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End of Activity Report

2019-2024

LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

Recommended Citation: The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. May 2024. *Bangladesh End of Activity Report 2019-2024.* Rockville, MD: Abt Associates.

Date: May 2024

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USAID Contract No: 7200AA18D00023 / 7200AA19F00014

Cover photo credits:
USAID LHSS Project (top and left images), Naogaon Municipality, Bangladesh (bottom image)

This publication was produced for review by the United States Agency for International Development (USAID). It was prepared with support from the Local Health System Sustainability Project under the USAID Integrated Health Systems IDIQ.

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ACRONYMS

ADB	Asian Development Bank
AMELP	Activity Monitoring, Evaluation, and Learning Plan
CDC	U.S. Centers for Disease Control and Prevention
DDFP	Deputy Director of Family Planning
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
DP	Development Partner
EPI	Expanded Program on Immunization
ESP	Essential Service Package
FY	Fiscal Year
GKS	Global Knowledge Strategy
GOB	Government of Bangladesh
HA	Health Assistant
HSC	Health Standing Committee
icddr,b	International Centre for Diarrheal Disease Research, Bangladesh
LGD	Local Government Division
LGI	Local Government Institutions
LHSS	Local Health System Sustainability Project
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development, and Co-Operatives
NGO	Non-Governmental Organization
NUHS	National Urban Health Strategy
PHC	Primary Health Care
TLCC	Town Level Coordination Committee
TOR	Terms of Reference
USAID	United States Agency for International Development

OVERVIEW

From March 2021 to April 2024, the USAID Local Health System Sustainability (LHSS) Project in Bangladesh worked with 14 local government institutions (LGIs), including three city corporations and 11 district municipalities, to improve equitable access to locally resourced and managed primary health care (PHC) in urban areas, particularly for vulnerable populations (Figure 1). LHSS Bangladesh applies systems-thinking as part of a robust collaborative approach that addresses challenges around health system performance and aligns with local priorities and resources.

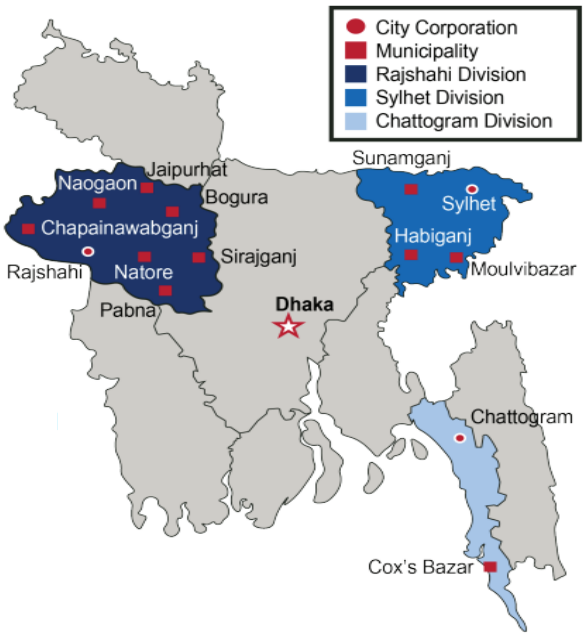
The LHSS Bangladesh Activity has two objectives:

- Improved capacity of LGIs to strategically plan, resource, manage, and monitor PHC in urban settings.
- Increased documented and disseminated knowledge about the evidence of impact and scale-up of sustainably financed models for urban PHC.

By providing targeted capacity-strengthening support for planning, coordinating, budgeting, monitoring, and managing PHC, the Activity supported LGIs in initiating the process of fulfilling their mandate to develop resilient and responsive urban PHC systems. The goal: to effectively mobilize, leverage, allocate, and use local resources to address evidence-based population needs. LGI's have very limited resources as this mandate is new so the Activity's support should be considered as establishing roles, mandates and planning processes rather than strengthening existing ones. Interventions included:

- Strengthening the capacity of LGIs to plan, resource, implement, and monitor PHC service delivery.
- Promoting local-level collaboration and partnerships in strategizing for PHC and mobilizing resources for its implementation.
- Increasing documented and disseminated knowledge about sustainably financed models and practices for urban PHC.

Figure 1: LHSS Bangladesh focal areas



Geographic areas of engagement in Bangladesh

- Sharing approaches and lessons learned among LGIs through peer-learning events and supporting LGIs in their advocacy efforts with LGD for increased resources and operational guidance for PHC.

The period of performance for the LHSS Bangladesh Activity was January 2021–April 2024. Total Activity funding was $6,350,000 over the life of the Activity.

BACKGROUND

Historically, the Government of Bangladesh (GOB) has not prioritized public health and primary health care (PHC) in urban areas relative to rural PHC[1]. The Ministry of Health and Family Welfare (MOHFW), which takes full responsibility for PHC in rural areas, is not mandated to act similarly in urban areas. The Local Government Acts from 2009 and 2010 assign the responsibility for urban PHC to their respective LGI. Historically, Bangladesh's cities and towns were largely served by vertical, donor supported PHC delivery programs, leaving LGIs without the experience or capacity to finance and manage large scale public sector PHC programs. In recent years, both donor funding and willingness among implementing partners to continue this approach has diminished, resulting in a decrease in accessible PHC services in urban areas. Recognizing the need for a solution, the GOB developed a National Urban Health Strategy (NUHS) Action Plan in 2020. This plan made urban LGIs responsible for not only managing and providing PHC services, but also for financing these programs, including dedicated budget line items with their own resources.

The Ministry of Local Government, Rural Development, and Co-Operatives (MOLGRDC) is responsible for guiding LGIs and providing them with block grants that LGIs can use only for development purposes in providing a wide range of services. Since LGIs have autonomy in how they decide to use these grants, they often prioritize infrastructure needs over investing in PHC. The health needs typically addressed by block grants consist primarily of public health activities like immunization, sanitation, and malaria control, and focus less on a holistic primary health care system that includes primary and public health services.

Drawing from guidance in the NUHS Action Plan, in early 2021, LHSS Bangladesh worked with 14 LGIs to strengthen their capacity to develop a primary care system to meet their population's needs. By engaging local stakeholders to co-assess their organizational, financial, and resource mobilization capacity, the Activity supported LGIs in co-developing locally viable strategies and building sustainable PHC service delivery models. LHSS Bangladesh started by exploring the existing gaps in PHC systems at the LGI level in budgeting, coordination, resource management, planning and monitoring. To address these gaps, the Activity engaged and revitalized existing LGI-led health standing committees (HSCs), a government-mandated platform for bringing key local health stakeholders together periodically to deliberate on health-related issues and guide LGI leadership in decision-making. LHSS Bangladesh supported HSCs in taking lead roles in strengthening urban PHC systems. Through the Activity's support in revitalizing these committees and institutionalizing their agenda-driven deliberations on priority health needs, HSCs in Activity-supported areas are more engaged and committed to prioritizing the funding and delivery of urban PHC programs. From 2023 onwards, LHSS Bangladesh worked with six LGIs to prepare costed PHC implementation plans for fiscal year (FY) 2023–2024.

[1] Urban PHC is not defined in any guidelines in Bangladesh. There is a defined essential package of services but in the absence of specific guidance LGI's determine what to include in their PHC implementation plans. The Activity has encouraged LGIs to use the WHO comprehensive definition of PHC, including public health activities in addition to personal facility-based care personal care, as an objective, recognizing that given low capacity, experience, and resources, LGI's will start with a minimal set of services.

ACHIEVEMENTS

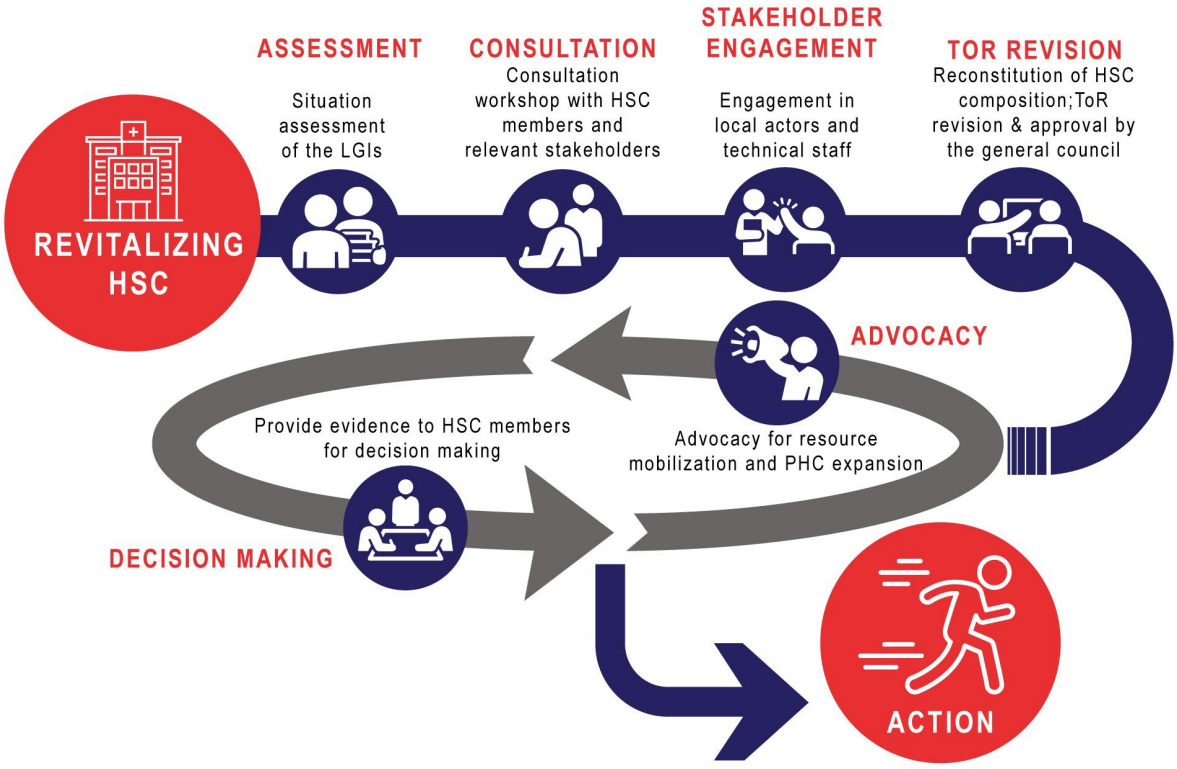
OBJECTIVE 1: IMPROVED CAPACITY OF LGIS TO STRATEGICALLY PLAN, RESOURCE, MANAGE, AND MONITOR PHC IN URBAN SETTINGS

