family planning directorate of the government said:

"If a mother has five children, she tries to help out the weakest one. Similarly, we should identify the areas that are weak socio-economically; and focus more from the policy perspective." – Dr. Lutfun Nahar Jesmin, Deputy Director Family Planning, Sylhet, MOHFW, Bangladesh

8. Political commitment: Political commitment and a better buy-in on UHC is indispensable. This may be achieved by going to the political parties before election and convincing them to include UHC in their manifesto.

RECOMMENDATIONS TO ADDRESS IMPLEMENTATION BARRIERS IN HEALTH SECTOR

1. Deciding on and adhering to quality criteria: Strict criteria for quality of care should be set, and a directive should be passed that providers would receive payment only if they comply with an agreed treatment protocol and quality criteria. Functioning referral mechanism should be ensured, along with a defined referral protocol. These require improved capacity of service providers; which can be attained through proper training. The training should not be limited to technical aspect of care, rather should include training on responsiveness or patient centered care, and quality of care. An advisor to an international NGO said:

> "A physician should be psychologically prepared in medical colleges, where they stay for five years. Our curriculum lacks issues like what should be the appropriate attitude in the profession they (students) are going, what should be their behavior. …There should be a review of the medical curriculum to orient them about the environment where they would be working. These should be included in medical education, or if not possible, then at least in the orientation trainings."
> – Dr. Golam Mothabbir, Save the Children in Bangladesh

2. Health systems strengthening: Comprehensive improvement in all health systems building blocks, such as financing, governance, human resources, etc., should be planned and operationalized. With an aim of overall health systems strengthening, PHC services should be prioritized, and duplication of services (between public and private sector, health and family planning, etc.) must be avoided.
3. Improve health service management: Health service management, including human resource management, inventory management, facility management, financial management, etc., needs to be further improved. Vacant positions need to be filled.

4. Improve monitoring and supervision: In order to improve supervision, the managers should get more support from the government, e.g., they should get vehicles and communication cost, etc.

5. Improve efficiency: To best utilize the existing resources, technical and allocative efficiency should be ensured. Decision-makers should push for improved tax management; managers should decide on priory expenditures. Costing analysis of all services is needed, which demands developing a costing unit under HEU.

6. Improve health promotion and disease prevention: In regards to the importance of SBCC in achieving UHC, a key informant from a multilateral organization remarked:

> "If we are able to provide good health promotion and preventive services at frontline level, and if we are able to bring about change in people's health seeking behaviour, we could make a significant impact on the overall costs of health care, as we would avert more expensive interventions at secondary and tertiary levels."– Dr. Valeria Oliveira de Cruz, WHO, Bangladesh

7. Involve ICT: Government of Bangladesh has placed importance on the utilization of ICT in various sectors. Building on government's commitment, health sector decision-makers also should use the ICT more to allow the hard-to-reach population to reach the services quickly,

and improve supervision and monitoring. Worth mentioning is the fact that, the health sector has already achieved much success in this regard; however, further work is recommended.

RECOMMENDATIONS TO ADDRESS DEMAND-SIDE BARRIERS

1. Patient/client education: We need to inform people about UHC in order to generate demand for it. We need to improve health literacy of general population; which is not possible only by the health sector. Health literacy should be enhanced through the general education as well. Common people should know what services are available.

2. Community empowerment: Communities should know what they are entitled to, and how to get the responsible persons accountable for their work.

RECOMMENDATIONS TO ADDRESS CROSSCUTTING BARRIERS

1. Research: In order to improve our knowledge and understanding on UHC, particularly in the context of Bangladesh, further research is necessary. The research should address the current pattern of health care expenditure, equity status of health care, different models of healthcare financing, various other issues related to different aspects health systems, relevant to UHC. A health systems practitioner from Sylhet said:

> "We need to identify why physicians are not going to the place where they are posted. If you give a physician posting to Shalna (a difficult place), why they don't stay there? We need to understand that first. I have been there, I know, if you are posted there, you will feel like, you are not even in this country." – Dr. Ismail Faruk, Divisional Director of Sylhet, MOHFW, GoB

2. Advocacy: Based on research, policy best practices, and multi-sectoral experiences, advocacy for UHC should continue.

Section 8: Theme 4: Commitments

In course of this study, we realized that, all high level stakeholders, starting from the Prime Minister herself, are committed to achieve UHC.

