HPNSDP

Health, Population and Nutrition Sector Development Program (2011-2016)

PIP

Program Implementation Plan

Volume-I

July 2011

Planning Wing

Ministry of Health and Family Welfare

Government of the People's Republic of Bangladesh

প্রত্যয়নপত্র

এই মর্মে প্রত্যয়ন করা যাচ্ছে যে, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক Health, Population and Nutrition Sector Development Programme (HPNSDP) শীর্ষক সেক্টর কর্মসূচীর উন্নয়ন কার্যক্রম মোট ২২,১৭৬.৬৬ (জিওবি ৮,৬০৩.৫০+প্রকল্প সাহায্য ১৩,৫৭৩.১৬) কোটি টাকা প্রাক্কলিত ব্যয়ে জুলাই ২০১১ হতে জুন ২০১৬ মেয়াদে বাস্তবায়নের জন্য প্রস্তাব করা হয়েছে। মধ্যমেয়াদী বাজেট কাঠামো (এমটিবিএফ)-এর আওতায় ২০১১-২০১২ হতে ২০১৫-২০১৬ অর্থ বছরে স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের অনুকূলে উন্নয়নখাতে প্রদত্ত মোট সিলিং (২০,৯৮৬.১৩ কোটি টাকা) এর মধ্যে সীমাবদ্ধ রেখে জিওবি (৮,৬০৩.৫০ কোটি টাকা) ও আরপিএ (৮,৬৯৭.৯৮ কোটি টাকা) বাবদ মোট ১৭,৩০১.৪৮ কোটি টাকা ব্যয় প্রাক্কলন করে প্রস্তাবিত সেক্টর কর্মসূচি প্রণয়ন করা হয়েছে।

উল্লেখ্য, প্রকল্প সাহায্য বাবদ প্রাক্কলিত ১৩,৫৭৩.১৬ কোটি টাকা অর্থায়নের বিষয়ে উন্নয়ন সহযোগী সংস্থাসমূহের সাথে যোগাযোগ অব্যাহত রয়েছে এবং ইতোমধ্যে ১১,৫১৫.৩৬ কোটি টাকা অর্থায়নের বিষয়ে প্রতিশ্রুতি পাওয়া গেছে। সেক্টর কর্মসূচির আওতায় কিছু কার্যক্রম উন্নয়ন সহযোগী কর্তৃক সরাসরি সম্পাদিত হবে। এসব কার্যক্রমের ব্যয় সরাসরি প্রকল্প সাহায্য (ডিপিএ) হিসেবে প্রস্তাবিত সেক্টর কর্মসূচিতে প্রতিফলন করা হয়েছে। উল্লিখিত ডিপিএ বাবদ প্রাক্কলিত ব্যয় এমটিবিএফ-এর সিলিং এ অর্ন্তভুক্ত হয়নি; তবে ভবিষ্যতে প্রাপ্তি সাপেক্ষে তা এমটিবিএফ-এর প্রাক্কলন ও প্রক্ষেপণে অন্তর্ভুক্ত করা হবে এবং উন্নয়ন বাজেট (এডিপির মাধ্যমে) বৃদ্ধিসহ সার্বিকভাবে স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়ের এমটিবিএফ সিলিং বৃদ্ধির প্রয়াস নেয়া হবে। প্রস্তাবিত Health, Population and Nutrition Sector Development Programme (HPNSDP) শীর্ষক সেক্টর কর্মসূচীর প্রাক্কলিত ব্যয়ের ডিপিএ অংশ ব্যতীত ব্যয় মধ্য মেয়াদী বাজেট কাঠামোর (এমটিবিএফ) সিলিং এর মধ্যে সীমাবদ্ধ রয়েছে।

মুহম্মদ হুমায়ুন কবির
৯।৮।১১

(মুহম্মদ হুমায়ুন কবির)
সচিব
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

মুহম্মদ হুমায়ুন কবির
সচিব
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
গণপ্রজাতন্ত্রী বাংলাদেশ সরকার।

HPNSDPÛi PIP Dci 26 I 30 †g 2011 Zvwi‡L AbwôZ wcBwm mfvq cwiKíbv Kwgk‡bi wm×vš Ges gšYvjq KZK MnxZ e¨e¯v wbgi¡ct-

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
5.1	¯v¯¨ I cwievi Kj¨vY gšYvjq †m±i KgmwPi gva¨‡g ¯v¯¨ wel‡q wewfb Dbqb KgmwP Mn‡Yi cvkvcwk ¯Zšfv‡e wewfb cKí Mn‡Yi †hŠw³KZv m¤ú‡K wcAvBwc‡Z D‡jL Ki‡Z n‡e| Ab¨vb¨ gšYvjq I †emiKvix ms¯v/GbwRI KZK ¯v¯¨, RbmsL¨v I cwó msµvš wel‡q MnxZ wewfb Dbqb KgmwP/cKímg‡ni ev¯evq‡b ^ØZZv, mgšqnxbZv I Ae¨e¯vcbv Ges A_ AcPq cwinv‡ii h_vc‡qvRbxq e¨e¯v MnY Ki‡Z n‡e|	miKv‡ii ivR‰bwZK cwZk“wZ I AMwaKvi Abhvqx wewfb mg‡q Uviwkqvix, †¯úkvjvBRW nvmcvZvj I †gwW‡Kj K‡jR nvmcvZvj cwZôvi Rb¨ ¯Zš cKí Mn‡Yi c‡qvRb nq| †m±i KgmPx `vZv ms¯v I evsjv‡`k miKv‡ii †hŠ_ A_vqbcó KgmPx, hv‡Z cv_wgK ¯v¯¨ †mev LvZ†K AMwaKvi c`vb Kiv nq| GRb¨ en`vKv‡ii AeKvVv‡gv wbgvYagx cKí msL¨v †m±i KgmPx‡Z h_vm¤e mxwgZ ivLv nq| †m±i KgmPx evisevi ms‡kvab K‡i AMwaKvi/ cwZk“wZgjK cKí †m±i KgmPx‡Z Ašf³KiY GKwU `xN I RwUj cwµqv| G‡Z ‡m±i KgmPxi Aax‡b Pjgvb Kvhµg e¨nZ n‡q _v‡K| Ab¨vb¨ gšYvjq/wefvM I †emiKvix ms¯v/GbwRI KZK ¯v¯¨, RbmsL¨v I cwó wel‡q MnxZ wewfb Dbqb KgmPx I cKímg‡ni mv‡_ AwaKZi mgšq †Rvi`vi Kiv n‡e, hv‡Z ^ØZZv I A_ AcPq cwinvi Kiv hvq| †m±i KgmPxi mxgve×Zv I Ab¨vb¨ gšYvjq/ms¯vi mv‡_ mgšq wbwðZ Kiv m¤ú‡K PIPÛi Ab‡”Q` 2.3 Ges 3.7 D‡jL Kiv n‡q‡Q (PIPÛi côv 7 Ges 32)
5.2	Rb, 2011-†Z mgvc¨ HNPSPÛi Dci AvBGgBwWÛi AšeZxKvjxb gj¨vqb cwZ‡e`bmn Mid Term Rivewÿi D‡jL‡hvM¨ Ask wcAvBwc‡Z msh³ Ki‡Z n‡e|	AvBGgBwW KZK HNPSP (2003-2011)Ûi mgwß gj¨vq‡bi Rb¨ wbh³ civgkKMY B‡Zvg‡a¨ gj¨vqb Kvhµg ïi“ K†i‡Q| gj¨vqb cwZ‡e`b GLbI Povš nqwb| eZgvb †c¶vc‡U MTR Ges APR Gi msw¶ßmvi ms‡hvRbx-L `óe¨ (cbMwVZ PIPÛi Volume-II Gi côv 102-142)|
5.3	1998 mv‡j c_g ‡m±i KgmwP‡Z ceZbKvjxb Ab‡gw`Z mvims‡¶‡ci Kwc cwiKíbv Kwgk‡b †ck Ki‡Z n‡e|	MZ 05/06/2011 Zvwi‡L GZ`msµvš mvi-ms‡¶‡ci Kwc cwiKíbv Kwgk‡b †ck Kiv n‡q‡Q|
5.4	c¯wZeZ wcAvBwc GK‡bK mfvq Dc¯vcbKv‡j wcAvBwcf³ 32wU Acv‡ikbvj c¨vb wWwcwc AvKv‡i cwiKíbv Kwgk‡bi gva¨‡g miKvix Lv‡Z Dbqb cKí cwµqvKiY, Ab‡gv`b I ms‡kvab c×wZ msµvš cwicÎ †g, 2008 Abhvqx GK‡bK KZK PovšÍfv‡e Ab‡gv`b Kivi wel‡q m¯úófv‡e w`K-wb‡`kbv/wm×v‡ši Rb¨ cwiKíbv Kwgkb KZK cYxZ c¯Íve GK‡bK mfvq Z‡j ai‡Z n‡e|	K. wm×vš †gvZv‡eK cwiKíbv Kwgkb Acv‡ikbvi c¨vb Ab‡gv`‡bi wel‡q w`K-wb‡`kbvi Rb¨ c¯ve GK‡bK mfvq Dc¯vcb Ki‡Z cv‡i| L. G wel‡qi ¯v¯¨ I cwievi Kj¨vY gšbvj‡qi gZvgZ wbæi¡ct 1998-2002 chš ¯v¯¨ I cwievi Kj¨vY gšYvj‡qi AvIZvq ``Health and Population Sector Programme (HPSP)" ev¯evqbKv‡j D³ KgmPxi Programme Implementtation Plan (PIP) ÛGK‡bKÛ KZK Ab‡gv`‡bi ci Dnv GwWwc‡Z cwZdjb Kiv nq| †m mgq †Kvb Acv‡ikbvj c¨vb (Iwc) GwWwc‡Z Ašf³ wQjbv| ÛGK‡bKÛ KZK Ab‡gw`Z PIP Gi j¶¨, D‡Ïk¨ Ges AMwaKvi Kvhµ‡gi Av‡jv‡K Dbqb mn‡hvMx ms¯v Ges miKv‡ii †hŠ_ D‡Ï¨v‡M cwZeQi Annual Opreation Plan (AOP) cYqb Ges gšYvj‡qi gšx g‡nv`‡qi mfvcwZ‡Z MwVZ w÷qwis KwgwUi gva¨‡g D³ AOP Ab‡gv`b Kiv nZ| 2003-2011 ‡gqv‡` MnxZ HNPSP Gi PIP GK‡bK KZK Ab‡gv`‡bi ci Bnvi Av‡jv‡K Operational

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
		Plan cYqb Kiv nq Ges GK‡bK Gi wm×vš Abhvqx ¯v¯¨ I cwievi Kj¨vY gšYvj‡qi gšx g‡nv`‡qi mfvcwZ‡Z MwVZ w÷qwis KwgwU KZK OP Ab‡gv`‡bi ci OP GwWwc‡Z Ašf³ Kiv nq| OP Ab‡gv`‡bi welqwU m¤ú‡K wcBwm mfvq Av‡jvPbv Kiv nq Ges gšYvjq g‡b K‡i SWAp c×wZi ‰ewkó Abhvqx OP Ab‡gv`‡bi ¶gZv gšYvj‡qi AvIZvq we`¨gvb _vKv c‡qvRb| G e¨vcv‡i gšYvj‡qi †hŠw³KZv Annexure-U G c`vb Kiv nj (cbMwVZ PIPÔi Volume-II Gi côv bs 405)|
5.5	Rb 2011-†Z mgvc¨ B‡Zvg‡a¨ ev¯ewqZ HNPSPÔi gj D‡Ïk¨ I Uv‡M‡Ui wfwË‡Z AwRZ mvdj¨, Uv‡MU I mvd‡j¨i e¨eavb, HNPSP Ges c¯wZ HPNSDPÔi gva¨‡g wbawiZ Uv‡M‡Ui m¯úó Zjbvgjk wPÎ Ges c‡e wbawiZ Uv‡MU AR‡b wedjZv/NvUwZ _vK‡j Zvi mwb`ó KviY/†hŠw³KZv PIP-†Z D‡jL Ki‡Z n‡e|	B‡Zvg‡a¨ Rb 2011-†Z mgvß HNPSPÔi gj D‡Ïk¨ I Uv‡M‡Ui wfwË‡Z AwRZ mvdj¨, Uv‡MU I mvd‡j¨i e¨eavb, HNPSP Ges c¯wZ HPNSDPÔ‡Z wbawiZ Uv‡M‡Ui Zjbvgjk wPÎ Ges NvUwZi weeiY ms‡hvRbx-O G †`L‡bv nj (cbMwVZ PIPÔi Volume-II Gi côv 148-149)|
5.6	GK‡b‡Ki AeMwZ I we‡ePbvi Rb¨ cwó msµvš Kvhµg cKí AvKv‡i MnY bv K‡i †m±i KgmwP‡Z Acv‡ikbvj c¨v‡bi AvIZvq Mn‡Yi wel‡q hw³ we¯vwiZfv‡e wcAvBwc‡Z D‡jL Ki‡Z n‡e| ZvQvov, HNPSPÔi AvIZvq ev¯evqbvaxb cwó Kvhµ‡gi mdjZv Ges ev¯e mgm¨v I Zvi mgvav‡bi mwb`ó c`‡¶c/Kvhµg wcAvBwc‡Z Ašf³ Ki‡Z n‡e|	Rb 2011 G mgvß GbGbwc g‡Wj Abmibce K †`‡ki mKj GjvKvq cwó Kvhµg m¤cmvibmn GgwWwRi j¶¨gvÎv ARb Kiv m¤e bq| APR-2009 Gi mcwi‡ki Av‡jv‡K cwó †mev‡K ¯v¯¨ Awa`ßi I cwievi cwiKíbv Awa`ß‡ii AvIZvaxb mKj ‡mev †K‡›`i gva¨‡g ‡mev `v‡bi gj †mvZavivq Avbq‡bi wm×vš MnY Kiv nq| Gi d‡j gv, beRvZK I wkï i cwógvb Dbq‡b mgwšZ Kvhµg MnY Kiv m¤e n‡e Ges mwPK cwói Dbq†bi gva¨‡g GgwWwR-Gi j¶¨gvÎv ARb Kiv m¤e n‡e e‡j Avkv Kiv hvq| GQvovI c¯wZ avivq Kvhµg ¯vqx n‡e| Vertical cK‡íi gva¨‡g GKw`‡K †hgb cwó‡K Mainstreamingmn m¤cmviY Kiv m¤e bq Ges Aciw`‡K Dbqb mn‡hvMx‡`i A_vqb cwßi Awbðqvi cwi‡cw¶‡Z cwó msµvš GgwWwRÔi j¶¨gvÎv AR‡bi Rb¨ National Nutrition Services (NNS) kxlK GKwU Acv‡ikbvj c¨vb ev¯evq‡bi c¯ve Kiv n‡q‡Q| cwó msµvš Kvhµg cKí AvKv‡i MnY bv K‡i †m±i KgmwP‡Z Acv‡ikbvj c¨v‡bi AvIZvq Mn‡Yi wel‡q cbMwVZ PIPÔi National Nutrition Services (NNS) Gi OP Summary-‡Z we¯wiZ D‡jL Kiv n‡q‡Q| (cbMwVZ PIPÔi côv-167 `óe¨)| 1996 mvj †_‡K cwó †mev G gšYvj‡qi AvIZvq AvBwcGBPGb I GbGbwc-Gi gva¨‡g cwiPvwjZ n‡q AvmwQj| D‡jL¨, gvV chv‡q GbGbwcÔi Kvhµg NGO KZK ev¯ewqZ n‡q‡Q| wKš NGO Ges AvBwcGBPGb KZK ev¯ewqZ Kvhµg I KvhKi †idv‡ij c×wZi Afv‡e cZ¨wkZ mvdj¨ AR‡b axiMwZ cwijw¶Z nq| ¯v¯¨ I cwievi Kj¨vY gšYvjq Gi AvIZvaxb GKwU KgmPx nlqv m‡Ël ¯v¯¨ Awa`ßi I cwievi cwiKíbv Awa`ß‡ii †mev c`vbKvix‡`i g‡a¨ bvggvÎ mgšq _vKvq †idv‡qj wm‡÷gmn Ab¨vb¨ wel‡q we`¨gvb g‡W‡j cZ¨wkZ gv‡bi Kv‡Ri cwi‡ek mwó nqwb| HNPSPÔi AvIZvq ev¯ewqZ cwó Kvhµ‡gi mdjZv

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
		Ges ev¯e mgm¨v I Zvi mgvav‡bi c`‡¶c cbMwVZ PIPÛi cô v 167 Ges ms‡hvRbx-H G cwZdjb Kiv n‡q‡Q (cbMwVZ PIPÛi Volume-II Gi cô v 76-84)	
5.7	¯v¯¨ I cwievi Kj¨vY gšYvj‡qi AvIZvq RjvB 2009-Rb 2014 †gqv‡` ev¯Íevqbvaxb "Revitalization of Community Health Care Initiative in Bangladesh (RCHCIB)" kxlK cK‡íi ‡Kvb K‡¤úv‡b›U ÒCommunity, Based Health CareÓ kxlK Acv‡ikbvj c¨v‡b Ašf³ n‡j cKí n‡Z D³ K‡¤úv‡b›U ev` w`‡q Ri“ix wfwË‡Z RCHCIB cK‡íi wWwcwc ms‡kvab Ki‡Z n‡e| Pjgvb cKí n‡Z †Kvb K‡¤úv‡b›U Acv‡ikbvj c¨v‡b ¯vbvš‡ii KviY wcAvBwc‡Z D‡jL Ki‡Z n‡e| G‡¶‡Î Pjgvb cKí Ges HPNSDP-†Z c¯weZ Acv‡ikbvj c¨v‡bi KgKv‡Ûi g‡a¨ ^ØZZv cwinv‡ii welqwU wbwðZ Ki‡Z n‡e| GQvov RCHCIB cKí mgwßi ci (Rb 2014) cK‡íi †Kvb †Kvb K‡¤úv‡b›U Acv‡ikbvj c¨v‡b Ašf³ n‡e Zv wcAvBwc‡Z mwb`ófv‡e D‡jL Ki‡Z n‡e|	"Revitalization of Community Health Care Initiative in Bangladesh (RCHCIB)" kxlK cK‡íi cwk¶b c`vb, JlacÎ, GgGmAvi, hšcwZ BZ¨w` K‡¤úv‡b›U ÒCommunity Based Health CareÓ kxlK Acv‡ikbvj c¨v‡b Ašf³ i‡q‡Q| DwjwLZ K‡¤úv‡b›U-Gi wmsnfvM KvR wcG Lv‡Zi A_vq‡b ev¯evq‡bi Rb¨ wbawiZ wQj| wKš cK‡íi AvIZvq wcG Lv‡Zi A_vq‡bi Avkvm bv cvIqvq ewYZ K‡¤úv‡b›U¸‡jv Iwci gva¨‡g cKí mvnv‡h¨I A‡_ ev¯evqb Kiv n‡e| G cwi‡cw¶‡Z wcBwmi wm×vš Abhvqx RCHCIB cK‡íi wWwcwc ms‡kva‡bi c`‡¶c MnY Kiv n‡e| ÒCommunity, Based Health CareÓ kxlK c_K Iwc I Pjgvb cKí n‡Z ‡Kvb †Kvb K‡¤úv‡b›U Acv‡ikbvj c¨v‡b ¯vbvš‡ii KviY cbMwVZ PIPÛ‡Z D‡jL Kiv n‡q‡Q (cô v t 58-59)| Iwc I cKí ev¯evqbKv‡j mgwšZ Kgcw iKíbv cYq‡bi gva¨‡g RCHCIB cKí Ges HPNSDP-†Z c¯weZ Acv‡ikbvj c¨v‡bi KgKv‡Ûi g‡a¨ ^ØZZv cwinv‡ii welqwU wbwðZ Kiv n‡e| HPNSDP-†Z KwgDwbwU wKwbK‡K †K›`we›` a‡i Upazilla Health System Strengthening-mn Community Health Care Mainstreaming Kivi c`‡¶c MnY Kiv n‡e| ZvB miKv‡ii AMwaKvigjK RCHCIB cKí mgwßi cil (Rb 2014) cK‡íi wbgvY e¨ZxZ Ab¨vb¨ mKj Kvhµg Rb 2016 chš Pvj ivLvi c`‡¶c MnY Kiv n‡q‡Q|
5.8	c¯weZ †m±i Kgm Pi AbK‡j ^e‡`wkK mnvqZv cwßi wel‡q nvjbvMv` Z_¨w` wcAvBwc‡Z AšÍf³ Ki‡Z n‡e|	HPNSDP Gi †gvU cv°wjZ ^e‡`wkK mnvqZvi cwigvY 1834.21 wg. gv. W. (mgcwigvb 13,573.16 †KwU UvKv)| A`¨vewa 1556.13 wg. gv. W. (mgcwigvY 11,515.36 †KwU UvKv) ^e‡`wkK mnvqZvi Avkvm cvIqv wM‡q‡Q| A_vr 278.08 wg. gv. W. (mgcwigvY 2057.80 †KwU UvKv) A_vqb NvUwZ (funding gap) i‡q‡Q| EC Ges KFW n‡Z †cvMvg PjvKv‡j AwZwi³ A_vqb cvIqv hv‡e e‡j Avkv Kiv hvq| HPNSDPÛ†Z Disbursment for Acclerated Achievements of Results (DAAR) (ms‡hvRbx-B, cbMwVZ PIPÛi Volume-II Gi cô v 22-23) Gi AvIZvq wek e¨vsK †_‡K Av‡iv 50.00 wg. gv. W. AwZwi³ mnvqZv cvIqvi m¤vebv i‡q‡Q| GQvovI GAVI, GFATM, IDB, KUWAIT BZ¨w` ms¯v n‡Z ‰e‡`wkK mnvqZv cvIqvi m¤vebv i‡q‡Q (ms‡hvRbx-M, cbMwVZ PIPÛi Volume-II Gi cô v 143-146)|
5.9	c¯weZ HPNSDP Gi wewfb Acv‡ikbvj c¨v‡bi AbK‡j Priority indicators with Benchmarks and Targets †Uwe‡ji cvkvcwk B‡Zvg‡a¨ ev¯ewqZ HNPSP-Gi gva¨‡g AwRZ mvd‡j¨i nvjbvMv` Z_¨ Dc¯vcb Ki‡Z n‡e|	Rb 2011-†Z mgvß HNPSP'র Uv‡M‡Ui wfwË‡Z AwRZ mvdj¨ c¯weZ HPNSDPÛi mswkó OPÛi (Chapter-4-Gi OP Summary) Priority Indicators Gi Baseline wn‡m‡e Z_¨ cwZdjb Kiv n‡q‡Q|

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
5.10	†m±i †cvMv‡gi h_vh_ I wbi‡c¶ cwiex¶‡Yi Rb¨ ¯v¯¨ gšYvjq, cwiKíbv Kwgkb, AvBGgBwW, mswkó Awa`ßi Ges jvBb WvB‡i±i Gi mgš‡q cwZ eQ‡i 1 evi KgmwPi gj¨vqb Ki‡Z n‡e| ZvQvov, Dbqb cKí/†m±i wfwËK Dbqb KgmwPi ev¯Íevqb cwiex¶Y I gj¨vqb c×wZ msµvš IMED-Gi cwic‡Îi Av‡jv‡K AvBGgBwW KZK KgmwPi Mid-term Evaluation Ki‡Z n‡e|	cwZeQi `vZv ms¯v I ¯v¯¨ I cwievi Kj¨vY gšYvjq KZK †hŠ_fv‡e Annual Program Review (APR) AbwôZ nq| APR cwiPvjbvi mKj chv‡q cwiKíbv Kwgkb, AvBGgBwW, BAviwWmn mswkó mKj ms¯vi cwZwbwa m¤ú³ _v‡K| HPNSDPÔi ga¨‡gqv`x gj¨vqb cwicÎ Abhvqx m¤úv`‡bi Rb¨ AvBGgBwW-‡K Ab‡iva Kiv n‡e (cbMwVZ PIP ct bs-272)|
5.11	¯vbxq miKvi wefvM KZK Urban Primary Health Care wel‡q MnxZ cK‡íi Kv‡Ri cwiciK KvR ¯v¯¨ I cwievi Kj¨vY gšYvjq KZK c¯wZ Kgmwpi AvIZvq MnY Kiv ‡h‡Z cv‡i, Z‡e G†¶‡Î Aek¨B mgš‡qi gva¨‡g %ØZZv cwinvi Ki‡Z n‡e|	¯vbxq miKvi wefvM KZK ev¯Íevqbvaxb UPHCP Gi ev¯evqb I gwbUwis Gi Rb¨ MwVZ wewfb Kwgw‡Z ¯v¯¨ I cwievi Kj¨vY gšYvjq, ¯v¯¨ Awa`ßi Ges cwievi cwiKíbv Awa`ß‡ii cwZwbwaZ i‡q‡Q| D‡jL¨, MoLGRDC Gi mwnZ mwweK mgšq K‡i GKwU Urban Health Strategy I Urban Health Plan cYq†bi D‡`¨vM MnY Kiv n‡q‡Q| c¯wZ HPNSDP†Z kû‡i ¯v¯¨ †mev Kvhµg UPHCPÔi Kvhµ‡gi cwiciK wnmv‡e MnY Kiv n‡q‡Q| GQvov mwweK mgšq †Rvi`vi Kivi R‡b¨ G wel‡q MvBWjvBb cYqb I D”P chv‡qi GKwU Kwgw U MVb Kiv n‡e|
5.12	c¯wZ †m±i KgmwPi mv‡_ mswkó mK‡ji ev¯e AwfÁZv I Ávb mg× Kivi wbwgË †mwgbvi, Kbdv‡iÝ, IqvKmc I cwk¶‡Y (†`kxq/‰e‡`wkK) mswkó mK‡ji AskMnY wbwðZ Kivi j‡¶¨ ¯v¯¨ I cwievi Kj¨vY gšYvj‡qi mwP‡ei mfvcwZ‡Z cwiKíbv Kwgk‡bi ¯v¯¨ †m±‡ii hM¦-cavb, mswkó Awa`ßi, AvBGgBwW, jvBb WvB‡i±‡iU I hM¦-cavb (¯v¯¨ I cwievi Kj¨vY gšYvjq) Gi mgš‡q GKwU †mwgbvi, Kbdv‡iÝ, IqvKmc I cwk¶Y wbaviY I PovšKiY Kwgw U MVb Ki‡Z n‡e|	HPNSDPÔi AvIZvq c¯ÍwZ †`kx-we‡`kx cwk¶‡Yi †¶Î/welqe¯, †UKwbK¨vj/wKwbK¨vj I e¨e¯vcbvMZ cwk¶‡Yi Pwn`v wbi¡cb, cwk¶‡Yi †gqv`, cv_x g‡bvbqb, cwk¶Y cwZôvb wbevPb BZ¨w` welqmgn we‡ePbv K‡i AwP‡iB ¯v¯¨ I cwievi Kj¨vY gšYvjq KZK GKwU cwk¶Y bxwZgvjv cYqb Kiv n‡e| wm×vš †gvZv‡eK DwjwLZ cwk¶Y bxwZgvjvi Av‡jv‡K cwk¶Y Kwgw U MVb Ges †m±i KgmwPi mv‡_ mswkó mK‡ji AskMnY wbwðZ Kiv n‡e|
5.13	c¯wZ †m±i KgmwPf³ wewfb Iwc‡Z ms¯vbKZ cwk¶‡Yi †¶‡Î welq, msL¨v, †gqv` I e¨q msµvš cY½ Z_¨w` GKwU †Uwej AvKv‡i wcAvBwc‡Z D‡jL Ki‡Z n‡e|	DGHS-Gi mKj mvavi Y I wKwbK¨vj cwk¶Y IST Iwc‡Z Ašf³| GQvov †cvMvgwfwËK cwk¶Y mswkó Iwc‡Z I e¨e¯vcbv m¤úwKZ cwk¶Y HRM Iwc‡Z Ašf³| PIP‡Z Ašf³ OPÔi mvi-ms‡¶‡c cwk¶Y A½ Ges cv°wjZ e¨q cwZdjb Kiv n‡q‡Q| cwk¶‡Yi Ab¨vb¨ Z_¨ mswkó OP-‡Z c`vb Kiv n‡e|
5.14	wew”Qbfv‡e wewfb Acv‡ikbvj c¨v‡bi AvIZvq hvbevnb/hšcwZ µq bv K‡i c¯ÍweZ †m±i KgmwPi Rb¨ mKj ai‡bi hvbevnb I hšcwZ mgwšZfv‡e GKwU Acv‡ikbvj c¨v‡bi AvIZvq µq Kiv †h‡Z cv‡i| c¯wZ hvbevnb I hšcwZi aiY, msL¨v, cwigvY, gj¨ I e¨envi/µ‡qi †hŠw³KZv msµvš hveZxq Z_¨ 1wU †Uwe‡j Dc¯vcwK ms‡hvRbx wn‡m‡e wcAvBwc‡Z Ašf³ Ki‡Z n‡e| Rb 2011-†Z mgvc¨ HNPSP n‡Z cieZx †m±i KgmPx‡Z (HPNSDP) ¯vbvšwiZe¨ mKj ai‡bi hvbevnb I hšcwZi nvjbvMv` Ae¯vmn ZwjKv wcAvBwc‡Z ms‡hvRb Ki‡Z n‡e|	SWAp KgmPxi Ab¨Zg D‡Ïk¨ n‡jv mgwšZfv‡e GKB ai‡bi KgKvÛ GKwU Iwcôi AvIZvq m¤úv`b| SWAp G w¯úwiU AbmiY K‡i wewfb OPÔi µq Kvhµg mgwšZfv‡e ev¯evq‡bi j‡¶¨ PPR/`vZv ms¯vi MvBW jvBb AbmiY K‡i LD†`i Pwn`v †gvZv‡eK ¯v¯¨ Awa`ß‡ii †¶‡Î CMSD Ges cwievi cwiKíbv Awa`ß‡ii †¶‡Î Procurement Storage and Supply Management OPÔi AvIZvq Kiv nq| HNPSPÔi AvIZvq msMnxZ Ges cieZx †m±i KgmPx HPNSDP Gi AvIZvq msMnxZe¨ hvbevn†bi ZwjKv PIPÔi ms‡hvRbx-G G c`vb Kiv n‡jv (cbMwVZ PIPÔi Volume-II Gi côv 63-75)| HNPSP-†Z msMnxZ hvbevnb I hšcwZ wewa-‡gvZv‡eK avivewnKfv‡e mswkó ms¯v I cwZôv‡b e¨eüZ n‡e| HNPSP Gi 38wU Iwci AvIZvq msMnxZ hšcwZi ZwjKv c`v‡bi Rb¨ mswkó jvBb

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
		WvB‡i±i‡`i cÎ †`qv n‡q‡Q| HNPSPÛi 2003-2011 ev¯Íevqb †gqv‡` msMnxZ hšcwZi ZwjKv cYqb mgq mv‡c¶ weavq ZwjKwU mswkó OP†Z msh³ Kiv n‡e|
5.15	c¯wеZ †m±i KgmwPi AvIZvq msMnxZe¨ hvbevnb KgmwPi cwµqvKiY/ev¯evqb/gwbUwis-Gi mv‡_ mswkó mKj cwZôv‡bi `vßwiK c‡qvR‡b cwßi welqwU wbwðZ Ki‡Z n‡e|	HPNSDPÛi AvIZvq msMnxZe¨ hvbevnb KgmwPi cwµqvKiY/ev¯evqb/gwbUwis-Gi mv‡_ mswkó mKj cwZôv‡bi `vßwiK c‡qvR‡b e¨envi/cwßi welqwU h_vh_fv‡e wbwðZ Kiv n‡e|
5.16	c¯wеZ KgmwPi AvIZvq nvmcvZvj wbgvY Z_v nvmcvZvj Upgradation Gi †¶‡Î nvmcvZv‡ji WBs/wWRvBb I †¯úmwd‡Kkb h_v_ I AvawbK gv‡bi n‡Z n‡e| cZ KvR m¤úb nIqvi ci h_vm¤e `“ZZvi mv‡_ hšcwZ I Avmevecî mieivn/¯vcb, Rbej wb‡qvM cwµqv m¤úb K‡i ‡mev c`vb wbwðZ Z_v nvmcvZv‡ji Kvhµg Pvj Ki‡Z n‡e|	m¤úwZ miKvi wmGgGgBD‡K AvawbK I kw³kvjx Kivi j‡¶¨ Health Engineering Department G DbxZ K†i‡Q| Awa`ß‡ii i¡cvš‡ii d‡j cwZôv‡bi mvsMVwbK KvVv‡gv I `¶Zvi Dbqb NU‡e| d‡j WBs, wWRvBb, †¯úwmwd‡Kkbmn Kvhµg Z`viwK ¸bMZ Dbqb NU‡e e‡j Avkv Kiv hvq| c¯wеZ HPNSDP†Z ¯v¯¨ ¯vcbv wbgvY KvR I wbgv‡YvËi hšcwZ, miÄgw` I AvmevecÎ msMn Ges Rbej wb‡qvM BZ¨w` Kvhµg mgqvbMfv‡e m¤úv`b I mgš‡qi Rb¨ GKwU D”P chv‡qi KwgwU MVb Kiv n†e Ges wbwgZ/gv‡bvbxZ ¯v¯¨ ¯vcbv n‡Z h_vmg‡q †mev c`vb Kvhµg Pvji welqwU wbwðZ Kiv n‡e|
5.17	wcAvBwcÛi Chapter-3 Gi AvIZvq c`Ë wewfb e·/†Uwe‡j cwZdwjZ Priority interventions mswkó wPwýZ IwcÛmg‡ni b¤‡i we`¨gvb Am½wZ `i Ki‡Z n‡e| GQvov wcAvBwc‡Z G ai‡Yi ¯úó †Kvb Am½wZ i‡q‡Q wKbv Zv cix¶v-wbix¶v K‡i †`L‡Z n‡e Ges †Kvb Am½wZ cwij¶Z n‡j Zv `i Ki‡Z n‡e|	PIPÛi Chapter-3 Gi AvIZvq c`Ë wewfb e·/†Uwe‡j cwZdwjZ Priority interventions mswkó wPwýZ OP mg‡ni b¤‡ii AmsMwZ `i K‡i cbMwVZ PIPÛ†Z h_vh_fv‡e cwZdwjZ Kiv n‡q‡Q|
5.18	Rb 2011-†Z mgvc¨ HNPSP-†Z Ašf³ 38wU Acv‡ikbvj c¨v‡bi (Iwc) cwZwUi Rb¨ wbawiZ Kvhµ‡gi wK wK ev¯ewqZ n‡q‡Q, wK wK evKx Av‡Q Ges c¯wеZ cieZx †m±i KgmPxi AvIZvq mswkó Iwc‡Z bZb wK wK Kvhµg MnY Kiv n‡e Zvi Zjbvgjx wPÎ ‡Uwej AvKv‡i wcAvBwc‡Z Dc¯vcb Ki‡Z n‡e|	HNPSP-Gi OPÛmg‡ni AvIZvq ev¯ewqZ cavb cavb Kvhµg Ges HPNSDP-Gi AvIZvq ev¯ewqZe¨ Kvhµ‡gi Zjbvgjx wPÎ ms‡hvRbx–F G †`Lv‡bv n‡q‡Q (cbMwVZ PIPÛi Volume-II Gi côv 43-62)|
5.19	‡`‡ki RbmsL¨v wbqš‡Y HNPSP-Gi AvIZvf³ Kvhµg I ev¯evqb AMMwZ Ges HPNSDP-Gi AvIZvq MnxZe¨ Kvhµg I Uv‡MUmgn wcAvBwc‡Z Dc¯vcb Ki‡Z n‡e|	‡`‡ki RbmsL¨v wbqš‡Y HNPSP-Gi AvIZvq MnxZ cavb cavb Kvhµgmgn ms‡hvRbx–N G †`Lv‡bv n‡q‡Q (cbMwVZ PIPÛi Volume-II Gi côv 147)	
5.20	‡m±i KgmwPi mô ev¯evqb wbwðZ Kivi ¯v‡_ Iwc wfwËK wcAvBwm I w÷qwis KwgwU MVb Kiv AZ¨vek¨K we‡ePbvq TOR mn G ai‡Yi KwgwU MVb Ki‡Z n‡e|	wm×vš †gvZv‡eK OP wfwËK PIC MVb Kiv n‡e (ms‡hvRbx–D, cbMwVZ PIPÛi Volume-II Gi côv 40)| RvZxq w÷qwis KwgwUi MVb I TOR ms‡hvRbx–E `óe¨ (cbMwVZ PIPÛi Volume-II Gi côv 41-42)|
5.21	c¯wеZ †m±i KgmwPi ev¯evqb †¶‡Î A‡_i Low Utilization †iva Kivi Rb¨ h_vh_ e¨e¯v MnY Ki‡Z n‡e|	m`¨ mgvß HNPSP‡Z Procurement Lv‡Z Kg AMMwZ n‡q‡Q weavq c¯wеZ HPNSDP ev¯evq‡b Procurement Kvhµg‡K Av‡iv MwZkxj, `¶ I ¯”Q Kivi j‡¶¨ Online tracking system, e-procurement, Single sources Procurement I framework contract BZ¨w`i gva¨‡g utilization ew× Kiv n‡e| MIS kw³kvjx Kivi gva¨‡g gwbUwis Kvhµg †Rvi`vi Kiv Ges Aw_K e¨e¯vcbv Dbq‡bI c`‡¶c †bqv n‡e| D‡jL¨ HPNSDP Gi fund

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
		disbursement mnRxKi‡Yi j‡¶¨ Dbqb mn‡hvMx‡`i mv‡_ Joint Financing Arrangement (JFA) ¯v¶i Kiv n‡e| GmKj Kvhµg Mn‡Yi d‡j c¯weZ †m±i KgmPx‡Z ms¯vbKZ A‡_i e¨envi A‡bKvs‡k e× cv‡e e‡j Avkv Kiv hvq|
5.22	¯v¯¨ †mevi †¶‡Î A‡Uv‡gkb c×wZ Pvj Kivi wel‡q B‡Zvg‡a¨ ev¯ewqZ Kvhµg Ges c¯weZ HPNSDPÛi AvIZvq MnxZe¨ Kvhµ‡gi we¯wiZ weeiY cbMwVZ PIP-†Z D‡jL Ki‡Z n‡e|	nvmcvZvjmg‡n A‡Uv‡gkb c×wZ Pvj Kivi j‡¶¨ BwZg‡a¨B PPP Gi AvIZvq cKí MnY cwµqvaxb i‡q‡Q| GZØ¨wZZ, HPNSDPÛi AvIZvq Health Information System (HIS) OPÛi AvIZvq 6wU Tertiary level nvmcvZvj Ges DGFP Gi Management Information System (MIS) OPÛi AvIZvq MCHTI, Azimpur Ges MFSTC, Mohammadpur G `wU cwZôvb A‡Uv‡gkb Kivi welqwU cbMwVZ PIP†Z D‡jL Kiv n‡q‡Q (cbMwVZ wcAvBwc ct 147-148 Ges 208 `óe¨)|
5.23	†m±i KgmwPi wewfb Iwcôi AvIZvq c¯weZ mKj Physical works Ges AeKvVv‡gv †givgZ I i¶Yv‡e¶Y msµvš Kvhµg mgwšZfv‡e Physical Facilities Development Acv‡ikbvj c¨v‡bi AvIZvq ev¯evqb Ki‡Z n‡e|	wm×vš †gvZv‡eK mKj Physical works Ges AeKvVv‡gv †givgZ I i¶Yv‡e¶Y msµvš Kvhµg mgwšZfv‡e PWD Ges HED KZK Physical Facilities Development Acv‡ikbvj c¨v‡bi AvIZvq ev¯evqb Kiv n‡e|
5.24	HNPSPÛi wewfb Iwcôi AvIZvq †h mKj dwbPvi, BKBc‡g›U, K¤úDUvi, d‡UvKwcqvi, GqviKjvi Ges Ab¨vb¨ hšvsk µq Kiv n‡q‡Q Ges c¯weZ †m±i KgmwPÛi AvIZvq DwjwLZ †h AvB‡Ugmgn µq Kiv n‡e Zvi Z_¨w`i GKwU cYv½ †Uwej (msL¨v/cwigvY, µ‡qi ZwiL, GKK e¨q I †gvU e¨q m¤wjZ) wcAvBwc‡Z Ašf³ Ki‡Z n‡e| HNPSPÛi AvIZvq Iwcmg‡n µqKZ D³ AvmevecÎ I hšcwZ c¯weZ †m±i KgmwP‡Z GKB wk‡ivbv‡gi Iwc‡Z e¨envi Ki‡Z n‡e Ges G mKj A‡½i cwigvY I e¨q †hŠw³Kfv‡e nvm Ki‡Z n‡e| GQvov HNPSPÛi Ab¨vb¨ †h mKj Assests and Liabilities c¯weZ KgmwP‡Z ¯vbvšwiZ n‡e Zvi GKwU cYv½ weeiY wcAvBwc‡Z D‡jL Ki‡Z n‡e|	HNPSPÛi AvIZvaxb 38wU Acv‡ikbvj c¨vb HPNSDPÛ‡Z 32wU‡Z i¡cvšwiZ n‡q‡Q| HNPSP-Gi gva¨‡g µqKZ AvmevecÎ I hšcwZ ¯v¯¨ I cwievi Kj¨vY gšYvj‡qi wewfb cwZôv‡b (wewfb chv‡qi nvmcvZvj, †gwW‡Kj K‡jR, bwms BÝwUwUDU, †nj_ †UKwbvjwR, gv I wkï ¯v¯¨ †K›` BZ¨w`) e¨envi n‡"Q Ges e¨envi Ae¨vnZ _vK‡e| HNPSPÛi 2003-2011 ev¯evqb †gqv‡` msMnxZ hšcwZi ZwjKv cYqb mgq mv‡c¶ weavq ZwjKwU mswkó OP†Z msh³ Kiv n‡e| †h‡nZ HNPSPGi AvIZvq AvmevecÎ I hšcwZ ¯vqx cwZôv‡bi †mev c`vb Kvhµ‡gi Rb¨ msMnxZ n‡q‡Q| ZvB GmKj Kvhµg HNPSDP†Z Ae¨vnZ _vK‡e|
5.25	c¯weZ †m±i KgmwPi wbweo I KvhKi ``Monitoring I Evaluation''-Gi Rb¨ IMEDÛi ZËveav‡b AvDU †mvwms-Gi gva¨‡g Kvhµg MnY Ki‡Z n‡e Ges G Lv‡Z c‡qvRbxq ei v‡Ïi ms¯vb ivL‡Z n‡e|	wm×vš Abhvhx †m±i KgmwPi wbweo I KvhKi Monitoring I Evaluation-Gi Rb¨ IMED wewa †gvZv‡eK h_vh_ e¨e¯v MnY Ki‡Z cv‡i|
5.26	c¯weZ †m±i KgmwPi mKj ai‡Yi µq cwiKíbv I µq Kvhµg wewa †gvZv‡eK AvBGgBwW KZK cwiex¶Y Ki‡Z n‡e Ges Rb 2011-†Z mgvc¨ HNPSPÛi AwfNvZ gj¨vqb (Impact assesment) h_vmg‡q m¤úb Kivi Rb¨ AvBGgBwW c‡qvRbxq e¨e¯v MnY Ki‡e|	HPNSDPGi µq cwiKíbv I Kvhµg AvBGgBwW wewagZ cwiex¶Y Ki‡Z cv‡i| Rb 2011-†Z mgvß HNPSPÛi AwfNvZ gj¨vqb (Impact assesment) Gi wel‡qI AvBGgBwW h_vmg‡q e¨e¯v MnY Ki‡Z cv‡i|
5.27	c¯weZ †m±i KgmwPi cY †gqv‡`i cwie‡Z c‡qvRbxqZvi wbwi‡L h_vm¤e mxwgZ mg‡qi Rb¨ PLMC MVb Ki‡Z n‡e Ges G eve` e¨q mxwgZ ivL‡Z n‡e|	cb¨, wbgvY I ‡mev µq Kvhµg `"Z, ¯"Q, `¶ Ges gvbm¤§Zfv‡e cwµqvKiY I m¤úv`‡bi Rb¨ gšYvj‡qi AvIZvaxb wewfb ms¯v‡K KwiMix mnvqZv c`v‡bi Rb¨ civgkK‡`i mgš‡q †m±i KgmPxi cY †gqv‡`i Rb¨ PLMC MV‡bi c¯ve Kiv n‡q‡Q Ges G eve` e¨q

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
		mxwgZ ivLvi wel‡q c‡qvRbxq e¨e¯v MnY Kiv n‡e|
5.28	†m±i †cvMv‡gi AvIZvq wRIwe A_vq‡b c¯weZ Rbej, Rbe‡ji msL¨v/aiY A_ wefv‡Mi Rbe‡ji msL¨v/aiY wbaviY KwgwU KZK mcwikKZ n‡Z n‡e|	MZ 28/06/2011 Zwi‡L A_ wefv‡M AbwôZ Rbej KwgwUi mfvi mcwikµ‡g Rbe‡ji c¯ve ms‡hvRbx-A G ‡`Lv‡bv n‡q‡Q (cbMwVZ PIPÛi Volume-II Gi côv 1-21)|
5.29	wcAvBwc‡Z PLMCÛi Terms of Reference Ges Composition D‡jL Ki‡Z n‡e| µq Kvhµ‡gi ¯"QZv I mgš‡qi Rb¨ wmwcwUBD KZK e¨eüZ Project Management Information System (PMIS) I Procurement Management Information System (PROMIS) mdUIq¨vi `ÛU Customize AvKv‡i e¨envi Ki‡Z n‡e|	c¯weZ PLMC-Gi TOR ms‡hvRbx-J `óe¨ (cbMwVZ PIPÛi Volume-II Gi côv 92-94)| PLMC Gi Composition mswkó OP †Z mwb‡ewkZ Kiv n‡e| µq Kvhµ†gi ¯"QZv I mgš‡qi Rb¨ wmwcwUBD KZK e¨eüZ PROMIS Software wU customize K‡i e¨envi Kivi c`‡¶c †bqv n‡e|
5.30	c¯weZ wcAvBwc‡Z AwaK gvÎvq International civgkK wb‡qv‡Mi cwie‡Z †`kxq civgkK wb‡qv‡M AMwaKvi/¸i"Z c`vb Ki‡Z n‡e, Ges Need based I mxwgZfv‡e civgkK wb‡qvM w`‡Z n‡e| c‡qvRbxqZvi wbix‡L I Kv‡Ri cKwZ we‡ePbv K‡i h_vmvaxe `"ZZvi mv‡_ civgkK wb‡qvM cwµqv m¤úb Kivi Rb¨ GKwU KwgwU MVb Ki‡Z n‡e| GQvov wcAvBwc‡Z civgk‡Ki aiY (¯vbxq/AvšRvwZK) D‡jLmn Iwc wfwËK civgk‡Ki msL¨v, Rbgvm, e¨q I Kv‡Ri msw¶ß eYbv m¯úófv‡e †Uwej AvKv‡i Dc¯vcb Ki‡Z n‡e|	mswkó Kv‡Ri †UKwbK¨vj Awvm‡c± we‡ePbv K‡i civgkK wb‡qvM †`qv n‡e| ˆe‡`wkK civgkK‡`i msL¨v bb¨Zg chv‡q ivLv n‡e| gšYvjq, `vZvms¯v Ges mswkó G‡RÝx mgš‡q MwVZ Technical KwgwUi mcwi‡ki wfwË‡Z civgkK wb‡qvM Kiv n‡e| welqwfwËK civgkK, msL¨v, Rbgvm, BZ¨w` Gchv‡q Povš Kiv m¤e bq| welqwfwËK m¤ve¨ AvšRwZK civgk‡Ki Pwn`vi GKwU wPÎ ms‡hvRbx–P G `óe¨ (cbMwVZ PIPÛi Volume-II Gi côv 150-162)|
5.31	c¯weZ Kvhµg ev¯evq‡bi †¶‡Î wPwýZ Challanges/mgm¨vejx mgvav‡bi Dcvq m¯úófv‡e wcAvBwc‡Z D‡jL Ki‡Z n‡e Ges mswkó Iwc‡Z c‡qvRbxq Kvhµg Ašf³ Ki‡Z n‡e|	PIPÛi Chapter-1 (Page:3-5) G c¯weZ †m±i KgmPxi Challange mgn eYbv Kiv n‡q‡Q Ges Chapter-2 Gi 2.2 I 2.6 Ab‡"Q‡` D³ Challange †gvKv‡ejvq †m±i KgmPxi AMwaKvi Kvhµg wbaviY Kiv n‡q‡Q (Page:6-9)| wm×vš Abhvqx mswkó OP†Z Gme wel‡q c‡qvRbxq Kvhµg Ašf³ Kiv n‡e|
5.32	wcAvBwc‡Z Dc¯wcZ mKj ev‡RU †Uwe‡j Kvhµgmg‡ni †KvW I mve-†KvWmn m¯úó weeiY, msL¨v, cwigvY I e¨q D‡jL Ki‡Z n‡e|	PIPÛ‡Z OP wfwËK ev‡RU †Uwe‡j wewfb Kvhµ‡gi msL¨v/cwigvb I cv°wjZ e¨q c`vb Kiv n‡q‡Q| †KvW, mve-‡KvW wfwËK we¯wiZ Z_¨ OP-‡Z c`vb Kiv n‡e|
5.33	Iwcmg‡ni Kv‡Ri mv‡_ msMwZ †i‡L jvBb WvB‡i±i (LD) wb‡qv‡Mi cvkvcwk Zv‡`i `¶Zv ew×i Rb¨ wbqwgZ cwk¶‡Yi ms¯vb ivL‡Z n‡e|	mswkó KgKZv‡`i Kv‡Ri mv‡_ m½wZ †i‡L Iwcmg‡ni LD wb‡qvM c`vb Kiv n‡e| cbMwVZ PIPÛ†Z Iwc wfwËK m¤ve¨ LD†`i Zwjkv c`vb Kiv n‡q‡Q| LD‡`i `¶Zv ew×i Rb¨ c‡qvRbxq cwk¶‡Yi ms¯vb mswkó Iwc‡Z ivLv n‡e (PIPÛi côv bs 34-35)	
5.34	wcAvBwcÛi 4bs Aa¨v‡q 4.1.3 Ab‡"Q‡`i AvIZvq c¯weZ Activity-¸‡jv B‡Zvg‡a¨ KZ¸‡jv Dc‡Rjvq Kiv n‡q‡Q Ges eZgv‡b KZ¸‡jv Dc‡Rjvq Kiv n‡e †m m¤ú‡K m¯úó Z_¨ wcAvB‡ZI D‡jL Ki‡Z n‡e|	wm×vš Abhvqx cbMwVZ PIPÛ†Z PwnZ Z_¨w` c`vb Kiv n‡q‡Q (cbMwVZ PIP ct bs 37, 38)|
5.35	c¯weZ KgmwPf³ Kvhµg ev¯evq‡bi †¶‡Î DGHS I DGFP-Gi g‡a¨ h_vh_ mgš‡qi Rb¨ GKwU i¡c‡iLv wcAvBwc‡Z D‡jL Ki‡Z n‡e|	‡m±i KgmwPf³ Kvhµg ev¯evq‡bi †¶‡Î DGHS I DGFP-Gi g‡a¨ mgš‡qi wel‡q GKwU i¡c‡iLv cbMwVZ PIPÛ†Z c`vb Kiv n‡q‡Q (cbMwVZ PIP Ab‡"Q`-3.7/côv-32-33 `óe¨)|
5.36	c¯weZ wcAvBwc‡Z Kvhµg wfwËK (†hgb-†mev, †`wk/we‡`kx cwk¶Y, cwKDi‡g›U, Rbej, wbgvY BZ¨w`) Costing Gi Summary Table ms‡hvRb Ki‡Z n‡e|	cbMwVZ PIPÛ‡Z cwZwU OPÛi Kvhµg wfwËK cv°wjZ e¨‡qi †Uwej c`vb Kiv n‡q‡Q|

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
5.37	evsjv‡`‡k ¯v¯¨ †mev †¶‡Î AvÂwjK ˆelg¨ `ixKiYv‡_ RvZxq chv‡q ¯v¯¨ †m±‡ii AvIZvq ev¯ ewqZe¨ mKj wbgvY Kv‡Ri GKwU mwbw`ó MvBW jvBb wcAvBwc‡Z D‡jL _vK‡Z n‡e| ZvQvov ¯v¯¨ †mev c`v‡bi Rb¨ GjvKv wbevP‡bi †¶‡Î GjvKvi Ae¯vb, RbmsL¨v, `wi`, we`¨gvb ¯v¯¨ mweav BZ¨w` we‡ePbvceK D³ MvBW jvBb cYqb Ki‡Z n‡e|	¯v¯¨ †mev c`v‡bi †¶‡Î AvÂwjK ˆelg¨ `ixKiYv‡_ GjvKvi Ae¯vb, RbmsL¨v, `wi`, we`¨gvb ¯v¯¨ mweav BZ¨w` we‡ePbvceK Physical Facilities Development kxlK lwci AvIZvq wbgvY msµvš GKwU MvBW jvBb I Master Plan cYqb Kiv n‡e (cbMwVZ PIP cô‡v bs- 252)| D‡jL¨, GIS Mapping Technology e¨envi K‡i ¯v¯¨ ¯vcbvmgn chvqµ‡g Google Map G wPwýZ Kivi KvR Pj‡Q| MIS DGHS G msµvš Kvhµg mgšq Ki‡Q|
5.38	wcAvBwcf³ 1g 3wU Acv‡ikbvj c¨vb h_vµ‡g Maternal, Neonatal and Child, Adolescent Health Care; Essential Service Delivery Ges Community Based Health Care-Gi AvIZvq hveZxq Kvhµg mgš‡qi Rb¨ cwiKíbv Kwgkb, AvBGgBwWmn mswkó mK‡ji mgš‡q GKwU †UKwbK¨vj KwgwU MVb Ki‡Z n‡e Ges G wZbwU lwcÔi Kv‡Ri g‡a¨ †Kvb ˆØZZv _vK‡j Zv wPwýZ K‡i cwinvi wbwðZ Ki‡Z n‡e|	lwcmg‡ni ˆØZZv cwinvi I mgšq wbwðZ Kivi welqwU cbMwVZ PIPÔ†Z eYbv Kiv n‡q‡Q (cbMwVZ PIP Ab‡”Q`-3.7.4.G/cô‡v-33 `óe¨)| wm×vš †gvZv‡eK DwjwLZ 3wU lwci Kvhµg mgš‡qi Rb¨ GKwU Technical KwgwU MVb Ges cwiKíbv Kwgkb, AvBGgBwWmn mswkó mKj‡K KwgwU‡Z Ašf³ Kiv n‡e|
5.39	wcAvBwcÔi 2bs Acv‡ikbvj c¨v‡b Mental Health Ges Tribal Health Gi we¯wiZ Kvhµg cbMwVZ PIP-†Z D‡jL Ki‡Z n‡e|	wm×vš Abhvqx Mental Health Ges Tribal Health Gi we¯wiZ Kvhµg cbMwVZ PIPÔ†Z D‡jL Kiv n‡q‡Q (cbMwVZ PIP ct bs 51-52)|
5.40	Avievb GjvKvq ¯v¯¨ †mev c`v‡bi †¶‡Î ¯vbxq miKvi wefvM Ges ¯v¯¨ I cwievi Kj¨vY gšYvjq KZK mgwšZfv‡e GKwU Urban Health Strategy I Urban Health Plan cYq†bi D‡`¨vM MnY Kiv n‡q‡Q| Gi gva¨‡g Avievb GjvKvq ¯v¯¨ †mev c`v‡b †¶‡Î G `wU gšYvj‡qi Kv‡Ri ˆØZZv cwinvi Kiv m¤e n‡e| GQvov mwPeK mgšq †Rvi`vi Kivi R‡b¨ GKwU MvBWjvBb cYqb I D”P chv‡qi KwgwU MVb Kiv n‡e|	¯vbxq miKvi wefvM Ges ¯v¯¨ I cwievi Kj¨vY gšYvjq KZK mgwšZfv‡e GKwU Urban Health Strategy I Urban Health Plan cYq†bi D‡`¨vM MnY Kiv n‡q‡Q| Gi gva¨‡g Avievb GjvKvq ¯v¯¨ †mev c`v‡b †¶‡Î G `wU gšYvj‡qi Kv‡Ri ˆØZZv cwinvi Kiv m¤e n‡e| GQvov mwPeK mgšq †Rvi`vi Kivi R‡b¨ GKwU MvBWjvBb cYqb I D”P chv‡qi KwgwU MVb Kiv n‡e|
5.41	`Community Based Health Care' lwci Kvhµ‡gi AvIZvq MnxZ Kvhµ‡gi mv‡_ Revitalization of Community Health Care Initiative in Bangladesh kxlK cK‡íi Kvhµg Ges GwWc eiv‡Ïi wel‡q %ØZZv cwinvi Ki‡Z n‡e Ges BbwW‡KUi †Uwej h_vh_fv‡e ciY Ki‡Z n‡e|	Community Base Health Care OPÔi AvIZvq MnxZ Kvhµ‡gi mv‡_ Revitalization of Community Health Care Initiative in Bangladesh kxlK cK‡íi Kvhµg Ges GwWc eiv‡Ïi wel‡q mKj ˆØZZv cwinvi Kiv n‡e Ges wcBwm Gi wm×vš Abhvqx BwÛ‡KUi †Uwej h_vh_fv‡e ciY Kiv n‡q‡Q (cbMwVZ PIP cô‡v-61 `óe¨)|
5.42	¯"QZv I Reve‡`wnZv wbwðZKiYv‡_ HNPSP Ges eZgvb †m±i KgmwP‡Z Ašf³ GKB/mgagx wewfb lwcÔi AvIZvq B‡Zvg‡a¨ ev¯ewqZ I ev¯ewqZe¨ Kvhµ‡gi ZjbvgjK wPÎ, AwRZ mvdj¨ I AwRZe¨ djvdj/Uv‡MU/BbwW‡KUi †Uwej AvKv‡i m¯úófv‡e wcAvBwc‡Z D‡jL Ki‡Z n‡e|	Rb 2011-G mgwß HNPSPÔi lwcÔi AvIZvq ev¯ewqZ Ges c¯weZ HPNSDPÔ†Z ev¯ewqZe¨ Kvhµ‡gi ZjbvgjK wPÎ ms‡hvRbx–F `óe¨ (cbMwVZ PIPÔi Volume-II Gi cô‡v-43-62)| HNPSPÔi AwRZ mvdj¨ Ges HPNSDPÔi Uv‡MU/BbwW‡KUi ms‡hvRbx-O G †`Lv‡bv n‡q‡Q (cbMwVZ PIPÔi Volume-II Gi cô‡v-148-149)|
5.43	ev¯ewqZe¨ Kvhµgmg‡ni KvhKi gwbUwis Gi mweav‡_ Process indicator Ges ev¯evqb †gwU· (Yearwise Financial and Physical Target Plan এবং Component wise Annual Work Plan) we¯wiZfv‡e mswkó lwc‡Z D‡jLmn Gi GKwU Summary table wcAvBwc‡Z ms‡hvRb Ki‡Z n‡e|	PIP-‡Z OP wfwËK Process Indicator D‡jL Kiv n‡q‡Q| ev¯evqb †gwU· wn‡m‡e ev‡RU †Uwe‡j Yearwise Financial and Physical Target cbMwVZ PIPÔi mswkó OPÔi ev‡RU †Uwe‡j D‡jL Kiv n‡q‡Q|
5.44	lwcmg‡n c¯weZ Kvhµ‡gi AbK‡j mwbw`ófv‡e	wm×vš Abhvqx mKj OPÔi Kvhµ‡gi AbK‡j c‡qvRbxq

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
	ev‡RU eivÏ ivL‡Z n‡e Ges G msµvš mKj AmsMwZ `i Ki‡Z n‡e|	ev‡RU eivÏ ivLv n‡q‡Q Ges cwijw¶Z AmsMwZ `i Kiv n‡q‡Q|
5.45	HNPSPÛi AvIZvq evsjv‡`‡ki 6wU wefv‡Mi 6wU †Rjvi wKQ Dc‡Rjvq cwiPwjZ Local Level Planning (LLP) KgKv‡Ûi djvdj mɑú‡K Ges c¯wZ 7wU †Rjvi †Kvb †Kvb Dc‡Rjvq cieZx LLP Kvhµg ev¯evqb Kiv n‡e †m wel‡q Zvi we¯wiZ weieY PIP-†Z D‡jL _vK‡Z n‡e|	B‡Zvg‡a¨ ev¯ewqZ 2wU †m±i KgmPx HPSP Ges HNPSP-Gi AvIZvq LLP Kvhµ‡gi Rb¨ LLP Tool kit cYqb Kiv n‡q‡Q| wewfb mxgve×Zvi Kvi‡Y cYxZ LLPÛi Av‡jv‡K Resources/Budget eivÏ c`vb Kiv m¤e nqwb| LLPÛi Rb¨ c¯wZ 7wU †Rjvi ZwjKv cbMwVZ PIP côv bs-140 `óe¨| †Rjvmg‡ni AvIZvq MnxZe¨ 14wU Dc‡Rjvi ZwjKv mswkó IwcÛ†Z c`vb Kiv n‡e|
5.46	13bs IwcÛi `Conduction and Dissemination of Research' K‡¤úv‡b‡›Ui Rb¨ c¯wZ e¨q ev` w`‡Z n‡e|	Planning Monitoring & Research kxlK OPÛi M‡elYv Kv‡Ri GKwU D‡jL‡hvM¨ Kvhµg n‡jv Conduction and Dissemination of Research, weavq GwU ev` †`qv hw³h³ n‡e bv|
5.47	wcAvBwcf³ 13bs Iwc‡Z DPP/RDPP cYqb Kv‡Ri Rb¨ c¯wZ e¨q ev` w`‡Z n‡e|	wm×vš Abhvqx wcAvBwcf³ mswkó Iwc‡Z DPP/RDPP cYqb Kv‡Ri Rb¨ c¯wZ e¨q ev` †`qv n‡q‡Q|
5.48	13bs IwcÛi Preparation of DPP/RDPP for Projects & LLP tool kit Revision & Update AvB‡UgwU Iwc †_‡K ev` w`‡Z n‡e|	wm×vš Abhvqx mswkó Iwci Preparation of DPP/RDPP for Projects AvB‡UgwU ev` †`qv n‡q‡Q| D‡jL¨, LLP Tool kit Revision & Update GKwU Ab¨Zg ¸i"ZcY KvR weavq GLv‡Z 15.00 j¶ UvKv eivÏmn AvB‡UgwU Ašf³ ivLv n‡q‡Q (cbMwVZ PIP côv bs-142 `óe¨)|
5.49	Health Information Systems (HIS), E-Health, Medical Biotechnology (MBT)-Gi AvIZvq †Kvb mg‡q wK wK Kvhµg ev¯evqb Kiv n‡e Zvi we¯wiZ wefvRb PIP-†Z D‡jL Ki‡Z n‡e|	wm×vš Abhvqx Health Information Systems (HIS), E-Health, Medical Biotechnology (MBT)-Gi Kvhµg/Z_¨w` I we¯wiZ wefvRb cbMwVZ PIPÛi côv 145-154 G c`vb Kiv n‡q‡Q|
5.50	``Health Education and Promotion''- kxlK IwcÛi AvIZvq Mid term evaluation of 128 model villages-Gi wbwgË MwVZe¨ KwgwU‡Z cwiKíbv Kwgkb Ges IMEDi mswkó †m±i n‡Z 1 Rb K‡i cwZwba Ašf³ Ki‡Z n‡e| ZvQvov, Av‡jvP¨ Acv‡ikbvj c¨v‡bi h_vh_ ev¯evqb wbwðZ Kivi Rb¨ cvi¤K chvq †_‡KB KvhKi Z`viwKi Rb¨ cwiKíbv Kwgkbmn mswkó c‡qvRbxq mn‡hwMZv c`vb Ae¨vnZ ivL‡Z n‡e|	wm×vš Abhvqx Mid term evaluation of 128 model villages-Gi c¯wZ KwgwU‡Z cwiKíbv Kwgk‡bi mswkó †m±i Ges IMED'i cwZwba Ašf³ Kiv n‡e| mvgwMKfv‡e †m±i KgmPxi h_vh_ ev¯evqb wbwðZ Kivi j‡¶¨ KvhKi e¨e¯vcbv I Z`viwKi Rb¨ c¯wZ PMMU Gi gva¨‡g cwiKíbv Kwgkbmn mswkó mK‡ji c‡qvRbxq mn‡hwMZv MnY Kiv n‡e (cbMwVZ PIP côv bs-157 `óe¨)|
5.51	Procurement, Logistics and Supplies Management, DGHS-kxlK IwcÛi AbK‡j PIP'i OP-wise Budget Requirement Table-G I 4.16.6bs Ab‡"Q‡` c`Ë †Uwe‡j e¨q c`k‡bi AmsMwZ ms‡kvabmn wcAvBwc‡Z G ai‡Yi mKj AmsMwZ `i Ki‡Z n‡e|	BwZc‡e g`YRwbZ f‡ji Kvi‡Y DwjwLZ Z_¨ weåvU N‡UwQj| G¶‡Y g`YRwbZ µwU Ges cwijw¶Z Ab¨vb¨ AmsMwZ `i K‡i ev‡RU †UwejwU ms‡kvab Kiv n‡q‡Q (cbMwVZ PIPÛi côv bs 165-166)|
5.52	cwievi cwiKíbv Awa`ß‡ii AvIZvq c¯wZ cK‡íi Kv‡Ri %ØZZv, Uv‡MU M"c Ges ewaZ KvR we‡ePbvq c‡qvRbxq AvB‡Ug I KvR mwVKfv‡e wbaviY Ki‡Z n‡e Ges mgM †`‡k wK cwigvY ¯v¯¨ †mevi Pwn`v i‡q‡Q Zvi wfwË‡Z OP mg‡ni AvËZvq Kvhµg wbaviY Ki‡Z n‡e| GQvov, ¯v¯¨ †mev Lv‡Z GO Ges NGO-Gi Ae`vb Z_¨ wfwËKfv‡e mgšq K‡i OP mgn cYqb Ki‡Z n‡e|	cwievi cwiKíbv Awa`ßi KZK cYxZ mKj OP †Z †`‡ki Pwn`v I Availlable Resources Gi cvc¨Zvi wfwË‡ZB Kvhµgmgn MnY Kiv n‡q‡Q| Kvhµg Mn‡bi †¶‡Î ^ØZZv cwinvi Kiv n‡q‡Q Ges c‡qvRbxq AvB‡Ug ev¯evbMfv‡e wbaviY Kiv n‡q‡Q| cwievi cwiKíbv †mev Lv‡Z GO Ges NGO Gi Z_¨mgn msMnceK mgšq mvabK‡í c‡qvRbxq Kvhµg Ašf³ K‡i OP mgn cYqb Kiv n‡e|
5.53	c¯wZ PIP-†Z TFR AMMwZ Ges 2016 mvj chš	eZgv‡b UESD 2010 Abhvqx TFR 2.5/Woman|

