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BANGLADESH | **UHC SESSIONS WITH OPERATIONAL PLANS**

Technical Note on
Working Sessions with Operational Plans

Moving Towards Universal Health Coverage Through Implementation of Operational Plan Activities

I have heard about UHC before, but this is the first time for me to attend a formal workshop.

- Participant of working session with National Nutrition Services OP

Moving Towards Universal Health Coverage

The movement towards Universal Health Coverage (UHC) is gaining momentum in Bangladesh, especially following approval of the Sustainable Development Goals (SDGs) with a clear mandate for UHC (through Goal 3), and strong political commitment from the highest echelons of government. Key initiatives, such as the Health Care Financing Strategy (2012-32), Bangladesh Health Workforce Strategy (2015), National Social Security Strategy (2015), Bangladesh Essential Service Package (ESP), and Communication Strategy for UHC (2014-16) demonstrate this commitment.

In 2015, the United States Agency for International Development (USAID) undertook a Health Financing Assessment and identified the need to "increase awareness of and demand for UHC among a broad range of stakeholders."[1] This was in line with the UHC communication strategy of the Ministry of Health and Family Welfare (MOHFW). USAID's Health Finance and Governance project (HFG) started working towards "Building awareness on Universal Health Coverage: Advancing the agenda in Bangladesh" in 2016. The objective was to raise awareness of and advocate for UHC, including its core concepts in health financing, so that a critical mass of stakeholders could advance the UHC agenda in Bangladesh.

UHC is still a new concept for many health managers who are not yet thoroughly conversant in or have internalized its different dimensions. However, there is tremendous potential for MOHFW Operational Plan (OP) managers (consisting of Line Directors, Program Managers, and Deputy Program Managers) to support progress on different aspects of UHC as they implement OP activities.

[1] Karen Cavanaugh, Mursaleena Islam, Sweta Saxena, Muhammod Abdus Sabur, and Niaz Chowdhury. 2015. Universal Health Coverage and Health Financing in Bangladesh: Situational Assessment and Way Forward. Washington, DC: USAID.

To capitalize on this potential – and advance progress towards UHC – OP managers need support as they plan activities. The USAID-funded HFG project organized and facilitated half-day working sessions with selected OP managers to not only strengthen understanding about UHC, but also provide practical ways to take forward the UHC agenda while implementing OP activities.

This technical note summarizes highlights from the working sessions and also provides guidance and a framework for incorporating UHC concepts in OP implementation.

It would be helpful to have some written guidance or a handbook that explains how to implement OP activities with a UHC perspective; then all OP personnel could act accordingly.

- Participant of working session with Non-Communicable Disease (NCD) Control OP

Objectives of the Working Sessions

- Advance the UHC agenda through OP implementation.
- Generate ideas and input on how planned OP activities could be implemented with an additional focus on UHC.

Approach for the Working Sessions

A half-day working session was chosen as OP mangers were unable to participate for a longer time-period, and this modality provided opportunity for maximum participation by OP personnel.

Activities in the MNCAH OP relating to UHC are really time-demanding but are much needed. All the discussions were really good.

Participant of working session with Maternal, Neonatal, Child, and Adolescent Health (MNCAH) OP

Bangladesh's 4th Health, Population and Nutrition Sector Program (HPNSP, 2017-2022) has 29 OPs, of which 14 relate to service delivery. Due to time constraints, eight OPs were selected covering priority service delivery areas, and addressed through five working sessions – see Table 1.

Each session included a short video on UHC; an introduction to UHC by the Health Economics Unit (HEU) of MOHFW; an overview of each OP by respective OP personnel; discussions with examples of specific OP activities to demonstrate and generate ideas about implementation with a specific focus on UHC (see Table 2 for a summary); and finally a wrap-up and way forward.

Professor Mohammad Abul Faiz and Dr. Muhammod Abdus Sabur facilitated the sessions.

