Private sector engagement to deliver maternal, newborn, child health and family planning services during COVID-19 in Bangladesh

Introduction

The spread of COVID-19 - together with the need to harmonize national and international health emergency response - has made it clear that efforts to achieve Universal Health Coverage (UHC) and to respond to health crises are reliant on a whole-of-society approach. Leveraging the private sector for healthcare service delivery is key to advance the UHC agenda and to efficiently respond to health emergencies, ensuring that all health-related services and goods are available, accessible, acceptable, and of high-quality for all, irrespective of where people seek care.

In this context, teams at WHO have intensified their work on private sector engagement to achieve UHC goals. The Health System Governance and Financing (HGF) department in 2020 launched the WHO Private Health Sector for COVID-19 Initiative (WHO-PCI) to offer rapid, real-time, evidence-based, and tailored support for countries to better respond to the pandemic and to prepare their health systems for the post COVID-19 period. Likewise, the department of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA) has been supporting 19 countries in five regions to mitigate the impact of COVID-19 on essential maternal, newborn and child health (MNCH) and family planning (FP) services.

Building on the existing efforts of WHO's HGF and MCA departments, this study will document the experience, benefits, challenges and lessons of engaging with the private sector to maintain the delivery and use of MNCH and FP services and protect UHC outcomes (quality, access, financial protection, etc.) during and post-COVID-19 pandemic. Three countries, corresponding to three different WHO regions, have been selected for this study: Bangladesh, Pakistan and Uganda. This paper summarizes the literature review conducted for Bangladesh.

Methodology

A literature search was performed in August 2021 utilising a comprehensive search strategy on the WHO COVID-19 electronic bibliographic database for articles published between January 2020 and June 2021. The search strategy was developed with Medical Subject Headings (MeSH) and text words, using Boolean operators to combine the search strings. We initially combined private sector related terms with MNCH and FP terms in the WHO COVID-19 electronic bibliographic database search string. However, this produced zero results. We therefore removed private sector related terms from the search string which yielded 95 citations. We also performed a google scholar search through Publish or Perish software. This yielded another 200 citations.

We used Rayyan as support software to screen and select the studies identified though the strategy search. Through Rayyan the titles and abstracts of the articles were firstly screened with the aim to exclude articles with titles and/or abstracts unrelated to essential service delivery during COVID-19. Through the search and screening process, there were 295 citations for Bangladesh. Extraction was done in an Excel matrix.

In total 24 articles were included in the literature review. These included 10 research articles, seven commentaries, five reviews, one regional WHO assessment and one Government of Bangladesh guideline on the national preparedness and response plan for COVID-19. The literature was client, service, system and programme focused. Key themes included:

- Client: Mothers and young children, slum communities, older populations with non-communicable diseases (NCDs)
- Service delivery: self-medication, paediatric surgery, medical supply, health worker perspectives
- System: information systems, preparedness, pharmaceutical sector, telemedicine, health systems trust, moral distress, private and non-profit sector, management and leadership, financing, regulation, corruption
- Programme: NCDs (cancer, diabetes), nutrition, maternal, reproductive, child and newborn services

The literature was predominantly Bangladeshi; authors were academics, medical or programme professionals based in country and from the diaspora.

Framework

Findings have been structured using the WHO governance behaviours, a framework adopted in the WHO strategy, "Engaging the private health service delivery sector through governance in mixed health systems". Behaviours have been operationalized for essential health services as follows:

- Align structures: alignment of public and private structures for the continuation of essential health services during the COVID-19 response
- Foster relations: coordination arrangements and sectoral engagement for the continuation of essential health services during the COVID-19 response
- Build understanding: private sector data capture and information exchange for the continuation of essential health services during the COVID-19 response
- Enable stakeholders: the development and implementation of financing mechanisms and regulations, to authorize and incentivize health system stakeholders for the continuation of essential health services during the COVID-19 response
- Nurture trust: recognition of competing and conflictive interests for continuation of essential health services during the COVID-19 response
- Deliver strategy: organisational learning and innovation to improve engagement of the private sector for the delivery of essential health services during the COVID-19 response

Align structures

This behaviour considered alignment of public and private structures for the continuation of essential health services during the COVID-19 response

Bangladesh's health system is described as pluralist with the government as the primary actor [1]. The health system is both large and largely unregulated [2, 3]. While private-sector hospitals are seen to provide better care, they do not tend to serve those without the means to pay for such care [1]. A large not-for-profit arm of the private sector also exists and addresses poorer segments of the population, including those in hard-to-reach rural areas and urban slums. There are many more informal providers including traditional healers, homeopathic practitioners, village doctors, and drug vendors. The health system and the underlying healthcare infrastructure are considered both "neglected and underdeveloped"[2] due to inadequate resources, mismanagement and corruption

and a highly centralized secondary or tertiary care [1, 3] . There are many “toes” in the health system, but few “footprints” leaving gaps in equitable access to essential services and quality of care.