SUB-IR 1.1: IMPROVED CAPACITY OF LGIS TO ENSURE ACCESS TO PHC

Revitalization of health standing committees

LHSS Bangladesh worked closely with city corporations, district municipalities (LGIs), and revitalized HSCs, playing a key role in getting focal LGIs to develop and approve terms of reference (TORs) that define stakeholder roles and enhance coordination. By including representatives from the MOHFW and non-governmental organizations (NGOs) into membership of HSCs, LHSS Bangladesh strengthened local management capacity to address PHC challenges. Figure 2 illustrates the process by which LHSS supported the revitalization and regular convening of HSCs where its members are now actively engaged and providing crucial financial, human resource, and logistical support for PHC initiatives.

Figure 2: HSC revitalization process



In mid-2023, the Activity conducted an operational research study to measure the effectiveness of the HSC revitalization process. The study was carried out in two city corporations and five municipalities supported by LHSS Bangladesh. It included key informant interviews and focus group discussions with LGI officials, staff, and others.

Findings showed that many HSC members learned about the government's legal mandate that LGIs assume responsibility for PHC due to LHSS's HSC revitalization work.

As one key informant from Sirajganj Municipality, Rajshahi Division shared:

“We had the health standing committee only on paper. All the meetings conducted before also were on paper. The members just signed in, but the meeting did not happen. After the LHSS Bangladesh project started working here, the health standing committee has been reformulated and strengthened.”

The study found that, across all municipalities, the selection of HSC members aligned with the TOR, which included a provision to engage members from non-LGI institutions associated with health-related activities. (e.g., the Directorate General of Health Services (DGHS), the MOHFW’s Directorate General of Family Planning (DGFP), development partners, and NGOs). The roles and responsibilities of HSC members outlined in the TOR ensured the effective functioning of these committees.

Another key informant from Sylhet City Corporation described an HSC meeting and how it had changed with LHSS’s support:

“*We were doing the same work before LHSS Bangladesh started their intervention but there was a difference. The difference was that we did not conduct the meeting systematically. In addition, now the committee includes multi-stakeholders from other sectors.”*

The operational research study found that the HSC decision-making process was participatory, and that HSCs effectively referred recommendations to the General Council or town-level coordination committee for approval. The study indicated that all LGIs used findings from a PHC mapping exercise that the Activity and LGIs had conducted during 2021 to identify vulnerable areas and populations lacking PHC services. For example, HSCs in Habiganj and Moulvibazar selected the locations to set up their first PHC centers based on population density, the number of poor residents, and their limited access to health care.

“During the plan preparation phase, we were struggling to identify locations for establishing PHC centers,” noted a medical officer from Sirajganj. *“The PHC mapping exercise helped us to identify priority wards. We have identified that large numbers of migrants (climate vulnerable) are living in this ward, which is far away from the rest of PHC centers.”*

LHSS Bangladesh’s support in revitalizing HSCs has yielded tangible results. The committees have started meeting regularly, addressing their lack of technical expertise by “crowding-in” expertise with participation from the MOHFW, making evidence-based recommendations, and encouraging LGIs to act on those recommendations.

For example, the HSC in Rajshahi City Corporation recommended re-opening a city hospital, while the HSC in Bogura decided to re-open four closed clinics. Similarly, HSCs in Habiganj and Moulvibazar municipalities decided to open a new PHC center (by renovating a community center) and a new satellite center, respectively. These decisions were validated at higher levels of government and implemented with support from the Activity. While some LGIs considered capital expenditures, the Activity persuaded planners to use existing infrastructure and equipment from former ADB or USAID-supported clinics or other buildings. This allowed LGIs to direct their limited funding toward human resources, medicines, and public health campaigns.

Despite these successes, additional improvements in HSC functionality are still needed. For example, ensuring greater and more consistent participation of all participating members and opening up the committees to be even more inclusive through representation from private providers (e.g., clinic diagnostic, pharmaceutical, and drug and chemist associations). Other LGI

units and departments such as the Conservancy Unit, whose work impacts public health outcomes have also expressed interest in participating in HSCs.

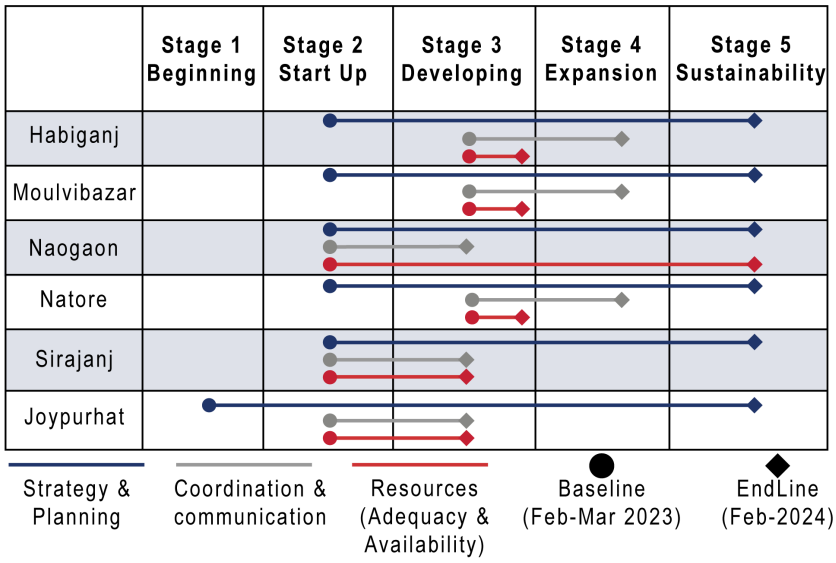
Strengthening LGIs' capacity for preparing PHC implementation plans

In the absence of technical implementation guidance for PHC planning in LGIs (the costed NUHS is not accompanied by detailed guidance for operational planning with limited budgets), LHSS Bangladesh developed a template for PHC planning and training materials for the preparation of plans. The Activity conducted comprehensive training for six LGIs (LGI staff and HSC members) in Habiganj, Moulvibazar, Natore, Naogaon, Joypurhat, and Sirajganj. The curriculum focused on enhancing their capabilities in PHC planning, budgeting, mobilizing resources, engaging with stakeholders, and monitoring PHC activities.

LHSS Bangladesh then supported the six LGIs in advocating for and developing a costed implementation plan centered on urban PHC service delivery and public health interventions. The Activity supported the HSCs in conducting an LGI mapping exercise to identify communities without access to a PHC facility and the location of existing infrastructure that could be used for this purpose. This initiative led to the preparation of costed PHC implementation plans tailored to the specific needs of each LGI. HSCs were critical to this process because LGI health units have very limited staff with little or no public health or planning experience. HSCs helped LGIs access the necessary expertise by engaging other LGI health department units.

The Activity then supported the LGIs in advocating with key decision-making bodies (e.g., town level coordination committees and the General Council) to ensure PHC plans were approved, signed, and integrated into the annual budgets of each municipality. The collective PHC annual budgets for FY 2023–2024 across the six municipalities totaled $200,490 (Bangladeshi Taka [BDT] 22.1 million), a substantial 78 percent increase over the previous fiscal year. The increased funding was sourced primarily from LGI's own municipal revenues, supplemented by MOLGRDC-funded block grants and external funds.

Figure 3: Organizational Capacity Assessment Findings



LHSS Bangladesh conducted an organizational capacity assessment to measure changes in LGIs' organizational performance as a result of capacity-strengthening support (Figure 3). For additional details on the definition of capacity dimensions, stages and scoring, please refer to Annex-E.

The Activity conducted a baseline assessment covering February to March 2023 and an endline assessment in February 2024. A comparison of these two assessments shows that six LGIs reached the "sustainability" stage in the "strategy and planning" domain. Three LGIs reached the "expansion" stage in the "coordination and

communication with stakeholders" domain. In the "resources" domain, five LGIs are in the developing stage. Habiganj, Natore, and Moulvibazar are in the developing stage, similar to their baseline. However, over time, their PHC services have expanded and have now reached an advanced stage, leading to increased demand for financial resources for managing operational costs. Although these LGIs have increased the PHC budget allocation over amounts budgeted last year, they feel the allocated amount is insufficient to ensure the quality of services. Naogaon stands out for progressing to the "sustainability" stage in resource management from its initial "start-up" phase in the baseline. Operating two PHC centers on a small scale has kept Naogaon's operating costs manageable and within their municipality PHC budget.

With LHSS's support the six LGIs developed costed PHC plans for the first time that were partly funded through their revenue budgets and are already experiencing the benefits. For example, there is an improved ability of LGIs to mobilize resources from external stakeholders; there is improved coordination among stakeholders during the plan preparation process, and increased implementation of public health interventions (e.g., administering deworming tablets among school children and insecticide fogging for killing mosquitoes) (Box 1). Despite these improvements, challenges and opportunities remain. For example, LGIs could make PHC plans more comprehensive by including emergency response elements such as addressing outbreaks of dengue or climate-induced health shocks. In addition, coverage by the current plans remains low and a substantial increase in financial resources is required for significant coverage increases.