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
	TFR 2.00/Woman AR‡bi †h j¶¨gvÎv wbaviY Kiv n‡q‡Q Zv h_vh_ Av‡Q wK bv Zv cbtci×¶v K‡i †`L‡Z n‡e| GQvov, CPR Gi (55.8%) eZgvb Ae¯v †_‡K e× K‡i 2016 mvj bvMv` 72% G DbxZ Kiv m¤e/ev¯em¤§Z wK bv †m wel‡q wbwðZ Ki‡Z n‡e|	2016 mvj bvMv` TFR 2.00/Woman AR‡bi j‡¶¨ cwievi cwiKíbv ¯vqx I `xN †gqv`x c×wZ MwnZvi nvi ew×Ki‡Yi Rb¨ B†Zvg‡a¨B wewfb KvhKi KgKvÛ OP mg‡n c¯ve Kiv n‡q‡Q| d‡j TFR 2.00/Woman bwg‡q Avbv Ges CPR Gi nvi 72% G DbxZ Kiv ev¯em¤e n‡e e‡j cZxqgvb nq| D‡jL¨, B‡Zvg‡a¨B Ljbv wefv‡M eZgv‡b TFR 2.00 Ges ivRkvnx wefv‡M TFR 2.4 G †b‡g G‡m‡Q|
5.54	eZgvb Unmet need †iU m¤ú‡K ¯úóxKiY Ki†Z n‡e| c¯weZ Kvhµ‡g 2016 bvMv` Unmet need 09% KZ nvi †_‡K Kwg‡q Avbv n‡e, wK cwµqvq Zv Kiv n‡e, Zv wek`fv‡e PIP-†Z D‡jL Ki‡Z n‡e|	wm×vš Abhvqx Unmet need welqK c‡qvRbxq Z_¨ cbMwVZ PIPÔi côv bs 194 †Z D‡jL Kiv n‡q‡Q|
5.55	c¯weZ PIP-Gi AvIZvq ev‡RU Kjv‡g wewfb Acv‡ikivj c¨v‡bi Rb¨ eQiwfwËK †dwRs-Gi mv‡_ mgšq K‡i K‡¤úv‡b›U IqvBR e¨q wefvRb mwVKfv‡e D‡jL Ki‡Z n‡e|	wm×vš Abhvqx cbMwVZ PIPÔi wewfb Acv‡ikivj c¨v‡bi ev‡RU †Uwe‡j eQiwfwËK †dwRs-Gi mv‡_ mgšq K‡i K‡¤úv‡b›U IqvBR e¨q wefvRb mKj OP mg‡n D‡jL Kiv n‡q‡Q| Z‡e c_g 3 eQi eQiwfwËK I cieZx `ÔeQi GKmv‡_ wefvRb Kiv n‡q‡Q, hv‡Z MTR Gi mcwik/ch‡e¶‡Yi Av‡jv‡K cieZx 2 eQ‡i ev¯evbM Kvhµg MnY Kiv hvq|
5.56	c¯weZ OP-20-†Z Urban Slum-Gi cwiwa I AvIZv m¤ú‡K †hŠw³K e¨vL¨v c`vb Ki‡Z n‡e| GQvov, we‡eP¨ Acv‡ikbvj c¨v‡b gqgbwmsn I w`bvRc‡ii cvnvox GjvKv mvgw`K, eb I eb¨vceY GjvKv I PivÂj `Mg GjvKvq Ôd¨wgwj cwbs mwf‡mm Bb nwW U wiP Gwiqvm Ô K‡¤úv‡b›UwU Ašf³ Ki‡Z n‡e|	wm×vš Abhvqx Family Planning Field Service Delivary Program kxlK OP-‡Z G msµvš c‡qvRbxq Z_¨-DcvË cbMwVZ PIPÔi côv bs 196 G D‡jL Kiv n‡q‡Q|
5.57	c¯weZ OP-21-Gi GjGjwc Kvhµg ev¯evq‡bi †KŠkj wnmv‡e †h mKj G‡cvP MnY Kiv n‡q‡Q Zv we¯wiZ D‡jL ceK ev¯evqb †KŠkj m¤ú‡K Av‡jvKcvZ Ki‡Z n‡e|	wm×vš Abhvqx GjGjwc Kvhµg msµvš c‡qvRbxq Z_¨ Planning and Monitoring kxlK OP-‡Z D‡jL Kiv n‡q‡Q (cbMwVZ PIPÔi côv bs 201-202)|
5.58	c¯weZ OP-22Gi D‡Ïk¨ Kjv‡g †h wZbwU K‡¤úv‡b›Ui D‡jL Kiv n‡q‡Q Zvi mv‡_ wewGm, Rbckvmb gšYvjq Ges miKvi KZK MnxZ AvBwmwU cK‡íi gva¨‡g B-Mf‡bÝ Pvj Kvhµ‡gi AvIZvq wewfb K‡¤úv‡b›Ui ˆØZZv ‡bB g‡g Zv wbwðZ Ki‡Z n‡e|	GB OPÔi c¯weZ Kvhµ‡gi mv‡_ DwjwLZ wefvM/ms¯vi Kvhµ‡g †Kvb ˆØZZv _vK‡e bv| cbMwVZ PIPÔi côv bs-206 G welqwU D‡jL Kiv n‡q‡Q|
5.59	c¯weZ OP-23 Gi D‡Ïk¨ Kjv‡g †h cvPwU K‡¤úv‡b›Ui D‡jL Kiv n‡q‡Q Zvi mv‡_ OP-18,19 I 20 Gi µm KwUs Bm¨ i‡q‡Q Ges OP-17 Gi mv‡_ mgšq Ki‡Z n‡e| GQvov, ¯ivó gšYvjq, AvBb wePvi I msm` welqK gšYvjq, gwnjv I wkï welqK gšYvjq, †hvMv‡hvM gšYvjq Ges ¯vbxq miKvi cjx Dbqb I mgevq gšYvjq G mswkó Kvhµg ev¯evqb Ki‡Q weavq G mKj Kvhµ‡gi AvIZvq wewfb K‡¤úv‡b›Ui ˆØZZv n‡”Q wK bv Zv wbwðZ Ki‡Z n‡e|	OP-17, 18, 19 I 20 Gi µm †idv‡iÝ wnmv‡e GB K‡¤úv‡b›U¸‡jvi bvg D‡jL Kiv n‡q‡Q wKš gjZ IEC OPÔi gva¨‡gB Kvhµgmgn ev¯Íewq Z n‡e| OP mg‡ni c¯weZ Kvhµgmgn ev¯evqbKv‡j Ab¨vb¨ gšYvj‡qi MnxZ Kvhµgmgn we‡ePbv Kiv n‡e Ges m¤ve¨ ˆØZZv cwinvi Kiv n‡e|
5.60	¯v¯¨ I cwievi Kj¨vY gšYvj‡q eZgv‡b µq Kvhµg ‡h †mU Avc Øviv Pj‡Q ‡m AwfÁZvi wfwË‡Z wKfv‡e, wK Amweav `i Kivi Rb¨ bZb c×wZ‡Z/†mU Avc cYqY Kiv n‡e †m wel‡q cix¶v wbwi¶vceK c¯Íve	¯v¯¨ I cwievi Kj¨vY gšYvj‡qi c¯weZ HPNSDPÔi AvIZvq Procurement Kvhµg‡K ¯”Q, `¶ I MwZkxj Kivi Rb¨ †m±i KgmwPi cY †gqv‡` GKwU PLMC MVb Kiv n‡e| ¯v¯¨ Awa`ß‡ii CMSD I cwievi cwiKíbv

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
	†ck Ki‡Z n‡e|	Awa`ß‡ii PSSM G c‡qvRbxq msL¨K civgkKmn e-Procurement Pvj Kiv n‡e| wbgvY Kvhµ‡gi Rb¨ HED Ges PWD†Z Abi¡c e-Procurement Pvj Kiv n‡e|
5.61	c¯weZ OP-Gi D‡Ïk¨ 4.25.2 Kjv‡g Other GO and NGO-Gi ¯‡j Foreign Countries, GO and NGO Kiv †h‡Z cv‡i| GQvov,K‡¤úv‡b‡›Ui 1-Gi AvIZvq g¨‡bR‡g›U †Uwbs, K¨vcwmwU wewìs †Uwbs BZ¨w`‡Z mswkó mKj gšYvjq/ wefv‡Mi cwZwbwai AskMnY wbwðZ Ki‡Z n‡e Ges K‡¤úv‡b‡›Ui 2-Gi AvIZvq HB g¨‡bR‡g›U †Uwbs Ges Higher Education/Diploma in abroad and research Programm cwiKíbv Kwgk‡bi mswkó DBs-Gi KgKZv‡`i Ašf³ Ki‡Z n‡e| †mg‡Z AskMnYKvixi msL¨v 16 †_‡K 2wU ewo‡q 18-†Z DbxZ Kiv †h‡Z cv‡i|	wm×vš †gvZv‡eK mswkó mKj gšYvjq/wefv‡Mi cwZwbwai AskMnY wbwðZ Kiv n‡e| cbMwVZ PIPÖi côv bs-231 Gi Training Component `óe¨|
5.62	bwms †m±‡ii Dbq‡bi Rb¨ B‡Zvg‡a¨ wbwgZ Ges wbwgZe¨ bwms cwZôvbmg‡ni h_vh_ e¨envi wbwðZ Kivmn bwms wk¶vi gvb DbqbK‡í cieZx †m±i KgmPx‡Z c‡qvRbxq Kvhµg/c`‡¶c AšÍf³ Ki‡Z n‡e| ZvQvov, bwms wel‡q KwiKjvg cYqbmn wcAvBwcÔi AvIZvq KgmwP Mn‡Yi †¶‡Î c‡e MwnZ cKí/KgmwPi mv‡_ †Kvb ˆØZZv _vK‡j Zv cwinvi wbwðZ Ki‡Z n‡e|	wm×vš †gvZv‡eK bwms Iwc‡Z c‡qvRbxq Z_¨ mwb‡ewkZ Kiv n‡q‡Q Ges ˆØZZv cwinvi wbwðZ Kiv n‡q‡Q| cbMwVZ PIPÖi côv bs-236-237|
5.63	`Sector Wide Program Management and Monitoring' kxlK IwcÔi AvIZvq †h Independent Review Team (IRT) wb‡qv‡Mi c¯ve Kiv n‡q‡Q Zvi wb‡qv‡Mi kZvejx, Kgcwiwa (TOR), wb‡qvM wewa Ges wb‡qvMKZ Rbej †`kxq bwK ‰e‡`wkK Zvi we¯wiZ weeiY PIP-†Z D‡jL Ki‡Z n‡e|	HPNSDP ev¯evqbK‡j eQiwfwËK Ges ga¨ †gqv‡` chv‡jvPbvi Rb¨ APR Ges MTR Abôv‡bi j‡¶¨ Independent Review Team (IRT) KvR K‡i _v‡K| IRT†Z †`kx I ˆe‡`wkK civgkKMY ¯í †gqv‡` wb‡qwRZ nb| ¯v¯¨ I cwievi Kj¨vY gšYvj‡qi hM¨-cavb (cwiKíbv) Gi mfvcwZ‡Z MwVZ Steering Committee KZK IRTGi Kvhcwiwa, civgkK‡`i cKwZ, cwaKvi welq/†¶Î BZ¨w` chv‡jvPbv K‡i wm×vš MnxZ nq| D³ KwgwU†Z cwiKícbv Kwgkb, AvBGgBwW, BAviWmn `vZv ms¯vi cwZwbwaZ i‡q‡Q| cwZ eQ‡ii APR G chv‡jvPbvi Rb¨ c_K cwaKv‡ii welq/†¶Î wPwýZ Kiv nq| APR Gi GKwU Overall TOR Gi Lmov i¡c‡iLv `Sector Wide Program Management and Monitoring' kxlK Iwc‡Z mwb‡ek Kiv n‡e|
5.64	`Sector Wide Program Management and Monitoring' kxlK Iwc‡Z ewYZ `Planning & Monitoring Strengthening Program I Capacity Development' AvB‡U‡g MOHFW I Directorate-Gi cvkvcwk cwiKíbv Kwgk‡bi mswkó †m±i‡K Ašf³ Ki‡Z n‡e|	wm×vš g‡Z mswkó AvB‡U‡g cwiKíbv Kwgk‡bi mswkó †m±i‡K Ašf³ Kiv n‡q‡Q (cbMwVZ PIPÖi côv 281-282)|
5.65	"Physical Facilities Development" kxlK IwcÔi AvIZvq BDwbqb, Dc‡Rjv ev †Rjv chv‡q wbwgZe¨ wewfb †fŠZ AeKvVv‡gvi Rb¨ Common/Proto-type design cYqbceK wcAvBwc‡Z ms‡hvRb Ki‡Z n‡e| ZvQvov, AÎ IwcÔi	BDwbqb, Dc‡Rjv ev †Rjv chv‡q wbwgZe¨ †fŠZ AeKvVv‡gvi Rb¨ Common/Proto-type design cYqbceK mswkó "Physical Facilities Development" kxlK OP-‡Z mwb‡ek Kiv n‡e| GQvov wbgvY msµvš bxwZgvjv AbmiY K‡i †Rjv,

µwgK bs	wcBwm mfvi wm×vš	gšYvjq KZK MnxZ e¨e¯v
	AvIZvq †h mKj †Rjv, Dc‡Rjv I BDwbq‡b wewfb ‡fŠZ KvR Kiv n‡e †m mKj GjvKvi ZwjKv I Kv‡Ri weeiY wcAvBwc‡Z ms‡hvRb Ki‡Z n‡e|	Dc‡Rjv I BDwbq‡bi wewfb †fŠZ ¯vcbv wbgv‡Yi ZwjKv cYqb I ev¯evq‡bi c`‡¶c MnY Kiv n‡e|
5.66	Rwgi m‡evËg e¨envi wbwðZ Kivi j‡¶¨ GKwU Administrative unit (†hgb †Rjv, Dc‡Rjv ev BDwbqb)-G ¯v¯¨ I cwievi cwiKíbv †mev Lv‡Z KgiZ mKj Staff-†`i Rb¨ Avewmk feb we”Qbfv‡e bv K‡i GKwU Complex-G wbgvY Ki‡Z n‡e|	wm×vš Abhvqx ev¯eZvi wbwi‡L I Rwg cwiß mv‡c‡¶ c‡qvRbxq e¨e¯v MnY Kiv n‡e (cbMwVZ PIPÛi côv bs-247)|
5.67	IMED KZK ÛPhysical Facilities Developmentû kxlK lwcÛi mKj ai‡Yi Procurement Audit m¤úv`b Ki‡Z n‡e Ges G eve` c‡qvRbxq e¨‡qi ms¯vb ivL‡Z n‡e|	wm×vš Abhvqx IMED wewa †gvZv‡eK ÛPhysical Facilities Developmentû kxlK lwcmn Ab¨vb¨ lwcÛi mKj ai‡Yi Procurement Audit m¤úv`b Ki‡Z cv‡i|
5.68	¯v¯¨ †m±‡ii wbgvY Kv‡Ri Wwqs, wWRvBb cYqb I Z`viKx m¤úwKZ Kvhµg m¤úv`‡bi Rb¨ e¨vcK nv‡i civgkK wb‡qv‡Mi cwie‡Z h_vm¤e miKv‡ii wbR¯ Rbej (¯vcZ¨ Awa`ßi, MYcZ Awa`ßi I ¯v¯¨ c‡KŠkj Awa`ß‡ii AwfÁ Rbej) e¨envi Ki‡Z n‡e| GKvš Awbevh Kvi‡Y civgkK wb‡qv‡Mi c‡qvRb n‡j Ac‡ikbvj c¨v‡bi ms¯v‡bi wfwË‡Z †mev µq msµvš AvBb/wea vbvejx `vZv ms¯vi MvBW jvBb AbmiY K‡i civgkK wb‡qvM w`‡Z n‡e|	wm×vš Abhvqx wbgvY Kv‡Ri Wwqs, wWRvBb cYqb I Z`viKx m¤úwKZ Kvhµg m¤úv`‡b h_vm¤e miKv‡ii wbR¯ Rbej e¨envi Kiv n‡e| c‡qvRb Abhvqx Ac‡ikbvj c¨v‡b ms¯vb mv‡c‡¶ `vZv ms¯vi MvBW jvBb AbmiY K‡i civgkK †mev MnY Kiv n‡e|
5.69	HNPSPÛi AvIZvq MnxZ mKj Am¤úY Kv‡Ri Rb¨ HPNSDP-‡Z c¯wewZ AvB‡U‡gi bvg Spillover works-Gi cwie‡Z Remaining works wk‡ivbv‡g e¨envi Ki‡Z n‡e Ges G‡¶‡Î Aewkó mKj Kv‡Ri GKwU cYv½ ZwjKv wcAvBwc‡Z ms‡hvRb Ki‡Z n‡e|	wm×vš †gvZv‡eK AvB‡U‡gi bvgKiY Remaining works Kiv n‡q‡Q Ges wm×vš †gvZv‡eK GmKj Kv‡Ri ZwjKv ms‡hvRbx-K G mwb‡ek Kiv n‡q‡Q (cbMwVZ PIPÛi Volume-II Gi côv 95-101)|
5.70	wcAvBwcÛi wewfb lwc‡Z TA/TA Support K‡¤úv‡b‡›Ui AvIZvq wK KvR Kiv n‡e Zvi we¯wiZ weeiY PIP-†Z D‡jL Ki‡Z n‡e|	m¤ve¨ TA/TA Support Plan Gi GKwU ZwjKv ms‡hvRbx-P G c`vb Kiv n‡jv (cbMwVZ PIPÛi Volume-II Gi côv 150-162)| TA/TA Support K‡¤úv‡b‡›Ui AvIZvq MnxZe¨ Kvhµ‡gi we¯wiZ weeiY mswkó `vZv ms¯v n‡Z cvIqv mv‡c‡¶ OPÛ†Z c`vb Kiv n‡e|

Table of Contents

ABBREVIATIONS

ABCN	Area Based Community Nutrition
AD	Auto Disable
ACT	Artemesinin based Combination Therapy
ADR	Adverse Drug Reaction
ADP	Annual Development Program
AFMC	Armed Forces Medical College
AIDS	Acquired Immune Deficiency Syndrome
AMC	Alternate Medical care
ANC	Ante Natal Care
APIR	Annual Program Implementation Report
APR	Annual Program Review
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
AUFPO	Assistant Upazila Family Planning Officer
AV	Audio Visual
BAMS	Bachelor of Ayurvedic Medicine & Surgery
BAVS	Bangladesh Association for Voluntary Sterilization
BBS	Bangladesh Bureau of Statistics
BCC	Behavioral Change Communication
BCPS	Bangladesh College of Physicians and Surgeons
BDHS	Bangladesh Demography and Health Survey
BFHI	Baby Friendly Hospital Initiative
BHMS	Bachelor of Homeopathic Medicine & Surgery
BFCI	Baby Friendly Community Initiative
BHW	Bangladesh Health Workforce/Basic Health Wooker
BMA	Bangladesh Medical Association
BMDC	Bangladesh Medical and Dental Council
BMMS	Bangladesh Maternal Mortality Survey
BMRC	Bangladesh Medical Research Council
BNC	Bangladesh Nursing Council
BNNC	Bangladesh National Nutrition Council
BNMRC	Bangladesh Nursing & Midwifery Research Council
BPC	Bangladesh Pharmacy Council
BP	Blood Pressure
BPDU	Building Planning & Design Unit
BSMMU	Bangabandhu Sheikh Mujib Medical University
BTV	Bangladesh Television
BUMS	Bachelor of Unani Medicine & Surgery
C4D	Communication for Development
DAAR	Disbursement of Accelerated Achievement of Results
CBO	Community Based Organization
CBE	Clinical Breast Examination
CC	Community Clinic
CCHPU	Climate Change and Health Promotion Unit
CCMG	Community Clinic Management Group
CCU	Coronary Care Unit
CDC	Communicable Diseases Control
CDD	Control of Diarrheal Diseases
CES	Cluster Evaluation Survey
CEmOC	Comprehensive Emergency Obstetric Care
CHCS	Community Health Care Service
CEP	Continuing Education Program
CHCP	Community Health Care Provider
CHT	Chittagong Hill Tracts
CMC	Construction Maintenance Cell
CME	Centre for Medical Education
CMMU	Construction and Maintenance Management Unit

CMSD	Centre for Medical Store Depot
CNU	Child Nutrition Unit
CPR	Contraceptive Prevalence Rate
CSBA	Community based Skilled Birth Attendant
CVD	Cardio -Vascular Diseases
COPD	Chronic Obstructed Pulmonary Disease
DDS	Drugs and Dietary Supplements
DFID	Department for International Development
DG	Director General
DGDA	Directorate General of Drug Administration
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
DMIS	Data Management Information System
DNS	Directorate of Nursing Services
DOTS	Direct Observed Treatment-Short Course
DPHE	Department of Public Health Engineering
DPs	Development Partners
DRA	Drug Regulatory Authority
DSF	Demand Side Financing
EBF	Exclusive Breast Feeding
EBP	Evidence Based Practices
EDL	Essential Drugs List
EDPT	Early Diagnosis and Prompt Treatment
ELCO	Eligible Couple
ELT	English Language Training
EmOC/EOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EMS	Emergency Medical Services
ENC	Essential Newborn Care
EICT	Education, Information and Communication Technology
EPI	Expanded Program on Immunization
EPR	Emergency Preparedness and Response
ESD	Essential Service Delivery
ESP	Essential Service Package
ETAT	Emergency Triage Assessment and Treatment
FHA	Female Health Assistant
FM	Financial Management
FMAU	Financial Management Audit Unit
FMR	Financial Monitoring Report
FP	Family Planning
FP-FSD	Family Planning Field Service Delivery
FPCST/QAT	Family Planning Clinical Supervision Team/ Quality Assurance Team
FPAB	Family Planning Association of Bangladesh
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FWVTI	Family Welfare Visitor Training Institute
FYP	Five year Plan
GAVI	Global Fund for Vaccination and Immunization
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GEV	Gender, Equity and Voice
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GIS	Geographic Information System
GMP	Growth Monitoring and Promotion
GMP	Good Manufacturing Practice
GNSP	Gender, NGO and Stakeholder Participation
GNSPU	Gender, NGO and Stakeholder Participation Unit
GOB	Government of Bangladesh
GP	General Practitioner

GR	Geographical Reconnaissance
HA	Health Assistant
HED	Health Engineering Department
HEU	Health Economics Unit
HFA	Health For All
HFRG	Health Financing Resource Group
HFWC	Health and Family Welfare Centre
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition & Population
HIS	Health Information System
HMIS	Human Resource Management Information System
HNPSP	Health , Nutrition and Population Sector Program
HPN	Health, Population & Nutrition
HPNSDP	Health, Population and Nutrition Sector Development Program
HPSP	Health and Population Sector Program
HR	Human Resource
HRH	Human Resource for Health
HRM	Human Resources Management
HRD	Human Resources Development
IBAS	Integrated Budget and Accounting System
ICDDR,B	International Centre for Diarrheal Diseases Research, Bangladesh
ICT	Information Communication Technology
IDA	International Development Association
IDS	Integrated Disease Surveillance
IDH	Infectious Disease Hospital
IEC	Information, Education and Communication
IEH	Information and Education for Health
IEDCR	Institute of Epidemiology, Disease Control and Research
IEM	Information, Education & Motivation
IHD	Ischemic Heart Disease
IHT	Institute of Health Technology
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
IPH	Institute of Public Health
IPD	Indoor Patient Department
IPHN	Institute of Public Health Nutrition
IPMS	Individual Performance Management System
IRS	Indoor Residual Spraying
IST	In Service Training
IT	Information Technology
ICT	Information Communication Technology
ITN	Insecticide Treated Net
IUD/ ICD	Intra Uterine /Contraceptive Devise
IYCF	Infant and Young Child Feeding
JCS	Joint Cooperation Strategy
JNM	Junior Nurse Midwife
LAPM	Long Acting Permanent Method
LCG	Local Consultative Group
LDs	Line Directors
LLP	Local Level Planning
LLIN	Long Lasting Impregnated Net
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MATS	Medical Assistant Training School
MBT	Medical Biotechnology
MBDC	Micro Bacterial Disease Control
MCH	Maternal and Child Health
MCRH	Maternal, Child and Reproductive Health
MCWC	Mother and Child Welfare Centre

MFSTC	Mohammadpur Fertility Services and Training Centre
MCs	Microscopy Centers
MDGs	Millennium Development Goals
MDR	Multi Drugs Resistance
MDTF	Multi Donor Trust Fund
MEU	Monitoring and Evaluation Unit
MICS	Multiple Indicators Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MNCAH	Maternal, Neonatal ,Child and Adolescent Health
MNH	Maternal and Neonatal Health
MNP	Micro-Nutrient Powder
MNT	Measles and Neonatal Tetanus
MOA	Ministry of Agriculture
MOC	Ministry of Commerce
MOCHTA	Ministry of Chittagong Hill Tracts Affairs
MOE	Ministry of Education
MOF	Ministry of Finance
MOFDM	Ministry of Food and Disaster Management
MOFL	Ministry of Fisheries and Livestock
MOHFW	Ministry of Health and Family Welfare
MOI	Ministry of Information
MOLGRDC	Ministry of Local Government Rural Development and Cooperatives
MOLJPA	Ministry of Law, Justice and Parliamentary Affairs
MOIn	Ministry of Industries
MOPME	Ministry of Primary and Mass Education
MOSW	Ministry of Social Welfare
MOU	Memorandum of Understanding
MOWCA	Ministry of Women and Children Affairs
MOYS	Ministry of Youth and Sports
MR	Menstrual Regulation
MSR	Medical and Surgical Requisite
MVA	Manual Vacuum Aspiration
MTBF	Medium Term Budget Framework
MTR	Mid Term Review
MWM	Medical Waste Management
NASP	National AIDS/STD Program
NAC	National AIDS Committee
NC	Nursing College
NCD	Non Communicable Diseases
NGO	Non Government Organization
NID	National Immunization Day
NIO&H	National Institute of Ophthalmology and Hospital
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
NIEOH	National Institute of Environmental and Occupational Health
NMR	Neonatal Mortality Rate
NMs	Nurse Midwives
NMIS	Nursing Management and Information System
NNP	National Nutrition Program
NNS	National Nutrition Service
NPSU	NGO and Private Sector Unit
NRC	Nursing Research Cell
NPSU	NGO and Private Sector Unit
NRR	Net Reproductive Rate
NSAPR	National Strategy for Accelerated Poverty Reduction
NSDP	NGO Service Delivery Program
NSV	No Scalpel Vasectomy
NT	Neonatal Tetanus

NTI	Nursing Training Institute
NTP	National Tuberculosis Control Program
NTC	National Technical Committee
NTCC	National Tobacco Control Cell
NTD	Neglected Tropical Diseases
NVAC	National Vitamin A Campaign
NTV	Nerve Tissue Vaccine
ODA	Overseas Development Administration
OP	Operational Plan
OPD	Out-door Patient Department
OPMS	Organizational Performance Management System
OTS	Online Tracking System
PAC	Post Abortion Care
PBF	Performance Based Financing
PCB	Pharmacy Council of Bangladesh
PCR	Polymerase Chain Reaction
PDS	Personal Data Sheet
PET	Post Exposure Treatment
PHC	Primary Health Care
PHED	Public Health Engineering Department
PIP	Program Implementation Plan
POL	Petrol Oil and Lubricant
PLMC	Procurement and Logistic Monitoring Cell
PMMU	Program Management & Monitoring Unit
PMIS	Personnel Management Information Systems
PNC	Post Natal Care
PROMIS	Procurement Management Information System
PP	Project Proforma
PPC	Program Preparation Cell
PPP	Public Private Partnership
PPR	Public Procurement Rules
PW	Planning Wing
PWD	People With Disability
PWD	Public Works Department
QA	Quality Assurance
QATG	Quality Assurance Task Group
R&D	Research and Development
RDT	Rapid Diagnostic Tool
RNM	Registered Nurse Midwife
RFW	Results Framework
RPA	Reimbursable Project Aid
RUD	Rational Use of Drug
RTA	Respiratory Tract Ailment
RTI	Reproductive Tract Infection
SACMO	Sub -Assistant Community Medical Officer
SEARO	South East Asian Regional Organization
SIA	Supplementary Immunization Activities
SOP	Standard Operating Procedure
SMC	Social Marketing Company
SRH	Sexual and Reproductive Health
SS	Sero-surveillance Survey
SSM	Sputum Smear Microscopy
STD	Sexually Transmitted Disease
STH	Soil Transmitted Helminthes
STI	Sexually Transmitted Infection
SVRS	Sample Vital Registration Survey
SWAp	Sector Wide Approach
SWPM	Sector Wide Program Management
TA	Technical Assistance
TAPP	Technical Assistance Project Proforma

TB	Tuberculosis
TBD	To Be Determined
TFR	Total Fertility Rate
TOE	Table of Equipment
TOR	Terms of Reference
TTI	Transfusion Transmissible Infections
TTU	Technical Training Unit
UESD	Utilization of Essential Service Delivery
UHC	Upazila Health Complex
UHFWC	Union Health and Family Welfare Centre
UHMC	Upazila Health Management Committee
UHS	Upazila Health System
UN	United Nations
UP	Union Parishad
UPHCP	Urban Primary Health Care Project
VIA	Visual Inspection of Cervix with Acetic Acid
VSC	Voluntary Surgical Contraceptive
WB	World Bank
WHO	World Health Organization
WMS	Waste Management System
XDR	Extensively Drug Resistant

EXECUTIVE SUMMARY

I. Program Brief

1. **Name of the Program:** Health, Population and Nutrition Sector Development Program (HPNSDP)
2. **Duration of the Program:** Commencement: July 2011
   Completion : June 2016
3. **Location of the Program:** All over Bangladesh
4. **Sponsoring Ministry:** Ministry of Health and Family Welfare (MOHFW)
5. **Implementing Agency:** MOHFW, DGHS, DGFP, DNS, DGDA, NIPORT, HED and PWD
6. **Total Cost (in crore taka) of the Program:**
   a. **Total:** TK. **56,993.54**
   b. **Total Revenue Cost:** **TK 34816.88**
   c. **Total Development Cost:** **TK 22176.66**

II. Program Financing Pattern

(Taka in Crore)

Financing Pattern	2011-2016	% of Total
GOB Non-Development (Revenue)	34816.88	61%
GOB Development	8,603.50	15%
Sub-Total of GOB	43,420.38	76%
Pool Fund/RPA	8,697.91	15%
DPA	4,875.25	9%
Sub-Total of PA	13,573.16	24%
Total of Development (GOB Dev.+ PA)	22,176.66	39%
Grand Total (Non-Dev. + Dev.)	**56,993.54**	**100%**

III. PA Cost and Source

Taka: 13573.16 crore (1834.21 m.US$).

a. World Bank and JICA Credit and Grant from DPs (EC, DFID, JICA, SIDA, CIDA, AusAID, USAID, WHO, UNICEF, UNFPA, GIZ, UNAIDS, GFATM, GAVI-HSS etc)

IV. DP's Support for the HPNSDP

An amount of Taka 13,573.16 crore equivalent DP support is being expected for the HPNSDP. However, as of now there has been an indication of BDT 11515.36 crore given by the DPs. Indication of DP-wise contribution is given below:

Indicative DP Contribution for HPNSDP

Sl. No.	Source	Amount in Million US $	Amount In BDT Crore Taka**
1	IDA Credit*	358.90	2655.86
2	UNICEF	130.00	962.00
3	WHO	75.00	555.00
4	CIDA	106.76	790.02
5	JICA	70.00	518.00
6	SIDA	80.00	592.00
7	DFID	191.00	1413.40

Sl. No.	Source	Amount in Million US $	Amount In BDT Crore Taka**
8	USAID	285.00	2109.00
9	GIZ	3.60	26.64
10	EC	27.00	199.80
11	KfW	30.71	227.25
12	UNFPA	46.00	340.40
13	AusAID	36.64	271.14
14	UNAIDS	6.00	44.40
15	GAVI-HSS	37.67	278.76
16	GFATM	71.85	531.69
	Total:	**1556.13**	**11515.36**

*There is also a provision of receiving an additional credit fund of US$ 43.08 under Disbursement for Accelerated Achievement of Results (DAAR) in the last year of the program, based on performance.

** US $ 1.00 = BDT 74.00

V. Program Background

The HPNSDP follows in recent history of health policy in Bangladesh drawing on the sector-wide approach (SWAp) that was first introduced in 1998. The first SWAp – the HPSP (1998-2003), was followed by a second SWAp - the HNPSP - began in 2003 and will expire in June 2011. The third SWAp – the HNPSDP – will begin in July 2011 for a period of 5 years through to June 2016. Its articulation and implementation are being actively linked to the preparation of the government's Sixth Five Year Plan (SFYP) for 2012- 2016.

The purpose of this Program Implementation Plan (PIP) document is to describe how the GOB, with partners, intends to implement the HPNSDP. The goal of the PIP is to identify how the resources of the GOB and DPs will be translated into specific programs and activities reflecting the priorities of the Strategic Plan for HPNSDP that can be managed and monitored towards successful implementation to achieve the expected results. The PIP is also intended to give summary descriptions of the Operational Plans (OPs) along with component wise budget. Further details of program activities along with economic code wise detailed budget for effective implementation will be incorporated into the Operational Plans (OPs), which are at the stage of finalization and are to be approved subsequently by the MOHFW following approval of the PIP by the ECNEC.

VI. PIP Document Design

This document is designed as Chapter 1 describes the background for the sector strategy, progress in health and health services, lessons learned in implementing previous sector strategies and challenges that lie ahead. In Chapter 2, the HPNSDP is described briefly with respect to its vision, mission, the sector strategic priorities and the two key components related to improving health services/provisioning and strengthening health systems. Chapter 3 maps these two key components of the HPNSDP along with their "priority interventions" to the operational plans. Recognizing that implementation is contingent not only on managing within the OPs but also across the OPs and across jurisdictions e.g. local and national and sectors e.g. agriculture and nutrition, Chapter 3 also describes the cross-cutting issues and their management for effective implementation of the HPNSDP. Against this framework a set of indicators are identified to monitor and evaluate progress in implementation of the HPNSDP drawing on the results frameworks (RFW). Chapter 4 provides a summary description of each of the OPs that constitute the services and programs of the DGHS, DGFP and MOHFW according to a standard template for each OP. Chapter 5 describes the resource envelope and financing arrangements from both the government of Bangladesh and Development Partners. A set of annexes provide details on i) human resources; ii) the Results Framework (RFW); iii) the initial 18 month procurement plan; iv) the TA plan; v) the summary evaluation of the HNPSP; vi) the minutes of the PEC; vii) the GoB circular; and viii) the Steering Committee Notification. This PIP document has brought together following the completion of the appraisal mission for the

HPNSDP. It draws primarily on the HPNSDP strategy document as well as a number of other key documents that are referenced appropriately.

VII. Main Objectives and Brief Description of the Program

The Government of Bangladesh (GOB) seeks to create conditions whereby its people have the opportunity to reach and maintain the highest attainable level of health as a fundamental human right and social justice. GOB has targeted to achieve MDG 4, 5, 6 and part of the MDG 1 and 8 and also health related vision 2021 through the next sector program.

To this end Government intends to establish a people oriented and people responsive health care, particularly emphasizing the needs of women, children, adolescents, the elderly, the poor and the marginalized, through developing an effective, efficient and sustainable health service delivery and management system with skilled and special emphasis on the development of a sustained health system and an improved and responsive efficient human resources.

VIII. Vision, Mission and Goal of HPNSDP

VISION: The vision is to see the people healthier, happier and economically productive to make Bangladesh a middle income country by 2021.

MISSION: The mission is to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health.

GOAL: The goal is to ensure quality and equitable health care for all citizens in Bangladesh by improving access to and utilization of health, population and nutrition services. A number of development activities in other key sectors implemented throughout Bangladesh will contribute to achievement of this goal along with HPNSDP.

IX. Development Objective of HPNSDP:

The development objective is to "improve access to and utilization of essential health, population and nutrition services, particularly by the poor".

X. HPNSDP Priorities and Strategies

Priorities

The HPNSDP PIP document sets out the sector's strategic priorities and explains how these will be addressed taking into account the strengths, lessons learned and challenges of implementing the last two sector programs, the HPSP and the current HNPSP. The details of priorities and interventions along with their implementation mechanisms shall be described under the Program Description Chapter of the respective Operational Plans.

The **drivers** for the HPNSDP are as follows:

- **Scaling up services for the achievement of the targets of MDG 1, 4, 5 and 6 by 2015.** The existing essential services, hospital services at the secondary and tertiary hospitals including communicable and non-communicable diseases are proposed for expansion and improvement according to the need and situation.
- **Addressing population growth with vigorous, fully integrated family planning services, and cross-cutting, multi-sector interventions. Focus is on Long term and permanent family planning methods including the unmet need, with participation of related different stakeholders, both in urban and rural areas.**
- **Mainstreaming nutrition in all service delivery points through the regular channels of DGHS and DGFP**. Nutrition service will be expanded throughout the country mainstreaming into the MNCH activities of DGHS and DGFP. DGHS is considered as the home for nutrition services management and

service delivery through different tiers of health facilities of both DGHS and DGFP, by defining as well as developing a skilled workforce.

- **Expanding access to health services for priority communicable and non communicable diseases**. Along with the CDC prioritized activities, the NCD issues are given same priority in regard to create facilities and expansion of related services.
- **Revitalizing the Community Clinic based services as part of a functional Upazila Health System (UHS).** A project being implemented outside the HNPSP titled *Revitalization of Community Health Care Initiative in Bangladesh* is considered as a flagship intervention of the Government. The Project components will be merged with the HPNSDP (to be implemented through a separate OP).
- **Strengthening overall health system and governance including establishing a sustainable Monitoring and Evaluation System.** Developing an M&E system for the HPNSDP is an essential component to provide convenient and timely information to policymakers as they track performance of the program in order to ensure necessary adjustments over its course.
- **Improving health equity for the poor and geographically marginalized population.** Collaboration and inter-sectoral coordination with MOCHTA, MOSA, private and individual social institutions will be strengthened with a view to increase support of the health sector, in partnership with NGOs. The clients and the service providers have to be motivated to use the health services available and to enable the disadvantaged to access health services.

Sector specific Strategies

- Streamline, expand the access and quality of MNCH services, in particular supervised deliveries (MDG 4 and MDG 5).
- Revitalize various family planning interventions to attain replacement level fertility.
- Improve and strengthen nutritional services by mainstreaming nutrition within the regular DGHS and DGFP services (MDG 1).
- Strengthen preventive approaches as well as control programs to communicable diseases (MDG 6).
- Expand NCD control efforts at all levels by streamlining referral systems and strengthening hospital accreditation and management systems.
- Strengthen the various support systems by increasing the health workforce at Upazila and CC levels, including their capacity building and enhanced focus on coordinated implementation of OPs, MIS and M&E functions.
- Strengthen drug management and improve quality drug provision and procurement with ICT and additional staff to reduce the time between procurement and distribution.
- Increase coverage and quality of services by strengthening coordination with other intra and inter-sectoral and private sector service providers.
- Pursue priority institutional and policy reforms, such as decentralization and LLP, incentives for service providers in hard to reach areas, PPP, single annual work plan, etc.

XI. New Elements or Issues that would add more value to HPNSDP

The next sector program will have elements that are different and or add value to the current program (HNPSP), particularly in maternal and neo-natal health and nutrition. Some notable ones are stated below:

- A new OP titled Maternal, Neonatal and Child Health Care will be put in place under DGHS for emphasizing MNCH issues separately.
- MNH services will address needs during preconception, pregnancy, childbirth and the immediate postpartum period by increasing number of skilled birth attendants.
- Facilities will be staffed and equipped to gradually provide 24/7 services, for appropriate management of complications in EmOC.
- Areas with high MMR, the geographically and socially disadvantaged, and the poor will be prioritized for providing quality MNH services including maternal and peri-natal death audits.
- The current maternal health strategy will be updated incorporating new born care and other recent issues needing attention for MNH service improvement.

- Community Clinic and domiciliary level will provide women-friendly preconception and pregnancy care. NGOs will be encouraged to provide similar services where appropriate.
- Detailed guideline will be prepared for functional integration of MNH services, incorporating expertise and facility sharing between DGHS and DGFP.
- Home-visit by a trained worker within two days of child birth will be ensured. Sick newborn services will be strengthened at the UHCs and district hospitals with rapid referral systems.
- MNH services for urban slums, in collaboration with MOLGRDC and other health care providers including NGOs will be promoted.
- Development of E-Health, E-Procurement and monitoring, automation systems etc;
- Nutrition services will be mainstreamed in an integrated way through all facilities providing MNCH services under DGHS and DGFP.
- The nutrition service will be housed in the DGHS and implemented through an OP titled "National Nutrition Service (NNS)".
- A medical officer of the UHS will be designated as medical officer (public health and nutrition) and will be responsible for coordinating NNS activities at upazila level and below.
- Community nutrition activities will be merged with the CCs for effective service provision.
- Nutrition activities will get priority for hard to reach and poorer areas through community based IMCI programs.
- MOHFW will collaborate with MOLGRDC for providing nutrition services (e.g., awareness creation, vitamin A and other micronutrient supplementation) in the urban areas.

XII. HPNSDP Priority Indicators with Benchmarks and Targets

INDICATOR	MEANS OF VERIFICATION & TIMING	BASELINE	TARGET 2016
Infant mortality rate (IMR)	BDHS, every 3 yrs	52, BDHS 2007	31
Under 5 mortality rate	BDHS every 3 yrs	65, BDHS 2007	48
Neonatal mortality rate	BDHS, every 3 yrs	37, BDHS 2007	21
Maternal mortality ratio	BMMS, every 5 yrs	194, BMMS 2010	<143
Total fertility rate (TFR)	BDHS, every 3 yrs	2.7, BDHS 2007	2.00
Prevalence of stunting among children under 5 years of age	BDHS, every 3 yrs	43.2%, BDHS 2007	38%
Prevalence of underweight among children under 5 years of age	BDHS, every 3 yrs	41.0%, BDHS 2007	33%
Prevalence of HIV in MARP	Sero-Surveillance Survey (SS), every 2 years	<1%, SS 2007	<1%

XIII. Major Program Components

The major components of the HPNSDP are: (i) Improving Health Services and (ii) Strengthening Health Systems and these are interdependent and mutually reinforcing. The component of improving health services aims at improving priority health services in order to accelerate the achievement of the health related MDGs by capitalizing on and scaling up the interventions undertaken under the HNPSP as well as introducing new interventions. This component will support the priority interventions of (a) Maternal, Neonatal, Child, Reproductive and Adolescent Health; (b) Population and Family Planning Services; (c) Nutrition and Food Safety; (d) Communicable and non-communicable Diseases; (e) Climate Change and Health Protection; (f) Disease Surveillance; (g) Alternative Medical Care (AMC); and (h) Behavior Change Communication (BCC) related programs.

The key elements of improving service provisions relate to primary health care through the Upazila Health System (UHS); CC led expansion of PHC services, piloting the UHS, making the union health and family welfare centers (UHFWC) and union sub-centers fully functional as part of the UHS, gradually deploying nurse

midwives at different level facilities under secured and congenial atmosphere, etc. Every union facility will be strengthened with capacity and readiness to conduct normal delivery and refer complicated cases to facilitate reaching the MDG 5 and to reduce newborn deaths. The CCs as part of the UHS will be the first contact point and entry to the health system. The essential service package (ESP) to be provided in the CCs will be updated, strengthened and promoted.

The hospital services will be improved through prioritizing: introduction of clinical protocols, equipping with modern materials and diagnostic facilities, making existing hospitals women friendly and improving EmOC services, establishing hospital accreditation and licensing and supervision of total quality management, initiating referral systems at secondary and tertiary hospitals and performance based system for all service providers, establishing effective hospital waste management system and ensuring provision of safe blood in the public and private hospitals, introducing hospital autonomy initially for the tertiary level specialized hospitals etc.

For improving service provision in urban areas, an urban health strategy and urban health development plan will be prepared in collaboration with MOLGRDC. Urban dispensaries will be strengthen and expanded for providing PHC services, referral system established between the urban dispensaries and the second and third level hospitals and feasibility of introducing GP system will be explored.

The HPNSDP will give priority to address difficult to reach populations through motivating and counseling the service providers for giving adequate care to the marginalized and socially excluded population, strengthen collaboration with the MOSW, MOCHTA, the CHT Board, the NGOs and the private sector. ESP will be provided in the difficult to reach areas through appropriate arrangements with NGOs/CBOs to overcome shortage of public sector human resources on the basis of comparative advantage.

To strengthen the health systems, the second major component of HPNSDP, MOHFW will give priority to addressing issues in the areas of stewardship and governance, legal and regulatory framework, mainstreaming gender, equity and voice in the core programs, like MNCH, nutrition and strengthening roles of the parastatal organizations like BMA, BMRC, BMDC, etc including effective use of the NGO and PPP.

Other priority areas for strengthening health systems relate to planning and budgeting, decentralization/ deconcentration and local level planning, monitoring and evaluation, health sector financing including development of resource allocation formula, and demand-side financing, health information system, research and development, strengthening of human resources for health, pre-service education and in-service training, nurse/midwifery services and training, establishing quality assurance system, regulation of drug administration and quality drug management, procurement and supply chain management, maintenance of physical facilities, inter-sectoral coordination and financial management.

XIV. Sub-sector wise Brief Description of the Program:

A. Health Sub Sector

Commendable progress has been achieved as evidenced by the findings of successive Bangladesh Demographic and Health Surveys as a result of HPSP and HNPSP implementation, in particular in the areas of maternal, infant and child health and control of some communicable diseases. The achievements in the area of child health are thought to be due to the successful implementation of EPI, IMCI, diarrhea disease control and control of acute respiratory tract infections, facilitated by an improvement in the care seeking behavior of the people in these areas.

Health services delivery includes MNCH, Communicable Disease Control, TB and Leprosy control, HIV/AIDS Prevention and Control, Non-Communicable Diseases Control including Emergency Preparedness Program and Climate Change, Hospital-based Emergency Obstetric Care, Health Education and Promotion, Hospital services at the upazila, district, and tertiary level, and alternative medical care. All of these are, in turn, supported by specialized support services. For the sake of improved manageability and accountability, the OP Summary for PIP of HPNSDP shows baseline data and targets for each of the health sub-sector service delivery programs.

The MNCH activities under this program are priority issues specially doubling the percentage of births attended by a skilled health worker by 2015 (from the current level of 24.4%) through training an additional 3000

midwives, staffing all 427 sub-district health centers to provide round-the-clock midwifery services, and upgrading all 59 district hospitals and ensure universal IMCI as stated by the Honorable Prime Minister while addressing the 65th General Assembly of the UN will be the top most priority. The HR placement will improved with skill mix and appropriate training at Districts hospital, MCWCs, UHCs and first aid/Basic EmONC services at UH&FWCs in order to increase institutional child births. Existing DSF piloting will be expanded on the basis of merits of options of services as per evaluation findings. The continuum of achievements in child health will be kept sustained under the support of IMCI facilities and their expansion for out-patient sick child services, to cover 480 Upazila, 59 district hospitals and 19 medical college hospitals in 64 districts with adequate quality IMCI services (80 Upazila, 40 district hospitals and 19 medical college hospitals). Community based management of childhood priority illness including Community IMCI, i.e. pneumonia, diarrhea, neonatal sepsis and first aid of common injuries by trained CHCPs / BHWs / CHWs focused appropriately. Special vaccination initiatives like introduction of new vaccines along with further strengthening of EPI will be continued.

Highlight of some other services

- Strengthening and expanding EPI service delivery with special focus on hard to reach and low performing areas
- Maintaining Polio free-status by conducting two rounds of NIDs in each year till the region is polio free
- Reaching Measles Elimination Status by 2015 through introducing 2nd dose of measles vaccine in routine EPI and periodic campaign
- Introducing New Vaccines following review and appropriate cost-benefit analysis: Pneumococcal vaccine, Rota Vaccine, Birth dose of Hepatitis B vaccine, DPT vaccine, Rubella vaccine
- Upgrading of health facilities (all UHCs, MCWCs and UH & FWCs/RDs in phases and to provide adolescent friendly SRH services
- Training of school teachers, local service providers and managers and student on good health habits, personal hygiene, hand washing, nutrition, helminthiasis, making healthful school environment, etc.
- Provide essential health care services at grass-root level by ensuring manpower, furniture, equipment, logistics, vehicle, etc. for newly constructed & upgraded facilities at all levels of facilities
- Collaboration with MOLGRDC, MOCHTA and CHT Board would be strengthened with a view to increase support of the health sector, in partnership with NGOs.
- Ensure health, family planning and nutritional services from the community clinics for all rural people through providing training to the CHCP, HA, FWA and other public providers including training to the Community Group, Support Group, Local Government Representatives and other stakeholders for the community participation and mobilization
- Pursue high quality DOTS expansion and enhancement
- Strengthening targeted interventions for STD/ HIV/AIDS
- Measures to decrease the incidence and mortality due to malaria and Control of Neglected Tropical Diseases, such as filariasis, kala-azar, soil transmitted helminthiasis etc
- To advocate and sensitize continuous advocacy and sensitization of policy and decision makers, so that personnel, materials and other resources could be used more efficiently and effectively
- Capacitating UHC with Human resources, equipment & logistics for early detection and care for the targeted NCDs
- Increase capacity in health services on disease surveillance skills and techniques
- Development of appropriate database on various MISs, its application and customized software, where and when applicable looking into factors like cost, deployability, scalability, inter-operability, security, and user-friendliness, etc.

B. Population Sub-sector

Bangladesh has achieved success in family planning programs against the backdrop of low literacy rate, low status of women, low income and so on. Despite this, one must note that due to past high fertility and falling mortality rates, Bangladesh's population has a tremendous growth potential built into its age structure. So, population continues to remain as one of the most important **nation's problems** as well as one of the major cause of poverty. Considering the fact, government has initiated to update the population policy 2004.

Major successes in population sector programs were achieved in expanded access to family planning services with introduction of a broader range of modern and effective methods. Replacement level of fertility by 2016 at the earliest is the priority vision of the GOB. In line with this vision present TFR of 2.7 children per woman (in 2007) needs to be reduced to 2.0 children per woman to attain net Reproductive Rate (NRR) =1 by 2016. To achieve replacement level of fertility by 2016, corresponding CPR has to be increased to 74% by mid-2016 from 55.8% (in 2007). Further efforts proposed to shift family planning use patterns towards more effective, longer lasting and lower-cost clinical and permanent methods covering low performing areas. But the major impact on fertility will be achieved by raising the age of marriage, which will push up age at first birth, and again trigger a tempo effect, to bring fertility down.

Mother and Child Welfare Centers (70) under DGFP are considered as centers of excellence for emergency obstetric care services. Upgrading one third MNCH centers to provide adolescent friendly and reproductive health services and reducing adolescent pregnancies through BCC/IEC are the important activities under DGFP.

Highlight of activities under Population Sub Sector

- Continuing and strengthening domiciliary services
- Strengthening IEC activities through multi-sectoral approach
- Introducing new approach; providing targeted HR, logistics and other management support; and strengthening monitoring and supervision at low performing and hard to reach area
- Ensuring commodity security and diversify local product
- Continuing Commodity Supply chain
- Ensuring community participation
- Institutionalization of Local Level Planning
- GO- NGO Collaboration and Public Private Partnership
- Increasing male participation
- Gender sensitization
- Ensuring quality of services
- Introducing new brand of contraceptives
- ICT and web based communication and monitoring
- Addressing infertility (3-5% of population.)
- Ensuring Human resources forecasting, management and development
- Introducing International Accounting Standard (IAS) from H.Q to field Offices / Ensuring Proper financial management from headquarter to field level
- Expanding FP services at urban areas (slum centered)/ special interventions at urban areas

C. Nutrition Sub Sector

Although there has been a decline in rate of underweight children over the years, the rates of underweight, stunting and wasting are still above the WHO's thresholds for very high levels, typically found in emergency situations. Nearly 51% of under-fives in the lowest quintile are undernourished, compared to 26% in the highest quintile (BDHS 2007). The causes of stunting are multifactor and include among other factors, lack of exclusive breastfeeding, inappropriate complementary feeding, and recurrent infections, etc.

In this SWAp, nutrition issues under MOHFW would be managed through a single OP under DGHS. In addition to existing human resource sufficient number of honest & dedicated nutrition/ public health specialist from DGHS & DGFP will be required to achieve the goal of NNS.

Nutrition service delivery will be mainstreamed at all service delivery point of DGHS & DGFP with the community clinics (CC) being the first contact point. However, where CC is not available and in hard to reach areas, special intervention modality like GO-NGO model would be considered. NNS will ensure implementation, coordination as well as advocacy role within the MOHFW and establish linkage with other relevant ministries (for example, MOFDM, MOA, MOI, MOFL, MOE, MOWCA, MOLGRDC, MOSW, MOI, etc), DPs, NGOs etc.

Highlights of nutrition activities are as follows:

- Mainstreaming nutrition and establishment of Nutrition Unit and IYCF corner in all UHCs. Setting a cell for Promotion & Support of Infant and Young Child Feeding (IYCF).
- Behavioral Change and Communication to Promote Good Nutritional Practices
- Human resource development (HRD)/ Training/Capacity Building
- Institutional Capacity Development
- Support to food safety laboratory at IPH and strengthen collaboration with other food safety laboratories;
- Management of severe acute malnutrition at facility level with referral from community;
- Monitoring and Evaluation / Nutrition Surveillance; and
- Mainstreaming Gender into Nutrition Program

XV. Operational Plans

The primary implementation structure of the HPNSDP is the "operational plan". There are 32 OPs for this PIP distributed across the Directorate General of Health Services, Directorate General of Family Planning and the MOHFW and other agencies. Each OP reflects a priority area of the HPNSDP. Each OP is led by a Line Director and has a functional administrative structure including staff, budget and infrastructure that permits the further development of the strategic directives and their effective implementation. For this PIP, a summary of each OP has been generated following a generic template that touches on key issues related to implementation. The OPs will be prepared for five years with provision for three years detailed activities along with budget and the next two years provision will be kept in block. OPs will be revised based on the progress of work, the ADP allocation and the concrete suggestions of the Mid Term Review (MTR). The Steering Committee (comprising of inter-ministerial representation and headed by the Honorable Minister for Health and Family Welfare) for this SWAp will have authority to approve all the OPs and subsequent revision thereof.

XVI. Mapping Strategy to Operations and cross-cutting Issues

The structure of the HPNSDP does not map directly, or simply, onto the OPs. Some strategic priorities require leadership from more than one OP e.g. Maternal Neonatal Child and Adolescent Health. For each strategic area and their priority interventions within the structure of the HPNSDP - component 1A Improving Health Services, component 1B Improving Service Provision and component II, Strengthening Health Systems – the PIP identifies the primary implementing OPs. Further, effective implementation of priority interventions often requires inputs from other OPs, other Ministries in Government and other sectors. The PIP maps these linkages between the strategy and the operational plans and draws attention to where cross-cutting engagement of multiple OPs, government Ministries and other sectors are required for effective implementation.

XVII. Procurement and PLMC

CMSD, DGFP Procurement and Logistics Unit and HED are considered agencies with good procurement capacity based on the Bank's experience in HNPSP as well as number of procurement-proficient staff in those agencies. The MOHFW will directly procure and execute contracts - with the establishment of PLMC. The role of the PLMC is to promote the stewardship role of the MOHFW to provide quality assurance and control to procurement plan preparation, bidding documents preparation and bid evaluation and overseeing, with terms of reference agreed with the DPs. The PLMC is also required to support the contracting out of consultants and non-consultancy services. As the capacity of other procuring entities is developed, they will be assessed and may be included based on the results of this assessment. The implementing agencies will submit quarterly PROMIS status report to DPs. MOHFW will roll out e-GP in CMSD, DGFP Procurement and Logistics Unit and HED. Capacity building of the focal points of procurement is one of the important activities.

XVIII. Human Resource Management

The main purpose of Human Resources management is – coordinating and preparing the HRH plan, heath workforce financing, HR recruitment , deployment, transfer, Promotion & Career Ladder, Education, Training,

Research & capacity building, and managing, reviewing, monitoring and evaluating various OPs on HRH interventions under the SWAp.

MOHFW attached the issues of shortages, mal-distribution of personnel, skill-mix imbalance, negative work environment and weak knowledge base under this program. The GOB has already created 13,500 new posts to work as CHCP to strengthen community based service delivery. Similarly, 3000 midwifery posts will be created to improve MNH services. Steps are to be devised for improving the quality of existing workforce in both the formal and the informal sectors. Moreover, the following are some of the important areas of focus for health sector's human resources development (HRD). The public sector HRD strategy, among other things, involve establishing career plans for specific lines of specialization, based on competence and experience, and clear principles for promotions, posting and transfers. Implementation of the policy recommendations under the Bangladesh Health Workforce Strategy related to HR in areas of financial and non-financial incentives, contracting in & contracting out of HR in hard-to-reach/rural areas will be a key issue to be addressed.

XIX. Monitoring and Evaluation Mechanism

The HPNSDP is strongly linked to the achievement of results as defined by the Results Framework (RFW). Each OP has identified a set of indicators to monitor implementation. These indicators draw on the conceptual basis of results framework (RFW) insofar as they monitor inputs, processes, outputs, outcomes and impacts. Every 6 months, the OPs will be reviewed to assess progress in implementation. This will require the production of a report drawing on the OP results indicators. The centrality of indicators for monitoring implementation is further emphasized through the Performance Based Financing framework that provides Disbursements for Accelerated Achievement of Results (DAAR). In responding to the demand for monitoring implementation, OPs are using SMART criteria (specific, measureable, attainable, reliable and time bound) to identify appropriate indicators.

The results and performance priority of the strategy places a premium on information and must be accompanied by an adequate investment in the capacity for production of these data. A program management and monitoring unit (PMMU) will be in place for strengthening monitoring and evaluation of the sector, equipped with adequate skilled professionals and logistics in the PW of MOHFW for management, coordination, monitoring and evaluation and to track progress of HPNSDP. The PMMU will also need to be supported by a team of international and national experts for making an effective M&E system in the MOHFW along with its agencies.

XX. Program Budget Requirement

Currently the combined public and private sources of health financing are insufficient to achieve full coverage of health services. On an average, about 3.2 per cent of GDP is spent on health, population and nutrition (HPN) sector in Bangladesh, of which about one percent of GDP is represented by the public sector. This share is quite low in terms of ensuring sustainable development of the sector. Although there is scope for improving utilization of available funds and achieving greater equity, the HPN sector demands higher allocations. The share of HPN allocation in the national budget therefore needs to increase year by year. This also calls for incremental funding from the Development Partners (DPs), who have been providing support to the development of the HPN sector in Bangladesh.

Estimated Budget and Expenditure of HNPSP

The Bangladesh Health, Nutrition and Population Sector Program (HNPSP) outlines activities from 2003-11 with a total estimated budget of Tk. 37,384.11 crore (US$ 5,417.98 million). Out of this Tk. 20,817.64 crore (US$ 3,017.04 million) is non development budget (55.7%) and Tk. 16,566.47 crore (US$ 2,400.93 million) is development budget (44.3%). 38 % of the total development budget is GOB contribution (Tk. 6,299.11 crore or US$ 912.91 million) and 62% is DP contribution (Tk. 10,267.34 core or US$ 1,488.02 million).

Considering 100 % utilization of 2010-11 ADP allocation, the total development budget expenditure for HNPSP will stand at Tk. 13,541.00 crore in June 2011. This implies that the utilization rate of the development budget during the period of HNPSP will stand at 82 %. The rate of utilization is even lower for DP contribution

(79.4%), as estimated expenditure is Tk. 8,156.03 crore (US$ 1182.03 million) against the commitment of Tk. 10,267.34 crore (US$ 1488.02 million) during the same period.

The main reasons for low utilization of funds are (i) non-availability of resources from DP's end and consequent reduction in GOB's matching fund as per the estimate, (ii) delay in procurement due to the complex procedural steps and (iii) reduction in absorption of funds due to frequent changes of the LDs. The absorption capacity varied significantly by OPs during HNPSP implementation. The allocated fund during HNPSP is fully utilized under only four OPs. Fund utilization rate was less than 70 % in 10 OPs and 50 % in 5 OPs[1]. However, the expenditure trend of the non development or revenue budget shows that the rate of utilization is higher (ranging from 95 to 100 per cent) than that of the development budget and will stand at 97 % assuming 100 % utilization of revenue budget of 2010-11. This provides evidence that the MOHFW's absorption capacity has increased during the SWAp implementation period over the last ten years.

Resource Envelope for HPNSDP

The projection of development budget of MOHFW for HPNSDP had widely been disseminated and the MOHFW received significant feedback from the stakeholders. On the basis of the comments and the substantial difference between the requested budget by the various LDs, the available budget indicated by MOF in the MTBF and absorption capacity of the implementing agencies, the MOHFW estimated the budget for HPNSDP and revised the OP-wise budget distribution based on (i) the trend estimated expenditure (ii) the budget requests by the LDs and (iii) the main 'drivers' of the new program (e.g. CC, PHC through UHS, etc), along with putting more resources in the areas emphasized for priority interventions.

The MOHFW has decided to set the development budget of HPNSDP Tk. 22176.66 crore for the period 2011-2016 based on a calculation of MTBF budget projections. The MTBF projection of the GOB development budget considers not only the budget spent under the OPs but also some parallel projects outside the OPs. The yearly development budget of MOHFW has been estimated by multiplying the average absorption capacity (82%) and the yearly projected amount by MTBF. The projected trend of the non development and development budget shows that the share of estimated non development budget has gradually increased from 59.9 % in 2011-12 to 63 % in 2015-16. On the other hand, during the same period the share of the development budget has decreased from 40% to 36 %. The average share of the non development budget (61 %) is higher than the average share of the development budget (39 %).

Estimated Development Budget Requirement by the OPs during 2011-16

The MOHFW has decided to reduce the number of OPs in the HPNSDP to 32. The ongoing 38 OPs have been rearranged in to 30 OPs and one new OP, the Community Based Health Care, has been proposed. The list of the old 38 OPs and the new 32 OPs is presented in the annex. The activities of the next sector program will be broadly similar in nature to the ongoing one with addition of new elements based on current needs. The budget for each OP is estimated taking 50% from the distribution based on expenditure trend and 50% from the distribution based on budget request made by the LDs. The strength of this approach is that it considers both previous expenditure trend and current budget requests reflecting the future need. According to this OP-wise distribution as suggested in Table below, the estimated budget is highest for Physical Facilities Development (22%) followed by Maternal, Neonatal and Child Health Care (14%). Community Based Health Care and Hospital Services Management has received 8 %, National Nutrition Service (NNS) and Family Planning Field

[1] The average fund utilization rate will decrease from 82 % at the end of the program if all the OPs cannot spend the entire allocation for the year 2010-11.

Services Delivery also has received 7 %, and Clinical Contraception Services Delivery has received 6% of the estimated budget.

Table: OP wise Budget Requirement for the HPNSDP

(Taka in Lakh)

Sl. No.	Name of the Operational Plan	GoB	RPA	DPA	Sub-total PA	Total	% of Total
1	2	3	4	5	6	7	8
DGHS							
1	Maternal, Neonatal, Child and Adolescent Health (MNCAH)	38,263.10	161,857.87	101,804.02	263,661.89	301,924.99	13.61%
2	Essential Services Delivery (ESD)	9,589.27	29,266.56	5,700.10	34,966.66	44,555.93	2.01%
3	Community Based Health Care (CBHC)	41,391.00	68,388.12	55,940.00	124,328.12	165,719.12	7.47%
4	TB and Leprosy Control (TB-LC)	3,300.86	4,635.14	24,248.00	28,883.14	32,184.00	1.45%
5	National AIDS And STD Program (NASP)	1,300.00	20,605.00	5,386.90	25,991.90	27,291.90	1.23%
6	Communicable Diseases Control (CDC)	13,826.55	17,965.50	28,550.00	46,515.50	60,342.05	2.72%
7	Non-Communicable Diseases (NCD)	13,824.00	27,787.00	10,300.00	38,087.00	51,911.04	2.34%
8	National Eye Care (NEC)	1,094.50	718.00	400.00	1,118.00	2,212.50	0.10%
9	Hospital Services Management (HSM)	84,962.07	85,553.50	15,700.00	101,253.50	186,215.57	8.40%
10	Alternate Medical Care (AMC)	7,105.00	800.00	-	800.00	7,905.00	0.36%
11	In-Service Training (IST)	9,437.00	19,411.00	4,900.00	24,311.00	33,748.00	1.52%
12	Pre-Service Education (PSE)	23,485.00	31,515.00	4,500.00	36,015.00	59,500.00	2.68%
13	Planning, Monitoring and Research (PMR-DGHS)	1,000.00	3,100.00	1,200.00	4,300.00	5,300.00	0.24%
14	Health Information Systems and E-Health (HIS-EH)	20,014.42	22,972.95	17,900.00	40,872.95	60,887.37	2.75%
15	Health Education and Promotion (HEP)	4,225.00	4,240.00	6,150.00	10,390.00	14,615.00	0.66%
16	Procurement, Logistics and Supplies Management (PLSM-CMSD)	40,474.00	1,300.00	2,000.00	3,300.00	43,774.00	1.97%
17	National Nutrition Services (NNS)	28,528.00	85,055.38	35,426.00	120,481.38	149,009.38	6.72%
	Sub-total(DGHS)=	341,819.77	585,171.03	320,105.02	905,276.05	1,247,095.86	56.23%
DGFP							
18	Maternal, Child, Reproductive and Adolescent Health (MCRAH)	20,015.00	38,398.00	29,491.00	67,889.00	87,904.00	3.96%
19	Clinical Contraception Services Delivery (CCSD)	68,295.35	19,005.00	48,514.00	67,519.00	135,814.35	6.12%
20	Family Planning Field Services Delivery (FPFSD)	34,399.00	88,836.00	38,175.00	127,011.00	161,410.00	7.28%
21	Planning, Monitoring and Evaluation of Family Planning (PME-FP)	200.00	700.00	100.00	800.00	1,000.00	0.05%
22	Management Information Systems (MIS)	2,587.00	3,013.00	200.00	3,213.00	5,800.00	0.26%
23	Information, Education and Communication (IEC)	5,122.00	4,878.00	3,500.00	8,378.00	13,500.00	0.61%
24	Procurement, Storage and Supplies Management (PSSM-FP)	7,519.00	340.00	172.00	512.00	8,031.00	0.36%
	Sub-total(DGFP)=	138,137.35	155,170.00	120,152.00	275,322.00	413,459.35	18.64%

Sl. No.	Name of the Operational Plan	GoB	RPA	DPA	Sub-total PA	Total	% of Total
1	2	3	4	5	6	7	8
Other							
25	Training, Research and Development (TRD)	3,025.00	4,725.00	3,377.00	8,102.00	11,127.00	0.50%
26	Nursing Education and Services (NES)	6,030.00	9,658.00	14,312.00	23,970.00	30,000.00	1.35%
27	Strengthening of Drug Administration and Management (SDAM)	1,005.00	1,527.00	623.00	2,150.00	3,155.00	0.14%
	Sub-total(other)=	10,060.00	15,910.00	18,312.00	34,222.00	44,282.00	2.00%
MOHFW							0.00%
28	Physical Facilities Development (PFD)	366,940.00	104,785.00	9,800.00	114,585.00	481,525.00	21.71%
29	Human Resources Management (HRM)	1,275.00	4,635.00	8,837.00	13,472.00	14,747.00	0.66%
30	Sector-Wide Program Management and Monitoring (SWPMM)	550.00	1,650.00	5,000.00	6,650.00	7,200.00	0.32%
31	Improved Financial Management (IFM)	726.00	1,900.00	950.00	2,850.00	3,576.00	0.16%
32	Health Economics and Financing (HEF)	842.00	570.00	4,369.00	4,939.00	5,781.00	0.26%
	Sub-total(Ministry)=	370,333.00	113,540.00	28,956.00	142,496.00	512,829.00	23.12%
	Grand Total(HPNSDP)=	860,350.12	869,791.03	487,525.02	1,357,316.05	2,217,666.21	100.00%

Justification for Incremental Budget Requirement for HPNSDP

The HPNSDP calls for incremental investment during the next five years with a view to implement the strategies and translate the development objective into actions. Construction of new facilities for expanding facility based services, up-gradation of existing facilities and repair, renovation and maintenance works of the ten entities within MOHFW comprise of the major cost components of the Physical Facilities Development OP and has the highest estimated budget. Considering the current low coverage of maternal health care (e.g. ANC, PNC, institutional delivery, etc.) and the current status of curative child health care in Bangladesh, the MOHFW has put more emphasis on MNCH related activities through allocating more resources for the concerned OP. Coverage of DSF has been included in the Maternal, Neonatal and Child Health Care of DGHS and Maternal, Reproductive and Adolescent health of DGFP. DSF will be expanded in another 100 Upazilas in next 5 years (20 in each year). Moreover, revitalization of Community Health Care Initiative in Bangladesh is one of the priority interventions of the GOB, reflected in the suggested budget. The CC based PHC service provision will require huge investment and this initiative will also help increase service utilization by the poor at the grass root level. Nutrition services will be expanded throughout the country (current coverage is 173 Upazilas) and therefore estimated budget of this OP has been increased compared to HNPSP. Safe blood transfusion along with quality assurance has been added to Hospital Services Management OP and consequently the estimated budget of this OP has been raised rationally. MOHFW has decided to expand the coverage of the Family Planning Field Services Delivery and Clinical Contraception Service Delivery to urban areas as well for achieving the targets for TFR and CPR under HPNSDP. In addition, more resources will be required to improve the support systems, e.g., establishing M&E, improving HIS, strengthening procurement, etc. All these interventions adequately explain the necessity for higher investment in the HPN sector during the next five years.