PUBLIC SECTOR

A central level government policy maker, in response to whether resource constraint is a barrier to UHC, mentioned:

> "Financial constraint is a big challenge everywhere in the world; there is no remedy for it. No one will come and solve my problem that I don't have money. This is something we ourselves need to find a way out. Blaming financial constraint for not adopting UHC will not take us anywhere." – Mr. Ashadul Islam, HEU, MOHFW, GoB

A local level government implementer said:

> "I can tell my seniors that I need human resources; but this may not solve my problem. Government has financial constraint. What I can do is to ensure the maximum utilization of existing facilities. This is my commitment." – Dr. Ujjwal Kanthi Dutta, Upazila Health and Family Planning Officer (UH&FPO), Jaintapur, Sylhet, MOHFW, Bangladesh

NGO SECTOR

Commitment for UHC was expressed by the not-for-profit private sector leaders as well. Deputy Country Director of an international NGO said:

> "Our policy is to provide our highest cooperation to the government. We will continue our complete technical support for policy or systems change, either through programmatic translation of evidences, or model demonstration, or through field level facilitation, …. so that we reach every last child or every last family." – Dr. Ishtiaq Manna, Save the Children in Bangladesh

Another senior personnel, the Senior Advisor of Health, Nutrition and HIV Sector committed:

> "The program, 'Every Last Child', that we have, we want to take it beyond health sector and merge with non-health programs as well. There are scopes of learning from all programs; we need to draw this collective learning and bring changes to the policy level. This is a long process; but I want to start the process." – Dr. Shamim Jahan, Save the Children in Bangladesh

MULTILATERALS AND DONORS

Representatives of multilateral agencies and donors expressed their commitment to provide high-level support to the government and work closely to achieve UHC. Country Manager of such an organization said:

> "We are committed to work in the UHC area and to support the government on implementing the healthcare financing strategy and we will stay committed with that. UHC including health financing, health governance and support for the healthcare financing strategy is our main focus area and we are mainly committed to those." – Dr. Mursaleena Islam, HFG Project, USAID, bangladesh

ACADEMIA AND RESEARCH

Representatives from research and academia committed to carry on their research to facilitate UHC, besides, emphasized on the need for advocacy as well. A Professor of a public health teaching and research institute mentioned:

> "This way (through research and capacity development) we can generate a critical mass or population, who can actually take this (UHC) forward effectively." – Syed Masud Ahmed, BRAC School of Public Health

MEDIA

Our respondent from the media expressed his commitment to be involved in every possible way to the journey of UHC. He said, media can contribute in terms of awareness building, advocacy, and consultancy. He said:

> "I want to involve myself entirely. But that is not possible for me alone; I need support. However, I cherish a desire to wage a campaign so that the people become aware. I want to do it by roaming the whole country. When people know about it (UHC), they will create a pressure on the policy makers." – Toufik Maruf, The Daily Kaler Kantho

Section 9: Conclusion

This qualitative study consisted of document reviews and key informant interviews and explored the policy contents related to UHC in Bangladesh, identified the existing activities by different stakeholders and barriers towards achieving UHC. Additionally, it offered policy recommendations to address the challenges and delineated the commitment of different stakeholders towards its realization. Evident from secondary data is the fact that Bangladesh has a very high rate of OOP, flagging the need for immediate actions towards UHC. However, fortunately, policy environment is quite favorable for a smooth takeoff. Almost all relevant policy documents of GoB explicitly acknowledge the need for UHC, and propose some directives. Added to these is the commitment from the highest political level, the Prime Minister of Bangladesh, given in her address at the 70th United Nations General Assembly in 2015.

Policy directives have already been translated into actions. The public sector, both at the central and local level, is working on implementing ESP as the basis for UHC, using ICT to reach the hard to reach population, striving to improve quality of care and responsiveness, and reinforcing the SBCC activities. NGOs are aligning their activities with that of the public sector, both at the grassroots and the policy and decision levels. Multilaterals and donors are providing technical assistance and working on generating a shared understanding about UHC among all stakeholders. Academia and researchers are generating evidence, building capacity, and advocating for a common ground on UHC. Demand creation for UHC among the general populace is largely done by the media. There are, however, some challenges to progress towards UHC in Bangladesh. Some barriers pertain to the larger policy level, often beyond the health sector (e.g., rigid public financing structure from colonial era), while others pertain to the health sector's implementation shortfalls (e.g., issues related to human resources, political interference, monitoring and supervision, quality of care, etc.). The issue of demand-side barriers has also been raised by most of the key

informants (e.g., religio-cultural disinclination, historical mistrust, lack of empowerment, etc.). Lack of a shared understanding about UHC has been identified as a barrier across all levels (policy, implementation, demand-side).

In order to overcome these barriers, several policies and strategies have also been proposed. These include, but are not limited to, redesigning the public finance structure, improving governance and regulatory mechanism, specifying code of conduct for service providers, introducing health-financing reform, and collaborating with different sectors. In order to address the implementation barriers, key informants proposed, adhering to service quality criteria, strengthening the overall health systems, improving the health service management, improving monitoring and supervision, etc. Patient education and community empowerment have been proposed to address the demand side barriers. A need for research and advocacy has also been pronounced, to address the crosscutting barrier, i.e., lack of common understanding on UHC.

