



GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

BANGLADESH HEALTH WORKFORCE STRATEGY 2015

Human Resource Management Unit
Ministry of Health and Family Welfare

MESSAGE



I am happy to know that the Ministry of Health & Family Welfare (MOHFW), Government of Bangladesh is going to launch “Bangladesh Health Workforce Strategy 2015”, which I think essential and timely. As we know that Bangladesh has made remarkable progress in achieving millennium development goals (MDGs) and almost all human development indicators are improving including health. All those successes led us to obtain a ‘middle income country’ status in 2015. Such historical achievement was possible due to joint effort of all of us under the commendable leadership of the present Government. All success stories are now inspiration for us to go ahead to achieve new targets set in line with our new expectations. We are now aiming to become an upper middle income country by 2021, targeting universal health coverage (UHC) by 2030 as a part of sustainable development goals (SDGs) and also preparing our vision for 2041.

Health workforce is the critical but vital component of the health system. In fact, there is no health without a health workforce. MOHFW has a responsibility to fulfill health and nutrition needs of the population and is constantly adopting new programs as required in collaboration with both public and private sector organizations. But proper management of the workforce in all sectors at all levels is still remaining critical in terms of maintaining service quality and efficient management of non-human resources. We all are looking for quality health workforce who can produce quality health service and the health system.

Formulation of “Bangladesh Health Workforce Strategy 2015” is a foundation stone in this regard as the strategy is envisioning a “Quality health workforce for health and wellbeing of the people of Bangladesh”. I believe the strategy contains specific directions to produce quality health service by a quality workforce which will help to progressively move ahead achieving the broader goals and objectives identified.

Finally I would like to congratulate the Human resource Management Unit of the MOHFW who led this activity and all its officials and also all distinguished personalities at both public and private sectors including development partners who took part in developing the strategy. I strongly believe that they will not stop here but will take necessary initiatives to implement the strategy. I wish you all the best in this regard.

Joy Bangla, Joy Bangabandhu.

Mohammed Nasim, MP

Minister

Ministry of Health and Family Welfare

MESSAGE



The centrality of health workers in achieving health outcomes has long been known. But now we have better evidence than ever before on what works and what doesn't in health workforce development across different aspects ranging from planning, education, management, retention and incentives.

A need based, updated health workforce strategy was a long cherished requirement for health and population sector. I am delighted to know that HRM Unit, Ministry of Health and Family Welfare is going to publish this strategic document. This important document is obviously a success which took substantial time for extensive consultation, team work and information gathering.

I wish to acknowledge the human resource for health team, which comprised of representatives from government and nongovernment organizations, training and educational institutions, regulatory bodies, professional associations, representatives from development partner and individual consultants.

I think there is always scope for further development in any document but in the beginning of SDG this health workforce strategy bears an utmost importance for policy people, planners, managers and academicians.

I wish every success of this endeavor

Joy Bangla
Joy Bangabandhu
Long live Bangladesh

Zahid Maleque, MP

State Minister

Ministry of Health and Family Welfare

FOREWORD



A capable and responsive health system is a prerequisite for any healthy and wealthy nation. Health workforce is an indispensable component of the health system. In fact, health system performance is heavily dependent on the workforce. In order to make the system responsive and functional, proper management of the workforce is important. Management of the workforce gets more importance in a context when we find them in a great variety and in large number and also the reality of presence of multiple stakeholders/interest groups. In this circumstance, development of the health workforce strategy is a guiding reference document in order to facilitate proper management.

Bangladesh is committed to achieve sustainable development goals and also aiming to achieve universal health coverage by 2030. We are also in a stage to finalize the 4th sector program for Health, Nutrition and Population. In this background, "Bangladesh Health Workforce Strategy 2015" has been developed which is very timely and helpful for planners, policy makers, managers and development partners (at both public and private sectors). It is expected that the strategy will address the key health workforce issues and challenges prevailing in the country in order to meet and support proper implementation of health plan and programs in line with meeting people's expectation.

The strategy is envisioning for a quality health workforce so that quality health service can be ensured at all level of care through initiatives of public private partnership, gender balance, continuous motivation of the workforce and also ensuring accountability and transparency for workforce governance.

I am pleased to know that the Ministry of Health & Family Welfare is going to publish this strategy, for which we waited for a long time. I congratulate all who were directly or indirectly involved in developing this document. However, only publication is not enough, the strategy will beget nothing unless it is implemented. Therefore, the big challenge is still remaining. I hope that HRM Unit and the related partners will carry this forward for implementation. I can ensure all cooperation from my side.

I wish a successful implementation of the strategy.

Syed Monjurul Islam

Secretary

Ministry of Health and Family Welfare

ACKNOWLEDGEMENT



It gives me immense pleasure to finally write the acknowledgement. Formulation as well as finalization of the Health Workforce Strategy (HWFS) was not an easy task given the presence of multiple stakeholders. However, the effort was successful due to adoption of a participatory consultative approach with an array of related stakeholders' involvement over a period of a year. The process has been led by Human Resources Management (HRM) Unit with full support and thoughtful guidance of the Honorable Minister of Ministry of Health & Family Welfare.

Since the beginning of the development process of the strategy, Secretary Mr. Syed Monjurul Islam actively contributed in the consultation process in framing the outline of the strategy. We sincerely acknowledge his contribution.

The whole effort of formulation was guided by a Technical Working Committee (TWC) chaired by Dr. Md. Shajedul Hasan, Joint Secretary. With support from the focal TWC members Professor Dr. Liaquat Ali from Bangladesh University of Health Sciences, Dr. SAJ Musa from UNFPA, Dr. Jamal Uddin Chowdhury from BPMPA, Dr. Khairul Islam from WaterAid, Dr. Iqbal Anwar from icddr,b, Dr. Md. Shafiqur Rahman from DGHS, Human Resource Management Unit organized the regional and national level stakeholders' consultations. HRM Unit also received valuable support and inputs from Professor Dr. Abul Kalam Azad, ADG (Admin) and Director, MIS, DGHS and also from Professor Dr. Md. Ismail Khan, Principal, Dhaka Medical College.

Special thanks to Ms. Meaghan Byers from Canadian High Commission & Co-Chair, HRTG, Dr. Bushra Binte Alam of World Bank, Dr. Shehlina Ahmed of DFID and HRH Technical Consultants from WHO for their thoughtful comments and suggestions on various drafts of the strategy.

Finally, sincere thanks are also provided to WHO Country Office and Cowater HRH Project, Bangladesh for actively supporting and assisting the development of the HWFS document through out the process.

It is the product of the collaborative effort by many professionals inside and outside of HRMU, MOHFW and all the actors in the health workforce strategy development process deserve thanks for their respective contributions.

Bashudeb Ganguly

Additional Secretary (Admin) &
Line Director, HRM, MOHFW

List of acronyms

ADP	:	Annual Development Programme
AMC	:	Alternative Medical Care
ASA	:	Association for Social Advancement
BBUAM	:	Bangladesh Board of Unani and Ayurvedic Medicine
BHB	:	Bangladesh Homeopathy Board
BHPC	:	Bangladesh Health Professional Council
BHWS	:	Bangladesh Health Workforce Strategy
BMA	:	Bangladesh Medical Association
BMDC	:	Bangladesh Medical and Dental Council
BNC	:	Bangladesh Nursing Council
BPCDOA	:	Bangladesh Private Clinic and Diagnostic Owners Association
BSMMU	:	Bangabandhu Sheikh Mujib Medical University
BTEB	:	Bangladesh Technical Education Board
CC	:	Community Clinic
CWCH	:	Centre for Woman and Child Health
DFATD	:	Department of Foreign Affairs, Trade and Development
DFID	:	Department for International Development
DG	:	Director General
DGDA	:	Directorate General of Drug Administration
DGHS	:	Directorate General of Health Services
DGFP	:	Directorate General of Family Planning
DP	:	Development Partners
DNS	:	Directorate of Nursing Services
EDCL	:	Essential Drug Company Limited
ESP	:	Essential Services Package
FIVDB	:	Friends in Village Development Bangladesh
GIZ	:	Gesellschaft für Internationale Zusammenarbeit
GOB	:	Government of Bangladesh
HED	:	Health Engineering Department
HEU	:	Health Economics Unit
HPC	:	Health Professional Council
HPN	:	Health, Population and Nutrition

HPNSDP	:	Health, Population and Nutrition Sector Development Programme
HR	:	Human Resources
HRM	:	Human Resources Management
HRIS	:	Human Resource Information Systems
HWF	:	Health Workforce
HWIS	:	Health Workforce Information System
IPM	:	Individual Performance Management
JICA	:	Japan International Cooperation Agency
JLI	:	Joint Learning Initiative
MBBS	:	Bachelor of Medicine and Bachelor of Surgery
MDG	:	Millennium Development Goal
ME&HMPD	:	Medical Education and Health Manpower Development
MOE	:	Ministry of Education
MOPA	:	Ministry of Public Administration
MOHFW	:	Ministry of Health & Family Welfare
NIPORT	:	National Institute of Population Research and Training
NIPSOM	:	National Institute of Preventive & Social Medicine
NGO	:	Non-Government Organisation
OSD	:	Officer on Special Duty
PCB	:	Pharmacy Council of Bangladesh
RCHCIB	:	Revitalization of Community-based Healthcare Initiatives in Bangladesh
RDRS	:	Rangpur Dinajpur Rural Service
SIDA	:	Swedish International Development Cooperation Agency
SEARO	:	South East Asian Regional Office
SDGs	:	Sustainable Development Goals
SMF	:	State Medical Faculty
TEMO	:	Transport & Equipment Maintenance Organisation
TMSS	:	Thengamara Mohila Sabuj Sangha
UHC	:	Universal Health Coverage
WFME	:	World Federation for Medical Education
WHO	:	World Health Organisation

Executive Summary

The Bangladesh Health Workforce Strategy (BHWS) 2015 has been formulated with the view to support achieving the pre-determined goals and objectives set for the development and advancement of the health, nutrition and population (HNP) sectors of the country. The BHWS 2015 strategy is aligned with the vision of the Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011-2016, the National Health Policy 2011, National Population Policy 2012, National Nutrition Policy 2015 and also the World Health Report 2006, which collectively recognise the importance of the central role of the health workforce (HWF) for a responsive and people-centred health system. The strategy provides a framework which includes strategic interventions and supportive actions in order to address priority health workforce management issues and challenges identified through adopting a participatory consultative approach assisted by a rapid situational analysis.