Expected GOB and DP Share: the Resource Gap

The total development budget of Tk. 22176.66 crore (US$ 2996.85 million) is to be spent through the OPs during the next five years starting from July 2011. As mentioned earlier, due to fund constraint the GOB is currently in a position to contribute a maximum of 38.8% (Tk. 8603.50 crore equivalent to US$ 1162.64 million) of the resources needed for implementing the HPNSDP while the rest 61.2% (Tk. 13573.16 crore equivalent to US $ 1834.21 million) is considered to be the funding gap, and needs to be ensured from external sources. There has been significant contribution of the DPs in the development programs of the HPN sector of

Bangladesh. Therefore, the expected contribution from the DPs is Tk. 13573.16 crore (US$ 1834.21 million). However, combining the development and non development budget of the MOHFW, the GOB share stands at about 76.18% and the DP share is expected to cover 23.82 % of MOHFW's budgetary requirement for implementing HPNSDP during 2011-16.

As of today, there has been an indication of DP contribution to the extent of TK. 11515.36 crore (US $ 1556.13 million). However an additional amount of US$ 43.08 million is expected to be received from IDA under Disbursement for Accelerated Achievement of Results (DAAR). Besides, there is a probability of receiving additional fund from JICA, EC and GAVI-HSS. Kuwait and IDB has also initiated discussion and shown willingness to provide fund in HPNSDP. All these indicate that the resource gap of US $ 278.08 million (about 9%) can be minimized with additional external resources.

Strong commitment to embrace change and bold decisions to tackle difficult tasks along with quality and result based management are required for implementing the next sector program. Increased efficiency in fund utilization is also required to minimize the funding gap. MOHFW, during the next sector program will ensure implementation of these changes in collaboration with all stakeholders, including the development partners of the HPN sector.

Secretary
Ministry of Health & Family Welfare

CHAPTER I: INTRODUCTION

1.1. Background

Over the period June 2010 through February 2011, a new Strategic Plan for the Health, Population and Nutrition Sector Development Program (HPNSDP) for the period 2011-2016 has been produced by the Planning Wing of the Ministry of Health and Family Welfare.

The HPNSDP follows in the recent history of health policy in Bangladesh drawing on the sector-wide approach (SWAp) that was first introduced in 1998. The first SWAp – the HPSP - was implemented during 1998-2003. It was followed by a second SWAp - the HNPSP - that began in 2003 and will expire in June 2011. The third SWAp – the HPNSDP – will begin in July 2011 for a period of 5 years through to June 2016. Its articulation and implementation are being actively linked to the preparation of the government's Sixth Five Year Plan (SFYP) for 2012- 2016.

The purpose of this Project Implementation Plan (PIP) document is to describe how the GOB, with partners, intends to implement the HPNSDP over a five -year period commencing July 2011. The goal of the PIP is to identify how the resources of the GOB and partners will be translated into specific programs and activities reflecting the priorities of the HPNSDP that can be managed and monitored towards successful implementation to achieve the expected results. Further details related to implementation will be incorporated into the Operational Plans (OPs) to be developed subsequently.

The PIP is informed by both the current and prospective national and international context, as well as lessons learned in implementation of previous SWAps from which a set of implementation challenges are identified.

1.2. Progress in Health and Health Services

Strong progress in the development of the health sector has been achieved over the past twenty years as evidenced by the findings of successive Bangladesh Demographic and Health Surveys, partly as a result of HPSP and HNPSP implementation. Bangladesh is on track to achieve MDG 4 with infant mortality rate per 1000 live births declining from 82.2 in 1996-97 to 52 in 2007 and under-five mortality rate per 1000 live births declining to 65 in 2007 from 115.7 in 1996-97. The achievements in the area of child health are due to the successful implementation of EPI, IMCI, diarrheal disease control and control of acute respiratory tract infections, facilitated by an improvement in the care seeking behavior of the people. However, neonatal mortality rate per 1000 live births has shown only a small decline to 37 in 2007 from 42 in 1996-97. The maternal mortality ratio (MMR) declined from 574 in 1990 to 348 (SVRS, 2008) to 194 in 2010 (BMMS 2011). Much of this decline is attributed to success in fertility reduction, and gains in female literacy and increased age at first childbearing. Much work has been done in strengthening services for dealing with life-threatening emergencies during childbirth but much more needs to be done to reach MDG 5 target of 143 deaths per 100,000 live births by 2015. Polio and leprosy are virtually eliminated. HIV prevalence is still very low, but there remain concerns of an increase due to its increase in most at risk populations. For these reasons the 65th UN General Assembly awarded Bangladesh' Prime Minister, the MDG award for progress towards MDG 4.

Strong and sustained policy interventions have led to steady reductions in the annual growth rate of population. The total fertility rate (TFR) declined from 3.3 in 1996-97 to 2.7 (2007). The contraceptive prevalence rate (CPR) reached 55.8 per cent in 2007. Life expectancy at birth continues to rise reaching nearly 67 years in 2008 (BBS-SVRS 2008) from 58 years in 1994 with women's life expectancy superior to men's. There has been slower than expected progress in reducing malnutrition in Bangladesh especially given the improvements in child survival and the increases in coverage of mirco-nutrient supplementation: the percentage of children 1-5 years receiving vitamin-A supplements in last six months has increased from 73.3 in 1999-2000 to 88.3 in 2007.

Various other output indicators are also laudable. The percentage of children who completed vaccination has improved to 81.9 in 2007 from 54.1 in 1996-97. The TB case detection and cure rates have already almost achieved MDG targets. The percentage of ante-natal check-ups by the trained providers has improved from 29 in 1996-97 to 51.7 in 2008. However, the percentage of delivery by trained persons shows only a slight improvement, i.e., an increase from 12 in 1995-96 to 18 in 2007. Gains were also impressive in the areas of

malaria, soil transmitted helminthiasis, night blindness and iodine deficiency disorders, due to prompt identification, case holding, communication interventions and improvement in water and sanitation.

The development of a countrywide network of health care infrastructure in public sector is remarkable. Various communication interventions, taken by Government and NGO service providers show encouraging results, similar to the overall expansion of literacy, female income generating prospects and expansion and utilization of mass media portals, e.g., television etc.

1.3. Lessons Learned

In 1998, the first SWAp (Sector Wide Approach) in the health sector marked a shift from a multiple project approach to a single sector program. This not only ensured Government's leadership in preparing and implementing the program but also created an opportunity for better coordination, harmonization and alignment of multiple donor funded projects and resources. The SWAp helped to focus on critical development objectives like equity and access and also led to efficiency gains. It enabled the government to establish connections between identified objectives, strategies, activities, resources and outcomes. It also reduced the transaction costs for government related to the multiple different agendas and official missions of development partners.

Both the sector programs – Health and Population Sector Program (HPSP) and Health, Nutrition and Population Sector Program (HNPSP) focussed on pro-poor essential services packages (ESP), which has helped to reduce the gap between rich and poor with respect to outcomes in rural areas. While achievement against some of the indicators are satisfactory, in general, there are pockets of underachievers geographically – upazila, district, division and topography-wise; which are linked to the socio-cultural factors of the given areas. For example, family planning achievements are better in the western divisions of the country than the eastern divisions. Some of the reasons of these differentials are: higher level of literacy and lower poverty in the western divisions, more conservative socio-cultural norms and more hard to reach areas in the eastern part of Bangladesh. Except in areas where the poor are being served in a focused way, there remain large gaps in primary health care coverage of urban areas where the quality and accessibility of health, family planning and nutrition services is yet to be managed efficiently either in public or in private sectors.

With the provision in 2001 to mainstream gender equity, there has been increasing recognition of the importance of improved gender equity in health sector plans and programs. However, the implementation of policies and plans was limited mainly due to weak institutional mechanisms and leadership. More generally, there is a growing consensus that no equity in health care will be achievable until there is equity in inputs including but not limited to gender, geography, poverty, illiteracy etc.

Although some improvements have been put in place in the area of maternal and newborn health, such as upgrading of selected facilities and training for Emergency Obstetric Care (EmOC), the overall impact is only beginning to be seen. The primary reasons are the chronic shortages of skilled persons for childbirth, both in normal conditions and in emergency situations where accessible and functional facilities are in short supply. Another area of concern is the absence of effective intervention programs for neonatal health care that are limiting gains in the reduction of the child mortality.

Insufficient coordination between various sub-sectors in health, population and nutrition resulted in duplication, wastage and missed opportunities both at the top as well as at the operational level. While there is multiplicity of line directors at the national level, implementation of their programs falls on the shoulder of far fewer number of workers at the fringe level, resulting in inefficiency from ineffectiveness. There is a necessity and scope for mainstreaming the nutrition related programs and community clinic based activities.

The revitalization of community health care initiative integrated in a wider Upazila Health System promises better access to health care services at the grass roots level. As a first level entry point, the community clinics provide an important opportunity to provide integrated primary care services.

Systems-wide improvements are needed to address weaknesses related to staff, drugs, money, materials, equipment, and management practices that inhibit service providers from performing their work according to need. Both the service providers and the support systems need to be guided by effective decision-making and



coordinated interactions among these components that ultimately define the performance of the health, population and nutrition (HPN) sector as a whole.

A further lesson goes beyond the MOHFW in view of the fact that the responsibility of providing public health, waste management (conservancy) and water supply in the urban (city corporation and municipalities) lies with the Ministry of Local Government, Rural Development & Cooperatives MOLGRDC. Similarly, Hill Development Boards of the three hill districts in Chittagong Division were also given the responsibility of running the administration of 23 of the Ministries of the Government, one of which is the MOHFW. In the planning of the health sector these realities were never reflected adequately in the past.

Above all poorly functioning health infrastructure, inadequate numbers of health workers, slow adoption of evidence-based health policies, insufficient focus on quality of care and equity and lack of efficient management culture are the main stumbling blocks in strengthening and improving health, nutrition and population related services.

1.4. New and Continuing Challenges

1.4.1. New health problems

While there has been much progress in health in Bangladesh, there are a number of new health challenges emerging. These include: the increasing incidence of injuries including acid and other burn injuries, drowning and other accidents including road traffic injuries; the spread of infectious diseases such Hepatitis B and C, as well emerging and re-emerging diseases; and the health effects of geo-climactic disasters and arsenicosis. They also include the rising importance of non-communicable diseases (NCDs), recognizing that cardio-vascular diseases and cancer have become leading causes of morbidity and mortality requiring more concerted policy attention at primary and secondary prevention. Diabetes prevalence is currently thought to be about 7%, with Bangladesh projected to be among the top ten countries for numbers living with diabetes by 2025.

1.4.2. Delivery of Priority Services

Despite significant efforts to expand EmOC services at the district and upazila level, institutional deliveries remain unacceptably low level with only 18% of all births delivered by skilled attendants in a facility. There is insufficient availability and quality of skilled attendance especially amongst poorer segments of the rural and urban populations and across administrative divisions and districts. Piloting of maternal health vouchers has been found to improve access in the short-run but requires further thinking about its system-wide effects in the longer term if it is to be scaled up further. Further gains in maternal and neonatal mortality will require access to trained birth attendants, backed by access to institutional delivery and EmONC-ready facilities that can treat both obstetric emergencies and acute neonatal disorders.

While there has been overall progress towards the family planning targets and improved access to services, there a significant regional variations in contraceptive prevalence rate and skews away from using LAPM contraception. Diversified and country wide, mass scale effective family panning service delivery remains a great challenge. Linked to population is rapid urbanization that is creating new challenges for effective urban primary health care service delivery.

In spite of efforts taken by the government, high rates of child malnutrition and micronutrient deficiencies along with gender discrimination still remains a challenge. The multi-factorial determinants of nutritional status and the multi-sectoral response that includes food security and livelihoods in addition to health services represents an important area for continued concerted research and programming.

Gender, disability, age, type of disease and cultural differences are too commonly the basis for discrimination, in access to, and utilization of, health services in Bangladesh. Poor women and children, especially those from tribal populations are poorly served by the current system, as are People with Disabilities (PWD), the elderly, adolescents and persons living with HIV/AIDS. People living in disaster prone areas are very vulnerable to further impoverishment and deterioration of their health status. Often the ‘voice’ of the poor and vulnerable gets trapped at local level. There is insufficient realization that equity in

health requires addressing the structural and societal inequities. So health sector inputs need to be gender sensitive and sensitive to other parameters that also affect equity, e.g. geographical location, poverty, illiteracy. Responsiveness of the service providers especially to the socially excluded service seekers also needs to be monitored while deciding for rewards or other incentives.

1.4.3. Support Systems

Implementation of services relies disproportionately on the strength of the health system building blocks or foundations that include: i) financing and budgeting; ii) information systems; iii) the health workforce; iv) procurement management; and v) physical infrastructure.

The way in which the health system is financed from a consumer perspective is perhaps the greatest challenge for the health sector. Two thirds of health expenditure comes directly from the citizen's pocket and is the cause of pushing thousands of individuals into poverty and indebtedness daily. Efforts are required to channel these resources into pre-payment financing systems and curb unnecessary expenditures on medicines and diagnostics that represent 80% of out of pocket expenditures.

The financial performance of the public sector reflects a conundrum. On the one hand, there is under utilization of available funds and on the other hand there are under-funded services with high unmet needs. The resolution of this contradiction calls for a radical re-examination of sector strategies along two lines: (i) how to utilize public-sector funds more efficiently and (ii) how to increase the HPN financial resource base.

Related to this is the challenge of how allocate public resources beyond the widespread practice of increments on the basis of historical norms, such as the number of beds in a health facility. Stronger needs-based allocation formulas are required that are sensitive to indicators on the extent of poverty, disease incidence and prevalence, population size and peculiarities of the localities and topographies. Moreover, planning and budgeting procedures are yet to provide adequate flexibility for Operational Plans (OP) revisions with regard to certain percentages of approved PIP enhancement and inter-OP and intra-OP cost increase/adjustment.

The multiple MIS of different directorates and the absence of any system to mainstream data collection and analysis results in duplication of information and an inability to provide timely data to assess progress. This problem emanates from the bifurcation of the MIS function between two directorates, many projects and programs and is also compounded by the fact that at the apical stage, i.e., in the Ministry itself, there is no unit for generating and managing information. Planning therefore is most often based on data from the past. Information generation is split and there is no bastion for unifying the data generated from several corners on several different indicators. Surveillance data on nutrition, HIV/AIDS and maternal mortality are either unavailable for long period of time or non available in time or from one single unit.

Human Resources inadequacies remain a major obstacle to provide quality service delivery. The main problems are shortage of human resources for health, inappropriate skill and gender-mix, poor coordination and inefficiency in their utilization and deployment, skewed concentration in urban areas and inadequate presence in rural areas. Despite some attention, there have been no substantial changes in the recruitment, deployment and promotion policies along with a career planning for the health workforce or the structure of incentives to providers to reward good performance and sanction bad performance.

Centralized procurement procedures coupled with lack of adequate capacity in GOB/WB procurement planning, management and maintenance of supply systems creates delay and inefficiency, notwithstanding the fact that for economy of scale, bulk purchase is useful. Inefficiency in procurement needs to be overcome through capacity and capability development in the area of procurement planning and management, storage and distribution and supervision at various levels of the system.

Despite the huge expansion/construction of physical facilities, the utilization of public health facilities by the poor remained low due to other supply-side barriers, such as lack of human resources, inadequate drugs and supplies, poor maintenance, various management inadequacies and attitudes of the service providers towards the clients / service seekers.

1.4.4. Stewardship and Governance

The stewardship role of the public sector is constrained by a weak legal framework and institutional inadequacies of regulatory functionaries, e.g. DGDA, DGHS, DGFP, DNS, BMDC, State Medical Faculty, BNC, Boards relating to AMC, etc. Although some reforms have taken place in BNC and BMDC, these need to be put in practice, with technically and socially skilled leadership. Institutes which were created for certain public health functions, i.e., IEDCR, IPH, IPHN, NIPSOM, NIPORT, etc. are suffering either from lack of effective use, quality, support or leadership and hence are unable to contribute to their fullest potential.

Challenges still remain in terms of too many Operational Plans (38 in the HPNSP) diluting and duplicating program priorities and activities with insufficient coordination among line directors, program managers and focal points working in independent offices. Added to this are, the rigid fund release and disbursement procedures, coupled with frequent change of key personnel at the policy/program implementation level, resulting in limited and delayed access to, and utilization of resources.

Insufficient coordination between various sub-sectors in health, population and nutrition resulted in duplication, wastage and missed opportunities both at the top as well as at the operational level. While there is multiplicity of line directorship at the national level, implementation of their programs falls on the shoulders of far fewer numbers of workers at the lower levels. Rationalization of OPs along with increasing coordination and collaboration with other ministries affecting health outcomes is required to streamline activities and improve efficiency.

The various agreements and negotiations with donors as part of the SWAp process have led to improvements in the relationship with the overall stewardship of the health sector. Nevertheless there remain some challenges. For example, categorized pooled funding covering limited area of procurement of goods, works and services (including training) in a centralized environment, provides little opportunities for manpower hiring, procurement or using funds locally, especially when there is an urgent need. Also, the intricacies of the World Bank's fund management procedures have resulted in barriers to access funds to accomplish the program activities in a timely way. Parallel and non-pool development partner harmonization is also yet to be achieved.

With the signing of the Joint Cooperation Strategy (JCS June 2010) by the Government of Bangladesh and the Development Partners, the MOHFW is faced with a new challenge of developing in-house capacity for addressing performance-based financing (PBF). By linking allocations of financial resources to achievement of pre-defined performance targets, PBF is seen as a strategy to align the incentives of providers and purchasers of health care services, thereby improving health systems efficiency.

CHAPTER II: OVERVIEW OF HPNSDP

2.1. VISION, MISSION AND GOAL OF THE HPNSDP

2.1.1. VISION

The vision is to see the people healthier, happier and economically productive to make Bangladesh a middle income country by 2021.

2.1.2. MISSION

The mission is to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health.

2.1.3. GOAL

The goal is to ensure quality and equitable health care for all citizens in Bangladesh by improving access to and utilization of health, population and nutrition services. A number of development activities in other key sectors implemented throughout Bangladesh will contribute to achievement of this goal along with HPNSDP.

2.1.4. DVELOPMENT OBJECTIVE

The development objective is to "improve access to and utilization of essential health, population and nutrition services, particularly by the poor."

2.2. PROGRAM PRIORITIES AND STRATEGIES

The HPNSDP strategic document sets out the sector's strategic priorities and explains how these will be addressed to a certain extent, taking into account the strengths, lessons learned and challenges of implementing the last two sector programs, the HPSP and the current HNPSP. The details of priorities and interventions along with their implementation mechanisms are described under the Program Description Chapter into the respective Operational Plans.

The **drivers** for the HPNSDP are as follows:

- **Scaling up services for the achievement of the targets of MDG 1, 4, 5 and 6 by 2015.** The existing essential services, hospital services at the secondary and tertiary hospitals including communicable and non-communicable diseases are proposed for expansion and improvement according to the need and situation;
- **Addressing population growth with vigorous, fully integrated family planning services, and cross-cutting, multi-sector interventions.** Focus is on Long term and permanent family planning methods including the unmet need, with participation of related different stakeholders, both in urban and rural areas;
- **Mainstreaming nutrition in all service delivery points through the regular channels of DGHS and DGFP.** IPHN considered as the home for nutrition services management and service delivery through different tiers of health facilities of both DGHS and DGFP, by defining as well as developing a skilled workforce;
- **Expanding access to health services for priority communicable and non communicable diseases.** Along with the CDC prioritized activities, the NCD issues are given same priority in regard to create facilities and expansion of related services.
- **Revitalizing the Community Clinic based services as part of a functional Upazila Health System (UHS).** A project is being implemented outside the HNPSP titled Revitalization of Community Health Care Initiative in Bangladesh is considered as a flagship intervention of the Government. These Project components are merged with the HPSDP (to be implemented through a separate OP).

- **Strengthening overall health system and governance including establishing a sustainable Monitoring and Evaluation System.** Developing an M&E system for the HPSDP is an essential component to provide convenient and timely information to policymakers as they track performance of the Program in order to ensure necessary adjustments over its course.
- **Improving health equity for the poor and geographically marginalized population.** Collaboration and inter-sectoral coordination with MOCHTA, MOSA, private and individual social institutions be strengthened with a view to increase support of the health sector, in partnership with NGOs. The clients and the service providers have to be motivated to use the health services available and to enable the disadvantaged to access health services.

Sector specific strategies include:

- Streamline, expand the access and quality of MNCH services, in particular supervised deliveries (MDG 4 and MDG 5).
- Revitalize various family planning interventions to attain replacement level fertility.
- Improve and strengthen nutritional services by mainstreaming nutrition within the regular DGHS and DGFP services (MDG 1).
- Strengthen preventive approaches as well as control programs to communicable diseases (MDG 6).
- Expand NCD control efforts at all levels by streamlining referral systems and strengthening hospital accreditation and management systems.
- Strengthen the various support systems by increasing the health workforce at Upazila and CC levels, including their capacity building and enhanced focus on coordinated implementation of OPs, MIS and M&E functions.
- Strengthen drug management and improve quality drug provision and procurement with ICT and additional staff to reduce the time between procurement and distribution.
- Increase coverage and quality of services by strengthening coordination with other intra and inter-sectoral and private sector service providers.
- Pursue priority institutional and policy reforms, such as decentralization and LLP, incentives for service providers in hard to reach areas, PPP, single annual work plan, etc.

2.3. BOUNDARIES OF THE HPN SECTOR

This document – PIP, is the plan for the health sector in its entirety and will encompass any health, nutrition and population related activities that are and will be implemented in the country, irrespective of the sector – public or private, office, ministry or individual at least notionally. All the activities undertaken in the sector will lead to the same vision, mission, goal and target in unison and will be monitored, reviewed and evaluated as such across the sector.

The previous sector program was without doubt the largest program to support the health sector, but it was not the only one. There are a total of 23 projects included in the HPN sector, of which 4 are under the responsibility of other Ministries, but operate within the sector (e.g. Urban Primary Health Care Project under the MOLGRDC). Moreover, MOHFW is implementing several parallel projects included in its ADP, which are outside the SWAp program. According to government political commitment there are need to undertake some specialized hospital and medical college projects at different points of time of the financial year on an urgent basis. Incorporating these projects into the sector program by revising PIP is a complex and time consuming task. In addition, sometimes the highest policy makers of the government directs MOHFW to take such separate parallel projects. Moreover, SWAp considers primary HPN care as priority services than the super-specialized and tertiary care. The boundaries of the sector extend beyond the mandate of the MOHFW. A true SWAp would encompass both urban and rural health services (i.e. MOLGRDC, MOHFW, and MOCHTA), as well as the buy in and participation from other players, including the Ministry of Finance (MOF).

However, MOHFW is not in a position to change the mandate of either this ministry or others. Health being an outcome of multi-sectoral interventions, it is not also desirable to be handled by the MOHFW alone. In the next sector program MOHFW will try to strengthen its coordination and functional relationship with other ministries



involved in providing health services. In addition it will try to bring gradually new and existing parallel projects of MOHFW under the SWAp modalities. It would include a clear strategy for working with the private sector – something which is essential given that more than half of all health expenditure in Bangladesh takes place within the private sector. It would also include a formal mechanism with the large NGO sector in the country that fills the gap where the MOHFW services are either inadequate or cannot be reached.

2.4. DURATION AND TIMING

HPNSDP is a five year commencing on July 1, 2011 and ending on June, 2016. OPs will be prepared for 5 years duration, where initial 3 years estimates will be shown as annual basis and the last two years estimates will be reflected as block. Manpower proposed under this Program will be for 5 years period. But if any manpower is transferred to the revenue budget in course of implementation of the Program, funding from GOB will be then stopped.

2.5. LOCATION OF THE PROGRAM

The Program will be implemented nationally in all seven division of Bangladesh, at all tiers of service delivery. The CCs will be one stop service delivery points at the community level.

2.6. IMPLEMENTATION PRIORITIES

The next sector program will have the following elements that would be different and or add value to the current program (HNPSP), particularly in addressing maternal and neo-natal health and nutrition. Some notable ones are stated below:

- In the DGHS, a new OP in the name of Maternal, Neonatal and Child Health ;
- MNH services address needs during preconception and pregnancy, childbirth and the immediate postpartum period and provided by increased number of skilled birth attendants.
- Facilities to be staffed and equipped to provide 24 hour services, 7 days a week gradually for appropriate management of complications in EmOC.
- Areas of high rates of MMR, geographically and socially disadvantaged, and the poor has given priority while providing quality MNH services including maternal and peri-natal death audits.
- The current maternal health strategy needs updating to implement new born care and other recent issues needing attention for MNH service improvement.
- Community Clinic and domiciliary services are to be woman-friendly preconception and pregnancy care. Similar services by NGOs are encouraged where found feasible and appropriate.
- Detailed guideline needs to prepare for functional integration of MNH services, incorporating expertise and facility sharing between DGHS and DGFP.
- Home-visit by a trained worker within two days of child birth considered.
- MNH services for urban slums, in collaboration with MOLGRDC and other health care providers including NGOs are promoted.
- Nutrition has been made a priority for the next sector program and all facilities under DGHS and DGFP providing MNCH services will be made available for integrated nutrition service delivery.
- The nutrition service housed in IPHN, under the DGHS and implemented through an OP titled “National Nutrition Service (NNS)”.
- One of the medical officers of the UHS is designated as medical officer (public health and nutrition) and assigned the responsibility of coordinating NNS activities at upazila level and below.
- The community nutrition activities merged with the CCs for effective service provision. Scaling up of nutrition activities will be done in the remaining upazilas, with particular priority given to remote and poorer areas.
- Community based IMCI programs along with programs through Community Clinics deliver nutrition services in rural areas.

- MOHFW would collaborate with MOLGRDC in providing nutrition services in the urban areas (e.g., creating awareness among the urban population, vitamin A and other micronutrient supplementation, etc.).

The appraisal mission for the HPNSDP identified a further set of implementation priorities for the HPNSDP referred to as "policy and reform issues... critical for improving health outcomes, particularly for the poor," which are highlighted below:

I. Allocating the necessary resources for scaling up emergency obstetric care and family planning services in high priority areas;
II. Mainstreaming nutrition in the services of the DGHS and DGFP;
III. Reviewing the institutional and regulatory framework of the sector, establishing a coordination mechanism for urban health;
IV. Introducing a single-budget plan whenever decided by GOB, based on MOF guidelines;
V. Decentralizing some management functions gradually to the district/upazila and piloting a new upazila health system;
VI. Improving efficiency through improving coordination between DGHS and DGFP, improving maintenance and operation of health facilities and medical equipment, and improving resource utilization through a resource allocation formula;
VII. Developing a health care financing policy position paper, engaging with the MOF to increase public financing for the health sector, scaling-up demand-side financing based on its evaluation;
VIII. Adopting pro-poor strategies such as revitalizing the Community Clinics, expanding the engagement with non-state providers, where appropriate, and incorporating pro-poor indicators to monitor the results;
IX. Addressing the shortage, skill-mix, retention, and deployment of human resources, such as introducing non-financial and financial incentives to deploy staff to rural and remote areas;
X. Improving collaboration with non-state providers through developing a framework to guide the contracting out of services to NGOs and Private Sector in order to ensure accountability and quality of their services; and
XI. Strengthening the fiduciary capacity of the MOHFW including the customization and the roll-out of the Integrated Budget and Accounting System (IBAS) and the introduction of e-GP and Procurement Management Information System (PROMIS) for effective, efficient and transparent procurement management

MOHFW, during the next sector program will ensure implementation of these new and reform issues through needs based planning, increasing human resources, effective monitoring and in collaboration with all stakeholders of the HPN sector.

CHAPTER III: MAPPING THE STRATEGY TO THE IMPLEMENTATION STRUCTURE

3.1 Introduction

This chapter identifies how the health sector plan, as described in the document - Strategic Plan for Health, Population and Nutrition Sector Development Program 2011-2016, maps on to the implementing structures of the MOHFW, relevant Ministries of the Government of Bangladesh and other partners. The primary implementing unit of the MOHFW is the "Operational Plan" (OP) of which there are 32 distributed across the Directorate General Health Services, Directorate General Family Planning and the MOHFW. Each OP, a summary of which is provided in Chapter 4, is meant to effectively implement some part of the HPNSDP. The structure of the HPNSDP, however, does not map directly or simply onto the OPs: some strategic priorities require leadership from multiple OPs and for many strategic priorities to be implemented effectively there will be a need for specific inputs from other OPs, other Ministries in Government and other sectors. The Chapter begins by providing an overall structure of the MOHFW which has the responsibility for implementing the HPNSDP. It then follows by mapping the HPNSDP structure -- component 1A Improving Health Services; component 1B Improving Service Provision and component II, Strengthening Health Systems -- and the priority interventions within these components, to the primary implementing OPs. Particular attention is given to cross-cutting issues that require the engagement of other OPs or other government sectors or non-governmental stakeholders. A set of macro-level considerations for implementation are identified that will require concerted attention above and beyond the implementation of the specific strategic priorities. A final section identifies the methods for monitoring implementation of the HPNSDP.

3.2 MOHFW Organization and Structure

The Ministry of Health and Family Welfare (MOHFW) is responsible for the implementation, management, coordination and regulation of national health, family planning and nutrition related policies, programs and activities. The core functions are identified as policy and strategies planning, monitoring, budget management, information management, reform management, aid management, and the management of contracts and commissions. The MOHFW management structure (see Figure below) comprises 2 main groupings:

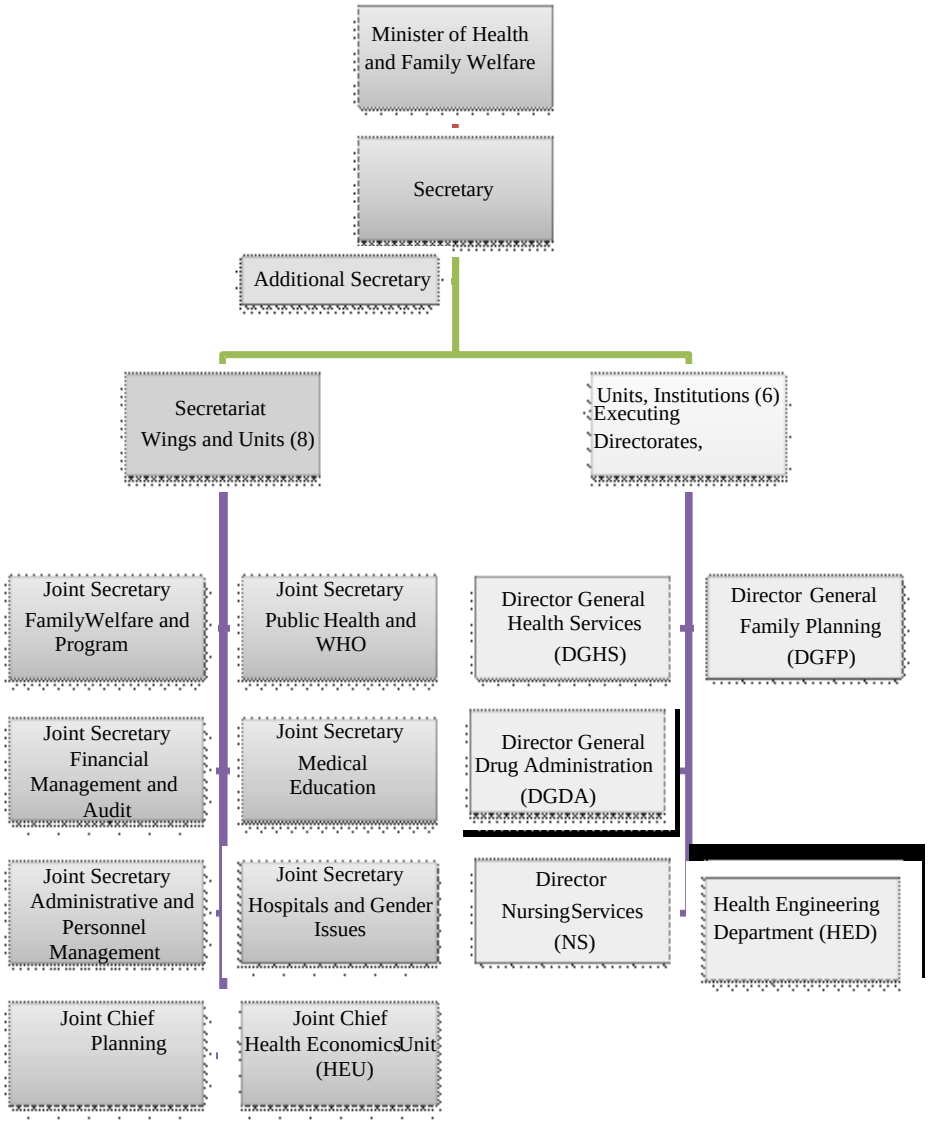
- the Secretariat responsible for policy development and administration comprising eight functional wings and units headed by a Joint Secretary or a Joint Chief; and
- Executing Agencies through which the MoHFW implements its policies and Programs comprising six Directorates, Units and Institutions

Both groups are headed by the Secretary who is supported by the Additional Secretary. The lead technical Directorates include Health Services (DGHS) and Family Planning (DGFP), each led by a Director General (DG) supported Directors. DGHS and DGFP have separate management and delivery structures from national to ward level.

In addition, another layer of health sector organization reflects the geographical arrangements of the country: 7 Divisions, 64 Districts, 483 sub-districts (Upazilas), 4,498 unions. Each unions have a number of smallest administrative unit known as wards. Wards are comprised at the community level of villages that on average have a population of 500 to 1000 people.

Unlike the rural areas, primary health care in urban areas is coordinated by the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC). Both ministries (MOHFW and MOLGRDC) partly coordinate their activities through the National Urban Primary Health Care Committee (NUPHCC) and National Project Steering Committee (NPSC).

Chart A: MoHFW Senior Management Structure



3.3 Linking Strategic Priorities to Implementation Structures

The priority interventions related to the different implementation structures as described in three components:

Component A: *Improving Health Services.*
Component B: *Improving Service Provision*
Component C: *Strengthening of Health Systems*

Component A: Improving Health Services.

3.3.1.Maternal, Neonatal, Child, Adolescent and Reproductive Health

The HPNSDP designates three components of services within this broad area: maternal and neonatal health; child health; and adolescent and reproductive health and within each of these identifies "priority interventions" (Table 3.3.1).

Table 3.3.1: Maternal, Neonatal, Child, Reproductive and Adolescent Health: *lead OPs are MNCAH and MCRAH*

Priority Interventions
(a) Maternal and Neonatal Health
• **Promoting MNH services nationwide including the urban slums, in collaboration with other health care providers including NGOs and using mass media.** • **Improving quality of maternal and neonatal health services from preconception to the postnatal period in facilities from medical colleges to community clinics, including management of satellite clinics and including evidence-based interventions, notably to address haemorrhage and eclampsia.** • **Strengthening 24/7 EmOC services gradually through improving HR development, placement and retention with skill mix at various tiers of service delivery and in identified facilities through a detailed mapping exercise considering emergency referrals, communication and transportation.** • **Training 3,000 midwives by the year 2015 as part of the scaling-up of skilled health workers to accelerate achievement of MDG5.** • **Improving strategies to expand skilled birth attendance at institutional level by initiating first aid/basic EMONC services at the UHFWCS and at home through continued CSBA training program with strengthened management and clinical supervision and in facilities.** • **Increasing efficiency through functional integration of MNH services, incorporating expertise and facility sharing between DGHS and DGFP and prioritizing low performing and hard to reach areas.** • **Updating the current Maternal Health Strategy and strengthening newborn care services at all levels with rapid referral mechanisms.** • **Expanding the DSF scheme based on the recommendations from the economic evaluation.** • **Strengthening the pre-service curriculum of doctors, nurses and paramedics in midwifery, essential newborn care and adolescent health.** • **Strengthening the maternal morbidity (Obstetric Fistula, Cervical Cancer, Breast Cancer, Uterine Prolapse) related treatment, prevention and rehabilitation services with referral mechanisms.**
(b) Child Health
• **Expanding IMCI particularly community based IMCI including child nutrition services.** • **Tackling ARI and diarrhea through expansion of IMCI particularly at the community level to cover the whole country with special emphasis on hard to reach areas.** • **Ensuring growth promotion and monitoring with counseling on appropriate feeding practices through training and orientation.** • **Strengthening and sustaining of routine immunization and related surveillance activities together with Supplementary Immunization Activities (SIA), NID, Measles/MNT Campaigns etc.** • **Developing and implementing strategies to prevent childhood injuries including drowning, accidental poisoning and other injuries.** • **Sustaining and expanding the ongoing School Health Teachers' Training activities including healthy school environment, hand washing practices, nutrition education in school.** • **Carrying out appropriate training of the doctors, nurses, paramedics, FWVs and field workers as per need.**
(c) Reproductive and Adolescent Health
• **Improving knowledge of women, men and particularly the adolescents on reproductive health (RTI/STI, abortion, infertility, etc) including HIV/AIDS, relevant legal and gender equity issues through activities of DGFP and DGHS and MOWCA, MOYS, MOE and NGOs.** • **Increasing access to reproductive and adolescent friendly health services through the frontline health and family planning personnel and appropriate NGO workers at individual level, school based programs, Community Clinics, strong social/community mobilization and opening up adolescent corners.** • **Creating positive change in the behavior and attitude of the gatekeepers of adolescents (parents, guardians,**

teachers, religious leaders, Peers, etc.) towards adolescent RH issues.

- **Carrying out appropriate training/ orientation of service providers of health and family planning and community health workers.**
- **Implementing the National Reproductive and Adolescent Health Strategies along with targeted intervention for out of school adolescent boys and girls.**

The primary implementing OPs are OP (1) – Maternal Neonatal Child and Adolescent Health of the DGHS and OP (18)–Maternal Child and Reproductive Health of DGFP. These OPs describe activities that respond to the priority interventions identified in the HPNSDP. There are a number of priorities that demand inputs from other OPs including:

Cross-cuts

1) Training 3,000 midwives by the year 2015 as part of the scaling up of pre-service education and training to skilled health workers for MNCAH: *OPs - MNCAH, MCRAH, NIPORT, Directorate Nursing Services, Human Resource Management.*
2) Investing in infrastructures such that it remains fully functional and maintained: *OPs Physical Facilities Development and GoB Revenue fund for repair and maintenance of facilities*.
3) Achieving more functional referral systems linking communities with facilities using ambulances and local transport and ensuring timely availability of funds for emergencies: *OPs- Essential Services Delivery; Community-based Health Care, Hospital Services Management.*
4) Introducing strategies for local recruitment and retention including performance-based incentives for health care workers: OP *Human Resources Management*.
5) Strengthening the Health Management Information System for MNCAH: *OPs - Health Information System, Management Information System. Human Resources Management*.
6) Developing a universal registration system for all pregnant mothers and their newborns at the community level with electronic linkages to national population and health registries: *OPs – Essential Service Delivery, Community-based Health Care; Health Information Systems; Management Information Systems, MOLGRDC and BBS*.
7) Establishing maternal and peri-natal death review systems both at community and facility level: *OPs – Essential Service Delivery, Community-based Health Care, Hospital Services Management and MOLGRDC*.
8) Strengthening procurement systems for essential commodities/supplies: *Procurement Logistics and Supplies Management, DGFP, Procurement Storage and Supply Management, DGHS (CMSD).*
9) Promoting MNH services for urban slums, in collaboration with other health care providers including NGOs: *OPs- Essential Service Delivery, Health Economics and Financing, and MOLGRDC.*

3.3.2. Population and Family Planning

The HPNSDP identifies service delivery priority (Table 3.2) focuses on the extension of family planning services, increased usage of family planning before and after the first birth and the introduction, and the promotion and usage of Long Acting and Permanent Methods (LAPM) of contraception. Implementation of this strategic priority is under the responsibility of two OPs within the DGFP: i) Clinical Contraception Service Delivery (CCSD); and ii) Family Planning Field Service Delivery (FPFSD). The other OPs within the DGFP provide support to these services namely Planning, Monitoring and Evaluation, Management Information Systems, Information Education and Communication, Procurement, Storage and Supply Management and NIPORT OP-TRD.

Table 3.3.2. Population and Family Planning: lead OPs are CCSD and FPFSD with strong supportive functions in OPs PME-FP, MIS, IEC, PSSM-FP, and NIPORT.
Priority Interventions
(a) Population and (b) Family Planning Services
• **Promoting delay in marriage and childbearing, use of post partum FP, post abortion FP and FP for appropriate segments of the population.** • **Strengthening FP awareness building efforts through mass communication and IEC activities and considering local specificities.** • **Using different service delivery approaches for different geographical regions and segments of the population.** • **Maintaining focus on commodity security and ensuring uninterrupted availability of quality FP services closer to the people (at the CC level).** • **Registering eligible couples with particular emphasis on urban areas to establish effective communication and counseling.** • **Compensating for lost wages (reimbursement for opportunity costs) for long acting and permanent method contraceptive performance.** • **Strengthening FP services especially post partum and post abortion FP and demand generation through effective coordination of services with DGHS utilizing appropriate opportunities.**

Cross-Cuts

The following cross-cutting issues (and their corresponding OPs) have been identified as critical to successful implementation:

1) Public information, motivation and counseling campaigns: *Information Education and Communications*.
2) Human resources development, recruiting and posting of new manpower: *Human Resources Management, NIPORT.*
3) Strengthening information systems: *Management Information Systems, Health Information System and Sector-Wide Program Management and Monitoring.*
4) Linkages with urban health and family services: *Maternal Reproductive and Adolescent Health, Family Planning Field Services delivery, Maternal, Neonatal, Child and Adolescent Health Care (MNCAH); Essential Service Delivery and MOLGRDC.*
5) Intersectoral issues related to female education and employment: *Ministry of Education, Ministry of Women and Children Affairs*.

3.3.3.Nutrition and Food Safety

This strategic priority focuses primarily on mainstreaming of nutrition services with particular attention to: micronutrient supplementation; treatment of severe-acute malnutrition; promotion of good nutritional practices; linkages with other relevant sectors; and gender mainstreaming (Table 3.3.3).

Table 3.3.3. Nutrition and Food Safety: lead OP is NNS
Priority Interventions
(a) National Nutrition Service
• **Providing high potency Vitamin A supplementation and de-worming to children during measles vaccination and to children 1-5 years during national events and through fortification of food with vitamin A, iron and iodine for children.** • **Providing micronutrient supplementation to pregnant women (Iron folate), and Vitamin-A supplementation to mothers and neonates at postnatal period.** • **Providing nutritional counseling to the adolescent girls, pregnant and lactating mothers together with Vitamin- A supplementation of mothers and neonates at their postnatal period.** • **Ensuring management of severe acute malnutrition and other nutrition services at facility level.** • **Ensuring expansion of community based nutrition services through C-IMCI programs along with programs in Community Clinics.** • **Managing malnourished cases at community level, IYCF, etc.** • **Strengthening inter-sectoral collaboration and efficient program implementation.** • **Link nutritional counseling and supplementation with the DSF scheme.**
(b) Food Safety

• **Raising awareness of relevant stakeholders on food safety and hygienic practices including hand washing.** • **Developing a food safety policy along with the action plan for implementation.** • **Establishing a central food testing laboratory at IPH and strengthen capacity of scientists and technicians.**

It is led by a single OP – National Nutritional Services but is highly dependent on effective linkages with other OPs in the HPNSDP strategy and other ministries of the GoB. These have been identified in the Action Plan for Mainstreaming Nutrition Services. There are a number of cross-cutting issues related to the priority interventions that include:

Cross-Cuts

1) Effective integration of priority nutrition interventions across all service delivery intervention points of DGFP and DGHS especially *OPs Maternal Neonatal, Child and Adolescent Health, Essential Service Delivery, Community-based Health Care, Hospital Services Management, Maternal, Reproductive and Adolescent Health, and Family Planning Field Service Delivery.*
2) Strengthen human resources necessary for provision of nutrition services: *OPs In-Service Training and NIPORT.*
3) Establish effective facility and population-based nutritional surveillance: *OPs Maternal Neonatal Child, and Adolescent Health, Essential Service Delivery, Community-based Health Care, Health Information Systems; Management Information Systems; Communicable Diseases Control.*
4) Provide nutrition education: *OPs Health Education and Promotion, Information Education and Communication, Ministry of Education*
5) Strengthen intersectoral collaboration on nutrition and food safety: *MoFDM, Mo Agr; Mo FLS; MoWCA.*

3.3.4. Diseases Control Program

This strategic priority includes two broad areas: i) communicable diseases control (CDC) and ii) non-communicable diseases (NCD) (Table 3.4). CDC focuses on Malaria, Neglected Tropical Diseases (including Filariasis, Kala-azar and soil-transmitted helminthes) and outbreak of infectious diseases such as Avian Influenza. Though Tuberculosis, Leprosy and HIV/ STD are communicable disease, but considering their major public health challenges, these diseases have been addressed through separate programs.

Table 3.3.4. Diseases Control Program: lead OPs are TB-LC, NASP, CDC, NCD, NEC.
Priority Interventions
(a) Communicable Disease Control (CDC)
• **Pursuing quality DOTS expansion and enhancement and establish interventions to address HIV associated TB and drug-resistant TB.** • **Forging partnerships to ensure equitable access to an Essential Standard of Care to all TB Patients; engage people with TB, and affected communities.** • **Strengthening identification and treatment of Malaria cases especially in 13 highly endemic districts.** • **Promoting ITN/LLIN in endemic areas, with particular emphasis in the three CHT districts.** • **Strengthening diagnosis and management of NTDs along with control of other communicable diseases.** • **Providing support and services for high risk groups, address vulnerability to HIV infection, strengthen treatment services to people living with HIV and promote safe practices in the health care system.** • **Increasing provision of diagnosis and management of HIV/ AIDS and STD, and raise awareness, among women in particular.**
(b) Non-Communicable Disease Control (NCDC)
• **Strengthening BCC activities for prevention of NCDs, and diagnosis and management of kidney diseases, diabetes and arsenicosis patients in primary, secondary and tertiary hospitals.** • **Strengthening prevention awareness and diagnosis of CVD in all three tiers of facilities in the health system and treatment and management in secondary and tertiary hospitals.** • **Screening for early detection of cancer and strengthening diagnosis and management including palliative care of cancer patients in secondary and tertiary hospitals.** • **Implementing the strategic action plan on injury prevention, NCD and Tobacco Control.** • **Updating and implementing the National Eye Care Plan and strengthening and expanding Emergency Medical Services.**

NCD includes both "conventional NCDS such as cardiovascular disease, cerebrovascular disease, cancers, diabetes, arsenicosis, eye care, mental health, hearing disability and oral health; and "non-conventional NCDs"

including road safety and injury prevention; violence against women, emergency preparedness and response, occupational health and safety and tobacco control and substance abuse. There are 5 OPs directly responsible for the implementation of the Disease Control Program. They include: Tuberculosis and Leprosy, HIV/AIDS, Communicable Diseases Control, Non-Communicable diseases and National Eye Care. The activities across these OPs stress primary prevention and access to good quality chronic care. In order for these and other issues related to a comprehensive "program" for disease control to be addressed, an explicit program coordination mechanism will be developed across the 5 OPs.

Implementation of the Disease Control Program requires coordination with a number of other OPs to address cross-cutting issues that include:

Cross-Cuts

1) To support the development of effective integrated disease surveillance for communicable and non-communicable disease that is reliable, timely and accessible to program managers and policy-makers: OPs Health Information Systems, National Nutrition Services.
2) Human resource training and deployment: *OPs In-Service Training and Human Resources Management.*
3) Procurement of necessary laboratory, clinical and medical supplies: *OP Procurement, Logistics and Supplies Management.*
4) Behavior change communication and awareness for early detection and prevention of communicable and non-communicable diseases in the community, workplace and health facilities and to reduce stigma: *OP Health Education and Promotion; Essential Service Delivery, Hospital Service Management and MOLGRDC.*
5) Increase effectiveness of services in urban areas amongst high risk populations: *OP Essential Service Delivery and MOLGRDC.*
6) Manage interface of communicable and non-communicable diseases with nutrition e.g. TB, HIV, cardiovascular diseases, and diabetes mellitus: *OP National Nutrition Service.*
7) Promote inter-sectoral coordination and collaboration to deal more effectively with Most At-Risk Populations (MARPs): *MO Information, MOWCA, MOHome Affairs.*
8) Promote interaction between service providers in the public, NGO and private sectors to enhance quality and comprehensiveness of services: *OP Health Economics and Financing – public private partnerships.*

3.3.5. Environmental Health and Climate Change

The strategy related to Environmental Health and Climate Change focuses on emergency preparedness and response as well as mitigation and adaptation related to longer-term health effects of climate change. This component is included in the Non-Communicable Diseases in the DGHS.

Table 3.3.5. Environmental Health and Climate Change: Lead OP is NCD
Priority Interventions
• **Strengthening activities of the CCHP Unit to combat the health impact of climate change and updating guidelines for health protection from adverse effects and pre and post disaster situation.**
• **Developing an advanced preparedness plan to face the consequences of climate change.**
• **Standardizing emergency health supplies and their stockpiling as part of readiness program on climate change.**
• **Establish an institute for environmental and occupational health safety.**

Cross-Cuts

1) Training in disaster preparedness and response across the health sector: *OPs In-Service Training; Essential Service Delivery, Community Based Health Care; and linkages with Ministry of Disaster Management (MoDM).*
2) Prevention of malnutrition due to climate change: *OP National Nutrition Service; and linkages with Food Division.*

3.3.6. Disease Surveillance

This strategic priority aims to achieve a country-wide, comprehensive integrated disease surveillance system. To do so, it aims to build an apex institutional capacity in the IEDCR for integrated disease surveillance of communicable and non-communicable diseases (Table 3.3.6). The implementation of this function is described in the OP Communicable Diseases Control under the Disease Control Program.

Table 3.3.6. Disease Surveillance: Lead OP is CDC
Priority Interventions
• **Strengthen the capacity of IEDCR/ NIPSOM to carry out disease surveillance effectively.**
• **Preparing a Map of all major diseases for each district and Upazila.**

The HPNSDP recognizes that effective implementation of this strategic priority requires a "coordination" mechanism led by the DG, DGHS that identifies priority diseases for surveillance, roles, responsibilities and reporting relationships among the multiple individual organizations and agencies involved in disease surveillance. Specifically, the OP Health Information Systems of DGHS has been identified as providing equipment, software and training support to institutions involved in IDS. Further, the HPNSDP foresees engagement of public and private health facilities as well as teachers of primary schools, NGO workers and community volunteers in the IDS system.

Achieving these ends demands clear mechanisms for engaging resources of concerned OPs.

Cross-Cuts

1) Integration of diverse service delivery activities and diverse health information structures that will provide information related to disease surveillance: *OPs Maternal Neonatal, Child and Adolescent Health, Essential Service Delivery, Community-based Health Care, TB and Leprosy Control, National AIDS and STD Program, Communicable Diseases Control, Non-Communicable Diseases, National Eye Care, Health Information Systems, National Nutrition Services, Maternal Reproductive Adolescent Health.*
2) Public awareness and engagement in disease surveillance activities: *OPs Health Education and Promotion; Information Education and Communication.*

3.3.7. Alternative Medical Care

The HPNSDP aims to strengthen alternative medical care through the development of a national strategy that will develop clearer standards of care, licensing for AMC providers, and accreditation for AMC colleges and hospitals (Table 3.3.7). Its implementation is described in the OP on AMC (10) under the DGHS.

Table 3.3.7. Alternative Medical Care (AMC): Lead OP is AMC
Priority Interventions
• **Preparing a national AMC strategy to streamline AMC education, research, monitoring, training, etc.**
• **Strengthening outdoor services at the public AMC hospitals.**

Cross Cuts

Effective implementation requires engagement of functions found in other OPs including:

1) Infrastructure Development: *OP Physical Facilities Development.*
2) More effective integration of AMC services in health facilities: *OPs Essential Services Delivery, Community-based Health Care; and Hospital Service Management.*
3) Strengthen quality assessment of traditional medicines through the AMC Unit in DG Drug Administration: *OP Drug Administration and Management.*
4) Licensing of AMC providers and registration of AMC training by competent regulatory body/OP HRM

3.3.8. Behaviour Change Communication (BCC)

This service delivery priority (Table 3.3.8) is informed by two strategies: i) the National Health Education and Promotion Strategy; and ii) the National Communication Strategy for Family Planning and Reproductive Health. These strategies aim to promote health through changes in people's behavior using diverse



communications media. These strategies are implemented by two OPs: i) the Health Education and Promotion in DGHS; and ii) the Information, Education and Communication DGFP.

Table 3.3.8. Behavior Change Communication (BCC): Lead OPs are HEP and IEC
Priority Interventions
• **Promoting health, family planning and nutrition services through electronic and print media and motivational programs in the form of feature films, posters, local dramas, etc.** • **Producing and printing regionally focused BCC/IEC materials and distributing these materials at all facilities of health and FP services.** • **Providing need based BCC/IEC support in order to increase awareness and community participation.**

Cross-Cuts

1) Behavioral change communications and health promotion are integral parts of all health, family planning and nutrition services: *OPs MNCAH, ESD, CBHC, TB-LC, NASP, CDC, NCD, NEC, HSM, AMC, NNS, MCRAH, CCSD, FPFSD.*

Component B: Improving Service Provision

This component of the strategy describes the priority points of entry for inclusive and integrated services from the primary to the secondary and tertiary levels, the urban setting as well as with respect to providing services to the hard-to-reach and disadvantaged populations.

3.3.9. Primary Health Care:

The HPNSDP continues Bangladesh's long-term commitment to the principles of primary health care as articulated in Alma Ata in 1978, renewed with the Community Clinics strategy of the government articulated in the Sixth Five Year Plan. The provision of primary health care is described around three tiers: upazila, union and the community with linkages to the district as part of the public sector health service.

Table 3.3.9. Primary Health Care (PHC): Lead OPs are MNCAH, ESD, CBHC, MCRAH, FPFSD
Priority Interventions
(a) The Upazila Health System (UHS)+(b) Health Care at Union Levels+ (c) Community Health Care Service (CHCS)
• **Providing adequate human resources, drugs and equipment etc. through the Upazila Health System to the CC and the UHFWC.** • **Defining the referral and supervision linkages between the various levels of care (District, Upazila, Union and Community) and spell out the responsibilities among all actors and stakeholders in order to ensure the necessary 'unity of command'.** • **Defining the composition and tasks/responsibilities of the Upazila Health Management Committee (UHMC) with tasks in planning, budgeting, priority setting, implementation, supervision and reporting.** • **Developing a Capacity Building Program that prepares the committee members in managing the various (support) services in the UHC, the Union-level facilities and the Community Clinics.** • **Involving local government institutions and NGOs to support the CC Management Groups (CCMG) for stimulating informed demand, quality services and appropriate utilization along with accountability, particularly to the poor, women and elderly.**

The implementation of primary health care is not delegated to any single OP as virtually all OPs have an important front-line function. It draws more heavily on the Essential Services Delivery OP; and the Community-based Health Care 0P with strong links to the local level planning (LLP) functions found in the Planning, Monitoring and Research OP and the Planning, Monitoring and Evaluation OP of the DGHS and DGFP respectively.

The priority interventions identified for primary health care relate entirely to "how" services can be provided more effectively touching on challenges of ensuring adequate and efficient supplies and use of human resources; defining referral and supervision linkages, and strengthening management capacity (Table 3.9).

The complexity of effective implementation of primary health care is seen in the multiplicity of cross-cutting issues involving multiple OPs described below.

Cross-Cuts

1) Capacity development, management, retention and rational use of health workers: *OPs Maternal Neonatal Child and Adolescent Health, TB and Leprosy Control, National AIDS and STD Program, Communicable Diseases Control, Non-communicable diseases control, National Eye Care, In-service Training, Pre-service Education, National Nutrition Services, Maternal, Reproductive, Adolescent Health, Family Planning Field Service Delivery, NIPORT, Nursing Education, Human Resources Management.*
2) Reliable, timely procurement and supply of commodities: *OPs Procurement, Logistics, Supplies Management, Procurement, Storage, Supply Management.*
3) Primary health care in urban areas: *linkages with NGOs (HEF), and MOLGRDC.*
4) Tribal Health: OPs providing services (MNCAH, ESD, TB-LC, NASP, CDC, NCD, NEC, AMC, NNS, MCRAH, FPFSD) and MOLGRDC.
5) Mental health*: OP Essential Service Delivery, Non-communicable Diseases Control.*
6) School Health: ESD, *Mo Education.*
7) Medical waste management: *OP ESD, Hospital Service Management, MoEnv and MOLGRDC.*
8) Health promotion: *OPs Health Education and Promotion, Information, Education and Communication.*
9) Functional referral system: *OPs providing services (ESD, MNCAH, TB-LC, NASP, CDC, NCD, NEC, AMC, NNS, MCRAH, FPFSD), OP Hospital Services Management.*
10) Monitoring and Evaluation, Information Systems, e-health and records management: *OPs Health Information Systems, Management Information Systems; Communicable Diseases Control; NIPORT.*
11) Physical Infrastructure development: *OP Physical Facilities Development.*
12) Involving local government institutions and NGOs to support the CC management groups (CCMGs) for stimulating informed demand, quality services and appropriate utilization: *OPs Planning Monitoring Research; Planning Monitoring and Evaluation, Health Economics and Financing, CBHC.*

3.3.10. Hard to Reach Populations and the Disadvantaged.

The HPNSDP identifies "ethnic populations"; people with disabilities; the elderly, professionally marginalized; and the geographically and socially excluded as those requiring greater attention with respect to their health needs and access to services.

Table 3.3.10. Hard to Reach Populations and the Disadvantaged: Lead OPs numbers are: MNCAH, ESD, CBHC, FPFSD

Priority Interventions
• **Preparing a map of the hard to reach areas of Bangladesh and ensuring need based provision of HPN services for the hard to reach population through the GOB network where available. Motivating the service providers through counseling for giving adequate care to the marginalized and socially excluded group of population.**
• **Strengthening collaboration with the MOSW, MOCHTA, Hill District Councils, the CHT Board, the NGOs and the private sector to address the health service of the hard to reach population and the disadvantaged.**
• **Engaging locally available private individuals, social clubs, CBOs and NGOs by MOHFW for stimulating informed demand of the hard to reach population and ensuring quality health services and appropriate utilization.**
• **Providing essential service packages with support from NGOs/CBOs, due to shortage of public sector human resources, through agreed arrangements, in the hard to reach areas.**

Priority interventions provided by the Strategy included mapping areas of needs, and intersectoral collaboration with local development authorities and service providers (See Table 3.10).

In general, in the implementation of all of the OPs, attention to the needs of these sub-groups should be a priority. There are some OPs, however, where cross-cutting actions will be disproportionately important including:

Cross-Cuts

1) Information systems that can map, track, monitor and report on the needs of the hard to reach and disadvantaged populations: *OPs Communicable Diseases Control, Health Information Systems, Management Information Systems, Health Economics and Financing.*



2) Health promotion messages and behavior change mechanisms that are culturally sensitive and appropriate: *OPs Health Education Promotion; Information Education Communication.*
3) Design of facilities that are accessible and appropriate for persons with disabilities and the elderly: *OPs Non-Communicable Diseases, Hospital Services Management, Physical Facilities Development.*
4) Training and retaining health workers to work in remote areas and have competencies to deal with diverse populations: *OPs In-service Training, Nursing Education and Services, Human Resources Management.*
5) Effective collaboration with other governmental departments and local development authorities such as the MOSW; MOCHTA, the CHT Board, and NGOs: *OP Sector Wide Program Management.*
6) Effective out-sourcing of essential service packages to local NGOs/CBOs: *OP Health Economics and Financing*.

3.3.11. Secondary and Tertiary Health Care

Table 3.3.11 Secondary and Tertiary Health Care: Lead OP is HSM
Priority Interventions
• **Strengthening performance of secondary and tertiary level hospital services by deploying skill-mixed HR; introducing clinical protocols; equipping with modern equipment and diagnostic facilities.** • **Transforming existing hospitals into women friendly hospitals and improving EmOC services and the critical cares.** • **Establishing hospital accreditation, licensing and supervision of total quality management (TQM) in the public and private hospital services.** • **Developing and initiating a referral system among primary, secondary and tertiary hospitals and a performance based system for all service providers.** • **Establishing effective hospital waste management system (WMS).** • **Ensure provision of safe blood in the public and private hospitals.** • **Strengthening emergency services in public hospitals and make them available in all non-public hospitals.** • **Introducing evidence-based practice and risk management practices.** • **Strengthening the Management Committees at hospitals for better and effective service delivery including ensuring utilization by the poor and women.** • **Introducing hospital autonomy initially for the tertiary level specialized hospitals and gradually extending to medical college hospitals.**

Comprising district, divisional, medical college and specialized hospitals, this strategic priority aims to improve hospital services management, increase autonomy, strengthen licensing and accreditation, promote safe blood transfusion services, appropriate waste management and gender-sensitive provision of care (Table 3.11). The primary implementing responsibility is under the Health Services Management of DGHS. This OP will manage many of the priority interventions identified in the HPNSDP.

Effective implementation is contingent however on a number of cross-cutting issues that involve other OPs including;

Cross-Cuts

1) Recruit appropriate skill mix of health workers: *OP Human Resource Management*.
2) Timely and efficient procurement of supplies: *OP* Procurement, Logistics and Supplies Management (CMSD), Procurement, Storage and Supplies Management –FP
3) Construction, repair, maintenance of infrastructure: *OP Physical Facilities Development.*
4) Manage hospital autonomy – more decentralization to hospital manager including financial issues: *OPs Sector-Wide Program Management; and Human Resources Management.*
5) Retaining clinical staff: OPs *Human Resources.*
6) Ensuring appropriate referral across primary, secondary and tertiary care: *all service delivery OPs (MNCAH, ESD, CBHC, TB-LC, NASP, CDC, NCD, NEC, NNS, MCRAH).*
7) Appropriate waste management: linkages with MOENV and MOLGRDC.

3.3.12. Urban Health Service.

With the delegation of responsibility for urban health services to the Ministry of Local Government, Rural Development and Cooperatives, the HPNSDP identifies the need for an urban health strategy and urban health development plan that clarifies the roles and responsibilities of the MOHFW and the MOLGRDC (Table 3.3.12).

Table 3.3.12 Urban Health Service: Lead OP is ESD
Priority Interventions
• **Developing an urban health strategy and an urban health development plan in collaboration with MOLGRDC. The focal person for urban health in MOHFW will take the initiative.** • **Commissioning a study as how best the two Ministries can jointly assess, map, coordinate, plan and work together to provide quality HPN services for the urban population.** • **Establishing a permanent institutional arrangement governance mechanism incorporating relevant ministries, agencies and institutions with responsibility for urban health.** • **Expanding urban dispensaries for effective and quality PHC services (including services for reproductive health, nutrition and health education).** • **Defining an adequate referral system between the various urban dispensaries and the second and third level hospitals, and explore feasibility of introducing General Physician (GP) system.** • **Developing and utilizing urban HIS for effective management of urban health care.** • **Building capacity of the various service providers under MOHFW and MOLGRDC.** • **Determining the role and accountability of different NGOs and the private sector in the delivery of urban health. Formalizing relationships through PPP and diversification of health service delivery strategies.**

The OP Essential Service Delivery under component 3 is the designated structural home for urban health in MOHFW/DGHS with an urban health focal point sitting in the planning wing of the MOHFW (OP Sector-Wide Planning Management). Beyond these explicit designations, there is an implicit function of all service delivery OPs under DGHS and DGFP (MNCAH, CBHC, TB-LC, NASP, CDC, NCD, NEC, HSM, AMC, NNS, MCRAH, CCSD, FPFSD) to link to urban health, nutrition and family planning services. Important cross-cutting functions include:

Cross-Cuts

1) Managing appropriate referral across levels of care: *all service delivery OPs (MNCAH, ESD, TB-LC, NASP, CDC, NCD, NEC, NNS, MCRAH)* and Hospital Services Management.
2) Developing health information systems in urban areas: *OPs Health Information Systems, Management Information Systems; Communicable Diseases Control, Non Communicable Disease Control and MOLGRDC.*
3) Strengthen service provider skills, planning capacity and career plans of urban health personnel working in MOHFW and MOLGRDC: *OPs In-service Training; Nursing Education and Services; Human Resources Management; and MOLGRDC.*
4) Determining appropriate roles for NGOs and the private sector with agreements on public-private mix of health care in terms of quality and accountability: *Essential Service Delivery, OP Health Economics and Financing.*

Component C: Strengthening Health Systems

Component B of the HPNSDP identifies 14 health systems functions or issues that are required to strengthen the performance of the Bangladesh health sector.

3.3.13. Governance, Stewardship and Legal Framework

This strategic priority aims to strengthen overall governance and stewardship of the MOHFW to improve health sector performance with a focus on enhancing implementation of the Citizen's Charter for health, strengthening the effectiveness of national regulatory bodies, reviewing the capacity of the MOHFW Directorates (DGHS, DGFP and DGDA), and establishing a regulatory framework for NGO and private-sector health care provision (Table 3.3.13).

Table 3.3.13. Governance, Stewardship and Legal Framework: Lead OP is SWPMM
Priority Interventions
• **Assuming strategic stewardship and governance roles by MOHFW for policy management and setting up a coordinating system for synergistic, effective and efficient contribution from public and non-public including**



private sector and health related NGOs. • **Strengthening MOHFW's regulatory and supervisory roles through revising the mandates of the regulatory bodies and capacity building for enforcement of standards.** • **Facilitating and strengthening MOHFW's engagement with the NGO and private sector based on comparative advantage.** • **Reviewing and updating the existing health related legal frameworks to include the health consumer's rights in the Consumer Rights Protection Act (2009).** • **Constituting a Taskforce to assess the need for (1) new law/ordinance, (ii) revise any existing ones, and (iii) determining measures to improve existing legal framework.**

The stewardship and governance functions reside mostly in the OP Sector wide program management and hence it will take primary responsibility for implementing the priority interventions. Efforts to strengthen regulatory bodies related to health professionals (BMDC, BNC, State Medical Faculty (SMF)) are the responsibility of the OP Human Resources Management. Moving towards synergistic public-private provision of services is delegated to the OP Health Economics Financing.

3.3.14. Gender, Equity and Voice.

The HPNSDP adheres to the GOB priority to promote gender equity and will review and revise the existing "Gender Equity Strategy 2001" of the MOHFW relating it to OP level activities (Table 3.3.14).

Table 3.3.14 Gender, Equity and Voice: Lead OP is HEF
Priority Interventions
• **Mainstreaming GEV issues in all components of the sector program and ensuring adequate budget for these (at central and local levels).** • **Improving coordination on GEV issues through assigning and strengthening GNSP Unit as the focal point. Align GNSPU with other GOB as well as WID mechanisms.** • **Ensuring that GEV and accountability concerns are addressed in the objectives, activities and indicators of all OPs and in the overall results framework (RFW).**

The primary OP responsible is the OP Health Economics, Financing and GNSP. A strong focus on capacity development of service providers for GEV requires engagement of OPs In-service Training, Nursing Education and Services and Human Resources Management. Accountability through dedicated GEV indicators across all OPs in the results framework (RFW) will require attention from the OPs responsible for health information (OPs *Health Information Systems, Management Information Systems; Training, Research and Development, SWPM* .

3.3.15. Parastatal Organizations

Given the importance of parastatal organizations in strengthening stewardship and governance, the HPNSDP aims to review, update and revitalize their mandates and structures (Table 3.3.15). The priority for review and revitalization will emerge from the Joint Secretaries of MOHFW specifically Joint Secretary (Admin) (OP HR Management) and followed up by the concerned OP e.g. for the stewardship functions OP of planning wing - SWPM.

