Framework for Monitoring Progress towards Universal Health Coverage in Bangladesh

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Abbreviations

ANC	Antenatal Care
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BHFS	Bangladesh Health Facility Survey
BMMS	Bangladesh Maternal Mortality Survey
BNHA	Bangladesh National Health Account
CC	Community clinic
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
EPI	Expanded Programme on Immunization
ESD	Essential Service Delivery
GATS	Global Adult Tobacco Survey
GDP	Gross Domestic Product
GoB	Government of Bangladesh
HB	Health Bulletin
HEU	Health Economics Unit
HIES	Household Income and Expenditure Survey
HPN	Health Population and Nutrition
HPNSDP	Health, Population and Nutrition Sector Development Program
HRH	Human Resources in Health
IHE	Institute of Health Economics
MARP	Most at Risk Population
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MOHFW	Ministry of Health and Family Welfare
NCD	Non Communicable Disease
NHA	National Health Accounts
NHDS	National Health and Demographic Survey
NTP	National Tuberculosis Program
OOP	Out of Pocket
SVRS	Sample Vital Registration Survey
THE	Total Health Expenditure
UESD	Utilization of Essential Service Delivery
UHC	Universal Health Coverage
WB	World Bank
WHO	World Health Organization

Executive Summary

Universal Health Coverage is concept of health system where everyone has access to the services they need and can take advantage of without risk of financial impoverishment. The World Health Organization (WHO) proposed a widely accepted conceptual framework in the World Health Report 2010. The WHO and the World Bank group propose a framework for tracking country and global progress towards UHC in 'Monitoring progress towards universal health coverage at country and global levels'. There are a proposed set of indicators for tracking progress in financial risk protection, service coverage and equity the central dimension of UHC in 'Indicators for measuring Universal Health Coverage: A five-country analysis'.

To monitor the progress towards UHC the Health Economics Unit (HEU) of Ministry of Health and Family Welfare (MOHFW) of Government of Bangladesh with technical support of the WHO country office Bangladesh developed a set of indicators. A combined method of reviewing strategic documents, reports and policies, analysis of health information tools and discussion with different stakeholders were used.

Most of the impact indicators adapted are from Millennium Development Goals (MDG) indicators; indicators identified cover all six domains of health systems according to the WHO's framework: 1. Human resources, 2. Service delivery, 3. Medicines and Technologies, 4. Information, 5. Governance, and 6. Financing. Indicators identified covered four main areas: access to health services, protection against financial risk, population coverage and quality of service. We proposed forty three of which eleven are financial protection indicators. Data of proposed service related indicators were collected from different survey reports, and from other records. Proposed financial protection indicators were calculated from existing data sources.

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1. Introduction

Universal health coverage (UHC) as a goal of health policy development has gained wide acceptance at country and global levels since the publication of the World Health Report 2010 and is now seen as a critical component of sustainable social development. Universal Health Coverage has also been listed as the goals of the post-2015 development agenda. The WHO has defined UHC as a situation where all people who need health services receive them, without incurring financial hardship. This definition entails two interrelated components: coverage with needed quality health services and access to financial risk protection, for everyone. United Nation adopted a resolution on 12 December 2012 that urges governments to move towards providing all people with the affordable quality healthcare services. This recognizes the role of health in achieving international development goals, and calls for countries, civil societies and international organizations to include UHC in the international development agenda. A global goal has been set by WB to end extreme poverty by 2030. The UHC is critical to achieving this goal, as it will prevent impoverishment of hundreds of millions of families due to OOP payments for health services. Securing the right to health and attaining the highest levels of health for all is the priority of WHO. The UHC will secure universal entitlement to health services, which are important contributors to improving the health status of the population.

The Government of Bangladesh is also committed to move progressively towards universal health coverage by 2032, which is documented by the Health Care Financing Strategy of 2012. It envisions strengthening financial protection, extending health services and providing population coverage. This means everyone who needs health services will be able to get it without undue financial hardship. To achieve this, three strategic objectives were proposed: generate more resources for health, improve equity (by pooling resources and allocating them in an equitable way) and enhance efficiency.

Implementation of UHC has to be adapted based on country context. Some countries have good health services and social setups where achieving the goal of UHC will not require much effort. In Bangladesh adaptation and implementation of the UHC will require addressing some key issues – Develop a national human resource policy and action plan for health services, Establish a national social health protection system, good health information system, strengthen the capacity of Ministry of Health. Though WB set target to end extreme poverty by 2030, in the context of Bangladesh and according to HCFS, UHC will be achieved by 2032.