The BHWS 2015 formulation process was initiated through formation of a technical working committee at the national level led by the Joint Secretary, HRM of the Ministry of Health & Family Welfare (MOHFW). Overall guidance was provided by the Human Resource Task Group, chaired by the Additional Secretary (Administration) and Line Director, HRM, MOHFW. Thematic papers on health workforce issues and challenges were drafted by the technical sub-groups with representatives from the service organisations, academia, research organisations, NGOs, professional associations and public sector organisations. After compilation as well as integration of the thematic papers, a preliminary draft was prepared and shared with the key stakeholders in central and regional level workshops which were later followed by national level stakeholder consultations. Collected feedback and suggestions were addressed and incorporated into the final draft before submitting it to the national level Human Resource Taskforce chaired by the Secretary, MOHFW.

HWF issues and challenges in a country like Bangladesh are many. Major HWF issues include chronic shortage of formally trained HWF, mal-distribution of them in rural, hard to reach and urban areas, skill mix imbalance, weak knowledge-base and accountability framework, traditional performance management systems, poor workforce monitoring mechanism, lack of supporting working environment, gender imbalance especially in senior level posts, lack of comprehensive HWF data, evidence-based policy making, lack of organisational/ health facility review (periodic) and highly centralised HWF decision making process at the public sector. All of these issues and challenges are summarized under five thematic areas. These are: (i) *Health workforce planning*; (ii) *Health workforce capacity development*; (iii) *Health workforce deployment, retention and professional engagement*; (iv) *Management of high performance standards*; and (v) *Health workforce information system*. Each of the thematic areas is guided by one strategic objective resulting in five total objectives in the BHWS 2015.

The strategy intends to cover the entire health workforce working in the country but initially focuses on the public sector workforces which is mostly under the MOHFW. However, it also contains directions to include the workforce under the private, NGO

and informal subsectors to begin with. Furthermore, this strategy is formulated for five years (2016-21) with long-term interventions up to 2030. The strategy will be reviewed and updated from time to time as progress is made in the priority areas and new priorities for action emerge. The actions needed in order to achieve strategic objectives of each thematic area are phased out. Priority actions for the short-term (2016-17) are noted together with explicit guidelines for actions. Specific descriptions of interventions for the medium-term (2017-21) and long-term (2021-30) are then outlined.

The strategy envisions a “quality health workforce for the health and wellbeing of the people of Bangladesh” with the mission to “ensure quality health service for all by developing skilled, motivated and responsive health workforce in adequate numbers and available equitably across the country”. The strategy is underpinned by four guiding principles: gender balance, motivation, partnership and transparency and accountability. These principles will guide implementation of the strategic interventions to support the realisation of the vision and mission of the strategy as a whole.

The BHWS (2015) strategic objectives along with supportive interventions are given below:

1. Health Workforce Planning

Strategic objective: Make available competent and adequate number of workforce as per health systems need.

- Develop and implement a comprehensive health workforce plan considering the skill mix and health systems needs with particular focus on UHC;
- Align production of the health workforce according to the projected requirement.
- Promote health systems research for evidence-based planning and maintenance of the health workforce.

2. Health Workforce Capacity Development

Strategic objective: Produce, develop and sustain quality health workforce at all levels.

- Improving skill mix
- Quality assurance/improvement and accreditation of academic/training programmes and institutes
- Education/production of health workforce
- Training in Health, Nutrition and Population sector;
- Task shifting

3. Health workforce deployment, retention and professional engagement

Strategic objective: Recruit, deploy and retain health workforce equitably.

- Support health workforce supply through multifaceted and sustainable approaches for recruitment and retention;

- Continue to develop health workforce information sharing (i.e., monitoring, evaluation and reporting) for potential solutions to challenges;
- Innovative approaches to address distribution issues, including incentives and disincentives to work in areas and sectors of greatest need, and workforce shortage;
- Use innovative models of service delivery to improve access to areas of physiographic and cultural need, and specialties in shortage;
- Explore and develop flexible working environments that reflect the changing needs and profile of the workforce;
- Explore and propose models that enable articulated, multiple career pathways to provide service-tenure career opportunities in the health sector;
- Promote initiatives that encourage the health workforce to maintain a level of skill, knowledge and competence that aligns with evolving consumer needs and changes in service delivery ensured through regulatory/legislative and professional bodies;

4: Management of high performance standard

Strategic objective: Promote and maintain high standards in health workforce performance.

- Understanding the implication of Performance Management System (PMS) as a part of HR;
- Health System strengthening through the development of an ideal and quality Performance Management System;
- Strengthening of the accountability framework by redesigning the roles, and responsibilities of the Ministry, different directorates and organisations;
- Updating the existing job description at a regular interval;
- Process development in the government. system for inviting more motivation and commitment of the service providers;
- Establishing institutional and individual appraisal system as a part of Performance Management;
- Improving performance and accountability framework according to organisation goal and objectives by IPM;
- Development/Introduction of Total Quality Management culture in the performance management system.

5: Health workforce information systems

Strategic objective: Promote evidence-based HWF decision making in improving health outcomes. Developing a comprehensive central HWF Information system and use it for evidence-based decisions.

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1. Introduction

“Health workforce” has been described as “the heart of the health system in any country” (WHO, 2006), “a fundamental component of health system strengthening” (WHO, 2007) and “the navigator of the health system” (WHO, 2006) in the contemporary literature. Performance of the health system is immensely dependent upon how best the workforce is developed, planned and utilised. A workforce strategy supports an organisation to achieve its vision, mission, goals and objectives. Bangladesh is aiming to become a middle-income country by 2021. Simultaneously, the Ministry of Health and Family Welfare (MOHFW) envisions to “see the people healthier, happier and economically productive to make Bangladesh a middle-income country by 2021”¹. The Ministry² is also aspiring to ensure universal health coverage (UHC) by 2032. It is worth mentioning that the Ministry is now in a process of formulating the 4th strategic plan for the health, population and nutrition (HPN) sectors as the 3rd sector programme (2011-2016) is supposed to end by June 2016. Therefore, it is vital that this workforce strategy supports the MOHFW’s plans and programmes undertaken in support to become a middle-income country by 2021 and also describes how best the health workforce can contribute towards achieving UHC.

2. Background

The health systems of Bangladesh has recently been applauded in the international arena for its remarkable performance achieved in the Millennium Development Goals (MDG) especially Goals 4 and 5 with significant declines in child and maternal mortality. Progress on reaching the MDG 1 regarding underweight children seems to be on track. These remarkable achievements have provided immense confidence to set UHC as one of the post MDG targets under the Sustainable Development Goals³ (SDGs) – Goal 3. Achievement of this success was possible due to the combined efforts of the health planners, policy makers, managers, frontline workers like physicians, nurses, all allied health workers, development workers who are directly and indirectly involved with the delivery process across sectors. Due to the presence of multiple stakeholders in the systems, a Lancet report (Ahmed et al. 2013) has characterized the prevailing health system as pluralistic combining different categories of the workforce across public, private (both “for profit” and “not for profit”), NGOs, associations, and informal sub-sectors.

Therefore, formulation of this health workforce strategy involves a participatory approach, which includes stakeholders engagement from public, private, NGOs, association and development partners.

¹ Health, Population and Nutrition Sector Development Programme (HPNSDP), 2011-2016

² Bangladesh Health Financing Strategy 2012-2032, Health Economics Unit, Ministry of Health & Family Welfare, Bangladesh.

³ Transforming Our World - the 2030 Agenda for Sustainable Development. Goal-3: Ensure healthy lives and promote wellbeing for all at all ages, September 2015 (accessed on October 26, 2015). available from <https://sustainabledevelopment.un.org/?menu=1300>.

Furthermore, observation, review of scientific literature and previous strategic papers and relevant official documents were also followed. The process, meanwhile, was supported by a rapid situation analysis, which led to identification of priority health workforce thematic areas followed by appropriate strategies for intervention. Finally a national health workforce strategy for Bangladesh has been attempted based on available health workforce data and information which contains a vision of the future health workforce, guiding principles, key strategies with appropriate actions to address key health workforce priorities requiring action up to 2030.

3. Situation analysis

3.1. Health workforce in policy guidelines

MOHFW, Bangladesh has adopted a sector wide approach to deliver its health and family welfare services. Its overall services are designed for and comprise three sectors, i.e. health, population and nutrition. For efficient management of those sectors, three national level policies are formulated as guidelines. Filling vacancies, addressing workforce shortages, capacity development and production, determination of health workforce needs, coordination among field level health workers and conducting research for evidence generation are the priority health workforce issues identified in all three national policies (i.e. National Health Policy 2011, National Population Policy 2012 and National Nutrition Policy 2015). Moreover, the National Health Policy (2011) particularly suggests formulating a health workforce strategy which should emphasise mitigation of prevailing skill mix imbalance, lack of incentives and ensuring justice in order to address shortage and mal-distribution of physician, nurse, pharmacist, physiotherapist, paramedics, technologist, and other health workers. The National Health Policy (2011) stresses strengthening health professional education and training through modernization and need-based curriculum including streamlining postgraduate medical education. The Health Policy also indicates to take necessary measures to ensure presence of the health workforce at the work station. All the policies emphasise ensuring transparency and accountability in recruitment, posting, transfer and promotion at all stages of the health system.

Bangladesh Health Financing Strategy (HEU, 2012) identified three major barriers for healthcare delivery: (i) inadequate health financing:- (ii) inequity in health financing and utilisation and (iii) inefficient use of existing resources. Available literature⁴ suggests that more than 50% of the total allocated budget for health is spent for HR management (i.e. salary, allowances and related expenditure). Hospitals consumes a significant portion of the budget and the government budget is allocated on the basis of the number of beds and staffs employed in the public sector, which does not always correspond to the actual need. However, health workforce financing data and information were not readily available and require more attention on strengthening the health workforce financial information system.