The key informants, each a representative of important stakeholders, did not limit themselves

to outlining their activities, identifying barriers, and proposing solutions. Rather, they all expressed their strong commitment to playing their part in facilitating the journey of Bangladesh towards UHC. Having identified the challenges and potential solutions, coupled with commitments from stakeholders and even the highest political level, we believe Bangladesh will accomplish its mission successfully towards equity and UHC.

References

Bangladesh Health Watch. 2012. *Bangladesh Health Watch Report 2011: Moving Towards Universal Health Coverage,* Ahmed SM, Mahmud S, Evans TG, Bhuiya AU, Chowdhury AMR (eds). Dhaka.

Carrin G, Mathauer I, Evans DB. 2008. Policy and practice Universal coverage of health services : tailoring its implementation. 49387: 857–63.

Garrett L, Chowdhury AMR, Pablos-Mendez A. 2009. All for universal health coverage. *The Lancet* 374: 1294–9.

Government of Bangladesh. 1972. *Constitution of the People's Republic of Bangladesh.*

Government of Bangladesh. 2017. Bangladesh National Health Accounts 1997-2015., Dhaka.

National Institute of Population Research and Training (NIPORT), Mitra and Associates, ICF International. 2015. Bangladesh Demographic and Health Survey 2014: Key Indicators., Dhaka, Bangladesh, and Rockville, Maryland, USA.

Ritchie J, Lewis J, Elam G. 2003. Designing and Selecting Samples. In: Ritchie J, Lewis J (eds). *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. SAGE Publications: Thousand Oaks, California, 77–108.

Starfield B. 2002. Equity in health. *Journal of Epidemiology and Community Health* 56: 483 LP-484.

The World Bank. 2014. World Development Indicators: Bangladesh.

United Nations Human Rights Office of the High Commissioner. 1976. I*nternational Covenant on Economic, Social and Cultural Rights*.

United Nations Human Rights Office of the High Commissioner. 1990. *Convention on the Rights of the Child.*

Walt G, Rifkin SB. 1990. The political context of primary health care. In: Streefland P, Chabot J (eds). *Implementing primary health care: Experiences since Alma-Ata.* Royal Tropical Institute: Amsterdam, 13.

World Health Organization. 2008. *The World Health Report 2008: Primary Health Care:* Now More Than Ever. World Health Organization: Geneva.

Annex

ANNEX I: NAME AND DESIGNATION OF KEY INFORMANTS

Key Informants from Dhaka

1. Mr. Ashadul Islam
   Director General, Health Economics Unit, Ministry of Health and Family Welfare, Government of Bangladesh
2. Dr. Valeria de Oliveira Cruz
   Program Management Officer (Health Systems), World Health Organization, Bangladesh
3. Dr. Ishtiaq Mannan
   Deputy Country Director, Save the Children, Bangladesh
4. Dr. Mursaleena Islam
   Country Manager, Health Finance & Governance Project, United States Assistance for International Development, Bangladesh
5. Professor Dr. Syed Masud Ahmed
   Director, Center of Excellence for Universal Health Coverage, James P Grant School of Public Health, BRAC University
6. Dr. A.T.M. Iqbal Anwar
   Project Director, Universal Health Coverage, Health System and Population Studies Division, International Center for Diarrheal Disease Research, Bangladesh
7. Mr. Imteaz Mannan
   Senior Advisor, Advocacy and Communication, Save the Children, Bangladesh.
8. Dr. Golam Mothabbir
   Senior Advisor, HNHIV Sector, Save the Children, Bangladesh.
9. Dr. Shamim Jahan
   Sector Director, HNHIV Sector, Save the Children, Bangladesh.
10. Mr. Toufik Maruf
    Health Journalist, The Daily Kaler Kantho

Key informants from outside of Dhaka

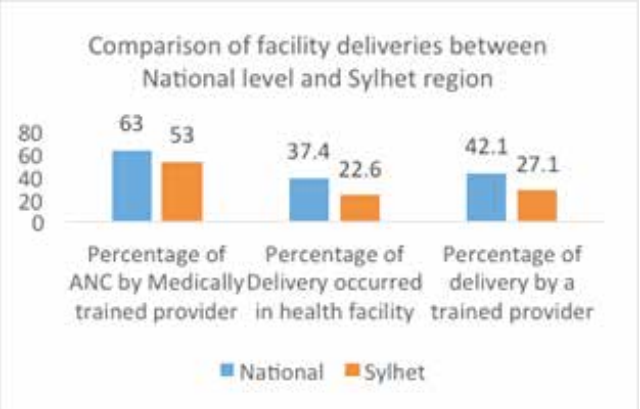
11. Dr. Ismail Faruk
    Divisional Director, Sylhet Division, Ministry of Health and Family Welfare, Government of Bangladesh
12. Dr. Kamal Raton Saha
    Assistant Director, Sylhet Division, Ministry of Health and Family Welfare, Government of Bangladesh
13. Dr. Ahmad Sirajum Monir Rahil
    MO-CS, Sylhet District, Ministry of Health and Family Welfare, Government of Bangladesh
14. Dr. Lutfun Nahar Jesmin
    Deputy Director, Family Planning, Sylhet Division, Ministry of Health and Family Welfare, Government of Bangladesh
15. Dr. Ujjwal Kanthi Dutta
    UH&FPO, Jaintapur Upazilla, Sylhet, Ministry of Health and Family Welfare, Government of Bangladesh