In response to the pandemic and under the leadership of the Directorate of Health Services, the Bangladesh health system was restructured. Restructuring primarily focused on COVID-19 services and less on the continuation of essential services [4]. Specific hospitals were designated for COVID-19 treatment however both facilities and staff were inadequately prepared, while private hospitals were not allowed to test patients for COVID-19 infection [3, 5]. COVID-19 designation also entailed a large proportion of doctors, nurses, and midwives being reassigned from essential services; this affected both hospitals and private chambers [6]. Financial resources were diverted from routine services to the response, which further affected the quality of essential services [7]. Efforts to reorganise essential services drew mainly on telemedicine as a pragmatic and protective solution for their continuation [8, 9]. Telemedicine, and the segregation of COVID-19 facilities, were the main adjustments cited by health workers and managers for the response [9].

Personal protection equipment (PPE) and the lack of testing became critical issues for the continuation of essential services in Bangladesh. Medical personnel shut their private practices [10, 11] or refused to see patients without having a COVID-19 test, something that was extremely difficult to secure in the early phase of the pandemic when there was only one test facility [12]. As widely covered in the media at the time, this resulted in non-treatment of patients due to health worker concerns with contracting COVID-19 [1, 13]. Concerns were founded as many health workers did contract COVID-19 in the early phase of the pandemic, which added to the fear and anxiety amongst the population [13].

There was inadequate engagement of pharmacies in the COVID-19 response and for the delivery of essential services. The role of pharmacies was considered a structural disconnect in the Bangladesh health care system prior to the pandemic [14], despite retail drug stores, both licensed and unlicensed, being a principal source of healthcare for patients [15]. This situation has existed despite the pharmaceutical industry in Bangladesh being one of the largest sectors, and generators of foreign exchange, in the country [16].

Foster relations

This behaviour considered coordination arrangements and sectoral engagement for the continuation of essential health services during the COVID-19 response

There was no reflection from the literature on how or if the private sector in health was represented in coordination arrangements for the continuation of essential services or the COVID-19 response. It was noted that coordination arrangements were slow to materialise and did not include the “right people in the right positions” [3, 6, 12]. Gender considerations did not inform coordination arrangements or decision making processes nor were the specific needs of women factored into the response [7].

The government developed guidelines for preparedness and response to the COVID-19 pandemic in March 2020 [17]. These did not explicitly address the continuation of essential services. In April 2020 the Government established a key coordination body, the National Technical Advisory Committee (NTAC). A lag in establishment of the NTAC was considered to have wasted critical time, given that COVID-19 cases were reported in the country a month previous to this [3, 5]. As reported during the initial phase of the pandemic, response measures were left to “bureaucrats or administrators [who] lacked expertise or experience in health, let alone pandemic management”[3]. Sector specialists

were missing from the NTAC which limited contribution or consideration of the complexity of the health system, as well as specific programmatic and population needs [2]. Decisions made at the central level were transmitted to committees at national and sub-national level for implementation, which according to government guides, numbered 500 in total [17]. Communication mechanisms did not adequately cater for information flow and feedback loops which may have contributed to disorganization of the response and increased exposure of response teams [2].

Build understanding

This behaviour considered private sector data capture and information exchange for the continuation of essential health services during the COVID-19 response

The literature provided information on the availability of essential services. Most of this was generated through bespoke studies addressing specific populations, conditions, or service adaptations.

One study indicated a reduction in access to immunisation services by mothers and their children, attributed to the "fear factor" and lockdown measures [4]. Sexual and reproductive health services were also affected and likely resulted in "an upsurge in unmet need for family planning, inappropriate contraception, unsafe abortion, unplanned pregnancy, increased rate of sexually transmitted infections"[4]. Another study addressing the urban poor in Dhaka, suggested that despite adaptations to service models, this did not translate into utilisation of maternal and child health and nutrition services [18].