⁴ Ministry of Health and Family Welfare, Bangladesh 2013. Annual reports 2012-2013 (accessed on October 26, 2015). available from http://www.mohfw.gov.bd/index.php?option=com_content&view=article&id=244&Itemid=173&lang=en

3.2. Supply and distribution

Studies suggest that HWF density influences the number of mortalities (JLI, 2004). This means when the density of health workers increases, maternal, infant, and under-five mortality all fall. Bangladesh was categorized in the list of severe health workforce shortage countries in the World Health Report, 2006 as the country falls below the threshold of 22.8 (physician, nurse and midwife density) per 10,000 population. World Health Statistics (WHO, 2014) denotes the present status of 5.8 (physician, nurse and midwives) per 10,000 population in Bangladesh, which is far below the international standard. This is even the lowest level among WHO South East Asian Regional (SEAR) countries (WHO SEARO, 2014).

However, healthcare services in Bangladesh are provided by multiple categories of workforce that can be divided under different sectors including public, private (both 'for profit' and 'not-for profit'), NGO, associations and informal sectors (e.g. kobiraj, village doctors, drug-sellers, herbalists, Totka, faith healers and others who do not have any formal academic training). Major formally trained health workforce include physicians, dentists, nurses, midwives, medical assistants, health technologists, trained domiciliary workforce, alternative medical care professionals and other allied health professionals attached with management, finance, and administrative functions. A rapid growth of the private sector in terms of the health workforce production has been observed in the last decade. From the year 2008 to 2014, the number of MBBS seats has increased by 24% and 148% in the public and private sectors respectively (DGHS, 2014). For Diploma Nurse the increase is 128% in the public sector and 408% in the private sector (HRMU, 2014).

At the end of 2014, the total health workforce⁵ in the formal sub-sector is approaching 350,000, which is about an 185% increase from the 2003 estimate of 120,000 (over the same period, Bangladesh's population increased by 15% to 160 million). At least 155,000 (45%) occupy posts in the public sub-sector within the two major Directorates-General of the MOHFW⁶. A further 35,000 (10%) are practitioners of Alternative Medical Care (AMC) who, with some exceptions, work for-profit⁷. About 160,000 (45%) work as for-profit providers⁸, who dominate health provision in the urban areas. A minority work as not-for-profit providers. According to the organizing body of 'village physicians', the front-line informal provider, about 1.4 million members are working across 87,000 villages in the country.

According to the Bangladesh Health Watch Report 2007, density of qualified allopathic providers (i.e. physician, nurse and dentist) in the formal side is more prominent in urban areas than those in the rural (Table 1). The number of unqualified allopathic providers, traditional birth attendants and healers is more prominent in rural than urban areas. In terms of gender distribution, inequality in overall numbers exists: males are dominant in all HWF categories except nursing.

⁵ Human Resource for Health: Country Profile, Bangladesh, August 2013, Human Resource Management Unit, Ministry of Health and Family Welfare, Bangladesh P-47.

⁶ Health Bulletin 2014, Management Information System, Directorate General of Health Services, Bangladesh.

⁷ HRH Country Profile 2013, p-35

⁸ Ahmed SM, Evans TG, Standing H, Mahmud S. (2013). "Harnessing pluralism for better health in Bangladesh", The Lancet, 2013. 382(9906):1746–55.

Table 1: Distribution of various health care providers (both formal and informal) according to sex and geographical distribution

	Qualified allopathic providers			Semiqualified allopathic providers*			Traditional birth attendants (trained and untrained)	Unqualified allopathic providers		Traditional healers		Homoeopaths	
	Doctors	Nurses	Dentists	Para-professionals	Community Health workers			Village doctors	Drugstore vendors	kabiraj (Ayurvedic, Unani)	Faith healers	Qualified	Non qualified
					Gov	Non-gov							
National	5.4	2.1	0.3	1.0	3.2	6.4	33.2	12.5	11.4	32.7	31.5	3.4	2.5
Rural	1.1	0.8	0.08	0.8	3.6	7.3	42.0	13.8	10.8	42.1	40.5	2.5	2.9
Urban	18.2	5.8	0.8	1.6	2.0	3.9	6.0	8.8	13.2	4.4	4.2	6.1	0.9
Male	4.5	0.2	0.2	0.3	1.2	0.2	0.0	12.0	11.0	23.4	22.2	3.2	2.3
Female	0.8	1.8	0.03	0.7	2.0	6.2	33.2	0.4	0.4	9.3	9.3	0.3	0.1

There are also 1-7 providers per 10000 population including circumcision practitioners, ear cleaners and tooth extractors. Data from Bangladesh Health Watch. 9* received varying length of training from formal institutions either governmental or non-governmental organisation.
Source: Ahmed SM, Evans TG, Standing H, Mahmud S., 2013. "Harnessing pluralism for better health in Bangladesh", *The Lancet*, 2013. 382(9906):1746-55.

3.2.1 Health workforce in the public sector

In the public sector, there are several institutional actors providing health and family welfare services. Among them MOHFW bears the major responsibility of formulating plans, policies and strategies and undertakes programme for implementation, monitoring and evaluation services (GOB, 2012). According to an estimate, about 35% (i.e. 25,207) of the total graduate medical doctors⁹ work under the MOHFW and about 3% (i.e. 1,858) of them work under other Ministries including Social Welfare, Home, Local Government and Cooperatives, Railway, Women and Children Affairs, Defence and others (HRMU, 2014).

Health workforce supply in the public sector suffers due to lack of coordination and collaboration among the various Ministries. It is true that the MOHFW provides formal training to produce and develop the HWF but there are other Ministries, which also produce and develop the HWF. Bangladesh Technical Education Board (BTEB) under the Ministry of Education is providing courses such as Diploma in Nursing Technology (4 years), Health Technology, and other short-term training courses (e.g. 6 months to 1 year) for development of the health personnel. But the quality, accreditation and professional licensing is uncertain. Often due to lack of coordination or isolation, much of the workforce's contribution is not taken into account while considering the health system's overall performance. This makes formulation of a comprehensive health workforce policy complex.

3.2.1.1 Overview of the Ministry of Health and Family Welfare

On behalf of the government, MOHFW guides and undertakes necessary plans and programmes in line with health needs and demands of the people. MOHFW renders its services through an extensive healthcare infrastructure rolled out from top to bottom i.e. the headquarters based in the capital city up to the community level.

⁹. HRH Data Sheet, 2014, Human Resource Management Unit, Ministry of Health and Family Welfare, Bangladesh

MOHFW provides healthcare services through its technical and support departments namely the Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), National Institute of Population Research and Training (NIPORT), Directorate General of Drug Administration (DGDA), Directorate General of Health Economics Unit (HEU), Health Engineering Department (HED), Directorate of Nursing Services (DNS), Transport & Equipment Maintenance Organisation (TEMO), National Electro-medical & Engineering Workshop (NEMEW), Revitalization of Community-based Healthcare Initiatives in Bangladesh (RCHCIB), and Essential Drug Company Limited (EDCL).

MOHFW's regulatory functions are carried out by the following agencies: Bangladesh Medical and Dental Council (BMDC), Bangladesh Nursing Council (BNC), Pharmacy Council of Bangladesh (PCB), State Medical Faculty of Bangladesh (SMF), Bangladesh Homeopathy Board (BHB) and Bangladesh Board of Unani and Ayurvedic Medicine (BBUAM).

The MOHFW Secretariat provides support in the formulation of policy guidelines and processes necessary for administrative approval on related issues of the implementing agencies. The Secretariat has its own structure to provide support to the Secretary and to the Minister.

The MOHFW Secretariat comprises 8 Wings under the revenue budget. The Wings are Administration, Hospitals, Discipline and Nursing, Medical Education & Development, Family Planning & Programmes, Public Health & WHO, Financial Management & Audit and Planning.

In reality, all of the wings to some extent carry out traditional personnel management functions of the Ministry. However, the Administration wing of the Secretariat is primarily responsible for most of the personnel management functions, such as post creation, recruitment, selection, deployment (e.g. transfer, posting and deputation), leave and promotions. The Human Resource Management Unit is a programme based set up of the Ministry and exists as an operational plan attached with the Administration wing. The Unit provides health workforce policy, plan and strategy formulation support to the Ministry along with HW data and information generation. Many of the HR functions are carried out by the other Wings of the Ministry though they should be coordinated by and fall under the purview of the HRM Unit. The Unit is, however, running understaffed. Reasonably, the APR (2013) recommended undertaking steps to strengthen the Unit (PW, 2013).

The MOHFW's vision, mission and strategies are materialised through the above implementing and regulatory bodies. Each and every department has its organisational structure (Table of Organogram), which is composed with necessary human resources.

Out of all technical/implementing agencies, the DGHS shares the major portion of the total health workforce employed by MOHFW. About 56 per cent of the total workforce works under the DGHS whereas the DGFP's share is about 29 per

cent and the DNS's share is 13 per cent, with the remaining 2 per cent, shared by other implementing agencies. The MOHFW has one of the largest public health service networks covering door-step domiciliary services in the field and health facilities at different levels including Ward (community clinic), Union (union sub-centre, union health and family welfare centre etc.), Upazila (10- 20 bed hospital, 31-50 bed upazila health complexes with dedicated maternal and child health units etc.), District (100-250 bed district hospitals, chest hospitals, chest clinics, trauma centres, school health clinics, maternal and child welfare centres etc.), Division (250-500+ bed medical college hospitals) and several specialised hospitals (most of them based in the capital city). Despite such robust and extended infrastructure, the government is yet to capitalise its full potential. Making the network fully functional has been regarded¹⁰ as a challenge (GED, 2015).

3.2.1.2 HRM issues and challenges

The HWF is pre-dominantly linguistically and culturally homogenous and transferable across the country, although individual circumstances affect deployment in practice. Employment within the government sub-sector is prized for its job security which can be regarded conducive for production of satisfactory performance. Therefore, HWF management has a critical role to play.