The level and distribution of effective coverage of interventions and financial risk protection have been proposed as the focus of monitoring progress towards UHC.
To develop the path to UHC and closely monitor its progress, there is a need to measure the current status of Bangladesh (baseline) with respect to who is covered, what services are

provided and at what cost. This is aligned with the thrust for global monitoring of progress with regard to achieving the MDGs and the emerging post-2015 development agenda. Developing simple and sound framework to assess country, regional, and global situations and monitor progress toward UHC is essential, if UHC is remain high on the global agenda and receive priority attention from policymakers. While the basic definition of UHC is conceptually straightforward, developing feasible metrics of UHC is less so. Variations in countries' epidemiology, health systems and financing, and levels of socioeconomic development imply both different approaches to UHC implementation as well as a potential range of relevant metrics.

Countries who are working to achieve UHC already rely on locally specific, routinely collected service statistics to measure their health system's performance and standard demographic and economic surveys in measurement of health status and economic development. At the same time, establishing new global goals, indicators, and targets could have a critical impact on governments' commitment to successful implementation of global declarations. In this line Bangladesh has also developed a UHC monitoring tools based on its own epidemiological and demographic profile, health system and health financing, level of economic development and the population's demands and expectations.

2. Background: UHC initiatives in Bangladesh

2.1 Overview of the service delivery system

Bangladesh has three tiers or levels of health facilities – primary, secondary and tertiary. In primary level there are community clinics (CCs), Union Health and Family Welfare Centers (UHFWCs), Union Sub-center, Upazila Health Complex (UHC). Each CC is covering approximate 6000 population. The community clinics are the lowest-level static health facilities located at the ward level. These have upward referral linkages with health facilities located at the union and upazila levels. There are 467 government hospitals at the upazila level and below, which altogether have 18,780 hospital beds. At the upazila level, there are 436 hospitals with 18,290 beds. At the union level, there are 31 health facilities with 490 beds and 5350 health facilities for outpatient services only. So, at the union level, there are 5381 health facilities. At the ward level, there are 12,527 community clinics in operation till date.

Secondary and tertiary care health facilities are those that provide more advanced or specialty health services than the primary healthcare facilities at the ward, union and upazila levels. However, many of the Upazila Health Complexes (UHCs) have clinical specialists who provide specialty care to the patients. The district hospitals are the secondary level hospitals as these have fewer facilities for specialty health services compared to those in medical

college hospitals. Tertiary hospitals include medical colleges and the super-specialty hospitals at national level that provide high-end health services in a specific fields.

Most of the secondary and tertiary facilities both government and private are located in urban areas. Health care in urban areas is inaccessible to urban poor mainly because of high costs. In rural areas Essential Service Delivery (ESD) mainly provided by the MOHFW, where as responsibility of primary health care in urban areas rests with city corporations, Pouroshovas and the ministry of Local Government, Rural Development and Cooperatives (MoLGRD&C). These local bodies run a number of small to medium sized hospitals and outdoor facilities.

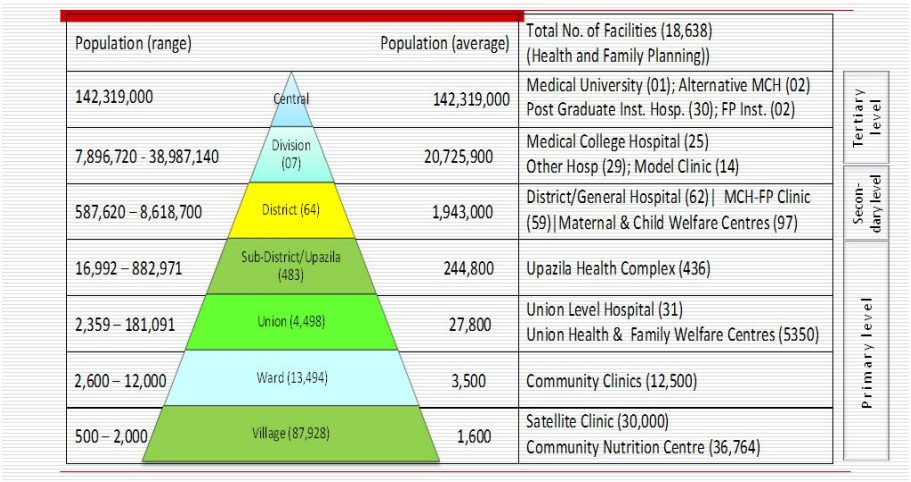

Figure 1: **Distribution of public health facilities**

2.2 Policies in Bangladesh to achieve UHC

The right to health and social equality is indicated in the constitution of Bangladesh. Article 15 (a) of the Constitution of the People's Republic of Bangladesh envisages that it is the fundamental responsibility of the State to attain a steady improvement in the standard of living of the people, by providing the basic necessities of life, including food, clothing, shelter, education and medical care; and according to the article 18 (1) The state shall regard the raising of the level of nutrition and the improvement of public health as among its primary duties. According to the article 19 (1) the State shall endeavour to ensure equality of opportunity to all citizens and by 19 (2) the State shall adopt effective measures to remove social inequality.