Table 3.3.15 Parastatal Organizations: lead OP HRM
Priority Interventions
• **Reviewing, updating and revitalizing mandate and structure of the regulatory bodies, to increase their effectiveness in strengthening government's stewardship functions.** • **Exploring requirements of setting new entities like accrediting bodies for medical education, hospital service delivery and for ensuring food safety.**

3.3.16. Non Governmental Organizations and Public Private Partnerships

Recognizing the significant and growing importance of NGOs in service provision, the HPNSDP aims to strengthen MOHFW engagement with the NGO and private sector (Table 3.3.16).

The primary implementing OP for this is the NGO cell of the GNSP Unit of the OP Health Economics and Financing for which the strategy recommends a reconstitution of its mandate to include private sector and public private partnership issues.

Table 3.3.16 Non Governmental Organizations and Public Private Partnership : lead OP is IFM
Priority Interventions
• **Strengthening NGO and private sector engagement based on comparative advantage.**
• **Reconstituting the current NGO Cell the GNSP Unit into an NGO and Private Sector Unit (NPSU) as focal point for NGO and PPP issues and development of a strategy for facilitating NGO and PPP participation.**
• **Constituting an advisory committee to provide policy guidelines and to oversee NGO and PPP related activities funded by MOHFW.**

3.3.17. Health Sector Planning, Budgeting and Health Financing

The HPNSDP groups five important functions under health sector planning and budgeting including: i) sector-wide planning and management; ii) decentralization; iii) monitoring and evaluation; iv) health sector financing; and v) health information systems.

3.3.17.1. ***Sector wide planning and management***

The Planning Wing (PW) of the MOHFW oversees sector wide policy, strategy, planning, budgeting, coordination and collaboration, and monitoring and evaluation. It is responsible for planning for the health sector including the preparation of PIP and providing guidance on the development of OPs by the LDs. The new HPNSDP aims to strengthen the planning process through the development of a new Coordination Section in the MOHFW that would join the Planning Wing and the Planning Units of DGHS and DGFP in an effort to produce a "single work plan". All proposed priority interventions in this area of the strategy (Table 3.3.17.1) would be undertaken by the OP Sector Wide Program Management with appropriate inputs from the DGHS, DGFP (OPs PMR-DGHS, PME-FP) and HEF of MOHFW.

Table 3.3.17.1. Sector Wide Planning and Management: Lead OP is SWPMM
Priority Interventions
• **Introducing joint review of non-development and development expenditure in the Ministry as well as in the Directorates on a monthly basis.**
• **Involving the field level cost centers in the preparation and management of development budget, similar to their current involvement in the preparation of non-development budget.**
• **Establishing new Coordination Section in the MOHFW and at the Directorate level to facilitate preparation and use of single work plan.**
• **Conducting a study to explore the possibility of financing the commonly funded items from a particular budget, either non-development or development.**
• **Reviewing periodically for making further improvements in work plan formats and procedures and link the Single Work Plan with LLP.**
• **Ensuring adequate flexibility by MOHFW in revising the OPs based on each year's APR and in inter and intra allocation and reallocation of development budget amongst the OPs.**
• **Reviewing and reaching agreement on the resource allocation formula, pilot sites, allocations for each pilot site and identification of additional funding, and mechanisms for accelerating local resource availability including new directives for financial delegation.**

3.3.17.2. ***Decentralization: the UHS and LLP***

Building on past efforts at decentralization of service delivery and delegation of planning, budgeting and management to the appropriate level, the HPNSDP aims to revise and update Local Level Planning (LLP) and to introduce changes in support systems that would enhance the likelihood of successful decentralization (Table 3.3.17.2).

Table 3.3.17.2 Decentralization: The UHS and LLP : Lead OPs are PMR-DGHS, PME-FP and SWPMM
Priority Interventions
• **Updating the LLP Toolkit reflecting the following changes: 3-year planning cycle; clearly spelt out responsibilities of the LLP Core Cell in arranging resource envelope and providing feedback to the local-level; budget demands as per OPs; complementation of goals and activities between the field-level services provided by the two Directorates; role of the community especially of the elected representatives of local government at Union and Upazila levels.**
• **Introduction of changes in the various support systems: (i) increased delegation of administrative and financial power to the cost centers, (ii) capacity building, including short training on administrative, management and financial management, (iii) developing performance indicators and evaluation mechanism, (iv) guidance and mentoring by the two Directorates and (v) meeting the needs for human resources, drugs and equipment.**

The primary OPs responsible include Sector-wide Planning Management, Planning Monitoring Research of DGHS; and Planning Monitoring Evaluation of DGFP. Mobilizing the support services necessary for decentralization would involve engagement of other OPs such as In-service Training/ TRD for short-term training on administration, procurement and financial management as well as Health Economics and Financing for resource allocation formulas.

3.3.17.3. Monitoring and Evaluation.

In response to prior reviews pointing to the limited capacity of the Monitoring and Evaluation Unit of the planning wing, the HPNSDP calls for the creation of a Program Management and Monitoring Unit (PMMU) to improve management, coordination, monitoring and evaluation of the HPNSDP (Table 3.3.17.3). The strategy also calls for a coordination committee to institutionalize the M&E functions in the MOHFW and to coordinate in relation to key information systems partners e.g. BBS.

Table 3.3.17.3 Monitoring and Evaluation : Lead OP is SWPMM
Priority Interventions
• **Establishing a program management and monitoring unit (PMMU), equipped with adequately skilled professionals and logistics in the PW of MOHFW for management, coordination, and monitoring and evaluation to track progress in HPNSDP.** • **Developing M&E Strategy and Work Plan to identify gaps, duplications and areas for improvement and streamlining the existing routine M&E system.** • **Investing to the direct improvement of the routine information of all MIS, including the regular production of meaningful quality data by all health facilities in the country and ensuring an effective involvement of all Directorates and the DMIS.** • **Developing a comprehensive capacity building plan comprised of courses and workshops to build M&E skills and capabilities at the central and OP levels.**

The SWPM OP is responsible for implementation. Alignment and improvement of routine information of all MIS requires involvement of all relevant OPs including Communicable Diseases Control, Health Information Systems, National Nutrition Service, Management Information Systems, TRD and Health Economics and Financing. Efforts to build comprehensive M&E capacity centrally and at OP levels will likely draw on OP SWPM. To coordinate the M&E functions among OPs of DGHS and DGFP the OPs PMR & PME will play vital role.

3.3.17.4. Health Sector Financing

The HPNSDP identifies three critical areas for improving the financing of the Bangladesh health sector including: i) active exploration of pre-payment systems that move away from out-of-pocket expenditure as the primary mode of finance for health care; ii) resource allocation to health facilities based on population needs; and iii) further development of incentives-based or "demand-side" financing (Table 3.3.17.4). The primary implementing OP is the Health Economics and Financing with significant participation of the MNCH and MCRAH in demand-side financing efforts. As recommended in the Aide-Memoire, the magnitude of the health financing challenge given trends in total health expenditure (more out-of-pocket and less from government) will require a concerted financing policy development process for universal health coverage that engages the Ministry of Finance and the MOLGRDC in addition to MOHFW as well as the private sector and development partners.

Table 3.3.17.4. Health Sector Financing: Lead OP is IFM, MNCAH and MCRAH
Priority Interventions
• **Reviewing different health financing instruments currently being discussed (demand side health financing, supply side financing, mixed systems, etc) on their inherent principles and in their capacity to contribute to an effective decrease of out-of-pocket expenditure and identify critical health financing constraints for their solutions.** • **Developing short and long term strategies to ensure access of the poor to quality health services, including joint development of agreed methodology on how to identify the poor.** • **Activating relevant task group that discusses the issues of health financing framework and review the weaknesses and strengths of the current national health financing system.** • **Reviewing and evaluating health financing approaches (e.g. role of pre-payment mechanisms (including community health financing), user fees (with and without retention), tax based financing, reallocation of health tax revenue for health sector, private sector financing and PPP, and various types of donor financing.** • **Scaling up on-going DSF program based on economic evaluation and review and piloting of new ones.**



3.3.17.5. Health Information Systems

The HPNSDP in adopting a results framework places a premium on the generation of comprehensive, high quality and timely information on health outcomes, delivery of health services and the tracking of administrative inputs. Priority interventions include an integrated HIS and strengthening routine health information systems (Table 3.3.17.5).

Table 3.3.17.5. Health Information System (HIS): lead OPs are HIS-EH and MIS
Priority Interventions
• **Designing an integrated HIS consolidating data from a range of sources to strengthen the national capacity to plan, monitor and evaluate progress of HPN services.** • **Strengthening the existing routine health information systems of DGHS and DGFP effectively, to ensure regular information flow and facilitate program monitoring.** • **Strengthening the ongoing e-Health initiatives by covering all the health facilities with adequate number of IT equipment, devices and trained human resources.** • **Encouraging participation of NGOs and private sector for innovation in the promotion of e-health services to achieve the long term deliverables of the National Guidelines.**

A number of OPs have important roles to play in the health information system integration including: Health Information Systems; Management Information Systems; Training, Research and Development, DMIS Unit of Sector-wide Program Management and Health Economics and Financing. Effective integration of HIS will require engaging other government Ministries and bureaus including; BBS, MOLGDRC, and development partners e.g. WHO, UNICEF/USAID/AusAID and others. Achieving the desired functionalities of the health information system requires a clearly designated leadership, an over-arching architecture of the health information system and the innovative use of e-technologies. DMIS under the Planning Wing will be linked to all existing MISs across the organizations of MOHFW and beyond. The strategy also calls for expansion of e-health capability to all health facilities through public-private partnerships for which OP Health Information Systems is the lead LD in implementation.

Cross-Cuts

1) *OPs Human Resources Management; Maternal Neonatal Child Health; Essential Services Delivery; Health Education Promotion; Information Education and Communication, National Nutrition Services; Non-Communicable Diseases; and Communicable Diseases Control.*
2) Establish an integrated data collection and flow model insuring interoperability and avoiding duplication in hardware/software procurement or data generation for all OPs generating health, health service, family planning and nutrition information*: all OPs.*
3) Promote training of staff across the MOHFW in HIS and IT: *In-service training; HIS and e-Health and TRD.*

3.3.18. Research and Development

In recent years, a National Health Research Strategy has been developed (January 2009) and a National Biotechnology Policy adopted (2006) with subsequent National Guidelines on Medical Biotechnology issued (2010). The HPNSDP recognizes these and recommends strengthening the BMRC – the primary stewardship institution for health research (Table 3.3.18). The BMRC is situated structurally in the OP Planning Monitoring and Research. There are, however, many other departments and institutions carrying out health research including NIPORT; IEDCR; Health Information Systems; Management Information Systems; Sector-wide Planning Management - DMIS.

Table 3.3.18. Research and Development (R&D): Lead OPs are PMR-DGHS and TRD
Priority Interventions
• **Strengthening BMRC after reviewing its mandate and structure for assuming strategic stewardship and governance roles for health related research.**

- **Conducting demographic behavioral aspects of family planning, reproductive health and nutrition program focused research / survey to strengthen the national program.**
- **Conducting national surveys: BDHS, BMMS, UESD surveys, facility survey, Urban Health Survey, etc. and disseminate the research findings to policy makers, program managers and researchers.**
- **Implementing medical biotechnology related activities based on the directives given in the National Biotechnology Policy and the National Guidelines on Medical Biotechnology.**

3.3.19. Human Resources for Health (HR), Training and Nursing Services

With the adoption of the Bangladesh Health Workforce Strategy by the MOHFW in 2009 a comprehensive HR action plan will be developed addressing diverse issues of shortages, mal-distribution of personnel, and skill-mix imbalance that constrain the effective provision of health services. The constraint of health workers and especially the relative absence of midwives have drawn attention with the present Government's commitment to train 3,000 Midwives by 2015.

In addition to addressing the health workforce challenges for the sector as a whole, the HR action plan also draws attention to the HR constraints in the Directorates of the MOHFW (HS, FP and DA) where there remain unacceptably high levels of vacant posts and shortages in key management cadres.

Priority interventions for this health system function of HPNSDP are organized according to the Pre-service education; In-Service Training; and Nurse/Midwifery Training (Table 3.3.19)

There are five OPs that deal directly with the implementation of HR strategy. These include i) In-Service Training; Pre-Service Training; Training, Research and Development where there is significant in-service training related to DGFP; Director Nursing Services; and Human Resources Management.

Table 3.3.19 Human Resources for Health (HRH), Training and Nursing Services

Priority Interventions
Strengthen Human Resources: lead OP is HRM
• **Developing and implementing a long term comprehensive Health Workforce Master Plan which has the provision of short, medium and long term interventions taking public, private and NGO sectors in perspective.** • **Scaling up production of the critical health workforce to minimize the immediate gaps.** • **Introducing specific incentives packages to deploy and retain health workforce in remote, rural and hard to reach areas.** • **Undertaking periodic comprehensive assessment of health workforce availability, requirements and gaps in all sub systems; measuring geographic, skill mix and gender inequalities; gather data on national and international migration, and accordingly producing and deploying the required health workforce in all places.** • **Creating a national health workforce career plan clearly describing staff development paths, promotion and deployment prospects for all types of health personnel and staff.** • **Working out mechanism to scale up Individual Performance Management System (IPMS) covering more and more health institutions/facilities; broaden concept of IPMS to transform it into Organizational Performance Management System (OPMS).** • **Improving capacity of all academic and training institutes in all required areas (quality teachers, laboratory, teaching facilities, automated library facilities, etc.) to train health personnel (nurses, midwifes, health technologists, medical assistants, community paramedics, family welfare visitors, Junior Midwives, Community Skilled Birth Attendants (CSBAs), Community Health Care providers (CHCPs), etc.).** • **Carrying out effective quality assurance scheme for medical education and training programs.**
In-Service Training (IST): Lead OPs are IST and TRD
• **Developing/ adapting comprehensive training curriculum and module(s) for training of trainers on relevant subjects and topics.** • **Establishing medico-legal and forensic medical services in the remaining district hospitals by providing training to the recruited staff.** • **Establishing a Health Management Institute/ National Academy of Health Management and Research center.** • **Strengthening NIPORT's facilities for effective in-service training of the FP personnel/ DGHS personnel.**
Nurse / Midwifery Services and Training: Lead OPs are NES & HRM
• **Reviewing and implementing the agreed upon actions for production of Midwives and CSBA.** • **Streamlining the recruitment and promotion rule of the nursing services and post/ recruit/promote staff as per standard.**

• **Increasing capacity of the Bangladesh Nursing Council to enable it to monitor all the nursing institutes and colleges in the public as well as in the private sector.**

The HRM is part of the Administration Wing of the MOHFW and focuses on the HR action plan preparation and coordination; health workforce financing and management; enhancing quality of education and training; and monitoring performance of the health workforce with an HR information system.

Given the centrality of the health workforce and staffing to all OPs, the implementation of this part of the strategy relies heavily on effective mechanisms to work across the OP structures with mechanisms to minimize duplication. Responding to the Prime Minister's priority for scaling up midwifery training, for example, requires a concerted agreement across four operational plans: Maternal Neo-natal Child Health; Maternal, Reproductive Adolescent Health; Nursing Education Services and Human Resources Management with a clearly defined focal point. Implementation is also contingent on more effective linkages with the public and private sector training institutions that do not fall directly under the authority of the government Line Directorates such as BSMMU, BCPS, etc.

Cross-cutting

1) Managing public-private-NGO links in health workforce master-plan as it pertains to education: *OPs Sector-wide Planning Management.*
2) All health, family planning and nutrition services must interact with In-Service Training and NIPORT to agree on agenda and priorities for in-service training: *OPs (MNCAH, ESD, CBHC, TB-LC, NASP, CDC, NCD, NEC, HSM, AMC, PMR-DGHS, HIS-EH, HEP, PLSM-CMSD, NNS, MCRHAH, CCSD, FPFSD, PME-FP, MIS, IEC, PSSM-FP, SDAM, PFD, HRM, SWPMM)* .
3) Assessing performance of health workforce and the establishment of an HR information system: *OP Health Information System.*
4) Strengthening research activities for post-grad students and developing medical biotechnology: *OPs Planning Monitoring Research, Health Information Systems.*
5) Improving health education institution capacities and laboratory, teaching facilities: *OP Physical Facilities Development.*

3.3.20. Quality Assurance Standards and Regulation

The HPNSDP identifies improvement of quality of services in hospital facilities as a priority. This includes priority interventions aimed at improving diagnostic facilities, strengthening the quality assurance committees; conducting patient and provider satisfaction surveys; updating SOPs in hospitals and developing a national quality assurance policy (Table 3.3.20). The primary OP for implementation of these priorities is OP Hospital Services Management in DGHS and OP Clinical Contraceptive Services Delivery in DGFP.

Table 3.3.20 Quality Assurance, Standards and Regulation: Lead OPs are HSM & FPFSD
Priority Interventions
• **Improving quality of diagnostic facilities and services at both public and private hospitals.**
• **Improving functioning of the National Steering Committee (NSC), National Technical Committee (NTC) and Quality Assurance Task Group (QATG) and strengthen the functional Quality Assurance system.**
• **Conducting regular client and provider satisfaction surveys in primary, secondary and tertiary level health facilities.**
• **Updating existing Standard Operational Procedures (SOPs) along with standard clinical and operational protocols to be practiced in all hospitals both public and private.**
• **Developing a national quality assurance policy and strategy for primary, secondary and tertiary level health care services.**

3.3.21. Drug Administration and Regulation

Through the Directorate General Drug Administration, the HPNSDP identifies priority interventions aimed at establishing international standard drug/vaccine testing laboratories; creating a monitoring cell for drug information and adverse drug reactions; training staff in quality assurance of drugs; and updating the National

Drug Policy (Table 3.3.21). The priority interventions are implemented through the OP Drug Administration and Management.

Table 3.3.21 Drug Administration and Regulation: Lead OP is OP-SDAM
Priority Interventions
• **Establishing a modern drug / vaccine testing lab to meet international standards at central level. Expand these lab facilities gradually to regional/district levels.** • **Establishing Drug Information and Adverse Drug Reactions Monitoring Cell within the DGDA for Rational Use of Drugs.** • **Strengthening field monitoring and quality assurance of drugs through staff training.** • **Updating the National Drug Policy for ensuring quality drugs in the market.**

3.3.22. Procurement and Supply Chain

The HPNSDP builds on recent efforts to strengthen procurement performance including the establishment of the "Procurement and Logistics Management Cell (PLMC) and its links to the PLSM of DGHS and PSSM of DGFP. Priority interventions relate to strengthening contraceptive procurement and distribution; on-line procurement tracking and automated store management systems (Table 3.3.22). The responsible OPs include PLSM; PSSM.

Table 3.3.22 Procurement and Supply Chain Management : Lead OPs are PLSM-CMSD and PSSM-FP
Priority Interventions
• **Ensuring efficient, timely and transparent procurement and distribution throughout the year to prevent stock-out of contraceptives DDS kits, Medical and Surgical Requisites (MSRs), equipment etc.** • **Ensuring an efficient storage, inventory, supply and distribution chain and utilization of procured goods and logistics.** • **Facilitating an efficient on line procurement tracking and automated store management systems.** • **Exploring options of e-procurement and framework contracts.** • **Building up capacity for procurement and strengthen monitoring and establish accountability of the procured goods and logistics.**

3.3.23. Physical Facilities and Maintenance.

Expansion of health services entails expansion of physical infrastructure and the HPNSDP identifies three strategic priorities in this regard: i) to build new infrastructures; ii) to make facilities user-friendly; and iii) to plan for the repair and maintenance of health facilities, equipment and vehicles (Table3.3.23). The OP responsible for implementation is Physical Facilities Development through the Health Engineering Department (HED) of the MOHFW and Public Works Department (PWD) under the Ministry of Housing and Public Works. The summary OP in addition to responding to the priority interventions draws attention to the need for strengthening the HED in terms of the numbers of workers, relative shortages in key areas, mobile maintenance teams, and the absence of an office building of its own.

Table3. 3.23. Physical Facilities and Maintenance: Lead OP is PFD
Priority Interventions
• **Mapping out the need for new constructions and that for upgrading of health facilities.** • **Designing need based user and women friendly health facilities.** • **Preparing a comprehensive plan for repair and maintenance of health facilities, equipment and vehicles along with budget requirement.**

A key concern with implementation of physical facilities, particularly new buildings, relates to their timely and functional occupancy. This requires coordination with other OPs related both to priority services as well as systems supports such as procurement (PLSM, PSSM-FP) and human resources management.

3.3.24. Sector-Wide Management and Coordination

Under this section of the HPNSDP four strategic areas are identified including: i) Sector reforms; ii) Institutional and multi-sectoral collaboration; iii) Aid effectiveness; and iv) Aid alignment and harmonization. The lead implementation OP for all of these areas is the sector wide program management.

3.3.24.1. ***Sector Reforms.***

The HPNSDP articulates 8 service delivery, 4 service provision and 14 health systems priorities bound by measureable targets as part of a Results Framework (RFW). This plan is translated into action through 32 operational plans briefly described in this Project Implementation Plan (PIP). It is the Planning Wing of the MOHFW that leads the development of this strategic plan through a consultative process with all relevant stakeholders.

3.3.24.2. ***Institutional and Multi-sectoral collaboration***

The HPNSDP recognizes the importance of other ministries, private and non-state health services, and various other non-governmental actors that contribute to health and upon whom successful implementation of the strategy is contingent. A variety of mechanisms are identified in the SWPM OP (30) component on collaboration and coordination. An inter-ministerial committee under the chairmanship of the honorable Minister of Health and Family Welfare will be formed to serve a forum for coordinating the related inter-ministerial activities.

3.3.24.3. ***Aid Effectiveness***

Commitment to the principles of aid effectiveness as codified in the Paris Declaration by both the MOHFW and the DPs will be pursued through a sub-group on health of Local Consultative Group as a meeting point of the senior management of the MOHFW and the DPs. A "code of conduct" as part of the Joint Financing Arrangement (JFA) that specifies the responsibilities and obligations of both MOHFW and DPs will be agreed within the first year of the HPNSDP.

3.3.24.4. ***Aid Alignment and Harmonization***

Given continued diverse practices and fragmentation amongst DPs in providing support to the health sector in Bangladesh, there will continue to be on-going dialogue to achieve greater consensus on harmonization and alignment following Joint Cooperation Strategy as agreed upon by both GoB & DPs. A harmonization manual could be developed in consultation with DPs.

3.3.24.5. ***SWAp Arrangements and DP Coordination***

A number of different mechanisms are planned to establish a functional system of coordination in implementation of the HPNSDP. Inter-Ministerial Coordination will be maintained through the Secretary's Committee Meetings with regular inter-ministerial meetings. A separate coordination mechanism will be established with the MOLGRDC related to urban health. The LCG sub-group on Health will provide regular interaction between the MOHFW senior staff and the DPs in the health sector. A number of Task Groups are foreseen related to MNCH, Nutrition, Public Health, M&E, HRH, HFRG, Procurement, Financial Management and Gender, Equity, and Voice and QM. An annual, independent, external review of the HPNSDP will be conducted annually (APR) and at mid-term (MTR) to inform revisions to OPs in line with the revised PIP and inform policy dialogue and the development of an agreed joint action plan (Aide Memoire) by the MOHFW and DPs. The Aide Memoire is used for the new annual work plan along with the budget (ADP) relating to the OPs. All of these mechanisms are implemented by the coordination and collaboration component of the OP Sector-wide Program Management (30).

3.3.25. Financial Management.

Despite improvements over the course of the first two sector programs (HPSP and HNPSP), Financial Management remains a critical area in the SWAp implementation process. Beyond the financial management



arrangement related to DPs support of the HPNSDP, the sector strategy attaches considerable importance to strengthening transparency, accountability, reporting, internal control and audits, efficiency, monitoring and oversight systems for the next sector program. The Improved Financial Management activities lie in the Financial Management and Audit Unit (FMAU) of the MOHFW

3.3.25.1. Funding modalities

The pooled fund modality of the HNPSP will continue but with changes that will enhance efficiency and increase harmonization (see Table below).

Table 3.3.25.1 Financial Management: Lead OP is HEF

Priority Interventions
• **The current system of separate reporting and tracking of pool funds practice decreases government ownership in the program and increases both time and transaction costs resulting in slow implementation progress, which needs to be changed in the next sector program.**
• **In the first year of program implementation, the pool funds disbursement by the WB may be made for three quarters at a time (based on OP wise RPA allocation in the ADP).**
• **The disbursement of 4th quarter RPA funds by the WB will require financial monitoring reports (FMRs) with reconciliation of disbursed funds up to the 2nd quarter in each year.**
• **The following years' disbursement of pool funds for up to the 3rd quarter will be made by the WB upon receipt of the FMRs with total reconciliation of previous year's disbursed funds.**
• **Pool funds disbursement for the last year of the Program will be made by the WB on a half-yearly basis and subject to receipt of the FMRs with reconciliation of funds disbursed in each case.**
• **Currently the government is heavily dependent on IDA for clearing the procurement documents above the threshold of US$ 300,000 which will likely to be raised to an acceptable amount to save transaction costs and shorten document processing and procurement time.**
• **A mapping of current GOB procurement practices would be done in order to establish the effectiveness of the system in terms of making efficient and transparent procurements. If procurement system to a large extent achieves good practices, in future GOB systems could be entirely used to process transactions.**
• **The possibility of using framework contracts will also be explored by the MOHFW in order to minimize procedural delay in procurement. Once a framework agreement is reached, this allows the government to use the supplier till the agreement time expires. This will reduce both procurement time and administrative cost as the MOHFW will not have to go through the procurement procedure again and again during the framework contract period.**
• **A fiduciary risk assessment of the financial management system of the MOHFW will be carried out during implementation of the next sector program, before firm decisions can be made on the choice of the best future funding modality. This will help all stakeholders to make (jointly) a better informed decision.**

3.3.25.2. Fund Management

All funding to the HPNSDP designated FOREX Account in Central Bank" will be recognized as "Pool Fund". This includes all of the IDA credit, MDTF and other DPs' funding to this account. It is agreed that the World Bank will continue to manage the pool fund for the HPNSDP. Identified deliverables related to financial management and procurement issues would be stipulated by Government of Bangladesh, Pooling Partners and the World Bank. A "Joint Financing Arrangement" will articulate the visions, principles, objectives, roles and responsibilities for the Pool Funding Mechanism as well as describe arrangements for non-pool funding. A Pooled Fund Management Committee will oversee the pooled fund and will be composed of members from MOHFW and DPs contributing to the pooled fund.

The Disbursement for Accelerated Achievement of Results (DAAR) approach for IDA part of the pooled fund will build on the experience and lessons learned from the Performance-Based Financing (PBF) modality of the HNPSP. This allows the MOHFW to font-load funds from year five to the first four year of implementation upon attainment of agreed targets that demonstrate accelerated achievement of program results and satisfactory levels of expenditure in a given year. The disbursement against the achievement of targets relies heavily on agreed and verifiable DAAR indicators of performance.

3.4 Technical Assistance

There is recognition that implementation of the HPNSDP may be enhanced by the appropriate sourcing of Technical Assistance (TA) (including technical cooperation) from national and international consultants to support the MOHFW with implementation of the sector plan. A coherent multi-year integrated and consolidated technical support plan is being developed to support the MOHFW in program implementation and in carrying out the agreed upon policy reforms. This plan is a consolidation of TA/TC supports provided separately by several DPs with the aim of coordination with the MOHFW to ensure effectiveness and responsiveness of technical supports to the diverse and evolving program needs.

3.5 Procurement Management

Procurement management is a critical cross-cutting function in the implementation of the HPNSDP as it has been in previous sector plans. Recent assessment by the World Bank concludes that CMSD, DGFP Procurement and Logistics Unit and HED along with the MOHFW are considered agencies with good procurement capacity. Other agencies including NASP, CDC, NNS and ESD are in need of further capacity development. Measures to mitigate risk in procurement management have been agreed that include: i) designated procurement focal points (PFP) from each agency; ii) an initial 18 months procurement plan; iii) use of Procurement Management Information System (PROMIS) and regular reporting to DPs; and iv) the establishment of the Procurement and Logistics Management Cell (PLMC). The role of the PLMC is to promote the stewardship role of the MOHFW to provide quality assurance and control to procurement plan preparation, bidding documents preparation and bid evaluation and overseeing, with terms of reference agreed with the DPs. The PLMC is also required to support the contracting out of consultants and non-consultancy services. As the capacity of other procuring entities is developed, they will be assessed and may be included based on the results of this assessment. Mitigating measures during implementation include: a training plan for systematic capacity building of staff handling procurement; quarterly PROMIS status reports to DPs; the roll-out of e-GP; standardized bidding documents; annual independent procurement audits; and World Bank review of 20% of the post review contracts to check compliance with the Bank's Procurement/Consultant Guidelines.

3.6 Macro-level considerations in implementation.

The mapping of strategic priorities onto the OPs indentifies an important set of challenges related to implementation that will need to be managed both within and across OPs. When looking at the implementation of the whole strategy, however, there are a further set of challenges to implementation that will require concerted attention. These challenges reflect a number of factors including:

- structural parallelism emerging from the overlap between DGHS and DGFP with duplicative functions such as two national strategies on behavior change or parallel facilities and workforces at local levels;
- heavy demands on the common cross-cutting health systems supports that are likely to surpass the ability of the health systems support OPs to respond effectively. These include: financial management and procurement; in-service training and technical assistance; pre-service training; human resources management; and health information systems;
- many of these health systems support functions are covered by multiple OPs e.g. information systems includes 5 different OPs, and thus require further designation of leadership and coordination among them in order to use resources and respond to demands most efficiently.
- complex integrative functions such as "referral" between levels of care that demand systems-wide changes in behavior inclusive of virtually all OPs but that lack clear mechanisms;
- multi-sectoral challenges e.g. urban health that are designated as priorities but lack crucial details related to public-private mix, the health workforce or other health systems functions such as financing;
- highest level political priorities such as maternal child health, the community clinics or midwifery training where expectations for action are paramount;



- capacity to mobilize for emergency implementation challenges e.g. response to geo-climactic catastrophe or outbreak illness;
- The mismatch between clearly defined implementation mechanisms related to the pooled funds and their minority role in financing the health sector in contrast with the virtual absence of implementation mechanisms required for more progressive national financing arrangements for health.

For these issues to be appropriately managed, new "institutional arrangements" are necessary that most often lie outside the pre-existing foundational structures of the MOHFW. The implementation plan must find ways to accommodate these challenges as failure to do so may jeopardize implementation in areas where mechanisms are much better established.

3.7 Coordination Mechanism in HPNSDP

Development of the health sector requires direct involvement, interaction and collaboration with policies and programs of other ministries, agencies and a variety of different role players, viz., (a) government ministries and agencies, (b) private and other non-state health service providers, (c) implementing level coordination among line components of respective OPs, and (d) professional associations, mass media, community organizations and various other non-governmental actors contributing to health sector's development. The feasibility of such collaboration will be addressed during HPNSDP with TA support to institutionalize the roles and responsibilities of various actors.

Establishing a functioning system of coordination among health, nutrition and family planning and between other Ministries (notably MOLGRDC) at all relevant levels of service delivery, including DPs and UN agencies, NGOs and the private sector will be required to avoid duplication and diversify service delivery and to enhance performance. MOHFW will continue its effort to strengthen inter-ministerial coordination through the Secretary's Committee Meetings and holding inter-ministerial meetings at a regular interval. Moreover, a separate coordination mechanism will be developed during the HPNSDP implementation with the MOLGRDC for improving the urban health service in Bangladesh.

Some important coordination mechanisms under the HPNSDP will be as follows:

1. Inter-Ministerial Co-ordination: An inter-ministerial committee under the chairmanship of the Honorable Minister for Health and Family Welfare would be formed to serve as a forum for coordinating the activities of all relevant ministries for issues of tribal health, urban health, nutrition such as MOCHTA, LGD, Food Division, MOSW and others.
2. Donor Co-ordination: Through LCG Sub-Group headed by the Secretary, MOHFW will coordinate the donor activities. SWPM-OP will be the lead OP for donor coordination.
3. Inter-Agency Co-ordination: Structural parallelism emerging from the overlie between DGHS and DGFP with duplicative functions in the areas of MNCH, BCC, MIS, same purpose parallel facilities as well as workforces and others is a great concern for coordination between two agencies. The current MNCH, BCC, MIS services will be reviewed to maximize the efficiency and effectiveness of services. For this, a detailed guideline will be prepared for functional coordination of MNCH and other services, incorporating expertise and facility sharing between DGHS and DGFP. In addition, there will be joint finalization of the potentially overlapping activities in OPs of the two agencies to ensure avoidance of duplication of resources. During implementation of the HPNSDP, an Inter-Agency Coordination Committee (IACC) will be formed headed by Secretary, MOHFW including the representatives from MNCAH, MCRAH, HEP, IEC, ESD, CBHC, FSDP, MIS, SWPMM OPs, with specific TORs related with overseeing the status of coordination and providing necessary guideline. A Technical Working Group (TWG) like PMMU will chalk out an action plan of the related OPs and identify challenges both within and across OPs related to coordination in implementation that will be placed as an agenda for discussion in IACC. At Division and District level, Divisional and District Program Coordination Committee representatives from the two parallel agencies will work to establish coordination amongst these agencies at the local level.



4. Inter-OP Coordination within Agency:

a. The three OPs under DGHS such as MNCAH, ESD and CBHC focus on delivery of the primary health care services particularly at the Upazila and below level. This in fact divides the PHC implementation into three separate LDs where coordination during implementation will be critical. Through the office of the Director-PHC, DGHS which will minimize the gap between MNCAH and ESD –OP will be minimized during implementation. To synchronize the inter-OP operation and maximize coordination, Director-PHC will be made LD of MNCAH and a senior level DD will be assigned to a post under Director (PHC), DGHS who will be given the responsibility of the LD for the ESD-OP thus ensuring these two OPs' implementation under the Director (PHC). The coordination of CBHC with those two OPs will be ensured through Upazila Health System, with referral linkages to service delivery issues such as BCC, Nutrition etc. A technical committee including representatives from concern sector Planning Commission and IMED will be formed to guide coordination among these OPs with defined TORs to improve coordination in this regard.

   The management issues of the CCs and its relation with UHFWCs and UHCs has been elaborated in a handout issued by MOHFW on 22.02.2011**(Annexure-S).**

b. An inter-wing coordination mechanism among the PFD, HSM, HRM and SWPM –OPs for making health facilities functional a High Level Committee to ensure synchronization of new/upgraded facilities within time provision of manpower, supplies and logistics.

c. National Nutrition Services (NNS) will be anchored at the Institute of Public Health Nutrition (IPHN) under DGHS and a Medical Officer of UHC will have a new designation as MO (Public Health Nutrition) for nutrition related activities. To facilitate coordination of NNS with the MCRAH-OP under the DGFP a DD level official from DGFP will be deputed to NNS full-time and he/she will be given responsibilities to establish bridges the NNS activities with the DGFP. MO (MCH) will be given responsibilities for nutrition services at the Upazila level activities. All parallel staff at the facilities under DGSH and DGFP will consider for the issues of parallelism for nutrition activities.

d. Many of the health systems support functions are covered by multiple OPs e.g. information systems includes 5 different OPs, and thus require further designation of leadership and coordination among them in order to use resources and respond to demands most efficiently. A national M&E Coordination Committee headed by Additional Secretary, MOHFW will oversee all survey, studies and review the MIS system regularly. Proposed PMMU will regular coordination across different MIS.

e. Foreign training under different OPs will be coordinated by JS (WHO) and recommended by the Standing Committee of the MOHFW. Joint Chief (MOHFW) shall be engaged with the committee to make synchronization planning with implementation of training opportunities.

f. Heavy demands on the common cross-cutting health systems supports that are likely to surpass the ability of the health systems support OPs to respond effectively. These include: financial management and procurement; in-service training and technical assistance; pre-service training; human resources management.

3.8 Monitoring Implementation of the HPNSDP

The HPNSDP is strongly linked to the achievement of results as defined by the Results Framework (RFW) **(Appendix of PIP-Vol I)**. Each OP has identified a set of indicators to monitor implementation. These indicators draw on the conceptual basis of results framework (RFW) insofar as they monitor inputs, processes, outputs, outcomes and impacts. Monthly ADP meetings at the MOHFW will review OP implementation. RFW

indicators will be monitored every 6 months. This will require the production of a report drawing on the OP results indicators. The centrality of indicators for monitoring implementation is further emphasized through the Performance Based Financing framework that provides Disbursements for Accelerated Achievement of Results (DAAR) (**Annexure-B)**. In responding to the demand for monitoring implementation, OPs are using SMART criteria (specific, measureable, attainable, reliable and time bound) to identify appropriate indicators. The results and performance priority of the strategy places a premium on the capacity to generate these data and as such underlines the importance of adequate investment in health information system platforms and their effective coordination. PMMU will be responsible to coordinate and monitor the above mentioned issue as an institute outside the existing structure of MOHFW to provide technical assistance.

3.9 The proposed 32 Operational Plans and designated / proposed Line Directors based on its management structure during the HPNSDP period (2011- 2016)

The table below shows the name of the Operational Plans and proposed Line Directors for the HPNSDP:

Sl. No.	Name of the Operational Plan	Line Directors
Directorate General of Health Services		
1	Maternal, Neonatal, Child and Adolescent Health	Director (PHC), DGHS
2	Essential Services Delivery	Director, DGHS (On Deputation)
3	Community Based Health Care	PD, RCHCIP
4	TB and Leprosy Control	Director (MBDC), DGHS
5	National AIDS And STD Program	Director, DGHS (On Deputation)
6	Communicable Diseases Control	Director (Disease Control), DGHS
7	Non-Communicable Diseases	ADG (Planning and Research), DGHS/Director, DGHS (On Deputation)
8	National Eye Care	Director, NIO
9	Hospital Services Management	Director, Hospital & Clinics, DGHS
10	Alternate Medical Care	Director (Homeo & Traditional), DGHS
11	In-Service Training	ADG(Admin), DGHS
12	Pre-Service Education	Director (Medical Education), DGHS
13	Planning, Monitoring and Research (DGHS)	Director, Planning , DGHS
14	Health Information Systems and E-Health	Director (MIS), DGHS
15	Health Education and Promotion	Chief, Bureau of Health Education DGHS
16	Procurement, Logistics and Supplies Management (CMSD)	Director, CMSD, DGHS
17	National Nutrition Services (NNS)	Director, IPHN, DGHS
Directorate General of Family Planning		
18	Maternal, Child, Reproductive and Adolescent Health	Director (MCH-Services), DGFP
19	Clinical Contraception Services Delivery	Dy. Director (Services), DGFP
20	Family Planning Field Services Delivery	Director (Finance), DGFP
21	Planning, Monitoring and Evaluation of Family Planning	Director, Planning, DGFP
22	Management Information Systems	Director(MIS), DGFP
23	Information, Education and Communication	Director (IEM), DGFP
24	Procurement, Storage and Supplies Management -FP	Director, Logistics, DGFP
25	Training, Research and Development	DG, NIPORT
Other Agencies		
26	Nursing Education and Services	Director, DNS, MOHFW
27	Strengthening of Drug Administration and Management	DG, DGDA, MOHFW
Ministry of Health & Family Welfare		

Sl. No.	Name of the Operational Plan	Line Directors
28	Physical Facilities Development	Joint Secretary (Development & ME), MOHFW
29	Human Resources Management	Joint Secretary (Admin), MOHFW
30	Sector-Wide Program Management and Monitoring	Joint Chief (Planning)/Deputy Chief (FW/Health), MOHFW
31	Improved Financial Management	Joint Secretary (Financial Management & Dev), MOHFW
32	Health Economics and Financing	Joint Chief, HEU, MOHFW

The Line Directors (LDs) are the key managers responsible for successful implementation of the respective OP activities resulting in improved performance of the HPN sector development. The LDs, in addition to respective technical training, will also be provided regular short training for their skill development in the areas of management principles and practices, improved financial management, procurement, performance audit, policy planning procedure of GoB, monitoring and reporting, etc.

CHAPTER IV: PROGRAM DESCRIPTION

A. DGHS

4.1. Maternal, Neonatal and Child, Adolescent Health Care (MNCAH)

4.1.1. Introduction

Maternal, newborn, child and adolescent reproductive health care are closely inter-related, and many interventions are delivered simultaneously and co-jointly. Overall, Bangladesh is on track to achieve major health related MDGs. Maternal mortality ratio has significantly declined from 574 in 1990 to 320 in 2001 and concurrently it further declined to 194 in 2010 (BMMS-2010) per 100,000 / LB. So it is to be ensured that Bangladesh is on track to achieve MDG-5. But skilled birth attendance during pregnancy, childbirth and post-natal period including PAC remain as critical issues. The incidence of births to adolescent mothers remains high, with 33% of women beginning childbearing when they are in their teens and are at higher risk of pregnancy complications and death. 70% of mothers suffer from nutritional anemia.

Bangladesh has succeeded in reducing under-5 mortality by 60%, from 146 deaths per 1000 live births in 1991 to 65 in 2007, far outstripping the developing country average of 28% and setting it on track to meet or exceed MDG-4. Bangladesh is one among only 19 countries that are on track and it has the highest rate of decline among low income countries. The reduction of maternal mortality has been achieved with strong government commitment through national policies and Program implementation. In particular, there been fewer deaths due to FP services resulting in low fertility, expansion of female education, safe MR services, improving access to CEmOC facilities, SBA services.

Factors contributing to rapid decline in under-5 and infant mortality include impressive gains in selected health indicators /coverage of interventions e.g. use of ORS, vitamin-A supplementation, EPI, IMCI (facilities and community) etc.

4.1.2. Objectives

- To Improve maternal, newborn & child health (MNCH) status of the population in Bangladesh through increased coverage and utilization of the quality MNCH services at facility and community level.
- To ensure 24/7 EmONC services at the upazila level in phases.
- To establish a functional referral system from community level to health facility level.

4.1.3. Components

1. Maternal and Neonatal Health (MNH)
2. Integrated Management of Childhood Illness (IMCI)
3. Expanded Program on Immunization (EPI)
4. Reproductive and Adolescent Health
5. School Health

Component-1: Maternal and Neonatal Health (MNH)

Improvement in maternal and newborn health cannot be achieved by vertical interventions. It requires a coordinated systems approach which is best coordinated at the district, upazila, Community Clinic and domiciliary level. The most critical interventions will aim at improving the availability and use of good quality services by rural and urban poor women and newborns. Such services (incl. woman-friendly preconception and pregnancy care such as specific ANC days and ANC corners, MR and post-abortion services, 24/7 services for childbirth, newborn and postpartum care including postpartum family planning, prevention and management of asphyxia and neonatal infections, and care for the Low Birth Weight and pre-term babies) will address needs during preconception and pregnancy, childbirth and the immediate postpartum period and be provided by skilled

birth attendants and together with prompt and appropriate management of complications in EOC facilities staffed and equipped to provide 24 hour services, 7 days a week.

Moreover, specific attention will be given to promote essential newborn care through trained providers. Specific measures are also needed to reduce long-term maternal morbidities (like Obstetric fistula), due to complications of pregnancy and childbirth among the women of reproductive age. At present C-EOC has been implementing in 59 district hospitals and 132 UHCs. On the other hand B-EOC has been implementing in the rest UHCs (386). In HPNSDP period C-EOC will be scaled up in 50 UHCs.

Expansion of GoB-UN Joint MNHI

The Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction Project (in short title Joint GOB-UN-MNH Initiative) would be a part of next sector Program under the operational plans of Maternal, Neonatal and Child Health (MNCH) of Directorate General of Health Services, and Maternal, Reproductive and Adolescent Health (MRAH) of Directorate General of Family Planning. MNHI will continue up to 2016 in ten (10) districts. CIDA fund would be utilized in MNHI as funding source and the allocation of budget would be incorporated clearly in the respective operations plans under next sector Program (HPNSDP). UNFPA through MNHI would provide support to the proposed Program Monitoring and Management Unit (PMMU) of the Planning Wing, and arrange mechanism for better coordination among all MNH Program under implementation along with pooled funded sector Program, avoiding duplication in interventions supported by different agencies, and update with regular information, research and studies. UN agencies will take reference from modalities applied in previous DBRHCP project implementation in selecting any particular agency who worked for DBRHCP funded by CIDA as DPA.

Strategies

- Give program priority to poor community of hard to reach and low performing areas
- Strengthen district- and upazila-specific planning and monitoring to accommodate the geographic variations
- Ensure EmONC services at the facility & field level, which will be identified in detail in OP.
- Performance based financing at facility level

Activities

- Ensuring perinatal care (including delivery) at home and facilities of all level
- Phase wise implementation of 24/7 EmOC services including Post abortion care (PAC) through improved HR placement with skill mix and appropriate training at Districts hospital, UHCs and first aid/Basic EmONC services at UH&FWCs in order to increase institutional child births.
- Expanding the DSF program
- Develop and expand Midwifery services by organizing midwifery training program.
- Expand C-SBA involving the community. Appropriate women from community level could be selected and provide C-SBA training to ensure sustainable and round the clock C-SBA services at the household level.
- Training on newborn resuscitation Helping Babies Breathe- (HBB) curriculum to all skilled attendants of national level to union level to union level public sector facilities and community CSBA's and providing equipment to all public facilities and provides with newborn resuscitator (bag and musk) will be ensured
- Increase skilled HR on EmOC including PAC. Collaborative activities will be given in urban slums involving NGOs.
- Scaling up of different interventions to reduce PPH and eclampsia (e.g. active management of 3rd stage of labour, use of misoprostol and Magnesium Sulfate).
- Performance based financing at facility level and field level in the hard to reach area to increase utilization of MNCH services.
- Strengthening the maternal morbidity (Obstetric Fistula, cervical cancer, breast cancer, uterine prolapsed) related treatment, prevention and rehabilitation services with referral mechanism.

- Strengthening the pre-service curriculum of doctors, nurses and paramedics in midwifery, essential newborn care and adolescent health.
- Develop guideline on functional integration of MNCH services between DGHS and DGFP.
- Develop integrated MIS between DGHS and DGFP MNCH services at the upazila and below level.
- Conduct Operational Research on MNH to introduce different intervention package to reduce NMR and IMR through different related organizations (eg. ICMH, NIPSOM, All medical Colleges, BSMMU)
- Advocacy with NGOs and local govt. authority to mobilize resources and collaborative MNCH activities at remote area especially in the urban slum.
- Training of nurses and MO on surgical contraception, IUD and MR.
- Training of Doctors & nurses on VIA, Cervical Cancer & Colonoscopy

Component-2: Integrated Management of Childhood Illness (IMCI)

The Government of Bangladesh decided to adopt the IMCI strategy in 1998. Up to June 2010, F-IMCI has been implemented in 48 districts (343 upazilas). Up to June 2010 C-IMCI is being implementing in 63 upazilas. Ten training centers for IMCI have been established where the Clinical Management Trainings (11-days CMT) are ongoing for all service providers (doctors, paramedics) from selected expansion upazilas. In 2010 IMCI has been included in under graduate medical curriculum and the process of inclusion is going on in Nursing Institutes and MATS. While expansion of F-IMCI is reported to be progressing well, implementation of C-IMCI, especially with regard to the provision of community-based sick child care by basic health workers (eg. HA, FWA) and informal village doctors, is reported to be slow. At present F-IMCI and C-IMCI have been implementing in 373 UHCs and 63 UHCs respectively. In the HPNSDP period F-IMCI and C-IMCI will be scaled up in 107 UHCs and 263 UHCs respectively. On the other hand F-IMCI has been implementing in 10 district hospitals and it will be scaled up in 49 district hospitals during HPNSDP period. At present F-IMCI is not being implemented in any medical college hospital but it has been proposed that F-IMCI will be implemented in 17 government medical college hospitals.

Tackling neonatal illness, pneumonia, diarrhea, malnutrition and drowning are the primary targets under IMCI component.

Strategies

- Rapid scale-up and saturation of Facility IMCI including neonatal health at all level of health facilities.
- Prioritizing and Rapid scale-up of Community IMCI including neonatal health and child nutrition service
- Special emphasis will be provided on hard to reach areas.

Activities

- Strengthening the delivery of neonatal and child health services through Facility IMCI
- Expand facility IMCI for out-patient sick child services. Achieve saturation to cover 480 upazilas, 59 district hospitals and 19 medical college hospitals in 64 districts with adequate quality IMCI services (80 upazilas, 40 district hospitals and 19 medical college hospitals)
- Strengthen referral care (including ETAT) for sick under-five in all UHCs/DHs
- Ensure growth promotion with counseling on appropriate feeding practices including exclusive breast feeding.
- Combine monitoring and supervision of IMCI and EPI at facility and community level.

Community IMCI

- Rapid scale-up of community IMCI
- Community based management of childhood priority illness, i.e. pneumonia, diarrhea, neonatal sepsis and first aid of common injuries by trained CHCPs/BHWs/CHWs

- Design and implement sustainable strategies to ensure access to essential neonatal and child health services

Neonatal Health Services

- Operationalize of National Neonatal Health Strategy and implementation of action plan involving NGOs and volunteers, if needed.
- Increase institutional deliveries. Emergency Triage Assessment and Treatment (ETAT) training will be given to 900 service providers at present none has been trained on ETAT.
- Establishing and commissioning of sick newborn care unit in the district hospitals and newborn care unit/corner
- Promoting home-based essential newborn care
- Community based management of neonatal sepsis, birth asphyxia

Child Injury Prevention:

- Home based and group counseling and other C4D interventions on child injury prevention
- Assess capacity of health facilities at different levels to manage common child injuries

Component-3: Expanded Program on Immunization (EPI)

The Expanded Program on Immunization (EPI) in Bangladesh was launched on April 7, 1979 (World Health Day). As vaccination canters were few and were located mainly in health care facilities in urban areas, the EPI coverage remained less than 2% by 1984. In 1985, the Government of the People's Republic of Bangladesh committed to the Global Universal Child Immunization Initiative (UCI), and expanded a phase-wise process of EPI intensification from 1985-1990. During this time period, EPI was intensified throughout all Upazila, Municipalities and City Corporations and made available to all target groups (infants and pregnant mothers).

The government of Bangladesh developed comprehensive multiyear plan (cMYP) 2011-2016 for national immunization Program for Bangladesh. This Plan provides a framework to plan activities to achieve important objectives of the expanded Program on immunization, as contained in the national health policy. This plan sets out the medium-term (2011-2016) strategic goals of the immunization program, the related objectives, indicators, milestones, key activities and the associated costing and funding plan.

Bangladesh was polio free from August 2000 but wild polio virus importation occurred in March 2006.

During the last few years, based on the data on disease burden, new vaccines for selected emerging diseases such as Hepatitis-B (2003) and Hib disease (2009) have been introduced into the EPI schedule. Hepatitis-B vaccine was incorporated into the Program with GAVI phase-1 support bundle with injection safety supply. Vitamin-A supplementation was added to the Program in 1990. In view of enhancing the injection safety auto-disable (AD) syringes were introduced into the Program from 2004.

In coming years new vaccines would be introduced in the EPI Program. For those new vaccines, schedule should also be followed as per technical direction and guideline of WHO.

Strategies

- RED strategy implemented in every district
- Strengthen coordination with development partners, local NGOs and GoB
- Strengthening of immunization coverage and VPD surveillance system in all districts
- Ensure sufficient, timely and potent vaccines and quality injection devices available at all level with no stock out
- Periodical review of the National EPI program performance at each level and take timely and appropriate measures accordingly
- Increase demand of service through implementation of communication activities
- Conduct Periodic polio SIAs for maintaining polio eradication status.

- Maintain high coverage with quality OPV routine immunization
- Strengthen polio eradication measures coordination with development partners, local NGOs and GoB
- Strengthened AFP surveillance system
- Make available all the logistics for Effective implementation of Polio eradication activities

Activities:

- Strengthening and expanding EPI service delivery with special focus on hard to reach and low performing areas
- Maintaining Polio free-status by conducting two rounds of NIDs in each year till the region is polio free
- Reaching Measles Elimination Status by 2015 through introducing 2nd dose of measles vaccine in routine EPI and periodic campaign
- Maintaining Maternal and Neonatal Tetanus Elimination Status
- Introducing New Vaccines: Pneumococcal vaccine, Rota Vaccine, Birth dose of Hepatitis B vaccine, DPT vaccine, Rubella vaccine
- Expansion of capacity of both cold and dry store at central and district level and cold chain maintenance by ensuring human resources and operational cost
- Ensure Effective Vaccine Management (EVM) at all level stores
- Reaching Measles Elimination Status by 2015 through introducing 2nd dose of measles vaccine in routine EPI and periodic follow-up campaign.
- Introducing new vaccines: Pneumococcal vaccine, Rota vaccine, Rubella vaccine, Td vaccine
- Strengthening vaccine preventable disease surveillance and AEFI surveillance by ensuring specific surveillance manpower and operational cost
- Ensure injection safety and waste management
- Timely procurement and distribution of vaccine and EPI Logistics
- Advocacy, Social Mobilization & IEC

Component-4: Reproductive and Adolescent Health Program

In Bangladesh, 34 million adolescents (age between 10 and 19) constitutes 23 percent of the population. Among them 13.8 million are female. Lack of knowledge and information of the adolescents about SRH leads them to unsafe sex, abortion etc. Services and conductive environment remain most vital. Improved access to service (counseling, contraceptive use) is not being addressed with active participation of adolescents. Due to their age structure, cultural norms and the limited socio-economic opportunities, they are also vulnerable to STI/HIV/AIDS, pre-marital sex, sexual abuse, unwanted pregnancy, violence, coercion, delinquency, drug addiction, exploitation, deprivation, repression, abduction and trafficking. They even do not know about their rights to lead a healthy reproductive health. Similarly, adolescent boys perceived wet dreams as a very serious health problem for them when they experience it frequently and associated with their physical weakness and psychological restlessness. Early marriage and motherhood is very common in Bangladesh.

Strategies

- Improve knowledge of women, men, and particularly the adolescents on Reproductive health (RTI/STI, abortion, infertility etc.).
- Introducing and expanding adolescent friendly health services
- Ensuring good quality of care in adolescent friendly outlets
- Promotion of adolescent friendly health services
- Effective dissemination of ARH knowledge and information through school curricula
- Organizing effective community-based dissemination of ARH information
- Carryout advocacy at community level for the gatekeepers of adolescents (parents/guardians, teachers, religious/community leaders etc)
- Develop and implement mass media campaign



Activities

- Upgrading of health facilities (all UHCs, and UH & FWCs/RDs in phases and to provide adolescent friendly SRH services
- Providing training on adolescent friendly SRH services including counseling and communication
- Counseling and developing awareness for adolescents specially senior girls students on personnel hygienic practices
- Management for minor gynecological problems of girl adolescents, i.e. Dysmenorrhea, puberty menorrhagia and supplementation of iron & folic acid and supply of sanitary-pad for emergency purpose in girl schools.
- Establishment of referral linkages between school health clinics and other health facilities
- Implement Deworming activities at the field level.
- Formation of coordination committee among the Adolescent Sexual and Reproductive Health (ASRH) implementing partners (GO, NGO, Private sector)
- Incorporation of ASRH component into the existing MIS of the Ministry of Health
- Community mobilization around ASRH issues through court yard meetings, inter-personal communication, and workshops,
- Develop and printing training manuals, guidelines, booklets regarding adolescent health.
- IEC activities: Short film show, poster, calendar, folder, wall-painting, bill-board, etc.
- Mass media campaign on ASRH issues
- Develop and disseminate key messages and materials
- Develop campaign plan and message dissemination using mass media

Component-5: School Health Program

Since 1951, 23 School Health Clinics in 21 districts are running under school health program in the old greater districts of the country. Each clinic has two graduate doctors, one pharmacist and one MLSS. The Medical Officers provide clinical service to the school going children, school visit, BCC & others. The program objectives are: (i) Improvement of the school environment; (ii) Improvement school health services and (iii) Health education to the school student.

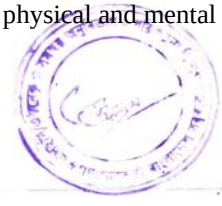
Under HPNSDP (2011-2016) school health services will be integrated with adolescent RH services program. School health services include training of school teachers for providing first-aid to the school students, personal hygiene, hand-washing, nutrition, safe water/sanitation and provision of first-aid box. At least one school teachers will be trained for this purpose.

Strategies

- To encourage and help student to inculcate knowledge, attitude and practices with regards to good health habits and personal hygiene
- To involve of school teachers for promoting healthy school environment personal hygiene and hand washing by providing orientation.
- Making provision of health screening by specialist health services

Activities

- Training of school teachers, local service providers and managers and student on good health habits, personal hygiene, hand washing, nutrition, helminthiasis, making healthful school environment etc.
- Orientation of members of the school management committee on good health habits, making healthful school environment, sanitation etc.
- Provision for supply of weighing machine with height measuring scale in school health clinic.
- To arrange periodic special health consultation camp with specialists (mainly Eye, ENT, Pediatrics, Dental) for detection and care of physical and mental defects/illness among primary school students


- To provide first-aid-box with essential drugs and MSR and establishment of referral system with near-by health facilities
- Develop and printing training manuals, guidelines, booklets regarding school health
- IEC activities: Short film show, poster, calendar, folder, wall-painting, bill-board, etc.
- Vitalization of existing school health clinics (23) services

4.1.4. Cross Cutting Issues

- Provide necessary HR, Equipment, supplies and budget for renovation and maintenance to all health facilities (OP-PFD & HRM)
- Establish functional referral system through arranging ambulance, local transports and emergency funds to link community with facilities (OP-ESD & CBHC)
- Provide pre-service training to doctors, nurses, midwifes and paramedics on reproductive health, essential and sick newborn care and adolescent health. (OP-IST & PSE)
- Introduce local level recruitment and performance based incentives for retention of trained staff in hard to reach areas (OP-HRM)
- Strengthen HMIS (OP-HIS-EH, MIS & HRM). Inclusion of DSF data in HMIS.
- Develop system to register all pregnancies and newborns at the community level with linkages to national population and health registries (OP-CBHC, HIS-EH, MCRAH, MIS, MOLGRD and BBS)
- Establish maternal and perinatal death review system both at community and facility level (OP-ESD, CBHC, HSM, MCRAH & Local Government)

4.1.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. More specifically, the activities planned under maternal and neonatal health, EPI, IMCI and Adolescent School Health contribute to all the results under Component 1 (Result 1.1, increased utilization of essential HPN services, Result 1.2 improved equity in essential HPN utilization, Result 1.3, improved awareness of health behavior and Result 1.4 improved primary health care-community clinics systems)

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of service providers trained on IMCI	Doctors-2736, Paramedics-7561	Doctors-750 Paramedics-2500	Doctors-1500 Paramedics-5000
2	Number of service providers trained in ETAT/sick newborn care	Doctors-70, Paramedics-90	Doctors-200 Paramedics-250	Doctors-400 Paramedics-500
3	Proportion of women age 15-49yrs. Received TT-5 doses of TT during their last pregnancy.	38.9% (CES, 2010)	70%	>80%
4	Proportion of children aged 12-23 months vaccinated by all scheduled of all vaccines by 12 month of age.	79% (CES, 2010)	85%	90%
5	Number of Upazila having DSF program	53 Upazila	103	153
6	Number of UHCs and UH&FWCs upgraded for providing adolescent-friendly RH services	NA (MNCAH reports annual)	UHCs- 65%, UHFWCs- 75%	All UHCs, All UH&FWCs
7	Number of Obs.gyn and Anesthetist pair present Upazila Health Complexes (UHC) in low performing districts with high maternal mortality rates	NA, MNCH	2 UHC in 5 low performing districts	2 UHC in 25 low performing districts
8	Availability of 12 Obstetric drugs in Upazila Health Complexes (UHC) in low performing districts with high maternal and	NA, MNCH	2 UHC in 5 low performing districts	2 UHC in 25 low performing districts

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
	child mortality rates			
9	Number of midwives trained	60	2732	3172
10	Number of UHC providing 24/7 C-EOC services	132 UHC	157	182

4.1.6. Budget

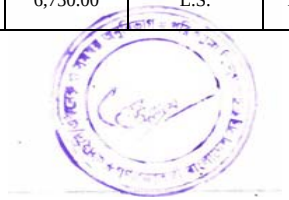
Component and Year Wise Physical and Financial Target of OPs

Agency: DGHS

Name of the OP: Maternal, Neonatal, Child & Adolescent Health (MNC&AH)

(Tk in Lakh)

Name of the Components' / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1: Maternal and Neonatal Health													
i) EOC													
06 months Training of OG & Anaes. for the Doctors	1136 Persons	82.87	701.00	848.00	1,631.87	208	290.50	208	247.00	240	284.00	480	810.37
02 Weeks Training on PAC for MO & Nurses / BT for MT (LAB) / OT Management for the SSN	2263 Persons	-	162.48	165.60	328.08	395	67.08	395	67.08	491	78.44	982	115.48
05 Days training on AMTSL for Doctors & Nurses	200 Persons	-	114.00	108.00	222.00	40	45.00	40	45.00	40	53.00	80	79.00
Training on Obs, Fistula for Doctors (OG,AN & Urology Dept.)	224 Persons	-	180.00	144.00	324.00	40	72.00	40	72.00	48	72.00	96	108.00
Training on Infection Prevention all staff of the Hospitals	500 Persons	-	12.00	14.40	26.40	100	6.00	100	6.00	100	6.00	200	8.40
15 days basic training on VIA & Cervical Cancer	408 Persons	-	43.00	172.00	215.00	36	18.00	108	54.00	120	61.00	144	82.00
10 days training on Colposcopy	52 Persons	-	-	48.00	48.00	4	3.50	12	11.00	16	15.00	20	18.50
Procurement of Consumable Store	Lump Sum	75.00	896.11	500.00	1,471.11	L.S.	254.34	L.S.	254.35	L.S.	306.14	L.S.	656.28
Procurement of Medicines	Lump Sum	-	1,500.00	1,500.00	3,000.00	L.S.	600.00	L.S.	600.00	L.S.	600.00	L.S.	1,200.00
Procurement of Medical and Surgical Supply	Lump Sum	-	1,000.00	2,500.00	3,500.00	L.S.	600.12	L.S.	700.09	L.S.	763.30	L.S.	1,436.49
Procurement of Machinery and other Equipments	Lump Sum	1,250.00	2,000.00	3,500.00	6,750.00	L.S.	1,404.80	L.S.	1,432.87	L.S.	1,636.32	L.S.	2,276.01



Name of the Components' / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Operational Cost	Lump Sum	993.92	-	2,910.00	3,903.92	L.S.	676.84	L.S.	560.94	L.S.	1,078.60	L.S.	1,587.54
ii) DSF Activities					-								
DSF Activities (53), increse 20 Upazila each year (Yearly maintenance cost for one DSF upazila in 74.00 lac taka)	153 Upazila	830.44	42,430.44	-	43,260.88	73	7,060.00	93	7,780.00	113	8,569.50	186	19,851.38
iii) C-SBA & Midwifery					-								
C-SBA Training (Including private participant)	8200 Persons	-	2,000.00	13,042.31	15,042.31	1400	1,552.31	1600	2,590.00	1800	2,700.00	3,400	8,200.00
Midwifery Training	3172 Persons	-	1,000.00	4,432.50	5,432.50	828	1,362.50	1296	2,110.00	648	1,370.00	400	590.00
iv) Incentive for Hard-to-reach area & strenthening referral system					-								
Incentive for Hard-to-reach area and strengthening referral system	Lump Sum	-	1,000.00	-	1,000.00	L.S.	180.00	L.S.	180.00	L.S.	220.00	L.S.	420.00
Sub-Total = MNH		**3,232.23**	**53,039.03**	**29,884.81**	**86,156.07**	**3,124.00**	**14,192.99**	**3,892.00**	**16,710.33**	**3,616.00**	**17,813.30**	**5,988.00**	**37,439.45**
Component-2: EPI					-								
i) Increase and sustain Routine EPI					-								
EPI Printing Materials	TT Card - 540 Lakh, Child Card - 329 Lakh etc.	2,515.10	-	-	2,515.10	TT Card-90 Lakh, Child Card-55 Lakh etc.	423.25	TT Card-90 Lakh, Child Card-55 Lakh etc.	423.25	TT Card-120 Lakh, Child Card-73 Lakh etc.	556.20	TT Card-240 Lakh, Child Card-146 Lakh etc.	1,112.40
Procurement of Vaccine	6332 Lac Dose		58,121.45	49,033.64	107,155.09	106,977,811	17,289.75	123,065,056	21,684.54	129,272,208	23,319.03	273,829,205	44,861.77
Procurement of AD Syringe & Logistics Supplies	2699 Lac Pcs	15,299.73	1,286.50	2,625.00	19,211.23	43,516,623	3,105.29	43,579,525	3,109.06	60,864,840	4,328.39	121,924,840	8,668.49
Porter / Casual Labour for Vaccine & Logistics supplies from Upazilla Health Complex to Distribution Point	1390 Persons	4,028.20	-	-	4,028.20	1,390	805.64	1,390	805.64	1,390	805.64	1,390	1,611.28

Name of the Components' / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Repair and Maintenance of Vehicles, Cold Chain Equipment & others	Need Based	1,099.43	-	-	1,099.43	Need Based	237.00	Need Based	215.24	Need Based	215.48	Need Based	431.71
Procurement of Cold Chain and other Equipments	Cold Room - 1860 M3, Freeze - 2700, Cold Box - 1100 & Vaccine Carrier - 15000 etc.	25.00	7,144.40	3,496.80	10,666.20	Cold Room - 120 M3, Freeze - 125, Cold Box - 100 & Vaccine Carrier - 2500 etc.	955.10	Cold Room - 60 M3, Freeze - 620, Cold Box - 800 & Vaccine Carrier - 7000 etc.	1,432.80	Cold Room - 120 M3, Freeze - 945, Cold Box - 200 & Vaccine Carrier - 3500 etc.	2,764.10	Cold Room - 1560 M3, Freeze - 1010 & Vaccine Carrier - 2000 etc.	5,514.20
Procurement of Computers and Accessories	40 Set	25.00	30.00	-	55.00	9	12.50	9	12.50	14	20.00	8	10.00
Procurement of Other Office Equipments	9 Set	17.48	-	-	17.48		-	3	2.78	2	4.70	4	10.00
Procurement of Furniture and Fixtures	475 Set	25.00	-	-	25.00	95	5.00	95	5.00	95	5.00	190	10.00
Operational Cost	Lump Sum	4,181.18	-	-	4,181.18	L.S.	811.52	L.S.	821.61	L.S.	826.80	L.S.	1,721.25
ii) National Immunization Day (NID) & Emergency preparedness for polio importation : National wide Mop-up Campaign					-								
Local Training (HA, FWA, FWV etc.)	180000 Persons	-	-	800.65	800.65	60,000	243.60	45,000	230.55	45,000	158.50	30,000	168.00
Orientation, Seminar & Conference (Volunteers)	3000000 Persons	-	-	2,151.70	2,151.70	600,000	212.80	600,000	438.90	600,000	500.00	1,200,000	1,000.00
Expenses for NID Volunteers	3000000 Persons	3,687.05	-	-	3,687.05	600,000	737.41	600,000	737.41	600,000	737.41	1,200,000	1,474.82
Procurement of OPV Vaccine	3000 Persons	-	35,000.00	-	35,000.00	600	7,500.00	600	7,500.00	600	7,500.00	1,200	12,500.00
Porter / Casual Labour for Vaccine & Logistics supplies from Upazilla Health Complex to Distribution Point	15925 Persons	550.50	-	-	550.50	15,925	110.10	15,925	110.10	15,925	110.10	31,850	220.20

Name of the Components' / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Operational Cost	Lump Sum	1,505.33	-	412.65	1,917.98	L.S.	544.34	L.S.	431.45	L.S.	339.56	L.S.	602.63
iii) Introduction of New Vaccine					-								
Salary for DISMOs Driver & F&AA Salary	175 Persons	-	-	463.80	463.80	35	92.76	35	92.76	35	92.76	70	185.52
Local Training for New Vaccine Introduce	10360 Batch	-	-	1,836.95	1,836.95	2,818	500.00	1,886	334.70	1,886	334.40	3,770	667.85
Orientation, Seminar & Conference	1835 Batch	-	-	1,836.94	1,836.94	500	500.00	334	334.70	334	334.39	667	667.85
Consultancy	1920 MM	-	-	1,344.00	1,344.00	384	268.80	384	268.80	384	268.80	768	537.60
Repair and Maintenance of Vehicles & Equipment	Need Based	-	-	108.00	108.00	Need Based	31.20	Need Based	19.20	Need Based	19.20	Need Based	38.40
Operational Cost	Lump Sum	-	-	1,301.56	1,301.56	L.S.	331.89	L.S.	241.49	L.S.	242.10	L.S.	486.08
Sub-Total = EPI		**32,959.00**	**101,582.35**	**65,411.69**	**199,953.04**		**34,717.95**		**39,252.48**		**43,482.56**		**82,500.05**
Component-3: IMCI					-								
Clinical Management training on IMCI	6500 Persons	-	301.55	533.55	835.10	1,300	152.78	1,300	154.84	1,300	173.68	2,600	353.80
Training on ETAT & sick new born care	900 Persons	-	41.76	73.88	115.64	180	21.16	180	21.44	180	24.05	360	48.99
Training on C-IMCI for community people	12000 Batch	-	556.69	985.00	1,541.69	2,400	282.06	2,400	285.84	2,400	320.63	4,800	653.16
IMCI orientation, planning & IMCI Review Meeting	100 Batch	-	100.00	530.80	630.80	300	110.00	300	125.00	300	150.00	600	245.80
Distribution of Drugs & Logistics	480 Upazila	-	3,049.57	2,000.00	5,049.57	480	1,592.70	480	992.70	480	886.39	480	1,577.78
Advertising & Publicity, Printing & Publication	Lump Sum	-	-	2,123.85	2,123.85	L.S.	424.77	L.S.	424.77	L.S.	424.77	L.S.	849.54
Operational Cost	Lump Sum	338.48	-	260.44	598.92	L.S.	113.22	L.S.	117.19	L.S.	121.29	L.S.	247.22
Sub-Total = IMCI		**338.48**	**4,049.57**	**6,507.52**	**10,895.57**		**2,696.69**		**2,121.78**		**2,100.81**		**3,976.29**
Component-4: Reproductive and Adolescent Health					-								
Training of Service Provider & Adolescent	788 Batch	-	767.95	-	767.95	155	128.00	155	128.00	178	170.65	300	341.30

Name of the Components' / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Procurement & supply of Medicine	Lump Sum	595.12	-	-	595.12	L.S.	175.00	L.S.	70.29	L.S.	116.61	L.S.	233.22
Printing & publication	Lump Sum	178.28	-	-	178.28	L.S.	62.00	L.S.	16.86	L.S.	33.14	L.S.	66.28
Operational Cost	Lump Sum	109.52	82.00	-	191.52	L.S.	22.84	L.S.	38.97	L.S.	38.97	L.S.	90.74
Sub-Total = Reproductive and Adolescent Health		**882.92**	**849.95**	**-**	**1,732.87**		**387.84**		**254.12**		**359.37**		**731.54**
Component-5: School Health					-								
Training of school Teachers & Service provider	635 Batch	-	503.67	-	503.67	150	114.61	75	52.61	160	124.15	250	212.30
Procurement & supply of Medicine	Lump Sum	-	439.30	-	439.30	L.S.	80.00	L.S.	80.00	L.S.	93.10	L.S.	186.20
Procurement & supply of MSR (First-Aid Box etc.)	Lump Sum	240.16	-	-	240.16	L.S.	72.20	L.S.	24.11	L.S.	47.95	L.S.	95.90
Printing & publication	Lump Sum	140.80	-	-	140.80	L.S.	42.25	L.S.	14.25	L.S.	28.10	L.S.	56.20
Machinery & other equipment (Weight & Hight Machine)	Lump Sum	-	620.00	-	620.00	L.S.	100.00	L.S.	100.00	L.S.	140.00	L.S.	280.00
Operational Cost	Lump Sum	469.51	74.00	-	543.51	L.S.	99.02	L.S.	77.56	L.S.	92.51	L.S.	274.42
Sub-Total = School Health		**850.47**	**1,636.97**	**-**	**2,487.44**		**508.08**		**348.53**		**525.81**		**1,105.02**
Vehicle for MNC&AH	Truck-4 Jeep - 5, Double Cabin Pickup -5, Microbus-1,	-	700.00	-	700.00	3	150.00	4	150.00	4	150.00	4	250.00
Total = MNC&AH		**38,263.10**	**161,857.87**	**101,804.02**	**301,924.99**		**52,653.55**		**58,837.24**		**64,431.85**		**126,002.35**

4.2. Essential Services Delivery (ESD)

4.2.1. Introduction

Essential Service Delivery under the Directorate General of Health Services will address LCC (Limited Curative Care), SS&C (Support Services & Coordination), MWM (Medical Waste Management), Urban Health, Mental health, Tribal Health in Upazila and below.