ANNEX II: EXAMPLE OF EQUITY FOCUSED HEALTH ACTIVITIES IN SYLHET*

Achieving equity in a health program means successfully reaching those people that are otherwise marginalized and less able than others to access those health services. This is central to many programs.

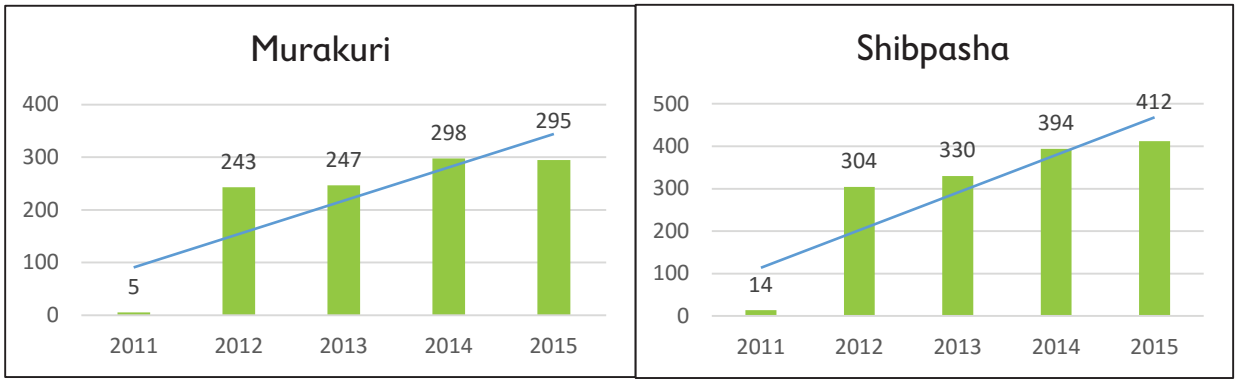
Child malnutrition rates in Bangladesh is one of the highest in the world, with a 36% under-five stunting rate and 33% are chronically undernourished. Only 23% of children aged between 6-23 months are fed appropriately based on recommended infant and young child feeding (IYCF) practices. The indicators of malnutrition are more severe in the hilly and wetlands of the Sylhet region of Bangladesh signifying 49.6% stunting, 12.1% wasting, and 39.8% underweight among under five children compared to national statistics (BDHS, 2014).

As illustrated in the graph, the divisional comparison of health facilities specify that Sylhet is the most deprived of maternal health indicators. The region has the lowest antenatal care facilities by a trained medical provider, percentage of delivery taking place in a health facility and percentage of deliveries undertaken by a skilled birth attendant in comparison to national data Bangladesh.



*Example of equity focused health activities in Sylhet - this case study is written by Taskin Rahman anad Tahrim Zinath Chaudhury.

However, there have been positive outcomes from the 24/7 health facilities intervention at the primary level. As denoted from the graph below, the health facilities in the Murakuri and Shibpasha region of Sylhet have witnessed a constant increase of birth from 2011 till 2015. Due to the presence of a functioning infrastructure, mothers are now able to deliver at health facilities with the assistance of a skilled birth attendant rather than at home through unskilled informal providers. Though a large sum of the population is residing in the lowest wealth quintile, the functioning of these 24/7 health facilities have enabled them to achieve the current health benefits and improved health outcomes. Yet, the country is lagging behind in health indicators, especially for the poorest and most deprived households.



In order to combat the issues of child mortality and maternal mortality the government of Bangladesh has integrated various programmatic interventions. The Ministry of Health and Family Welfare (MoHFW) has integrated the pneumonia vaccine in routine EPI and National Community Management of Acute Malnutrition (CMAM) training module. The pneumonia vaccine has rolled out across the country which went on to contribute to the positive momentum of the government and development partners. Furthermore, the government committed on 'A Promise Renewed' declaration to tackle maternal, newborn and child deaths. On nutrition, the Government integrated the nutrition indicators in the Government's Health Management Information System (HMIS) for more effective monitoring of nutrition in the country. Basic nutrition package guidelines were developed and trainings were provided to support national nutrition services in Bangladesh.