Table 1: Summary of the Working Sessions

OPs Covered	Date and Venue	No. of Participants
Maternal, Neonatal, Child, and Adolescent Health (MNCAH)	5th December 2017 Integrated Management of Childhood Illnesses (IMCI) Conference Room, Expanded Program on Immunization (EPI) Building, Mohakhali, Dhaka	33
Maternal, Child, Reproductive, and Adolescent Health Clinical Contraception Services Delivery Program	8th January 2018 Meeting Room, Maternal and Child Health Services Unit, Directorate General of Family Planning (DGFP), Dhaka	24
Community Based Health Care(CBHC)	18th March 2018 CBHC Conference Room, Bangladesh Medical Research Council Building, Mohakhali, Dhaka	18
National Nutrition Services Lifestyle & Health Education and Promotion	21st March 2018 Institute of Public Health Nutrition Conference Room, Mohakhali, Dhaka	19
Hospital Services Management Non-Communicable Disease (NCD) Control	17th April 2018 Conference Room, Hospital and Clinic Section, Directorate General of Health Services (DGHS) New Building, Mohakhali, Dhaka	20

Table 2: Key Discussions

Maternal, Neonatal, Child and Adolescent Health OP	
OP Components and Activities	**OP Implementation and UHC Considerations**
Maternal health Increase safety of deliveries, including through provision of Emergency Obstetrical Care	As 67 percent of deliveries take place at home (Bangladesh Demographic and Health Survey [BDHS] 2014), provision of skilled birth attendants is needed to make deliveries safer. Current efforts to train female Health Assistants (HAs) and Community Health Care Providers (CHCPs), along with Family Welfare Assistants (FWAs), should be strengthened. There is also need to increase the number of private Community Skilled Birth Attendances (CSBAs) through proper training, as is being done by many non-governmental organizations (NGOs), as well as through other initiatives. CSBAs need to compete with existing traditional birth attendants (dais). Therefore, an increase in both government and private CSBA numbers may increase safe deliveries if combined with proper promotion. In addition, quality of CSBA care can be ensured if supervised by Family Welfare Visitors (FWVs), as demonstrated by a pilot initiative. Provision of comprehensive Emergency Obstetrical Care through the upazila health complex not only improves coverage, but also provides protection against financial risk. While experiences to date are not yet promising, both the obstetrician and anesthesiologist should be retained at the upazila health complex to achieve UHC.
EPI Increase and sustain routine EPI	Although current EPI coverage at 82.5 percent is a success, there is a remaining gap of 17.5 percent. Improved micro-planning is needed to increase coverage, along with strengthened efforts in counseling, promotion, and follow-up to reduce drop-outs. Since EPI sessions are free and are conducted close to where people live, there are no financial hardship implications. EPI in urban areas poses a challenge. Neither field workers (e.g., HAs or FWAs), nor networks of facilities (e.g., Community Clinic [CC], Union Health and Family Welfare Center [UH&FWC]/ Union Sub Centre) exist. Service delivery is the responsibility of the respective municipality or city corporation, but they have inadequate capacity, including inadequate human resources. Through the Urban Primary Health Care project in selected municipalities and city corporations, services are provided by contracted NGOs or NGO networks (e.g., Smiling Sun or Marie Stopes). However, most NGOs charge a fee for EPI, which may be a barrier to access. In addition, coverage by NGOs is not comprehensive, as some areas are overcrowded while others are not covered. To achieve UHC, municipalities and city corporation authorities need support to map existing EPI sites run by NGOs, to request new sites or relocate existing sites, and to negotiate for exemption for the poor for charges.
National Newborn Health Program Promote birth preparedness, newborn care preparedness, and proper care seeking through a comprehensive social and behavior change communication approach	All pregnant women and their family members, particularly decision-makers, need to be aware of the different components of and reasons for birth preparedness. Sometimes an individual may be unable to address all aspects of birth preparedness, such as transport or blood requirements, or money for a caesarean section. A community approach is therefore required, such as CC community support groups. Likewise for newborn care preparedness and proper care seeking, pregnant women and family members, as well as existing birth attendants (whether skilled or traditional), need to be oriented, particularly on existing harmful practices. To achieve UHC, all pregnant women should be birth-prepared, and all newborns should receive essential newborn care.
Adolescent health Provide adolescent-friendly sexual and reproductive health services through health facilities	Improved access to free, quality sexual and reproductive health services for adolescents through government facilities will help in achieving UHC. Robust training for service providers from different health facilities (e.g., upazila health complex, Union Sub-Center/H&FWC, and CC) is needed to provide quality services, covering counseling and communication, as well as technical aspects of service delivery.