Box 1: A municipality leader shares their story on implementing the collaborative model

"This year, we initiated the opening of a primary health care center in one of our wards. We have arranged the building for the center, but our main concern was managing the monthly supply of medicines and equipment identified the potential stakeholders who can support us with resources. We have reached out to the Pharmaceutical Representative Association (PHAREA) and Clinic Owners' Association. We have had meetings with them and were able to secure a regular medicine supply from PHAREA for the center. The clinic owners' association has also committed their cooperation. These developments have changed our perspective regarding resource management and opened up new possibilities!"

Uma Chowdhury, Mayor of Natore Municipality at the workshop on "Developing and Implementing Primary Health Care Plans: Lessons Learned and Best Practices" held in August 2023.

SUB-IR 1.2: IMPROVED IMPLEMENTATION OF PHC ACTIVITIES BY LGIS

PHC plan implementation progress

All six LGIs started implementing their planned PHC activities in FY23. The Activity oriented HSC members (e.g., elected councilors, members of the Civil Surgeon and Family Planning offices, and officials from all six municipalities) on implementing PHC plans and monitoring service delivery. LHSS also supported municipalities in establishing PHC management and

monitoring teams and oriented them on the TORs. This training included tracking the progress of planned activities, mobilization of essential resources towards operational readiness of PHC centers, mechanisms for recording, reporting, and monitoring activities, and strategically engaging communities through health awareness campaigns.

As a result of the Activity's support, each municipality's health department led the rollout and monitoring of their respective PHC implementation plans with guidance from HSCs. For example, Habiganj, Natore, and Naogaon municipalities used a collaborative approach to establish PHC centers in underserved wards through a partnership with key local stakeholders, repurposing empty buildings and office spaces and renovating these new venues using their revenue budget. In addition to the collaborative approach or model, LHSS identified two additional PHC service delivery models being implemented across its geographic region: a contracting model implemented in Bogura and a self-financed and implemented model in Chattogram City Corporation. The Activity collaborated with the LGIs to document these models and share the learnings among LGIs that prepared the PHC implementation plans. Box 2 describes the different approaches used. Bogura's contracting model is discussed in further detail below.

Box 2: PHC models documented and used for LGI peer learning

Collaborative Model: In this model, healthcare services are delivered through a collaboration between the municipality and additional stakeholders, including government health offices such as the MOHFW's Civil Surgeon's and Family Planning Offices, private sector organizations, local elites, and local non-governmental organizations. The municipality provides financial and human resources and coordinates to ensure additional funding and provision of health care personnel, equipment, and medicines through stakeholder collaboration.

Contracting Model: This model is a public-private partnership approach where LGIs collaborate with private healthcare providers to deliver an agreed package of essential services (i.e., nutrition, maternal health, newborn, infant, and child health). Under this model, the LGI enters into contractual agreements with private entities, outlining the terms and conditions for service delivery.

Chattogram City Corporation: Using their own revenue and block grant allocations from the Local Government Division, LGIs deliver PHC through their own facilities and salaried health care personnel and procure their own medicines.

To support the implementation of the PHC plans and functionality of PHC centers, LGIs planned to mobilize resources from various stakeholders. Municipalities planned to contribute approximately 42.5 percent of the budget from their own internally generated revenue, with an additional 24 percent coming from central block grants from the MOLGRDC. The remaining funds were to be sourced from external funding streams such as grants from development partners, donations from non-resident Bangladeshis, local elites, corporate social responsibility initiatives, and corporate funding. The Activity supported LGIs in advocating with MOLGRDC and non-government institutions for mobilizing more resources and technical guidance. This advocacy was done by facilitating the planning and logistics of meetings and presenting evidence-based materials like LGI mapping of vulnerable communities and costed PHC implementation plans.

All six LGIs intensified public health awareness activities, such as school health programs, dengue prevention campaigns, vitamin A supplementation campaigns, and deworming programs, often in partnership with national health campaigns and national school health

programs. The Activity ensured that municipalities included these activities in their implementation plan, expanded them where possible, and monitored progress against their implementation plans.

The Activity's support resulted in all six LGIs making progress on implementing their PHC plans. Monitoring reports indicated progress on implementing planned activities, including higher spending by LGIs on PHC and improved collaboration with local stakeholders. In all six LGIs, HSC members regularly track and review the progress of the implementation of the PHC plan. Figure 4 illustrates municipality-level progress against selected indicators.

Figure 3: PHC Plan Implementation Progress (July 2023 – February 2024)

Indicators	Habiganj	Moulvibazar	Sirajganj	Naogaon	Natore	Joypurhat
No. of new PHC centers and satellite clinics established by municipality	1	2	0	2	1	0
No. of outpatient visits in PHC centers, new satellite clinics & local pharmacies managed by LGIs	1523	645	25918	1924	1252	1789
No. of children fully immunized under EPI program by LGI (in satellite clinics and PHC centers)	1392	982	28985	2413	1938	1370
No. of new health care providers mobilized from CS DDFP NGO	5	0	0	0	1	0
No. of new health care providers recruited by the LGIs	1	0	0	2	1	0
No. of schools where health education/health promotion program were organized	90	58	42	130	30	87
No. of ward-level meetings organized for building health awareness	5	9	118	6	3	7

By implementing PHC plans, all key health system functions were strengthened. These included service delivery (by opening new service points in PHC centers or satellite centers), human resources (recruitment, secondment of human resources on a part-time basis from offices of the Civil Surgeon and the Deputy Director of Family Planning, increased availability of medicine (through procurements and in-kind donations), monitoring (including established mechanisms for data collection and analysis), and governance (through engagement of stakeholders). LGIs did face challenges in implementing their PHC plans. For example, some were unable to mobilize resources in a timely manner due to delays in regular follow-up with non-government or private sector stakeholders, while others were slow to appoint public health officers and other support staff required to strengthen the capacity of their health units. Some specific successes are provided below.

Supporting LGIs in human resource optimization

In FY 23, LHSS collaborated with Rajshahi City Corporation to train 146 under-utilized health assistants in community-based preventive and promotive components of the Essential Service Package (ESP).

The Activity supported Rajshahi City Corporation in revising its health assistant job description, developing training materials, and orienting its 146 health assistants on their updated position

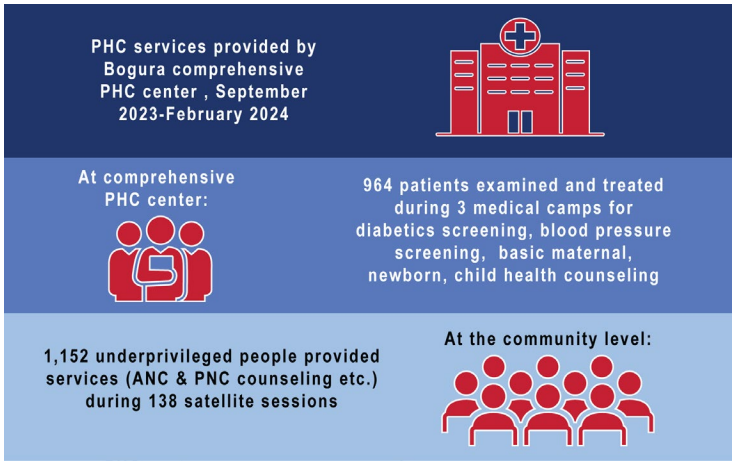
responsibilities. LHSS also supported training on selected ESP components, including the pregnancy registration reporting mechanism and on using the monthly reporting form for health assistants.

With LHSS support, the city corporation increased the effectiveness of its health workforce by optimizing the role of its existing health assistants. As a result, newly trained health assistants provided counseling services to 2,526 adolescent girls, 1,404 pregnant women, and 2,149 lactating mothers between June–August 2023. Similar interventions could be implemented in other LGIs where the available health workforce is underutilized, provided that revised job descriptions and training are included in this effort. A summary of this activity has been developed.

Bogura Municipality's contract management capacity strengthened and used for PHC

Through a public-private partnership approach, LHSS Bangladesh supported Bogura municipality in contracting out health infrastructure (i.e., four previously non-functional but equipped clinics) to a private, non-governmental organization to deliver PHC services (Figure 5). To oversee the functioning of the contracted private agency, the Activity supported the Bogura municipality in establishing a Contract Management Committee, orienting the committee on its TOR, and establishing a reporting mechanism from the contracted organization. Originally, the contractor shared the progress of health care services and challenges with the municipality through in-person meetings and emails without LHSS Bangladesh support. However, by the end of the Activity, the contractor was adapting and rolling out health service registers (provided by the Ministry of Health and Family Welfare) and reporting forms in accordance with national standards.

Figure 4: Bogura Municipality Results, September 2023 – February 2024



LHSS Bangladesh's support to Bogura municipality strengthened its capacity to manage the contracting and contract management processes for PHC. The contractor has operationalized one of the four PHC centers (i.e., the comprehensive PHC center). Since September 2023, the contractor has organized health camps and community-based satellite sessions to provide PHC services. The main purpose of these health camps and satellite sessions is to generate demand for services from the new comprehensive PHC center. Since December 2023, Bogura municipality has used the comprehensive PHC center to hold vaccination clinics under the Expanded Program on Immunization (EPI). Bogura's contractor has generated notable interest among other Activity-supported LGIs that are interested in learning from the Bogura experience.