Limited curative care objective is to meet the basic health need of the people specially children, Women & the poor providing treatment of medical emergencies.

Support Services & coordination is one of the key components of ESD. This component acts as a link between the different components of ESD as well as between the Line Director, ESD and Other Line Directors. The major objective is to provide support in the monitoring, supervision, various report compilation, fund disbursement, facilitating procurement process and providing management support to Line Director, ESD in the implementation of the operational plan.

Medical waste management initiative are to ensure safe, environment friendly and cost-effective management of sharps and other hospital wastes derived from curative, diagnostic, immunization and other preventive services both in public and private sector.

Urban health service will be provided with strong coordination with MOLGRDC.

With the rapid change of lifestyle, mental health has become a public health problem which needs to be addressed with targeted objectives.

The challenges to provide quality and equitable health care for tribal people needs to be met in the next sector program.

4.2.2. Objectives

The objective of the OP is to provide health care to the un-served and underserved population as far as possible, at their door steps, at an affordable cost

4.2.3. Components

ESD is composed of the following components:

1. Support Services & Coordination
2. Limited Curative Care
3. Urban Health Services
4. Medical Waste Management
5. Mental Health
6. Tribal Health

Component 1- Support Services & Coordination

Support Services & coordination is one of the key components of ESD. This component acts as a link between the deferent components of ESD as well as between the Line Director, ESD and Other Line Directors.

Strategy

- Provide essential health care services at grass-root level by ensuring manpower, furniture, equipment, logistics, vehicle etc. for newly constructed & upgraded facilities at the level of Upazila & below
- Establish referral linkage among the public-public and public-private facilities
- Develop IEC / BCC materials for awareness and motivation
- Holding of quarterly M&E sessions at each district level

Activities

- To provide manpower, furniture, equipment, logistics etc. for the facilities:

- Monitoring, Supervision, Evaluation & Reporting of the ongoing activities
- BCC activities at the level of Upazila & below

Component 2- Limited Curative Care

Limited curative care objective is to meet the basic health need of the people specially children, Women & the poor providing treatment of medical emergencies.

Strategy

- To meet the basic health need of the people especially children, women and the poor providing treatment of medical emergencies including asthma.
- To provide First Aid for common injuries like burn, snakebite, drowning, accidents including road traffic accident.
- To treat common diseases of skin, eye, ear and dental problems.
- Patients referral to the higher facilities for better treatment (when necessary) by providing all possible assistance.

Activities

- Provide medicine for medical emergencies
- Provide basic first aid for common injuries and treatment of diseases including skin, eye, ear and dental diseases etc.

Component 3- Urban Health Services

Urban health services are the responsibility of the Ministry of Local Government, Rural Development & Cooperatives (MOLGRD&C). The Municipal Administration Ordinance of 1960, the Pourashava Ordinance of 1977 and the City Corporation Ordinance of 1983 clearly assigned the provision of preventive health and of limited curative care as a responsibility of the city corporations and municipalities. But due to limited resources and manpower public-sector health services have not kept up with needs. Private health care providers are the main source for delivery of curative care, including tertiary and specialized services to the urban people, but are not attracted to provide preventative and promotive health services.

Strategy

- To ensure proper utilization of resources for urban primary health care activities.
- To provide PHC services to the urban population.
- Strong coordination between MOLGRDC and MOHFW

Activities

- Developing an urban health strategy and an urban health development plan in collaboration with MOLGRDC. DGHS will support Bangladesh Urban Health Network (BUHN)n in performing advocacy, knowledge sharing and awareness raising activities.
- Strengthening urban dispensaries for effective and quality PHC services (including services for reproductive health, nutrition and health education).
- Defining an adequate referral system between the various urban dispensaries and the second and third level hospitals, and explore feasibility of introducing General Physician (GP) system.
- Developing and utilizing urban HIS for effective management of urban health care.
- Building capacity of the various service providers under DGHS and MOLGRDC.
- Awareness raising program related to reproductive health urban slum dwellers (eg. Garment workers)

Component 4 - Medical Waste Management

Medical wastes are generated as a by-product of health care activities and its generation is unavoidable. The wastes produced in the hospitals carry a higher risk of infection than any other waste particularly for the service

provider and waste handlers. An environmental assessment conducted by MOHFW revealed that upazila health complexes generates wastes on an average 1.5 kg/bed/day, of which 20% is infectious in nature. As there is no policy of waste management, the generated wastes are collected together resulting in mixing of different type of wastes and making the whole bulk as infectious waste. Furthermore, there isn't any proper waste disposal system in place resulting in exposure of the population to a highly hazardous situation.

The medical waste is capable of transmitting diseases either through direct contact or by contaminating soil, air and water. If not properly handled, medical waste is a risk to individuals, community and the environment.

Strategy:

Strategies to be adopted for the Medical Waste Management program at upazila level under ESD are:

- To establish a feasible and sustainable system for safe medical waste management, which will include safe disposal of sharps and other medical wastes;
- To improve community awareness regarding hazards of sharps and infectious medical wastes and the safe ways for their disposal;
- To ensure safety of the health care providers, recipient and waste handlers.

Activities

- Construction of pits in UHC
- Procurement of logistic
- Training/Orientation of personnel on Medical Waste Management (MWM)
- Community awareness on MWM
- Supervision and Monitoring

Component 5- Mental Health

Developmental Disorder, Mental Health & Autism: The Govt. has decided to address mental health as it is becoming a problem due to rapid change of life style. Given the emerging size of the mental health problems amid changing life styles and in pursuance of government's strong commitment for adequately addressing the counseling and treatment of mental health, partnerships with the media and NGOs will be developed to raise public awareness about appropriate attitude and behavior towards mental patients. In addition to public sector workers, NGO/ CBO workers and school and religious teachers, will be trained to identify and counsel substance abuse and mental and emotional cases, provide and follow up simple treatment as per feasibility, provide life skill training and refer serious cases to an appropriate facility. This OP will give focus on community awareness, identification of autism cases, providing health services including necessary counselling to mental patients at upazila level and establishing referral system for mental health cases.

Strategy

- To adequately address the counseling and treatment of mental health patients.
- To develop partnerships with the media and NGOs to raise public awareness about appropriate attitude and behavior towards mental patients.

Activities

- Updating National protocol for mental health care
- Identification and counseling of mental illness including autism at primary level
- Develop appropriate BCC material

Component-6- Tribal health

It is estimated that there are 2.5 million people in Bangladesh, who are the members of "ethnic populations". Majority of them (42%) live in three hill districts of the Chittagong Hill Tracts (CHT), while others are scattered in the northern hilly regions and some costal districts. They have low level of literacy and nutritional status. And their cultural setting is also different.

Strategy

- To develop special measures and adjustment in delivery mechanism of tribal health for ethnic people
- To strengthen collaboration with MOCHTA and CHT-Hill District Council with a view to increase support of the health sector.

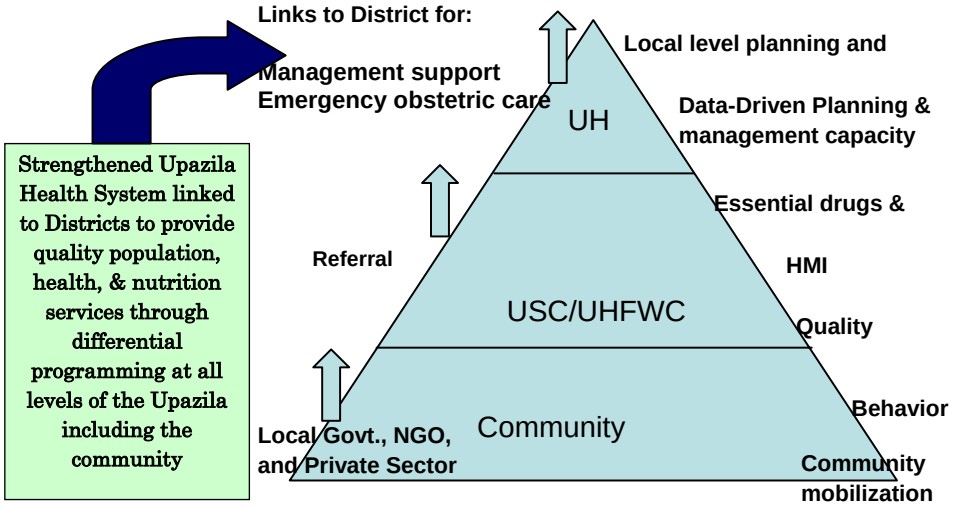
Activities

- Strengthening health services delivery system of CHT districts;
- Develop guideline to provide health service delivery at national level for all ethnic population; and
- Develop effective collaboration mechanism with MOCHTA and CHT-HDC.

Component-7 Upazila Health System (UHS)

UHS is the transformation of the fragmented, inefficient, centralized, separated curative from preventive care and apartheid health system existing at the Upazila level into a coherent unified national health system capable of addressing the health needs of the population, especially those living in the poverty. The goal is the provision of an equitable, efficient and effective health service that is based on the primary care approach.

Figure- 1



Communities and

The Upazila Health Complex (UHC) is the first inpatient facility in the network, and provides both primary and secondary level services, serving as an apex of the Upazila Health System (UHS). The UHS in Bangladesh comprises linking a community with the district through the functional UHS.

UHS is not just a structure or form of organization, but is also the manifestation of a set of activities such as community involvement, integrated and holistic health care services, intersectoral collaboration and a strong 'bottom-up' approach to planning, policy development and management. The organization and management of the entire health system proposed to be Upazilla based, meaning that policy areas such as health sector financing, utilization of the UHCs, the relationship with the private sector and governance should be UHS-based or UHS-centered. The community based and the facility based HPN activities would be implemented under a single HPN plan for a given population and area. It will also comprise the relationship of the UHS and the respective roles of each spheres of the government particularly local government, NGOs, Private sector and district health services and lower level UHFWCs as well as CCs. The district level health administration will

play a crucial role to oversee the work of the UHS and provide the support needed as part of the national decentralization process.

Some of the important activities for UHS are:

- Formation of National UHS Task Team to provide policy guideline and preparation of action plan with support of TA;
- Formation of Upazila Health Financing Committee for making expenditure reviews and development of practical budget for Upazila health services;
- Development of a core package of ESD services with a comprehensive, integrated MNCAH Programs, Nutrition, TB, BCC, QA and UHCs services;
- Development of an appropriate and equitable resource allocation guideline;
- Preparation of Upazila Manager's handbook, Guide to Upazila Health Planning, Norms and Standards of Clinics;
- Development of Patient's Charter;
- Establishment of Upazila integrated HIS with a number of indicators would be developed for the proposed pilot Upazila;
- Appropriate delegation of financial power and administrative authority should be taken.

In the first 2-3 years of the next sector program, MOHFW would start piloting the UHS with a limited number of selected Upazilas, where the required staff (doctors, nurses, paramedics, etc) and equipment is available for caesarians and other surgical interventions. After successful piloting, the UHS will gradually be scaled up countrywide.

Component – 8: Referral System in the HPNSDP

Primary health care centers need to maintain a close relationship between all the levels of a health system. This linkage between primary health care services and first referral units upwards is crucial in providing health care for the people of any country. Continuous collaboration between health care personnel at primary health care level and those of referral facilities is very essential. In order to bring down mortalities and disabilities following any disease condition or accidental injuries, availability of an operational referral system is one of the prerequisites where it will help the patient to receive optimal Health care from the next level of referral care.

Although a limited number of patients will develop life threatening complications, very few of these can be predicted. Therefore the system of referring any of the patients to the next referral centre needs to be improved. However, the first care referral centers need to be provided with essential equipments and facilities to handle any such complications of those referred patients. It also recognizes the importance of support and linkages with the household and community for safe care.

Referral system network will start from the Community Clinics (CCs), Union Health and Family Welfare Centre (UHFWC), Upazilla Health Complex (UHC) & upwards. Equal importance should be given to the downward referrals as well. Effective referral requires clear communications to assure that the patient receives optimal care at each level of the system.

While establishing well functioning and effective & structured referral system some key factors to be considered:

- Identification of types of services to be provided through each level of institutions
- Development of referral protocols and referral form.
- Streamline the referral procedures.
- Creating awareness among the health staff and the communities on the referral mechanism
- Provision of adequate resources based on the norms for each level of institutions
- Establishment of proper communication mechanism between UHC and other higher Level referral centers.
- Identification of suitable transport mechanisms to transfer the patients in need for referral care. Developing transport systems to transfer the patient to the higher level is also very essential.
- A diseases code (ICD-10) to be used for better patient management

4.2.4.Cross Cutting Issues

- Capacity development. (OP- MNCAH, ESD, IST, PSE & NES)
- Supply of logistics. (OP-PLSM-CMSD)
- Retention of manpower. (OP-NES, HRM)
- Urban health (MOLGRD, NGOs)
- Tribal health (OP-MNCAH, CBHC, CDC & MOLGRD)
- Mental health. (OP-HSM)
- School health. (MOE)
- Medical waste management. (OP-HSM, MOLGRD)
- Health promotion (OP-HSM)
- Functional referral system. (OP-CBHC & HSM)

4.2.5.Indicators

The activities planned under support services and coordination, limited curative care, urban health, MWM, MH, UHS are related to component 1, Result 1.4, improved primary health care. The activities planned under waste management contribute to Component 2, Result 2.5, sustainable and responsive procurement and logistic system, and result 2.6, improved infrastructure and maintenance.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number (%) of upgraded/constructed UHCs provided with furniture, equipment, logistics etc.	232	36 (New)	52 (New)
2	Number of Upazila introduced with Upazila Health System (UHS)	NA	20	30
3	No. of UHCs with trained personnel on Medical Waste Management	250 Upazila (OP report)	400 Upazila	421 Upazila
4	Number of UHCs having functional disposal Pits	206 Upazila (OP report)	306 Upazila	421 Upazila
5	Number of Urban Dispensaries strengthened	NA	34	34
6	Mental Health care services introduced in PHCs level	NA	Done	Done
7	Action plan with guideline developed for all ethnic communities	NA	Done	Done

4.2.6. Budget

Component and Year wise physical and financial target of OPs

Agency: DGHS

Name of the OP: Essential Service Delivery

(Tk in Lakh)

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
2	3	4	5	6	7	8	9	10	11	12	13	14	15
Support Services & Coordination													
1. Upgradation of UHCs from 31 bed to 50 bed													
a) Procurement of Furniture	227 Set	4260.11			4260.11	20	375.34	29	544.24	40	750.68	138	2589.85
b) Procurement of Equipment	264 Set		12244.91	125.00	12369.91	42	1913.38	40	1815.12	57	2650.30	125	5991.12
2. New 31 bedded Hospital (or New UHCs)					0.00								
a) Procurement of Furniture	8 Set	179.12			179.12							8	179.12
b) Procurement of Equipment	8 Set		233.20		233.20							8	233.20
3. New 20 bedded hospital					0.00								
a) Procurement of Furniture	4 Set	55.39			55.39							4	55.39
b) Procurement of Equipment	5 Set		163.45		163.45							5	163.45
4. 20 bedded Trauma Centre					0.00								
a) Procurement of Furniture	7 Set	96.93			96.93							7	96.93
b) Procurement of Equipment	7 Set		393.00		393.00							7	393.00
c) Ambulance	7 No		210.00		210.00							7	210.00
5. Strengthen the 418 UHCs					0.00								
Air Cooler, (for X-ray machine)	80 No		50.44		50.44			35	22.07	45	28.37		0.00
E.C.G. Machine	105 No		264.81		264.81	20	50.44	20	50.44	65	163.93		0.00
Ultra sonogram Machine	285 No	0.00	2371.55	1000.00	3371.55	120	1419.60	100	1183.00	65	768.95		0.00
X-Ray Machine (300 m.A)	80 No		1300.00		1300.00			35	568.75	45	731.25		0.00
6. Computer and accessories for HQ	14 Set		50.82		50.82			4	14.52	4	14.52	6	21.78
7. Motorcycle 100 cc for UHC	1672 No		2006.40		2006.40	500	600.00	500	600.00	672	806.40	0	0.00

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
2	3	4	5	6	7	8	9	10	11	12	13	14	15
8. Training (local)	418 batches			550.00	550.00	20	26.32	20	26.32	65	85.54	313	411.82
9. Referral System			101.84		101.84		30.37		30.37		30.37		10.74
10. Other recurrent cost	LS				0.00								
a) Pay of Officer		194.76			194.76		36.00		37.04		38.81		82.91
b) Pay of Establishment		415.00			415.00		76.00		79.00		83.00		177.00
c) Allowances		481.50			481.50		90.00		93.00		96.09		202.41
d) Supplies and Services		1126.46	300.00		1426.46		225.00		324.77		325.17		551.52
e) Repair and Maintenance		85.00	200.00		285.00		67.00		67.00		67.00		84.00
Sub Total		**6894.27**	**20015.42**	**1550.00**	28459.69		**4979.44**		**5425.64**		**6610.38**		**11444.23**
Limited Curative Care					0.00								
1. Medicines	LS	830.00	3000.00		3830.00		766.00		766.00		766.00		1532.00
2.Medical and Surgical Requisites (MSR)	LS	865.00	1000.00		1865.00		300.00		400.00		400.00		765.00
Sub Total		**1695.00**	**4000.00**		5695.00		**1066.00**		**1166.00**		**1166.00**		**2297.00**
Urban Health Services		400.00	3451.14	1000.00	4851.14		950.00		950.00		950.00		2001.14
Sub Total		**400.00**	**3451.14**	**1000.00**	**4851.14**		**950.00**		**950.00**		**950.00**		**2001.14**
Medical Waste Management													
1. Supplies and Services			1000.00		1000.00		200.00		200.00		200.00		400.00
2. Training of field Staff	1178 batches			530.10	530.10	200	90.00	200	90.00	200	90.00	578	260.10
3. Training of field Manager	35 batches			70.00	70.00	7	14.00	7	14.00	7	14.00	14	28.00
Sub Total		**0.00**	**1000.00**	**600.10**	1600.10		**304.00**		**304.00**		**304.00**		**688.10**
Mental Health					0.00								
1. Training	25 batches		25.00	25.00	50.00	5	10.00	5	10.00	5	10.00	10	20.00
2. Seminar, Conference	50 batches		100.00	100.00	200.00	10	40.00	10	40.00	10	40.00	20	80.00
3. Medicines	LS			100.00	100.00		20.00		20.00		20.00		40.00
Sub Total		**0.00**	**0.00**	**350.00**	350.00		**70.00**		**70.00**		**70.00**		**140.00**
Tribal Health					0.00								
Tribal Health in CHT		300.00	500.00	700.00	1500.00		300.00		300.00		300.00		600.00

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
2	3	4	5	6	7	8	9	10	11	12	13	14	15
Tribal Health other than CHT		300.00	300.00	500.00	1100.00		300.00		300.00		200.00		300.00
Sub Total		**600.00**	**800.00**	**1200.00**	2600.00	**0.00**	**600.00**	**0.00**	**600.00**	**0.00**	**500.00**	**0.00**	**900.00**
Strengthening UHS	**LS**	**0.00**	**0.00**	**1000.00**	1000.00		**200.00**		**200.00**		**200.00**		**400.00**
Grand Total		**9589.27**	**29266.56**	**5700.10**	**44555.93**		**8169.44**		**8715.64**		**9800.38**		**17870.47**

4.3. Community Based Health Care (CBHC)

4.3.1. Introduction

The Government of Bangladesh recognized the importance of primary health care even before the Alma Ata Declaration in 1978 of universal primary health care. Just after independence in 1971, a setup of primary health care starting from sub-district hospitals, then district hospitals and successively tertiary hospitals were established. The government recognized that, as the population size of the country has been increased to a large extent; universal primary health care could not be possible without extending health care facilities to the grass root levels. The community clinics program began in Bangladesh in 1998 with the implementation of first health and population sector reform program named as Health and Population Sector Program (HPSP). The HPSP aimed to provide a defined Essential Service Package (ESP) for health and family planning service through an integrated approach. The unique component of "Essential Service Package" was to deliver services to the rural community from a static community-based facility named as "community clinic".

It was planned to establish one CC for about 6,000 people to provide health care in each old ward (the sub-union tier). The community people welcomed the decision of the Government and assisted the program by donating lands required for constructing the facilities. A community clinic management group was formed to oversee the activity of CC. A total of 10,723 community clinics were constructed and over 8000 of them commissioned by the year 2000. With the change of the government in 2002, activities of the community clinics were suspended.

The aim of the community clinics is to provide comprehensive primary health care, family planning services and nutritional services to the people from a single center. The present government took the decision to provide services from CCs at door step of the rural people. It is planned that a total of 13500 community clinics will be constructed by June 2012 to address WHO's global call for revitalizing the Primary Health Care.

To achieve the desirable goal of the government, in 2009 the government approved a project titled "Revitalization of community health care initiatives in Bangladesh". The implementation period for the project is July 2009- June 2014. The project aimed to revitalize the community health care system of Bangladesh through strengthening and/or re-establishing the community clinic system, which is one of the highest priority agenda of the government of Bangladesh. It is estimated that there would be a need for about 18000 rural health facilities through which all rural people can get their health, population and nutritional services. About 4500 Upazila and union health facilities, viz. UHC, UHFWC, rural dispensaries, Union Family Welfare Centers etc could provide the necessary health, population and nutritional services for the adjacent rural people. Thus there is a crucial need to establish at least 13500 CCs which would cover all the rural people of Bangladesh. The number might increase considering the geographical (char, haor, hill, hard to reach etc.) and ethnic priorities.

Objective of the ongoing project:

- To strengthen 10624 existing community clinics located in the rural area of Bangladesh
- To introduce community clinic functions in 4500 existing government-owned union and Upazilla health facilities
- To re-build 99 demolished CC's
- To establish 2777 new community clinics in rural areas where community clinics are absent
- To institutionalize all community clinics under an integrated Upazilla and District health system and channelizing effective referral linkage.

Reason for separate Operational Plan

The revitalization of Community Clinics activity started through the project "Revitalization of Community Health Care Initiatives in Bangladesh" since July 2009 & will continue till June 2014. The estimated cost of the project is 2677.48 crore taka with the provision of 500.00 crore taka PA. Since the project got no PA support some of the important activities still remained to be implemented. The foundation training for the Community Health Care Provider (CHCP) and other important training were also planned to be implemented under PA support. Thus it is essential to get the PA for implementing the project line activity.

During last two years of implementation of the project it was felt that some new activities/components need to be included for i) effective service delivery, ii) involvement of the community in CC activities and iii) sustainability of CC. Community Clinic concept is a very well taken concept to the experts who have been working in Primary Health Care. CCs are the important facilities to render primary health care services at the door-step of the rural people. Such an important Program should not run vertically in a projectile approach for an indefinite period. Thus the main streaming of the CC activities is also essential. But since the project is in the middle stage and some of the major activities are in process, both the project and the OP need to work together. After the project completion (June 2014), the activities of the CC will be mainstreamed and merged with the health system to serve the rural people.

To implement all these activities require additional resources. The new activities/ components are planned to be implemented through the sector Program. To complement, supplement and for better services from next fiscal year and for continuation of CC activities after June 2014 the new Operational Plan (OP) titled "Community Based Health Care" has been prepared under the next sector Program (HPNSDP) for the period from July 2011-June 2016.

The ongoing GAVI-HSS support will be continued with the modification in the principles of Health Funding Platform (HSFP) of GAVI. The funding and activities of future GAVI support will be harmonized with the next sector Program.

4.3.2. Objectives

- Ensure health, family planning and nutritional services from the community clinics for all rural people;
- Functional linkage among the public facilities in union and below level to ensure the community participation for health, family planning and nutritional services;
- Establish and maintain effective functional cooperation and coordination of all health, family planning and nutrition service provider in the rural area;
- To institutionalize all community clinics under an integrated Upazilla Health System(UHS) and District Health System(DHS) and channelizing effective referral linkage;
- To reduce child and maternal mortality and morbidity;
- To provide health care services to the senior citizen, adolescents, disabled and under privileged people of the rural community;
- Introduce e-health in community clinics;
- To increase the contraceptive prevalence rate (CPR) and decrease the Net Reproductive Rate (NRR) at replacement level;
- To ensure healthy life style and increase life expectancy of people;
- BCC will be strengthened through CC;
- Strong MIS will be established;
- Mainstreaming the Community Clinic Approaches in the HPN sector.

4.3.3. Components

Component-1: HR Management

Activity:

- Institutionalization of community clinics under an integrated Upazilla Health System and District Health System
- Explore the scope for functional linkage among the public facilities in union and below level and establish the linkage to ensure the community participation for health, family planning and nutritional services;
- Establish and maintain effective functional cooperation and coordination of all health, family planning and nutrition service provider (GO and NGO) in the rural area;



Component-2: Procurement of goods and services

Activity:

- Procurement of medicine, furniture, MSR, equipments, printed materials, vehicle etc. to ensure supplies and services in the CC and office;
- Provide one three wheeler (VAN) to 500 CC for piloting: (the three wheeler will be given to a poor family by the CG with the condition that the poor man will provide free service to the CC through transferring the patient to the UHFWC/UHC when necessary);
- Provide one motorcycle to one MO in the UHC to ensure monitoring and supervision of CC activities.

Component-3: Establish e-health and MIS in the CC

Activity:

- Introduce e-health for the rural people through CCs;
- Establish Strong MIS in the CC and linking it with the UHS
- Establish online reporting system;

Component-4: HR Development

Activity:

- Provide training to the CHCP, HA, FWA and other public providers to ensure services;
- Provide overseas training & study tour to the concerned officials.

Component-5: Community mobilization

Activity:

- Provide training to the Community Group, Community Support Group, Local Government Representatives and other stakeholders for the community participation and mobilization;
- BCC for MNCH activity promotion in the CC to reduce maternal and child mortality;
- BCC on health seeking behavior and family planning from CC

Component-6: Mainstreaming the CC in the UHS

Activity:

- Mainstreaming the Community Clinic Approaches in the HNP sector though establishing a regular GOB set-up;
- Channelize effective referral linkage;
- Introduction of Family Health Card to maintain complete data of every individual in the family
- Introduction of Growth monitoring chart for monitoring the growth of children

Component-7: Infra-structure Management and Monitoring & supervision of CC

Activity:

- Establish solar panel in the community clinic where electric supply is not available
- Ensure routine maintenance of the CC in coordination with HED and local body.
- Electric line installation where ever possible
- Ensure monitoring, supervision (as per annex- plan) and evaluation to ensure services in the community clinics.
- Functional linkage of domicile and static Health, Family Planning and Nutritional Services in the rural Health system.

4.3.4. Cross Cutting Issues

- Training. OP-MNCAH, ESD, TB-LC, NASP, CDC, NCD, NEC, IST, NNS, MCRAH, FPFSD, TRD
- Management of HR, DGHS,DGFP & CC project
- Procurement OP-PLSM-CMSD, PSSM-FP
- Monitoring and evaluation. OP-PMR-DGHS, HIS-EH, MIS



- E- Health and online reporting. OP- HIS-EH, MIS
- Infrastructure development. OP -PFD
- Medical waste management. OP-ESD, HSM

4.3.5. Indicators

The activities planned under this OP will contribute to all the results under Component 1 (Result 1.1, increased utilization of essential HPN services, Result 1.2 improved equity in essential HPN utilization, Result 1.3, improved awareness of health behavior) and, in particular, Result 1.4 improved primary health care-community clinics systems.

Sl. No	Indicators	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
(1)	(2)	(3)	(4)	(5)
1.	Community Clinics (CC) are available (in terms of number of CCs functional)	10,624 (RCHCIB- study 2010)	13,500	Sustain
2.	Community Clinics (CC) utilized	10323	13,500	Sustain
3.	Number of community clinic functional with trained staff and medicines	None with CHCP	13,500	Sustain
4.	Number of community clinic management committee meeting held	500	13,500	18,000
5.	% of community clinic with medicines available	60%	100 %	100 %
6.	Number of CHCP trained	Nil	13,500	sustained
7.	Training of the community group (CG)	1000	13,500	18,000

4.3.6.Budget

Component and Year wise physical and financial target of OPs

Agency: DGHS/MOHFW

Name of the OP: Community Based Health Care

(Tk in Lakh)

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1: Salary for CHCP and Officials	13559 Persons	29091.20	0.00	0.00	29091.20	0	0.00	0	0.00	0	0.00	13559	29091.20
Sub Total		**29091.20**	**0.00**	**0.00**	**29091.20**	**0**	**0.00**	**0**	**0.00**	**0**	**0.00**	**0**	**29091.20**
Component-2: Training													
Training of CHCP	13500	-	4914.00	-	4914.00	11,168	4065.00	2,332	849.00	0	0.00	-	0.00
Training of CG	162000	-	1935.00	-	1935.00	136,884	1635.00	25,116	300.00	0	0.00	-	0.00
Training of UP Chairman & Members	22500	-	2010.00	-	2010.00	-	0.00	22,500	2010.00	0	0.00	-	0.00
Training of Support Group	607500	-	3888.00	-	3888.00	-	0.00	607,500	3888.00	0	0.00	-	0.00
Refreshers training of CHCP	13500	-	700.00	-	700.00	-	0.00	-	0.00	13,500	700.00	-	0.00
Training of CHCP on IT	13500	-	756.00	-	756.00	-	0.00	13,500	756.00	0	0.00	-	0.00
Training /Study Tour for the UZ/District/Central level managers	370	-	1400.00	-	1400.00	-	0.00	93	350.00	93	350.00	185	700.00
Sub total		**0.00**	**15603.00**	**0.00**	**15603.00**	**148052**	**5700.00**	**671041**	**8153.00**	**13593**	**1050.00**	**185**	**700.00**
Component-3: Procurement of Goods													
Bi-cycle	13500	-	675.00	-	675.00	-	0.00	13,500	675.00	0	0.00	-	0.00
Mobile Set for CHCP	13500	-	405.00	-	405.00	-	0.00	13,500	405.00	0	0.00	-	0.00
Three Wheeler Van for Patient carrying (500 Piloting)	500	-	100.00	-	100.00	-	0.00	250	50.00	250	50.00	-	0.00
Motor Cycle(for 1 MO in each Upazilla)	500	-	750.00	-	750.00	-	0.00	500	750.00	0	0.00	-	0.00

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Vehicle (1 Jeep, 1 Pick-up)	2	-	100.00	-	100.00	-	0.00	2	100.00	0	0.00	-	0.00
Steel Almirah to old CCs (10624)	10624	-	1593.60	-	1593.60	-	0.00	5,624	843.60	5,000	750.00	-	0.00
Carrying Bag for CHCP	13500	-	270.00	-	270.00	-	0.00	13,500	270.00	0	0.00	-	0.00
Sub Total		**0.00**	**3893.60**	**0.00**	**3893.60**	**0**	**0.00**	**46876**	**3093.60**	**5250**	**800.00**	**0**	**0.00**
Component-4: Procurement of Works													
Establishment of solar panel in CC	2000	-	-	1500.00	1500.00	-	0.00	667	500.00	667	500.00	667	500.00
Electric line installation where ever possible	8000	700.00	-	-	700.00	-	0.00	2,000	200.00	2,000	200.00	4,000	300.00
Sub Total		**700.00**	**0.00**	**1500.00**	**2200.00**	**0**	**0.00**	**2667**	**700.00**	**2667**	**700.00**	**4667**	**800.00**
Component-5: Recurrent expenditure													
Maintenance Cost for CC	13500	-	-	8100.00	8100.00	-	0.00	1,500	900.00	2,500	1500.00	9,500	5700.00
Procurement of medicine	13500	1000.00	41863.12	9358.90	52222.02	-	0.00	-	0.00	-		13,500	52222.02
Transport cost of Medicine from Upazilla Health Complex to CC	13500	696.00	1000.00	324.00	2020.00	-	0.00	-	0.00	-	400.00	13,500	1620.00
CG meeting related expenditure	13500	243.00	1134.00	243.00	1620.00	-	0.00	833	100.00	1,833	220.00	10,833	1300.00
Utility Services	40500	7249.50	-	-	7249.50	-	0.00	2217	419.50	6454	1200.00	31828.5	5630.00
Sub Total		**9188.50**	**43997.12**	**18025.90**	**71211.52**	**0**	**0.00**	**4550**	**1419.50**	**10787**	**3320.00**	**79161.5**	**66472.02**
Component-6: Printing and publication													
Stationary for the CCs (11500-13500)	13500	1024.00	515.00	81.00	1620.00	-	0.00	3,500	420.00	6,667	800.00	3,333	400.00
Printing of Register, forms, outdoor tickets etc.	13500	320.71	1041.27	320.71	1682.69	-	0.00	3,070	382.69	8,023	1000.00	2,407	300.00
Family Health Card	13500	-	1859.38	22671.14	24530.52	51	100.00	1,749	3436.21	9,938	17530.00	1,763	3464.31
Growth monitoring chart	13500	66.59	518.75	101.25	686.59	-	86.59	1,294	200.00	1,294	200.00	10,912	200.00
Sub Total		**1411.30**	**3934.40**	**23174.10**	**28519.80**	**51**	**186.59**	**9613**	**4438.90**	**25922**	**19530.00**	**18415**	**4364.31**

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-7: Supervision & Monitoring													
Supervision from National, Division, District & Upazilla level	13500	1000.00	960.00	13240.00	15200.00	167	200.00	2,500	2000.00	4,167	5000.00	6,667	8000.00
Sub Total		**1000.00**	**960.00**	**13240.00**	**15200.00**	**167**	**200.00**	**2500**	**2000.00**	**4167**	**5000.00**	**6667**	**8000.00**
Grand Total		**41391.00**	**68388.12**	**55940.00**	**165719.12**		**6086.59**	**737,247.00**	**19805.00**	**62,386.00**	**30400.00**	**109,095.50**	**109427.53**

4.4. TB and Leprosy Control (TB-LC)

4.4.1. Introduction

The Operational Plan for Mycobacterial Disease (Tuberculosis and Leprosy) Control (MBDC) comprises of two major programs, viz. National Tuberculosis Control Program and National Leprosy Elimination Program. Tuberculosis is one of the most significant health problems in Bangladesh since long. About more than 50% of the adult population is infected with Mycobacterium tuberculosis. Every year more than 300,000 people develop active TB; nearly 50% of them are infectious pulmonary TB and can spread the infection to others. About 64,000 people die every year from this disease. Under the Mycobacterial Disease Control (MBDC) unit of the Directorate General of Health Services (DGHS), the National Tuberculosis Control Program (NTP) is working with a vision of eliminating TB as a public health problem from Bangladesh. The NTP adopted the DOTS strategy and started its field implementation in November 1993. The program progressively expanded to cover all Upazilas by mid-1998. By 2003, 99% of the country's population including metropolitan cities was brought under DOTS services and by 2007, the geo-administrative coverage was 100%. Bangladesh is implementing Stop TB Strategy since 2006. High treatment success rates were achieved from the beginning and the target of 85% treatment success has been met since 2003. The program has successfully treated nearly 92% of the new smear positive cases registered in 2008 and has detected 74 % of the estimated new smear positive cases in 2009. National Tuberculosis Control Program is expected to contribute significantly to the achievement of the TB related Millennium Development Goal such as halving the TB death rate and TB prevalence rate (compared to 1990) and, halt and begin to reverse the TB incidence by 2015.

Leprosy was eliminated as a public health problem (prevalence of less than 1case per 10,000 populations) nationally in 1998. However, it is still endemic (over 1 case per 10,000 populations) in 5 districts and 5,238 new cases of leprosy were detected during 2009. Training of health care staff, awareness Program among the population, active detection of leprosy cases in pockets of high leprosy prevalence and treatment of patients and assistance for cured but deformed persons needs to be continued. For removal of stigma, the Leper`s Act (1898) needs to be repealed. To reduce grade 2 deformity rate to less than 5% among the newly detected cases it is very much needed to ensure early case detection.

4.4.2. Objectives

- To reduce the TB morbidity, mortality and decrease transmission of infection until it is no longer a public health problem.
- To achieve by mid-2013 leprosy elimination in all five districts, while reducing leprosy prevalence at national level to less than 0.15 cases per 10,000 populations.

4.4.3. Components

1. National Tuberculosis Control Program (NTP)
2. National Leprosy Elimination Program

Component 1: National Tuberculosis Program

TB control is a successful public health program to be maintained. Estimated mortality is 45/100,000 population. TB prevalence rate (all forms) fell from 630 per 100,000 population in 1990 to 223 in 2007, TB incidence (all forms) reduced from 264 per 100,000 population in 1990 to 223 per 100,000 population in 2007, and the TB incidence (new smear positive cases) reduced from 119 per 100,000 population in 1990 to 100 per 100,000 population in 2007. (Global TB Control WHO Report 2009) -The quality of DOTS will be strengthened as well as laboratory diagnosis, case identification and case holding. MDR TB will be reduced from 3.6% to 2.0%. Laboratories at some of the relevant levels may have to be strengthened and utilization of some existing laboratories may be co-opted to serve the TB program. There have been difficulties in assuring the quality of sputum smear microscopy (SSM). Capacity and commitment at microscopy centers (MCs) needs to be strengthened. As TB is a poverty-related disease, any contribution in the area of improving overall living conditions, increasing household income, improving nutrition, etc. has also an impact on reducing the burden of TB.

The new sector program will fully support National Strategic Plan to Control TB (2011-2015) as a priority in order to halve the prevalence and mortality and begin to reduce the incidence includes. Supportive supervision has to be meticulous to ensure that DOTS is implemented with commitment and referral is followed up effectively to preclude development of MDR, XDR-TB. ACSM will be enhanced to improve compliance. Existing private practitioners will be mobilized in a more organized and sustained way. One of the reasons of spread of TB and MDR-TB is the low nutritional status of the patients, most of whom are poor. The TB control program will liaise with the nutrition program to facilitate nutrition services for these patients. This will be monitored on a regular basis. Measures will be taken for sustainability of the successes achieved through supervision, monitoring and strengthening of MIS system.

Activities (TB)

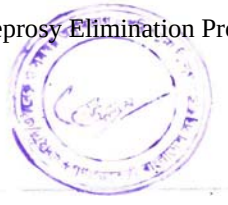
- Pursue high quality DOTS expansion and enhancement
- Address TB/HIV, MDR-TB, and the needs of poor and vulnerable populations
- Strengthening DOTS service at primary health care level
- Ensure quality of Lab. services and diagnosis of MDR TB by establishing national and regional reference Lab.
- Engage all care providers
- Empower people by TB promotion and prevention, and communities through partnership
- Enable and promote research
- Capacity Building (HRD) for improving quality of services
- Procurement of drugs, equipments and other logistics for Tuberculosis Control
- Supervision, monitoring & other Management Services for improving Program management
- Develop IEC material
- Strengthening TB MIS at National and Sub National Level

Component 2: National Leprosy Elimination Program

During 1991, at the time of adaptation of WHO resolution, Bangladesh was estimated to have 136,000 leprosy cases, giving a prevalence of 13.6/10,000 population. Country wide expansion of MDT including all upazila hospitals, integration of leprosy services into the general health services, establishing model partnerships with NGOs, effective collaboration with some key groups like village doctors, religious leaders, Bangladesh Scouts and implementation of some focused activities like SAPEL, LEC, etc. have resulted in remarkable reduction of registered prevalence. At the end of December 1998, the registered prevalence came down for the first time to less than one case per 10,000 population nationally (0.87/10,000 population). The registered prevalence is gradually declining in each year and has reached at 0.51/10,000 population by end of 2003. But still there were 8 districts and 2 metros where prevalence was more than 1/10,000 population. These are Dhaka and Chittagong metropolitan cities and Nilphamari, Rangpur, Lalmonirhat, Gaibandha, Dinajpur, Khagrachari, Rangamati and Bandarban districts. Another important indicator for leprosy elimination which has not been achieved in National Leprosy Elimination Program (NLEP) of Bangladesh is grade 2 deformity rate among newly detected cases is about 8.92% at the end of 2003 and it should be reduced to less than 5%. Now NLEP is consolidating its efforts to achieve sub-national (district level) elimination and to sustain elimination status with further reduction of prevalence at national level and to achieve grade 2 deformity among new cases to less than 5%. The main objectives of NLEP are to detect leprosy cases and ensure whole course of treatment. As a result, the leprosy patients will be cured and will get rid of development of physical deformity or disability and thus economic destitution. On the other hand, treatment of cases will cut the chain of transmission and will thus ensure healthy environment for other people.

Activities

- Simplification of National Guidelines for further integration of Leprosy Services into the General Health Services.
- Establishing partnership with academic institution private practitioners and dermatologists and other stakeholders
- Strengthening of Urban Leprosy Elimination Program


- Alliance with all stakeholders for keeping Leprosy as a health agenda
- Increasing community awareness
- Organized skin camp at UPZILA, district and metro city to detect new leprosy cases
- Supervision of MDT centre\
- Strengthening of MIS monitoring and reporting.
- To give more emphasis on leprosy in medical curriculum
- Conduct researches on leprosy
- Organized training and refresher program on leprosy for medical officers and field label health workers.

4.4.4. Cross Cutting Issues

- Management of Nutrition for TB. OP-TB-LC, NNS
- Capacity Development, Training: OP-IST, PSE
- Integration of TB MIS with routine HIS: OP-CDC & HIS-EH
- Rehabilitations of leprosy affected deformed/ disabled persons and palliative care. MOSW

4.4.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. More specifically, this OP contributes to Component 1. Service Delivery, Result 1.1 increased utilization of essential HPN services. The activities under this OP also contribute to Result 1.2, improved equity in essential HPN service utilization and Result 1.4, improved primary health care- community clinics.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Percentage of smear positive TB cases detected among 100,000 population	74% (2009, NTP MIS Report)	>75%	>75%
2	Percentage of detected smear positive TB cases treated successfully	92% (2009, NTP MIS Report)	>92%	>92%
3	MDR Survey conducted	Nil	1	1
4	MDR patients identified and managed	286 (2009, NTP MIS Report)	1,502	2,452
5	Sustaining Leprosy Elimination at the national level and reducing the new cases at least 10% per year.	0.28/10,000 (2009, Leprosy Program)	<0.20/10,000	<0.15/10,000
6	No. of districts with Leprosy prevalence <1/10,000 population	5 districts (2009, Leprosy Program)	0	0
7	Percentage of newly detected cases with visible deformity	10.73% (2009, Leprosy Program)	<8.00%	<5%

4.4.6.Budget

Component and Year wise physical and financial target of OPs

Agency: DGHS

Name of the OP: Tuberculosis and Leprosy (TB & Lep) Control

(Tk in Lakh)

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-TB:													
Human Resource *		-	-										
Consultancy	18 Persons	-	-	1,449.48	1,449.48	18	262.32	18	275.44	18	289.21	36	622.52
Pay of Establishment	36 Persons	-	-	576.32	576.32	36	104.30	36	109.52	36	114.99	72	247.52
Training & Seminar, Conference												-	-
Local Training	6426 Batch	-	273.19	2,266.35	2,539.54	1,071	458.82	1,071	482.17	1,071	506.68	2,142	1,091.87
Foreign Training	60 Persons	-	-	580.19	580.19	10	105.00	10	110.25	10	115.76	20	249.18
Seminar, Conference/Meeting	462 Nos	22.10	-	812.00	834.10	77	166.40	77	166.60	77	166.81	154	334.29
Procurement												-	-
Medicine/Drugs	18 Package	1,177.92	3,316.16	13,312.17	17,806.25	3	4,247.24	3	4,434.11	3	3,050.40	6	6,074.49
MSR	18 Package	535.99	778.84	812.00	2,126.83	3	359.40	3	421.75	3	434.72	6	910.96
Motor Vehicles (Pickup)*	6 Nos	-	-	173.88	173.88	-	-	6	173.88	-	-	-	-
Machinery and Other Equipment	5 Package	27.63	-	1,356.50	1,384.13	1	276.30	1	276.55	1	276.81	2	554.47
Computers and Accessories	5 Package	27.63	-	47.84	75.47	1	18.80	1	16.84	1	15.02	2	24.81
Computer Software	5 Package	13.81	50.00	-	63.81	1	52.50	1	2.63	1	2.76	2	5.93
Other Office Equipments	5 Package	11.05	-	-	11.05	1	2.00	1	2.10	1	2.21	2	4.75
Furniture and Fixtures	5 Package	16.58	-	-	16.58	1	3.00	1	3.15	1	3.31	2	7.12
Tele communication equipments	5 Package	11.06	-	-	11.06	1	2.00	1	2.10	1	2.21	2	4.75
Stationary, etc. *	5 Lump sum	8.29	-	-	8.29	1	1.50	1	1.58	1	1.65	2	3.56
Repair & Maintenance (Vehicles & Equipments)	Lump sum	179.60	-	175.00	354.60		67.50		69.13		70.84	-	147.14
Research	90 Nos		148.65	151.20	299.85	15	50.24	15	57.49	15	79.85	30	112.27

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Services, Supplies, Works, etc.	Lump sum	704.52	-	2,325.71	3,030.22		573.90		618.16		598.26	-	1,239.91
Renovation and remodeling	5 Package	200.00	-	-	200.00	2	100.00	1	50.00		-	1	50.00
CD VAT *	Lump sum	276.28	-	-	276.28		50.00		52.50		55.13	-	118.66
Sub Total		3,212.45	4,566.84	24,038.64	31,817.94		6,901.22		7,325.92		5,786.61		11,804.19
Component-Leprosy:												-	-
Training & Seminar, Conference					-							-	-
Local Training	518 Batch	-	68.30	137.30	205.60	83	37.98	83	39.47	88	41.04	176	87.10
Foreign Training	18 Persons	-	-	55.26	55.26	3	10.00	3	10.50	3	11.03	6	23.73
Seminar, Conference/Meeting	30 Nos	5.53	-	-	5.53	5	1.00	5	1.05	5	1.10	10	2.37
Research	30 Nos	82.88	-	16.80	99.68	5	18.36	5	19.11	5	19.90	10	42.32
Sub total	596	88.41	68.30	209.35	366.06	96.00	67.34	96.00	70.13	101.00	73.07	202.00	155.52
Grand Total		3,300.86	4,635.14	24,248.00	32,184.00	96.00	6,968.56	96.00	7,396.06	101.00	5,859.68	202.00	11,959.71

4.5. National AIDS/STD Program (NASP)

4.5.1. Introduction

HIV prevalence in Bangladesh is currently low, with a prevalence of less than 0.1% of the reproductive age population. However, prevalence in injecting drug users (IDU) has become an emerging threat which needs to address with special emphasis.

The number of reported HIV diagnoses was 1745 as of 2009. Many are migrant workers who were screened before or during employment. The total number of people with HIV, estimated by NASP is 7,500. Less than 500 people are currently receiving anti-retroviral therapy (ART). At present, ART service providers, provision of diagnostic services and in-patient facilities are very limited in both public and private sector.

Youth aged 15-24 years are approximately one-fifth of the total population of Bangladesh. Although their estimated HIV prevalence is negligible, a national survey of 11,188 youth conducted in 2008 (NASP, Save the Children USA, & ICDDRB, 2009 (forthcoming)) showed that young people are at risk of contracting STIs and HIV because of their lack of knowledge and awareness regarding HIV, their risky sexual behavior and their limited access to sexual and reproductive health information and services.

The National AIDS Committee (NAC) is a multi sectoral body, chaired by the Minister for Health and Family Welfare, mandated to govern the national response. Three technical sub-committees support the NAC. The National AIDS/STD Program (NASP) coordinates and supports partners in the national AIDS response, including government agencies, civil society organizations and development partners..

Prevention services are implemented mainly by NGOs, especially the interventions targeting the most vulnerable groups such as injecting drug users, sex workers and men who have sex with men.

Between 2005 and 2009, the main interventions for HIV prevention were funded by three main financing streams–GFATM (rounds 2 and 6), USAID's Bangladesh AIDS Program, and HIV/AIDS Targeted Interventions under MOHFW's Health, Nutrition and Population Sector Program (HNPSP). These interventions primarily focused on prevention services, implemented mainly by NGO, targeted at the most at risk population (MARP) such as IDU, MSM, MSW, transgender, internal migrants, FSW and their clients. The intervention package included distribution of condoms (and lubricants), distribution of clean needle and syringe (for IDU), voluntary counselling and testing, behaviour change communication and providing ART for HIV positive people.

There is a National Strategic Plan for HIV and AIDS (NSP 2011-2015) tol guide the national response and activities.

4.5.2. Objectives

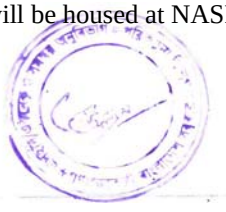
- Implement services to prevent new HIV infections ensuring universal access;
- Provide universal access to treatment, care and support services for people infected and affected by HIV;
- Strengthen the coordination mechanisms and management capacity at different levels to ensure an effective multi-sector HIV response; and
- Strengthen the strategic information systems and research for an evidence based response.

4.5.3. Components

1. Strengthen the management capacity of NASP for national program management
2. Increasing the scale and quality of targeted interventions for vulnerable population
3. Achieve universal treatment, care and support for people with HIV
4. Develop and implement one unified national monitoring and evaluation plan, including surveillance.

Component 1: Strengthen the management capacity of NASP for national program management

A core team with a few full time experts will be housed at NASP to ensure the stewardship and coordination.



Activities:

- TA for financial management, procurement, contract management, monitoring and evaluation, operational research, etc.
- Training (both local and overseas) for the core team.

Component 2: Increasing the scale and quality of targeted interventions for vulnerable population

The most vulnerable groups are Female sex workers of Brothel, Street and Hotel/Residence based, and their clients, MSM and Transgender, IDUs and External Migrants. Based on population size and local appropriateness, services might target more than one of these groups.

Activities:

- A comprehensive service package will be developed for most at risk population (MARPs) which will include:
    a. Provision of condom/lubricant
    b. Behaviour change communication
    c. Diagnosis and treatment of sexually transmitted infections (STI)
    d. Voluntary counseling and testing (VCT)
    e. Assessment of need and referral to health services (e.g. TB and hepatitis B and C).
- Additional harm reduction interventions for IDUs which will include:
    a. Distribution of clean needle and syringe
    b. Opioid substitution therapy
    c. Provision of primary health care needs arising out of injection use (e.g. abscess management).

Component 3: Achieve universal treatment, care and support for people with HIV

Activities:

- Procurement of ARV
- All HIV positive patients will be registered with NASP to ensure that all those who are eligible are on ART. NASP and the
- Guidelines on ART will be developed and updated as required and the health professionals will be trained on administering ART.

Component 4: Develop and implement one unified national monitoring and evaluation plan, including surveillance

Activities:

- Conduct serological surveillance and behavioural surveillance surveys in every other year.
- Monitoring and evaluation of program implementation and track the indicators regularly.
- A national AIDS MIS that is currently being piloted will be developed and maintained.
- Supervision of the NGO services adequately and carryout performance evaluation of the NGO by developing an implementation guideline.

4.5.4. Cross Cutting issues

- Promote intersectoral coordination and collaboration to deal more effectively the MARPs. (OP-MOWCA, MOInf, MOHA, MORA, MOYSA)
- Promote awareness and behavioral change and strategies for MARP. (OP-HEP, IEC)
- Integrated diseases surveillance. (OP-CDC)
- Manage nutrition of HIV/AIDS cases and palliative care. (OP-NNS)



4.5.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. More specifically, the activities under this OP contribute to the achievement of Result 1.1, increased utilization of essential HPN services, Result 1.2, improved equity in essential HPN service utilization and Result 1.3, improved awareness of healthy behavior.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Prevalence of HIV among Injecting Drug Users	0.9% BSS, Annually, NASP	0.9%	0.9%
2	Prevalence of active syphilis among sex workers	BSS, Annually, NASP		
	• Brothel based (female)	1.7 - 10.7, NASP	1.4 – 7.0	1.0 – 5.0
	• Street based (female)	6.2 - 7.5, NASP	5.5 - 7.0	3.5 – 5.5
	• Hotel based (male)	1.6 - 6.1, NASP	1.0 –4.5	0.5 – 3.0
3	Number of Medical personnel trained in HIV-	NA , NASP	500	800
4	Number of Health facilities with capacity to deliver care to HIV positive people	NA , NASP	40	60
5	Number of treatment of opportunistic infections.	NA , NASP	500	600
6	Number of eligible HIV+ on ART	510	700	800

4.5.6.Budget

Component and Year wise physical and financial target of Ops.

Agency: DGHS, MOHFW.

Name of the OP: National AIDS/STD Program (NASP)

(Tk in lakh)

Name of the Components/Major Activities	Total Physical and financial target					Year – 1		Year – 2		Year – 3		Year – 4 & Year – 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	**2**	3	4	5	6	7	8	9	10	11	12	13	14
Component 1:	Strengthen the management capacity of NASP for national program response and management												
Conduct advocacy in different level	100	0.00	500.00	0.00	500.00	20	100.00	20.00	100.00	20.00	100.00	40.00	200.00
Observation of World AIDS Day	5	0.00	500.00	0.00	500.00	1	100.00	1.00	100.00	1.00	100.00	2.00	200.00
Procure TA support – consultants for NASP	216mm	0.00	324.00	0.00	324.00	24	36.00	48.00	72.00	48.00	72.00	96.00	144.00
Procure support staff for NASP	3	0.00	80.00	0.00	80.00	3	16.00	3.00	16.00	3.00	16.00	3.00	32.00
Procure different goods	LS	0.00	165.00	0.00	165.00	Lt	165.00	0.00	0.00	0.00	0.00	0.00	0.00
Organize Training/ Workshop	6080	0.00	2000.00	0.00	2000.00	1000	350.00	1200.00	450.00	1400.00	450.00	2480.00	750.00
Program Monitoring & Overhead cost	LS	800.00	200.00	0.00	1000.00	LS	150.00	LS	200.00	LS	200.00	LS	450.00
Subtotal		800.00	3769.00	0.00	4569.00		917.00		938.00		938.00		1776.00
Component 2:	Increasing the scale and quality of targeted interventions for vulnerable population												
Intervention for Brothel based Sex Workers/ Client of Sex Workers	10	0.00	1630.00	222.00	1852.00	1.00	470.00	2.00	470.00	3.00	470.00	4.00	442.00
Intervention for Street based Sex Workers	8	0.00	1280.00	0.00	1280.00	1.00	256.00	3.00	356.00	2.00	356.00	2.00	312.00
Intervention for Hotel and Residence based Sex Workers	5	0.00	1100.00	0.00	1100.00	1.00	220.00	1.00	220.00	1.00	220.00	2.00	440.00

Name of the Components/Major Activities	Total Physical and financial target					Year – 1		Year – 2		Year – 3		Year – 4 & Year – 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	**2**	3	4	5	6	7	8	9	10	11	12	13	14
Intervention for Internal/External Migrants	10	0.00	1550.00	0.00	1550.00	2	310.00	2	310.00	2	310.00	4	620.00
Intervention for MSM and Transgender	5	0.00	1400.00	0.00	1400.00	1	280.00	1	280.00	1	280.00	2	560.00
Harm Reduction Program	5	0.00	1000.00	0.00	1000.00	1	150.00	1	200.00	1	200.00	2	450.00
Drug Substitution	5	0.00	670.00	0.00	670.00	1	134.00	1	134.00	1	134.00	2	268.00
Intervention among emerging and new vulnerable groups	10	0.00	670.00	0.00	670.00	2	134.00	2	134.00	2	134.00	4	268.00
Intervention for the Youth	7	0.00	736.00	0.00	736.00	1	147.20	2	247.20	2	247.20	2	94.40
Subtotal		0.00	10036.00	222.00	10258.00	11.00	2101.20	15.00	2351.20	15.00	2351.20	24.00	3454.40
Component 3:	Achieve universal treatment, care and support for people with HIV												
Voluntary Counseling and Testing services	5	0.00	1000.00	0.00	1000.00	1	200.00	1	200.00	1	200.00	2	400.00
PMTCT and Couple based program	5	0.00	350.00	0.00	350.00	1	70.00	1	70.00	1	70.00	2	140.00
Community and Home based care of PWHAs	5	0.00	450.00	0.00	450.00	1	90.00	1	90.00	1	90.00	2	180.00
Anti-retroviral drugs (ARV)	LS	0.00	4500.00	0.00	4500.00	LS	500.00	LS	1000.00	LS	1000.00	LS	2000.00
CD/VAT		500.00	0.00	0.00	500.00		100.00		100.00		100.00		200.00
Subtotal		500.00	6300.00	0.00	6800.00	3.00	960.00	3.00	1460.00	3.00	1460.00	6.00	2920.00
Component 4:	Develop and implement one unified national monitoring and evaluation plan, including surveillance												
Conduct integrated bio-behavioral surveillance	3	0.00	300.00		300.00	1	100.00			1	100.00	1	100.00
Develop guideline, module, manual etc.	5	0.00	200.00		200.00	1	40.00	4	160.00				
Sub total		0.00	500.00	0.00	500.00	2.00	140.00	4.00	160.00	1.00	100.00	1.00	100.00
Component 5: Activities under GFATM	LS												
Advocacy to create enabling environment		0.00	0.00	421.05	421.05		84.21		84.21		84.21		168.42

Name of the Components/Major Activities	Total Physical and financial target					Year – 1		Year – 2		Year – 3		Year – 4 & Year – 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	**2**	3	4	5	6	7	8	9	10	11	12	13	14
Strengthening NASP, monitoring and evaluation system		0.00	0.00	1552.15	1552.15		310.43		310.43		310.43		620.86
Strengthening the capacity of PR for effective national response		0.00	0.00	503.55	503.55		100.71		100.71		100.71		201.42
Conduct Operational Research		0.00	0.00	1968.75	1968.75		393.75		393.75		393.75		787.50
Programme Management-GOB		0.00	0.00	719.40	719.40		143.88		143.88		143.88		287.76
Subtotal		0.00	0.00	5164.90	5164.90	0.00	1032.98	0.00	1032.98	0.00	1032.98	0.00	2065.96
Grand Total=		1300.00	20605.00	5386.90	27291.90		5151.18		5942.18		5882.18		10316.36

4.6. Communicable Diseases Control (CDC)

4.6.1. Introduction

Control of communicable diseases continues to be one of the highest public health priorities, both nationally and internationally. Reduction in morbidity and mortality due to communicable diseases will have positive impact on a number of MDG goals as these diseases often affect the children and mothers. The communicable diseases of public health importance include malaria, Kala-azar, infestation with filarial and other worms, and avian influenza and influenza by novel virus. The country has been facing emergence of zoonotic diseases like Nipah, anthrax, brucellosis and food and waterborne diseases like hepatitis due to viruses, diarrhoeal disorders, enteric fever and leptospirosis. The arthropod borne diseases like dengue and Chikungunya with proved and potential of epidemicity and endemicity. Bangladesh is a signatory of International Health Regulation (IHR) 2005 and has to build its capacity in terms of detection and responding to case and outbreak of emerging diseases and has to strengthen its capacity to deal with the public health emergency with national and international concern. The country has started a number of target oriented programs to alleviate the sufferings like that for malaria, Kala-azar, filarial, intestinal worms, avian and pandemic influenza etc. and has achieved some progresses. Evidence based intervention and public health approaches through an integrated IT based surveillance system might augment the programs. Due to lack of evidence based intervention and policy planning, there remains weakness in achieving health related MDG and ensuring equitable access to health care services by the marginalized and disadvantaged groups of population. The operation plan proposed for communicable diseases including disease surveillance will help the country to attain at different goals of MDG and a medium earning country by 2021 during 50th anniversary of independence.

Bangladesh is at very high risk from climate change impacts, including those related to human health. It is estimated that the lives and livelihoods of 36 million people in the southern coastal regions will be affected by climate change, eg. water and food-borne diseases (e.g. cholera and other diarrheal diseases); vector borne diseases (e.g. dengue and malaria); respiratory diseases due to increases in air pollution and aeroallergens; impacts on food and water security (e.g. malnutrition); and psychosocial concerns from the displacement of populations through sea level rise and after disasters. CDC will address the cross cutting issues related to climate change impact on health.

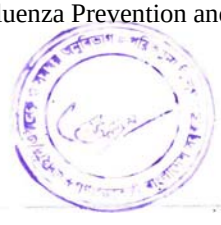
4.6.2. Objectives

- To reduce malaria morbidity and mortality by 60% of the base line of 2008 within 2016
- To eliminate filaria from endemic areas reducing the Mf prevalence to <1% by 2015 and to reduce the burden of soil transmitted helminthiasis to 15% by 2016
- To eliminate Kala-azar reducing the burden to <1 per ten thousand population in the endemic area by 2016
- To strengthen capacity for detection, containment and management of emerging diseases with special emphasis for reducing death related to rabies
- To prevent and control avian and pandemic influenza and to prepare for reducing morbidity & mortality in human with the aim to minimize socio-economic & environmental impact
- To facilitate efforts in reduction of disease burden by providing evidence in planning and implementation of public health activities through disease surveillance

4.6.3. Components

Under this operational plan six (06) individual components will be implemented. The programs are as follows:

1. Malaria and other Vector Borne Disease Control Program
2. Filariasis Elimination & STH Control Program
3. Kala-Azar Elimination Program
4. Emerging & Re-emerging Disease Control Program
5. Avian and Pandemic Influenza Prevention and Control Program



6. Integrated Disease Surveillance

Component-1: Malaria and Other Vector Borne Diseases Control

a. Malaria Control Program

Malaria is one of the major public health problems in Bangladesh being endemic in 13 districts with 70 endemic upazilas covering 620 unions with a total population of 10.9 million. Over 98% of the total malaria cases of the country are reported from these areas. These endemic areas are in the east and north-east border facing international boundaries with the eastern states of India and a small part of Myanmar. The forested and hilly terrain has the geo-physical potentials for intense malaria transmission throughout the year. Malaria focal outbreaks are also reported every year from the eight epidemic prone districts due to seasonal surge and tropical aggregation of labor forces to these areas. Increased mobility of the non-immune population as tourists in the Hill Tract Districts, and cross-border movement further add to the risk of transmission

With support of Global Fund grants, National Malaria Control Program has achieved momentum in its control activity. Through the approach of community based EDPT detection rate has increased side by side death rate has showing decreasing trend. Integrated vector management through increasing awareness and promotion and use of ITNs/LLINs with selective IRS for containment of outbreaks are found to be supportive in the control measure. The activities include

- Provide early diagnosis and prompt treatment (EDPT) with effective drugs to 90% of malaria patients
- Expand use of LLIN, 2 nets per household, to achieve 100% coverage in 3 high malaria endemic districts and maintain 80% coverage with ITN/LLIN in the remaining districts by 2016
- Strengthen malaria epidemiological surveillance system
- Establish Rapid Response Team (RRT) at national and district levels and increase preparedness and response capacity for containment of outbreaks
- Promote community participation, and strengthen partnership with private sector and NGOs for malaria control.

b. Dengue Control and Prevention

Dengue (fever) is a reemerging vector borne communicable disease in Bangladesh established after its outbreak in the year 2000. Before which the disease was fairly unfamiliar though its presence was evident by a well organized scientific study in 1996-1997 by the National Control Program. The outbreak started in summer 2000 as acute febrile illness involving mainly three major cities of Bangladesh Dhaka, Chittagong and Khulna with the highest incidence rate in Dhaka. Since then it has been occurring with varying intensity with sharp increase in alternate year. Though during the first and subsequent outbreaks, there was concern over management of dengue fever, but gradually with experience of the physicians, it was overcome to a greater extent with reduction in mortality. Emphasis is laid on raising awareness, reducing breeding places, preventing biting by the vector and capacity building for improvement of dengue management and reduction of mortality.