Since the health workforce is the key health systems input, proper utilisation of it mainly depends on how the workforce is best planned and managed. But the HWF planning function has not been given much importance to determine the need and demand of the categories of workforce as per requirement of the population's health needs and international standards. Post creation, recruitment and selection are regular phenomena done through traditional practices as an administrative function, which has little or no strategic impact and is also rarely supported by scientific research and evidence. These decisions are primarily made on the basis of a 'rule of thumb'. Traditional personnel management practices are still in place within the Ministry instead of modern HRM concepts and techniques. Often health facilities are constructed and established without paying sufficient attention to human resource recruitment needs, which has left many health facilities underutilised. Functional or performance audit of the functioning institutions/ department are rarely conducted to ensure proper utilisation of resources. Financial audits are annually conducted but reports are rarely disclosed.

Recruitment, selection and deployment are important functions of the HRM Unit. According to the Rules of Business, 1996 of the Government, the Ministry of Public Administration (MOPA) bears the responsibility of formulating, reviewing, updating and approving all laws, rules and regulations related to all public servants. Technical ministries can propose to the MOPA necessary changes to any of the rules and regulations upon ensuring compliance. Many recruitment rules and promotion policies of the DGHS and the DGFP were formulated in 1980s and 1990s and have not been updated in recent years. Though a few steps were taken to update a couple of rules (i.e. medical physicist, statisticians), progress has been very slow. To increase efficiency in terms of performance, integration is needed between the two Directorates.

¹⁰-7th Five year Plan, FY 2016- FY 2020: Accelerating Growth, Empowering Citizens, December 2015. General Economic Division, Planning Commission, Ministry of Planning, Bangladesh.

The DNS has been facing problem for a long time because of its backdated recruitment rule, formulated in 1977. Recruitment and promotion of experienced and qualified nurses have not taken place due to absence of an appropriate recruitment rule. To comply with the commitment of the honourable Prime Minister, posts for about 2,996 midwife posts are gradually being created between 2015 and 2020. 600 posts have already been created at Upazila and Union Sub-centre level.

The health workforce in Bangladesh has ample opportunity of earning remittances and contributing to the country's economy, after meeting domestic need. WHO's Global Code of Practice on International Recruitment of Health Personnel (WHO, 2010a) can be a guiding document for the Ministry to take necessary action on this.

Vacancy is an important but common phenomenon at the MOHFW health facilities. It has been observed that on an average 20% of the total sanctioned posts are remaining vacant, which is not conducive at all for proper functioning of the organisation. Absenteeism and sub-optimal attendance of the HWF at their workplaces particularly in rural, remote and hard to reach areas, are frequently reported in the media. Thus rural retention of the

Sl.	Division	Registered Hospital & Clinic	Registered diagnostic centre
1	Barisal	107	250
2	Chittagong	526	1444
3	Dhaka	1505	2923
4	Khulna	661	586
5	Rajshahi	337	642
6	Rangpur	236	342
7	Sylhet	115	235

Source: Private Hospital and Clinics. (accessed on May 05, 2015) available from <http://www.hsmgdghs-bd.org/>

workforce is a challenge for the Ministry. There are many positions at the DGFP and the DNS which have never been filled since their creation. It has also been noticed that a good number of Director level positions are not filled by regular officers particularly in the DGFP and the NIPORT. In the DNS all most all permanent positions are temporarily filled by 'Current Charge' or 'In-Charge' mechanism. Regularisation of the individual employee into the post has not yet taken place. Skill mix imbalance is a priority concern for the policy makers. National Health Policy (MOHFW, 2011) stresses the skill mix composition, which includes 1 physician, 3 nurses and 5 allied professionals considering the international standards. But the scenario of the current workforce in the country is reverse i.e. the total number of registered medical doctors (MBBS; 75,514) is nearly two times more than that of nurses (Diploma; 38,452) and the number of medical technologists (Diploma; 16,454) is less than half of the total number of nurses (HRH Data Sheet, 2014). The ratio can be calculated as 1.00 (physician): 0.5 (nurse): 0.2 (medical technologist).

Deputation and deployment practices in the public health system frequently attract attention. Studies show that the density of physicians and nurses is significantly more in the urban areas (mostly in the capital city) compared to the rural. Sometimes health workforces (especially physicians) take advantage of the deputation policy for studying postgraduate courses. Deputation and deployment policies need to be reviewed for strict and fair application with proper engagement of the relevant

stakeholders. Moreover, absenteeism of health personnel at the workplace is detrimental to service delivery which causes suffering for the service seekers. However, unauthorised absence is regarded as a misconduct as per service regulation¹¹ and strict disciplinary measures are advised. The local monitoring and supervision mechanism needs to be strengthened in this regard. 'Officer on Special Duty' (OSD) is another means of deployment which frequently occurs in the civil service administration. However, OSD is not considered as a viable mechanism not only for the individual but also for the organisation due to certain limitations.

3.2.2 Healthworkforce in the private, NGO, associations and informal sub-sectors

The private, NGOs and other associations significantly contribute to the health service of the country. About 3,487 private hospitals and clinics and about 6,422 diagnostic centres were registered with the DGHS up to December 2013. However media reports suggest that the actual number may be much more than this. A study conducted by the Bangladesh Private Clinic and Diagnostic Owners Association (BPCDOA)¹² reveals that over 32,000 illegal private clinic and diagnostic Centres are being run in the country disregarding the medical Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982. Due to lack of capacity for proper monitoring and supervisory mechanisms, their services are remaining fully or partially un-regulated. A serious concern has emerged that dishonest and fake doctors are involved with illegal medical businesses, as a consequence, issues related to irrational use of drugs, over prescription, unnecessary and wrong medical diagnosis are frequently reported. Such cases, as described in the mass media, often directly contribute to high out of pocket expenditures, and finally can even threaten to lives.

The informal sector significant contributions to healthcare services in Bangladesh. Collectively the informal healthcare providers are the biggest in number. Among them are semi-qualified allopathic providers (e.g. community health workers, medical assistants, trained midwives), unqualified allopathic providers (drug shop retailers, rural doctors, etc.), traditional healers (practitioners of Ayurvedic, Unani and homeopathic medicine) and faith healers (WHO, 2015). Studies suggest that about 75% of the rural and 84% of the urban population depend on private, small, informal health-care service providers who are mostly semi-skilled with no professional training (WHO, 2015).

In Bangladesh, 13% of treatment-seekers use government services, 27% use private/NGO services, and 60% use unqualified services (Cockcroft et al., 2004). The findings represent the key challenges regarding the health workforce for the country as a whole for paving the pathways towards UHC while addressing availability, accessibility, acceptability and quality dimensions (GHWA, 2013). This can also be regarded as one of the major bottlenecks towards securing the status of a higher, middle-income country.

¹¹The Government Servants (Discipline & Appeal) Rule, 1985

¹²Shah Alam Nur. 32,000 Pvt. clinics, diagnostics centres operating illegally: Authorities apathy blamed (accessed on May 14, 2015) available from http://epaper.thefinancialexpress-bd.com/?archiev=yes&arch_date=15-12-2014#

On the NGO side, BRAC is the largest health workforce employer in the country next to the Government. It has about 90,000 community health workers (CHWs), i.e. “Shasthoy Shebika” and “Shasthoy Kormi”), along with other health workers (such as medical doctors, nurses, and technologists) across the country. Other prominent NGOs include Gonosasthoy Kendro, Grameen Shasthoy, Shajeda Foundation, ASA, TMSS, RDRS, FIVDP, CWCH and others.

From the international NGOs (INGOs), Development Partners (DPs), and UN agencies the leading organisations are WHO, UNFPA, UNICEF, UNAIDS, ICDDR,B, USAID, GAC Canada, DFID UK, European Union, JICA, SIDA (Swedish), GIZ, AUSAID, CARE International, Good Neighbors, Oxfam and others. These agencies are directly or indirectly involved in provision of health services in collaboration with the MOHFW and/or local partners.

Most of the private sector organisations including hospitals provide profit based curative services. NGOs and associations such as “Bangladesh Diabetes Association” and others operate not for profit.

Professional associations play a critical role in terms of protecting and nurturing professional groups’ interests as they also influence the HWF policymaking process. Bangladesh Medical Association (BMA) has a long history of contributing to the growth and development of the medical profession in this country and also closely works with the Government for rendering health services. Bangladesh Private Medical Practitioners Association (BPMPA), Family Planning Association of Bangladesh, Bangladesh Nurses Association, Bangladesh Midwifery Association, Bangladesh Physiotherapy Association and other Associations play an important role in contributing to HWF decisions at national level.

3.2.2.1. HRM Issues and challenges:

Private, NGOs, associations and informal sectors organisations are collectively the largest employers of the HWF and significant contributors to improving health sector performance. But in terms of quality, accreditation, equity of access and fairness of service provisioning little is known about them. The Ministry has yet been able to create a database of the non-state health workforce. Information regarding the number and type of non-state health workforces is not readily available. This makes the formulation of a national HWF plan and projection difficult. Health workers save lives (GHWA, 2013). Poor quality of health workforce produces poor quality of health services. If health workers make mistakes while providing life-saving services, the recipients/people suffer.

The stewardship role of the state agencies particularly MOHFW is highly recognised (WHO, 2000; MOHFW, 2015). Since HWFs are the stewards who guide and set examples, they need to be highly efficient, ethically sound and properly motivated.

Monitoring staffing mix and employment arrangement of the workforce under these sub-sectors is collectively a big challenge for the Ministry. In fact, up-to-date and specific guidelines as a standard ‘staffing pattern’ as well as standardised ‘Table

of Organogram' for the private sector health facilities (Hospital, Clinic and Diagnostic Centres) are not available. 'Dual practice' of Government medical doctors is a common phenomenon. 'Moon lighting' behaviour of civil servant doctors needs to be addressed with appropriate measures through establishing proper accountability frameworks and strengthening supervisory capacities at different levels.

To protect basic employment rights, the health workforce needs to look for legal protection from another Ministry, i.e. Ministry of Labour and Employment. The Labour Law 2006 of the GOB (amended in 2013) provides minimum protection of the health workers employment.