Maternal, Child, Reproductive, and Adolescent Health OP (Cont.)	
OP Components and Activities	**OP Implementation and UHC Considerations**
Maternal health Provide four antenatal care (ANC) sessions with counseling for pregnant women and their families covering birth preparedness and complication readiness	ANC uptake is low – only 31 percent of pregnant women completed four or more ANC visits (BDHS 2014). Although 78 percent women undertake at least one ANC visit, only 64 percent of deliveries are by medically trained providers (BDHS 2014). In order to ensure quality and comprehensive service provision, there is need to increase ANC uptake to four or more visits, with services delivered by medically trained providers. Providing services closer to where people live reduces the potential for financial hardship – ANC should also be provided during domiciliary visits by CSBAs, or through satellite clinics, CCs, or UH&FWCs. Birth preparedness and complication readiness counseling should cover all pregnant women and their families, particularly decision-makers, with particular attention to those who are usually excluded (e.g., hard-to-reach communities, marginalized and minority populations, and the disabled). Mother's Bank is a good example of birth preparedness. Other components include identifying more than one skilled birth attendant; identifying the facility where both comprehensive and basic emergency obstetrics care are available; and identifying proper transport in case of need so that delays in reaching the appropriate facility can be avoided. To reduce maternal mortality, proper ANC visits delivery by skilled attendants (at home or in the facility), and access to comprehensive and basic emergency obstetrics care in case of need are crucial. In order to achieve UHC, the health system needs to be ready to provide required services.
National Newborn Health Program Provide sick newborn management services at UH&FWCs by developing the capacity of service providers, ensuring the supply of commodities and drugs, and emphasizing referral linkages as per national guideline with simplified antibiotic regimen	Managing sick newborns at the UH&FWC would be a step towards UHC. This requires robust capacity development of service providers to ensure quality of care, along with ensuring the supply of required commodities. UH&FWCs are located in close proximity to rural populations and services are provided for free, which reduces potential for financial hardship. Effective referrals can improve coverage and quality, and to some extent financial hardship, if the referral facility pays proper attention to patients.
Child healthcare services Provide proper counseling on appropriate feeding practices, including exclusive breast feeding	Fifty-five percent of infants under six months are exclusively breastfed (BDHS 2014), which represents a drop since the 2011 BDHS (64 percent). Given the importance of exclusive breastfeeding for the child's nutritional status, and this downward trend, effort is needed to increase rates. All domiciliary and facility-based providers should promote exclusive breastfeeding at every encounter, particularly among pregnant women and their family members.