Activities

- Increase awareness on dengue prevention
- Provide training on clinical management of Dengue/DHF
- Establishing multisectoral collaboration on prevention and control of dengue

Component-2: Filariasis Elimination and STH control Program

a. Filariasis Elimination Program

Filariasis (Lymphatic Filariasis) is a leading cause of permanent and long-term disability worldwide and hence WHO targeted it as one of the seven communicable diseases for elimination by the year 2020. The target of Bangladesh is to eliminate the disease by 2015 through transmission and morbidity control. Out of 64 districts of the country it is endemic in 34 (based on ICT survey). About 20 million people of the area are suffering from the disease, most of them are children. It is estimated that about 70 million are at risk of infection and clinical cases are reported from 51 districts. Filariasis Elimination Program (FEP) was started from January 2001 as a new program under Director, Communicable Disease Control (CDC) of DGHS. The main strategy for filariasis elimination is mass drug administration (MDA) to the entire population at risk and morbidity control.

Activity

- Mass drug administration of risk population in endemic districts
- Increase awareness and social mobilization on Filariasis elimination and mobility control
- Provide training on morbidity control and management
- Establishing multisectoral collaboration on Filariasis elimination and morbidity control

b. Soil Transmitted Helminthiasis (STH) Control

Soil Transmitted Helminthes is one of the major health problems, particularly affecting pre-school and school aged children. All the targeted children have to be reached for twice a year de-worming regimen to attain the World Health assembly target of 75% - 100% of the school aged children. Health and Hygiene education has to be given to school children, non-enrolled school aged children, parents and community gradually.

Activities:

- De-worm all school aged children (5-14 years) in 64 districts
- Social Mobilization through BCC Campaign

Component-3: Kala-azar Elimination Program

In Bangladesh, Kala-azar started to re-emerge in the late 1970s. During 1981-85, only 8 Upazilla reported cases, while in 2004, 105 Upazilla reported cases. During the last decade the annual reported number of cases ranges from over four thousands to ten thousand. Eight Upazilla of the country mainly from greater Mymensingh district has the major burden with >2.5 cases per ten thousand population. Most of the affected Upazilla have few cases reported annually.

The political commitment for elimination of Kala-azar is high. In May 2005, the three countries in this region(Bangladesh, Nepal and India) have signed an MOU committing themselves to mutual cooperation towards elimination of kala-azar from their respective countries. Bangladesh is committed to elimination of Kala-azar by 2015. A Regional Strategic Plan has been prepared and endorsed the guidelines and standard operating procedures to ensure the application of interventions in the endemic countries uniformly. A Kala-azar Research Center at SK. Hospital, Mymenshing is being established with the collaboration of JICA and DNDi.

Activities

- All suspected cases of Kala-azar and PKDL will undergo diagnosis and treatment and provide available effective drugs and diagnostics for diagnosis and prompt treatment (EDPT) to 100% endemic Upazilla.
- Vector control by indoor residual spray (IRS) with suitable insecticides. Improvements in housing and personal preventive methods would be promoted through community involvement. To complement IRS, insecticide treated nets (ITN) or long lasting insecticide treated nets (LLIN) will be promoted
- Mapping of the cases and vectors will be made
- Web based surveillance will be used in this program



- Periodical entomological surveys to assess vector density, distribution, vector bionomics and susceptibility to insecticide will have to be done to plan vector control interventions. Evaluation of diagnostics, drugs and insecticides recommended for the Kala-azar elimination Program
- Operational research to monitor the drug and insecticide resistance, quality of drugs, treatment compliance, pharmaco-vigilance, ITNs use etc. would be undertaken.
- Social mobilization and building partnership through community participation
- Different appropriate methods and media will be used for dissemination of messages to the community effectively.
- Initiation of activities of Kala-azar Research Center at SK. Hospital, Mymenshing
- A well designed IEC material & campaign will be launched to motivate people and raise their awareness for adopting preventive methods and seeking treatment early.

Component-4: Emerging & Re-emerging Diseases Control and Prevention Program

Emergence of diseases like SARS, Avian influenza has attracted attention of the health community of the newly evolving diseases and its public health importance. The world also experienced the pandemic influenza in 2009 with huge morbidity and concern. Bangladesh has also experienced emergence of a number of disease as part of international community and even a unique experience of having Nipah presently the sole country in reporting the disease. Bangladesh has joined the international club of responding to the emerging diseases during last five years demonstrating appreciable competency in dealing with those. It has attained good capacity in investigation of case and outbreak, detection of causative agents, containment of outbreak and management of the cases.

Rabies an old neglected disease of the country is thought to be responsible at least for two thousands deaths annually. The disease is 100% preventable, if early and proper intervention is taken. Disease control unit of DGHS has adopted a strategy to prevent death from this dreadful disease. It has set up rabies management centers in the Infectious Disease Hospital (IDH) in the capital Dhaka and three of the seven divisions. It is working to set up centers in the remaining divisions and all the districts for providing wound care and post exposure prophylaxis with tissue culture vaccine and rabies immunoglobulin in category three bites. Inclusion of awareness raising program and reduction of animal reservoir through animal vaccination and control of birth may augment the effort in reduction of rabies death significantly.

For sustainable improvement dealing with emerging diseases the following activities are proposed in the next sector program

- Strengthen capacity for investigation of cases and outbreak reducing the response time
- Training of the health personnel on the emerging diseases and its prevention and control activities
- Creating laboratory facilities for diagnosis of emerging and re-emerging diseases.
- Human resource development for diagnosis of emerging and re-emerging diseases.
- Operational Research on emerging and re-emerging diseases
- Surveillance on emerging & re-emerging diseases
- Prevention and Control of human rabies
- Collaboration with regional and International organizations

Component-5: Avian and Pandemic Influenza Prevention and Control Program

Avian influenza has been a potential threat for another pandemic in spite of its spread to poultry and human about a decade ago. In addition to infection in poultry the virus often is passing to human in at least 15 countries along with Bangladesh. The virus has a mortality rate of more than sixty percent and can mix with another strain of influenza virus having capacity of rapid spread may initiate another influenza pandemic. Currently Bangladesh has to face huge number of AI outbreak in poultry and has to cull millions of poultry and other bird imposing negative impact on economy and the nutritional aspect in addition to threat for more human infection. The country has putting emphasis to prevent outbreak in poultry, to reduce risk of human infection and



improving capacity to deal with any wide spread human infection in terms of health care facility, logistics and human resources.

Activity:

- Outbreak investigation of the newly emerging diseases
- Training of the health personnel about the emerging diseases and its prevention and control activities
- Creating laboratory facilities for diagnosis of emerging and re-emerging diseases
- Human resource development for diagnosis of emerging and re-emerging diseases
- Control of re-emerging diseases by newly adopted method of treatment
- Operational Research on emerging and re-emerging diseases
- Survey on emerging and re-emerging diseases
- IEC campaign on emerging and re-emerging diseases
- Introduction of Hand Hygiene in all Hospitals of the country
- Procurement of MSR, drugs & logistics

Component-6: Disease Surveillance

In the context of the globalization and rising burden of both prevailing and emerging and re emerging communicable as well as non-communicable diseases, early detection and effective containment of outbreaks is of paramount importance. To ensure adequate preparedness well ahead of such epidemic strike, Bangladesh needs to improve the existing surveillance system for creation of a reliable information system that is fairly responsive to tackle disease outbreaks.

Communicable diseases still remain as a major concern in Bangladesh. The main causes of morbidity and mortality are infectious and parasitic diseases including Tuberculosis (TB), Diarrhea, Malaria and Acute Respiratory Infections (ARI). The rising burden of non-communicable diseases and other health events (occupational, injury, food safety, chemical, biological and radio-nuclear hazards etc) also add to the problem. The integrated disease surveillance strategy calls for a coordinated approach to data collection, analyses, interpretation, use, and dissemination of surveillance information for decision making and implementation of public health interventions with the goal to control and prevent communicable and non-communicable diseases and health events. Use of modern IT facilities for reporting and feedback can enormously reduce huge burden in disease surveillance. In this regard, the incorporation of IT along with integrated software into the disease surveillance system is a timely and effective step. State-of-the-art laboratory facilities, use of GIS, detection capacity of climate-sensitive changes are prerequisite for a modern well equipped surveillance system. A well functioning disease surveillance system is critical to the health system in providing evidence-based information for planning, implementation, monitoring and evaluation of public health intervention programs. Integrated disease surveillance is expected to improve resource mobilization and utilization, motivate health personnel, promote partnership, and improve data compilation, flow, and timely use. IEDCR and will act as lead Institution in integrated disease surveillance. Other institutes like NIPSOM, ICMH and other related organizations will also be involved in the process.

Activities

- To advocate and sensitize continuous advocacy and sensitization of policy and decision makers, so that personnel, materials and other resources could be used more efficiently and effectively.
- To support the strengthening of surveillance data management and utilization of information for disease control activities for planning, implementation, monitoring and supervision and resource mobilization at all levels through establishment of effective communication network.
- To strengthen the capacity and involvement of laboratories at upazilla, district and national levels in disease surveillance as well as establishing laboratory network.
- To support training and retraining of health workers on integrated disease surveillance at all levels.



- To ensure regular monitoring and evaluation of integrated disease surveillance activities at all levels

4.6.4. Cross Cutting Issues

- To support the development of effective, integrated diseases surveillance including regular and reliable reporting. OP- MNCAH, TB-LC, NASP, CDC, NCD, NEC, HIS-EH, NNS & MCRAH
- HR Training and deployment OP-IST, PSE, TRD
- Procurement of necessary laboratory and medical supplies. Op-PLSM-CMSD
- Behavior change communication to prevent CDC and introduction of Hand washing practices in the community and facility level. OP-ESD, HSM, HEP & LGED

4.6.5. Indicators

The planned activities planned under Malaria, Kala-Azar, Filariasis, emerging and re-emerging diseases all contribute to the achievement of Result 1.1, increased utilization of essential HPN services, Result 1.2, improved equity in essential HPN service utilization and Result 1.3, improved awareness of healthy behavior.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Malaria incidence/ 1000 population	5.13 M&PDC- MIS, 2010	3.56	<3
2	Malarial mortality/1000 population	0.0034(Total 37), M&PDC- MIS, 2010	0.0030	0.0025
3	Case fatality rate (%) due to dengue	0.25 %, CDC (2003)	<.01 %	<.01 %
4	Incidence of Filariasis (percentage)	1.25% CDC (2010)	<1%	<1%
5	STH (Soil Transmitted Helmenthes) prevalence among school children	20.2% 2009 DGHS	18%	15%
6	Incidence of Kala Azar per 10000 population in endemic area	4.48 (2009, DGHS) CDC annual report	<1%	<1%
7	Number of Rabies management centre	Four (IDH, Dhaka-1, Divisions-3)	61 (Division 4, District 57)	All centers functional
8	National Avian and Pandemic Influenza Plan updated	Reviewed in 2009	Reviewed	Updated
9	Number of diseases under surveillance	8	12	15
10	Number of Upazila under web based surveillance	NA, IEDCR	100%	100%



4.6.6.Budget

Component and Year wise physical and financial target of OPs

Agency: Director General of Health Services

Name of the OP: Communicable Diseases Control (CDC)

(Tk in lakh)

Name of the Components/Major Activities	Total Physical and financial target					FY-2011-12		FY-2012-13		FY-2013-14		FY-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Pay and Allowances	35 persons	400.00			400.00		80.00		80.00		80.00		160.00
1) Mal & VBDC Program													
Training and workshop	275 Batches	200.00	417.00	490.98	1107.98	77 batches	283.11	79 batches	254.53	55 batches	245.02	64 batches	325.32
Foreign Training	2 Batches		30.00		30.00			1 Batch	15.00	1 Batch	15.00		
Research & Survey	25Number	0.00	560.00		560.00	10 Number	130.00	21 Number	131.00	11 Number	145.00	9 Number	154.00
Computer & Accessories, Other Office equipments,	99 Units	113.00	90.50		203.50	23 Units	47.00	43 Units	92.00	20 Units	39.50	13 Units	25.00
Medicine ,MSR, Insecticide	34 Lots	1235.75	1037.00	15184.32	17457.07	10 lots	5391.26	8 lots	4028.13	6 lots	2642.17	10 lots	5395.51
Printing of Material	18 Prints	53.00	50.00		103.00	4 prints	20.00	5 prints	40.00	5 prints	23.00	4 prints	20.00
Audio Video/Film Production/Advertising and Publicity/Display IEC Material etc.	11 Productions	20.00	106.00		126.00	3 production	30.00	2 production	20.00	3 production	36.00	3 production	40.00
Repairs and Maintenances.	121 Units	47.75	72.50		120.25	13 units	13.00	8 units	8.00	45 units	44.50	55 units	54.75
Utility & Other Expenses	60 Months	274.25	93.00	3274.70	3641.95	12 months	433.63	12 months	1010.84	12 months	636.81	24 Months	1560.67
Total		**2343.75**	**2456.00**	**18950.00**	**23749.75**	**0.00**	**6428.00**	**0.00**	**5679.50**	**0.00**	**3907.00**	**0.00**	**7735.25**
Filariasis Program													

Name of the Components/Major Activities	Total Physical and financial target					FY-2011-12		FY-2012-13		FY-2013-14		FY-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Training and workshop	447 Batches	704.73	780.00	950.00	2434.73	112 batches	357.00	163 batches	415.00	137 batches	685	235 batches	977.73
Foreign Training	2 Package	0.00	50.00		50.00				50.00				
Research & Survey	83 Number	107.00	272.00	1250.00	1629.00	20 Number	390.00	24 Number	469.00	19 Number	372	20 Number	398
Computer & Accessories, Other Office equipments,	40 Units	48.00	31.00		79.00	17 units	34.00	7 units	13.00	13 units	26	3 units	6
Conduction of school de-worming program by volunteers/teachers and its supervision	10 Lots	410.00	355.00		765.00	Two	125.00	Two	300.00	Two	210	Four	130
ICT, Mf,worm infestation ,case finding survey-LF/STH	18 Surveys	166.00	163.00		329.00	3 Surveys	50.00	9 Surveys	165.00	5 Surveys	100	1 Survey	14
Medicine ,MSR, Insecticide	5 Lots	259.48	1589.00		1848.48	1 lot	702.00	2 lots	838.48	1 lot	251	1 lot	57
Printing of Material	209 Prints	126.70	110.00	800.00	1036.70	51 prints	254.00	70 prints	345.70	45 prints	225	43 prints	212
Audio Video/Film Production/Advertising and Publicity/Display IEC Material etc.	30 Productions	82.00	200.00		282.00	12 production	120.00	16 production	156.00	1 production	5	1 production	1
Repairs and Maintenances.	9 Units	9.60			9.60	3 units	3.10	3 units	3.00	2 units	2	1 units	1.5
Utility & Other Expenses	60 Months	437.49	235.00		672.49	12 months	98.80	12 months	174.82	12 months	75.6	24 Months	323.27
Total		**2351.00**	**3785.00**	**3000.00**	**9136.00**		**2133.90**		**2930.00**		**1951.60**		**2120.50**
Kala azar Elimination programme													
Training and workshop	786 Batches	0.00	1285.00	2200.00	3485.00	136 batches	680.00	279 batches	1394.00	121 batches	605.00	250 batches	806.00
Foreign Training	2 Package	10.00	56.00		66.00				20.00		46.00		
Research & Survey	15 Number	20.00	25.00	700.00	745.00	3	145.00	3	180.00	3	180.00	6	240.00

Name of the Components/Major Activities	Total Physical and financial target					FY-2011-12		FY-2012-13		FY-2013-14		FY-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Computer & Accessories, Other Office equipments,	186 Units	280.80	114.00		394.80	67 units	148.70	50 units	100.00	40 units	86.10	29 units	60.00
Medicine ,MSR ,Insecticide	11 Lots	3946.00	2500.00		6446.00	3 lots	2500.00	5 lots	2000.00	2 lots	1246.00	1 lots	700.00
Printing & Material Campaign	32 Prints	50.00	71.00	35.00	156.00	6 prints	28.00	10 prints	50.00	7 prints	33.00	9 prints	45.00
Audio Video/Film Production/Advertising and Publicity/Display IEC Material etc.	62 Productions	179.00	358.00	65.00	602.00	10 productions	95.00	30 productions	295.00	12 productions	120.00	10 productions	92.00
Repairs and Maintenances.	93 Units	92.60			92.60	17 units	17.00	27 units	27.00	17 units	17.00	32 units	31.60
Utility & Other Expenses	60 Months	326.40	138.00		464.40	12 months	231.30	12 months	104.30	12 months	94.40	24 Months	34.40
Total		**4904.80**	**4547.00**	**3000.00**	**12451.80**		**3845.00**		**4170.30**	**3**	**2427.50**	**6**	**2009.00**
Emerging and Re-emerging programme													
Training and workshop	411 Batches	406.00	901.00	750.00	2057.00	80 Batches	398.00	168 Batches	840.00	80 Batches	402.00	83 Batches	417.00
Research & Survey	31 Number	250.00	351.00		601.00	9 Surveys	178.00	16 Surveys	316.00	5 Surveys	97.00	1 Surveys	10.00
Double Cabin A.C Pickup with carryboy	2 Units	0.00	100.00		100.00	2 Units	100.00				0.00		0.00
Computer & Accessories, Other Office equipments,	40 Units	75.00			75.00	10 Units	20.00	10 Units	20.00	10 Units	20.00	10 Units	15.00
Medicine ,MSR ,Insecticide	5 Lots	378.00	1686.50	1050.00	3114.50	1 Lot	629.50	2 lot	1020.00	1 Lot	500.00	1 Lot	965.00
Printing of Material	53 Prints	163.00	100.00		263.00	22 prints	110.00	14 prints	70.00	16 prints	78.00	1 print	5.00
IEC Material etc.	14 Pkg	87.00	60.00		147.00	2	22.00	10	103.00	2	22.00	0	0.00
Repairs and Maintenances.	55 Units	55.00			55.00	17 Units	17.00	12 Units	12.00	17 Units	17.00	9 Units	9.00
Utility & Other Expenses	60 Months	286.50	269.00		555.50	12 months	87.00	12 months	307.50	12 months	87.00	24 Months	74.00

Name of the Components/Major Activities	Total Physical and financial target					FY-2011-12		FY-2012-13		FY-2013-14		FY-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Total		**1700.50**	**3467.50**	**1800.00**	**6968.00**		**1561.50**		**2828.50**		**1223.00**		**1355.00**
Avian and Pandemic Influenza Programme													
Training and workshop	180 Batches	200.00	500.00	380.00	1080.00	36 Batches	216.00	36 Batches	216.00	36 Batches	216.00	72 Batches	432.00
Foreign Training	4 package		100.00		100.00		30.00		40.00		30.00		
Research & Survey	6 Number	75.00			75.00	2 Survey	25.00	2 Survey	25.00	2 Survey	25.00		
Computer & Accessories, Other Office equipments,	219 Units	250.00	188.00		438.00	50 Units	99.00	110 Units	220.00	46 Units	93.00	13 Units	26.00
Establishment of BSL2 Laboratory at 25 Medical Colleges and 250 Bed Dist. Hospital	25 Lots	7.00	280.00	220.00	507.00	2 Units	40.00	10 Units	205.00	2 Units	40.00	11 Units	222.00
Medicine ,MSR ,Insecticide	8 Lots	230.00	792.00	700.00	1722.00	.5 lot	245.00	1 lot	595.00	1 lot	372.00	1 lot	510.00
Printing of Material	10 Prints	49.00			49.00	2 prints	9.50	4 prints	20.00	2 prints	9.50	2 prints	10.00
IEC Material etc.	5 pkg	51.00			51.00	1	10.00	1	10.00	1	10.00	2	21.00
Repairs and Maintenances.	86 Units	86.00			86.00	22 Units	22.00	20 Units	20.00	22 Units	22.00	22 Units	22.00
Utility & Other Expenses	60 Months	458.5	30.00		488.50	12 months	121.00	12 months	169.00	12 months	123.50	24 Months	75.00
Total		**1406.50**	**1890.00**	**1300.00**	**4596.50**		**817.50**		**1520.00**		**941.00**		**1318.00**
Diseases Surveillance													
Training and workshop	414 Batches	395.50	1170.00	500.00	2065.50	53 Batches	265.00	180 batches	900.00	79 batches	395.00	102 Batches	505.50
Research & Survey	5 Number	96.00			96.00	1 Number	20.00	2 Number	40.00	1 Number	20.00	1 Number	16.00
Double Cabin A.C Pickup with carry boy	3 Units	0.00	150.00		150.00	1 unit	50.00	2 Units	100.00				
Computer & Accessories, Other Office equipments,	39.5 Units	80.50			80.50	10 Units	20.00	12.5 Units	25.00	8 Unit	16.00	9 Units	19.50
Medicine ,MSR,	5 Lots	129.00	500.00		629.00	1 lot	125.00	2 lots	130.00	1 lot	129.00	1 lot	245.00

Name of the Components/Major Activities	Total Physical and financial target					FY-2011-12		FY-2012-13		FY-2013-14		FY-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Insecticide													
Printing of Material	9 Prints	40.00			40.00	2 Print	7.00	4 prints	20.00	1 Print	5.00	2 prints	8.00
IEC Material etc.	4 Pkg	48.00			48.00	1	9.00	1	13.00	1	9.00	1	17.00
Repairs and Maintenances.	78 Units	78.00			78.00	16 Units	16.00	15 Units	15.00	16 Units	16.00	31 Units	31.00
Utility & Other Expenses	60 Months	253.00			253.00	12 months	59.00	12 months	77.00	12 months	39.00	24 Months	78.00
Total		**1120.00**	**1820.00**	**500.00**	**3440.00**		**571.00**		**1320.00**		**629.00**		**920.00**
Grand Total		**13826.55**	**17965.50**	**28550.00**	**60342.05**		**15356.90**		**18448.30**		**11079.10**		**15457.75**

4.7. Non-Communicable Diseases Control (NCDC)

4.7.1. Introduction

The burden of chronic non-communicable diseases (NCD), especially heart disease, stroke, hypertension, diabetes, cancer and chronic respiratory disease, is rising in low and middle-income countries like our country. NCD deaths account for 60% of all deaths in the world and one in two deaths in the Asian region. Prevention Programs and policies are in their early phase in Bangladesh and struggle to achieve priority because of the more established and pressing needs of infectious disease control. Reduction of morbidity and premature mortality due to the 'conventional' non-communicable diseases (NCDs) will require appropriate actions at all levels from primary prevention to treatment and rehabilitation in an integrated manner. The government will, in partnership with local government bodies and the private sector, create greater awareness of, and provide Comprehensive prevention services for the control of unhealthy diet and lifestyle related major NCDs, such as cardio-vascular diseases, cancer and diabetes, COPD etc. together with the assistance of Bureau of Health Education, NIPSOM, IEDCR, NICVD, NIKDU, NITOR, NICRH, NIDCH, NIMH and other related public health institutions. Existing preventive and curative measures with respect to all NCDs will further be expanded and strengthened to increase access to these services. The capacity at all stages, to implement NCD programs will be further strengthened through providing effective number of personnel, training, logistics and funding.

4.7.2. Objectives

- To ensure and promote the development and implementation of effective, integrated, sustainable, and evidence-based public policies on chronic disease and public health problems, their risk factors, and determinants.
- To encourage and support the development and strengthening of countries' capacity for better surveillance of chronic diseases, their consequences, their risk factors, and the impact of public health interventions.
- To foster, support, and promote social and economic conditions that address the determinants of chronic diseases and empower people to increase control over their health and to adopt healthy behaviors.
- To facilitate and support the strengthening of the capacity and competencies of the health system for the integrated management of chronic diseases and their risk factors.

4.7.3. Components

1. Conventional NCD including CVD, Diabetes, COPD, Cancer, Renal Disease, Deafness, Arsenicosis, Osteoporosis, Oral Health & Thalassemia
2. Non Conventional NCD (Road Safety and Injury Prevention including Child Injury, Violence against Women (VAW)
3. Occupational Health and Safety (Industrial & Agriculture)
4. Climate Change, Air Pollution, Water Sanitation & Other Environmental Health issues
5. Emergency preparedness and Response (EPR), Post Disaster Health Management and Emergency Medical Services
6. Mental Health, Tobacco, Alcohol & Substance Abuse

Component 1: Conventional NCD including CVD, Diabetes, COPD, Cancer, Renal Disease, Deafness, Arsenicosis, Osteoporosis, Oral Health & Thalassemia

Cardio-Vascular Disease: Remarkably increasing incidence of Ischemic Heart Disease (IHD) has reached 10% due to modern life style, resulting in increased premature mortality and morbidity. This disease will be addressed through scaling up both preventive and curative approaches. Raising awareness through mass-media and gradually creating more CCU facilities at the tertiary hospitals will be the priority intervention in handling



cardio-vascular diseases during the next sector program. This disease, however, can be reduced by interventions starting from community level.

Cerebro-Vascular Diseases: Stroke constitutes about 9% of the hospital admission among those aged 30 or above. A CC based preventive approach along with monitoring hypertension will be introduced during the next sector program. The rate of hypertension could be further reduced by applying the cost effective prophylactic measure.

Cancers: Every year about 150,000 people are diagnosed with cancer (Cancer Society of Bangladesh). Among women the most common being those of the breast and the reproductive organs, e.g., uterus, cervix, ovary and others. Tobacco consumption is the leading cause of lung cancer in Bangladesh. Oral, laryngeal and lung cancers constitute 37.4% of all cancers irrespective of sexes. Tobacco control program will be intensified for prevention of lung cancer. Emphasis will be given for cancer prevention activities during the next sector program and BCC campaign on the causes and effects will be undertaken.

Diabetes: Population data indicate an increasing trend in diabetes prevalence especially in urban areas, just double (10.5% in urban Dhaka) (WHO, 2007). This could reflect the effect of unplanned urbanization that lacks the environment for physical activity, consumption of junk food and exposure to stressful life in cities. The reduction in the prevalence of diabetes in urban areas will be addressed by developing awareness, educating people on the causes and consequential effects, motivating people to changing the life style, etc through a large scale BCC program implementation during the next sector program. Diabetes corner will be gradually established at tertiary and secondary hospitals.

Kidney Diseases (Renal Diseases):
Over 20 million people in the country suffer from some form of chronic kidney disease or another, and 40,000 die every year from kidney failure. A kidney patient reportedly needs about 250,000 taka to 300,000 taka each year for dialysis. On the other hand, about 250,000 taka is required for kidney transplantation and for meeting immediate medical expenses and this costly treatment is out of reach of the 95 percent of the patients. Strengthening the capacity of services at all level related to renal diseases is planned under this OP.

Hearing Disability (Deafness): About 13 million people are suffering from variable degree of hearing loss (HL) in Bangladesh of which 3 million are suffering from severe to profound HL leading to disability. Deafness and hearing impairment are major but neglected causes of disability. Early detection of impaired hearing and proper management could prevent permanent hearing disability. Early detection at the primary level and for the management of these cases, strengthening of services at the secondary and tertiary level will be initiated. The strategic plan developed for control of hearing disability (Deafness), will play an important role for implementation of hearing disability related activities in the next sector program.

Chronic Obstructive Pulmonary Diseases (COPD): Prevalence of COPD (Asthma) in people aged 30 or above is 3% in the general population and 6% in medical college inpatients. The National Institute of Diseases of Chest and Hospital (NIDCH) the only referral hospital for chest diseases in Bangladesh, admits about 4500 patients annually in the department of respiratory medicine, of them 19% suffer from COPD. Smoking and indoor air pollution and thought to be the most two important causes of COPD in Bangladesh.

Arsenicosis: About 30 million people are being exposed to arsenic contaminated water. Patients are gradually increasing and recent knowledge of health threats posed by arsenic indicates that it gives rise to cancer, diabetes mellitus and cardiovascular disease. At present, DGHS is conducting awareness programs, training of health care service providers and patient screening programs. DPHE conducts water screening for arsenic. The collaboration between DGHS and DPHE at field level, may help make their interventions more effective. DGHS, in the next sector program, will run training programs, arsenicosis mitigation programs and help DPHE to strengthen water screening at the community level.



Oral Health: Lack of knowledge and awareness regarding oral hygiene are the main issues which cause oral diseases to be a public health problem. Preventive approach through mass education and raising awareness will be the priority oral health intervention. Similarly adoption of proper cleaning procedure of the oral cavity and bringing strict restrictions in bad habits could reduce most of the common and complicated oral diseases.

Thalassemia: Thalassemia is the tenth most common disease among 5-14 years old patients in public hospitals (Health Bulletin 2009). Preventive measures and awareness campaign could be instrumental to combat the disease. The priorities are screening for thalassaemia, provision for genetic counseling services, prenatal diagnosis, and creating public awareness to prevent marriage among carriers. It is also important to setup adequate laboratory services in government medical colleges, human resource development and training on standard care of thalassemia in next sector Program.

Activities:

- Establishment of National coordination mechanism by establishing an NCD alliance
- Establishment of electronic database, Website and it's maintenance at the DGHS (Logistics, human resource & IT and Network)
- Dissemination of surveillance data through Periodic publication of newsletters, reports
- Training of Field heath staff, on feasible screening/diagnostic methods of the targeted NCDs and risk factor (Diabetes, Hypertension, obesity etc)
- Supply of NCD screening tool (BP machine, Glucometer, Cardio Check, Measuring tape, field surveillance register etc.) and register to the Upazila and below
- Mass media campaign to inform people on earlier signs of Major NCDs (eg. Hypertension, Diabetes, Cancer, COPD, Oral Health etc.), availability of NCD services at primary health care level and encourage them for screening
- Establishment of NCD notification and reporting system at UHC
- Orientation of Service providers including GPs, MOs of public hospital (IPD & OPD) on NCD management
- National NCD risk factor survey in 2012 & 2016
- National NCD survey in 2011& 2016
- Sensitization meeting with policy makers about NCD epidemic
- Observance of important days for NCD related diseases and events ("World No Tobacco Day", "World COPD Day", "World Diabetes Day", World Mental Health Day, etc.)
- Development and printing of manuals on detection, treatment and prevention of Selected NCDs (Diabetes, Hypertension, Mental disease etc)
- Orientation of religious leaders about NCDs and utilizing them for health promotion.
- Raise community awareness on healthy diet and promote the consumption of at least two servings of fruit and three servings of vegetables every day "2 plus 3 A Day" campaign.
- Advocacy of healthy lifestyle among All group of people with special emphasize on children (Leaflet publication, distribution, demonstration etc)
- Operational research on prevalence of risk factors and social determinants of NCD
- Establishment of major NCD (Cancer, Stroke, Injury, Psychiatric illness) registry at specialized and tertiary Hospitals
- Provide Support to different associations, professional bodies and civil society organizations for working to prevent and control NCDs (eg. Network of NCD, NCD Forum).
- Development of population specific clinical guidelines for care of Selected NCDs (Hypertension, Diabetes, Heart disease, Cancer and Mental health problem)
- 'Well Women Clinic' initiative in model Upazilas for providing screening services for hypertension, diabetes, breast and cervical cancer to adult women along with other services.
- Piloting of NCD counseling centers at six NCD model upazilas.
- Piloting population based cancer registry at model NCD prevention upazilla
- Population based screening of oral cancer
- Operational research on distribution and determinant of oral health problem

- ‘Brush after meal’ promotion campaign initiative among population
- Training of primary health care physicians, nurses and health workers on management of Thalassemia
- Campaign for raising awareness about Thalassemia among general population
- Strengthening of mass awareness programs on Arsenic free safe drinking water
- Improve patient screening (house to house searching) programs.
- Capacity building of human resources and facilities for effective Arsenicosis case management and referral
- Conducting surveys, research on Arsenicosis
- Strategic partnership with local bodies and community based organization regarding the mitigation of Arsenicosis.

Component 2: Non Conventional NCD (Road Safety and Injury Prevention including Child Injury, Violence against Women (VAW)

Road Safety and Injury Prevention

The Bangladesh Health and Injury Survey 2005 showed that an estimated 30,000 children die each year due to injury. This represents 38% of all deaths among children 1-17 years of age. In total approximately 70,000 deaths occur each year due to injury (burning, drowning, acid and accidents at work). Some 40 to 45% of injuries are due to road traffic accidents in urban areas and 54% of them are pedestrians.
The NCD strategy (2007-2010) will be the guiding principle to implement NCD related programs, e.g., dialogue with the Ministry of Communication and Transportation for safety policies and regulation, enhance skills of MOHFW service providers to handle injury patients, build up awareness of the people on pedestrian safety measures, dialogue with Ministries of Industries and Commerce to prevent/ protect from hazards and injuries from industrial products, imported products and wastes etc. A separate strategy document will be developed by the line director, NCD for prevention, control and management of injuries.
The common causes of injuries are: fall, burn, cut, RTA, occupational trauma, sports injury, violence etc. Burn injury occurs to over 170,000 children per year with over 30,400 of permanent disability (Study Report, NCD, DGHS, 2010).

Violence against Women

Violence against women and girls is a problem of pandemic proportions. A population study done by ICDDR, B confirms the high levels of domestic violence and also confirms that it remains a major public health problem in Bangladesh. High levels of domestic violence in Bangladesh imply that a large proportion of the women accessing health services are victims of violence. A number of interventions are needed to provide health care support to women victimized by violence.

Acid Burn

Acid burns constitute 8.76% of all the burn cases treated in Bangladesh. Most of such cases are of intentional origin (attempts to disfigure the face, eyes, nose, genital organ). Young girls are common victims and the incidence is more in rural than in urban areas. Special interventions are needed to prevent the incidence as well as the morbidity arising from acid burn.

Activities:

- Workshops to develop the BCC materials on road safety and injury prevention
- Provide support to Bureau of Health Education (BHE) for development of documentary films/TV stops/Radio spots on injury/ Acid burn/ VAW
- Training of community based Workers on Injury Prevention Counseling
- Training of Health Service Providers (doctors, nurses and field workers) on injury prevention, Basic Life Support, Advance Life Support
- Development of training materials/ modules/ algorithms
- Piloting of establishing rehabilitation facility in selected district hospitals



- Community awareness workshops on prevention of drowning
- Advocacy for formation of national task force on injury prevention

Component 3: Occupational Health and Safety (Formal and non-formal sector)

Globally the issue of health and safety of industrial workers has evolved into Occupational Health and Safety. But the Occupational Health and Safety Services in Bangladesh is still in the developmental stage. With the rapid industrialization, the unsafe use of chemicals, number of industrial accidents, fire, etc, there is an increasing need to establish occupational related health care services, as well as hospitals near industrial areas. A major portion of the workers from the informal sectors is at risk of developing acute and chronic toxicity, due to exposure to many toxic pesticides, chemicals and fertilizers, occurrence of occupational diseases and injuries. The current rules and regulation should be modified to empower the occupational health unit, so that they can work with more authority to oversee the occupational health and safety status and to employ occupational health graduates and experts in the industries and relevant sectors.
At the central level an autonomous institute for 'Environmental and Occupational Safety and Health' manned by relevant multidisciplinary personnel should be established. Environmental health and Occupational health are cross-disciplinary areas, concerned not only with protecting the safety, health and welfare of people engaged in work or employment, but also with the environment and the community.

Activities:

- Development and implementation of sustainable qualitative OHS care providers at GOB and NGO Level.
- Development and publication of posters, pamphlets, booklets and books to be produced to spread the message of occupational health and safety.
- Training on occupational health, safety, industrial hygiene and ergonomics for physicians, nurses, Para-medics, safety professionals, regulatory staff.
- Research on assessment of OSH status
- Development and continuation of monitoring, evaluation on OHS compliance
- Development of uniform OHS reporting system.
- Development of appropriate BCC Strategy
- Arrangement of Training and Advocacy for factory owners and factory management
- Mass awareness among workers on occupation specific health problem, or disease, existing laws, rights and privileges
- Establishment of National Institute of Environmental and Occupational Health (NIEOH)
- Strengthening capacity of DOEH, NIPSOM

Component 4: Climate Change, Air Pollution, Water Sanitation & Other Environmental Health issues

Climate Change

The changing climate will inevitably affect the basic requirements for maintaining health: clean air and water, sanitary environments, sufficient food and adequate shelter. Many diseases and health problems may be exacerbated by climate change.The health concerns and vulnerabilities due to climate change will burden both communicable and non-communicable diseases. All people will be affected by natural disaster and a changing climate, but the initial health risks will be on the groups bearing most of the resulting disease burden, i.e., poor, children, women and elderly people. Creating a well coordinated approach for protecting health from climate change remains a great challenge for the government. Effective surveillance system needs to be developed and institutional capacity to manage these problems including of health professionals. Bangladesh in recent years has experienced some severe effects of climate change. To build capacity and strengthen health systems to combat the health impact of climate change, the Climate Change and Health Promotion Unit will be housed in DGHS and will focus on adaptation and mitigation plan on climate change. It has been widely recognized that the health sector does not receive adequate funding in proportion to the extent of the problem. It's a cross cutting issue with many OPs but NCD will be lead OP as Emergency preparedness and disaster responses are placed under NCD.



Air Pollution

ARI and other respiratory diseases form the largest share of the reported disease burden in Bangladesh and air pollution is one of the leading cause of respiratory disease. In rural households the use of bio mass as cooking fuel is the main cause of indoor air pollution; Vehicular air pollution is a major cause of respiratory distress in Urban Bangladesh.

Water, Sanitation & Other Environmental Health issues

Effective water supply and sanitation coverage in Bangladesh is significantly lower than the expectation. Especially, the rapidly growing urban centers need support aimed at developing sustainable water and sanitation systems.

Attention needs to be given to improve understanding of the contribution of poor water supply, sanitation and hygiene to the national burden of disease.

The Government of Bangladesh has initiated a multi-year program on total sanitation starting in October 2003. Water quality surveillance in some 120 towns re-started. Together with continued laboratory strengthening, an overall surveillance system, covering bacteriological and chemical parameters needs to be developed. With frequent natural disasters, collaboration between water supply, health and disaster preparedness sectors should lead to a greater response capacity.

Activities:

- Increase capacity in health services on Climate Change and related disease surveillance skills and techniques
- Increase awareness of health consequences of climate change;
- Strengthen the capacity of health systems to provide protection from climate-related risks through e-Health and Telemedicine;
- Capacity building for health consequences of climate change
- Coordination of Emergency Medical Service (EMS) and School Health Promotion to reduce health hazards during disasters and emergencies related with climate change.
- Research on assessment of health impact of climate change
- Training of health service providers at field level, on feasible screening/diagnostic methods of the targeted Diseases
- Sensitization and orientation of health facility staff on targeted climate attributed vector borne, water borne and emerging diseases etc
- Advocacy for notification of climate sensitive disease
- Institutionalize CCHPU in DGHS for mainstreaming climate change and health issues as a co-benefit in all climate related negotiations in home and abroad.
- Development of promotion material on Health Impact of Climate Change and adaptation
- Developing material on efficient energy use during service delivery at all level of health care services
- Strengthening collaboration between DGHS and DPHE to increase coverage of water quality testing at the community level.

Component 5: Emergency preparedness and Response (EPR), Post Disaster Health Management and Emergency Medical Services

The geographical location and the topographical features of the country make Bangladesh vulnerable to natural disasters. The EP&R Program of the DGHS is responsible for the health response to natural and man-made disasters/emergencies, in close co-operation and partnership with other agencies.

The main strategies aim to increase the level of readiness at all tiers of the health system and improve the capacity of the sector for coordinated post-disaster management. Standard national guidelines for mass casualty management as well as manual for local level health response will be developed and necessary training will be conducted. Standardization of emergency health supplies and their stockpiling will be part of the readiness program for flood, cyclone, tornado and earthquake. A TA supported strategic study will be commissioned. Trainings will be arranged for health and family planning staff in collaboration with Civil Defense Department



and Red Crescent Society on risk/ vulnerability assessment, vulnerability reduction, disaster mitigation, review of emergency preparedness and humanitarian assistance. Guidelines, protocols and standard operating procedures (SOP) will be developed.

Emergency Medical Services (EMS)

Significant reduction in morbidity and mortality rates can be achieved by tackling emergency patients with quality and efficiency at different tiers of the health system, especially at the district level and below. Upazila health complexes (UHC) have a critical role in managing emergencies and in linking communities to the larger health care system. At present, efficiency and effectiveness of emergency services in the district hospitals and the UHC are compromised by shortage of skilled professional staffs, poor use of resources, nonfunctioning equipment, and lack of transportation and inadequate supply of life saving medicine and supplies and a poor referral system. Strengthening emergency services at the district and upazila level would bring quality health care closer to the door steps of the people.

Activities:

- Strengthening capacity of hospital services on emergency preparedness and response
- Establishing System for early warning sign for early preparation for health service delivery in disaster prone area
- Train community volunteers on disaster preparedness and response and establish network of volunteers
- Initiate program on 'Hospital Preparedness in Emergencies' HOPE for hospital personnel
- Development of promotion material on Health Impact of Community Disaster Preparedness and Response

Component 6: Mental Health, Tobacco, Alcohol & Substance Abuse.

Developmental Disorder, Mental Health & Autism

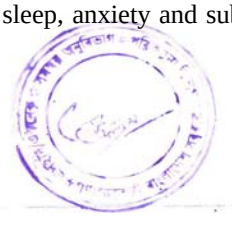
The National survey on mental health in Bangladesh showed that 16.1% of the adult population of the country suffers from some form of mental disorder, requiring immediate treatment. In an urban survey the prevalence of mental disorders including mood, sleep, anxiety and substance related disorders was found to be 28%. Among the hospitalized cases, schizophrenia is the main disorder. A WHO sponsored community survey showed prevalence of child mental disorders of 18.35%, epilepsy 2.02%, mental retardation 3.81% and substance abuse 0.78%. Given the emerging size of the mental health problems amid changing life styles and in pursuance of government's strong commitment for adequately addressing the counseling and treatment of mental health with emphasis on mental disorder and autism, partnerships with the media and NGOs will be developed to raise public awareness about appropriate attitude towards and behaviour with mental patients.
Three types of service providers/ volunteers may be helpful for mental health related services at the community level: public sector workers, NGO/ CBO workers and school and religious teachers, who could be trained to identify and counsel substance abuse and mental and emotional cases, provide and follow up simple treatment as per feasibility, provide life skill training and refer serious cases to an appropriate facility.

Tobacco Use

According to Global Adult Tobacco Survey (2009), 58.9% of the male adult surveyed use tobacco and 28.7% of the females use tobacco. Of the adult population 60% smoke and 27% consume smokeless tobacco. Smoking is more pervasive among the poor (70%) and among those who have no education (73%) (NIPORT,2009). There are over 1.2 million cases of tobacco related illnesses in Bangladesh each year and around 9% of all deaths in a year (57,000 deaths) in the country are result of tobacco use (WHO, 2008).
National anti tobacco campaigns should be started addressing strategic plans developed for control of NCD &.

Substance abuse (Alcohol and other addictive drugs)

Substance abuse and drug dependence have shown significant increase in Bangladesh. In an urban survey, the prevalence of mental disorders including mood, sleep, anxiety and substance related disorders was found to be


28%. A WHO sponsored community survey showed prevalence of substance abuse 0.78%.. Capacity building, advocacy and awareness campaigns, innovative community-based management Programs, development of training material, support for research on issues related to substance abuse are needed.

Activities

- Mass media campaign against smoking in public place of workshop
- Campaign to raise awareness about harm of smokeless tobacco
- Operational research on distribution and determinants of tobacco use and its impact
- Tobacco cessation initiative (Establishment of counseling hotline center)
- Workshops with policy makers and lawyers, professional bodies and law enforcing body for enforcing FCTC
- Mass media campaign against substance abuse
- Training of primary health care physicians, nurses and health workers on mental health & substance abuse
- Training of religious leaders, traditional healers, & faith healers of model upazilla
- Awareness & coordination meetings about mental health with health work force
- Designing material (manuals, data collection forms, referral forms) for use at different levels of service delivery
- Establishing A "Help Hotline" for 24 hours emergency help in National Institute of Mental Health, Dhaka,

4.7.4. Cross Cutting Issues

- Prevention of Malnutrition due to Climate Change – OP-NNS
- Capacity development for NCD and disaster management; (OP-HSM, IST & PSE)
- Procurement / MSR. (OP-PLSM-CMSD)
- Awareness for behavioral change for NCD. (OP-HEP)
- Integration with HIS and e-health, IEDCR, and strengthening of BAN-NET. (OP-CDC, HIS-EH)
- Communicable diseases related to Climate Change and occupational health. (OP-CDC, MO labor and Manpower)
- Emergency preparedness and response. (OP-CDC, HSM and MOE&F, Food Div)

4.7.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. More specifically, the activities planned contribute to Result 1.1, increased utilization of essential HPN services and Result 1.3, improved awareness of healthy behaviors.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of Upazila and below health facilities providing hypertension screening	NA (NCD)	142 Upazila	472 Upazila
2	Number of Upazila and below health facilities providing diabetes screening	NA (NCD)	142 Upazila	472 Upazila
3	Number of service providers trained on arsenicosis screening and management	70,000 (NCD)	5,000 Batch	10140 Batch
4	Number of service providers trained on major NCDs in District and below level	NA (NCD)	5000 Batch	10140 Batch
5	NCD Prevention, control and management Strategy developed and implemented	02 (NCD)	7	11
6	Number. of awareness campaigns on injury (traffic, child and other injuries)	NA (NCD)	142	330
7	Number of districts provided occupational health safety training and awareness in factories	NA (NCD)	7	13
8	Number of Surveillance points on Climate Sensitive Disease developed	NA (NCD)	3	6

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
9	Environment & Occupational Health center established –in NIPSOM	NA (NCD)	Done	Done
10	Number of Educational Institutes (Schools/College/University) covered for Anti Tobacco campaign	NA (NCD)	700	1000
11	Number of disaster prone Upazilas completed training of Health personnel on disaster preparedness.	NA (NCD)	40	64
12	Number of Upazila with trained Service Providers on management of VAW	NA	175 Upazila	380

4.7.6.Budget

Component and Year wise physical and financial target of OPs

Agency: DGHS

Name of the OP: Non-communicable Disease

(Tk in Lakh)

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Pay and Allowances	30 Persons	**400.00**			400.00	**30**	**80.00**	**30**	**80.00**	**30**	**80.00**	**30**	160.00
Conventional NCD including Arsenicosis, Major NCDs													
Training of fieldworkers, nurses, paramedics, doctors, social leaders	10140 Batch	1098.12	3044.43	853.38	4995.93	2075	1268.52	3255	1213.01	3059	1489.56	1752	1024.84
Module Preparation and Development	6 Nos	31.86	72.13	16.01	120.00	1	24.55	2	38.52	2	36.2	1	20.73
Printing of Modules	202000 Nos	398.25	501.62	200.14	1100.01	41326	306.88	64839	281.48	60940	252.53	34894	259.12
Foreign training & Study tour	10 Persons	13.28	30.05	6.67	50.00	2	10.23	3	16.05	3	15.08	2	8.64
Surveillance and House to house survey of Major NCDs	3 nos	1945.55	4004.61	977.73	6927.89	1	1499.18	1	2352.16	1	1810.72	1	1265.83
Medicine, Chemicals and reagents (as per List)	LS	424.80	1361.72	213.48	2000.00	LS	427.34	LS	513.58	LS	482.7	LS	576.38

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Mass Awareness(Announcing, media campaign, billboard, leaflet, poster etc.)	LS	212.40	480.86	106.74	800.00	LS	163.67	LS	256.79	LS	241.35	LS	138.19
Procurement of Stationary, equipments, MSR, fuel, furniture etc.	LS	326.57	439.33	164.11	930.01	LS	251.64	LS	294.82	LS	271.07	LS	112.48
Monitoring & Supervision(As per described)	LS	66.38	150.27	33.36	250.01	LS	51.15	LS	80.25	LS	75.42	LS	43.19
Supply & Services(LS)	LS	53.10	120.22	26.69	200.01	LS	40.92	LS	64.2	LS	60.34	LS	34.55
Research	10 Nos	39.83	90.16	20.01	150.00	2	30.69	3	48.15	3	45.25	2	25.91
Procurement of Vehicle	2 Nos	13.28	30.05	6.67	50.00	0	0	2	50	1	0	0	0
Sub-total=		**4623.42**	**10325.45**	**2624.99**	**17573.86**		**4074.77**		**5209.01**		**4780.22**		**3509.86**
Non Conventional NCD													
Training of fieldworkers, nurses, paramedics, doctors, social leaders	10140 Batch	1334.91	2038.96	922.13	4296.00	2075	1129.91	3255	1109.33	3059	980.08	1752	1076.68
Module Preparation and Development	6 Nos	32.88	70.59	16.53	120.00	1	24.55	2	38.52	2	36.2	1	20.73
Printing of Modules	202000 Nos	274.03	388.26	337.71	1000.00	41326	204.59	64839	320.99	60940	301.69	34894	172.73
Foreign training & Study tour	10 Persons	20.55	44.12	10.33	75.00	2	15.34	3	24.07	3	22.63	2	12.96
Procurement of medicine, chemicals, reagents, fuel, stationary, equipments, furniture etc.	LS	307.24	659.55	154.40	1121.19	LS	229.38	LS	359.89	LS	338.25	LS	193.67

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Mass Awareness(Announcing, media campaign, billboard, leaflet, poster etc.)	LS	219.22	270.60	310.17	799.99	LS	163.67	LS	256.79	LS	241.35	LS	138.18
Monitoring & Supervision(As per described)	LS	109.61	235.30	55.09	400.00	LS	81.83	LS	128.39	LS	120.67	LS	69.11
Supply & Services(LS)	LS	137.02	294.13	68.86	500.01	LS	102.29	LS	160.49	LS	150.84	LS	86.39
Research	10 Nos	41.10	88.24	20.66	150.00	2	30.69	3	48.15	3	45.25	2	25.91
Procurement of Vehicle	1 Nos	8.22	17.65	4.13	30.00	0	0	1	30	0	0	0	0
Sub-total=		**2484.78**	**4107.40**	**1900.01**	**8492.19**		**1982.25**		**2476.62**		**2236.96**		**1796.36**
Occupational Health and Safety Health Issues													
Training of fieldworkers, nurses, paramedics, doctors and other stake holders	800 Batch	647.79	1576.15	826.05	3049.99	164	564.90	257	1043.21	241	980.48	138	461.40
Preparation & Development 4 Training Module for FW, Nurse, Paramedics, Doctors	4 Nos	26.09	60.80	13.11	100.00	1	20.46	1	32.10	1	30.17	1	17.27
Printing of Training Module for FW, Nurse, Paramedics, Doctors	20000 Nos	26.09	60.80	13.11	100.00	4092	20.46	6420	32.10	6034	30.17	3455	17.27
Mass Awareness(Announcing, media campaign, billboard, leaflet, poster etc.)	LS	195.64	456.04	98.32	750.00	LS	153.44	LS	240.74	LS	226.26	LS	129.56
Procurement of Stationary, equipments, MSR, fuel, furniture etc.	LS	160.72	374.62	80.77	616.11	LS	126.05	LS	197.76	LS	185.87	LS	106.43
Supply & Services(LS)	LS	195.64	456.04	98.32	750.00	LS	153.44	LS	240.74	LS	226.26	LS	129.56
Research	10 Nos	32.61	76.01	16.39	125.01	2	25.57	3	40.12	3	37.71	2	21.61
Procurement of Vehicle	1 Nos	7.83	18.24	3.93	30.00	1	30.00	0	0.00	0	0.00	0	0.00

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Sub-total=		**1292.41**	**3078.70**	**1150.00**	**5521.11**		**1094.32**		**1826.77**		**1716.92**		**883.10**
Climate Change, Air Pollution, Water Sanitation & Other Environmental													
Training/Workshop of fieldworkers, nurses, paramedics, doctors and other stake holders	483 Batch	699.71	1224.75	851.64	2776.10	99	567.95	155	891.09	146	837.51	83	479.55
1 Training Module (for Doctors) Preparation & Development	1 Nos	25.20	62.13	12.67	100.00	0	20.46	0	32.10	0	30.17	0	17.27
Printing of Training Module Doctors	600 Nos	25.20	62.13	12.67	100.00	123	20.46	193	32.10	181	30.17	104	17.27
Foreign training & Study tour	5 Persons	25.20	62.13	12.67	100.00	1	20.46	2	32.10	2	30.17	1	17.27
Mass Awareness(Announcing, media campaign, billboard, leaflet, poster etc.)	LS	302.46	445.54	452.00	1200.00	LS	245.50	LS	385.18	LS	362.02	LS	207.30
Procurement of Stationary, equipments, MSR, fuel, furniture etc.	LS	186.52	459.75	93.73	740.00	LS	151.39	LS	237.53	LS	223.25	LS	127.83
Procurement of Vehicle	1 Nos	7.56	18.64	3.80	30.00	0	0.00	1	30.00	0	0.00	0	0.00
Research	5 Nos	31.51	77.66	15.83	125.00	1	25.57	2	40.12	2	37.71	1	21.60
Supply & Services(LS)	LS	189.04	465.96	95.00	750.00	LS	153.44	LS	240.74	LS	226.26	LS	129.56
Sub-total=		**1492.40**	**2878.69**	**1550.01**	**5921.10**		**1205.23**		**1920.96**		**1777.26**		**1017.65**
EPR & Post Disaster Health													
Training/Workshop of fieldworkers, nurses, paramedics, doctors and other stake holders	1450Batch	862.67	2053.29	1134.04	4050.00	297	828.57	465	1300.00	437	1221.82	250	699.61
Preparation & Development of 4 Training Module for FW, Nurse, Paramedics, Doctors	4 Nos	26.24	60.58	13.19	100.01	1	20.46	1	32.10	1	30.17	1	17.28

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Printing of Training Module for FW, Nurse, Paramedics, Doctors	20000 Nos	26.24	60.58	13.19	100.01	4092	20.46	6420	32.10	6034	30.17	3455	17.28
Procurement of medicine, chemicals, reagents, fuel, stationary, equipments, furniture etc.	LS	695.76	1606.24	349.65	2651.65	LS	542.49	LS	851.15	LS	799.96	LS	458.05
Mass Awareness(Announcing, media campaign, billboard, leaflet, poster etc.)	LS	249.27	575.46	125.27	950.00	LS	194.36	LS	304.94	LS	286.60	LS	164.10
Research	10 Nos	170.55	393.74	85.71	650.00	2	132.98	3	208.64	3	196.10	2	112.28
Procurement of Vehicle	1 Nos	7.87	18.17	3.96	30.00	0	30	0	0.00	0	0.00	0	0.00
Sub-total=		**2038.60**	**4768.06**	**1725.01**	**8531.67**		**1769.32**		**2728.93**		**2564.82**		**1468.60**
Mental Health and Autism, Tobacco, Alcohol & Substance Abuse.													
Training/Workshop of fieldworkers, nurses, paramedics, doctors and other stake holders	967 Batch	780.45	1088.44	992.21	2861.10	198	585.34	310	918.38	292	863.15	167	494.23
Preparation & Development 4 Training Module for FW, Nurse, Paramedics, Doctors	4 Nos	27.28	59.01	13.71	100.00	1	20.46	1	32.10	1	30.17	1	17.27
Printing of Training Module for FW, Nurse, Paramedics, Doctors	30000 Nos	27.28	59.01	13.71	100.00	6138	20.46	9630	32.10	9051	30.17	5182	17.27
Procurement of medicine, chemicals, reagents, fuel, stationary, equipments, furniture etc.	LS	362.80	785.00	182.32	1330.12	LS	272.10	LS	427.00	LS	401.27	LS	229.75

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Mass Awareness (Announcing, media campaign, billboard, leaflet, poster etc.)	LS	177.31	383.49	89.10	649.90	LS	132.98	LS	208.64	LS	196.10	LS	112.18
Supply & Services(LS)	LS	109.11	236.05	54.83	399.99	LS	81.83	LS	128.39	LS	120.67	LS	69.10
Procurement of Vehicle	1	8.16	17.70	4.10	30.00	1	30.00	0	0.00	0	0.00	0	0.00
Sub-total=		**1492.39**	**2628.70**	**1349.98**	**5471.11**		**1143.17**		**1746.61**		**1641.53**		**939.80**
Grand Total=		**13824.00**	**27787.00**	**10300.00**	**51911.04**	**30.00**	**11349.06**	**30.00**	**15988.90**	**30.00**	**14797.71**	**30.00**	**9775.37**

4.8. National Eye Care (NEC)

4.8.1.Introduction

Avoidable blindness is one of the major public health problems in Bangladesh. Bangladesh National Blindness and Low Vision survey 2000 showed that the age specific standardized blindness prevalence rate is 1.53% and thus there are 750,000 blind adults above the age of 30 years in the country. 80% of bilateral adult blindness is due to cataract. The number of individuals suffering from Low Vision (LV) is 3-fold to that of blindness. In addition, about 40,000 children are blind and this is also a major public health problem, considering DALY. 90% of this blindness and LV is avoidable. About 5 million people including children suffer from refractive errors, about 2.8% of population aged 35 years and above suffer from glaucoma, 25% of diabetic patients are suffering from Diabetic retinopathy (Bangladesh National blindness and low vision survey 2000). The other predominant diseases which the program will have to address are retinal diseases, corneal diseases, ocular trauma (due to agricultural and occupational hazards), ocular growth and malformations. A strategy for early detection and management of these problems is an economically and socially productive proposition.

During the last 5 years, government has initiated measures to mitigate blindness problem in the banner of National Eye Care program (2006-11) in HNPSP - in cooperation with local and INGOs utilizing available facilities. The major thrust of the program (2006-11) was to improve infrastructure and technology at secondary level service centers (district hospitals) to provide quality eye care services.

Bangladesh is a signatory to the V2020 (Right to sight) initiative of IAPB & WHO and committed to achieve the goal of elimination of avoidable blindness by the year 2020. NEC in HPNSDP will give the opportunity to achieve Vision 2020 target through district V2020 committees in all districts; improve infrastructure at secondary level hospitals; training for eye care providers, paramedics, nurses and PHC workers. The innovative activities during this operational plan will be establishment of vision centers at UZHC for correction of refractive errors and identification of cataract and other ophthalmic cases for referral, introduction of child sight testing, establishment of subspecialty services at tertiary centers, demand side financing, MIS eye health system and incorporating primary eye care to community clinic services.

4.8.2. Objectives

- To develop/ improve eye care facilities at secondary and primary care level through improving skill of ophthalmologists, paramedics and supplying appropriate equipment.
- To increase awareness of mass population on blindness prevention.
- To strengthen coordination among GO-NGO and private eye care providers.
- To control childhood blindness.
- To introduce vouchering scheme to increase accessibility of the poor, elderly, women and children in need of cataract surgery.

4.8.3. Components

1. Capacity development of NEC program
2. Advocacy and coordination
3. Planning and research
4. Procurement
5. Monitoring & Supervision
6. Human Resource Development
7. Service Delivery/ special activity

Component 1: Capacity development of NEC program

Office of the NEC in situated in National Institute of Ophthalmology (NIO) using its own HR and its facilities. To carry out the program at national level, additional HR is needed for smooth functioning of the program.

Activities:

Recruitment & utilization of following position:

- National Consultant 01
- Accountant 01
- Computer Operator 02
- Messengers/MLSS 02

Component 2: Advocacy and coordination

BCC is one of the important components of the program which relates to awareness creation for change in the health-seeking behavior of the population for increasing voluntary reporting of cases at outpatient department of secondary and primary eye care centers.

Coordination & cooperation between public, private, NGOs are required in respect of human resources development, Service delivery (Geographical areas & quality) to avoid duplication & maintain uniformity.

Activities

- Development of BCC material in collaboration with HEP of DGHS
- Orientation of community leaders on prevention of avoidable blindness
- Awareness raising program for agricultural and industrial workers to prevent ocular trauma
- Development of need based awareness creation program

Component 3: Planning and research

Epidemiological behavioral health system and health work force research as a part of national program of eye health and prevention of blindness and visual impairment.

Activities:

- Development of district eye care plan
- Revision of training manuals for doctors, nurses & field worker (workshop)
- Conducting research
- Nationwide blindness survey to estimate diseases burden for effective planning

Component 4: Procurement

To provide quality eye care at district and upazila level equipments and other logistics will be procured.

Activities:

- Providing MSR & equipment support for eye care at designated service centers.
- IOL support for cataract surgical camps.
- Protecting glass to prevent ocular trauma
- Vehicle for field supervision

Component 5: Monitoring & Supervision

To ensure quality of care and quality of training, close monitoring of the following activities are included in the OP:

Activities:

- Monthly OPIC meeting
- Field visit by the national level supervisor for performance monitoring.

Component 6: Human Resource Development

Training of ophthalmologists, paramedics, nurses and PHC workers are of paramount importance for providing quality eye care services at eye care centers and field levels.

Activities:

- Vision 2020 workshop at different level,
- Training of the eye care providers
- Orientation of community leaders
- Incorporation of eye care data (GO & NGO's) international MIS

Component 7: Service Delivery/ Special Activities

- Establishment of sub specialty department in five tertiary level hospitals
- Conduction of Cataract screening and surgical camps
- Sight testing for primary school students
- Demand Side Financing/vouchering scheme for poor patients
- Supply of protecting glass to agricultural and industrial workers

4.8.4. Cross Cutting Issues

Cross cutting issues to be addressed during the implementation period of the Operational plan are:

- Vitamin A deficiency blindness through NNS, immunization against measles through EPI (child health) and control of childhood diarrhea through CDD (OP-ESD, NNS)
- Liaise with non-communicable disease control program and neglected tropical diseases prevention and control (OP-NCD)
- Liaise with health education & promotion in respect of preparation of IEC materials (Print, Electronic media and observation of World Sight Day)
- Promote partnership between the public, private and voluntary organization at national & international level (OP-IFM).

4.8.5. Indicators

The activities planned contribute to Result 1.1, increased utilization of essential HPN services and Result 1.4, improved primary health care community clinics.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of adult cataract pts undergone surgery per million populations. ?	1164 (2009 NEC)	1500	1600
2	Number of cataract patients received cash voucher	NA (NEC)	6,000	10,000
3	Number of patients with diabetic retinopathy received services	NA (NEC)	2000	3000
4	Number of hospitals following standard protocols.	150 (2009 NEC)	200	250
5	Number of child cataract surgery performed annually.	4000 (2009 NEC)	5000	5000



4.8.6.Budget

Component and Year wise physical and financial target of OPs

Agency: Directorate General of Health Services

Name of the OP: National Eye Care

(Taka in Lakh)

Name of the Components[1]/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Pay of Establishment	5	42.00	0.00	0.00	42.00	5	8.40	5	8.40	5	8.40	10	16.80
i) Development TV spot	5		10.00	0.00	10.00	1	2.00	1	2.00	1	2.00	1+1	4.00
ii) Development Radio Spool	10		5.00	0.00	5.00	2	1.00	2	1.00	2	1.00	2+2	2.00
iii) Development & Printing of IEC Materials (Posters, Leaflets Stickers 10000 each per year)	50000		7.50	0.00	7.50	150000	1.50	150000	1.50	150000	1.50	300000	3.00
iv) Observance of World Sight Day (Rally & advocacy meeting)	5 each		10.00	0.00	10.00	1	2.00	1	2.00	1	2.00	1+1	4.00
v) Development, Printing, Distribution of Eye Care messages booklet for school children	100000		10.00	0.00	10.00	0	0.00	100000	10.00	0	0.00	0	0.00
vi) Installation of bill board at service centers	10		25.00	0.00	25.00	2	5.00	2	5.00	2	5.00	2+2	10.00
2. Advocacy (through mass media and IEC)	Lumsum	0.00	67.50	0.00	67.50		11.50		21.50		11.50		23.00
i) Development of District Eye Care Plan	Lumsum	0.00	40.00	0.00	40.00	4	8.00	4	8.00	4	8.00	4+4	16.00
ii) Revision of Training manuals for Doctors, Nurses & Field Workers (Workshop)	Lumsum	0.00	6.00	0.00	6.00	3	6.00	0	0.00	0	0.00	0	0.00
iii) Study on pattern of corneal ulcer & treatment of rural areas of Bangladesh	Lumsum	0.00	10.00	0.00	10.00	0	0.00	0	0.00	1	10.00	0	0.00

Name of the Components[1]/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
3. Planning & Research for eye care planning	Lumsum	0.00	56.00	0.00	56.00	7.00	14.00	4.00	8.00	5.00	18.00	0.00	16.00
4. Repair & Maintenance	Lumsum	95.00	0.00	0.00	95.00	Lumsum	19.00	Lumsum	19.00	Lumsum	19.00	Lumsum	38.00
5. MSR	75000 patients	345.00	0.00	0.00	345.00	12000	60.00	15000	75.00	18000	90.00	30000	120.00
i) Eye Care publication	5	0.50	14.50	0.00	15.00	1	3.00	1	3.00	1	3.00	1+1	6.00
ii) Printing cards, forms, files, pad etc	Lump sum	0.00	5.00	0.00	5.00	Lump sum	1.00	Lump sum	1.00	Lump sum	1.00	Lump sum	2.00
iii) Printing, photocopy & binding OP	Lump sum	1.30	0.00	0.00	1.30	Lump sum	0.50	Lump sum	0.20	Lump sum	0.20	Lump sum	0.40
6. Printing & publication	LS	1.80	19.50	0.00	21.30	1.00	4.50	1.00	4.20	1.00	4.20	0.00	8.40
i) Monthly OPIC meeting	50	12.00	3.00	0.00	15.00	10	3.00	10	3.00	10	3.00	20	6.00
ii) Field visit by the National level supervisor for performance monitor	40	10.00	2.00	0.00	12.00	8	2.40	8	2.40	8	2.40	8+8	4.80
7. Monitoring & Supervision	LS	22.00	5.00	0.00	27.00	18.00	5.40	18.00	5.40	18.00	5.40	20.00	10.80
i) Vision 2020 workshop at National level	2	0.00	20.00	0.00	20.00	1	10.00	0	0.00	0	0.00	0+1	10.00
ii) Vision 2020 workshop at district level	20	0.00	60.00	0.00	60.00	4	12.00	4	12.00	4	12.00	4+4	24.00
iii) Vision 2020 workshop at upazila level	20	0.00	20.00	0.00	20.00	4	4.00	4	4.00	4	4.00	4+4	8.00
iv) Microsurgery training for Ophthalmologist Batch of 4 duration 4 weeks	15	0.00	45.00	0.00	45.00	3	9.00	3	9.00	3	9.00	3+3	18.00
v) OT, ward management & Counseling Training for Nurses/ MLOP Batch of 10 duration 2 months	10	0.00	40.00	0.00	40.00	2	8.00	2	8.00	2	8.00	2+2	16.00
vi) Orientation/short term fellowship on retina/ paediatric Ophthalmology Batch of 6 duration 1 month	10	0.00	20.00	0.00	20.00	2	4.00	2	4.00	2	4.00	2+2	8.00
vii) 2 days TOT for District Trainer team on PEC Batch of 20 (4 per district)	5	0.00	15.00	0.00	15.00	1	3.00	1	3.00	1	3.00	1+1	6.00

Name of the Components[1]/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
viii) 2 days Training of PHC workers on PEC Batch of 30	30	0.00	30.00	0.00	30.00	6	6.00	6	6.00	6	6.00	6+6	12.00
ix) 1 day Orientation of Community leaders on prevention of avoidable blindness Batch of 100	30	0.00	15.00	0.00	15.00	6	3.00	6	3.00	6	3.00	6+6	6.00
x) Development of the system for incorporation of eye care data (GO & NGO's) National MIS	1	0.00	5.00	0.00	5.00	1	5.00	0	0.00	0	0.00	0	0.00
xi) Development of monitoring tools for eye care performance (Workshop)	4	0.00	8.00	0.00	8.00	2	4.00	2	4.00	0	0.00	0	0.00
xii) Training need assessment of eye care service providers (Doctors, MLEP, PHW) Workshop	2	0.00	6.00	0.00	6.00	2	6.00	0	0.00	0	0.00	0	0.00
8. Human Resource Development for eye care	149 batch	0.00	284.00	0.00	284.00		74.00		53.00		49.00		108.00
9. Special Activities													
i) Establishment of subspecialty at tertiary centres	5	25.00	0.00	0.00	25.00	1	5.00	1	5.00	1	5.00	1+1	10.00
ii) Conduction of Cataract Screening and surgical camp	25	125.00	0.00	0.00	125.00	5	25.00	5	25.00	5	25.00	5+5	50.00
iii) Sight Testing for School Student	20	0.00	10.00	0.00	10.00	4	2.00	4	2.00	4	2.00	4+4	4.00
iv) Demand Side Financing/ vouchering scheme for poor patient	10000 Patients	0.00	150.00	0.00	150.00	2000	30.00	2000	30.00	2000	30.00	4000	60.00
Sub Total		150.00	160.00	0.00	310.00	2010	62	2010	62	2010	62	4000	124
10) Utility Management Cost	Lump sum	128.00	0.00	0.00	128.00	Lump sum	25.00	Lump sum	28.00	Lump sum	25.00	Lump sum	50.00
11) Consultancy													

Name of the Components[1]/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
National Consultant	36 mm	0.00	48.00	0.00	48.00		9.60		9.60		9.60		19.20
12) Survey													
Nationwide blindness survey	1	0.00	0.00	400.00	400.00		50.00		200.00		150.00		0.00
13) Acquisition of Asset													
i) Procurement of Eye Care Equipment for district Hospital	6	42.00	0.00	0.00	42.00	2	14.00	1	7.00	1	7.00	1+1	14.00
ii) Procurement of eye care equipment for upazila Hospital (vision centre)	19	60.90	0.00	0.00	60.90	3	10.90	5	15.60	3	9.80	5+3	24.60
iii) Procurement of eye care equipment for upazila Hospital Eye OT	19	89.00	0.00	0.00	89.00	5	24.00	2	13.00	3	14.00	3+6	38.00
iv) Equipment for sub specialty centre	5	95.76	0.00	0.00	95.76	0	0.00	2	46.61	0	0.00	3+0	49.15
v) Procurement of furniture for upazila eye OT & vision centre	152	13.54	0.00	0.00	13.54	39	3.58	31	2.91	27	2.52	55	4.53
vi) Procurement of vehicles for field supervision(Jeep)	1	0.00	60.00	0.00	60.00	0	0.00	1	60.00	0	0.00	0	0.00
vii) Procurement of photocopier	2	2.50	0.00	0.00	2.50	1	1.25	1	1.25	0	0.00	0	0.00
viii) Procurement of Computer	10	5.00	0.00	0.00	5.00	5	2.50	5	2.50	0	0.00	0	0.00
ix) Protecting glass for Agro/industrial workers	20000	2.00	18.00	0.00	20.00	5000	5.00	5000	5.00	10000	10.00	0	0.00
Sub Total		310.70	78.00	400.00	788.70		111.23		353.87		193.32		130.28
Total		1094.50	718.00	400.00	2212.50		404.63		647.97		495.42		664.48

4.9. Hospital Services Management (HSM)

4.9.1.Introduction

In Bangladesh, Hospital Service Delivery is focused in three functional levels: primary, secondary and tertiary. The secondary and tertiary level hospital services in the public sector are the most visible utilized area of the clinical service delivery. As its name implies the OP- Hospital Services management has been formulated with the objective that "Appropriately equipped hospitals at all levels will provide efficiently the expected services with quality care and equity of access". The public hospitals offer the best accessibility for the economically challenged and vulnerable population of our country. With the increasing demand on services, several hospitals have been upgraded from their previous bed strengths. In this context the OP-HSM is aimed to continue the proper functioning of these hospitals by appropriately equipping them, maintaining their proper functioning with quality of care. A flourishing non-public sector is growing very fast, mostly located at district and above, at present which total bed capacity is more than public sector hospitals.