OBJECTIVE 2: INCREASED DOCUMENTED AND DISSEMINATED KNOWLEDGE ABOUT EVIDENCE OF IMPACT AND SCALE-UP OF SUSTAINABLY FINANCED MODELS FOR URBAN PHC

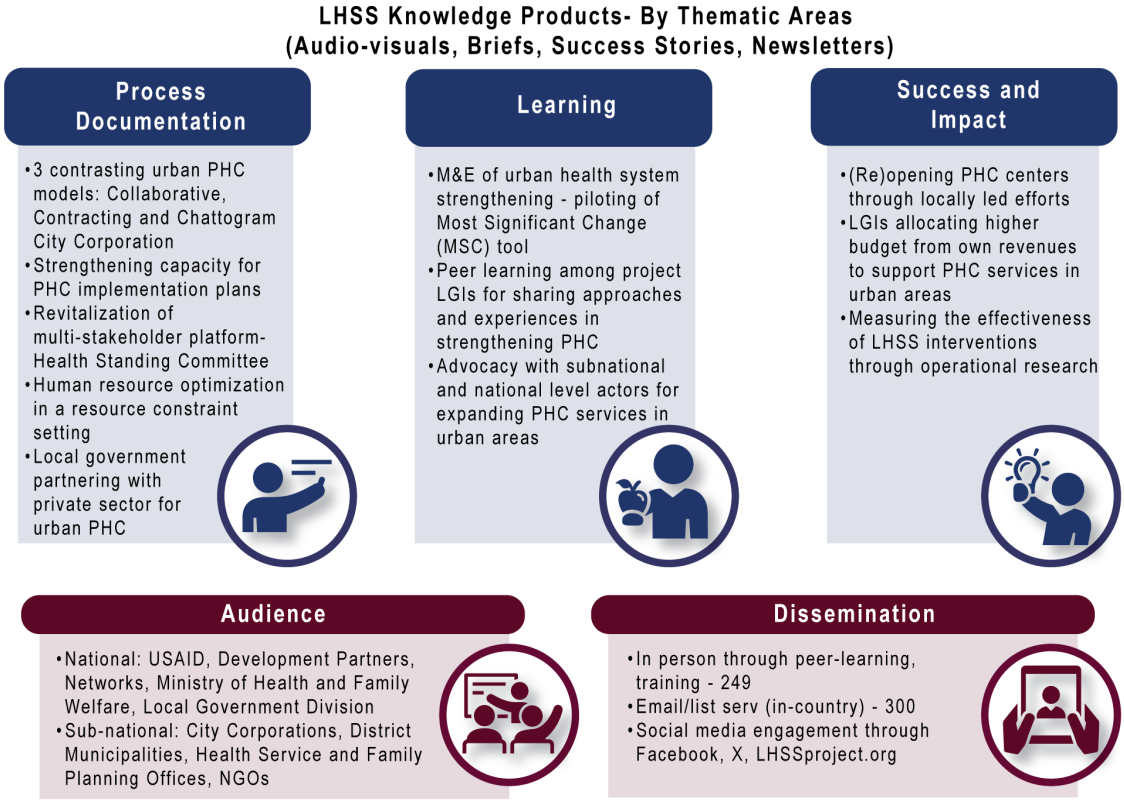
SUB-IR 2.1: INCREASED DOCUMENTATION OF EXISTING LOCALLY RESOURCED MODELS, IDENTIFYING RESOURCES USED, PROCESSES FOLLOWED, AND IMPACT MADE

Document and disseminate various PHC approaches

The LHSS Bangladesh knowledge management approach includes documenting and disseminating knowledge and evidence on sustainable and effective urban PHC models to targeted internal and external audiences. The Activity produced and disseminated various knowledge products, including audio-visuals, briefs, newsletters, and success stories. For example, two learning briefs document the Activity's support in revitalizing HSCs and in leveraging this platform to strengthen the health system functions for urban PHC through local stakeholder collaboration. Similarly, LHSS documented the processes and learnings from Bogura's experience contracting out public health infrastructure to a private agency to provide PHC services. These products were disseminated to key audiences such as development partners, LGIs, LGDs, and urban health networks through various channels, including in-person events, the LHSS global website, social media, and email newsletter. The Activity also hosted knowledge-sharing workshops. Figure 6 summarizes LHSS Bangladesh's work developing and disseminating knowledge products throughout the life of the Activity.

These resources proved valuable to national and local governments and development partners dedicated to enhancing urban PHC in Bangladesh. For example, the learning briefs on HSC were instrumental in encouraging LGDs to issue an order making the representation of the Civil Surgeon and Family Planning in HSCs mandatory for all LGIs. Similarly, LHSS's support in establishing a comprehensive health clinic in Bogura through a public-private partnership sparked interest among other LGIs during the Activity's mayor's dialogue event.

Figure 5: LHSS Bangladesh's development and dissemination of knowledge products



Measuring the effectiveness of LHSS Bangladesh interventions through operational research

To measure the effectiveness of its interventions, LHSS Bangladesh provided a grant to the International Centre for Diarrheal Disease Research, Bangladesh (icddr,b) to carry out operational research. The research evaluated the effectiveness of the Activity's capacity-strengthening support to revitalize HSCs and develop PHC implementation plans. It also identified barriers, opportunities, and conditions for sustainability for these interventions in urban settings. Findings from the research indicate that LHSS Bangladesh's capacity strengthening initiatives improved knowledge and understanding among HSCs about their mandate to provide PHC through costed public health and PHC implementation plans (Box 3).

Box 3: Key Findings from Operational Research

- LHSS Bangladesh interventions played a crucial role in revitalizing HSCs. All LGIs successfully developed and approved comprehensive TORs. In most LGIs, HSC meetings were conducted as specified in the TOR.
- The technical assistance and capacity-building initiatives of LHSS Bangladesh have been pivotal in empowering LGIs to develop and implement PHC plans.
- Activity-supported community needs assessments enabled all program municipalities to identify vulnerable communities with limited access to PHC services. This data was used to ensure that PHC centers were established in areas with high needs.
- All municipalities were able to allocate budget from revenue sources for PHC implementation, but local resource mobilization from the non-public sector varied across LGIs.
- LHSS Bangladesh interventions facilitated and strengthened coordination between MOHFW (DGHS and DGFP) and MOLGRDC.

SUB-IR 2.2: ESTABLISHED AND SUPPORTED PEER LEARNING AND DISSEMINATION OF PHC MODEL EXPERIENCE

Peer learning

LHSS Bangladesh used peer learning approaches to facilitate learning among LGIs. This was achieved by supporting LGIs in showcasing their progress toward expanding access to PHC services and facilitating opportunities for LGIs to learn from each other's experiences. The Activity facilitated four peer learning sessions that influenced decision-making in LGIs (e.g., Bogura and Habiganj municipalities and Rajshahi City Corporation), which have self-financed the establishment of PHC centers. Habiganj established plans to hire its own staff (including a doctor), while Rajshahi was initially unwilling to consider using its own resources to start up a PHC initiative because Asian Development Bank-supported facilities were still operating there. After hearing about the initiative less wealthy LGIs took, however, the chief health officer changed strategic direction at the second peer learning session and began preparing a PHC implementation plan. The peer learning workshops have influenced six LGIs to prepare and endorse integrated PHC implementation plans encompassing service delivery and public health interventions.

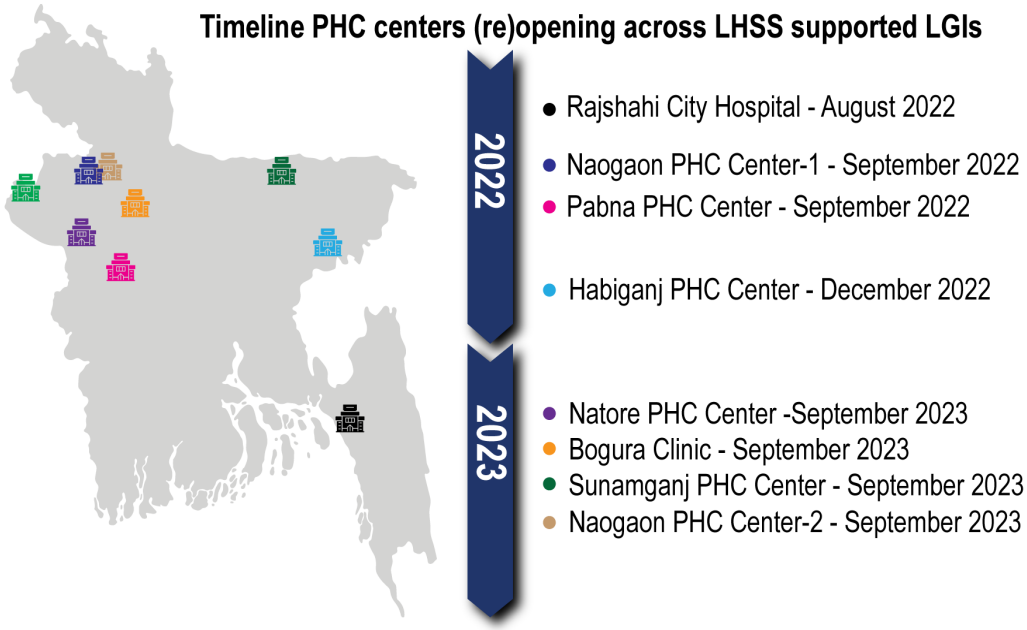
The first peer learning event attended by officials from Rajshahi and Sylhet City Corporation was held in Moulvibazar in March 2022. Participants discussed reopening closed centers and opening new facilities in underserved wards. They also vetted initial ideas on establishing a collaborative model to generate resources from local actors. In September 2022, LGIs shared their experiences of reopening PHC centers at a second event held in Rajshahi City Corporation. The positive peer engagement during these events contributed to an enhanced comprehension of the technical assistance provided by LHSS Bangladesh. The event also sparked discussion on establishing PHC centers in Habiganj and Moulvibazar, and other LGIs expressed interest in replicating the contracting model used by the Bogura municipality (Box 4).