The Office of the Director of Hospital and Clinic under DGHS has been given the responsibility to monitor, evaluate and process approvals for establishment of private hospital, clinic and diagnostic centres throughout the country. However HR as well as functional audits of this department has not been conducted for some time.

On the other hand, the Office of the Director of Medical Education and Health Manpower Development under the DGHS has the responsibility to monitor, evaluate and approve both public and private academic institutions with engagement of relevant bodies as per policy guidelines. HR audit as well as functional audit of this department is crucial for ensuring quality and effective educational services for the professionals.

3.3. Health workforce education, training and development

Education and training are fundamental to health workforce development and key areas of concern for capacity development in line with the health systems need. The Lancet Commission Report¹³ (Frenk et al. 2010) urges countries to adopt a system thinking approach for any reform agenda and recommends pursuing transformative learning through institutional and instructional changes for health professional education to prepare the health workforce as an agent change. WHO has provided 11 recommendations for member states for transforming health professional education and training which covers faculty development, curriculum development, simulations, admissions, inter-professional education, accreditation and continuous professional development.

In Bangladesh, education management services (pre-service education) are provided by individual professional departments for example allopathic (both Bachelor and Diploma level) and alternative medical education (Bachelor degree level) services are provided by the Office of the Director of Medical Education and Health Manpower Development (ME&HMD) and the Office of the Director of Alternative Medical Care (AMC), respectively, under the DGHS. Nursing and midwifery education is managed by the DNS. Bangladesh Homeopathy Board (BHB) and Bangladesh Board of Unani and Ayurvedic Medicine (BBUAM) are entitled to look after their respective Diploma courses. These Directorates and Boards are responsible for managing academic courses in terms of their quality, student admission, curriculum development, etc. The

¹³ Frenk J, Chen L, Bhutta ZA., et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010. December 4. 376:1923–58.

performance of these institutions is rarely assessed given that their workload has immensely increased due to remarkable increase in the number of institutions in both public and private sectors.

The overall pre-service education is hampered by a number of workforce related issues such as shortage of adequate number of teaching staff and also prevalence of high vacancy rates. Medical education is hampered by the shortage of teachers of basic and non-clinical subjects. There is an urgent need of bio-medical engineers and medical physicists in the country's health system. But production of these workforces is yet nominal (only one private university 'the Gono University' is admitting students in limited numbers). Post creation, recruitment rules and policy for their career advancement are yet to be in place.

There is little scope for systems and team-based learning in the under graduate medical curriculum. The curriculum also has deficiencies of lessons relating to management and behavioural competencies. Key informants revealed that the nursing curriculum seems heavy with lots of lessons on too many subjects. The three-years Diploma Midwifery course has already started in the existing nursing colleges and nursing institutes where there was already a shortages of teaching workforce (discipline wise) and limitations of accommodation, laboratories, library, internet facilities and support staff.

The country has no national accreditation body for health institutions. As per the recently published circular of the World Federation for Medical Education (WFME), physicians looking for a career outside the country (especially in the US) from 2023 onwards need to have recognition or certification from a competent national accreditation body. A need was also felt for a separate health professional council (HPC). There are certain health professionals who are providing healthcare services without any formal certification or registration such as physiotherapist, public health professionals, health caregivers, technologists and others. If an HPC is established, these health professionals, other than physicians and nurses, will come under regulation. Besides, there are now two public sector organisations providing technical education for the development of the workforce, i.e. State Medical Faculty of Bangladesh under the MOHFW and Bangladesh Technical Education Board under the MOE, both are offering Diploma level courses. There is an urgent need of coordination and collaboration between the two agencies for streamlining their services and also to avoid isolation as well as professional differentiation.

The National health workforce in-service training guideline has long been under the process of finalisation. Efforts should be taken to finalise this. A training information system should be developed and put into practice for proper HR development planning. Distribution of training opportunities should be on equity and priority basis. Training need analysis should be conducted for different agencies so that appropriate areas for training can be identified. Post training evaluation and utilisation of acquired training is necessary for proper utilisation of investment.

3.4. Supportive working environment

Creating a supportive working environment is regarded as one of the major determining factors of satisfactory health workforce performance. Leadership and management skills are required to ensure a healthy working environment where the health workforce is valued and supported and has the opportunity to develop while providing quality health care. Studies show that poor working environment compromises supply and quality of care (WHO, 2010b).

In Bangladesh, little attention is given to improve the working environment. Poor interior design, lack of medicine and technologies, other logistics, poor inventory mechanism, lack of monitoring and reporting system, bullying, nepotism, absenteeism, health safety and insecurity are common issues found in many of the health facilities, which negatively affect health workforce performance.

The Ministry has a chronic problem of retaining health workforce especially medical doctors and nurses in rural and hard to reach areas. Lack of a supportive working environment is identified as one of the major problems in a study conducted by the Health Economics Unit, the MOHFW (HEU, 2010). The study also reveals that there is inadequate living conditions, a lack of basic utilities (e.g. essential medicines, adequate water and electricity supply etc.) and functional equipment (e.g. medical apparatus) in remote areas, lack of career advancement opportunities, inadequate private practice opportunities compared to the urban centres, substandard accommodations, poor quality schools, and lack of physical security.

The MOHFW is one of the biggest employers of female workforce but it does not yet have a written code of conduct to avoid workplace harassment. This code needs to be developed and distributed for information of healthcare providers in all workstations for gender-sensitive dealing of female clients. Gender imbalance in the workplace has different dimensions. Within the DGHS health workforce¹⁴, men outnumber women three-to-two. If nursing and midwifery cadres are excluded, the ratio becomes three-to-one. There is no data regarding the number of facility apex posts held by women. A suitable gender balance among the HWF is an important factor in the Bangladeshi cultural context for female patients to access services.

¹⁴ Health Bulletin 2014, Director General of Health

4. Process of health workforce strategy development

In late 2014, in preparation for developing the health workforce strategy the Ministry of Health & Family Welfare (MOHFW) sought the perspectives of a range of stakeholders to introduce a diversity of thinking and objectivity. With support from international and national consultants from the WHO country office, a technical group of experienced practitioners and experts was formed with a roadmap to accomplish the task. Drafts of earlier health workforce documents and related approved policies were all reviewed. In January 2015, the Human Resources Management (HRM) Unit gathered all accessible data and constructed a detailed situation analysis. In February 2015, the technical committee was divided into thematic area wise small groups and studied relevant areas extensively. Distinguished key informants were invited to contribute to the draft. National stakeholders' consultations were conducted which included an intensive workshop outside Dhaka. The draft was circulated among human resource task group (HRTG) members for their comments. A first draft was prepared and shared with national level stakeholders in May and June, 2015. The final draft was then prepared incorporating the comments received from the discussants and also from the development partner organisations especially from the World Bank, DFID, GAC, WHO and Save The Children.

5. Thematic areas for intervention

Drawn from the key findings of the situation analysis and also from the country commitments towards achieving UHC, the HWF Strategy addresses five thematic areas. The priority concerns were derived from the specific HWF context portrayed in the situation analysis. The inter-connectedness of the thematic/strategic areas is recognised. Developments in one thematic area may register as progress in another.

The Following priority areas are recognised –

1. Health workforce planning
2. Health workforce development
3. Health workforce deployment, retention and professional engagement
4. Management of high performance standard
5. Health workforce information system

6. Guiding principles (cross-cutting)

6.1. Gender balance

Gender balance or equality and women empowerment are fundamental to the recognition of human rights and key to effective, sustainable and balanced development (UN, 2011). MOHFW wishes to become a gender balanced organisation through its adherence to the national commitments on non-discrimination on the basis of a person's sex in opportunities including professional development, allocation of resources or benefits, and access to services (MOHFW, 2015; HEU, 2012). Therefore, gender balance has been recognised as a guiding principle throughout this workforce strategy in order to create enabling conditions.

6.2. Motivation

Motivation is the underpinning stimuli of employee's work performance. Organisational success can be traced based on its motivated workforce. Given the contextual background of the health workforce (e.g. shortage, skill mix imbalance, lack of career planning, inadequate training opportunities, etc) motivation has been identified as the guiding principle for the strategy.

6.3. Partnership

Both state and non-state actors contribute to health and family welfare services. Adopting a partnership approach is useful for this strategy, since it will create provisions to work collaboratively with stakeholders. A partnership approach is also conducive to create a high performance work culture at the work places.

6.4. Transparency and accountability

Transparency and accountability are the two essential components of any governance system. Transparency promotes acceptability and trustworthiness which are instrumental for the HRM decision making process and sustainability. Accountability allows holding one responsible for the activities or work performances, which is directly linked with results or outcomes. Therefore, these two concepts are identified as guiding principles for this strategy to direct the related activities towards expected outcomes.

7. Vision

"Quality health workforce for the health and wellbeing of the people of Bangladesh"

8. Mission

"Ensure quality health service for all by developing skilled, motivated and responsive health workforce in adequate numbers and available equitably across the country".

9. Strategic objectives

To realise the vision and mission of this strategy and to contribute to attainment of health related SDGs and UHC, the strategic objectives are :

- 1. Make available competent and adequate number of workforce according to the health system's need;**
- 2. Produce, develop and sustain quality health workforce at all level;**
- 3. Recruit, deploy and retain health workforce equitably;**
- 4. Promote and maintain high standards in health workforce performance;**
- 5. Promote evidence-based health workforce decision-making in improving health outcomes.**

10. Definition of health workforce

Due to the presence of multiple categories of workforce in the health system, it is important to define the term “health workforce” used in the document. According to WHO’s World Health Report, 2006, health workers are **“all people engaged in actions whose primary intent is to enhance health”** (WHO, 2006). This includes physicians, nurses and midwives, but also laboratory technicians, public health professionals, community health workers, pharmacists, and all other support workers whose main function relates to delivering preventive, promotive or curative health services. It is further mentioned that health workers typically operate in collaboration with the wider social service workforce, that is responsible for ensuring the welfare and protection of socially or economically disadvantaged individuals and families. A closer integration of the health and social service workforce can also improve long-term care for ageing populations. In Bangladesh there are different categories of workforce that directly or indirectly contribute to improving the health and well-being of the people.