The continuation of delivery services was also impacted with more pregnant women opting to deliver at home. The home delivery rate was reported to have increased from about 50 per cent to 73 per cent following the initial lockdown [10]. This affected all districts to different degrees, including Dhaka where rates of facility-based normal and caesarean delivery decreased by over 40 per cent [19]. Issues with blood donations were also reported, necessitating some women to organise blood donors themselves [4]. Surgeries, including paediatric, were stopped, resulting in a large backlog of cases, in the context of an already overloaded workforce [20]. It was further suggested that the decision to halt surgeries may have triggered anxiety among the general population, and led to a decline in surgeries for emergency conditions, with an expected increase in disease complications [20].

Older populations were also constrained in accessing medicine and receiving routine medical care, in particular for NCDs. One study noted that a lack of clarity from health officials on how and who should access essential services hindered their delivery in practice [12]. Uncertainty had decisive public health impacts given that NCDs such as diabetes are a major public health issue, affecting one in every ten adults in urban areas in Bangladesh [12].

Self-medication, already common in Bangladesh, was reported to have increased [11, 16]. Two studies reported increased demand for medications such as antibiotics, painkillers, medicines for common colds and vitamins, leading to shortages [15, 16]. Shortages of other medications that pre-existed the pandemic, such as those for NCDs, were further exacerbated [12, 16]. Price increases/gouging were reported but varied in practice and by product [15, 16].

Information systems were strengthened in response to the pandemic. COVID-19 provided further impetus to extend DHIS2 coverage "to the most distant primary care facilities"[8]. These efforts did not shed light on the degree to which this included the private sector nor how private sector data was routinely captured within DHIS2. While this may have provided opportunity for greater data

capture for vital registries and screening programmes [8], there were concerns voiced that COVID-19 surveillance systems did not facilitate data availability or effective planning and monitoring, forcing the need for "stringent measures without meticulous assessment of the magnitude of disease"[2].

Enable stakeholders

This behaviour considered the development and implementation of financing mechanisms and regulations, to authorize and incentivize health system stakeholders for the continuation of essential health services during the COVID-19 response

The Bangladesh health care system is under resourced in real and relative terms. This situation pre-existed the pandemic and has not improved over time. For example, total government expenditure on health decreased in 2018 by more than 40 per cent, from a total of 5.2 per cent to 3.0 per cent [21]. External resourcing through donors has also decreased over time; in contrast, out-of-pocket expenditure has increased [21]. Out-of-pocket expenditure was reported to have increased during the COVID-19 pandemic at a time when household income reduced [22]. Low public spending on health care coupled with high out-of-pocket expenditure, has been associated with high rates of foregone care in Bangladesh [21].

Despite this situation, there was little government intervention in the health market during the pandemic. A range of opportunistic behaviours and adverse practices were reported in both the public and private sectors. In addition to price gouging, illicit trade of medicines and other medical products were reported during the pandemic [7], in part spurred through social and mainstream media, which encouraged self-medication among the general population [16]. Procurement rules also privileged selected private sector actors, deemed to be "politically blessed" [5]. This included procurement of PPE, some of which were found to be counterfeit but had been approved by the health department [5]. The media also covered discriminatory care where entire hospitals were reserved for "very important people" and their family members [5]. This situation affected the availability and quality of both COVID-19 and essential services.

Existing regulatory and legal frameworks were also reportedly not up-to-task. This was documented in relation to telemedicine and the pharmaceutical sector and pre-existed the pandemic. For example, while effort was made by the government to introduce "model pharmacies", unregulated drug shops remain essential for a large swatch of the population, as greater regulation has introduced additional costs, which are passed on to consumers [15]. During the pandemic there was a "dire drug crisis" due to unavailability or unaffordability of medicines, which went unmitigated by government [12]. Telemedicine also attracted costs and was considered more expensive than in person-visits for some services [12]. As the main service adaptation, telemedicine enlisted a range of platforms, including telephone, mobile phone, Facebook and other web pages, online apps, and other media [11]. While the government enacted the digital security act in 2018, there is no specific article or law for telemedicine service, leaving it unregulated [18].