There are directions towards health insurance and universal health coverage in different policy papers. Those are –

2.2.1 The Sixth Five Year Plan (2011 – 2015):

HPN sector's financing will be raised through cost sharing by well-to-do patients when they are treated in public hospitals. Moreover, the Government will encourage promotion of Health Insurance Pilots at different levels.

2.2.2 The National Health Policy-2011:

Introduction of health insurance is needed in the formal sector to solve the financing problem in the health sector. In phases, the insurance program can be extended to other sections of population. It is necessary to ensure free health care for the very poor and disadvantaged population. The GoB can provide health cards for the poor in a recognized way.

2.2.3 Vision 2021:

The strategy facilitates the growth of insurance programs targeted to the poor and vulnerable groups. Modern and adequate social health insurance could mitigate the costs to the individual, family and society.

2.2.4 HPNSDP (2011-2016):

Development objective is "to improve access to and utilization of essential HPN services, particularly by the poor". Program priority should be given to improve health equity for the poor & geographically marginalized population

2.2.5 Health Care Financing Strategy:

The HCFS outlines a path to achieve universal health coverage by reducing the current high level of OOP and catastrophic payments.

2.2.6 National Social protection strategy

Government of Bangladesh will provide equitable health care to its citizen by implementing health financing strategy, focusing to prevent health related shocks for the poor and vulnerable population.

2.3 Health Financing

Bangladesh is a low-income country with a per capita income of US$ 1,044 in 2012-13 (BBS). People living below the poverty line is about 31% and large number (73%) of people living in rural area. In the financial year 2014-15 the national budget is Taka 2,50,516 crore and the share of MOHFW is Taka 11,146 crore, which is 4.45% of the national budget. Percentage increase of total government budget as to previous fiscal year is 31.39%, where as it is only 1.74 % increases of MOHFW budget as to previous (2013-14) fiscal year. According to the 2011 estimates, Bangladesh public health expenditure is 1.4% of GDP on health, and total health expenditure is 3.7% as of GDP In Bangladesh per capita health expenditure is US$27 while US$54 is needed for a basic minimum package of individual care, of this only $9.7 is

spend by the Government. Among the total health expenditure (THE) 64% is OOP. In Bangladesh coverage of insurance is less than 1% and about 10% of household face catastrophe due to the OOP expenditure on health care cost.

3. Framework of Measurement of UHC monitoring

The UHC is a goal where all people who need health services (prevention, promotion, treatment, rehabilitation, and palliative) receive them, without undue financial hardship. It consists of three inter-related components:

i) Full spectrum of quality health services according to need
ii) Financial protection from direct payment for health services when consumed; and
iii) Coverage for the entire population

In WHO World Health Report 2010 UHC cube is used as a starting point for measurement. The service coverage dimension captures the aspiration that all people can obtain the health services they need while the financial coverage dimension aims to ensure that they do not suffer financial hardship linked to paying for these services at the time they need them. The extent and distribution of coverage across various population groups is reflected in the third dimension which highlights the importance of equity in coverage across income groups, gender, age, urban/rural, migrant population, minorities and with priority for the poorest 40%.

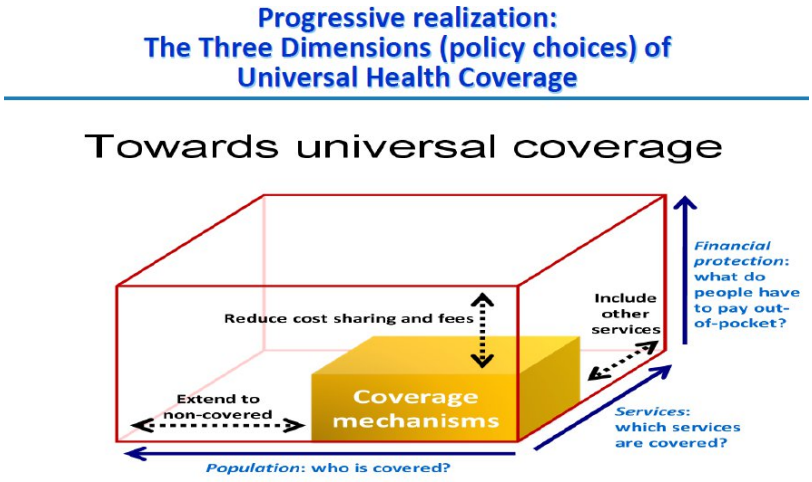

Figure 2: Three Dimensions of Universal Health Coverage

In looking at the various dimensions, indicators for each is determined to best reflect Bangladesh's its unique epidemiological and demographic profile, population demands, health system and level of economic development in this document. While the focus for UHC monitoring are the outcomes, it will be part of a more comprehensive monitoring of health sector performance that is inclusive of critical inputs, outputs and health outcomes as shown in the figure below:

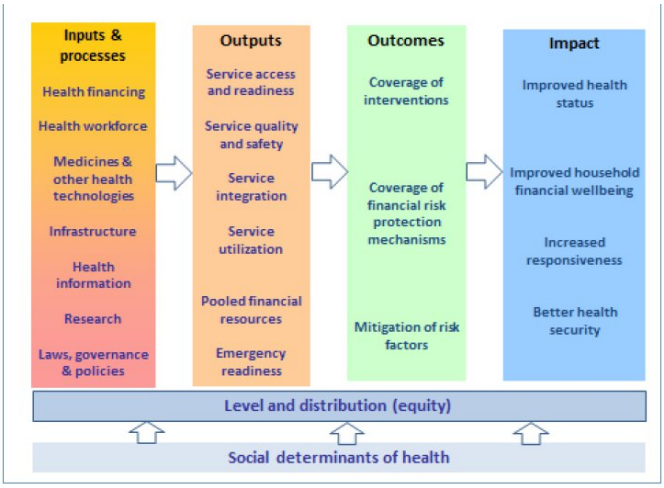

Figure 3: Results framework focus for UHC monitoring

World Health Organization and WB jointly proposed a framework on "*Monitoring Progress towards Universal Health Coverage at Country and Global levels"* The framework is part of a comprehensive monitoring of national health system performance.

Service Coverage

For service coverage, two different sets of indicators are proposed by WHO:

1. The set of interventions related to the health MDGs, with focus on communicable diseases, reproductive health, and nutrition for mothers and children
2. The set of interventions related to Chronic Conditions and Injuries (CCIs), with focus on addressing NCDs, mental health and injuries for adolescents, adults and elderly

Health experts of Bangladesh health systems think that to achieve UHC in Bangladesh; the monitoring tools should not be confined only in MDGs and CCIs. It should also include other indicators covering the six building blocks of Health system as outlined by WHO.

Within each of these service coverage areas, specific indicators of coverage for priority services are selected based on:

- *Relevance* – Indicators should meet the priority health needs. Service should be cost effective and the source of the service covered major health expenditure.
- *Quality* – Indicators should have quality and be measured effectively.
- *Availability* – Indicators should be regularly, reliably, and comparably measured (i.e. numerators/denominators/equity stratification) with existing instruments (e.g. household surveys or health facility information systems).

Financial Risk Protection Coverage

For financial risk protection coverage, there are two commonly used indicators:

1. Incidence of catastrophic health expenditures: number of households of all income levels who suffer financial hardship because of relatively large health payments in a given time period (with equity sub-indicator)

2. Incidence of impoverishment due to out of pocket health payments: captures the fact that even relatively small payments can have severe financial consequences for people living in poverty or close to the poverty line

Financial risk protection should be covered 100% of population. This "protection from catastrophic spending" indicator will measure the percent of the population that does not experience catastrophic payments, while a "protection from impoverishment" indicator will be the percent of the population that is not impoverished through out-of-pocket spending. The impoverishment measure the poverty gap in the absence of out-of-pocket payments as a share of the actual (larger) poverty gap. The more out-of-pocket payments push non-poor families into poverty and already-poor households deeper into poverty.

Equity in Coverage

One of the major goals of UHC is equity, which means full coverage of the population as per need. For measuring equity in coverage, it is essential to have measure disaggregated by range of socio-economic and demographic stratifiers. In the line of proposed global framework Bangladesh will measure three primary elements of disaggregation – income/wealth, gender, place of residence (e.g. rural/urban). Performance of indicators in disadvantaged population (e.g. char population, hilly population, ethnic minorities) should be measured and this need to be addressed and should be take account for capturing differences in comparison between the level of the extreme group and the population as a whole.