Box 4: Lessons and Recommendations from Peer Learning Convenings

- Peer learning has been an important tool used by LHSS Bangladesh to engage with LGIs who, understandably, value experience from their peers over theoretical models that technical assistance can provided.
- Peer learning that provides an LGI the opportunity to publicly present what it has achieved on PHC had a "positive peer pressure" effect on other LGI in addition to sharing learnings
- LHSS revealed the absence of an effective learning relationship for PHC between LGIs and the Local Government Division – their parent ministry. An institutionalized mechanism for a regular dialogue among these parties is necessary for advancing urban PHC financing and implementation.

In FY 24, LHSS Bangladesh facilitated two regional peer learning workshops attended by eight LGIs from Sylhet and Rajshahi regions that enabled participants to exchange knowledge, share progress in implementing their PHC plans, and strategize on sustaining and expanding their efforts. The events emphasized coordination and knowledge-sharing, leading to a commitment among municipalities, including Habiganj and Moulvibazar, to strengthen PHC services by leveraging sustainable resources and effective stakeholder partnerships. The timeline of PHC center openings and reopenings in Figure 7 reflects how peer learning events influenced subsequent PHC investment decisions.

Figure 6. Sharing of experience in peer learning sessions, resulting in PHC center establishment



The Activity also supported five LGIs from Habiganj, Natore, Sirajganj, Rajshahi City Corporation, and Chattogram City Corporation in conducting peer-learning visits (e.g., to Chattogram City Corporation) to see various PHC models in practice. The purpose of these visits was to facilitate the replication and scale-up of similar models in urban areas.

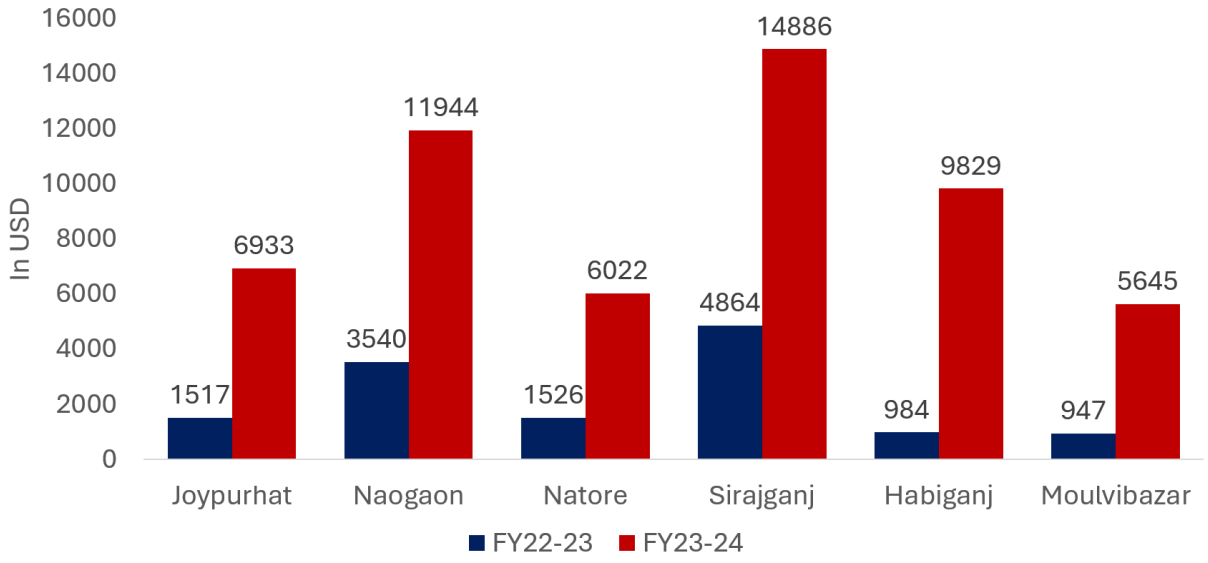
As a result of LHSS's peer learning support, LGIs were encouraged to implement their PHC mandate, increasing their PHC allocation from $44,639 (BDT 4.9M) in 2022-23 to $202,259 (BDT 22.2M) in 2023-24 using internally generated revenue.

LHSS support for advocacy efforts at the national and sub-national level

LHSS supported the MOLGRDC in organizing two workshops on PHC to understand LGIs' efforts to expand access to PHC and identify their challenges and constraints. These workshops resulted in the MOLGRDC issuing revised guidance for strengthening HSCs and increasing the block grant for PHC activities from $455,561 (BDT 50M) in FY 2022–2023 to $637,817 (BDT 70M) in FY 2023–24.

Figure 8 illustrates increased funding through LGD block grants allocated to Activity-supported LGIs. To support the scaling of LGIs' efforts in PHC, the MOLGRDC has begun drafting standard operational procedures for urban PHC, effectively taking over the process started by LHSS Bangladesh in these six LGIs. The results from these efforts (Box 5) can be attributed to several intentional outcomes of the Activity's support, including advocacy supported by LHSS Bangladesh but led by the LGIs themselves, presenting their experiences developing and carrying out their PHC implementation plans. Second, the implementation plans were costed and progress against these plans was evidence-based. Having reliable data was crucial for effective advocacy to the MOLGRDC.

Figure 7: LGD block grants for PHC (in USD) for LHSS Bangladesh-supported LGIs. Source: LGD official circular



Box 5: Key Results from National Advocacy

First advocacy event

- The LGD gained a better understanding of the resource constraints facing LGIs and understood the value of providing block grants to LGIs for PHC.
- The LGD learned about the positive role being played by HSCs in strengthening LGIs' PHC activities. This learning contributed to the LGD issuing revised official guidance on HSCs nationwide in April 2023.

Second advocacy event

- The LGD learned how the six Activity-supported LGI's had prioritized PHC, as evidenced by their implementation plans and progress.
- The LGD was made aware of the need to provide guidance to LGIs for operationalizing their PHC mandate.

Additional LHSS Bangladesh support at the national level

In its first year of implementation, the Activity completed the NUHS 2020 Action Plan costing in partnership with the University of Dhaka, following extensive consultations with development partners, expert groups, and the technical working committee (a small informal group formed by the USAID Mission in Bangladesh). LHSS supported this committee in developing a concise brief for policymakers. This brief was effectively used by the committee to advocate for shaping the Urban Health Operational Plan within the GoB's fifth Health Population Nutrition Sector Plan, which notes and prioritizes the needs of urban populations.

The Activity collaborated with the Directorate General of Health Services in the MOHFW to ensure that the directorate receives regular PHC reports from private providers. Reliably receiving this information is important to the directorate's efforts to improve its decision-making processes. Specifically, LHSS Bangladesh supported drafting a legal mandate requiring private sector health service providers to routinely share PHC data with the Ministry.

The Activity also supported the development of a public financial management training manual, which was reviewed by the National Academy for Planning and Development, the Ministry of Finance, and the MOHFW. The final materials were handed over to the Finance Management and Audit Unit of Health Services Division after MOHFW identified financing to carry out these trainings at scale.

LESSONS LEARNED

LHSS Bangladesh identified and documented lessons learned from the activity implementation experiences. To capture these learnings, the Activity applied various methodologies such as progress review meetings, pause and reflect sessions, stakeholder interviews, and operations research. To identify lessons learned about the determinants of health system performance improvement, LHSS Bangladesh invited a selection of counterparts to participate in LHSS's global-level initiative known in the project as the Global Knowledge Strategy (GKS). This section presents important lessons learned that provide recommendations for future program design in the context of urban public and primary health systems.

Lessons learned from implementation experience

Throughout the project, LHSS Bangladesh prioritized learning and adaptation, routinely holding 'Pause and Reflect' sessions as part of its activity monitoring, evaluation, and implementation of the learning plan. The Activity adapted its programming based on the lessons identified during these sessions.

Politics, leadership, and coordination

- **LGI leadership and management are highly political; therefore, consistent engagement with this group is required to ensure support for resource mobilization to expand PHC access.** LGIs are more political in nature relative to the MOHFW, which is more technocratic. Health departments within LGIs are not affiliated with the MOHFW. So historically, collaborative efforts have been limited to immunization and occasional partnerships on national campaigns for vitamin deficiency or other disease-specific programs. Activity implementation focused on capacity strengthening, engagement, advocacy, and collaboration skills within the health departments and LGI leadership. The need to develop these skills reflected PHC objectives that shifted away from the delivery of a few specific preventive services (e.g., immunization, vitamin supplementation) toward managing a more complex system that considers population needs more holistically. The health departments had to combine public health objectives with LGI leadership political objectives to obtain buy-in for a more resource-intensive approach relative to letting development partners address PHC needs or not providing PHC at all. Focused and sustained engagement activities will need to continue for successful resource mobilization and further expansion of PHC programs, especially at times of government or political leadership change.
- **LGI health units have limited technical capacity; therefore, engaging and collaborating with elected representatives and other LGI units is required to expand capacity.** The health department and PHC focal point can achieve this through the HSC membership, which includes the Pouro Nirbahi Officer, social development officer, town planner, accounts officer, and other health department unit officers such as sanitary inspectors, conservancy inspectors, EPI inspectors, and the assistant engineer for water supply. The health department unit responsible for managing PHC is the immunization unit, which has few staff, mostly vaccinators, and typically none with management or planning capacity. This engagement, through the HSC member collaboration, was and will be critical for 'crowding-in' in missing expertise, skills, and connections, as well as conducting advocacy for more financial resources when expanding access further.
- **Effective and integrated coordination and implementation among health department sub-units (e.g., conservancy, water and sanitation, EPI) in LGIs is essential for addressing public health and PHC challenges**. While LHSS Bangladesh brought representatives from all three units together during the preparation of PHC plans, coordination among them during implementation is also crucial. Institutionalizing coordination between the three units through periodic meetings is important, and all three units' activities should be reflected in the PHC plans in the future.
- **LGIs' financial scope for contracting is limited for now but contracting capacity should be developed as budgets are increasing.** Although 14 NGOs participated in a pre-bid meeting for the Bogura Municipality contracting process, only one submitted a proposal. This resulted in less negotiating power and dilution of certain clauses within the contract, particularly those regarding the rent amount and the provision of medical equipment for the

PHC center, which was the main LGI or "public" contribution to the partnership. To secure more attractive terms for the contract, more competition is required. As budgets/resources for PHC increase, more scope may increase the attractiveness of such contracts to NGOs. Additionally, to increase the number of proposal submissions in future bids, offering more in-person pre-bid workshops, longer bidding periods, and more comprehensive technical support to potential contractors is essential.