It is the intention that all medical colleges and tertiary levels hospitals will only accept referred patients and acts as referral hospitals. Strengthening of the network of well-worked out structured referral system(both upward & downward) is to be emphasized strongly, so that patients are assured of receiving treatment with dignity & acknowledged from health facilities and that patient load at the higher levels is not needlessly burdened by those who can be treated at the local level. The service providing capacity & bed occupancy medical college & specialized are hampered due to non functioning of structured referral system. Upward & downward Referral linkages needs to be developed functionally between the specialized, tertiary and secondary & primary level hospitals effectively and given due profile. To implementing the strong structured referral system, vacant post of medical officer& specialists need to be filled up immediately. Ownership of the service providers is one of the big challenges, at present for implementing the structured referral system.

For ensuring optimum and modern treatment facility to the people hospital will be equipped with necessary and need based modern electro-medical instrument/equipment. Emphasis could be given towards repair and maintenance of electro-medical instrument/equipments also.

Development of National Health Care Standards is very much essential. The main purpose of the National Health Care Standards is to, develop a common definition of quality of care, which should be found in all health establishments of Bangladesh as a guide to the public and to managers and staff at all levels, Establish a benchmark against which health establishments can be assessed, gaps identified, strengths appraised & Provide a national framework to certify health establishments as compliant with standards.

Total Quality Management (TQM) service will be introduced & strengthened for ensuring the quality of the services with satisfaction of the service provider & service recipients. Standards operating system (SOP), monitoring tool kits, patient satisfaction survey, functioning of the different QA committee & development & implementation of Clinical Quality Indicators for different areas are the most important tools for ensuring the Quality Assurance of hospital services. The new concept of development of evidence based practice (EBP), Infection control Program & clinical protocol in different areas will be strengthened more for the effective & quality clinical service delivery. Hospital emergency management services needs to more effective in both public & private sectors. Hospital & laboratory accreditation system will be introduced in the public & private hospitals with the joint collaboration of NGOs. Provision of technical assistance will be explored to make the accreditation system in place.

Hospital autonomy will be introduced initially for the tertiary level hospitals. Administrative and financial autonomy will be explored for better management of the existing secondary and tertiary level public sector hospitals. Management Committees at hospitals will be strengthened for better and effective service delivery including ensuring utilization by the poor and women. The principle to be adopted will center on maximum delegation of financial power and administrative authority without compromising transparency and accountability. The policy level reform & strong initiative of the major stakeholder are the visible challenges to introduce & implement the hospital autonomy system.

Developing of local level strong monitoring, ownership & accountability of the service provider seems to more important for effective hospital service delivery. Proper & regular posted of hospital superintendent, capacity development of the hospital manager in DH & MCH are the big challenges for effective hospital management. Accountability of the hospital manager needs to be ensured & should be monitored strongly from central level by introducing the management development Program. Community participation is to be ensured by local hospital management committee, might be the important factor for better management regarding manpower.

Resource mobilizations and number of beds will increase on local need & bed occupancy rate. The government will establish new specialized hospitals under PPP initiative. To fulfillment of the public demand, private sector health service delivery is growing fast, accreditation tool, independent regulatory body and medical waste management system would be implemented mandatory for ensuring transparent and quality service delivery.

Ensure MWM as it's a critical environmental issue that is within the remit of the health sector. For final treatment and disposal of medical waste, government will go for centralized treatment facility, so that all the public and private health care facilities could be brought under the same umbrella. For effective implementation of MWM nationwide, strong coordination is needed with MoLG&RD.

Performance of Hospital services would be strengthening by ensuring blood safety, QA, emergency management, improving EmNOC services, infection prevention program, Burn/critical care and transforming existing hospitals into women and baby friendly hospitals.

4.9.2. Objectives

- To strengthen and upgrade secondary and tertiary level hospital services for improvement of patient care and accessibility;
- To improve the Quality of Care in the health care services by introducing of National Health Care Standards, Quality Assurance Program, Total Quality Management (5S-Kaizen-TQM);
- To reduce the maternal mortality by strengthening existing 24/7 CEmNOC activities;
- To introduce Structured Referral system in the hospital services for the proper functioning of health care system;
- To supply equipment, furniture and other logistics to the upgraded and newly constructed secondary and tertiary hospitals for provision of the expected range of services;.
- To introduce standard waste management (Phase wise) in both public & private sector;
- To establish Women Friendly Hospital for improving the accessibility, equity, equality and effective treatment of women;
- To improve hospital emergency management services for the reduction of mortality both in public and private hospitals;
- To improve the clinical service delivery of hospitals service by introducing the evidence-based practices(EBP) , Infection control Program, club foot management , poisoning management & Clinical Management Protocol;
- To strengthen the strong regulatory framework for the private sector and NGOs hospitals/ Clinics/ Laboratories by upgradation 1982 clinic ordinance;
- To control TTI by effective introduction of safe blood transfusion Program countrywide;
- To establish Coronary Care Unit in selected district hospitals;
- To establish Intensive Care Unit (ICU) in medical college hospital and district hospitals in phases; and
- To establish hospital & laboratory accreditation system in the both public & private health care sector for ensuring the Quality of care

4.9.3. Components

Component 1: Continuation of the public sector hospital support services (District Hospitals, Medical College hospitals & Specialized Hospitals)

The support services for the physical facilities those have already been constructed or expanded under the previous sector Programs and not yet been transferred in the non-development budget would be continued

through the HPNSDP till its transfer to non-development budget. Necessary salaries, allowances, logistics and other supports will be provided through this OP. At the same time, any completed new construction or expansion of secondary, tertiary and specialized facilities under HPNSDP will be supported by necessary equipment and logistic supports through this OP till their transfer to non-development budget. Accountability & effective utilization of fund will be ensured by effective monthly monitoring meeting.

Activities:

- Salaries, allowances, logistic support services/ or operational cost for existing expanded/ constructed facilities to be continued till their transfer to non-development budget;
- Equipment and logistics supply for the completed new construction or expansion under the HPNSDP;
- Supply of equipment, furniture and logistics for the Begum Fazilatunnessa Mujib Memorial Specialized Hospital and NTC, Cardiac ICU at Dhaka Shishu Hospital (as per Ministry of Social Welfare guideline)
- Standardization of different level hospitals in respect of manpower, instrument/equipments and bed distribution according to the discipline.

Component 2: Introduction of Medical Waste Management at Public & Private Hospitals

Improvement of the Hospital environment & Quality Service will be provided by the effective implementation of Medical waste management in the public & private hospitals. Capacity development & awareness of the service provider will be the most important aspect of MWM. Provided Necessary logistics & effective coordination among the MOHFW & LGED may be the key point of effective waste management. Proper implication of Medical Waste management law might play the vital role by the implementer. For outhouse management PPP will be encouraged more in the next sector wide Program.

Activities:

- Awareness building for service providers and recipients;
- Supply of necessary logistics for MWM; and
- Capacity development of the service providers.

Component 3: Scale Up of the Structured Referral system.

The aim of structured referral system is to maximize the utilization of UHC & load minimization of the secondary & tertiary level hospitals by introduction of effective upward & downward referral system. Structured Referral System is to be rolled out countrywide from Primary, Secondary & Tertiary level hospitals by defining the specific catchments area in collaboration with other related OPs. By ensuring the ownership & accountability of the hospital service provider, referral system will be implemented effectively. Patient will be properly aware and priority clinical management will be ensured by successful implementation of referral system. Development of data base of the referral patient will be ensured by introduction of different referral registers, form, diseases code, ICD-10, etc.

Activities:

- Capacity building of the service providers;
- Printings & distribution of different forms, guideline and registrars to the different hospitals
- Development of Referral data base; and
- Supervision & Monitoring.

Component 4: Development & Introduction of Hospital & Laboratory accreditation

By development & implementation of Hospital & Laboratory Accreditation system in Bangladesh, the quality of health care will be ensured at international standard both in the public and private sector gradually. An independent & autonomous National Medical Accreditation Body will be formed.

Finalization & Approval in the parliament & proper implementation of Private Health care Act-2011 which will be replaced 1982 clinic ordinance will play very important role for ensuring Quality Health Care Service in the private sector

Activities;

- Finalization & approval of the strategic concept paper & action plan of Hospital & Laboratory Accreditation System;
- An independent autonomous National Accreditation Body (NAB) formation & their activities
- Piloting of the Hospital & Laboratory Accreditation system with the TA of UNIDO & FHI
- Functioning of Hospital & Laboratory Accreditation system ; and
- Finalization and enforcement of Private Health Care Act-2011.

Component 5: National Health care Standards, Quality Assurance Program and TQM

Development of national Health care standards: The main purpose of the National Core Standards is to develop a common definition of quality of care, which should be found in all health establishments in Bangladesh as a guide to the public and to managers and staff at all levels.

Introduction of **Quality assurance** Program into the service delivery Program and accreditation of the hospitals are key issues for improving overall quality of the health care services. By activation of National Steering committee, National Technical committee, National Task Force QA will be strengthened. Introduction SOP, patient's satisfaction survey and monitoring tool kit will be used in DH & UHC .Women friendly Accreditation system will be strengthened more for ensuring the QA.

Total Quality Management is a newly introduced Program, which will be introduced by the secondary DH as a piloting project under the technical assistance of JICA. 5S-Kaizen-TQM will be the main approach, step by step. Improvement of the hospital environment will be the main focus for TQM implementation. Active participation of lower & mid level manager will play the key role for proper implementation of the Program.

Activities:

- Developments of National Health care Standards;
- Introduction of SOP, Clinical Indicator & different tool kit by QAP;
- Preparation of guidelines/ manuals for the 5S-Kaizen- TQM;
- Capacity of the service provider regarding 5S; and
- Piloting of 5S- Kaizen- TQM in the selected hospitals.

Component 6: Safe Blood Transfusion

Since the beginning the requisite numbers of manpower for the blood transfusion centers were not fulfilled, which compromised the standard operating procedure, coupled with weakness in the maintenance system. Presence of unauthorized blood bank posed challenges for maintaining the quality of blood collection system. Inadequate manpower and resources in the licensing unit (Director Hospital and his/her team) have been unable to execute regular monitoring and inspection of authorized and unauthorized blood transfusion centers. Uncoordinated activities of voluntary blood donor organizations for collection of blood leads to inequitable and improper utilization of valuable resources and the government blood centers suffer from shortage of blood. Power interruptions hinder cold chain management. Interest to use blood component is inadequate among the clinicians. Absence of physical structure and manpower for blood collection is critical for government blood transfusion centers, this also hampers building up of an adequate stock of blood. Frequent changes of key implementers of SBTP at short intervals slows down the spirit of the program. Fill up the regular post and District hospitals manager need to be more accountable. Close monitoring both from centrally & locally will be strengthened.

Activities

- Procurement and supply of equipments, reagents, blood bags etc;
- Capacity development of service provider involving transfusion medicine services in both public & private sector; and
- Monitoring and supervision of the SBT activities.

Component 7: Strengthening of the Hospital Services through Decentralization/Autonomy

Hospital autonomy will be introduced initially for tertiary level hospitals and gradually be extended to medical colleges and district hospitals. Appropriate TA will be engaged for this purpose.

The provision of the autonomous boards will be given liberty to raise funds locally for meeting short falls in the budget of these hospitals. Management Committees at hospitals will be strengthened for better monitoring and evaluation.

Activities:

- Approval of the draft Hospital Autonomy Bill by MOHFW; and
- Piloting of the selected hospitals.

Component 8: Strengthening of the Hospital Service delivery

Introduction of Clinical protocols, Infection control Program & Evidence Based Practice (EBP)_ in the hospital service delivery will play important role for effective & Quality clinical service delivery. Coronary Care Units (CCU) in all district hospitals and ICU at medical college hospitals and districts hospitals in phases with supply of necessary equipments and logistics will be established gradually. The 24/7 CEmoNC service will be ensured in all district hospitals. Strengthening of the reconstructive surgery in different tertiary level hospitals will be done by providing necessary fund, logistics.

Emergency service management, infection control Program, hand hygiene & poisoning management will play the effective role for strengthening of service delivery by development of capacity of the physician. Necessary logistics will be provided through this OP.

Shishu Bikash Kendra in the public sector hospital will be established by providing space & necessary logistics, primarily in the Medical College hospitals gradually. Club foot deformity management will be established in the NCH & DH .

Club foot management by pontessi technique with the TA of Walk for life (NGO) in all public hospital will be implemented immediately.

Activities:

- Development & Introduction of Clinical Management protocol, Infection control Program, EBP and infection control program;
- Scale up of women friendly hospital and hospital risk management program;
- Ensuring 24/7 CEmoNC in all district hospitals by close supervision & monitoring;
- Establishment of modern CCU in all district hospitals;
- Establishment of ICU at medical college hospitals and districts hospitals in phases;
- Establishment of Shishu Bikash Kendra focusing mental disorder and autism care, Fistula management & Club foot management in all medical colleges hospitals gradually in phases;
- Delegation of more financial and administrative authority to the hospitals; and

Component 9: Strengthening of the NEMEW & TEMO

For better Hospital equipment, instrument & logistics maintenance, NEMEW & TEMO will be strengthened.

Activities:

- Preparing a comprehensive plan for repair and maintenance of equipment and vehicles along with budget requirement; and
- Supply of equipment and logistics.

4.9.4. Cross Cutting Issues

- Regarding manpower recruitment, training , reward, punishment & for construction, Line director IHSM will directly & indirectly depends on LDs of HRM, Procurement, Logistics and Supplies Management,, Physical Facilities Development and Pre-Service Education etc.

4.9.5.Indicators

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of DH, MCH & Specialized Hospital supported with logistics and equipments	MCH-5; DH-18 Specialized hospital-11 =33 (IHSM)	33 (old) 57 (New) centre	New MCH-10 Spe.H-4, GH-4 DH-22, CCU-3 Burn unit- 14 (MCH)+ old 33
2	Development of National Health Care Standards		Core & Development standards	Implementation 3 DH 3 MCH. Monitoring & Supervision
3	Number of DH and UHC introduced quality assurance	8 DH (IHSM)	34 DH 270 UHC	30 DH 206 UHC
4	Number of DH, MCH introduced Clinical Management protocol, infection control Program & poising management		20DH, 7 MCH	39 DH, 7 MCH
5	Number of Specialized hospital & MCH introduced EBP	Nil	2 Specialized & 2 MCH	4 Specialized & 4 MCH
6	Number of hospitals, by category, where MW management has been introduced	10 specialized hospital, 3 MCH (IHSM)	25 DH, 4MCH 7 Spec. hosp	59 DH, 14 MCH
7	Regulatory frameworks for private clinic updated and placed for parliamentary approval	1982 Clinic Ordinance	Done	Done
8	Number of public sector hospitals introduced decentralization & Hospital autonomy	Draft autonomy bill (IHSM)	3 DH & 3 MCH	3 DH & 3 MCH
9	Number of hospitals (DH and UHC)introduced S-Kaizen- TQM model to improve patient satisfaction	NA	2 MCH 3 DH, 3 UHC	2 MCH 3 DH 3 UHC
10	Number of hospitals introduced structured Referral system	26 DH & 6 MCH (IHSM)	15 DH & 5 MCH	18 DH & 5 MCH
11	Number of hospitals declared as Women friendly	15 DH & 4 UHC (IHSM)	14 DH	20 DH
12	Number of facilities introduced safe blood transfusion services	114 facilities (IHSM)	214 facilities	317 facilities

4.9.6.Budget

Component and Year wise physical and financial target of OPs

Agency: Directorate General of Health Services
Name of the OP: Hospital Service Management

(Tk in Lakh)

Name of the Components / Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty / unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Continuation of the Public sector hospital services.		**70,707.00**	**54,507.22**	**15,541.00**	**140,755.22**		**17,803.73**		**40,865.92**		**38,045.17**		**44,040.40**
Pay & allowance of staffs	3-Specialized 4-DH	7,315.00	-	-	7,315.00	3-Spec. Hos. (Old) 4-DH (Old)	1,463.00	3-Spec. (Old) 4-DH (Old)	1,463.00	3-Spec. Hos. (Old) 4-DH (Old)	1,463.00	3-Spec. Hos. (Old) 4-DH (Old)	2,926.00
Printing & Publication of IEC materials, guide lines	4-Type	18.00	-	-	18.00	4-Type	2.00	4-Type	4.00	4-Type	4.00	4-Type	8.00
Procurement of Medicine & Consumable	59-Hospital	2,505.00	1,150.00	-	3,655.00	50-Hospital	726.00	50-Hospital (Old) 4-Hospital (New)	925.00	54-Hospital (Old)	1,114.00	54-Hospital (Old) 5-Hospital (New)	890.00
Procurement of MSR	59-Hospital	6,381.65	3,125.00	-	9,506.65	50-Hospital	2,178.40	50-Hospital (Old) 4-Hospital (New)	2,417.50	54-Hospital (Old)	2,696.75	54-Hospital (Old) 5-Hospital (New)	2,214.00
Procurement of Diet	59-Hospital	5,986.00	-	-	5,986.00	50-Hospital	1,774.16	50-Hospital (Old) 4-Hospital (New)	1,718.11	54-Hospital (Old)	1,718.11	54-Hospital (Old) 5-Hospital (New)	775.62
Contracting services	59-Hospital	6,457.00	-	-	6,457.00	54-Hospital	1,668.00	59-Hospital	1,867.00	59-Hospital	2,048.00	59-Hospital	874.00
Other related expenditure (stationary, bills, bedding/clothing, chemicals, oil & lubricant etc.)	61-Hospital	18,869.35	15,033.22	14,159.03	48,061.60	61-Hospital	4,438.17	61-Hospital	12,912.31	61-Hospital	12,912.31	61-Hospital	17,798.81

Name of the Components / Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty / unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Vehicle to Begum Fazilatunnesa Mujib Specialized Hospital and other Public hospital (Jeep-41 ,Microbus- 6 , Pick up-2, Ambulance-8, Bus-1, Motor Cycle-4, Covered Van-6)	64 Nos	-	2,400.00	-	2,400.00		1,200.00		1,200.00				
Supply of Logistics to Begum Fazilatunnesa Mujib Specialized Hospital and other Public hospital (Furniture, equipments)	61-Hospital	23,175.00	35,199.00	1,381.97	59,755.97	54-Hospital	5,554.00	59-Hospital	19,559.00	59-Hospital(Old)	16,089.00		18,553.97
Introduction of Medical Waste Management at Public & Private sector.		**1,109.00**	**1,656.00**	-	**2,765.00**		**636.00**		**806.00**		**691.00**		**632.00**
Printing & Publication of IEC materials for service providers	15- type IEC	112.00	40.00	-	152.00	15- type IEC	40.00	15- type IEC	50.00	15- type IEC	50.00	15- type IEC	12.00
Development / production/ advertisement & publicity of IEC materials for mass awareness	5- Types IEC	80.00	209.00	-	289.00	1-Types (New)	40.00	2-Types (New)	95.00	2-Types (New) 3-types (Old)	55.00	2-Types (New) 3-types (Old)	99.00
Capacity development of the service providers on Medical waste management	1230-Batch	152.00	400.00	-	552.00	230- Batch	150.00	345-batch	125.00	268-Batch	125.00	385-Batch	152.00
Training expenditure (Abroad) for capacity development of managerial people	7-Batch	-	157.00	-	157.00	2-Batch	40.00	2-Batch	55.00	1-Batch	62.00	-	-

Name of the Components / Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty / unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Supply of Medical Waste Management related Logistics to the Gov. hospitals	18-MCH, 7-Specialized, 59-DH	454.00	800.00	-	1,254.00	10-MCH, 7-Specialized, 20-DH	300.00	12-MCH, 7-Specialized, 20-DH	400.00	14-MCH, 7-Specialized, 22-DH	300.00	18-MCH, 7-Specialized, 59-DH	254.00
Other related expenditure to implement standard medical waste management	18-MCH, 7-Specialized, 59-DH	311.00	50.00	-	361.00	10-MCH, 7-Specialized, 20-DH	66.00	12-MCH, 7-Specialized, 20-DH	81.00	14-MCH, 7-Specialized, 22-DH	99.00	18-MCH, 7-Specialized, 59-DH	115.00
Continuation of Structured Referral System.		**99.00**	**355.00**	**-**	**454.00**		**80.00**		**105.00**		**105.00**		**164.00**
Printing of different form, registrar, diseases code, guide etc on referral system	7-types	57.00	50.00	-	107.00	7-types	15.00	7-types	30.00	7-types	30.00	7-types	32.00
Capacity development of the service providers	75-Batch	42.00	90.00	-	132.00	15-Batch	30.00	15-Batch	30.00	15-Batch	30.00	30-Batch	42.00
Training expenditure (Abroad) for the managerial people	9-Batch	-	215.00		215.00	1-Batch	35.00	2-Batch	45.00	2-Batch	45.00	4-Batch	90.00
Development & Introduction of Hospital and Laboratory Accreditation		**89.00**	**220.00**	**-**	**309.00**		**65.00**		**70.00**		**70.00**		**104.00**
Printing of accreditation document & tool kits	2-Type	47.00	-	-	47.00	2-Type	15.00	1-Type	15.00	1-Type	15.00	2-Type	2.00
Capacity development of the service providers	75-Batch	42.00	90.00	-	132.00	15-Batch	30.00	15-Batch	30.00	15-Batch	30.00	30-Batch	42.00

Name of the Components / Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty / unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Training expenditure (Abroad) for capacity development of managerial people	5-Batch	-	130.00	-	130.00	1-Batch	20.00	1-Batch	25.00	1-Batch	25.00	2-Batch	60.00
Safe Blood Transfusion		**708.05**	**7,078.28**	**-**	**7,786.33**		**1,380.60**		**3,669.47**		**2,084.56**		**651.70**
Procurement of Kits, reagents, Blood bags	LS	475.25	861.28	-	1,336.53	LS	285.00	LS	464.37	LS	415.06	LS	172.10
Capacity development of the service providers	18-Batch	2.00	85.00	-	87.00	5-Batch	22.00	7-Batch	35.00	4-Batch	20.00	2-Batch	10.00
Training expenditure (Abroad) for capacity development of managerial people	4-Batch	-	85.00	-	85.00	1-Batch	25.00	1-Batch	25.00	1-Batch	25.00	1-Batch	10.00
Printing & Publication of IEC materials, guide lines for service providers	6-Types	15.00	15.00	-	30.00	4-Types	5.00	5-Types	5.00	6-Types	10.00	6-Types	10.00
Procurement of Instrument & Equipments	218-Center	30.00	5,811.00	-	5,841.00	50-Center	1,010.00	50-Center	3,045.00	50-Center	1,510.00	3-Center (New) 10-Center (Old)	276.00
Pay & allowance of staffs and Other related expenditure	218-Center	185.80	221.00	-	406.80	50-Center	33.60	50-Center	95.10	50-Center	104.50	3-Center	173.60
Quality Assurance		**464.00**	**1,319.00**	**-**	**1,783.00**		**295.00**		**396.00**		**395.00**		**697.00**
Printing & Publication of SOPs, Training module & TOT manuals	10-Type	21.00	-	-	21.00	10-Type	4.00	10-Type	5.00	10-Type	8.00	10-Type	4.00
Bill board, Display flow chart, Sign Board, TV program for mass awareness	34-Hosital 270-Upazilla	64.00	150.00	-	214.00	6-Hosital (New) 50-Upazilla	50.00	7-Hosital (New) 55-Upazilla	50.00	7-Hosital (New) 55-Upazilla	50.00	14-Hosital (New) 110-Upazilla	64.00

Name of the Components / Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty / unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Capacity development of the service providers	763-Batch	68.75	885.00	-	953.75	100-Batch	125.00	165-Batch	206.25	166-Batch	207.50	332-Batch	415.00
Procurement of Logistics	3-Pkg	45.00	84.00	-	129.00	1-Pkg.	5.00	2-Pkg.	79.00	2-Pkg (Old)	15.00	2-Pkg (Old)	30.00
Pay & allowance of QA cell staffs	QA Cell	95.00	-	-	95.00	QA Cell	19.00	QA Cell (Old)	19.00	QA Cell (Old)	19.00	QA Cell (Old)	38.00
Other related expenditure	QA Cell. 34-Hosital 270-Upazilla	170.25	50.00	-	220.25	QA Cell. 34-Hosital 270-Upazilla	62.00	QA Cell. 34-Hosital 270-Upazilla	6.75	QA Cell. 34-Hosital 270-Upazilla	65.50	QA Cell. 34-Hosital 270-Upazilla	86.00
Total Quality Management (TQM)		**561.00**	**210.00**	**-**	**771.00**		**128.00**		**179.00**		**206.00**		**258.00**
Printing & Publication of IEC materials, guide lines for service providers	3-Types	100.00	-	-	100.00	3-Types	20.00	2-Types	20.00	2-Types	20.00	2-Types	40.00
Capacity development of the service providers	100-Batch	30.00	70.00	-	100.00	20-Batch	20.00	20-Batch	20.00	20-Batch	20.00	40-Batch	40.00
Training expenditure (Abroad) for capacity development of managerial people	2-Batch	-	60.00	-	60.00	1-Batch	30.00	1-Batch	30.00	-	-	-	-
Supply of Logistics to the Gov. hospitals	6-Hospitals	175.00	-	-	175.00	6-Hospitals	20.00	6-Hospitals	30.00	6-Hospitals	45.00	6-Hospitals	80.00
Other related expenditure to implement TQM	6-Hospitals	256.00	20.00	-	276.00	6-Hospitals	38.00	6-Hospitals	79.00	6-Hospitals	91.00	6-Hospitals	68.00
Strengthen of the Hospital Services through Decentralization / Autonomy		**746.00**	-	**-**	**746.00**		**228.00**		**231.00**		**261.00**		**26.00**

Name of the Components / Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty / unit	Financial				Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial	Physical Qty / unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Capacity development, seminar and Conference	27-Batch	50.00	-	-	50.00	9-Batch	15.00	9-Batch	15.00	9-Batch	20.00		-
Supply of Logistics to the hospitals	12-Hospitals	508.00	-	-	508.00	3-Hospitals	160.00	3-Hospitals	160.00	3-Hospitals	180.00	3-Hospitals	8.00
Other related expenditure	12-Hospitals	188.00	-	-	188.00	3-Hospitals	53.00	3-Hospitals	56.00	3-Hospitals	61.00	3-Hospitals	18.00
Strengthen of Hospital Services delivery		**10,479.02**	**20,208.00**	**159.00**	**30,846.02**		**3,722.65**		**6,962.75**		**9,030.17**		**11,130.45**
Pay & allowance of staffs	Under 3-Activity	1,000.00	-	-	1,000.00	Under 3-Activity	200.00	Under 3-Activity	200.00	Under 3-Activity	200.00	Under 3-Activity	400.00
Printing & Publication of IEC materials, guide lines under 18-activity.	12-Types	685.00	185.00		870.00	12-Types	186.00	12-Types	212.00	12-Types	225.00	12-Types	247.00
Training expenditure (Abroad) for managerial people under 18-activity	30-Batch	-	800.00	-	800.00	10	266.66	10	266.67	10	266.67	-	-
Capacity development of the service providers under 18-activity	1064-Batch	517.00	2,627.00	69.00	3,213.00	230-Batch under 18-Activity	276.00	255-Batch under 18-Activity	374.50	253-Batch under 18-Activity	338.50	330-Batch under 18-Activity	2,224.00
Other operational & Related expenditure	18-Activity	8,277.02	16,596.00	90.00	24,963.02	18-Activity	2,793.99	18-Activity	5,909.58	18-Activity	8,000.00	18-Activity	8,259.45
GRAND TOTAL		**84,962.07**	**85,553.50**	**15,700.00**	**186,215.57**		**24,338.98**		**53,285.14**		**50,887.90**		**57,703.55**

4.10. Alternate Medical Care (AMC)

4.10.1. Introduction

Alternative Medicine includes Homeopathic, Unani and Ayurvedic Medicine in this region. In Bangladesh the practice of alternative medicine is very common particularly in rural area for quite long time, as it is cheap & simple with less side effects, involves indigenous technology & labor and
is locally available & culturally acceptable
Alternative medicine (AM) plays a significant role in health care delivery not only in developing countries but also in the developed countries. The Alternative medicine in Sri Lanka meets the basic health needs of 70% of population. Up to 80% of the people in Africa are reported to seek traditional medicine for their medical care. In China it is said to be 40%. The percentage of traditional medicine utilized in Australia is reported to be 48%, 70% in Canada, 42% in the USA, 38% in Belgium and 75% in France.
After the Drug Control Act of 1982 Bangladesh Government has taken different steps for the development of alternate medical care. Government Unani and Ayurvedic Medical College & Hospital with Production & Research Unit was established in 1990. Homeopathic Medical College & Hospital established separately in the same year. Bachelor of Unani Medicine & Surgery (BUMS), Bachelor of Ayurvedic Medicine & Surgery (BAMS), Bachelor of Homeopathic Medicine & Surgery (BHMS) degrees are given in the three disciplines after five years of study. After graduation one year internship is compulsory in the 100 bed hospital established for the AMC. In addition there are one private Homeopathic degree College, 11 Unani , 7 Ayurvedic, and 38 homeopathic diploma institutes has established in Bangladesh. These diplomas are given after four years of study and 6 months of internship. All these courses are accredited by the Unani, Ayurvedic & Homeopathic board. This board is also responsible for providing practice registration. Bachelor degrees in any of these three disciplines are given by the University, e.g., Dhaka University and registration for Graduate Doctors are given by the DGHS. Near about 80,000 different categories AM doctors are practicing in our country and about 700 industries are producing Unani, Ayurvedic & Homeopathic drugs.
In the 40th World Health Assembly held in May 1987, a resolution urging the member states to utilize the Alternative/Traditional medicine of their country optimally was adopted unanimously. In the draft National Health Policy, 2010 of Bangladesh particular emphasis has been given to encourage systematic improvement in the practice of alternative medicine and to engage additional man power & giving particular attention to the scientific evaluation of alternative medicines.

During HPSP & HNPSP 45 Alternative Medical officer, 64 Support Personal (Compounder), & 467 Herbal assistant has been appointed in selected District Hospitals & Upazila Health Complexes for providing AMC medical services. These HR are in the process to be transferred in revenue set up. Scaling up of these services required to be strengthened and expanded to district & Upazila Health facilities.

4.10.2. Objectives

- To develop Unani, Ayurvedic & Homeopathic Medical Services as an effective treatment and give it institutional shape;
- To strengthen existing AMC Institute;
- To analyze present situation on use of medicinal plant base drugs for primary health care;
- To build-up capacity of the AMC service providers by conducting workshop orientation & training (Local/Overseas); and
- To helps environmental balance by plantation of more medicinal plants & creating more herbal garden within the vacant places of existing health promises & un-utilized public land.

4.10.3. Components

I. Preparing a national AMC strategy to streamline AMC education, research, monitoring, training etc.
Activities



- Preparing a national Unani, Ayurvedic and Homeopathic strategic Plan to streamline AMC services, Education research, monitoring, training etc.
- Strengthening and functioning the AMC regulatory/licensing system, existing herbal garden

II. Strengthening outdoor services at the public AMC hospitals

Activities

- Continuation of AMC Services by providing adequate human resources, drugs and equipments through the LD, AMC, DGHS to the districts and UHCs
- Public Awareness about AMC treatment

4.10.4. Cross Cutting Issues

1. Infrastructure and development OP-PFD
2. More effective integration of AMC in health facilities. OP-ESD, HSM, SDAM
3. Strengthening AMC unit in DG drug OP-SDAM

4.10.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. The activities planned under this OP will contribute to Component 1, Service delivery improved by offering alternative medical services. It will also contribute to Result 1.3, improved awareness of healthy behaviors.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	% of patient received Unani, Ayurvedic, Homeopathic services	20% OPD patient at selected district hospital (AMC year 2010)	25%	30%
2	Unani, Ayurvedic, Homeopathic (AMC) Services expanded	45 District Hospitals	59 District Hospitals, 07 Medical College & 403 UHCs	59 District Hospitals, 07 Medical College & 403 UHCs
3	Prepared Unani, Ayurvedic & Homeopathic Pharmacopoeia & Formularies prepared	2	4	6
4	Number of herbal garden (Plantation of Medicinal Plants) prepared	467	489	531

4.10.6. Budget

Component and Year wise physical and financial target of Ops

Agency: DGHS

Name of the OP: Alternative Medical Care (AMC)

(Tk in Lakh)

Name of the Components[1]/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1: Providing & Continuing Unani Ayurvedic & Homeopathic Services in District & Upazila Health Complex.													
Pay & Allowances	1103 persons	6000.00	0.00	0.00	6000.00	1103	1200.00	1103	1500.00	1103	1800.00	2206	1500.00
Sub Total		6000.00	0.00	0.00	6000.00	-	1200.00	-	1500.00	-	1800.00	-	1500.00
Component-2: Development for Unani Ayurvedic & Homeopathic Services System													
a. Up-gradation of Course Curriculum of Under-graduate & Post graduate Course.	3 Types (Unani, Ayurvedic, Homepathic)	30.00			30.00	3 Type	0.00	3 Type	30.00	3 Type	0.00	3 Type	0.00
b Research, Publication , & Survey .	3 Types (Unani, Ayurvedic, Homepathic)	60.00			60.00	3 Type	30.00	3 Type	0.00	3 Type	0.00	3 Type	30.00
c. Establishment of AMC Council .	1	75.00			75.00	1	25.00	1	25.00	1	25.00		0.00
d. Strengthening of Existing Registration Activities	3 Types (Unani, Ayurvedic, Homepathic)	25.00			25.00	3 Types	5.00	3 Type	5.00	3 Type	5.00	3 Type	10.00
e. Support to Unani, Ayurvdic & Homeopathic Board	3 Types (Unani, Ayurvedic, Homepathic)	75.00			75.00	3 Type	15.00	3 Type	15.00	3 Type	15.00	3 Type	30.00
Sub-total		265.00	0.00	0.00	265.00	-	75.00	-	75.00	-	45.00	-	70.00
Component-3: Procurement													
a. Unani, Ayurvedic & Homeopathic Medicine	531 Health Center	200.00	300.00	-	500.00	531 Health Center	50.00	531 Health Center	50.00	531 Health Center	150.00	531 Health Center	250.00

Name of the Components[1]/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
b. Furniture & Equipment for 3 Hospital	3 Hospital	100.00	500.00	-	600.00	3	50.00	3	550.00	-	0.00	-	0.00
Sab Total		300.00	800.00	0.00	1100.00	3	100.00	3	600.00	0	150.00	0	250.00
Component-4: Plantation Medicinal Plants & Awareness Build-up Regarding AMC Services.													
a. Extension of Plantation,& Maintenance the herbal garden	467 herbal Garden	50.00	-	-	50.00	467 herbal Garden	50.00	-	0.00	-	0.00	-	0.00
b. Creation a central herbal Garden	01 in Dhaka	30.00	-	-	30.00	01 in Dhaka	30.00	-	0.00	-	0.00	-	0.00
c. Awareness Building for medical personals, NGO leaders. Social workers, Journalist etc.	Lump sum	50.00			50.00	LS	10.00	LS	10.00	-	10.00	-	20.00
Sab total		130.00	0.00	0.00	130.00	0	90.00	0	10.00	0	10.00	0	20.00
Component-5: Capacity Build-up													
a. Training (local & foreign) for AMC Doctor & Staff	06 Group 30 persons	150.00			150.00	06 Group	10.00	06 group 30 Person	50.00	03 group	50.00		40.00
b. Training for heath Managers.	All Directors Health, C/S, UH&FPO,	90.00			90.00	All Driector Health, C/S, UH&FPO,	30.00	All Driector Health, C/S, UH&FPO,	30.00	All Driector Health, C/S, UH&FPO,	30.00		0.00
c. Orientation Workshop for Skill Development the AMC Health Provider	1088 Persons	120.00			120.00	1088 Persons	30.00		40.00		30.00		20.00
d. IEC on AMC	Lump sum	50.00			50.00	LS	10.00		10.00	LS	10.00		20.00
Sub Total		410.00	0.00	0.00	410.00	0	80.00	0	130.00	0	120.00	0	80.00
Grand Total		7105.00	800.00	0.00	7905.00		1545.00		2315.00		2125.00		1920.00

4.11. In-Service Training (IST)

4.11.1. Introduction

A need based in-service training (IST) program to improve the knowledge and skills of different level of health service providers is a continuous activity of sector wide program since July 1998 through HPSP. Before the sector program most of the IST activities were linked with different vertical project activities. During HPSP a Technical Training Unit (TTU) was established to provide support to LD-IST and the unit continues its activities in HNPSP. Major activities of IST are to develop training need assessment, curriculum development, support to identify training institutes, contracting out local and foreign training, supervision, monitoring and evaluation of all training activities.

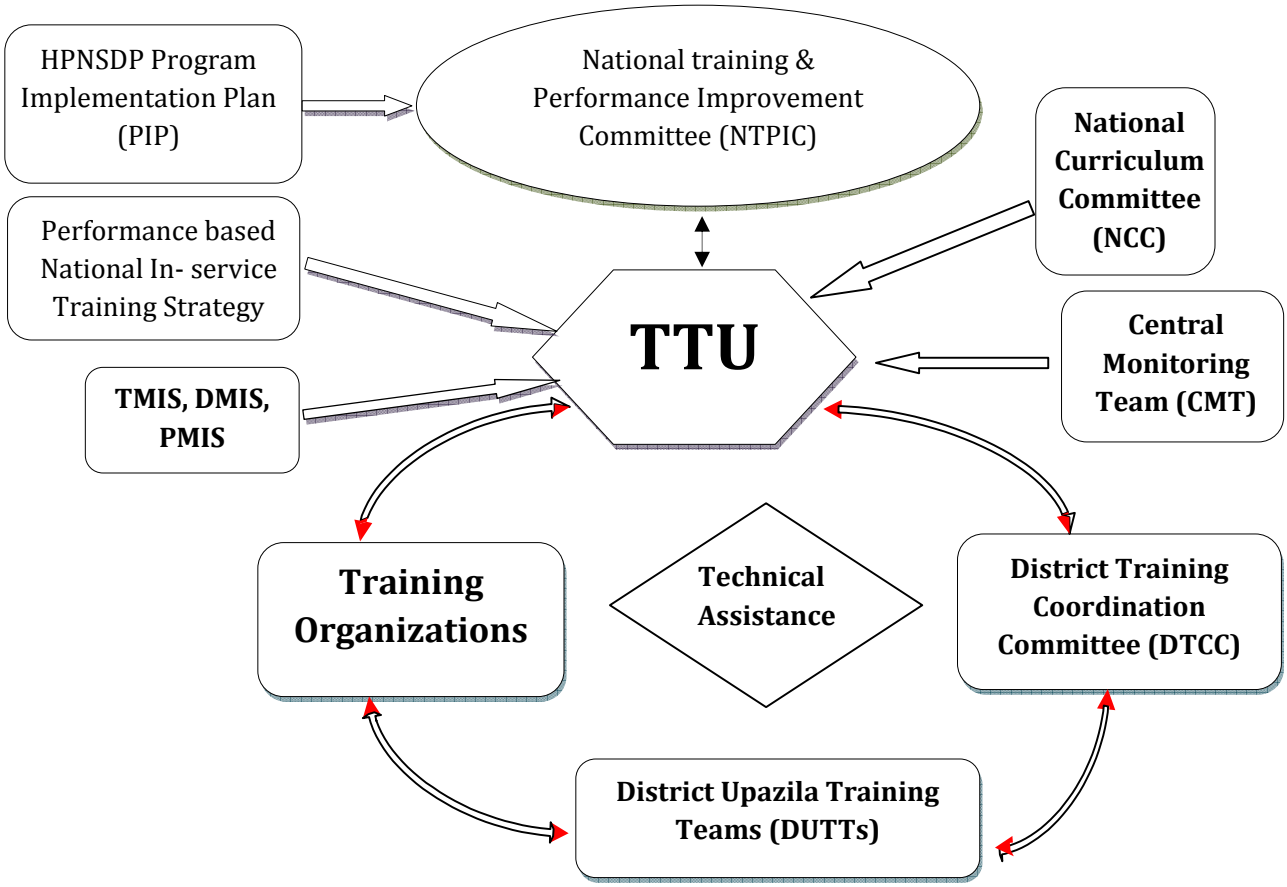
Training of field service providers will be implemented through a coordination mechanism between TTU and district and Upazilla health system by developing a district training coordination team headed by civil surgeon of the district. For better coordination of the training programs a National Training and Performance Improvement Committee involving other LDs will be formed for assessing the specific needs of training of the other LDs.

National Health Management Academy and Research Center is being established to institutionalize the training for the health service providers and managers on the different aspects of management e.g. (i) Personnel Management (ii) Project Management (iii) Financial Management (iv) Logistics Management, etc. The TTU will support their training, need assessment, material development, mentoring for quality training, supervision and impact evaluation. All resource (manpower and logistic) of Technical Training Unit (TTU), DGHS will be merged with the National Health Management Academy and Research Center.

Various national level institutions are capable to run in-service training in their respective fields/specialties, namely, Centre for Medical Education (CME), National Institute of Preventive and Social Medicine (NIPSOM), Institute of Public Health (IPH), Institute of Epidemiology Disease Control and Research (IEDCR), National Institute of Kidney Diseases & Urology (NIKDU), National Institute of Mental Health Research (NIMHR), Bangladesh College of Physicians and Surgeons (BCPS), Institute of Child and Mother Health (ICMH).

These institutions will act as lead training organizations and support will be provided to strengthening capacity of these institutions. Some NGO/ private institutes will also act as lead training organization on contractual basis.

Chart B: Training Management Strategy for In-service Training (DGHS) under HPNSDP



4.11.2. Objectives

- Strengthening the capacity of Technical Training Unit, Lead Training organizations, upazilla and District Training facilities
- Training need assessment (TNA) for different categories and tiers of health personnel
- Develop/ adapt/ update/review a standard training curricula for training of different categories/ tiers of health personnel
- Conduct research for improving the training quality
- To ensure the quality of training Program- Supervision, monitoring and evaluation
- Capacity building of Medical/health professional through overseas training on clinical (Heart diseases, DM, Cancer, Orthopedic and eye disease) and public health management.

4.11.3. Components

1. Capacity building of Technical Training Unit (TTU) and Lead training organizations (CME, NIPSOM, IPH, IEDCR, NIKDU, NIMH&R and BCPS)
2. Support for establishing National Health Management Academy and Research Center (NHMARC)
3. Training Need Assessment (TNA) for different categories and tiers of health personnel
4. Need based curriculum development.
5. Planning, implementing and monitoring and supervision of local and overseas training.

Component 1: Capacity building of Technical Training Unit (TTU) and Lead training organizations (CME, NIPSOM, IPH, IEDCR, IPHN, NIKDU, NIMH &R, BCPS and ICMH)

Activities:

- Strengthening TTU capacity to plan, co-ordinate, monitor and evaluate the performance based in-service training;
- Strengthening capacity of the training organizations (physical and human resources) at national, district, and Upazila level to implement in-service training to improve their performance including monitoring and follow-up of trainers and trainees at work site;
- Implementing and monitoring National Training Standards;
- Contracting out of training program to GO, NGOs & Private organization.
- Strengthening the DTCC & DUTT for implementing training.
- Strengthening the Training MIS (TMIS) including linkage with PMIS

Component 2: Support for establishing National Health Management Academy and Research Center (NHMARC)

Activities:

- Provide training equipment & furniture for NHMARC
- Recruitment of additional HR of NHMARC.
- Support for establish the ICT system for NHMARC.
- Develop residential training strategy in NHMARC

Component 2: Training Need Assessment (TNA) for different categories and tiers of health personnel

Activities:

- Planning & developing of different types of TNA tools (checklist).
- Prepare report on the findings for future planning.

- Workshop, Seminar
- Performance evaluation

Component 3: Need based curriculum development

Activities:

- Formation of working group
- Workshop & finalization of curriculum
- Develop / review curriculum on :
    i. Essential Service Delivery Training
    ii. Training Courses complementary to Essential Service Delivery (ESD)
    iii. Specialized Training
    iv. Other Management Training
- Approval of National Training Curriculum Committee.

Component 5: Planning, implementing, monitoring and supervision of local and overseas training.

Activities:

- Develop year-plan of training
- Develop coordination with DTCC and DUTT for implementing training
- Organize TOT in lead training organization
- Contract out training program to GO/ NGO and private institutions
- Contract out international organizations for overseas training on clinical/ management and public health specialty

4.11.4. Cross Cutting issues

- Understanding needs, developing curriculum, selecting training for all category of health personnel OP- All DGHS, NIPORT
- Alignment of all training with human resource development and linking with HMIS and personnel management- OPHIS-EH, HRM

4.11.5. Indicators

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of batches of trained health personnel in the area of Essential Service Delivery (ESD)	1030 Batches (IST)	2585	5176
2	Number of batches of trained health personnel in the area of Management Training	938 Batches, Batches (IST)	1285	2570
3	Number of trained health personnel in the area of Different Clinical Specialty.	34 Batches, Batches (IST)	71	158
4	Number of trained health personnel in the area of Public Health Specialty	18 Batches, Batches (IST)	58	99

4.11.6. Budget

Component and Year wise physical and financial target of Ops

Agency: DGHS

Name of the OP: In-Service Training

(Tk in lakh)

Name of the Components/ Major Activities	Total Physical and financial target					Year-2011-12		Year-2012-13		Year-2013-14		Year-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Components-1:Capacity building of Technical Training Unit (TTU) , Lead Training Organization, DTCC and DUTT													
Orientation for the personnel of Technical Training Unit (TTU) and Lead Training Organizations.	12 Batch		120.00		120.00	3	20.00	3	30.00	3	30.00	4	40.00
Masters of public health (MPH) for Health Managers specially field level	50 Person		130.00		130.00	10	20.00	15	40.00	15	40.00	12	30.00
Orientation for the members of DTCC and DUTT	124 Batch		124.00		124.00	24	20.00	40	40.00	40	40.00	24	24.00
Upgradation of National Training strategy	L.S		20.00		20.00		20.00						
Upgradation of Training management information system (TMIS).	L.S		38.00		38.00		6.00		10.00		10.00		12.00
Sub-Total	186	0	432.00	0	432.00	37	86.00	58	120.00	58	120.00	40	106.00

Name of the Components/ Major Activities	Total Physical and financial target					Year-2011-12		Year-2012-13		Year-2013-14		Year-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Components-2 :Support for establishing Bangladesh Institute of Health Management (BIHM)													
Development of Training strategy for BIHM	1 Work shop		10.00		10.00			1	10.00				
Furniture and Equipment	L.S	1500.00			1500.00						900.0		600.00
Sub-Total	1	1500.00	10.00	0.00	1510.00	0	0	1	10.00	0	900.00	0	600.00
Components-3 :Training Need Assessment (TNA) for different categories and tiers of health personnel													
Development and printing of TNA tools and assessment of Training needs.	10 TNA tool		60.00		60.00	2	12.00	2	12.00	2	12.00	2	24.00
Dissemination of TNA findings	10 workshop		35.00		35.00	2	7.00	2	7.00	2	7.00	4	14.00
Sub-Total	22	0	95.00	0.00	95.00	4.00	19.00	4.00	19.00	4.00	19.00	6.00	38.00
Components-4: Curriculum development													
Develop and review of curriculum	129 Curriculum		270.00		270.00	29	50.00	33	70.00	24	50.00	48	100.00
Sub Total:		0	270.00	0	270.00		50.00		70.00		50.00		100.00
Components-5: Local Training :													

Name of the Components/ Major Activities	Total Physical and financial target					Year-2011-12		Year-2012-13		Year-2013-14		Year-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Training of different Essential Service Delivery (ESD) components for 64 categories of Training.	5176 Batch	460.00	7576.00		8036.00	676	1238.00	1700	2640.00	1440	2235.00	1239	1923.00
Management Training	2570 Batch	390.00	2794.00		3184.00	421	521.00	882	1093.00	620	768.00	647	802.00
Subject wise Specialized Training to be Implemented by ICMH,IPH,NIPSOM, IEDCR,BCPS,CME	1182 Batch	2162	0.00		2162.00	219	401.00	225	411.00	225	411.00	513	939.00
Work shop and seminar on emerging and re-emerging issues	140 Batch		200.00		200.00	28	40.00	28	40.00	28	40.00	56	80.00
Sub total		3012.00	10570.00	0.00	13582.00		2200.00	2835	4184.00	2312	3454.00	2455	3744.00
Overseas Training :													
Different Clinical Specialty.													
Short Term (28 days or less) Clinical Training for Health Service Providers.	350 Person		2150.00	2500.00	4650.00	70	1000.00	70	1000.00	70	1000.00	140	1650.00
Short Term (28 days or less) Training for Basic Science Para clinical Teachers.	90 Person		324.00		324.00	18	65.00	18	65.00	18	65.00	36	129.00
Medium term Training (3-6 months) in clinical services like Eye , Orthopedics, Cancer, Critical care, Pain Management, Burn and bone Marrow, Other transplantation etc.	135 Person		1620.00		1620.00	27	324.00	27	324.00	27	324.00	54	648.00
Long term fellowship (More than 6 months)/ Diploma	100 Person		1700.00		1700.00	23	380.00	22	380.00	20	340.00	35	600.00

Name of the Components/ Major Activities	Total Physical and financial target					Year-2011-12		Year-2012-13		Year-2013-14		Year-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Different Management & Public Health Specialty.													
Short Term (28 days or less) Training on Training and Teaching technology , Hospital Management, Personnel Management, Waste Management , Exposure visit of Teachers for curriculum development	300 Person		1200.00		1200.00	75	300.00	75	300.00	50	200.00	100	400.00
Specialized overseas training :													
A. Short Term (28 days or less) hands on Clinical Training for Health Service Providers in local institutions Resource person will come from abroad.	2350 Person	2275.00	0	2400.00	4675.00	470	1410.00	470	1410.00	470	1000.00	940	855.00
B. Exchange visit among the Institutions of Home and Abroad .	180 Person		720.00		720.00	38	150.00	38	150.00	38	150.00	68	270.00
Sub-Total	3505	2275.00	7714.00	4900.00	14889.00		3084.00	720	3084.00	692	2944.00	1372	5777.00
Pay & Allowances of Officers & Staff, Supplies, Services, Repair & Maintenance (GoB)													
Pay of Officers ,staff and allowances	16 Person	349.23	0	0	349.23	27	49.70	27	56.84		66.67	27	176.02
Supplies and services & repair and maintenance	Gross	1142.00			1142.00		204.58		215.16		223.18		499.08
Sub-Total	27	1491.23	0.00	0.00	1491.23	27	254.28	27	272.00	0	289.85	27	675.10

Name of the Components/ Major Activities	Total Physical and financial target					Year-2011-12		Year-2012-13		Year-2013-14		Year-2014-16	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Acquisition of Assets (GoB)													
Vehicle (Micro bus and Double cabinet pick-up)	4 Pcs		320.00		320.00	2	160.00	2	160.00				
Training and office equipment, furniture , IT component etc	500 pcs	1158.77			1158.77		287.50		417.35		263.77		190.15
Sub-Total	504	1158.77	320.00	0.00	1478.77	2	447.50	2	577.35	0	263.77	0	190.15
Grand Total		9437.00	19411.00	4900.00	33748.00		6140.78		8336.35		8040.62		11230.25

4.12. Pre-Service Education (PSE)

4.12.1. Introduction

Pre-service education (PSE), as one of the important functional areas of HRD under HNPSP refers to producing appropriately skilled personnel to meet sector needs. Under HPNSDP, ongoing efforts will be continued to further improve the quality of medical education and of paramedics and other auxiliary personnel and ensure its appropriateness to community needs. Monitoring and evaluation of the regular curriculum updating and quality assurance in medical education.

Health sector is not only labor intensive but it requires a large variety of skilled health manpower to support and manage a wide range of health services. Bangladesh has a large number of educational and training institutes for producing health professionals in various areas. They also provide a congenial environment to those who are interested in conducting research activities. Side by side private medical education facilities are expanding rapidly. At present 63 Medical colleges (19 public and 44 private) , 16 Dental colleges (03 public and 13 private), 70 Institutes of Health Technology (06 public and 64 private) and 51 Medical Assistant Training Schools (07 public and 44 private) are producing related health service providers.

The Operational Plan of Pre- service Education is mainly concerned with education for making medical/dental graduates and health technologist. By producing skilled health manpower according to the recommendation of the 'Human Resource Strategy' of the MOHFW it will contribute to the poverty alleviation target of PRSP by improving the health status of the people.

4.12.2. Objectives

- To enhance national capacity for pre-service education and training.
- To improve the quality of pre-service education in both professional and technical aspect.
- To further modify and revise the strategies in the medical education system to meet the changing needs of the health care delivery system

4.12.3. Components

1. Supply, services & acquisition of assets in different medical teaching institutions
2. Quality Assurance Scheme for Public and Private Medical Colleges.
3. Improvement of Medical Education Units & Medical Skill Centers at academic institutions.
4. Capacity building in recently established medical institutions and institutions that will be established

Component 1: Supply & acquisition of assets in different medical teaching institutions -

Activities:

- Up gradation of labs, tutorials & teaching rooms with modern furniture, equipments, accessories.
- Up gradation of libraries with laboratory equipments, latest books & journals.

Component 2: Quality Assurance Scheme for Public and Private Medical Colleges

National standard of students in different medical teaching institutions like medical colleges, post-graduate institutions, institutions of health technologies & medical assistant training school is required to be standard as to that of same international teaching institutions. For this annual performance report of teaching institution seems to be mandatory every year with due flavor. To assure the quality of students as well as the teachers medical education unit in all the institutions required to be upgraded with modern facilities and equipments. Publication of annual report containing the academic performance and hospital records of medical college. Student's summative assessment procedure and related matters need to be assessed by the external examiner by a suitable pre formed questionnaire. RFST program is strongly recommended to make them community oriented doctor.

Activities:

- Continuing medical education (CME) program of all health workforces
- Training of teachers by different program at home & abroad
- Strengthen research activities in teaching institutions.
- All teachers will be brought under Quality Assurance program by phases.
- Medical education units are equipped with latest facilities.
- Publication of Annual report of teaching institutions

Component 2: Improvement of Medical Education Units & Medical Skill Centers at academic institutions –

Strengthening of facilities of post-graduate medical studies in medical colleges and where post graduate medical studies are running. Improvement in this sector is needed for standard post graduate studies. Pre Service Medical Education on IMCI is being implemented in 19 government medical college and 48 private medical colleges will be expanded in HNPSDP.

Activities:

- Established medical education unit in each institutions
- Improvement of services in research activities in post graduate institutions and in colleges where post graduate course is running.
- Equip medical education unit

Component 3: Capacity building new medical institutions and institutions that will be established –

To combat the growing needs of nation's new medical colleges, IHT & MATS etc is being established and some are under process of establishment.

Activities:

- Capacity building in different newly established teaching institutions by all the means.
- Improving capacity of health technologists, medical assistant and other paramedical workers

4.12.4. Cross Cutting Issues

- Managing public –private link in the area of health education. OP-IST, TRD, SWPMM, IFM
- Monitoring mechanism with HRD. OP-HIS-EH
- Improving quality, teaching facilities. OP-NES, PFD
- Strengthening research activities and development of MB. OP-PMR-DGHS, HIS-EH.

4.12.5. Indicators

The activities planned under this OP will increase the number of health providers competent and available to provide health services and should therefore contribute to Result 1.1, increased utilization of essential HPN services.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of fourth year medical and dental students received residential field site training (disaggregate medical/dental)	2000 (PST)	2300	2300
2	Number of teachers (Medical College) trained on Quality Medical Education	650	1200	2000
3	Establish medical education unit in Medical College	3 (Govt.) 8 (Private)	8 (Govt.) 20 (Private)	8 (Govt.) 20 (Private)

4.12.6. Budget

Component and Year wise physical and financial target of OPs

Agency: Ministry of Health and Family Welfare

Name of the OP: Pre-service Education

(Tk. In lakh)

Name of the Components[1]/ Major Activities2	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
1) Residential Field Side Training for 4th year Medical & Dental Students	18 MC & 3 Dental College	485.00		-	485.00	18 mc & 3 dental coll.	100.00	18 mc & 3 dental coll.	100.00	18 mc & 3 dental coll.	100.00	36 mc & 3 dental college	185.00
2) Vehicles (RFST Program) for new 3 Medical college, new 2 IHT.	5 Car (3 MC & 2 IHT)	-	175.00	-	175.00	-	-	-	-	5 Car	175.00	-	-
3) Quality Assurance Scheme For Public Medical Colleges, IHT.	18 MC, 3 Dental College& IHT	175.00	-	2,500.00	2,675.00	18mc & 3 dental	660.00	18 mc & 3 dental coll.	660.00	18 mc & 3 dental coll.	660.00	36 mc & 3 dental college	695.00
4) Improvement of Medical Education: Medical Education Units & Medical Skill Centers at Medical Colleges	18 M.C & 3 dental college	225.00	-	2,000.00	2,225.00	18mc & 3 dental	415.00	18mc & 3 dental	415.00	18mc & 3 dental	415.00	36 mc & 3 dental college	980.00
5) Supply and Services for Govt. Medical Colleges including all new Medical college.	10 MC & 5 new MC	3,690.00	5,650.00	-	9,340.00	18 M.C	2,390.00	18 M.C	2,390.00	18 M.C	2,390.00	36 M.C	2,170.00
6) Support to Post-graduate Medical Education in Medical Colleges/ Dhaka Dental College and Different Post- Graduate Institutes and Library facilities.	8 MC	885.00	360.00	-	1,245.00	8 MC	375.00	8 MC	375.00	8 MC	375.00	16 MC	120.00

Name of the Components[1]/ Major Activities2	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
7) Strengthening Facilities for Govt. Medical Assistant Training Schools.	5+ 3 new MATS	705.00	830.00	-	1,535.00	8 MATS	415.00	8 MATS	415.00	8 MATS	415.00	16 MATS	290.00
8) Strengthening Local Training Facilities for IHT	3+3 new IHT	825.00	920.00	-	1,745.00	70 IHT	340.00	70 IHT	350.00	70 IHT	350.00	70 IHT	705.00
9) Establishment of Monitoring and Evaluation Mechanism for HRD	1 for each institution.	290.00	1,125.00	-	1,415.00	1 Macha.	375.00	1 Macha.	375.00	1 Macha.	375.00	1 Macha.	290.00
10) Revision of Medical, Dental, paramedical and Other Curriculum	03 times	125.00	870.00	-	995.00	1 time	250.00	0	250.00	1 time	250.00	1 time	245.00
11) Strengthening the CME, National Health Library & Documentation Center.	35 institutions	225.00	250.00	-	475.00	35 institutes	110.00	35 institutes	110.00	35 institutes	110.00	35 institutes	145.00
12) Monitoring, Supervise & Evaluation in Medical College & other cost center	250 Number	120.00	-	-	120.00	50 Number	30.00	50 Number	30.00	50 Number	30.00	100 Number	30.00
13) English Language Training (ELT) for Medical & Dental Students.	18 MC & 3 dental	930.00	-	-	930.00	18 mc & 3 dental	215.00	18 mc & 3 dental	215.00	18 mc & 3 dental coll.	215.00	18mc & 3 dental	285.00
14) Strengthening the New IHT	8 IHT	1,125.00	1,485.00	-	2,610.00	8 IHT	675.00	8 IHT	675.00	8 IHT	675.00	8 IHT	585.00
15) Machinery, Equipment, Furniture-Fixture for Medical College, IHT	35 institutions	12,825.00	18,220.00	-	31,045.00	35 institutes	8,195.00	35 institutes	8,160.00	35 intsitute	7,910.00	35 institute	6,780.00
16) Strengthening the Research Activities for Post-Graduate Students in different Institutes.	8-MC	-	285.00	-	285.00	8-MC	65.00	8-MC	65.00	8-MC	65.00	8-MC	90.00

Name of the Components[1]/ Major Activities2	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
17) Publication of Annual Report of Medical Colleges	350 publication	185.00	180.00	-	365.00	70 publication	85.00	70 publication	85.00	70 publication	85.00	140 publication	110.00
18) Improvement of museum Anatomy, Pathology & Forensic Medicine dept. in different Medical colleges.	18-MC	175.00	210.00	-	385.00	18-mc	90.00	18-MC	90.00	18-MC	90.00	18-MC	115.00
19) Support service for Bangladesh College of Physiotherapy in Dhaka.	1 number	195.00	165.00	-	360.00	1 number	80.00	1 number	80.00	1 number	80.00	1 number	120.00
20) Fellowship for the teachers of pre and Para clinical departments	13Subject in 18 MC	125.00	625.00	-	750.00	13Subject in 18 MC	160.00	13Subject in 18 MC	160.00	13Subject in 18 MC	160.00	13Subject in 18 MC	270.00
21) Others	L/S	175.00	165.00	-	340.00		75.00		75.00		75.00		115.00
Grand Total		**23,485.00**	**31,515.00**	**4,500.00**	**59,500.00**		**15,100.00**		**15,075.00**		**15,000.00**		**14,325.00**

4.13. Planning, Monitoring and Research (PMR-DGHS)

4.13.1. Introduction

The HPNSDP Strategic Plan sets out the sector's strategic priorities and explains how these will be addressed to a certain extent, taking into account the strengths, lessons learned and challenges of implementing the last two sector programs, the HPSP and the current HNPSP. In this aspect, the next sector program will pursue with priority the strengthening overall health system and governance including establishing a sustainable Monitoring System and priority institutional and policy reforms, such as decentralization and LLP, incentives for service providers in hard to reach areas, PPP, single annual work plan, etc .

Health research is essential to improve design of health intervention and systems, service delivery and pro-poor policies. Health research will emphasize on priority areas of biomedical, public health, epidemiological, health systems and policy, social and behavioral, and operational research. It will also play a vital role in advocating research findings for policy and programmatic adoption, as well as for raising citizen's awareness. The capacity of various research institutions and individuals will be augmented to achieve the above stated goals. A National Health Research Strategy has been developed (January 2009) by MOHFW, to use as the guiding principle in determining research subjects, study areas and their funding. Appropriate measures will be taken to link research and survey findings with the programs of the respective agencies.

In this regard, this OP has various important functions, one is the development of LLPs, the other is reviewing, monitoring, and evaluating the implementation of the OP plan of the DGHS and leading the Research and Development Unit (RDU). The Planning also provides assistance and coordination to the LDs under DGHS.

4.13.2. Objectives

- To develop capacity of health personnel at District level in respect of Planning, Monitoring & evaluation;
- To develop and conduction of LLP at selected Districts & Upazilas level;
- To conduction and disseminate health related researches.
- To build capacity in Health-Research field
- Intra & Inter-sectoral cooperation and coordination

4.13.3. Components

1. Planning and Monitoring
2. Research and Development

Component – 1: Planning & Monitoring

a) Local Level Planning (LLP):

Considerable experience has been gained through the lessons of a number of pilot initiatives on local level planning (LLP) in the past two SWAp periods. However, this exercise could not be linked to budget process and as such no resources could be allocated. With the current Governments' interest to support decentralization as a policy, which is also reflected in the draft National Health Policy 2010 and the draft National Population Policy, decentralized planning had found greater acceptance. The prioritized action plan prepared following the APR 2009, had "feasibility and implementation plan for operation of pilots on 6 local level district plans as one of the six performance based financing indicators".

Over the last few years, LLP exercises were being carried out at Upazila level by the MOHFW and identified six districts in six divisions as Pilots for operation of LLP. The Districts are: Bhola, Cox's Bazar, Sherpur, Satkhira, Lalmonirhat and Sunamganj. MOHFW wanted to move forward with this action plan in order to give a fair trial time to LLP operation. The feasibility of operation of a district plan under the present legal, administrative and budgetary system was examined and found not realistic. A number of suggestions have been made for the 'next steps' to be taken over the medium-term regarding LLP. However, the PHC service through

the UHS will be linked to LLP. Now LLP will be implemented in 14 selected Upazila's in 7 District out of 7 Division under next sector program and selection of Upazilas under the selected district will be made where EOC program is available. The previously selected districts (Cox's Bazar, Bhola, Sherpur, Sathkhira, Lalmonirhat and Sunamgonj) will be given preference in the selection process of districts for LLP and the new district under Rangpur Division will be selected during initiation of LLP implementation.

Developing an M&E system for the HPNSDP is essential to provide convenient and timely information to policymakers as they track its performance in order to make necessary adjustments over its course. The process of introducing RFW in the next sector program will strengthen the monitoring culture within MOHFW. The M&E unit will also facilitate several important population surveys through the respective agencies in collaboration with the DPs.