4. Methods

Health Economics Unit, MOHFW led the development of UHC monitoring tools. Core team was assisted technically and financially by WHO. This core team composed of representatives from MOHFW, DGHS, DGFP, NIPSOM, icddr,b, IHE, University of Dhaka, WB etc. This team is entrusted to ensure the performance of the tasks for UHC Monitoring and assist in institutionalizing it. This team conducted extensive literature review of different documents on policies and different countries experiences, and discussed with different experts. Following which they proposed a set of indictors as draft UHC monitoring tools. Draft monitoring tools is validated by workshops with wider participation from different stakeholders. Regular meetings took place for its updating. These monitoring tools were endorsed and finalized as set of UHC monitoring indicators by MOHFW. Data was collected and analyzed by literature review and analysis the existing data after validation of monitoring tools. The draft document was widely circulated through e-mail for inputs and observations. After receiving feedback a workshop was held with wider participation of different stakeholders. The draft document again circulated widely through e-mail to the experts of different specialties. The valuable inputs which were incorporated and indicators for monitoring UHC were finalized.

5. Indicators of Universal Health Coverage in Bangladesh

Input & Process	
	Health Workforce
1.	Number of doctors per 10,000 population
2.	Number of Nurses & midwives per 10,000 population
3.	District/UPZ hospital and below have 1 Obs/Gynae + 1 anaesthesiologist
	Infrastructure
4.	Number of Hospital beds per 10,000 population
	Medicines
5.	Availability of essential medicines in public facilities
6.	Median drug price ratio for tracer drugs
	Health Information & Research
7.	Health Facilities having electronic health records (EHR)
	Health Care Financing
8.	Public spending in health (per capita, as a % of TEH)
9.	Social HI contribution (per capita as % of TEH)
10.	Other health insurance (ex. Employer-supported health insurance) (per capita as % of TEH)
11.	Share of health spending in total government expenditure
12.	Health expenditure per capita
13.	Health expenditure as % of GDP
14.	OOPS for health (per capita as % of THE)
OUTPUT	
	Service access and readiness
15.	Index of service readiness & Availability
16.	Proportion of health facilities offering EOC & IMCI services
	Service quality and safety
17.	% clients expressing satisfaction with health facilities
OUTCOME	
	Service delivery/ Coverage of Intervention

18.	% of pregnant women attending 4 ANC visits
19.	% of institutional deliveries
20.	TB treatment success rate
21.	ITN (Insecticide treated bed net) coverage among HH of endemic area
22.	% of children under one year with 3rd dose Pentavalent vaccine
23.	Case fatality rate among hospitalized ARI cases
	Risk factors and Behaviours
24.	% of HH with access to safe water
25.	% of HH have access to improved sanitation
26.	Incidence of Drowning
27.	Contraceptive prevalence rate
28.	Tobacco prevalence rate
	Health Care Financing
29.	OOPS for health in total household consumption expenditure
30.	Share of population (%) lack adequate healthcare due to financial hardship
IMPACT	
	Improved Health Status
31.	Life expectancy at birth
32.	Neonatal mortality rate
33.	Infant mortality rate
34.	Total fertility rate
35.	Population growth rate
36.	Maternal Mortality Ratio
37.	% of underweight among under 5 children
38.	% of stunted among under 5 children
39.	Prevalence of HIV among MARP
40.	TB prevalence rate
41.	% of diabetic & hypertension receiving treatment
	Health Security
42.	Share of population (%) fall into poverty due to OOPS
43.	Share of households (%) facing catastrophic health spending

6. Logical Framework of UHC monitoring tools

Level	Indicators	Means of Verification	Assumption
IMPACT			
To Improve health and nutritional status of people, especially the poor and excluded population	Life expectancy at birth Neonatal mortality rate Infant mortality rate Total fertility rate Population growth rate Maternal mortality ratio % of underweight among under 5 children % of stunted among under 5 children TB prevalence rate Prevalence of HIV among MARP % of diabetic & hypertension receiving treatment Share of population (%) fall into poverty due to OOPS Share of households (%) facing catastrophic health spending	• Bangladesh Demographic Health Survey (BDHS) • Bangladesh Maternal Mortality and Health Care Survey • Urban Health Survey (UHS) • EPI coverage evaluation survey • Administrative records • Multiple Indicator Cluster Survey (MICS) • Sample Vital Registration Survey (SVRS) • Household Income and Expenditure Survey (HIES) • National Health Accounts (NHA) • Health Bulletin • Utilization of Essential Service Delivery (USED) survey • State of Food security and Nutrition in Bangladesh • Other relevant documents	• Government and development partners should committed to reduce poverty and achieve Universal Health Coverage • Political and economic instability; Any epidemic or pandemic; global or country economic depression Disaster and climate change
OUTCOME			
Improve and strengthened equitable and quality health service delivery systems to achieve universal health coverage especially for poor and excluded	% of pregnant women attending 4 ANC visits % of institutional deliveries TB treatment success rate ITN (Insecticide treated bed net) coverage among HH of endemic area % of children under one year with	• Bangladesh Demographic Health & Survey (BDHS) • Bangladesh Maternal Mortality and Health Care Survey • Urban Health Survey (UHS) • National Nutritional Survey	The availability and quality of services will be affected by limited resources to deploy and retain health care personnel, especially in remote areas.