11. Scope of the strategy

The strategy intends to focus on the entire health workforce working in the country. Initially the strategy focuses on the public sector workforce mostly under the MOHFW. However, it also contains directions to include the workforce under the private, NGOs and informal subsectors as well. Furthermore, this strategy is formulated for five years with long-term projection up-to 2030. The strategy will be reviewed and updated when necessary but generally every five years as progress is made in the priority areas and new priorities for action emerge. The actions needed in order to achieve the strategic objectives of each thematic area are phased out. Priority actions for the short-term (2016-17) are noted, along with the main agent for the actions. Less specific descriptions of interventions for the medium-term (2017-21) and long-term (2021-30) are then outlined.

12. Bangladesh health workforce strategy

The strategy recognises five strategic areas and proposes certain activities to address HWF issues and challenges with the purpose of materialising the vision, mission, and corresponding objectives as indicated. Each of the strategic areas is underpinned by four guiding principles (i.e. gender balance, motivation, partnership and transparency and accountability).

12.1. Thematic area 1: Health workforce planning

Strategic objective: Make available competent and adequate number of workforce according to the health systems need.

Context

The first prerequisite for ensuring necessary healthcare services is to avail the right number of healthcare providers. Since the health workforce plays a critical role in delivering health services, it is imperative that the health planners and policy makers ensure the right number of health workers, with the right skills, deployed at the right place at the right time, to deliver right health services according to the health needs of the population at an affordable cost. Evidence-based HWF planning is instrumental to make those choices. HWF planning aims to balance or to address the mismatch between available and required HWF to deliver priority health services.

The Health Policy 2011- acknowledges the contribution of the alternative medical practitioners such as the Homeopaths, Unani and Ayurvedic doctors. In addition, it is difficult to engage with the more than 300,000 informal providers, though associations of informal providers exist. Regulation of the for-profit and not-for-profit formal providers is constrained by the practicalities of execution of the regulations (e.g. lack of capacity of the regulatory bodies). Some providers fall within the jurisdiction of other ministries (e.g. Ministry of Local Government). Nevertheless, the MOHFW, as the country's single biggest health workforce employer, can strive to lead developments, if not entirely manage them.

Strategic intervention:

12.1.1. Develop and implement a comprehensive health workforce plan considering the skill mix and health systems needs with particular focus on UHC.

Short term activities (2016/17)

1. Initiate determination of service level-wise (e.g. primary, secondary and tertiary) health workforce needs and project demand up to 2030 considering the national and international context, standards and organisational skill mix.

In Bangladesh health services are primarily provided at three levels, i.e. primary, secondary and tertiary level stretched over the administrative tiers. Primary healthcare services are provided through health facilities situated at Ward, Union and Upazila level. Secondary level healthcare services are provided through district based hospitals. Lastly tertiary level health care services are provided through the medical college hospitals and specialised hospitals situated at the central and regional and some at the district level.

It is recommended that the various categories of service providers in the country be estimated based on The population projections of the country (as indicated in the National Health Policy, 2011; National Population Policy, 2012). Present staffing patterns of the health facilities both public and private established at different level at

different geographical location can be reviewed to determine the HWF needs and requirements based on 1) disease profile, 2) location, 3) essential services packages (ESP), and 4) service utilisation patterns. However, given the considerable gap in meeting the standards or skilled HWF set by the WHO, a gradual approach can be adopted to meet the need. Formulation of a HWF production and recruitment plan can be useful.

Also considering the constraints of availability of skilled providers and affordability issues as well as perceived beliefs in the different healthcare systems, the alternative and informal care providers will need to be continue contributing to healthcare especially in the remote and less exposed areas.

2. Develop a costed Health Workforce Plan up to 2021 without projection

Medium-term activities

1. Determine health workforce needs and project demand up to 2030 considering the national and international context, and standards and organisational skill mix.

2. Develop a costed health workforce plan with projection up to 2030

Health workforce financing data and information are required for costing analysis of the plan. Data needs should be identified and collected for conducting the costing analysis. The process should be started at the beginning of the year. The costed HWF plan is to be formulated for the period up-to the year 2030 considering country commitment and targets (e.g. UHC).

3. Develop, review and update “Table of Organogram” of different Sections, Units, Departments, Wings, Directorates and other Organisations under the MOHFW.

4. Implementation of the costed HWF plan.
Implementation of the plan will start during this period.

Long-term activities

1. Continue implementation of the HWF plan.

Implementation of the HWF plan will continue beyond 2021. Proper monitoring and evaluation mechanism will ensure implementation among the related departments/agencies.

12.1.2. Align production of the health workforce according to the projected requirement.

Short-term activities (2016-17):

1. Develop an inventory system (automated) of the educational institutions;

An inventory of the educational institutions (from all sectors public, private, NGOs, associations/voluntary) needs to be developed to learn inputs, outputs, gender, disciplines and other necessary particulars.

2. Review and update health workforce production related policies and guidelines/strategies to remove inconsistencies among different sectors (i.e. public and private);

Health workforce production is not only limited to the Ministry of Health and Family Welfare (MOHFW), others stakeholders like the Ministry of Defence, the Ministry of Education, and private sector organisations are also involved in producing the health workforce. Inconsistencies are looming within the system in terms of establishment of new institutions, quality maintenance, and medico-legal compliance. Coordination as well as harmonisation among the related Ministries and other organisations need to be ensured and this can be done through review of health workforce production related policies and strategies.

Medium-term activities:

1. Continue follow up of implementation of previous activities and review policies and guidelines;
2. Develop new categories of workforce such as Medical Physicist, Biomedical Engineer, Midwife, Medical Biotechnologist, Health Workforce Specialist, Health Informatics and other categories on the basis of technology advancement and future need for the improvement of service delivery.

Long-term activities:

1. Update, review and continue the previous activities and make necessary modification

12.1.3. Promote health systems research for evidence-based planning and maintenance of the health workforce.

Short-term activities (2016-17):

1. Strengthen HRM Unit through re-structuring on the basis of future needs.

To provide due importance on formulation of needs-based and affordable HWF plan including its implementation, monitoring and evaluation, re-structuring the HRM Unit at both central and agency level is emphasised.

- 1.a. Undertake steps to regularize the existing set-up of the HRM Unit, MOHFW under revenue budget;
- 1.b. Develop proper monitoring and evaluation mechanism in order to assess progress of implementation in the health workforce strategy;
- 1.c. Undertake steps for capacity building at the individual as well as the institutional level;
- 1.d. Hire subject specific technical experts where skill is rare and hard to access within the public sector in order to carry out priority as well as essential activities;

2. Support health workforce research for generation of knowledge and evidence

The HRM Unit will support and promote health system research with particular focus on the health workforce in order to practice evidence-based policymaking. The HRM Unit will generate as well as allocate resources and also explore opportunities for resource generation through itself and collaboration with other organisations (both public and private). To make HWF management functions realistic and system based, due attention needs to be provided on undertaking HWF research and studies with the purpose to strengthen the knowledge base and assessing HWF performance in all sectors.

3. Undertake baseline survey to gradually map out non-state health workforce *who did not receive any formal training in order to bring them under formal mechanism and also to take into account their services;*

Medium-term activities:

1. Activities completed as part of strengthening the HRM Unit, MOHFW.

2. Establish a repository of health workforce related studies, research, evaluation and other publications:

To strengthen institutional as well as individual knowledge base, a depository/archive is to be created within the HRM Unit, MOHFW where HWF related scientific studies, research reports and other publications will be stocked to use for HWF policy considerations and decisions.

Long-term activities:

1. Continuation of short term and medium-term activities.

12.1.4. Challenges

- Absence of a functional HR information system makes it extremely difficult to know the exact number of skilled workforce produced, available in or serving outside the country
- Capacity to engage the private sector meaningfully
- Time sensitiveness
- Political commitment

12.2. Thematic area 2: Health workforce capacity development

Strategic objective: Produce, develop and sustain quality health workforce at all levels.

Context:

Capacity development is an important area of intervention, which creates opportunities to make the workforce competent and motivated to meet the need of the health system. A bundle of 5 approaches are adopted to address capacity development aspects: *improving skill mix*, quality assurance and accreditation, HRH education and production, in service training and *task shifting*. Reviewing the existing skill mix and matching tasks and responsibilities and setting a new standard in the country context are priority activities of the strategy. Production in right number and quality assurance in the curriculum are taken into account. Health workforce tasks – indeed any workforce tasks are divided into three overlapping arenas: technical or clinical tasks; communication or education tasks; and administrative or managerial tasks. (e.g. a qualified midwife needs to be technically competent in her use of episiotomy scissors, interpersonally competent in her verbal and non-verbal communication with the mother-to-be and administratively competent in her accurate and timely record keeping). It is the integration of these three skill sets that determines quality care. Weakness of any one or two, leads to suboptimal health care provision. The strategy will make sure all three areas are addressed and developed in unison.

In the healthcare field, just acquisition of knowledge is hardly sufficient. It is the HWF's behaviour and skills in the application of that knowledge that makes a positive change for the service user. The strategy will prioritize changes in behaviour and attitude, not merely the acquisition of knowledge. It will also give priority to skills development of the existing HWF over those of the future workforce.

Strategic intervention:

12.2.1. Improving skill mix

Short-term activities (2016-17):

1. Initiate review of organisational and individual skill mix;
2. Identify and develop institutions for appropriate skill development programmes according to the needs;
3. Link skill development initiatives with in-service training, incentives and career plan;
4. Revise/update the academic/ in-service training programmes to equip the workforce with the required skills.