Nonetheless, given the government's strategy of an inequitable budget allocation approach for the thematic areas of health - residents of North Eastern provinces of Bangladesh such as Sylhet are hard hit compared to other areas of Bangladesh. Remote provinces have the lowest access to health and are consistently left behind. A differential budgeting mechanism and need based programming - which is contextual so as to allocate the most budget to the most deprived population to ensure that no one is left behind. The government needs to improvise its policy and its implementation so that the health systems approach can benefit the excluded groups. The government also needs to take urgent policy to improve equal access to quality health services for the left behind provinces.

Hence, scale up approach of the health facilities at the primary (union) levels in Bangladesh is a good initiative towards universal health coverage in Bangladesh. A costed action plan was presented to the honorable Minister of Health, MOHFW to functionalize 4000+ Family Welfare Centers at the primary level. The approach will integrate and provide access to health care facilities for the excluded population especially pregnant mothers, newborn and children in the hard to reach areas who are the most deprived of health care services. The Government has

agreed to functionalize 24/7 delivery services at union level by providing necessary infrastructure support, service providers and logistics across Bangladesh.

Reference:

Bangladesh Demographic Health Survey, BDHS (2014)
World Bank, WB (2015) Maternal Mortality Ratio, http://data.worldbank.org/indicator/SH.STA.MMRT
Bangladesh Health Facility Survey, BHFS (2014); Preparedness: how ready are the facilities to provide services.
Bangladesh Maternal Mortality Survey, BMMS (2010)

ANNEX III: SUMMARY OF POLICY DOCUMENTS RELATED TO UNIVERSAL HEALTH COVERAGE IN BANGLADESH

Name of the document, year of publication, and publishing authority	Main findings
Overarching GoB documents, not specific to health sector	
Seventh Five-Year Plan Fiscal Year 2016-2020: Accelerating Growth, Empowering Citizens. December 2015. General Economic Division, Planning Commission.	Dedicated Chapter 10 for health sector and proposed the Health, Nutrition, and Population Development Strategy. Placed a special emphasis on protecting the interest of the poor in service delivery. Committed to ensure that the poor and the marginalized people are able to access and utilize health services. Health financing reform has been stated as one of the commitments of serving the poor population. Acknowledged the existing deficiency in per capita health expenditure, deficiency in the share of the national budget for health, high OOP, and lack of quality of care. In order to tackle these issues, it referred to the Health Care Financing Strategy (2012-2032) for solutions.
National Social Security Strategy (NSSS) of Bangladesh. July 2015. General Economic Division, Planning Commission.	Acknowledged the importance of health financing reform in curbing health shocks. Proposed some reforms and action plans, and listed relevant ministries to collaborate with. Expressed the commitment of the GoB to introduce health insurance, which has also been acknowledged as an example of a health sector program that closely complements social security initiatives.
National Health Protection Act (draft). 2014. National Health Protection Authority, Ministry of Health, and Family Welfare.	Acknowledged the importance of sustainable health financing option that entails to strengthen financial risk protection, and extend health services and population coverage, with an aim to achieve UHC. This Act has been envisioned by the MoHFW to serve as the legal basis for new health financing mechanism, and provide a legal framework to GoB's UHC targets.

Name of the document, year of publication, and publishing authority	Main findings
Shasthyo Shandhan (Search for Health): A Guideline on Universal Health Coverage for The Mass Media. 2016. Press Institute of Bangladesh.	Developed with financial assistance from the Rockefeller Foundation, in order to generate awareness among journalists on UHC. Easy-to-comprehend document written in Bengali, covering the basic concepts of health, health governance structure of Bangladesh, health care structure, challenges in health sector, and health financing issues. Provides information on the concept of UHC, experiences of other countries (e.g., Thailand, I ndia, Brazil, and China) with UHC, feasible options for Bangladesh, etc.
Overarching GoB documents specific to health sector, but not specific to health financing	
National Health Policy 2011. January 2012. Ministry of Health and Family Welfare.	Admitted the insufficient budgetary allocation in health sector and recommended increasing it. In Strategic Principle part, proposed ensuring equitable care for the disadvantaged, poor, marginalized, elderly, and disabled population. In 'Strategies' part, proposed health insurance for formal sector employees, which would later be extended gradually to other groups. For ultra-poor and disadvantaged populations, proposed free health services.
Health Population and Nutrition Sector Strategic Plan (HPNSSP) 2011 – 2016. September 2010. Planning Wing, Ministry of Health and Family Welfare.	Dedicated a chapter on 'health sector financing', where it proposed a health-financing framework, advocated demand-side financing, and proposed a resource allocation formula. Stated specific purpose in relation to health financing to make sufficient funding available to ensure that all individuals have access to effective public health and personal health care. Proposed some priority activities, which included identify financing constraints; assess the strengths and weakness of the existing financing mechanism; assess suitability of different financing schemes; review examples from other countries, etc.
Health Nutrition and Population Strategic Investment Plan (HNPSIP) 2016-2021. April 2016. Planning Wing, Ministry of Health and Family Welfare.	Identified 'essential health service package' as the first milestone on the road to UHC. Clearly outlined three guiding principles for attaining UHC: quality, equity, and efficiency across health services. Identified 10 driving forces for HNPSIP, the final one of which suggested greater investment in health, ensuring a focus on managing demand, increasing efficiency, and developing the evidence base for future health funding. Proposed eight strategic objectives; the third of which was "To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage." This strategic objective, envisioned to achieve three outputs: 1. Increase overall financial resources in the health sector; 2. Achieve equitable access to services and financial protection, especially for people in the bottom 40 percent; and 3. Enhance efficiency in financial resource allocation and use. Going one step further, outlined priority activities in order to achieve the proposed outputs.