	3rd dose Pentavalent vaccine	• EPI coverage evaluation survey • Administrative records • Multiple Indicator Cluster Survey (MICS) • Sample Vital Registration Survey (SVRS) • Utilization of Essential Service Delivery (UESD) survey • Household Income and Expenditure Survey (HIES) • National Health Accounts (NHA)	
	Case fatality rate among hospitalized ARI cases		
Increase adoption of healthy practices and lifestyle	% of HH with access to safe water		• Proper health education on increased health knowledge and awareness and involvement needed multi-sectoral partners • Health practices in excluded group
	% of HH have access to improved sanitation		
	Incidence of drowning		
	Tobacco prevalence rate		
	Contraceptive prevalence rate		Reduced cultural barriers to accessing health care services
	OOPS for health in total household consumption expenditure		
	Share of population (%) lack adequate healthcare due to financial hardship		
OUTPUT			
Improved accessibility and readiness of the health services	Index of service readiness & Availability	• Bangladesh health facility survey • Service availability and readiness assessment (SARA)	• Absenteeism of health care providers in rural and remote areas. • Social and cultural factors prohibiting the poor and women from accessing facility based services • Physical factors and infrastructure • Natural calamity
	Proportion of health facilities offering EOC & IMCI services		
Improved service delivery	% clients expressing satisfaction with health facilities	• Surveillance/Survey	
INPUT			
Strengthened human resources for health	Number of doctors per 10,000 population	• Bangladesh health facility survey • Administrative records	• Increase institutions which develop health care personnel other than physician • Focus may shift to only doctors
	Number of Nurses & Midwives per 10,000 population		
	District/UPZ hospital and below have		

	1 Obs/Gynae + 1 anaesthesiologist		or establishing medical colleges • Migration of health worker
Improved physical assets and logistics management	Number of Hospital beds per 10,000 population		• Increase capacity to achieve Universal Health Coverage • Proper development of leadership and managerial capability in public health • Appropriate support to develop technology and skilled of health personnel
	Availability of essential medicines in public facilities		
	Median drug price ratio for tracer drugs		
Improved M&E and health information systems	Health Facilities using electronic health records (EHR)		
Increase financing in health sector	Public spending in health (per capita as % of THE)	• Budgetary / Financial analysis • NHA • HIES	• Improved governance in health and financial management • Economic stability and political commitment will ensure public spending in health
	Social HI contribution (per capita as % of TEH)		
	Other health insurance (ex. Employer-supported health insurance) (per capita as % of TEH)		
	Share of health spending in total government expenditure		
	Health expenditure per capita		
	Health expenditure as % of GDP		
	OOPS for health (per capita as % of THE)		

7. UHC Monitoring Indicators with data

Sl	Indicator	Disaggregation by	Baseline			Frequency of data availability
			Data	Year	Source	
	Health Workforce					
1.	Number of doctors per 10,000 population	National	4.04	2013	HRH country profile	Yearly
		Rural	45%			
		Urban	55%			
		Male	69%			
		Female	31%			
2.	Number of Nurses & Midwives per 10,000 population	National	2.04	2013	HRH country profile	Yearly
		Male	5%			
		Female	95%			
3.	District/UPZ hospital and below have 1 Obs/Gynae + 1 anaesthesiologist		32%	2014	Records	Yearly
	Infrastructure					
4.	Number of Hospital beds per 10,000 population	National	6.08	2013	HB	Yearly
	Medicines & Reagents					
5.	Availability of essential medicines in public facilities	37 drug list	26% facilities have75% or more of essential medicines	2011	BHFS	Bi-yearly
6.	Median drug price ratio for tracer drugs		283	2011	BHFS	Bi-yearly
	Health Information & Research					
7.	% of health facilities having electronic record (EHR)		<1%	2014	Records	Yearly
	Service access and readiness					
8.	Index of service readiness & Availability	National	29.12	2011	BHFS	Bi-yearly
9.	Proportion of health facilities offering EOC & IMCI services		30.8%	2014	Administrative records	Yearly
	Service quality and safety					
10.	% clients expressing satisfaction with health facilities	National Mean score	3.04	2011	Health Facility Survey	Bi-yearly
		% facilities with score 3 or more	90.1%			