Medium-term activities:

1. Implement the organisational and individual skill mix initiatives;
2. Develop an appropriate regulatory framework for training institutes;
3. Ensure implementation and strengthen monitoring systems;

Long-term activities:

1. Activities continued, reviewed and appropriately modified.

12.2.2. Quality assurance/improvement and accreditation of academic/training programmes and institutes

Short-term activities (2016-17):

1. Review the existing rules, regulations and policies of the presently operating all regulatory bodies in the health sector.
2. Coordinate with relevant bodies to accelerate establishment of the “National Accreditation Board/Council” affiliated with the MOHFW;
3. Initiate creation of a Bangladesh Health Professionals Council (BHPC) with an appropriate Act and bring the remaining health professionals (physiotherapists, public health professionals, clinical psychologists, AMC, technologists, medical attendant/care giver, and paramedics etc.) under a regulatory framework;
4. Initiate educational and training programmes on Quality Assurance in this sector.

Medium-term activities:

1. Strengthen the relevant Regulatory Bodies with appropriate capacity development including amendment of their Acts if necessary;
2. Review the existing quality assurance process and revitalize the quality improvement teams;
3. Implement External Quality Assurance mechanism on a systematic and regular basis;
4. Complete formation of the BHPC;
5. Implement the QA training programme;

Long-term activities:

1. Exploring the possibilities for decentralising the activities of the regulatory bodies;
2. Review and continue the activities of the BHPC;
3. Review and continue the QA training programmes.

12.2.3. Education/production of health workforce

Short-term activities(2016-17):

1. Gap analysis on existing institutional capacity (both in public and private sector, with proper government approval) to generate HWF degrees, diplomas, certificates, refresher trainings, etc. according to present and future requirements estimated by the strategic activities under HWF Planning;
2. Restructure the organisation and function of the Human Resource Management Unit of the health care institutions and organisations so that it functions simultaneously with Human Resource Development;
3. Link downstream organisations like DGHS, DGFP, DNMS, DGDA, NIPORT, NIPSOM, BSMMU and other with the HRM Unit, MOHFW and other relevant private sector organisations.

Medium-term activities:

1. Increase the capabilities of the individual academic/training institutes reflecting the requirement for each type and level of HRH which will be required in the future;
2. Evaluate in-house capacities of health workforce training organisations;
3. Develop a comprehensive policy to create a group of full-time professionals dedicated to academic (including research) and training activities other than those who will be dedicated primarily to health service delivery;
4. Streamline the roles, responsibilities of the Ministry of Health & Family Welfare and Ministry of Education in generation of HWF and accreditation of the academic/training programme related to HWF.
5. Develop appropriate organisational and regulatory frameworks to ensure the implementation, monitoring and improvement of the system

Long-term activities:

1. Medium-term activities to be continued;
2. Review of the result of implementation

12.2.4. Training in Health, Nutrition and Population sector

Short-term activities (2016-17):

1. Formulate in-service training guideline;
2. Organise in-service training in a more priority-based and coordinated way and on a periodic but continuous basis;
3. Link In-service training with incentives and a career plan (the UHCs may be clustered around district hospitals/medical college hospitals to create a scope for recognition of the trainings);
4. Need analysis for training of the private sector HWF.

Medium-term activities:

1. Develop appropriate organisational and regulatory framework to ensure the implementation and monitoring of the system;
2. Initiate training of the private sector (formal and informal) HWF.

Long-term activities:

1. Medium-term activities to be continued;
2. Review of the result of implementation
3. Incorporation of the review findings and finalisation of the long-term strategy

12.2.5. Task shifting

Short-term activities (2016-17):

1. Critically evaluate the course-curricula of each academic/ training programmes to assess the knowledge/expertise generated by individual programmes;
2. Explore the possibilities of updating/upgrading the expertise/skills of the individual professionals through short-term in-house training;
3. Revisit the job descriptions of various levels of health care professionals on the basis of their updated knowledge and skills generated through the academic programme and extra training.

Medium-term activities:

1. Incorporate the revised responsibilities in the service related MIS to be used by management;

Long-term activities:

1. Medium-term activities to be continued;
2. Review of the result of implementation;
3. Incorporate the review findings and finalise the long-term strategy

12.2.6. Challenges

The following issues can be regarded as challenges while implementing the strategies:

- Setting standards for quality of medical education;
- Monitoring;
- Regulating areas with poor production capacity nurses, midwives, medical technicians, bio-medical engineers for repair and maintenance functions;
- Frequent leadership change in the public sector.

12.3. Thematic area 3: Health workforce deployment, retention and professional engagement

Strategic objective: Recruit, deploy and retain health workforce equitably.

Context:

Recruitment and deployment are important functions of HR management to hire the rightly trained and skilled individuals and to post them at the right job at the right place. In the public sector, recruitment and selection are lengthy processes. The time that is spent to complete one recruitment process can automatically generate vacancies on the other hand. Therefore, there should be steps to find out ways to reduce recruitment times considering the urgent need of the service. A recruitment plan is also needed to determine how many health workforce personnel will have to be recruited in the consecutive years based on fair and just principles. Further, a deployment policy also needs to be put into action so that equity can be ensured. Personnel with technical skills, of which there is shortage (e.g. basic sciences and anaesthesia) need to be properly distributed. It also needs to be ensured that they are accessible in a timely manner. For the public sub-sector to achieve a return on its investment in pre-service training, the HWF needs to be maintained in service for as long as of possible. This is the best use of resources. It also allows the retention of institutional memory, an invaluable resource, which would otherwise be lost. Retaining the HWF in the rural and hard-to-reach areas is a particular challenge. Many interventions have been proposed; few have been consistently applied and evaluated. Continued professional development and opportunities are important options to be considered to improve retention.

Strategic intervention:

12.3.1. Support health workforce supply through multifaceted and sustainable approaches for recruitment and retention.

Short-term activities (2016-17):

1. Revisit and update recruitment, deployment and retention policy as per need.

Medium-term activities:

1. Assess current delegation of authority for selected recruitment and/or deployment and other management functions from the administrative division and below for greater control and supervision of the professionals;

Long-term activities:

1. Continuation of previous activities.

12.3.2. Further continue to develop health workforce information sharing (i.e., monitoring, evaluation and reporting) for potential solutions to challenges

Short-term activities (2016-17):

1. Coordinate with HWF MIS among the MOHFW and other concerned supply side players;
2. Promote retention of doctors by creating a supportive culture through the use of modern technological interventions such as tele-medicine, tele- conference among professionals and/or community members;
3. Strengthen supportive supervision, monitoring and mentoring

Medium-term activities:

1. Continuation of previous activities.

Long-term activities:

1. Continuation of previous activities.

12.3.3. Innovative approaches to address distribution issues, including incentives and disincentives to work in areas and sectors of greatest need and workforce shortage.

Short-term activities (2016-17):

1. Update deployment plans according to need;
2. Strengthen mechanisms for provision of rewards and sanctions of workforces

Medium-term activities:

1. Update deployment plans according to need.
2. Strengthen mechanisms for provision of rewards and sanctions of workforces
3. Introduce incentive package for remote areas (hard to reach and hilly) and high risk populations/areas;

Long-term activities:

1. Develop a contractual model for recruiting skilled persons from private to public institutions;
2. Adopt and customise the WHO global code of practice for international recruitment of health personnel.

12.3.4. Use innovative models of service delivery to improve access to areas of physiographic and cultural need, and specialties in shortage.

Short-term activities (2016-17):

1. Collaboration of Public-Private Partnership and GO-NGO for better accessibility of services;

Medium-term activities:

1. Continuation of previous activities.

Long-term activities:

1. Continuation of previous activities

12.3.5. Explore and develop flexible working environments that reflect the changing needs and profile of the workforce

Short-term activities (2016-17):

1. Undertake inter-ministerial co-ordination and decision on ensuring accommodation, safety, security for motivation and retention of workforce
2. Undertake policy review and update, and when required, formulate new policies for elimination of work place harassment;

Medium-term activities:

1. Continuation of previous activities

Long-term activities:

1. Continuation of previous activities

12.3.6. Explore and propose models that enable articulated, multiple career pathways to provide service-tenure career opportunities in the health sector

Medium-term activities:

1. Re-examine existing career plan and initiate an updated career plan that meets the demands (medium-term)

Long-term activities:

1. Execution of the prepared updated career plan

12.3.7. Continue and enhance initiatives aimed at promoting innovation, leadership and collaboration in work environment

Short-term activities (2016-17):

1. National recognition and award/honours to encourage innovation, leadership, and performance.

Medium-term activities:

1. Continuation of previous activities

Long-term activities:

1. Continuation of previous activities

12.3.8. Promote initiatives that encourage health workforce to maintain a level of skill, knowledge and competence that aligns with evolving consumer needs and changes in service delivery ensured through regulatory/legislative and professional bodies.

Short-term activities (2016-17):

1. Initiation of dialogue with the professional bodies/stakeholders for playing appropriate roles;
2. Review existing roles, responsibilities and engagement of professional bodies.

Medium-term activities:

1. Capacity development of the professional bodies to discharge their redefined roles and responsibilities.

Long-term activities:

1. Continuation of previous activities

12.3.9. Challenges

- Lengthy process of recruitment through Public Service Commission;
- Lengthy process for administrative approval of updated rules;
- Political as well as professional groups influence on decision-making regarding transfer and posting.

12.4. Thematic area 4: Management of high performance standard

Strategic objective: Promote and maintain high standards in health workforce performance.

Context:

Managing individual as well as organisational performance is always a challenge for health sector planners and managers. However, culmination of individual performances denote organisational performance. There is tremendous potential for improvement in workforce effectiveness and efficiency by using familiar, yet over-looked, basic management techniques. The strategy will increase overall service output and improve individual productivity (output per person) through the introduction and application of fundamental line-management principles.

In the public sector, a traditional type of individual performance management system i.e. annual confidential report (ACR) is in practice for the public servants. Although the concerned authority is assessing how to introduce better management tools, no significant process has been made. Performance management function is still thought to be an administrative task with no or little strategic impact on decision-making. There are many drawbacks of the present practice. Under the current framework of assessment, there is no scope of the supervisee to see the evaluation of his/her supervisor which diminishes the level of confidence in the process and ultimately affects performance. Maintaining fairness through proper transparent performance management processes at both public and private sectors are critical for health workforce management.