Name of the document, year of publication, and publishing authority	Main findings
Monitoring and Evaluation Strategy and Action Plan: Health Population and Nutrition Sector Development Program (HPNSDP). December 2014. Program Management and Monitoring Unit, Planning Wing, Ministry of Health and Family Welfare.	Did not explicitly discuss UHC; but it proposed monitoring and evaluation plans for financial progress for different operational plans. We felt that the monitoring and evaluation plans should have included components of equity, so that, programs can be evaluated for equity gains (or losses) as well.
GoB documents specifically related to health financing	
Health Care Financing Strategy 2012-2032: Expanding Social Protection for Health towards Universal Coverage. September 2012. Health Economics Unit, Ministry of Health and Family Welfare.	The most important policy documents for UHC. Aligned with the vision of HPNSDP 2011-2016, the UHC, and the National Health Policy 2011; and acknowledged the importance of bringing more funds to the health sector and pooling the resources effectively. Summarized challenges of health financing in Bangladesh as: 1. Inadequate health financing; 2. Inequity in health financing and utilization; and 3. Inefficient use of existing resources. Designed to address the health financing issues for the next 20 years, proposed ways to combine funds from tax-based budgets with proposed social health protection schemes (including for the poor and the formal sector), existing community based and other pre-payment schemes and donor funding to ensure financial protection against health expenditures for all segments of the population, starting with the poorest. Recognized the importance of and proposed collaboration with the for-profit and not-for-profit private sector, development partners, and the community people; to resolve the health financing challenges. Proposed a gradual process to achieve universal coverage, starting from the poor and the formal sector (public, for-profit private, and not-for-profit private), progressively to remaining segments of the population by 2032. Proposed three strategic objectives: 1. Generate more resources for effective health services; 2. Improve equity and increase healthcare access, especially for the poor and the vulnerable; and 3. Enhance efficiency in resource allocation and utilization. Proposed three strategic interventions and supportive actions: 1. Design and implement a Social Health Protection Scheme; 2. Strengthen financing and provision of public healthcare services; and 3. Strengthen national capacity.

Name of the document, year of publication, and publishing authority	Main findings
Framework for Monitoring Progress Towards Universal Health Coverage in Bangladesh. 2014. Health Economics Unit, Ministry of Health and Family Welfare.	Developed a set of indicators, with technical support of the WHO Bangladesh country office, to monitor the progress towards UHC. There were 43 indicators, covering four areas: 1. Access to health services, 2. Protection against, financial risk, 3. Population coverage, and 4. Quality of services.
Operational Mechanism for Social Health Insurance in Poverty Prone Sub-districts of Bangladesh: Developing Tools and Guidelines. March, 2005. Health Economics Unit, Ministry of Health and Family Welfare.	Described the mechanisms of the social health insurance that GoB is currently piloting in two sub-districts of Bangladesh. Discussed constraints and remedies of social health insurance in Bangladesh, basic principles and practices of commercial insurance in the context of Bangladesh, and the problems involved in community based health insurance.
Bangladesh National Health Accounts (BNHA)-V 1997 – 2015. September 2015. Health Economics Unit, Ministry of Health and Family Welfare.	Important policy tool to decide the distribution of societal resources for healthcare as it provided information on different aspects of total health expenditure, and monitor the flow of funds at different levels. Showed that, 23% of total health expenditure (THE) is shared from public, 67% from OOP, and the rest 10% from other sources. Provides a functional classification of THE; where the highest percentage was spent on medical goods (46.6%), followed by services of curative care (25.3%), preventive care (10.9%), ancillary services (5.5%). Only 2% goes for education, research, and training of health personnel.
GoB documents not directly related to, but with implications for UHC	
Strategic Planning on Quality of Care for Health Service Delivery in Bangladesh. January 2015. Quality Improvement Secretariat, Ministry of Health and Family Welfare.	Recognized that the issue of quality of care (QoC) has become more important in the context of UHC, as it requires optimizing the resource use and expanding coverage with QoC. Set the basis for a focused and coordinated framework or implementing quality improvement activities. Proposed strategic objectives: 1. Introduce consumer and patient-centered services; 2. Improve patient safety; 3. Improve clinical practice; 4. Improve leadership management systems; 5. Improve public health and preventive services; 6. Ensure all necessary inputs for quality improvement; 7. Ensure all necessary support services; and 8. Develop effective outcome measurement system for quality improvement.