Sl	Indicator	Disaggregation by	Baseline			Frequency of data availability
			Data	Year	Source	
	Service delivery/ Coverage of Intervention					
11.	% of pregnant women attending 4 ANC visits	National	25.5	2011	BDHS	4 yearly
		Rural	19.8			
		Urban	44.7			
		Highest quintile	81.4			
		Lowest quintile	45.3			
	% of pregnant women attending 4 ANC visits	National	25.0	2013	Utilization of Essential Service Delivery Survey (UESD)	
		Rural	18.4			
		Urban	44.9			
		Highest quintile	43.6			
		Lowest quintile	8.9			
12.	% of institutional deliveries	National	32.8	2013	UESD	
		Rural	26.0			
		Urban	53.1			
		Highest quintile	56.8			
		Lowest quintile	14.3			
		Public	12.			
		Private	15			
13.	TB treatment success rate	National	92.0	2012	NTP	
		Highest quintile	12.3			
		Lowest quintile	28.0			
14.	ITN (Insecticide treated bed net) coverage among HH of endemic area	National	96.2	2012	Health & Morbidity Survey	
		Rural	96.5			
		Urban	95.2			
		Male	96.2			
		Female	96.1			
15.	% of children under one year with 3rd dose Pentavalent vaccine	National	89.65	2011	EPI Coverage Survey	Yearly
		Rural	89.7			
		Urban	89.2			
		Male	89.5			
		Female	89.8			
		Highest quintile	92.3			
		Lowest quintile	86.2			
16.	Case fatality rate among hospitalized ARI cases	National	4.3	2013	UESD	
		Rural	4.5			
		Urban	3.8			

Sl	Indicator	Disaggregation by	Baseline			Frequency of data availability
			Data	Year	Source	
		Male	4.9			
		Female	3.7			
		Highest quintile	2.4			
		Lowest quintile	6.3			
	Risk factors and Behaviours					
17.	% of HH with access to safe water	National	97.9	2012	MICS	5 years
		Rural	98.2			
		Urban	99.4			
18.	Incidence of Injury	Incidence of fatal drowning per 100,000 among 1-17 years	28.6	2005	BHIS	
19.	% of HH have access to improved sanitation	National	55.9	2012	MICS	5 years
20.	Contraceptive prevalence rate	National	63.0	2010	BMMS	
		Rural	61.7			
		Urban	65.1			
		Male	6.0			
		Female	61.0			
		Highest quintile	61.6			
		Lowest quintile	63.9			
		Public	70.3			
		Private	29.3			
21.	Tobacco prevalence rate	National	43.3	2009	GATS	
		Male	58			
		Female	28.7			
	Improved Health Status					
22.	Life expectancy at birth	National	67.7	2010	SVRS	Yearly
		Rural	67.4			
		Urban	68.9			
		Male	66.6			
		Female	68.8			
23.	Neonatal mortality rate	National	26	2010	SVRS	Yearly
		Rural	26			
		Urban	25			
		Male	28			

Sl	Indicator	Disaggregation by	Baseline			Frequency of data availability
			Data	Year	Source	
		Female	24			
24.	Infant mortality rate	National	36	2010	SVRS	Yearly
		Rural	37			
		Urban	35			
		Male	38			
		Female	35			
25.	Total fertility rate	National	2.3	2011	BDHS	Bi-Yearly
		Rural	2.5			
		Urban	2.0			
		Highest quintile	1.9			
		Lowest quintile	3.1			
26.	Population growth rate	National	1.36	2010	SVRS	Yearly
27.	% of underweight among under 5 children (≤ 2SD & ≤ 3SD)	National	45.0	2011	Nutrition, Health and Demographic Survey (NHDS)	
		Rural	45.0			
		Urban	43.0			
		Male	44.4			
		Female	44.8			
28.	% of stunted among under 5 children (≤ 2SD & ≤ 3SD)	National	40.2	2011	Nutrition, Health and Demographic Survey (NHDS)	
		Rural	42.0			
		Urban	37.0			
		Male	40.2			
		Female	40.2			
29.	TB prevalence rate/100,000 population	National	45.0	2013	MDG Progress Report	
30.	Prevalence of HIV among MARP	National	< 1%	2011	National HIV sero surveillance report	
31.	Percentage of diabetic patient taking treatment	National	64.7			
		Male	64.9			
		Female	64.4			
	Percentage of hypertensive patient taking treatment	National				
		Male				
		Female				
32.	Maternal Mortality Ratio	National	194	2010	BMMS	
		Rural	199			
		Urban	178			
		Highest quintile	123			
		Lowest quintile	234			