The use and display of organograms, the inclusion in job descriptions of immediate managers and immediate subordinates, the meaningful use of those job descriptions, the introduction of face-to-face supervision and follow-up all count among obvious first steps. Facilitators, supervisors and managers will need training. Later, further management and administrative practices, such as management-by-objectives and the calculation of productivity rates, may supplement the managers' tools.

Strategic intervention:

12.4.1. Understanding the implication of Performance Management System (PMS) as a part of HR

Short-term activities (2016-17):

1. Review the existing system of performance management for identifying lapses and gaps;
2. Exploring the evidence-based best practices

Medium-term activities:

1. Develop a guideline for creating awareness about the concept of a PMS.
2. Develop a plan for disseminating the guideline for proper inception of the concept;

Long-term activities:

1. Continuation of medium-term activities

12.4.2. Health System strengthening through the development of an ideal and quality Performance Management System

Short-term activities (2016-17):

1. Formation of a working group for designing effective and structured PM model;

Medium-term activities:

1. Development of a PM model through a consultative process;
2. Capacity development of the different stakeholders;
3. Initial implementation of the model in a selected district/ institution;

Long-term activities:

1. Review of the result of implementation;
2. Incorporation of the review findings and finalisation of the document;
3. Scaling up the model under the health system

12.4.3. Strengthening of the accountability framework by redesigning the roles, and responsibilities of the Ministry, different Directorate and organisation.

Medium-term activities:

1. Conducting a study for reviewing the accountability framework

Long-term activities:

1. Formulating new role and responsibilities on the basis of study findings;
2. Capacity development of the stakeholders to improve the accountability framework;
3. Regular review of the formulated new roles and responsibilities compliance

12.4.4. Updating the existing job description at a regular intervals

Short-term activities (2016-17):

1. Examining all the existing job description to identify the lapses and gaps and future needs in the line of organisational goal and objectives and addressing Universal Health Coverage, attaining post MDG sustainable development goals.

Medium-term activities:

1. Update existing job descriptions at a regular interval

Long-term activities:

1. Continuation of the activities

12.4.5. Process development in the government system for inviting more motivation and commitment of the service providers

Short-term activities (2016-17):

1. Examine the areas/programmes where incentives can be introduced to invite more motivation, commitment and accountability frameworks

Medium-term activities:

1. Developing a model on the basis of identified areas and other findings;
2. Implementation of the model in a selected district;
3. Reviewing the performance and finalisation of the model on the basis of review findings

Long-term activities:

1. Scaling up the revised model

12.4.6. Priority Strategies for Intervention/ Implementation

Short-term activities(2016-17):

1. Examining and reviewing the existing delegation of authority at different levels

Medium-term activities:

1. Finalising the delegation of authority for establishing centralised management
2. Capacity development for implementation;
3. Implementation of centralised management system

Long-term activities:

1. Process to be continued

12.4.7. Establishing institutional and individual appraisal system as a part of Performance Management.

Short-term activities (2016-17):

1. Examine the institutional and individual appraisal system of the country
2. Develop guidelines for institutional appraisal (indicator based and weighted method) and individual appraisal systems

Medium-term activities:

1. Capacity development of the managers on institutional and individual appraisal system;
2. Implementation of the institutional and individual appraisal system. Implementation of centralised management system.

Long-term activities:

1. Activities to be continued

12.4.8. Improve performance and accountability framework according to organisation goal and objectives by IPM;

Short-term activities (2016-17):

1. Reviewing the IPM document

Medium-term activities:

1. Updating the document on the basis of review findings
2. Capacity development;
3. Implementation in phases

Long-term activities:

1. Activities to be continued

12.4.9. Development/Introduction of Total Quality Management culture in the performance management system

Short-term activities (2016-17):

1. Reviewing the existing guideline and formulation of updated TQM guideline

Medium-term activities:

1. Capacity development;
2. Phase-wise implementation;
3. Performance review and taking measure on the basis of review findings.

Long-term activities:

1. Activities to be continued

12.4.10. Challenges

- Development of a new accountability framework would be a challenging task due to poor monitoring mechanisms, commitment and poor employee engagement in the public sector;
- Delegation of authority would be critical due to resistance from the key stakeholders.

12.5. Thematic area 5: Health workforce information systems

Strategic objective: Promote evidence-based HWF decision making in improving health outcomes.

Context:

Health system strengthening has increasingly become a major focus of international concern and a primary political, social, and economic issue in nearly every country. Although Human Resource for Health (HRH) is considered as the backbone of any health system and is one of the 6 Health Systems Building Blocks of the WHO, the Health Workforce Information System (HWIS) is poorly organised in most low and middle-income countries. In reality the HRIS is rarely used for planning and management decision support for better health systems performance. This is due to complexity of its structure and diversity of HWF distribution. In Bangladesh, the health workforce is divided into formal and informal healthcare providers. The informal health care providers are beyond any regulatory framework and their actual statistics are rarely available. The formal human resources for health (accredited and non-accredited) are distributed over public and private sectors of the service delivery system.

Dual practice is common and overlaps between public and private sector. The rapidly growing not-for-profit private sector is also deploying increasing numbers of HWF. In the public sector, HWF are available in other ministries such as in the ministries of industries, home affairs, social welfare, armed forces, local government etc. Within MOHFW the HWF are distributed among different agencies and directorates such as DGHS, DGFP, DNS, NIPORT, HED, DGDA, and DG-HEU. Some agencies, although not all, have HRIS. Of them, the DGHS has a well-developed HRIS and has been developed for capturing countrywide HWF both in public and private sectors. However, health workforce data is not readily available in one place anywhere in the country. Hence strengthening existing HWIS is a priority action of the ministry.

Strategic intervention:

12.5.1. Developing of a comprehensive central HWF Information systems and using it for evidence-based decisions

Short-term activities(2016-17):

1. Formation of a high level committee at MOHFW level;
2. Conducting an analysis of the current situation of the HWF information system in both the public and private sector;
3. Defining the information needs;
4. Specifying data requirements;

5. Specifying how the data is to be obtained;
6. Determining where the data is to be stored;
7. Determining how the data is to be held (choice of database);
8. Determining who is to be responsible for the overall system and different levels of the health system, including mechanisms for coordinating the system;

Medium-term activities:

1. Preparation of an implementation plan including piloting;
2. Designing procedures to operate with the system;
3. Development/improvement of online monitoring and evaluation of HRH through HWIS;
4. Organisation, management, dissemination of HWIS data for planning and management
5. Training staff in the new procedures and maintenance of data;

Long-term activities:

1. Monitoring and reviewing the system after implementation;
2. Institutionalization

12.5.2. Challenges

- Institutionalization of HRM practices such as online transfer, posting, performance appraisal and similar functions through automated HWIS
- Monitoring HWF data in the private sector on a regular basis due to lack of institutional capacity
- Regional strategy on strengthening health workforce education and training

13. Way forward

The Bangladesh Health Workforce Strategy (BHWS) 2015 is only a collection of strategic directions in the form of strategy and sub-strategy. It envisions for a quality health workforce who will ensure health and wellbeing of the people of Bangladesh. In order to ensure quality health workforce a total of 26 strategies and more than 130 sub-strategies are formulated and outlined under 5 thematic areas. The BHWS 2015 aims to embody all contemporary health workforce (HWF) commitments of the Government related to e.g. upcoming 4th sector program, Universal Health Coverage (UHC) along with Sustainable Development Goals (SDGs). However, successful implementation of the strategy would depend on the commitment and leadership of the GOB, which are highly attributed by allocation of appropriate human and financial resources to carry out.

In addition, coordination and collaboration including mutual understanding are essential among different organizations such as line Ministries in the public sector, development partners, private sector organizations, NGOs, and professional associations. The strategy will substantially guide the policy makers, program implementers, researchers and all other relevant stakeholders to address and act upon key HWF issues and challenges prevailing in this country. Successful implementation of the strategy can be highly assisted by a pragmatic design of the implementation plan, which can include a result framework. The framework would indicate how HWF contributes to make change in the health indicators at national level. MOHFW will now strive to pursue the development of the implementation plan of the strategy, which is expected to ensure delivery of quality health service through the HWF.

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Annex: List of contributors

1. **Dr. Md. Shajedul Hasan**
Joint Secretary, HRM, MOHFW
2. **Professor Dr. Abul Kalam Azad**
Additional Director General (Admin)
and Director, MIS, DGHS.
3. **Dr. Syed Abu Zafar Md. Musa**
Ex. Director, PHC and Line Director, MNCH, DGHS
4. **Prof. (Dr.) Md. Ismail Khan**
Dean, Faculty of Medicine, University of Dhaka
5. **Prof. (Dr.) Md. Ridwanur Rahman**
Department of Medicine, Shaheed Suhrawardi Medical College
6. **Prof. Dr. Liaquat Ali**
Vice Chancellor, Bangladesh University of Health Sciences
7. **Jasmin Nahar**
Deputy Secretary, HRM Unit, MOHFW
8. **Dr. Jamal Uddin Chowdhry**
Secretary General, Bangladesh Private Medical Practitioners Association
9. **Dr. Md. Khairul Islam**
Country Director, Water Aid
10. **Md. Mahfuzur Rahman**
Senior Assistant Chief, HRM Unit, MOHFW
11. **Ms. Salma Khatun**
DPM, HRM, DNS
12. **Dr. Md. Shafiqur Rahman**
DPM, PMR, DGHS
13. **Dr. Mohammad Shabbir Haider**
DD, Health Economics Unit, MOHFW
14. **Dr. Mohammad Harun Ur Rashid**
DPM, HRM Unit, MOHFW
15. **Dr. Mohammad Moazzem Hossain Sarker**
Assistant Surgeon (Attached), HRM Unit, MOHFW
16. **Mr. Ajoy Ratan Barua**
Deputy Director (MIS), DGFP
17. **Md. Nuruzzaman**
Technical Assistant (WHO), HRM Unit, MOHFW
18. **Ms. Feroza Sarker**
Deputy program Manager, HRM Unit & Member Secretary of BHWF, MOHFW

Human Resource Management Unit

Ministry of Health and Family Welfare

Bangladesh Secretariat

E-mail: mohfwhrm.gov.bd@gmail.com



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