Name of the document, year of publication, and publishing authority	Main findings
Strengthening Stewardship Functions of the Regulatory Bodies under MoHFW. August 2014. Ministry of Health and Family Welfare.	Reviewed the stewardship and governance functions of the regulatory bodies under the MoHFW. Suggested recommendations for these bodies in order to increase effectiveness of the regulatory functions including updating the mandate and structure of the regulatory bodies. Proposed feasible action plans in implementing the recommendations with possible sources of funding. Their review included all the statutory and professional regulatory bodies including national regulatory bodies such as Bangladesh Medical and Dental Council, Bangladesh Nursing Council, Pharmacy Council of Bangladesh, State Medical Faculty, etc.; and various MoHFW directorates such as Directorate General of Health Services, Directorate General of Family Planning, and Directorate General Drug Administration.
Bangladesh Essential Service Package, August 2016. Ministry of Health and Family Welfare.	Described itself as a powerful tool for UHC, as it could help selecting the services that should be made available to the whole population as a guaranteed minimum, thus enhancing equity. Stated that Essential Service Package (ESP) provision should prioritize hard to reach and vulnerable population, and be sustainable in the long run. The three purposes of ESP, as outlined by the MoHFW, were claimed to be aligned with the realization of UHC. These three purposes were: 1. Associated with UHC initiatives, the ESP represents the GoB commitment to ensure the right to health and that the whole population has access to most essential health services; 2. The ESP will become the basis to define the set of standards by type of health facility; and 3. The package, common to the whole territory, is to be used for resource allocation in a way that promotes equity and increases efficiency.
Bangladesh Health Workforce Strategy. 2015. Human Resource Management Unit. Ministry of Health and Family Welfare.	Summarized the issues and challenges related to human resources for health (HRH) in Bangladesh under five thematic areas with one strategic objective for each: 1. Health workforce planning: Make available, competent and adequate number of workforce as per health systems need; 2. Health workforce capacity development: Produce, develop, and sustain quality health workforce at all levels; 3. Health workforce deployment, retention, and professional engagement: Recruit, deploy, and retain health workforce equitably; 4. Management of high performance standards: Promote and maintain high standards in health workforce performance; and 5. Health workforce information system: Promote evidence-based health workforce decision-making in improving health outcomes. The strategy was underpinned by four guiding principles: 1. Gender balance, 2. Motivation, 3. Partnership, and 4. Transparency and accountability.

Name of the document, year of publication, and publishing authority	Main findings
Health Bulletin. 2016. Management Information System, Directorate General of Health Services. Ministry of Health and Family Welfare.	Flagship publication of Directorate General of Health Services, highlighting the overall health scenario in Bangladesh. Useful source of information in regards to UHC activities, status, and progress in Bangladesh.
Documents related to UHC, not published by GoB	
Bangladesh Health Watch Report 2011: Moving Towards Universal Health Coverage. 2012. James P Grant School of Public Health, BRAC University.	Multi-organization civil society network to hold the state and non-state sectors accountable for their performance in delivering quality health care to the citizens. Commissioned several studies to investigate Bangladesh's preparedness to achieve UHC within the foreseeable future, and identify opportunities as well as challenges, which need to be overcome. Looked at Bangladesh's experiences with public sector in-patient health care; demand side financing; health care financing by NGOs; and for profit private health insurance. Messages emerging from these studies included: 1. The need to establish a shared understanding of universal coverage; 2. Two dimensions are important: a comprehensive set of quality services according to need and financial protection in accessing care ensuring that individuals are not economically compromised in paying for care. Drew seven overarching recommendations: 1. Establishing a shared understanding of UHC; 2. Making a strong case for UHC; 3. Moving to pre-payment financing is imperative; 4. Educating and empowering beneficiaries; 5. Accelerating provision of more equitable and efficient health services; 6. Transforming information and evidentiary systems; and 7. Acquiring core competencies for UHC.
The Path to Universal Health Care in Bangladesh: Bridging the Gap of Human Resources for Health. 2015. World Bank.	Identified few challenges in terms of HRH in Bangladesh, HRH policy challenges, as well as policy options for UHC in relation to HRH. HRH challenges were identified to be: 1. Shortages, 2. Production shortfalls, 3. High vacancy rates and slow recruitment, 4. Skill-mix imbalances, 5. Urban and gender biases, 6. Quality of healthcare provision and productivity of healthcare providers, and 7. Work environment. HRH policy challenges included: 1. A complex array of national policies; 2. A highly centralized and cumbersome bureaucratic system with weak response capacity; 3. A range of powerful stakeholders, some with competing interests; and 4. Weak regulatory and enforcement capacity, contributing to high rates of absenteeism and many unqualified health workers. HRH policy options for UHC included: 1. Address HRH shortages; 2. Improve the skill-mix; 3. Address geographic imbalances; 4. Retain health workers; 5. Adopt strategic payment and purchaser mechanisms; 6. Establish a central human resources information system; 7. Target HRH interventions to improve maternal and newborn health. Several strategies have also been proposed under each policy options.