Capacity building

- **Traditional didactic training is the norm, but adult learning approaches are more effective and appropriate.** LHSS reviewed existing training materials, finding they were presentation-heavy, jargon-laden, and not geared toward LGI audiences focused on PHC. Therefore, LHSS developed a tailored curriculum, refined during each training, and used a range of tools such as posters, charts, role-playing, storytelling, and group work. This approach increased participants' engagement in the learning process, built on their experiences managing local government processes, and enhanced their understanding of the content.
- **Ministry of Health and Family Welfare engagement is critical so that LGIs can benefit from the health ministry's experience and resources.** LGIs need to leverage the capacity of the MOHFW to develop and implement PHC plans. LHSS Bangladesh found that local government-level MOHFW units like the Civil Surgeon and Family Planning departments are experienced in strengthening the capacity of health staff/officials on PHC monitoring, quality assurance, and service delivery because they run secondary-level facilities and model PHC-type facilities that deliver PHC services. Their engagement with LGIs supported the capacity building of LGIs' health staff on the maternal, child, and adolescent health programs, immunization programs, management of emergency health issues (e.g., dengue and COVID-19), and their reporting processes. The Activity found that these MOHFW units at the sub-national level were eager and willing to engage and offer support to LGIs but that this collaboration needed nurturing to become regularized.
- **Establishing a mechanism for regular dialogue between the LGD and LGIs, such as peer learning events, can serve as an advocacy opportunity and promote 'positive' peer pressure between LGIs.** These types of information and learning exchange mechanisms strengthen the capacity to advance the PHC agenda. This experience-sharing culture creates an opportunity for learning about urban PHC best practices. Existing platforms like the Municipal Association of Bangladesh could be explored.

LHSS GLOBAL KNOWLEDGE STRATEGY: UNDERSTANDING THE FACTORS THAT DETERMINE HEALTH SYSTEM PERFORMANCE

As a global project, LHSS is carrying out its Global Knowledge Strategy, an initiative to broadly disseminate lessons and promising practices to inform and advance the global field of integrated health system strengthening. As part of this effort, LHSS Bangladesh performed an in-depth exploration of the local health system performance improvements it contributed to over the life of the Activity. Using the GKS standardized methodology (Annex C), the LHSS Bangladesh convened counterparts and stakeholders to identify key health system performance improvements connected with its work, study the factors that affected the improvements, and identify the conditions and actions needed to sustain the improvement.

For the Bangladesh Activity, health system performance improvement was defined as "improved coordination, management, and oversight by the municipality health department and other LGI units to strengthen budgeting, planning, and implementation of the municipality's PHC system with GOB resources." The LHSS activity focused on strengthening specific processes and skills within LGI's health department, which is responsible for implementing PHC and public health activities. While budgeting, planning, and implementation processes are PHC-specific, LHSS also needed to strengthen the more general skills of this unit's staff, specifically coordination and management, to ensure that the PHC-specific technical activities could be implemented successfully, leading to the PHC access improvements shared in this report.

During a workshop held in March 2024, LHSS Bangladesh reviewed and validated this performance improvement and its supporting evidence with its LGI counterparts. The LGI and LHSS teams then identified factors that obstructed or enabled the achievement of this performance improvement. Annex C presents additional information on the GKS process and framework applied in this Bangladesh exercise.

Table 1 presents the enabling or impeding factors and actionable lessons the LGI and LHSS teams identified. These lessons are a combination of actions supported by LHSS Bangladesh and other actors, including LGIs, HSCs, and LGDs. The enabling and inhibiting factors are organized into three domains: capacity, resources, and political will/stakeholder engagement. Factors identified by workshop participants as most significant are presented in Table 1.

Table 1: GKS findings on perceived positive and negative determinants of health system strengthening improvements with mitigating or supporting actions and actors

Main Determinant	Lesson	Actors | Supporting or Against
Resources		
Advocacy with LGD (Local Government Division) for increased block grants was successful and resulted in additional resources Positive (+)	• Use data and experience sharing to build LGD confidence that the LGI can spend PHC earmarked budget well by assessing the use of money with objective criteria, including plan performance, and by following LGD instructions. • LGD should provide operational guidance to LGIs on what to spend the funding on. • Advocacy should be done collectively by LGIs (e.g., through Municipalities Association of Bangladesh).	• LGI health department Chief Health Officer must be fully committed to this work as it is time-consuming and additional to their existing responsibilities (LHSS was not able to make progress in LGI's with non-committed officers and intensive support was wound down). • Mayor's engagement critical to be the LGI "spokesperson" in front of the LGD.
Lack of human resources for health or management, medicine, and other resources at the onset Negative (-)	Constraints faced by LGIs can be mitigated: • Resources to address medicines and HRH can be obtained through collaboration with partnership/advocacy with the private sector. • Resources (essential medicines) were mobilized from the health ministry's Directorate General of Health Services and Directorate General of Family Planning units via district hospitals by some LGIs. • Initially LGI's believed that they were not allowed to hire doctors but once one LGI set aside resources to do so and then hired a doctor and shared that experience through peer learning, then other LGIs replicated these activities. • LHSS Bangladesh supported peer learning has gathered and shared mitigation measures used across LGIs.	• LGD with technical support from MOH and facilitation support from partners would: a) Develop detailed operational guidance that could be provided to LGIs to support the effective use of block grants for PHC. b) Engage the health ministry's Directorate General of Health Services and Directorate General of Family Planning to develop and disseminate guidance to its sub-national district offices to support LGIs.
Mobilizing adequate financial resources for PHC at the local level	• Strengthen LGIs' capacity for transparency in resource use and demonstration of its impact.	• Ministry of Finance and LGD to work with selected LGIs to establish good practices in expansion of fiscal space, for

Main Determinant	Lesson	Actors | Supporting or Against
Positive (+)	• Establish mechanisms for regular follow-up with key stakeholders. • Make a convincing case for mayors to invest more in PHC with evidence of gaps/needs • Expand fiscal space at LGI level through technical assistance for improved tax compliance and ear marking	transparency in resource use and its impact via resource tracking and making a case for higher block grants from LGD and higher allocations by LGIs from their revenue budget.
Capacity		
Lack of guidance on implementing PHC at national level Negative (-)	• Although the costed action plan of National Urban Health Strategy (NUHS) 2020 developed by MOH in consultation with LGD does contain some guidance, it is high level. LGIs needed specific, guidance at the operational level which LHSS developed and trained them on	• Urban Development Wing of LGD with help from DPs to gather all existing evidence and generate new evidence from different urban PHC models and practices (e.g., ADB Asian Development Bank clinics, Smiling Sun Clinics and LHSS materials), including public health interventions to develop and share recommendations with LGD and MOH for their use in developing operational guidance on PHC for LGIs.
Having an operational plan for improved management and monitoring of PHC Positive (+)	• Supporting LGIs to prepare PHC plans is beneficial for them. Helping them implement the plan through coaching is also important and requires strong management and monitoring mechanisms. • Significant scope exists to build on the LHSS Bangladesh efforts to refine different aspects of PHC plan preparation and implementation. LGIs could use early success in the implementation of PHC plans as a tool in its advocacy efforts with national and local actors.	• National Institute of Local Government to help LGI refine LHSS Bangladesh-supported PHC plan processes—both plan preparation and plan implementation processes.
Less interest in health in some LGIs due to 1) lack of recognition and acknowledgement (e.g., it is perceived to be MOFHW "business"); and 2) Perceived low political benefits from investing in health	• As PHC-related interventions are new to most LGIs, a change of mindset of mayor and councilors is needed which requires continuous sensitization through a) Peer learning/socialization.	• LGD to orient LGIs on 1) Their PHC mandate; 2) The importance of PHC; and 3) Possible strategies for advancing the agenda.

Main Determinant	Lesson	Actors | Supporting or Against
Negative (-)	b) CSO (Community Support Group) engagement/community. c) Revitalized ward committee. d) Addressing the high-level policy issue – LGIs were not engaged during the development of the Urban Health policy or the 5th Health Sector Development Plan.	• LGD to incentivize LGIs for investing in PHC through mechanisms such as matching block grants. • Local champions to push for inclusion of PHC discussion on the meeting agenda for General Council and TLCC (Town Level Coordination Committee).
Political will and stakeholder engagement		
Functional HSC (Health Standing Committee) with regular convening Positive (+)	• Getting LGD to emphasize regular convening of HSC by including it as one of the conditions for its allocation of block grants for PHC. • LGIs recognizing the importance of HSC: keeping some budget for supporting HSC meetings and assigning a person for its regular convening and follow-up of decisions.	• LGD to make it mandatory for LGIs to have regular convening of HSC. • Identify HSC champions in each LGIs to realize the full potential of HSC platform and showcase the same to other LGIs and LGD.
Lack of coordination leads to difficulty in mobilizing resources Negative (-)	• LGIs' coordination and collaboration with different stakeholders impacts their efforts to define and advance its PHC agenda.	• LGD to work with a few committed LGIs to understand various facets of coordination and develop guidance for and capacity of LGIs to perform this role effectively. • Getting mayors to appoint an officer/focal person for this role.
Lack of mandate for CS (Civil Surgeon) and DDFP (Deputy Director Family Planning) to contribute resources for PHC Negative (-)	• National level advocacy for formalized coordination on PHC between the MOH and LGD in urban areas remains a critical issue.	• Urban Health Coordination Committee and Urban Health Working Group could be engaged by LGD and LGIs and Mayors together to advocate for effective coordination between MOH and LGD on the PHC agenda at the sub-national level.
Political willingness of mayors to influence Positive (+)	• Mayors have a decisive role in the bringing PHC agenda to the center-stage of LGIs' development agenda.	• Local champions to make mayors see the connection between addressing PHC needs of its people and political gains.