Sl	Indicator	Disaggregation by	Baseline			Frequency of data availability
			Data	Year	Source	
	Health care financing and Health protection					
33.	Public spending in health (per capita; as a % of THE)		500.34 BDT; 23.1%	1997-2010	BNHA	10 yearly
34.	Social HI contribution (per capita as % of THE)					10 yearly
35.	Other health insurance (ex. Employer-supported health insurance) (per capita as % of THE)		BDT 1.48; 0.1%	1997-2010	BNHA	10 yearly
36.	Share of health spending in total government expenditure		4.7%	1997-2010	BNHA	10 yearly
37.	Health expenditure per capita		BDT 2,144 US$ 27 PPP$ 68	1997-2010	BNHA	10 yearly
38.	Health expenditure as % of GDP		3.5%	1997-2010	BNHA	10 yearly
39.	OOPS for health (per capita as % of THE)		1371.77 BDT; 63.30%	1997-2010		
40.	OOPS for health in total household consumption expenditure		4.30%	1997-2010	HIES & BNHA	
41.	Share of population (%) lack adequate healthcare due to financial hardship		15.57%	2010	HIES	
42.	Share of population (%) fall into poverty due to OOPS		3.50	2010	Research study on HIES 2010 data	
43.	Share of households (%) facing catastrophic health spending		14.20%	2010	Research study on HIES 2010 data	

8. Strength and Weakness of information system for monitoring progress towards UHC

Strengths

- Government has strong political commitment to achieve and ensure UHC
- Bangladesh developed strong online data transfer system from field or hospital to central level
- A good software is established for proper data sending and data analysis.
- Demographic and Health survey is conducted routinely
- There are many different surveys are conducted by different institutions for desired data collection
- Well established institutions are developed for conducting surveys related to health and demography
- Yearly publication of central and local health bulletin

Weaknesses

- Reliable data are unavailable in routine data collection system
- There are low Levels of data Completeness and timeliness in routine data
- There are delays in compiling routine data
- There are delays in publication of survey reports
- Lack of coordination between the different stakeholders collecting routine HIS
- Duplication of data collection
- Community health workers yet to be fully sensitized
- Incorporation of data from private and NGO health service providers
- Data from primary health care activities of urban settings conducted by MOLGRD are not merged with HMIS.

Recommendations for Measuring and Monitoring Progress towards UHC

- Government should take necessary steps to improve collecting quality epidemiological data from both public and private facility and also from field level
- Mobilize adequate and appropriate technical and financial resources to institutionalize key monitoring studies in financial risk protection
- Capacity building in measurement methods, particularly in the area of protection against financial risk
- Capacity building of HEU, MOHFW to enable them to monitor UHC indicators and analyze national survey data.
- MOHFW should feed data regularly to policy maker on UHC progress which help policy maker to take decision.
- Data of DGHS, DGFP and MOLGRD should be interoperable

- Government should have effective coordination mechanism for monitoring, evaluation and review of UHC progress
- Institutions and stakeholders who are responsible for measuring UHC should produce regular report to monitor the UHC progress.
- Creation a sub-link in the HEU webpage sharing the message of UHC
- Prepare a dashboard of UHC monitoring tools in the Website
- Annual congregation may be arranged to share the issues with the concerned stakeholders.
- Equity analysis should be done on the UHC monitoring tools

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Annex I: Goal and Targets proposed by WHO-WB group are -

Goal

Achieve UHC. All people obtain the good-quality essential health services that they need without enduring financial hardship.

Targets

- By 2030, all populations, independent of household income, expenditure or wealth, place of residence or gender, have at least 80% essential health services coverage.
- By 2030, everyone has 100% financial protection from out-of-pocket payments for health services.

Indicators

1. **Health services coverage**
   - **1.1 Prevention**
     - 1.1.1 *Aggregate:* coverage with a set of tracer interventions for prevention services.
     - 1.1.2 *Equity:* a measure of prevention service coverage as described above, stratified by wealth quintile, place of residence and gender.
   - **1.2 Treatment**
     - 1.2.1 *Aggregate:* coverage with a set of tracer interventions for treatment services.
     - 1.2.2 *Equity:* a measure of treatment service coverage as described above, stratified by wealth quintile, place of residence and gender.
2. **Financial protection coverage**
   - **2.1 Impoverishing expenditure**
     - 2.1.1 *Aggregate:* fraction of the population protected against impoverishment by out-of-pocket health expenditures, comprising two types of household: families already below the poverty line on the basis of their consumption and who incur out-of-pocket health expenditures that push them deeper into poverty; and families for which out-of-pocket spending pushes them below the poverty line.
     - 2.1.2 *Equity:* fraction of households protected against impoverishment or further impoverishment by out-of-pocket health expenditures, stratified by wealth quintile, place of residence and gender.
   - **2.2 Catastrophic expenditure**
     - 2.2.1 *Aggregate:* fraction of households protected from incurring catastrophic out-of-pocket health expenditure.
     - 2.2.2 *Equity:* fraction of households protected from incurring catastrophic out-of-pocket health expenditure stratified by wealth quintile, place of residence and gender.

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