Name of the document, year of publication, and publishing authority	Main findings
Bangladesh Health System Review. 2015. World Health Organization.	Provided a detailed description of health system and of policy initiatives of Bangladesh. Examined approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; described the institutional framework, process, content, and implementation of health and health-care policies; and highlighted challenges and areas that required more in-depth analysis. Identifies some critical challenges for the health system: 1. Lack of coordination across two different ministries for implementing primary healthcare service delivery in rural and urban areas; 2. Critical shortage of trained health providers with appropriate skill-mix in the public sector and widespread increase in unregulated informal providers for an alternative source of care; 3. Low annual allocation to health in the government budget and high out-of-pocket payments by households; and 4. Inequitable access to health services between urban and rural areas including variable health financing mechanisms, which have slowed achieving UHC.
Health Equity and Financial Protection Datasheet: Bangladesh. 2012. World Bank.	Provided a picture of equity and financial protection in the health sector of Bangladesh. Covered topics included: 1. Inequalities in health outcomes, health behavior, and health care utilization; 2. Benefit incidence analysis; 3. Financial protection; and 4. The progressivity of health care financing.
Bangladesh Demographic and Health Survey 2014: Key Indicators. 2015. National Institute of Population Research and Training (NIPORT), Mitra and Associates, ICF International.	Nationwide sample survey, the seventh of its kind in Bangladesh, of ever-married women of reproductive age designed to provide information on: 1. Fertility and childhood mortality levels; 2. Fertility preferences; 3. Use of family planning methods; 4. Maternal, newborn, and child health including breastfeeding practices; 5. Nutritional status of under-5 children; 6. Knowledge and attitudes toward HIV/AIDS and other sexually transmitted infections (STI); and 7. Community-level data on accessibility and availability of health and family planning services. This up-to-date information was intended to assist policymakers and program managers in evaluating HPNSDP and in designing programs and strategies for improving health and family planning services in the country.

Name of the document, year of publication, and publishing authority	Main findings
The Bangladesh paradox: exceptional health achievement despite economic poverty	Argued that the exceptional performance of Bangladesh in health sector might be attributed to a pluralistic health system that had many stakeholders pursuing women centered, gender-equity-oriented, highly focused health programs in family planning, immunization, oral rehydration therapy, maternal and child health, tuberculosis, vitamin A supplementation, and other activities, through the work of widely deployed community health workers reaching all households. Government and NGOs had pioneered many innovations that had been scaled up nationally. Bangladesh offers lessons such as how gender equity can improve health outcomes, how health innovations can be scaled up, and how direct health interventions can partly overcome socioeconomic constraints.
Harnessing pluralism for better health in Bangladesh	Suggested key areas for managing pluralism: 1. Participatory governance; 2. Accountability and regulation; 3. Information systems; and 4. Capacity development.
Community-based approaches and partnerships: innovations in health-service delivery in Bangladesh	Identified three distinctive features that enabled Bangladesh to improve health-service coverage and health outcomes: 1. Experimentation with, and widespread application of, large-scale community-based approaches, especially investment in community health workers using a doorstep delivery approach; 2. Experimentation with informal and contractual partnership arrangements that capitalize on the ability of NGOs to generate community trust, reach the most deprived populations, and address service gaps; and 3. Rapid adoption of context-specific innovative technologies and policies that identify country-specific systems and mechanisms.
Explaining equity gains in child survival in Bangladesh: scale, speed, and selectivity in health and development	Discovered that there remain significant residual inequities in survival of girls and lower wealth quintiles as well as a host of new health and development challenges such as urbanization, chronic disease, and climate change. According to the authors, further progress requires stronger governance and longer-term systems thinking that addresses health workforce shortages, shortfalls in effective coverage of services, and enhanced engagement of partners within and beyond the health system.
Reducing the health effect of natural hazards in Bangladesh	Was on impact of natural disaster in Bangladesh, and argued that urbanization and climate change created new challenges, and earthquakes remains an unaddressed threat.
Innovation for universal health coverage in Bangladesh: a call to action	Proposes a pragmatic reform agenda for achieving UHC in Bangladesh: 1. Development of a long-term national human resources policy and action plan; 2 Establishment of a national insurance system; 3. Building of an interoperable electronic health information system; 4. Investment to strengthen the capacity of the MoHFW; and 5. Creation of a supra-ministerial council on health. Short (1-5 years) and medium (5-15 years) term actions commensurate with each agenda have also been proposed.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