Clinical Contraception Services Delivery Program OP	
OP Components and Activities	**OP Implementation and UHC Considerations**
Strengthening long-acting reversible contraceptive and permanent method (LARC&PM) services Target young married couples aged up to 24 years to reduce unmet need; introduce peer activities such as counseling, promotion, and group discussion to increase referrals for LARC&PM services	Young married couples are often excluded from family planning (FP) due to their shyness and/or inexperience in using services. Addressing the unmet need of young couples will improve coverage and therefore accelerate progress towards UHC. Focus areas include: reaching men (and women) for counseling sessions; targeting couples who are usually excluded (e.g., minority, disabled, or ethnic groups, bedes, and hard-to-reach communities); increasing access to confidential services closer to where people live; increasing service quality (both actual and perceived) through appropriately trained service providers; providing effective counseling about side-effects or discontinuation processes; and reducing financial risk by increasing accessibility and providing free supplies where possible.
Effective implementation of post-partum FP action plan Ensure availability of post-partum FP services, particularly post-partum bilateral tubal ligation, post-partum intra-uterine device services, and post-partum implant services, as well as post Menstrual Regulation/ Menstrual Regulation with Medication (MRM)/Post Abortion Care (PAC) FP services in DGHS hospitals, DGFP facilities, private hospitals, and NGO facilities.	The post-partum period is a critical opportunity for FP method acceptance. Engagement by all facilities where deliveries take place (including those belonging to DGHS or DGFP, as well as private or NGO facilities), can improve coverage and therefore contribute towards UHC. In most circumstances, services are provided by qualified staff, thus ensuring quality, and FP services are free with some compensation (e.g., stipend or transport) provided, thus reducing financial risk. However counseling services may be sub-optimal, which limits quality and may lead to discontinuation. Effective counseling is therefore needed for all post-partum FP clients.
Strengthening LARC&PM services in hard-to-reach, low performing, and urban areas Register all slum and non-slum couples in urban areas through government-NGO collaboration with the assistance of volunteers	In order to achieve UHC, all eligible couples from both slum and non-slum areas should be registered for services. With the assistance of volunteers, coverage of eligible populations can be increased by identifying and registering excluded couples, especially those in slum areas or living on the streets. Once eligible populations are registered, appropriate and quality FP services should be provided closer to where they live (reducing financial risk). Proper counseling is also important to avoid discontinuation due to discomfort or other side-effects.

Community Based Health Care OP	
OP Components and Activities	**OP Implementation and UHC Considerations**
Proper staffing of CC Undertake initiatives to improve staffing of CCs to deliver ESP services	All the services mentioned in the ESP for the CC level could be delivered if appropriate staffing were in place, and staff capacity built. This would increase access to quality services closer to where people live for free, thus satisfying all UHC elements.
Community engagement Prepare a community engagement manual detailing roles of different stakeholders (e.g., CC staff and their supervisors, community group and community support group members, Union Parisad, and other local institutions such as NGOs, schools, and religious institutions) to create community momentum for improved health outcomes.	Currently each CC has one community group and three community support groups, but their engagement varies. Some limitations need to be addressed: • Committee formation should be representative, with inclusion of females; • Committees should meet frequently with an adequate quorum, active participation by all, decision-making, minutes, and follow-up of decisions; and • Broad community engagement is needed for improved health outcomes. Community groups and support groups need to be revitalized through orientation on their roles and responsibilities, not only for proper functioning of the CC, but also to create community momentum for a health movement. This can be achieved through inclusive engagement of other institutions, such as Union Parisad, NGOs, schools, and religious institutions to promote healthy lifestyles, ensure a conducive environment for health, and ensure utilization of all required services from CCs and higher-level facilities.
Referral system Orient CC staff on the referral system, including their respective roles and responsibilities.	CCs are required to send their patients to higher-level facilities where necessary through appropriate referral and adequate follow-up. Initially CCs may refer patients to the Upazilla Health Complex, and where union facilities have been strengthened, to union facilities. CC staff orientation on quality referrals, including where patients can access appropriate, quality services through referral, is an important dimension of UHC.
Urban health Address barriers to urban dwellers, particularly the poor, preventing access to and use of available health services	Municipality/city corporation authorities are responsible for delivering health services to their respective dwellers. Overcoming barriers to and utilization of health services, especially by the poor, requires working with these authorities to improve access without financial risk.