Nurture trust

This behaviour considered recognition of competing and conflictive interests for continuation of essential health services during the COVID-19 response

Health systems and political leadership failure was a "dominant feature" of the pandemic response in Bangladesh and led to "low quality, discriminatory, or no service" [3, 5]. This reportedly affected health worker and the public's trust in the health system. For the public, this "manifested in health seeking from unqualified providers, nonadherence to health advice, and increased tension between

the service seekers and providers" [5]. Health workers, as the "face of the health system" were at the frontline of such tension, despite being unprepared, untrained and often unprotected (due to a lack of PPE) themselves [3]. There was limited recognition of the reciprocal obligations of governments and employers to minimize risks to health-care workers to the extent reasonably possible in the face of the pandemic. Suspensions were threatened or meted on some health workers in the initial phase of the pandemic for refusing to provide services [1, 2] which added to tensions. This situation was not specific to one sector and limited the ability of the *whole sector* to safely provide COVID-19 and essential services [18].

The pandemic response did not reflect the needs of the "marginalised majority" operating in the informal sector; this population comprises 87 per cent of the workforce in Bangladesh [23]. Containment measures created significant adversity for this population and other vulnerable groups [6, 13] and increased food and wealth insecurity [19]. This may have reduced the capacity of these populations to avail essential services from health facilities [19]. Designation of COVID-19 facilities customed by such households, also left them to identify alternate care pathways for essential services [9]. Telemedicine was also reported to have contributed to an uneven service landscape and deepened inequities due to the "digital divide" in Bangladesh [8].

Deliver strategy

This behaviour considered organisational learning and innovation to improve engagement of the private sector for the delivery of essential health services during the COVID-19 response

Systemic and pandemic-induced inequities were reported to stem from sectoral self-interests, underpinned by a competitive relationship between the public and private sectors, including non-profit organisations [24]. Inequities revealed "the shortcomings of the fragile and unplanned health system" and the appropriateness of the health policies and programmes [19]. It was suggested that rather than addressing systemic issues, a "blame-game" continued further escalating tensions between health sectors and society [1]. This limited the ability to deliver strategy, to learn and innovate, respond to crisis and maintain essential services.

> *"Bangladesh was ill-prepared for COVID-19. The same system that failed to meet regular healthcare demands was put to a sterner test"* [2].
>
> *"To construct a trustworthy healthcare system that equitably serves the people of Bangladesh requires a better allocation of resources, efficient systematic changes, mutual cooperation, and a healthy relationship between patients and physicians. Moreover, the vision of and will to make changes are prerequisites"* [1].

The literature further suggested that a holistic national response framework was needed in the immediate term given the fragility of the healthcare system, to ensure delivery of essential services, especially to the most vulnerable populations [22]. Regulatory frameworks also need to be "up-to-task" and enforced and reflect service adaptations introduced or scaled up as part of the pandemic response. They should also promote a more coherent engagement of the private and pharmaceutical sectors in the health system and the national response. Finally, the need to (re)build trust in the health system by health workers and service users was highlighted.

Next steps

The Bangladesh literature review is part of a sequential process (Figure 1) to facilitate progressive and diverse engagement of country stakeholders in public policy and the role of the private sector in maintaining and delivering essential health services.

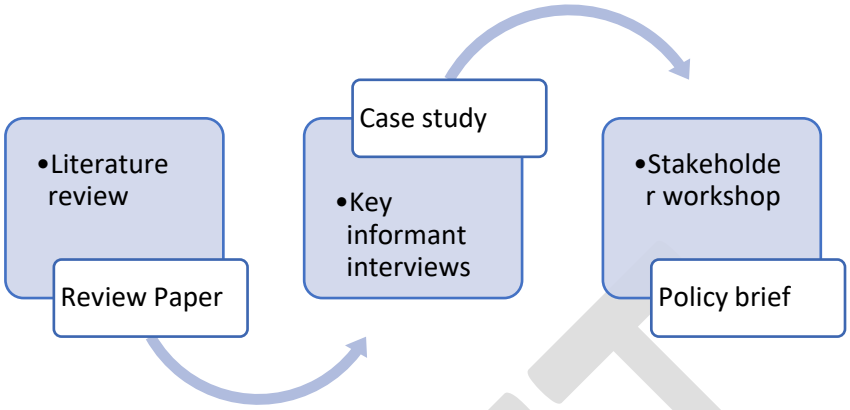

Figure 1. Policy engagement process

The literature review will inform qualitative interviews with public, private and civic sector stakeholders in Bangladesh. This will form the basis of a case study. A multi-stakeholder workshop will be held to validate findings from the literature review and case study, distil insights and policy recommendations. The output of the workshop will be the formulation of a policy brief to improve engagement of the private sector for the delivery of essential health services. Finally, country literature reviews and case studies will be used to prepare a manuscript for peer-review publication.

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