LOOKING FORWARD

During the LHSS Bangladesh GKS Workshop, the Activity, LGIs, and urban health experts from development partners in the country, including USAID and UNICEF, developed a vision for improved health system performance over the next three to five years in Bangladesh.

Recognizing that the LHSS implementation period reflects a start-up period for urban PHC led and funded by LGIs, stakeholders envision a future where coordination, management, and monitoring capacities are further strengthened and institutionalized to enable the effective mobilization and use of additional resources to increase access to PHC and public health services.

This vision captures the key performance improvement associated with the LHSS Activity. During the GKS workshop, participants identified the conditions that must be strengthened and institutionalized to sustain gains achieved to date in the areas of coordination, management, and monitoring. These conditions are stated in **bold** in the following descriptions and represent the next steps recommended under each function.

1) **Coordination:** Consistent and ***broad participation*** in Health Standing Committee membership where membership is ***mandatory*** and is not limited to local health actors (e.g., Civil Surgeon Office, Family Planning Unit and NGOs), but is expanded to include ***private sector providers***, ***public providers***, community members (not only representatives) in addition to other LGI units such as Water/Conservancy and Social Development.

Including private providers could facilitate partnerships and build networks with lab and diagnostic centers, private pharmacies, and other stakeholders, driving and scaling innovation and collaboration. Finally, community participation could support accountability, ownership, and responsiveness of PHC activities. Effective management of an expanded committee requires strong facilitation by the health department's PHC focal point, addressed next.

2) **Management:** ***Skilled managers*** can use evidence-based plans that include ***public health and PHC service*** delivery to build a stronger enabling environment to establish an effective PHC system.

Strengthening the capacity of LGIs health units by hiring skilled managers, preferably with a public health background and with experience using evidence to plan PHC and manage public health care activities, will create a more favorable environment for a robust, resilient health system.

Realizing this will require additional conditions and actions at the national level:

- Having a dedicated urban health wing at the LGD level is essential. To achieve this, LGDs must formally delegate authority and necessary funds to the urban health unit responsible for developing LGI capacity and providing technical oversight.
- Developing a feasible costing plan for implementing the NUHS and operational manual is essential. However, the plan must consider the realities of LGIs' fiscal space and technical capacity, as was the case with LHSS Bangladesh-supported PHC implementation plans. The plan can then expand over time as finances and capacity grow. Achieving this requires engaging with and supporting national-level forums such as the Urban Health Working Group, working closely with the MOH and LGDs in developing guidance for LGIs for PHC.

3) **Monitoring:** ***Quality data*** is a crucial component for effective decision-making and resource allocation. High-quality and readily available data can lead to efficient planning, effective and ***adaptive management, accountability, and advocacy.***

Generating relevant, reliable, and timely quality data allows the health administration to better plan and manage programs, be more responsive to public health emergencies, be accountable to civil society, and support evidence-based advocacy efforts.

In the future, a health management information system unit at each LGI could lead monitoring and performance review mechanisms. However, resources are currently limited. To build efficiency, LGDs and the management information system unit of the Health Services division of MOHFW could collaborate at a national level by aligning and expanding reporting mechanisms and overseeing capacity building at the LGI level. LGIs could form a monitoring team (within the health department or the HSC) that performs periodic reviews in tandem with the Civil Surgeon's Office, presenting these data to HSC and the LGI leadership, such as the General Council.

Conclusion

The USAID-funded LHSS Bangladesh activity was tasked with developing approaches through which LGIs could improve access to primary health care and public health services for urban populations, especially the most vulnerable. Over the life of the Activity, LHSS Bangladesh supported chief health officers, Pouro Nirbahi officers, elected counselors, mayors, and other LGI officials to collaborate, coordinate, and implement activities through HSCs and PHC implementation plans. By funding and implementing these plans, six LGIs have delivered services to over 30,000 people in seven months of implementation for which data are available.

Through peer learning and mayoral advocacy, these LGIs have established new channels to advocate with the LGD for increased resources and technical support. They are also able to advocate with MOHFW counterparts at the LGI level for resources and capacity building. With LHSS Bangladesh's support, health system stakeholders across ministries, sectors, and government levels have gained experience, established collaborative partnerships, developed capacity-strengthening materials and tools, and learned important lessons. Today, these LGIs and their partners are on their way to expanding and scaling access to PHC for urban populations in Bangladesh.

RESULTS ON ACTIVITY MEL PERFORMANCE INDICATORS

Life of Project (LOP) Performance Indicator	LOP Target	FY-2022 Achievement	FY-2023 Achievement	FY-2024 Achievement	Cumulative Performance
Routine monitoring indicator					
Indicator-1: Number of laws, policies, regulations, action plans or standards formally proposed, adopted, or implemented as supported by USG assistance	7	Total=1** Proposed=1 (Sylhet City Corporation)	Total= 7 Adopted=6 (PHC plans) Proposed=1 (DHIS2 private data rule)	Total= 6 Implemented=6 (PHC plans)	Total= 7 Implemented=6 (PHC plans) Proposed=1 (DHIS2 private data rule)
Indicator-2: Number of health facilities made functional with non-donor funds in urban areas as a result of USG support	10	Total = 2 RAJ=2	Total=6 RAJ=4 SYL=2	0	Total=8 RAJ=6 SYL=2
Indicator-3: Value ($) of non-donor resources mobilized for local development priorities	>45165.04 USD (BDT 4.9 million) (6 LGIs allocate more budget for PHC than previous year's value)	Total= 349337.7 USD (BDT 37.9 million) RAJ= 107843 USD (BDT 11.7 million) SYL=241494.7 USD (BDT 26.2 million) (12 LGIs in RAJ and SYL allocated budget for PHC)	Total = 203703.5 (BDT 22.1 million) RAJ=107483 USD (BDT 11.7 million) SYL=96782.22 USD (BDT 10.5 million) (6 LGIs allocated more budget for PHC than previous years)	N/A	Total = 553963 USD (BDT 60.1 million) RAJ= 215686.1 USD (BDT 23.4 million) SYL=338276.9 USD (BDT 36.7 million)
Indicator-4: Number and percentage of USAID supported administrative units engaging in evidence-based planning and budgeting	6	N/A	N/A	Total=6 (100%) RAJ=4 SYL=2	Total=6 (100%) RAJ=4 SYL=2
Indicator-5: Number of local government persons trained in PHC management	192	0	Total: 63 RAJ=44 SYL=19	Total= 119 RAJ=88 SYL=31	Total= 182 RAJ=132 SYL=50

Life of Project (LOP) Performance Indicator	LOP Target	FY-2022 Achievement	FY-2023 Achievement	FY-2024 Achievement	Cumulative Performance
Indicator-6: Number of service providers trained in Essential Service Package (ESP)	225	Total=60 CTG=24 SYL=36	Total =195 RAJ=176 CTG=19	N/A	Total =255 RAJ=200 CTG=55
Indicator-7: Number of health standing committees (HSCs) functional in city corporations/municipalities as a result of USG support	7	Total=12 CC=2 Mun =10	Total=10 CC=1 Mun=9	Mun=7	Mun=7
Indicator-8: Number of evidence-based policy and/or programmatic recommendation briefs developed and disseminated with USAID support	9	1	3	3	7
Indicator-9: Number of advocacy and learning sessions organized	9	2 (peer learning)	Total=4 2 (National Advocacy) 2 (Peer Learning)	2 (peer learning)	8
Special study-based indicator					
Context Indicator-1: Out-of-pocket health expenditure as share (%) of total health expenditure*	N/A	Not available	Not available	Not available	N/A
Context Indicator-2: Percent of births attended by skilled health personnel*	N/A	Not available	69.8%	Not available	N/A
Context Indicator-3: Contraceptive prevalence rate*	N/A	Not available	54.7%	Not available	N/A
Context Indicator-4: Vitamin A supplementation coverage*	N/A	Not available	Not available	Not available	N/A

Life of Project (LOP) Performance Indicator	LOP Target	FY-2022 Achievement	FY-2023 Achievement	FY-2024 Achievement	Cumulative Performance
Context Indicator-5: TB treatment success rate*	N/A	96.85%	Not available	Not available	N/A

* Targets for this indicator are not applicable. Changes in the indicator cannot be directly attributed to the Activity. Therefore, the achievements of targets are outside of the control of LHSS Bangladesh. The indicators are included here for tracking and contextual purposes only.