National Nutrition Services OP	
OP Components and Activities	**OP Implementation and UHC Considerations**
Nutrition-specific activities Promote, protect, and support Infant and Young Child Feeding (IYCF) Practices	According to BDHS 2014, 23 percent of children aged 6-23 months are fed according to recommended IYCF practices. Feeding practices have changed very little (2 percentage point increase between 2011 and 2014 BDHS), and this is far below the target of 45 percent by 2022. Appropriate feeding is especially low during the period 6-8 months (7 percent), increasing to 34 percent among 18-23 month-old children. Boys are as likely as girls to be fed according to recommendations. Adherence to IYCF practices is better in urban areas than in rural areas (29 compared with 21 percent). The recommended IYCF practices are lowest in Sylhet (17 percent) and highest in Khulna (31 percent). Overall IYCF practices are low among all subgroups, but IYCF practices improve with the mother's education level and wealth score. Even among the highest wealth quintile, only 3 out of 10 children receive appropriate feeding. This suggests a lack of knowledge about appropriate feeding practices. Creation of more rigorous awareness is required to achieve UHC for IYCF, particularly targeting the low uptake period (6-8 months), rural areas, and Sylhet division, as well as sub-populations with low literacy levels or in the poorest economic groups.
Control of micronutrient deficiencies Implement bi-annual Vitamin A supplementation program for children aged 6-59 months	Sixty-two percent of children aged 6-59 months received vitamin A supplementation (BDHS 2014) – this has only increased by two percentage points since 2011 (BDHS). Among children aged 6-23 months, 67 percent consumed foods rich in vitamin A (BDHS 2014). Sub-clinical vitamin A deficiency is 20 percent in pre-school aged children (Programme Implementation Plan [PIP] of 4th HPNSP). Achieving UHC for Vitamin A supplementation requires significant interventions.
Promotion of adolescent nutrition Raise awareness and promote adolescent nutrition	Around 10 percent of adolescent girls (aged 10-18 years) are undernourished (National Food Security Nutritional Surveillance Project 2014). Prevalence of iron deficiency is 10 percent in school aged children (12-14 years), increasing to 40 percent among older school aged children (PIP of HPNSP). Achieving UHC for adolescent nutrition requires multiple efforts in both macro and micronutrients.
Promotion of maternal nutrition Counsel pregnant and lactating women during ANC and post-natal care services, as well as during domiciliary visits by health and FP workers.	As mentioned earlier, ANC from a medically trained provider is 64 percent, while this is 36 percent for post-natal care (BDHS 2014). Eleven percent of currently-married women said they were visited by a government FP fieldworker, four percent by a government health worker, and five percent by an NGO fieldworker. In order to promote maternal nutrition, domiciliary visits by health and FP workers need to improve substantially.

Lifestyle and Health Education and Promotion OP	
OP Components and Activities	**OP Implementation and UHC Considerations**
Comprehensive social and behavior change communication strategy Facilitate district level workshop on promotion of a healthy diet, the effects of dietary salt intake, hazards of excessive sugar and oil intake, and the need for high fruit and vegetable intake; implement activities to stop tobacco consumption and substance abuse; and conduct public education campaigns about the benefits of exercise.	By cascading district level workshops, anti-tobacco initiatives, and public education campaigns involving all segments of society and using correct information and messages, will accelerate progress towards UHC. This approach ensures every individual is aware of and practicing promotive health, and provides financial protection through disease prevention.
Inter-sectoral collaboration on lifestyle, including private sector engagement Promote safe and healthy environments within facilities, the household, workplaces, and schools, including increasing cleanliness, ordinary and medical waste management, and sanitation facilities.	Inter-sectoral collaboration, including with the private sector, can result in an improved environment in terms of increased cleanliness, sanitary facilities, and waste management. This will be a step forward in promotive and preventive health from which the whole population can benefit (through households, workplaces, and schools/ academic institutions) without financial risk.
Communication campaign through different media for behavior change Use different communication methods to change individual and community behavior and social norms.	Changing individual and community behaviors and social norms around healthy lifestyles, early treatment seeking, and compliance with health provider advice, contributes significantly to UHC. Healthier lifestyles prevent or control disease, and early treatment seeking and compliance contributes to early detection and/or improved recovery, which reduces financial risk.
Occupational and environmental health Engage employers and supervisors, concerned ministries, Bangladesh Small and Cottage Industries Corporation (BSCIC), trade/worker unions, and interested organizations to develop appropriate policies and foster workplace norms, design communication programs to reduce health hazards, and raise awareness about climate change, food safety, injuries, and healthy aging.	More people are joining the workforce, but every occupation has inherent health and safety hazards. Being aware of and taking appropriate measures to prevent accidents, including using appropriate protective devices, can prevent mortalities and morbidities. This requires engagement with stakeholders, including business owners, legislative bodies, and worker organizations to use quality, consistent messages and practices to promote health and prevent hazards. This will contribute towards UHC by reducing/ preventing morbidities and mortalities and contributing significantly towards financial risk protection.

Hospital Services Management OP	
OP Components and Activities	**OP Implementation and UHC Considerations**
Structured referral system Prepare and implement referral procedures and rules across health service levels, and within and between institutes.	Improved and structured referrals across different levels or tiers of health facilities will results in better access to and utilization of quality health services by those in need, thus addressing multiple UHC dimensions. In addition, referral services are often provided close where people live, and are usually provided by government, thus reducing financial risk.
Support to secondary and tertiary care hospitals Provide support to District Hospitals, Medical College Hospitals, and Specialized Institutes and Hospitals.	The current aim is to upgrade all existing District Hospitals to 250 beds, so that District Hospitals are the referral facility for corresponding Upazila Health Complexes in each district, and provide primary care and the ESP for their urban catchment population. The capacity and efficiency of Medical College Hospitals will be enhanced. Old Medical College Hospitals will be upgraded to 1,000 beds with all specialized services available. These will be tertiary level referral hospitals providing all services. National Institutes will be truly national centers of excellence, providing state-of-the-art specialized services, as well as acting as a national resource center for technical support and guidance throughout the country in their technical field. Together, secondary and tertiary facilities will therefore be a critical component of progress towards UHC, ensuring access to quality services for all, and providing services at an affordable cost.
Private healthcare facilities Update the regulatory framework to ensure close supervision of private healthcare facilities. Establish an autonomous National Accreditation Body.	Through enforced regulation, private healthcare facilities may contribute towards improving access to quality services at an affordable cost. An accreditation body will improve access to and enable provision of quality services, while also regulating the cost of services and thus contributing to financial protection.

Non-Communicable Diseases Control OPs	
OP Components and Activities	**OP Implementation and UHC Considerations**
Screening Use the primary health care system (community, CCs, union health facilities, and Upazila Health Complexes) for prevention of non-communicable diseases (NCDs) through public awareness, screening, and early detection, treatment, and referral.	Public awareness, screening, early detection, treatment, and referral by community workers, CCs, UH&FWCs, and Upazila Health Complexes will accelerate progress towards UHC. This approach will ensure every individual receives required quality services close to where they live and through government facilities either for free or at minimum cost and thus with no financial hardship.
Conventional NCDs (Cardiovascular Diseases, Diabetes, Chronic Obstetric Pulmonary Disease (COPD) Cancer) Provide quality care for NCDs at: the primary care level (CCs, UH&FWCs/ Union Sub Centers, and Upazila Health Complexes); secondary level (District Hospital); and tertiary level (Medical College Hospital and Specialized Institutes). Establish strong referrals with feedback from the CC to the Upazila Health Complexes, with further referral to the District Hospital, and Maternal and Child Health or other specialized institutes.	This activity will ensure provision of quality care for NCDs in health facilities at all levels. If quality care for NCDs can be availed for free and close to where people live, financial protection would also be addressed. Improving quality of care and institutionalizing quality service delivery across the health system will not only address the core UHC concept of quality, but also reduce the NCD burden. A robust referral system with feedback mechanisms will improve care quality and equity, as referrals ensure service access for everyone.
Specialized NCD program. Target marginalized populations and migrant workers.	Specialized NCD programs are needed for marginalized populations and migrant workers. Marginalized populations, especially ethnic minorities (e.g., *bede and horijon* communities), are often excluded from mainstream health programs due to their limited access to services. Accessibility and financial risk protection can be addressed if services are provided within communities. Migrant health workers often cannot access services due to the high cost in migrating countries/cities. Identifying the geographic location of migrant workers and providing services according to their health needs would increase population coverage in line with UHC.