** LHSS redefined this indicator in FY2023 and excluded the city corporation level PHC plan from the target and achievements

ANNEX A. TECHNICAL DELIVERABLES

FY 21[2]

- Community Engagement Model – Submitted July 19, 2022 (Approved September 6, 2022)
- Combined Assessment Report of The Health Standing Committee of City Corporations & Municipalities – Submitted July 19, 2022 (Approved September 6, 2022)
- National Health Protection Act Compilation Memo – Submitted July 19, 2022 (Approved September 6, 2022)
- Public Financial Management Training for Local Government Institutions' Health Managers One-Day Training Manual – Submitted July 29, 2022 (Approved September 6, 2022)
- Public Financial Management in Health Sector Training of Trainers Training Manual, Three-day Training Module – Submitted July 21, 2022 (Approved September 6, 2022)
- Advanced Public Financial Management (PFM) and Procurement Pre & Post Training Assessment Questionnaire 5-Day Training Module – Submitted July 29, 2022 (Approved September 6, 2022)
- Public Financial Management in Health Sector Training of Trainers Training Manual – Submitted July 29, 2022 (Approved September 6, 2022)

FY 22

- Using Systems Thinking to Spearhead Primary Health Care in Urban Bangladesh – Submitted April 2, 2023 (Approved May 14, 2023)
- Strengthening Health Standing Committees to Improve Local Governance and Primary Health Care in Urban Bangladesh – Submitted July 17, 2022 (Approved September 6, 2022)

FY 23

- LGI Capacity Needs Assessment – Submitted October 15, 2022 (Approved April 11, 2023)
- National Urban Health Strategy 2020 Costing Documents – Submitted October 30, 2022 (Approved April 11, 2023)
- Local Government Institution Peer-Learning for Urban PHC in Bangladesh Report, Submitted December 29, 2022 (Approved April 11, 2023)
- Mayor's Dialogue Event Report: Dialogue on Primary Health Care of Urban Local Government Institutes – Submitted December 29, 2022 (Approved April 11, 2023)
- Technical Brief on LHSS Peer Learning Activities in Bangladesh – Submitted November 2023
- A Case Study on Human Resources for Health Optimization in Rajshahi City Corporation – Resubmitted June 6, 2024
- Technical Report on Urban PHC Implementation Planning – Resubmitted June 7, 2024

[2] These deliverables were part submitted in FY22 but were part of a FY21 work plan that was rescoped.

- Advocacy for Urban Primary Health Care: The LHSS Bangladesh Experience – Submitted November 14, 2023

FY 24

- Lessons from the Three PHC Models within LHSS Bangladesh Supported Local Government Institutions – Submitted November 11, 2023
- Investigating the Effectiveness of Local Health System Sustainability Activity Interventions to Strengthen Urban Primary Health Care in Bangladesh – Submitted February 19, 2024

ANNEX B. SUCCESS STORIES AND BLOGS

Learning Briefs

- Strengthening Health Standing Committees to Improve Local Governance and Primary Health Care in Urban Bangladesh
- Using Systems Thinking to Spearhead Primary Health Care in Urban Bangladesh
- Experiences and Emerging Lessons from Primary Health Care Public-Private Partnership in Urban Bangladesh | Local Health System Sustainability Project

Factsheets and Newspaper Mentions

- LHSS Fact Sheet: Bangladesh
- Newsletter: Primary Health Care Delivery Updates in Bangladesh

Infographics and Posters

- Piloting of the Most Significant Change (MSC) Monitoring Tool in LHSS Bangladesh
- Strengthening primary health care systems in urban Bangladesh through effective collaboration and resource mobilization

Success Stories

- A Locally Led Approach Strengthens Urban Health Care in Bangladesh
- Creative Funding Model Helps Cities Expand Primary Health Care in Bangladesh
- Revitalizing Primary Health Care for Urban Bangladeshis

Audio-Visuals

- Bridging the Gap in Urban Health Care: Transforming Affordable Care in Habiganj through Collaboration
- Transforming Health Care in Bangladesh Urban Communities
- Improving the Primary Health Care System through Peer Learning in Urban Bangladesh
- Transforming Primary Health Care in Urban Bangladesh

ANNEX C. METHODOLOGY

The Bangladesh Activity performed an in-depth exploration of local health system performance improvements it contributed to -- one of several LHSS countries to undertake this process. Using a standardized methodology created by LHSS, country teams identify one or more key health system performance improvements connected to their work, study the determinants of the improvement, and identify conditions and actions needed to sustain the improvement. The findings from these efforts are reflected in the Achievements, Lessons Learned, and Looking Forward sections of the country activity final reports, such as this Bangladesh report. This annex summarizes the methodology LHSS countries use to arrive at their findings.
Overall, the methodology seeks to answer the question, *what are lessons learned regarding determinants of health system performance?* The methodology includes three main steps, as described below.

Step 1: Select and clearly describe the performance improvement that will be examined and gather evidence to substantiate the performance improvement.
For the purposes of this effort, a health system performance improvement is defined as a positive change in the functioning of the local health system or a specific part of the health system. To select a performance improvement, LHSS staff discuss the following questions:

- Which health system performance improvement supported by LHSS was most significant and has credible evidence?
- Which organizations, collaborations and/or networks were prioritized for capacity strengthening by LHSS to improve the performance of the health system?
- What LHSS activities were implemented that contributed to the improved performance?
- What quantitative and/or qualitative evidence is available to substantiate the improved performance of the health system?
- How did this performance improvement contribute to increased equity, quality, resource optimization and/or resilience?

Once staff have selected one or more performance improvements, the country MEL specialists gather and document evidence of the improvement. Evidence may come from various sources, including a.) internal sources such as LHSS reports, AMELPs, learning diaries, deliverables, or other knowledge products such as conference or case competition materials, and data on CBLD-9, and b) external sources such as government information, implementing partner and donor reports, academic sources, and media sources.

Step 2: Identify determinants of the selected performance improvement, and extract lessons learned about the most important determinants.
This step assumes that there were multiple determinants that together contributed to the performance improvement, some of which LHSS was involved with and others it was not. To identify determinants and lessons learned, country teams and stakeholders, usually including USAID Mission staff, participate in a facilitated learning session where they discuss three guiding questions:

- What are the perceived determinants of this health system performance improvement? (positive and negative)
- How important were each of these determinants in achieving performance improvement?

- What are lessons learned about the determinants of performance improvement?

These are catalogued into the domains of capacity, resources, political will and stakeholder engagement in a follow-up survey. Participants rate the importance of each determinant to the achievement of the improvement.

Step 3: Identify conditions and actions needed to sustain, institutionalize, and/or scale up the performance improvement.
For this exercise, the *sustainability* of a performance improvement means the degree to which an organization or health system can continue to perform a function at a level that is sufficient to maintain and/or improve health system outcomes, including adaptability and durability to shocks and changing circumstances. *Institutionalization* is the process of ensuring that a performance improvement is a regular occurrence or behavior that is formally and culturally integrated into the structure and functioning of a health system. Institutionalized improvement is part of a regular function of the health system, supported by behavioral norms, capacity, and laws/policies/regulatory or procedural frameworks (as appropriate), cultural acceptance and widespread legitimacy. *Scaling up* a performance improvement means expanding, replicating, adapting, and sustaining successful health system performance improvements in geographic space and over time to reach a greater number of people, with the intent to reach a national or other appropriate level of impact.

To identify the needed conditions and actions, country teams and stakeholders participate in a facilitated learning session where they discuss three guiding questions:

- What is a 3-5 year plausible vision for a sustained, institutionalized and/or scaled-up health system performance, given the context of the health system and relevant external factors?
- What conditions – e.g., capacities, resources, and political will and engagement from health system stakeholders -- are needed to achieve the vision for the health system performance?
- What practical actions can country stakeholders take to sustain, institutionalize, and/or scale up the PI post-LHSS, in line with the 3-5 year vision?

When defining actions in this step, teams and stakeholders also identify the key actor(s) who should be responsible for taking the action. Finally, the country teams and high-level stakeholders may participate in a final meeting where they commit to action by answering the question, *what will local actors commit to do to sustain and build upon the performance improvement after the LHSS country activity ends?*

ANNEX D. WASTE, CLIMATE RISK MANAGEMENT / ENVIRONMENTAL MITIGATION AND MONITORING REPORT

The approved work plan determines that the LHSS Bangladesh Activity qualifies as a categorical exclusion, according to the USAID Bangladesh IEE and the LHSS IDIQ IEE. Thus, accompanying reports are not required.

ANNEX E. LHSS ORGANIZATIONAL CAPACITY BUILDING (OCB) ASSESSMENT SCORING

Capacity Dimension**: Strategy and Planning**
Definition: Develop long-term strategies and short- and medium-term operational plans to implement the strategy

Level 1: Beginning	Level 2: Start-Up	Level 3: Developing	Level 4: Expansion	Level 5: Sustainability	Scoring (1-5)
Short- and medium-term operational plans and/or annual work plans do not exist	Operational plans and/or annual work plans are in the beginning stages of development	Operational plans and/or annual work plans are being developed	Operational plan developed but not used to guide activities	Operational plan developed and used to guide activities	

Capacity Dimension**: Resources**
Definition: Adequacy and efficient use of resources to carry out functions

Level 1: Beginning	Level 2: Start-Up	Level 3: Developing	Level 4: Expansion	Level 5: Sustainability	Scoring (1-5)
Organization lacks resources to pay basic operating costs	Organization has limited resources to pay basic operating costs	Organization has some but not sufficient resources to pay basic operating costs	Organization has most of the resources it needs to pay basic operating costs	Organization has ample resources to pay basic operating costs	

Capacity Dimension**: Coordination and Communication with Stakeholders**
Definition: Ability to assess and fruitfully engage with stakeholders

Level 1: Beginning	Level 2: Start-Up	Level 3: Developing	Level 4: Expansion	Level 5: Sustainability	Scoring (1-5)
Organization has not defined who its key stakeholders are	Organization has begun to define who its key stakeholders are	Organization has defined who its key stakeholders are	Organization has defined who its key stakeholders are	Organization has defined who its key stakeholders are	
No outreach to stakeholders	Outreach to stakeholders is just beginning	Outreach to stakeholders is underway	Outreach to stakeholders is reasonably effective	Outreach to stakeholders is frequent and very effective	
Mechanisms for engaging stakeholders are not in place nor are there any plans to establish them	Plans exist for establishing mechanisms for engaging stakeholder	Mechanisms for engaging stakeholders are being established	Mechanisms for engaging stakeholders are established but not fully used	Mechanisms for engaging stakeholders are established and fully used	
No skills for communication with stakeholders	Skills for communication with stakeholders are weak	Skills for communication with stakeholders exist but need further strengthening	Capacity to engage stakeholders is modest.	Capacity to engage stakeholders is strong.	