Health System Implications

Although the OPs were all related to service delivery, there were some discussions about health system implications for OP implementation and thus UHC advancement. For example:

- The availability of funds to pre-finance activity expenses is constrained by delays in budget disbursement and permission (which may involve Ministry of Finance).
- Imprest funds in non-DGFP facilities are not currently available to increase long-acting and permanent method contraceptives.
- Retention of staff, particularly in hard-to-reach areas, is challenging.
- Continuity of OP personnel is problematic, with frequent changes of Line Director, Program Manager, and Deputy Program Manager.
- Coordination – within different components of each OP, and between different OPs, as well as between MOHFW departments (e.g., DGHS, DGFP, Directorate General of Nursing and Midwifery, and National Institute of Population Research and Training) and with other ministries (e.g., Ministry of Local Government, Rural Development and Cooperatives, Ministry of Chittagong Hill Tracts Affairs, Ministry of Women and Children Affairs, and Ministry of Social Welfare) is poor.

Framework for Incorporating UHC Concepts in OP Implementation

Many of the participants stressed the need for a common framework to help implement OP activities addressing UHC concepts. Based on the working session discussions and the three core UHC thematic areas (coverage for all, service coverage and quality, and financial protection), illustrative examples were identified from each service delivery OP and summarized as a framework. This framework (see Table 3) can be applied during implementation of any OP activity so that UHC thematic areas are addressed.

Table 3: OP Implementation Framework for Addressing UHC

OP and a Relevant Component	Thematic Area for UHC		
	Coverage for All	Service Coverage with Quality	Financial Protection
MNCAH* Integrated Management of Childhood Illness (IMCI)	Community case management training for all field level service providers following the IMCI protocol will cover all children for IMCI	IMCI case management in the community by trained field-level service providers will ensure quality service coverage for IMCI	IMCI case management in the community, close to where people live, and by trained field level service providers, will reduce financial risk
Maternal, Child, Reproductive and Adolescent Health* Reproductive Health Care Services	Strengthening safe menstrual regulation by skilled service providers at facilities (UH&FWCs, Upazila Health Complexes, and Mother and Child Welfare Centers (MCWCs) will be step forward to cover all	Menstrual regulation by skilled service providers at UH&FWCs, Upazila Health Complexes, and MCWCs will improve coverage and ensure quality service provision	Menstrual regulation services provided at UH&FWCs, Upazila Health Complexes, MCWCs will help ensure financial protection as services are provided for free and close to residences
National Nutrition Services* Iron Folic Acid (IFA) Supplementation	IFA supplementation for pregnant or lactating women and adolescent girls will help ensure coverage for all suffering from micronutrient deficiencies	Quality IFA supplementation with appropriate dosage for pregnant and lactating women and adolescent girls will ensure coverage of those who require this service	Financial protection will be ensured as IFA supplementation will be free and availed during other services
Communicable Disease Control Malaria Elimination Program	Universal coverage of rapid diagnosis and prompt treatment (RDT) in the 13 appropriate districts	RDT by trained workers ensures availability of essential and quality services in the relevant 13 districts	RDT is provided free and close to patient homes, ensuring financial protection
Tuberculosis (TB), Leprosy and AIDS/ Sexually Transmitted Disease (STD) Programme Case detection of TB	Increase detection of TB cases through strengthening and scaling up laboratory diagnostic facilities to cover all	Quality diagnostic facilities to ensure case detection of all who need services	Financial protection is ensured through providing free services. Other costs such as transportation or wage loss may be minimized through community resource mobilization
NCD Control* Health Promotion and Risk Reduction	Massive and rapid public health campaign to cover all for healthy lifestyles and practices	Qualitative information of the campaign to cover those who need to adopt proper healthy lifestyles and practices	Since prevention is much cheaper than cure, financial protection is ensured through adopting appropriate lifestyles
National Eye Care Service Delivery	Eye health care services at upazila and district hospitals will improve coverage for all	Quality eye care services at upazila and district hospitals will increase availability	Free services at upazila and district hospitals will support financial protection. Other costs such as transportation and wage loss may be covered through community resource mobilization
CBHC* Tribal Health	District-specific tribal health strategies for each of three districts in the Chattagram hill tracts (CHT) will help ensure coverage, especially where populations are usually excluded	Quality services needed for diverse populations may be provided through proper implementation of district-specific tribal health strategies in the CHT	By implementing district-specific tribal health strategies, and providing services close to where people live and for free, financial protection will be ensured

OP and a Relevant Component	Thematic Area for UHC		
	Coverage for All	Service Coverage with Quality	Financial Protection
Hospital Services Management* afe Blood Transfusion	Universal access to safe blood for the patient	Safe blood through proper screening and cross-matching will ensure provision of essential, quality services	Financial protection may be ensured through the provision of safe blood close to the point of requirement and at affordable cost
Clinical Contraception Services Delivery Programme* Strengthening LARC&PM services in hard-to-reach, low performing, and urban areas	Coverage of LARC&PM will be improved through the Regional Service Package and by involving the Roving Team, which is a step towards universal coverage	Quality LARC&PM services provided by the Roving Team will ensure coverage for eligible couples	LARC&PM services are provided for free with compensation for wage loss and transportation costs. In addition, Roving Teams provide services close to the place of residency, which addresses financial protection
FP Field Services Delivery Strengthening Field Services Delivery	Strengthening domiciliary services through FWAs will accelerate universal coverage	Proper client selection using the appropriate FP method will ensure provision of quality FP services	Financial protection is ensured as services are provided at home and for free
Lifestyle, and Health Education and Promotion* Legislative Framework	Implementation of appropriate legislation (e.g., banning smoking in public places, or wearing a helmet while driving motor cycles) will contribute towards universal coverage of health promotion	Implementation of appropriate legislation for proper management of medical waste will improve quality of care at facilities and coverage of medical waste management services	Changes in lifestyles and health promotion through legislation will ensure prevention of diseases and injuries, and thus improve financial protection
Information, Education and Communication Community Mobilization, Sensitization and Advocacy	Country-wide awareness campaigns will strengthen universal coverage of FP	Client awareness will also increase demand for coverage and quality of needed FP services	Client awareness will lead to uptake of FP services, which are free and provided by the closest outlet, thus protecting from financial risk
Alternative Medical Care (AMC) Strengthening AMC services	Availability of AMC services in public facilities, such as the Upazila Health Complex or District Hospital, will contribute to universal coverage	Qualified AMC providers ensure the quality of required services through public health facilities	Free AMC services at Upazila Health Complexes or District Hospitals will contribute towards ensuring financial protection

* HFG conducted sessions with these eight OPs. In addition to these, the framework contains examples from six other service delivery OPs.

Way Forward

Participants appreciated the sessions as they helped improve their understanding of UHC issues and their ability to implement their respective OP activities. Some Line Directors committed to keeping UHC as a standing agenda item in all their trainings, thus equipping more stakeholders to take forward the UHC agenda. Through improved understanding of and commitment to UHC by a wide range of stakeholders involved in service delivery, more people and communities in need will be covered by quality services. In addition, with increased understanding of financial risk protection, services are expected to be affordable.

The Health Finance and Governance (HFG) project works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. Designed to fundamentally strengthen health systems, the HFG project improves health outcomes in partner countries by expanding people's access to health care, especially to priority health services. The HFG project is a five-year (2012-2017), $209 million global project funded by the U.S. Agency for International Development under Cooperative Agreement No: AID-OAA-A-12-00080.
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