Priority interventions will include:

- Revision and update of the LLP Toolkit, reflecting the following changes: 3-year planning cycle; clearly spelt out responsibilities of the LLP Core Cell in arranging for resource envelope and providing feedback to the local-level; budget demands as per OPs; complement of goals and activities between the field-level services provided by the two Directorates; role of the community especially of the elected representatives of local government at Union and Upazila levels.
- Introduce changes in the various support systems: (i) increased delegation of administrative and financial power to the cost centers, (ii) provision of capacity building, including short trainings on administrative, management and financial management, (iii) development of performance indicators and evaluation mechanism, (iv) guidance and mentoring by the two Directorates and (v) meeting the needs for human resources, drugs and equipment.

Activities

- Implementation of LLP in 14 Upazila's under 7district out of 7 division
- Orientation for LLP implementation at Upazila and District level.
- Updating of LLP tool-kit
- Training, Orientation & Workshop for capacity development of related health personnel on Planning, Administration, Financial Management, Monitoring & Evaluation.
- Development and implementation of effective monitoring tool for monitoring and evaluation of upazila and district level activity.
- Coordination meeting with LD's, PD's, PM's, DPM's and related managers of different institutes (PWD, FMAU, IMED, ERD, PPC, etc)
- Establish a sustainable M&E system in DGHS for management, coordination, and monitoring and evaluation to track progress in HPSDP.

Component – 2: Research & Development

b) Research and Development (R&D)

Health research is essential to improve the design of health intervention, policies and service delivery. Research will, therefore, be an integral part of the Health, Nutrition, and population sector Program (HNPSP) and will play an important role with regard to evidence based decision-making, facilitation of innovation, supporting adjustments in sectoral resource and in support of policy development for HNPSP and the longer term. The range of research to be undertaken will include basic medical and bio-medical research, demographic, epidemiological, operational, and policy research & clinical research, including research on reproductive health, impact and cost-effectiveness studies, behavioral and health systems research. Research results will serve to guide policy development, Program priorities, and improvement of service delivery; they will also be essential to monitoring Program achievement and assessing Program impact. Increased emphasis will be given to research that will have direct implications for health interventions and is designed to improve the quality of care and health status of the people and to research that relates spending patterns to disease burden.



The current allocation/spending in research are inadequate for guiding sectoral policies. Institutes that are involved in research are not suitably developed and need strengthening. Research efforts are sometimes characterized by duplication, inappropriate prioritization and inadequate dissemination. These issues will be addressed to provide overall guidelines for research priorities as well as research Co-ordination and dissemination. Failure to utilize research results, another identified research issue, is a widespread problem not limited to concerned policy or implementation areas in the design, progress and results of the research from the initial stages onward.

Activities:

- Strengthen BMRC after reviewing its mandate and structure for assuming strategic stewardship and governance roles for health related research.
- Conduction and dissemination of health related research
- Capacity development of health professionals in health research fields.
- Decentralization of health related research activities in divisions, districts and below.

4.13.4. Cross Cutting Issues

- Linkage & sharing with other LDs about LLP findings & way to materialize. OP-All of DGHS, PME-FP, SWPMM
- Sharing & preparation of budget of LLP piloting Districts & Upazilas with other LDs. OP- MNCAH, ESD, CBHC & PME-FP
- Alignment of sector wide program management & monitoring activities done by MOH&FW with DGHS –OP- All DGHS OP, SWPMM
- Creating a National research database .OP-HIS-EH, MIS, TRD
- Coordination with the research activities and studies. OP-HIS-EH, MIS, TRD & SWPMM

4.13.5. Indicators

The activities proposed under this OP will contribute to Result 2.2, strengthened monitoring and evaluation systems and Result 2.8, decentralization through LLP procedures.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of LLP workshops conducted in pilot districts with all UZs	141 (2009-10), PMR	555	925
2	Number of Upazila plans prepared and functional	NA(PMR)	57 in 7 District	All functional
3	Number of training batches for health personnel in Planning, Monitoring at District and below	34 (2009-2010), PMR	84 Batches	140 Batches
4	Number of training batches for health personnel in Research methodology	NA (PMR)	16	18
5	Number of research studies conducted by topic	30 (2009-10), PMR	90	150
6	Number of dissemination workshops held on research activities	5 (2009-10), PMR	15	25
7	Number of Research/studies conducted by BMRC	29 (2008-09), PMR	90	150

1.1.1.

4.13.6. Budget

Component and Year wise physical and financial target of OPs

Agency: Ministry of Health & Family Welfare.

Name of the OP: Planning, Monitoring & Research

(Tk in Lakh)

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1: Local Level Planning and Implementation	**14 Upazila under 7 District in 7 Division (14x5)**												
Orientation for Local Level Planning Implementation	7350 Persons	0.00	125.00	0.00	125.00	1470	25.00	1470	25.00	1470	25.00	2940	50.00
Updating of LLP tool-kit	550 Persons	15.00	0.00	0.00	15.00	110	3.00	110	3.00	110	3.00	220	6.00
LLP Implementation		240.00	1140.00	200.00	1580.00	0	300.00	0	314.00	0	334.00	0	632.00
LLP at district level (District Hospital)	4620 Persons	0.00	0.00	105.00	105.00	924	21.00	924	21.00	924	21.00	1848	42.00
Support of Technical Assistant (TA-WHO)	10 Persons	0.00	0.00	105.00	105.00	2	21.00	2	21.00	2	21.00	2	42.00
Subtotal		**255.00**	**1265.00**	**410.00**	**1930.00**	**2506.00**	**370.00**	**2506.00**	**384.00**	**2506.00**	**404.00**	**5010.00**	**772.00**
Component-2: Strengthening of Planning, Monitoring & Research Unit, DGHS													
Training on Planning & Management		100.00	0.00	100.00	200.00	0	40.00	0	40.00	0	40.00	0	80.00

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Workshop/ Seminar (Central/ Local)/ Monitoring Meeting	300 Persons	10.00	0.00	0.00	10.00	60	2.00	60	2.00	60	2.00	120	4.00
Pay and allowances	3 Persons	25.00	0.00	0.00	25.00	1	5.00	1	5.00	0	5.00	1	10.00
Supervision and Monitoring	250 Nos	10.00	10.00	0.00	20.00	50	4.00	50	4.00	50	4.00	100	8.00
Printing and Publication		20.00	0.00	0.00	20.00	0	4.00	0	4.00	0	4.00	0	8.00
Supply and services		240.00	0.00	40.00	280.00	0	56.00	0	56.00	0	56.00	0	112.00
Repair and Maintenance		75.00	0.00	0.00	75.00	0	15.00	0	15.00	0	15.00	0	30.00
Procurement of Logistics		115.00	0.00	0.00	115.00	0	23.00	0	23.00	0	23.00	0	46.00
Subtotal		**595.00**	**10.00**	**140.00**	**745.00**	**111.00**	**149.00**	**111.00**	**149.00**	**110.00**	**149.00**	**221.00**	**298.00**
Component-3: Capacity Development and conduction of Research through DGHS													
Training of Health Professional on Research methodology	500 Persons	25.00	30.00	25.00	80.00	100	16.00	100	16.00	100	16.00	200	32.00
Workshops/Seminar on Research activities	500 Persons	0.00	10.00	25.00	35.00	100	7.00	100	7.00	100	7.00	200	14.00
Conduction of Research	150 Nos	0.00	900.00	100.00	1000.00	30	200.00	30	200.00	30	200.00	60	400.00
Dissemination Workshop on Research	25 Nos	0.00	10.00	0.00	10.00	5	2.00	5	2.00	5	2.00	5	4.00

Name of the Components[1]/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
findings													
Subtotal		25.00	950.00	150.00	1125.00	235.00	225.00	235.00	225.00	235.00	225.00	465.00	450.00
Component-4: Strengthening of BMRC and Commission of Research		125.00	875.00	500.00	1500.00		300.00		450.00		450.00		300.00
Grand Total		1000.00	3100.00	1200.00	5300.00		1044.00		1058.00		1078.00		2120.00

4.14. Health Information Systems and E-Health (HIS-EH)

4.14.1. Introduction

The HPN and National Vision 2021 call for timely and evidenced based decision making supported by a robust health information system (HIS) and quick service delivery through ICT for creating citizens' universal access to health care. The National ICT Policy 2009 emphasizes on digital health and specified 36 key deliverables for MOHFW, which also keeps provision for allocating 5% and 2% of development and revenue budgets respectively for ICT. In the last 2-3 years, there was substantial progress in HIS and e-Health in the country. The HIS moves are trying relentlessly to fulfill the critical need for core health indicators from routine HIS. Work for geographical reconnaissance has been started to develop a web-based national population registry to serve purpose of universal vital registration system; estimating MDG progress, understanding resource needs and measuring health service coverage. From national to upazila level, there exists reliable data communication network and system. Health Bulletins and web publications are regular events, which prove improved data quality and availability. Availability of updated HR data has been improved and is awaiting transformation into automated system. MIS-Health's Year Books summarize health program achievements; however, recently introduced customized database (DHIS2) is helping to speed up collection and processing of health program data. With UNICEF's support, consistent improvement was made in EmOC and IMCI database management. The USAID started supporting to develop "Logistic Tracking and Inventory/Procurement Management System". However, deployment of a functional financial-HIS would be needed. MIS-health also introduced GIS-based HIS in health sector. Bangladesh health service made phenomenal change in E-Health. The E-Health programs that have caught attention include video conferencing, practiced quite often; a uniquely designed monitoring cell at MIS-health in reducing doctors' absenteeism from remote health facilities; telemedicine network over 8 hospitals; free of cost mobile phone health service, available in all of 418 upazila and 64 district hospitals; and number of other M-Health services, such as, SMS advice for safe pregnancy, bulk SMS, complain/suggestion box, etc. Work is ongoing to use mobile phone as a data collection tool. Two recent E-Health innovations, viz. web based absenteeism reporting by facility heads and remote biometric time attendance system, acquired strong policy support for rapid scaling up. Rapid deployment of newer technologies, like biotechnology, to confront country's future health, nutrition and livelihood challenges, is Government's one of the major policy decisions. A National Taskforce on Biotechnology chaired by Hon'ble Prime Minister, adoption of National Biotechnology Policy, and several sector-specific National Biotechnology Guidelines including one for Medical Biotechnology are evidences. The ministry has recently published a gazette which includes deliverables in next 25 years. Number of workshops was held for orientation of the medical doctors and teachers on MBT. However, more thrust is required for timely implementation of the government's policy decisions in this regard.

Effective mechanism will be created in next sector program for utilization of the MIS data for evidence based decision making. A multi-stakeholder Steering Group will be created with few technical groups to sit frequently and identify data needs, mechanism of collection of data reliably and on time and for making data available in appropriate reporting formats so that they become suitable for decision making. The OP keeps provision for creating a local level information culture so that local health managers, staffs and people become interested about knowing and using the information for assessing health service performance, making plan and decisions. The multi-stakeholder steering and technical groups will also include representatives from other ministries, agencies under MOHFW, LDs of other OPs, development partners, NGOs and private group. The other initiative both within and outside health sector, viz. MOVE-IT (Measurement of Vital Events through IT), NPR (National Population Register) and Civil Registration (Birth and Death Registration) will help improving availability and utilization of data. Recently, This OP has started to get sufficient resources, viz. SDMX-HD from WHO (which provides standard set of core indicators with data definitions, standards, standard source of data, mechanism of data collection, utilization of data, etc.), ICD-10 (International Classification of Diseases), HL7 (vocabularies of health information communications), Open MRS and Care2x (Open source software for Hospital Information System), iHRIS (Open source software for Integrated Human Resource Information System), Open ELIS (Open source



software for Electronic Laboratory Information System). MIS health is currently using DHIS2 (Open source software named District Health Information System version2) for collecting public health program data. Private health facilities are also using DHIS2 to provide data to MIS of DGHS. MIS-health also created a local software developer forum to support the OP for further development and customization of the software. Currently MIS-health is working with different development partners and local health organizations to improve data quality environment.

Besides, involving multi-stakeholder technical groups and massive staff training (not only of HIS staffs but also of other groups of staffs), the OP has also kept provision of hiring managed services and creation of revenue posts in due time to take over greater role in management and implementation of HIS and e-Health. It must be mentioned that ICT, HIS and e-Health are emerging technologies with rapid evolutions. Only HIS or health sector staffs will not be able to provide solutions for complex problems or implementation needs that would arise. Outsourcing services and hiring managed services will remain as an effective solution for the sustainability, robustness and cost-effectiveness. The OP of HIS/DGHS carefully considered this practical option. The design of the next OP is done so carefully that it will fulfill the gaps that prevail about the HIS of Bangladesh.

4.14.2. Objectives

i. To improve health information system through:
   - Development and operation of population based HIS
   - Strengthening institution-based HIS
   - Strengthening human resource related HIS
   - Strengthening program based HIS
   - Developing and strengthening logistic tracking, and inventory management and procurement system
   - Developing financial management system
   - Expansion of GIS in health service
   - To improve infrastructure and human resource capacity necessary for HIS
   - To sustain the HIS initiatives and encourage public-private partnership.

ii. To improve E-Health through:
   - Continuation and further development of mobile phone health service and other m-Health
   - Strengthening and expansion of video conferencing
   - Expansion of telemedicine service
   - Introduction of other e-Health services and programs
   - To improve infrastructure and human resource capacity necessary for e-Health
   - To sustain the e-Health initiatives and encourage public-private partnership.

iii. To introduce newer technologies through:
   - Achievement of the short and medium term deliverables mentioned in the National Guidelines on Medical Biotechnology
   - Creation of conditions for achieving the long term deliverables of the National Guidelines on Medical Biotechnology.

4.14.3. Components

Component 1: Improvement of Health Information System (HIS)

Under this component strengthening and further development of country's health information system will be made taking a holistic view so that all aspects of health information system are covered taking the framework of Health Metrics Network as reference and standard. Necessary ICT backbone and institutional capacity will be built with a view to generate by end of the OP period, all core health indicators, through routine HIS, and thereby minimize need for conducting separate surveys or studies.



i. Components-wise strategic objective

- To put in place a comprehensive, readily available and easily accessible ICT based HIS on a set of nationally agreed core indicators for population, health institutions, human resource, health programs, logistics, inventory, procurement and finance, building on the existing HIS;
- To make further expansion of GIS in health service; and
- To improve infrastructure and human resource capacity necessary for HIS, sustain the initiatives and encourage public-private partnership for the cause.

ii. Activities

- Equipping with computers, laptops, accessories, gadgets, etc.
- Continuation and expansion of Internet connectivity both in terms of bandwidth and coverage
- Placement, maintenance and upgradtion of software (database, application, customized, etc.) and servers, where applicable and as appropriate looking into factors like cost, deploy ability, scalability, integration, inter-operability, security, user-friendliness, auto-reporting, dashboard, etc.;
- Establishment of Data Center
- Use of mobile phones, handheld devices, and other technologies and tools based on suitability and effectiveness;
- Strengthening o f human resource capacity through training, and in case of shortage in-house, through outsourcing of services
- Liaison, feedback, monitoring and supportive supervision to ensure data quality in terms of reliability, timeliness and adequacy inclusive of non-state providers
- Repair and maintenance function and supply of logistics
- Data analysis, interpretation, report writing, dissemination and communication to appropriate stakeholders and public through print, web and electronic media for the sake of evidence based planning and decision making; as well as to satisfy the citizens' rights to information;
- Liaison and advocacy with the policy makers will to sustain and further boost up the HIS initiatives and public-private-NGO collaboration

Component 2: Improvement of e-Health

The purpose of the e-Health activities will be to deliver health services to citizens in easy to use, quick and cost-effective ways through ICT. People living in rural, remote and hard to areas and vulnerable groups like poor, women and children (preferably pregnant women, neonates and young children), elderly and those requiring urgent medical care are the target beneficiaries. Strengthening health service efficiency, monitoring of staff attendance in work place, listening to citizens, creating health awareness of people, and improving teaching/training including distance learning, etc. will comprise other e-Health functions. The program will be built on e-Health progress already made by MOHFW, and using, as far as possible, the same resources placed for HIS functions. Focus to bridging urban-rural digital divide and linking with government's overall national ICT vision and principle will be maintained. HIS will give due focus on e-health through improving health system efficiency, accountability and delivering services to citizens by ICT. Currently This OP is successfully implementing mobile phone health service, various digital systems for monitoring office attendance, video conferencing, telemedicine network, group emails, bulk sms, complain/suggestions box, pregnancy care advice by sms, etc. In the next sector program, these services will be improved and rolled out as well as other services will be introduced. Various e-Health initiatives will be mainstreamed in the different Programs through creating multi-stakeholder steering group and technical groups through common understanding that data design and implementation, sharing model and inter-operability will be ensured jointly.

To make a foundation for this automated environment, a population based health registry is being prepared that would be synchronized with the forthcoming National Population Register. Electronic Health Record System, Health Workforce database, Enterprise Resource Management System (asset and logistic planning,



inventory, procurement, tracking, etc.), Lab Information System, Work process management system, etc. all will be part of the automation. During the HPNSDP period at least 6 hospitals will be brought under computerized automated recording system and MIS.

i. Components-wise strategic objective

- To continue the mobile phone health service in the upazila and district hospitals and extend the service down to community clinics; carrying out communication program to encourage citizens to increasingly use the service;
- To continue existing m-Health services, such as, bulk SMS, pregnancy advice through SMS, complain/suggestion box, etc. along with further improvement and to explore other innovative and effective m-Health services;
- To promote the use of video conferencing for quick and cheaper instant communication, remote monitoring, online meeting, scientific and clinical conference, distance learning and teaching training, etc.
- To continue and strengthen the existing telemedicine service and roll out it down to community clinics through locally appropriate technology and method;
- To introduce other e-Health services and programs for dissemination of information, listening to citizens, creation of health awareness, improving health systems efficiency and quality, etc.;
- To improve infrastructure and human resource capacity necessary for e-Health;
- To sustain the e-Health initiatives and encourage public-private partnership.
- Supply of computers, accessories, gadgets, etc., if required, in addition to those provided for HIS
- Appropriate database, application and customized software, where and when applicable looking into factors like cost, deploy ability, scalability, inter-operability, security, and user-friendliness, etc.
- Strengthening human resource capacity through training, and in case of shortage in-house, through outsourcing of services
- Production and development of promotional materials to encourage people utilize the mobile phone health service, telemedicine and/or other e-Health services
- Strengthening liaison, feedback, monitoring and supportive supervision to ensure service quality and improve coverage
- Repair and maintenance function and supply of logistics will be continued and strengthened;
- Liaison and advocacy with the policy makers to sustain and further boost the e-Health initiatives and public-private-NGO collaboration

Component 3: Introduction of newer technologies

As the government envisions, medical biotechnology will be introduced in the country under the leadership of MOHFW, as per the guidelines provided in the National Biotechnology Policy and government gazette on National Guidelines on Medical Biotechnology (NGMBT). The National Technical Committee on Medical Biotechnology (NTCMB) headed by Secretary of MOHFW and Core Group of the NTCMB will provide leadership to carry forward the activities. Under this OP, the short and medium term deliverables of the national guidelines (as shown below) will be implemented and an environment for achieving the long term deliverables (as shown below) will be created.

ii. Component-wise strategic objectives

a) Achievement of the short and medium term deliverables (shown under activities) assigned in the National Guidelines on Medical Biotechnology;
b) Creation of conditions for achieving the long term deliverables (shown under activities) of the National Guidelines on Medical Biotechnology.

Activities

- Following measures will be taken for implementing short and medium term deliverables of the National Guidelines on MBT:
- Center for Medical Biotechnology

- Situation analysis of medical biotechnology
- Medical biotechnology plan
- Sensitization / orientation training / workshops, updating medical curriculum with focus on medical biotechnology
- Medical biotechnology resources in medical libraries
- Postgraduate and technologist courses and career group for medical biotechnology will be identified gradually
- Orientation of the core group members and concerned officials on medical biotechnology
- Institutional capacity through development of lab facilities, clinical services and epidemiological surveillance for medical biotechnology
- R&D environment through supporting related research projects
- Opening Department of Medical Biotechnology in the National Institute of Biotechnology and establishing a Center of Excellence for medical biotechnology
- Appropriate communication programs with potential entrepreneurs of medical biotechnology
- Appropriate public awareness programs
- Developing and enforcing standards, codes of practice and regulatory framework for medical biotechnology

Conditions will be created for achieving the following long term vision (25 years or more) of National Guidelines on MBT:

Activity

- Medical biotechnology initiatives and infrastructures at globally competitive level
- Medical biotechnology industries, laboratories and services capable to compete globally and keep pace with global development trends
- High quality medical biotechnology products and services for local market as well as for export to the global market; and
- Making availability of a world-class higher education and research base to serve the rapidly growing medical biotechnology needs both in home and in abroad
- Effective leadership, monitoring and supervision will be ensured.

4.14.4. Cross Cutting Issues

a) Multipurpose community volunteers for vital registration and services – OP- MNCAH, ESD, CBHC, CDC, NCD, HEP, NNS, IEC & HRM
b) Integrated data collection and flow model for all OPs concern and avoiding duplication in hardware procurement and data collection and repetition – OP-CBHC
c) Promote training to the service providers on data & IT –OP-IST, HRM
d) Reasonable and persistent administrative and financial support would be required to sustain the hardware, connectivity, software and human-resources through and by which data will be captured, flown, processed and distributed.

4.14.5. Indicators

The activities under this OP contribute towards the strengthening of the health system, Component 2. In particular, the activities contribute directly to Result 2.2 Strengthened monitoring and evaluation systems, as well as Results 2.5, sustainable and responsive procurement and logistic systems.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	A set of core health indicators developed with data definition and process of data collection	Exist, need revision (MIS), 2010	Revised & adhered to	Adherence improved
2	% of health facilities submitting timely and adequate report as specified by MIS-Health	80% (MIS), 2010	90%	100%

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
3	Number of LDs provided specified routine program data to MIS on time	NA	All	All
4	MIS reports on health service delivery published and disseminated	Health Bulletin (MIS), 2010	Done annually	Done annually
5	Vacancy statements on major staff categories in government health facilities available	Available annually (MIS), 2010	Available half yearly	Available quarterly
6	MIS reports posted on the website and updated	Updated annually (MIS), 2010	Half yearly	Quarterly
7	Percentage of community clinics providing mobile phone health service	District & upazila hospitals started (MIS), 2010	30% community clinics	70% Community clinics
8	Number of health facilities having specially designed telemedicine centers	8 (MIS), 2010	12	20
9	Medical biotechnology (MBT) situation analysis report and MBT plan prepared	NA (MIS), 2010	Situation analysis report	Plan available
10	Documented evidence of public awareness articles and radio or television shows on MBT	NA	At least 10 annually	At least 20 annually

4.14.6. Budget

Component and Year wise physical and financial target of OPs

Agency: Ministry of Health & Family Welfare.

Name of the OP : Health Information System (HIS) & e-Health

(Tk in Lakh)

Name of the component (Major Activities)	Total physical and financial target					Year -1		Year - 2		Year - 3		Year-4 & Year-5	
	Physical quantity (Quantity/ Batch)	Financial				Physical Qty	Financial	Physical Qty	Financial	Physical Qty	Financial	Physical Qty	Financial
		GOB	RPA (GOB)	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
HIS & e-Health													
Local Training													
Computer, HIS and e-Health Training	536 Batch	0.00	3590.24	4800.00	8390.24	124	798.06	134	878.74	99	440.32	179	6273.12
Training including refreshers training of Community Health Care Providers on HIS	2803 Batch	0.00	1129.80	4020.00	5149.80	403	161.40	600	742.10	600	742.10	1200	3504.20
Training of health workers on PDA and Health workers diary	1278 Batch	0.00	754.53	2200.00	2954.53	85	50.54	153	588.83	400	733.00	640	1582.16
Foreign Training													
Various disciplines and areas related to HIS, e-Health and MBT to contribute to national system development	40 Persons	0.00	200.00	0.00	200.00	8	40.00	8	40.00	8	40.00	16	80.00
Sub Total : (Local & foreign Training)		**0.00**	**5674.57**	**11020.00**	**16694.57**		**1050.00**		**2249.67**		**1955.42**		**11439.48**
GR forms data entry	30 Millions	600.00	0.00	0.00	600.00		600.00		0.00		0.00		0.00

Name of the component (Major Activities)	Total physical and financial target					Year -1		Year - 2		Year - 3		Year-4 & Year-5	
	Physical quantity (Quantity/ Batch)	Financial				Physical Qty	Financial	Physical Qty	Financial	Physical Qty	Financial	Physical Qty	Financial
		GOB	RPA (GOB)	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Internet connection and bills (all hospitals, health facilities, UH&FWC including 13500 community clinics) in phase	19000 Institutes	5959.79	0.00	0.00	5959.79	9000	762.47	14000	1099.32	19000	1366.00	19000	2732.00
Motor vehicles (3 Jeeps and 1 Micro Buses)	4	0.00	110.00	0.00	110.00	0	0.00	3	80.00	1	30.00	0	0.00
Tertiary level hospital automation (6 Hospitals)	6	500.00	850.00	0.00	1350.00	1	250.00	2	450.00	2	400.00	1	250.00
TA for strengthening HIS	1	0.00	0.00	5000.00	5000.00	1	0.00		1000.00		500.00		3500.00
Server	9	45.00	0.00	0.00	45.00	0	0.00	3	15.00	6	30.00	0	0.00
Personal Computer (Desktop)	8000	2122.00	1500.00	0.00	3622.00	1000	452.76	3500	1584.62	3500	1584.62	0	0.00
Laptop Computer ((all hospitals, health facilities, UH&FWC including 13500 community clinics)	18000	3000.00	5000.00	0.00	8000.00	3000	500.00	12000	6000.00	3000	1500.00	0	0.00
Laser Printer ((all hospitals, health facilities, UH&FWC including 13500 community clinics)	18000	1500.00	2500.00	0.00	4000.00	3000	300.00	12000	2800.00	3000	900.00	0	0.00
Data Center, Network and other accessories (MIS HQ & all hospitals)	492	0.00	1359.80	0.00	1359.80	0	0.00	1	650.00	0	0.00	491	709.80
Expansion of Telemedicine and Peripherals (100 hospitals)	100	366.00	700.00	0.00	1066.00	20	200.00	20	219.00	20	219.00	40	428.00

Name of the component (Major Activities)	Total physical and financial target					Year -1		Year - 2		Year - 3		Year-4 & Year-5	
	Physical quantity (Quantity/ Batch)	Financial				Physical Qty	Financial	Physical Qty	Financial	Physical Qty	Financial	Physical Qty	Financial
		GOB	RPA (GOB)	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Solar Panel (200KW)	1	0.00	1000.00	0.00	1000.00	0	0.00	1	1000.00	0	0.00	0	0.00
Multimedia (all upazilas health offices), Photocopy, generator, Scanner, Air conditioner, fax, digital camera, Wi-Fi, other devices, etc	1718	210.00	768.00	0.00	978.00	15	63.00	1716	599.00	1	57.00	2	259.00
Telecommunication equipment (PDA, GPS, Wireless Modem, etc)	19983	237.36	393.14	0.00	630.50	14000	391.86	4300	190.64	100	16.00	1583	32.00
Printing, survey, consultancy, computer stationery, repair & maintenance, etc	0	5149.79	2984.28	1880.00	10014.07	0	1173.93	0	1821.56	0	3706.71	0	3311.87
Total : (HIS & e-Health)		**19689.94**	**22839.79**	**17900.00**	**60429.73**		**5744.02**		**19758.81**		**12264.75**		**22662.15**
Medical Biotechnology (MBT)													
Local Training													
2-day sensitization workshop	50 Batch	0.00	65.35	0.00	65.35	10	13.07	10	13.07	10	13.07	20	26.14
Training workshop for medical teachers	86 Batch	0.00	60.07	0.00	60.07	21	17.05	23	14.54	14	11.55	18	16.93
Sub-Total (Training)	136 Batch	**0.00**	**125.42**	**0.00**	125.42		**30.12**		**27.61**		**24.62**		**43.07**

Name of the component (Major Activities)	Total physical and financial target					Year -1		Year - 2		Year - 3		Year-4 & Year-5	
	Physical quantity (Quantity/ Batch)	Financial				Physical Qty	Financial	Physical Qty	Financial	Physical Qty	Financial	Physical Qty	Financial
		GOB	RPA (GOB)	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Machinery and other equipment (2-Multimedia projector, 2- Projector screen, 1-OHP, 2- photocopier, 4-AC 1-Generator and others)	17	313.88	7.74	0.00	321.62	10	67.76	1	48.44	4	72.54	2	132.88
Computers and accessories (5-Laptop, 10 - Desktop computer, 2-Laser printer, 2- Inkjet printer, 10-UPS)	29	10.60	0.00	0.00	10.60	22	8.10	0	0.00	7	2.50		0.00
Sub Total : (MBT)	**182**	**324.48**	**133.16**	**0.00**	**457.64**		**105.98**		**76.05**		**99.66**		**175.95**
Grand total=		**20014.42**	**22972.95**	**17900.00**	**60887.37**		**5850.00**		**19834.86**		**12364.41**		**22838.10**

4.15. Health Education and Promotion (HEP)

4.15.1. Introduction

Health Education, as a health promotion and protection intervention, started in Bangladesh in 1958 under the Directorate of Health, and is considered as the precondition for successful health care delivery. Its network is extended up to the grass root level. In Bangladesh, Information and Education for Health (IEH) is considered to have contributed significantly in the alleviation of health problems in the country like smallpox eradication, malaria control, diarrhoeal disease control and success in child immunization etc.

Bureau of Health Education is to carry out comprehensive Health Education Promotion services to the target population at all level. It will also provide health education support to Health, Nutrition and Population Sector programs in the country. It, therefore, requires both administrative and socio-political commitments to achieve the objectives of HEP in support of HPNSDP.

The activities of the BHE are intended to bring about behavioral changes among the people towards safe motherhood, breast feeding, climate change, emerging and re-emerging diseases, food safety, vaccination, vitamin A administration, RTA, neonatal care, violence against women, family norms, nutrition, decrease in IMR, MMR, etc through special emphasis on interpersonal communication, electronic and print media.

The BCC interventions will be functionally integrated in the areas of counseling, referral, reproductive health, BCC campaigns, etc to promote health, nutrition, and MNCH services and to provide need based support.

Health Education and Promotion is a cross cutting issue and presumed to support health development Programs towards development of positive health behavior among the target population for the attainment of their respective goals. Relevant strategies have been formulated in some areas e.g. FP-MCH IEC Strategy, IEC Strategy of BINP, IEC Strategy of HIV/AIDS Control. All these strategies reveal to change attitude and behavior of the target population as well as to address the impediment in the change process. Some important assumptions have been considered for the strategic implementation of Health Education and Promotion of the Health Sub-Sector. A national Health Education Strategy will be formulated for the attainment of aims and objectives of HEP under HPNSDP.

4.15.2. Objectives

- To provide with BCC support and optimize utilization of health and nutrition services;
- To provide BCC at some specific locations such as hospitals, schools and community level in Model villages, community clinics, EPI out-reach centers etc to improve health and nutritional status of the people;
- To improve health seeking behaviour of the community with emphasis on health promotion for the vulnerable groups;
- To strengthen community participation in health promotion activities and ensure optimum use of health services;
- To promote social values that facilitates determinants of health and improves family health development;
- To bring about behavioral change among the people towards improvement of maternal and child health prevention and control of communicable and non-communicable diseases including emerging & re-emerging disease;
- To aware of the people through IPC & uses by electronic and print media. And also conducted special program like advocacy and social mobilization activities for community Participation in running program.

4.15.3. Components

Component-1: **Health Education Strategy, Development & Finalization**

A national Health Education Strategy will be formulated under HPNSDP for the attainment of aims and objectives of HEP. Health Education and Promotion will affect change in health behavior of the individuals as well as enable them to take right decisions at the right time in a more dynamic and interactive way in order to address the determinants of health. Moreover, this intervention will enable them to promote social values (conducive to health) that will reduce the magnitude of health hazards and increase of utilization rate of health services. It will contribute and facilitate the program (HPNSDP) to increase availability and utilization of equitable, affordable and accessible quality services in regard to awareness and education.

Activities

- Health Education Strategy Development & Finalization

Component-2: Awareness, Sensitization and Motivation

Some packages will be developed with a view to creating demand for particular group of stakeholders' interests and also to make the health awareness, promotion and motivational services cost-effective, user friendly particularly considering right place, right time and right language of the audience. This will cover communicable & Non-communicable diseases emerging & re-emerging diseases (Polio, TB, Leprosy, STDs/RTIs, HIV/AIDS, diabetes, hypertension, cancer), drug addiction, smoking, pollution free environment, maternal- neonatal - child health (MNCH) and improvement of Nutritional status particularly for the poor and vulnerable.

Activities:

Awareness, Sensitization and Motivation:

- Communicable and non communicable disease prevention
- Drug addiction, smoking and pollution free environment.
- Improvement of Health seeking behavior of vulnerable group of pro-poor health status

Component-3: Media Campaign and Transmission for Health Education & Promotion

Organizing of media campaign through IEC activities such as broadcasting of MNCAH,CDC, NCD and other messages through TV and Radio channels, Musical show Folk song/ Jari gan and street drama using local team with local dialect. Private channels will be included in the media campaign.

Activities:

- Country wide campaign regarding prevention of (i) Communicable and non- communicable diseases, (ii) spot announcement during disaster management, (iii) message disseminating through electronic and print media.
- Arranging folk song, debate, art competition, essay competition, social advocacy meeting with community elite person to create awareness for health promotion.

Component-4: Production, distribution & display of IEC materials

Under this component various types of IEC materials such as Bill Boards, Neon signs, electronic boards, TV spots, TV drama, TV magazines, posters, leaflets etc. will be produced and will be displayed throughout the country up to the grass root level. This will promote individual health care, increased understanding of the vulnerable groups about nature of communicable and non communicable diseases, malnutrition and others.

Activities:

- Production of IEC Material like poster, leaflet, sticker, hand bill, brochure, flip book, booklet, flipchart, Calendar, Dairy and distribution Country wide health service centre for dissemination of health message to health promotion of the people
- Production of Cinema film, Drama serial, tale-off, T.V. and Radio Spot and C.D. dissemination of health messages.

- Production and display of bill board, Banner, Neon sign and neon board, digital display board for people awareness and motivation.
- All IEC materials production and distribution.

Component-5: Strengthening of inter-sectoral & multi-sectoral coordination

Inter-sectoral and multi-sectoral coordination and collaboration will be strengthened in support of health promotion to avoid duplication and to bring new, update information into the IEC materials and media campaigns on demand.

Activities:

- A Committee formed for coordination with the members from relevant Line Directors (LDs)
- Inter-sectoral and multi-sectoral coordination meeting at National, division and district level to increased sectoral support to participation and co-ordination in HEP activities.

Component-6: Campaign at Community on Health Education & Promotion

To increase Awareness of people to solve their health problems health messages will be disseminated to the patient and attendance at community clinic through Inter personal communication (IPC) and IEC materials.

Activities:

- Health message dissemination to the patient and attendance at community clinic through Inter personal communication (IPC)
- Message disseminate through display Board, Posters and distribution of others IEC Materials
- Arrange the advocacy meeting for social mobilization to increased Participation of Community Clinic Services.
- Aware the people understand that health is valued as an asset of the community and to protect it with their own actions and efforts.

Component-7: Established 128 Model Health Education & Promotion villages

An area to serve as model area (128 Model Villages) for application of health education approaches with various methods and tools of health education to assist the Community people to increase their health and economic status through fruit and kitchen garden, animal and poultries firm, water and sanitation to arranged by their own cost and efforts to enable the people of that area to solve their health problems will be continued through the HPNSDP. Evaluation of the effectiveness of improvement the Maternal & Child Health Care, personal hygienic, environmental sanitation, prevention of communicable & non-communicable diseases and nutritional status etc of the model villages will be done during this sector Program. Representatives from the concerned sector of Planning Commission and IMED will be included in this evaluation process.

Activities:

- Evaluate the effectiveness of improvement the Maternal & Child Health Care, personal hygienic, environmental sanitation, prevention of communicable & non-communicable diseases and nutritional status.

Component-8: Capacity Building and Logistic Support of BHE

Activities:

- Training for Health Education & Promotion Personnel
- Upgrading & Modernized Printing Press

4.15.4. Cross Cutting Issues

- Behavior change communication and health promotion are integral part of health services (OP-MNCAH, ESD, CBHC, TB-LC, NASP, CDC, NCD, NEC, HSM, AMC)



- Need to link and coordinate with DGFP Information education Communication (OP-IEC)

4.15.5. Indicators

The activities under this OP contribute to achieving Result 1.1, increased utilization of essential HPN services, and Result 1.3, improved awareness of healthy behaviors.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of trainings for BHE personnel by topic	NA, HEP	250	+ 311 = 561
2	Printing press modernized	NA, HEP	Press 1	Done
3	Health Education Strategy Finalized	NA, HEP	1(one)	Done
4	Number of health awareness campaigns conducted, by topic and disseminated media (print, TV, radio, poster, etc.)	NA, HEP	39	+ 26 = 65
5	Media Campaign and Transmission for Health Education & Promotion	NA, HEP	39	+ 26 = 65
6	Number of IEC materials printed and disseminated by topic	NA, HEP	1200,000	+ 800,000 = 2000,000
7	Number of Inter-sectoral and multi-sectoral coordination meeting held	NA, HEP	804	+ 536 = 1340
8	Number of Community clinics campaign conducted	NA, HEP	90	+ 60 = 150
9	Establish Model Health Education & Promotion Village	NA, HEP	64	+ 64 = 128

4.15.6. Budget

Component and Year wise physical and financial target of OP's

Agency : Directorate General of Health Services (DGHS)

Name of the OP: Health Education & Promotion

(TK. In lakh)

Name of the Components/Major Activities	Total physical and Financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1:Capacity building and logistic support of BHE													
Training for HEP Personnel and others	64+5 Batch (Local-64, Foreign-5 batch of 5)	200.00	600.00	2350.00	3150.00	60 (Local-50, Foreign-5)	320.00	115 (Local-100, Foreign-5)	520.00	133 (Local-120, Foreign-3)	680.00	253 (Local-230, Foreign-5)	1630.00
Upgrading & Modernized Printing Press	1	0.00	450.00	0.00	450.00	0	0.00	1	450.00	0	0.00		0.00
Logistics for BHE	LS	500.00	0.00	0.00	500.00		100.00		100.00		100.00		200.00
Pay and allowances		150.00	0.00	0.00	150.00		30.00		30.00		30.00		60.00
Other	LS	1000.00	0.00	0.00	1000.00		200.00		200.00		200.00		400.00
Sub-Total		1850.00	1050.00	2350.00	5250.00	0.00	650.00	1.00	1300.00	0.00	1010.00	0.00	2290.00
Component-2:Health Education strategy Finalized					0.00								
Health Education strategy review, development & Finalized	1	0.00	90.00	0.00	90.00	-	0.00	-	0.00	1	90.00	-	0.00
Sub-Total	1	0.00	90.00	0.00	90.00	-	0.00	-	0.00	1.00	90.00	-	0.00
Component-3:Awareness, Sensitization and Motivation					0.00								

Name of the Components/Major Activities	Total physical and Financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Country-wide Health Education Campaign to increase Awareness Sensitization and Motivation of people to solve priority health problems.	12 Pkg	100.00	200.00	1535.00	1835.00	2 Pkg	400.00	2 Pkg	400.00	2 Pkg	400.00	6 Pkg	635.00
Sub-Total	12 Pkg	100.00	200.00	1535.00	1835.00	2 Pkg	400.00	2 Pkg	400.00	2 Pkg	400.00	6 Pkg	635.00
Component-4:Media campaign and transmission of health education and promotion					0.00								
To increase understanding of the vulnerable groups about nature of Communicable and non-communicable diseases and prevention, control and cure.	65 Pkg	0.00	1070.00	2000.00	3070.00	13 Pkg	47.23	13 Pkg	47.23	13 Pkg	47.23	26 Pkg	2928.31
Sub-Total	65 Pkg	0.00	1070.00	2000.00	3070.00	13 Pkg	47.23	13 Pkg	47.23	13 Pkg	47.23	26 Pkg	2928.31
Component-5:Production, distribution and display of IEC materials					0.00								
-Production of manual /guide books and other support materials for IEC	2000000	2275.00	795.00	0.00	3070.00	40,000	614.00	40,000	614.00	40,000	614.00	80,000	1228.00
Sub-Total		2275.00	795.00	0.00	3070.00	40000.00	614.00	40000.00	614.00	40000.00	614.00	80000.00	1228.00
Component-6:Strengthening intersectoral & multisectoral coordination and advocacy					0.00								

Name of the Components/Major Activities	Total physical and Financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Strengthened multisectoral and private sector activities in support of health promotion	1325	0.00	100.00	0.00	100.00	265	20.00	265	20.00	265	20.00	530	40.00
Sub-Total	1325	0.00	100.00	0.00	100.00	265.00	20.00	265.00	20.00	265.00	20.00	530.00	40.00
Component-7:Coordination with other OPs for Health Education					0.00								
To ensure health, population & Nutrition Promotion Services	15			100.00	100.00	3	20.00	3	20.00	3	20.00	6	40.00
Sub-Total	15	0.00	0.00	100.00	100.00	3.00	20.00	3.00	20.00	3.00	20.00	6.00	40.00
Component-8: Campaign at Community Clinic on HEP					0.00								
To increase Awareness of people to solve their health problems	5		135.00	165.00	300.00	1	60.00	1	60.00	1	60.00	2	120.00
Sub-Total	5	0.00	135.00	165.00	300.00	1.00	60.00	1.00	60.00	1.00	60.00	2.00	120.00
Component-9: Model villages					0.00								
Replication of Model HEP Village in new 128 Village	128		600.00		600.00	20	150.00	42	150.00	41	150.00	25	150.00
Evaluation of 128 Model Villages activities	128		200.00		200.00	-	100.00	-	0.00	128 MV	100.00	-	0.00
Sub-Total		0.00	800.00	0.00	800.00	20.00	250.00	42.00	150.00	41.00	250.00	25.00	150.00
Grand Total :		4225.00	4240.00	6150.00	14615.00		2061.23		2611.23		2511.23		7431.31

4.16. Procurement, Logistics and Supplies Management (PLSM-DGHS)

4.16.1. Introduction

Central Medical Stores Depot (CMSD) plays an important role to ensure procurement of instruments, medicines, insecticides, office equipments for health institutions of Bangladesh. It is one of the specialized procuring entities of MOH&FW and responsible for procurement as well as distribution of logistics as per requisition of respective Line Directors of Health Directorate. Equipments (bio-medical, electronic, electrical, power and IT) required for health sector agencies under DGHS are also procured through CMSD.

4.16.2. Objectives

- To procure goods for all Line Directors in time;
- To ensure proper storage of the procured goods;
- To ensure proper distribution of the goods;
- To implement e-procurement & online procurement system;
- To keep Electro-medical Equipment of public Hospitals (District & Upazilla level) operational by repairing as & when reported; and
- To improve the operational capability of CMSD

4.16.3. Components

Component-1: Procurement & Clearance

Procurement of goods like medical instruments, medicines, insecticides, office equipments etc are done by this component of CMSD. Through IDA & GOB funding, CMSD will procure different kinds of goods as per the requisition placed by the Line Directors. PPR & WB guide lines for procurement will be followed as applicable.

In case of international procurement, clearance activities are done by advising C&F agents and paying/depositing CD/VAT in Account Current in favor of respective customs officials at different port of entries. Appointed Clearing & Forwarding agents are directed to collect the goods and transport it to CMSD or hand over them to different Health Care Organizations as the pre-defined need. The stored goods (medicine/equipment etc) from CMSD are transported to end users as per the allotment/distribution given by the Line Directors/Ministry.

Activities:

- Collection and collation of the procurement demand from Line Directors and arrange them into packages/ lots etc;
- Preparation of procurement processing plan & obtain approval from concerned authority;
- Finalization of the specification;
- Preparation of bidding document, publication of IFB, Opening of Bid, Evaluation of Bid ,Opening of LC etc.
- Clearance the goods by C&F agents from different port of entries (Dhaka Air port, Chittagong sea port, ICD Kamlapur & Benapole land port.)

Component: 2 Storage & Distribution

CMSD is the central store depot of health sector. All types of medical & related non-medical goods are stored at CMSD for a certain period. Proper storage facilities including central air conditioning, fire protecting system & Generator facilities are ensured for storage purpose. Ideal storage facilities for medicine, injectables, fluid, equipment, vaccine etc are also available. CMSD is a KPI area. Security of the area is maintained at all cost.

Activities:

- Receive goods & arrange them in order;
- Maintain optimal temperature & humidity required for different items;
- Maintain proper inventory & storage procedure; and
- Ensure proper and timely distribution of goods & medicines according to the allocation given by respective LDs.

Component: 3 Installations, Repair & Maintenance:

CMSD has an Instrument Salvage and Maintenance (IS&M) department that is responsible for installation of all newly procured equipments. It also maintains liaison between supplier & end user as per contract. Repair of faulty equipments are also looked after by this section through collaboration with suppliers within warranty period and also by repair farms beyond.

Activities:

- Installing of electro-medical equipment Hospitals and other facilities;
- Repair of vehicle, computer, furniture etc; and
- Repair of Electro Medical Equipment as per requirement.

Component: 4 Logistics Management

CMSD plays a role to keep warehouse equipment, Office equipment, Vehicles, etc. operational so as to perform its responsibilities effectively.

Activities:

- Procurement and utilization of logistics such as computers, vehicles, office contingency, fuels etc;
- Committee Meetings; and
- Train CMSD personnel in procurement, Office management, Storage system etc

Component: 5 Strengthening of CMSD

CMSD personnel's are engaged in procurement & supply chain management. Adequate technical support in developing human resources is important. Ensuring proper technology is of paramount importance for timely and efficiently discharges of responsibilities. MOHFW has already initiated establishing an effective monitoring through an integrated Online Tracking System (OTS). The online tracking of the procurement status and inventory for goods (medicine, furniture and equipments etc.) in CMSD will be established and maintained.

In line with the recommendations of the Procurement Assessment Report steps will be taken to ensure improved performance in procurement and logistics management. Different alternatives will be explored to decentralize the procurement system including identification of potential procuring entity. Under the DGHS, CMSD is the biggest procurement agency and its staffing needs to be further strengthened.

Activities:

- Training of CMSD personnel at home & abroad;
- Technical Assistance;
- Provision of biomedical engineer for preparation of technical specification/ advice/ procurement of relevant goods;
- Development of e-procurement system with the support of PLMC;
- Develop online tracking system for:
    - Procurement
    - Storage & distribution
    - Repair & maintenance

4.16.4. Cross Cutting Issues

CMSD procure goods as per demand of Line Directors. Procurement status and performance of CMSD are dependent on proper, timely; need based demand as well as placement of fund by the LDs

4.16.5. Indicators

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Computerized storage & distribution system developed and functional	Partly existing since 2008	All Upazila	All upazila and below
2	Number of packages procured against target	90 % (2011)	100%	100%
3	No of personnel trained on procurement	65 (2010)	15 foreign training, 100 local training	All
4	Percentage of procurement done within timeframe after receiving request from LDs	90% (2010-11)	100%	100%
5	Percentage of contracts awarded within initial bid validity period (a) ICB (b) NCB	95%	100%	100%
6	Online procurement system developed and functional	NA	Done	Done

4.16.6. Budget

Component and Year wise physical and financial target of OPs

Agency: Line Director, Procurement Logistics & Supplies Management, CMSD, DGHS.

Name of the OP: Procurement Logistics & Supplies Management. DGHS.

(Tk in Lakh)

Name of the Components/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1 Strengthening Of CMSD													
1. TA(Biomedical engineer, On line tracking system, procurement)	4	-	206.00	1,000.00	1,206.00	4	250.00	4	250.00	4	200.00	4	506.00
2. Vehicle	2	-	52.00	-	52.00	2	52.00		-		-		-
3. Local Training	500 persons	-	228.00	-	228.00	200	54.00	100	54.00	150	40.00	50	80.00
4. Foreign Training	50 persons	-	-	800.00	800.00	15	20.00	15	580.00	20	200.00	-	-
5. Seminar/Workshop	15 Workshop	-	50.00	-	50.00	5	10.00	5	10.00	5	30.00	0	-
Sub Total		-	536.00	1,800.00	2,336.00		386.00		894.00		470.00		586.00
Component-2: Procurement & Clearance													
1. CD VAT	L/S	34,315.00	-	-	34,315.00	L/S	6,426.00	L/S	6,100.00	L/S	7,073.00	L/S	14,716.00
2. Out Sourcing for Logistic Handling	L/S	221.00	-	200.00	421.00	L/S	100.00	L/S	100.00	L/S	100.00	L/S	121.00
3. Others (C & F Agent commission, port charge & advertisement etc.	L/S	4,829.50	-	-	4,829.50	L/S	921.00	L/S	948.00	L/S	973.00	L/S	1,987.50
Sub Total		39,365.50	-	200.00	39,565.50		7,447.00		7,148.00		8,146.00		16,824.50
Component-3: Storage & Distribution													
1. Freight & Transport	L/S	644.00	-	-	644.00	L/S	128.00	L/S	128.00	L/S	130.00	L/S	258.00
Subtotal		644.00	-	-	644.00		128.00		128.00		130.00		258.00

Name of the Components/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-4 Installation, Repair & Maintenance													
1. Vehicle, Furniture & Equipment	L/S	187.00	-	-	187.00	L/S	50.00	L/S	50.00	L/S	50.00	L/S	37.00
2. Others (Telecommunication, electric item etc.)	L/S	70.00	-	-	70.00	L/S	10.00	L/S	10.00	L/S	10.00	L/S	40.00
Sub Total		257.00			257.00		60.00		60.00		60.00		77.00
Component-5 Logistics Management													
1. Computer & Accessories (11 categories)	539 nos	-	305.00	-	305.00	200 nos	70.00	150 nos	70.00	150 nos	73.00	39 nos	92.00
2. Office Equipment (10 Categories)	239 nos	-	154.00	-	154.00	100 nos	30.00	100 nos	30.00	39 nos	35.00	0	59.00
3.Air conditioner	30 nos	-	74.00	-	74.00	20 nos	10.00	10 nos	20.00	0	30.00	0	14.00
4. Furniture (12 Categories)	1111 nos	-	171.00	-	171.00	600 nos	34.00	400 nos	34.00	100 nos	34.00	11	69.00
5.Others Equipment (11 Categories)	44 nos	-	60.00	-	60.00	30 nos	10.00	14 nos	10.00	0	15.00	0	25.00
6. Office Contingency & Stationeries	L/S	100.00	-	-	100.00	L/S	20.00	L/S	20.00	L/S	30.00	L/S	30.00
7. Others (Entertainment, Honorium to TEC etc.)	L/S	107.50	-	-	107.50	L/S	20.00	L/S	20.00	L/S	30.00	L/S	37.50
Sub Total		207.50	764.00	-	971.50		194.00		204.00		247.00		326.50
Grand Total		40,474.00	1,300.00	2,000.00	43,774.00		8,215.00		8,434.00		9,053.00		18,072.00

4.17. National Nutrition Services (NNS)

4.17.1. Introduction

Although there has been a decline in rate of underweight children over the years, the rates of underweight, stunting and wasting are still above the WHO's thresholds for very high levels, typically found in emergency situations. Nearly 51% of under-fives in the lowest quintile are undernourished, compared to 26% in the highest quintile (BDHS 2007). The causes of stunting are multifactor and include among other factors, lack of exclusive breastfeeding, inappropriate complementary feeding, and recurrent infections, etc.

Deficiencies in key micronutrients continue to be a public health challenge in Bangladesh. Vitamin A deficiency was identified as a public health problem since the 1960's and has been the single most important preventable cause of night blindness in children. In last 25 years, vitamin A supplementation program targeting children 9 - 59 months of age has been implemented by the IPHN reduces night blindness in children 12-59 months of age living in rural areas reduced from 3.5% (1983) to 0.62% (1998). To eliminate vitamin A deficiency in the population, supplementation needs to be complemented with more effective and sustainable improvements in dietary vitamin A, which can be achieved with fortification of edible oil and other foods.

Based on the urinary iodine out-put in school going children, the IDD problem in Bangladesh is classified as mild. The 2004/5 National IDD and USI Survey found that only 51% of household salt is adequately iodized a (≥15 ppm) .Unlike iodine and vitamin A deficiency, over the years there has been very limited progress on anemia. Anemia is widespread across the different age groups, with 46% of pregnant women, 64% of children aged 6-23 months, 42% of children aged 24-59 months, 30% of adolescent girls and 33% of non-pregnant women (BBS/UNICEF, 2004). Low birth weight is also very high in this country that needs intervention. Over nutrition and its complications are also an emerging public health problem in urban area.

In 1974 the Government established the Institute of Public Health Nutrition (IPHN) to provide technical support to formulate policy and strategy for nutrition related activities and programs and also to conduct research, training and surveillance. In 1975, the Bangladesh National Nutrition Council (BNNC) was established to develop policy & strategy. Community based nutrition intervention (BINP, NNP) implemented in limited area (173 Uz) with negligible coordination with DGHS & DGFP. All these three setting under the same ministry were working for different aspect of nutrition and could not achieve their desired goal.

Under HNPSP, there were two OPs named National Nutrition Programme (NNP) and Micronutrient Supplementation.(MNS). Facility based **limited** services were provided through MNS and community based services were undertaken through NNP-OP. There was evidence of lack of coordination and duplication activities among these two OPs. Moreover, the NNP interventions were contracted to several NGOs and had fragile or no links with the mainstream health system. Referral and intensive management for children with severe acute malnutrition was very inadequate. There are also several other nutrition related projects/ programme run by the different Ministries/Divisions supported by DPs but their activities were not well coordinated and monitored.

In the HNPSP, the total estimated cost of the NNP- OP (FY 2003 to 2011) for the interventions in 263 Upazila was 1251 crore TK. But the NNP was implemented about 173 Upazilas in phases which was covered only 25% of population. The APR-2009 recommended that to scale up the nutrition interventions the only option is to mainstream the critical nutrition interventions in the services provided through DGHs and DGFP. If the present model of NNP is continued country wide by contracting NGOs, the cost for NNS interventions will be about 5000.00 crore. And it would not possible to achieve MDG target by 2015 with the implementation of the existing model. Under the HPNSDP, the mainstreamed nutrition programme aims to deliver the nutrition services country wide through the existing DGHS and DGFP set up will costs only about 1490.00 crore TK, which will be cost-effective and more sustainable in future. Since MOHFW being implemented SWAp in a sustainable manner from 1998 which covers almost all HPN services, it will not be worthy to have a separate project for the nutrition services with only GOB resources, as because DPs will not fund for the parallel project outside the scope of HPNSDP.

4.17.2. Objectives

- To implement a mainstreamed, comprehensive package of nutrition services to reduce maternal and child nutrition and ensure universal access
- To develop and strengthen coordination mechanisms with key sectors (especially Ministry of Food and Disaster Management, Ministry of Agriculture, Ministry of Livestock and Fisheries, Ministry of Local Government and Rural Development and Cooperative) to ensure a multi-sectoral response to malnutrition
- To strengthen the human resource capacity to manage, supervise and deliver nutrition services at the different levels of the health system
- To strengthen and linked with central MIS
- To conduct operations research for ensuring an evidence-based response.

4.17.3. Components

Component-1: Behavioural Change and Communication to Promote Good Nutritional Practices

Mass media campaigns, social mobilization and behavioral change and communication activities at health facility and community levels will be implemented to promote good health and nutrition practices. Specific behaviors to be targeted for improving nutrition situation.

Activities:

- Awareness development campaign to address malnutrition
- Workshop/seminars/ mass media campaign/IPC etc.

Component-2: Human resource development (HRD)

Capacity building and various forms of training will be a major priority for NNS because of two main reasons. First, the weak capacity to sufficiently and effectively supervise and monitor the implementation of the NNP has been identified as a key hindrance of the effectiveness of the current program. Second, the mainstreaming process will require that many health personnel (from UHC through Community Levels) will be required to perform duties and responsibilities for which they have not received any or sufficient training for. Therefore, NNS will develop and implement a capacity building strategy to enhance the capacities (human as well as institutional) of NNS as well as that of other line directorates with the responsibilities for delivering any nutrition service/intervention. Trainings will be in the form of: special courses for experts (CC level service provider, Nurses and Medical Officers) on specialized topics such as IYCF, Management of Severe Acute Malnutrition, Nutrition Counseling, etc; inclusion of core nutrition modules for pre- and in-service training of HAs, FWVs. and CHPs; refresher training of HAs, FWVs and CHCPs.

For proper implementation of nutrition services for vulnerable group as well as general population. Developed human resource would be required in the following areas: Nutrition/public health expert, IT, finance, monitoring & evaluation, procurement etc.

Activities:

- Development of plan for capacity building
- To identify the relevant resource at home and abroad.
- Development of training module in relevant cases.
- Formation of master and core trainer team
- Training of relevant service providers

Component-3: Control of Vitamin A deficiency disorder (supplementation of children 6-59 months & lactating mother)

Bangladesh has had much success in attaining as well as sustaining high coverage of Vitamin A supplementation. This high coverage has been attained through bi-annual Vit A campaigns for children 6-



59 months. Hence NNS will strive to increase further and strengthen this high coverage and ensure that areas or population groups that have not been reached thus far, are better targeted. Lactating mother would receive VAC within 42 day of delivery.

Activities:

- Awareness creation about food based approach
- Training of service provider
- supplementation

Component-4: Control & prevention of anemia

Iron-folic acid supplementation for pregnant women Bangladesh has one of the highest prevalence of maternal anemia in the world. The country has a policy of providing iron-folic acid supplements to pregnant women (during ANC) in order to reduce the incidence and prevalence of anemia. However, poor coverage, compliance and stock-outs have affected the effectiveness of this intervention. Therefore the program will help to set up systems to ensure adequate procurement and supply of IFA tablets at all levels of the health system and; train health workers including HAs, CHCPs and FWAs to develop their skills to counsel women to enable full compliance.

Iron Supplementation and De-worming of Adolescent Girls: NNS will endeavor to provide structures BCC sessions for adolescent girls to provide them with the necessary knowledge on reproductive and nutritional health through individual and group counseling. The girls will also be provided with de-worming tablets and iron-folate tablets when they come into contact with the health system and though ABCN activities.

Activities:

- Awareness creation about food based approach
- Training of service provider
- supplementation

Component-5: Iodine deficiency disorder & Salt Iodization

The salt iodization Program will continue to be strengthened and expanded through advocacy at household and national level. The BCC component of the program, for example, will promote awareness of and increased use of iodized salt by households and help sustain consumer demand of the product.

Activities:

- Awareness creation about food based approach (e.g. Iodized salt)
- Training of service provider

Component-6: Other micronutrient problems of Public Health importance (zinc, vitamin D, calcium etc.)

Zinc Supplementation during treatment of diarrhea: The incidence of diarrhea among Bangladeshi children is amongst the highest in the sub-continent, hence contributing to infant and young child malnutrition. Zinc supplementation during treatment of diarrhoea has been shown to have both curative (reduction in the severity of diarrhoea) as well as preventive (few future episodes). Therefore, NSP will promote and strengthen support that the provision (including procurement) of zinc supplements along with ORS is part of the protocol for the management of diarrhea as it has already started in the ongoing program. The BCC component of the program will educate caregivers and other household decision makers on the importance and benefits of full compliance with taking zinc supplements for the full 10 days during treatment/management of diarrhea.

Calcium and Vitamin D: These are now becoming micronutrient related public health nutrition problem in many part of the country and need intervention.

Activities:

- Awareness creation about food based approach
- Training of service provider

- Supplementation

Component-7: Management of severe & moderate acute malnutrition (facility and community)

Mainstreaming the implementation of nutrition interventions into health and family planning services will ensure more coordination in the treatment of moderate and severe acute malnutrition at the health facility as well as community level. At the health facility level, children with severe acute malnutrition and who have additional medical complications will be treated according to national & internationally recommended protocols. At the community level, the GOB will address community-based management of acute malnutrition through the community based IMCI program & community clinic services.

Activities:

- Guideline development
- Training module development
- Development of trained manpower
- Setting of SAM & MAM unit in secondary and tertiary level facilities of DGHS & DGFP
- Strengthening of SAM/MAM management at all facilities and community

Component-8: Institutional capacity building

In this SWAp nutrition issues under MOHFW would be managed through a single OP under DGHS. IPHN would be the home for it and Director IPHN would be LD of NNS. In addition to existing human resource IPHN requires sufficient number of dedicated nutritionist/ public health specialist from DGHS & DGFP to achieve goal of NNS. Existing development staff of NNP will continue their job in NNS & expertise developed from DGHS & DGFP in NNP will be utilized in NNS. A nutrition implementation coordination committee headed by DGHS would be formed with appropriate TOR. Nutrition service delivery will be mainstreamed at all service delivery point of DGHS & DGFP with the CC being the first contact point. However, where CC is not available and in hard to reach areas, special intervention modality like GO-NGO model would be considered.

Activities:

- Development of an organogram for NNS (including provision of TA)
- Deployment of skill manpower according to approved organogram
- Training of deployed manpower in both technical & managerial aspect
- Deployment of manpower as per organogram
- Establishment of nutrition unit at tertiary, district and Upazila level.

Component-9: Promotion and support of Infant and Young Child Feeding (IYCF)

IYCF encompasses Breastfeeding and appropriate Complementary Feeding practices, activities cut across local & national level nutrition services. Interpersonal Counseling (IPC) and Behavior Change Communication (BCC) within identified services will include promotion of optimum breast feeding, exclusive breast feeding up to six months, followed by introduction of appropriate complementary feeding at seven months. In addition to scaling up and sustaining Baby Friendly Hospital Initiative (BFHI), NNS will (i) support activities for enforcement of the law on the marketing and distribution of breast milk substitutes (ii) promote and campaign for breast feeding and complementary feeding intensively on a national scale and (iii) mother support activities up to the community level. Greater focus will be given to Infant and Young Child Feeding (IYCF) and to Baby Friendly Community Initiative (BFCI).

Activities:

- Setting a cell for Promotion & Support of IYCF including BFHI & BMS Code
- Establishing Nutrition corner in facilities from tertiary level to UzHC
- Campaign for IYCF up to community clinic & community, breast feeding week and through Mass media

Component-10: Food fortification (Salt Iodization, fortification of oil/other food with Vitamin 'A', iron etc.)

- Need based improvement of universal salt iodization
- Need based fortification of vitamin A
- Need based fortification of Iron

Component-11: School Nutritional education Program:

- Provide nutrition education among the teachers and student of school level
- TOT for selected
- Guideline development for school/madrasa and incorporation nutrition issue in secondary curriculum.

Activities:

- Awareness development campaign for teachers
- TOT for selected teachers
- Small budget allocation for school/madrasas

Component-12: Food quality & food safety

Each year millions of citizens suffer from food insecurity & bouts of illness following the consumption of unsafe food. Aside from acute effects arising from food contaminated by microbial pathogens, long term health impacts may result from consumption of food tainted by chemical substances and toxins. By minimizing consumer's exposure to unhygienic, contaminated and adulterated food it is possible to significantly reduce the morbidity and mortality associated with unsafe food.

There are various ministries (MOFDM, MOA & MOWCA) that oversee sectors of the food security, food supply chain, and it is important they continue to work together (through regular meetings of the National Food Safety Advisory Council) to eliminate gaps in food control, as well as duplication of effort and result in improved public health and nutrition. Further enhancement of the roles and responsibilities of the DGHS is essential so it takes a strategic role in managing food safety in collaboration with the city corporations and municipal authorities. Measures which raise awareness of food security & safety will lead to reductions in food contamination and reduce the burden of food borne illness. Food supplementation through VGD program would be implemented in collaboration with FAO, WFP & MOWCA.

Activities:

- Raising awareness on food safety, hygienic practices, hand washing etc.
- Developing an action plan for implementation of food safety policy with existing policy/policies of the country (like TPP has developed one)
- Up gradation of exiting laboratory of IPHN in collaboration with IPH.
- Ensure quality of baby food as per BMS act 1984.

Component-13: Monitoring, Evaluation, Operation research

An M&E system will be established to monitor the implementation of the program and linked to existing HIS tools and systems of the GOB and other stakeholders. The M&E data will be used to monitor progress not only in key nutritional outcomes (anthropometric indicators) but also provide data on inputs, outputs (coverage) and program performance.

Activities:

- Monitoring tool development
- Establish linkage with central MIS
- Need based operation research
- Establishment of a national resource centre for nutrition

Component-14: Surveillance & Survey

The availability and use of quality data is essential for evidence-based decision making to improve nutrition programming. The availability of accurate and timely data can enhance to progress in implementation. The nutrition surveillance component of the program will provide important data on the scope, coverage and effectiveness on the nutrition program's activities.

Activities:

- Nutrition Surveillance Program
- Operations Research, Survey

Component-15: Establishment of new nutrition unit (NU) and strengthening of existing NU: IPHN has already 20 centers in UzHC of 19 greater districts and one in IPHN. NNS will establish this unit in all UzHC.

Activities:

- Planning of nutrition unit at UzHC
- Functioning of NU

Component-16: Community based Nutrition (CBN): CBN will be implemented CC & through special arrangement (GO-NGO) in under-served, hard to reach area, areas where CC is not functioning & urban slums where service is not available.

Activities:

- Identification of underserved, hard to reach, urban slum area
- Development of package for these groups
- Out sourcing through special arrangement

Component-17: Consultancy service: would be required in the area of nutrition, implementation, finance etc.

Activities:

- CC would be equipped for providing nutrition service delivery
- Mapping of targeted areas for CBN
- Review and update CBN package to address nutrition
- Implementation of comprehensive package in targeted areas through outsourcing

Component-18: Multi-sectoral Coordination of Nutrition Activities across Different Sectors

Malnutrition is intrinsically multi-sectoral, and hence achieving sustainable nutrition security is fundamentally a multi-sectoral cross-cutting challenge requiring a coordination of policies and strategies of different sectors/ministries on a sustained basis. Therefore, the NNS will develop mechanisms for effective coordination for nutrition-related activities in all sectors.

Activities:

- Formation of National Nutrition Coordination Committee for coordination among ministries, GO-NGOs, DPs and all relevant organization
- Update of food & nutrition policy

Component-19: Mainstreaming Gender into Nutrition Program

Gender and nutrition are closely associated in Bangladesh, and there are strong linkages between a woman's status and both her health and her children's nutritional outcomes. Therefore, both the health facility and the



community-based nutrition interventions will involve all community and household members who are responsible for decision making and those who can influence maternal, infant and young child feeding practices as well as other nutrition behaviors. Such an approach will ensure that the concerns of men and women, when it comes to household food and nutrition security, are considered as the joint responsibilities for the nutritional well-being of all household members of men, women and the community as a whole, with an emphasis on nutritional status of adolescent girls in the country.

Activities:

- Collection of gender-disintegrated data on Nutrition
- Emphasize on women targeted services (e.g. Lactating and pregnant women, adolescent girl and female child)
- Development of women friendly service delivery system

Component-20: Nutrition during Emergencies and climate change

Bangladesh is prone to natural calamities and seasonal lean periods in different part of the countries. NNS will have a functional coordination system with MOA and MOF&DM to remain prepared for emergency situations and mobilize its workforce specifically to provide essential nutrition services (e.g. food and micronutrient supplementation in the affected areas, management of severe and acute malnutrition among women and children, etc.) in the affected areas.

Activities:

- Development of guideline on nutrition for emergency
- Awareness development campaign to address nutrition issue during emergency
- Preparation action plan for nutrition management during management

Component-21: Procurement:

NNS will be ensuring the supply of vitamin A supplements (for mothers and children), iron/folic acid, calcium, de-worming tablets, and measuring equipments to nutrition corners at the Upazila Health Complex level and Community Clinics. NNS will also be procuring equipments and re-agents to functionalize the Food Safety Laboratory at IPHN.

Activities:

- Procurement and supply of need base commodities at all service delivery points through CMSD and LD.

Component-22: Growth Monitoring and Promotion (GMP): GMP, the regular measurement, recording and interpretation of a child's growth change in order to counsel act and follow-up on results, will be implemented to detect growth faltering of infants and young children early and enhance the transfer of nutrition information in order to take the preventive and curative actions needed.

Activities:

- GMP at all service centre including CC
- GMP card review, updating, printing and supply
- Weight monitoring of pregnant women
- Supply of logistics (eg. GMP card, Register, Weighing scale) to service centre

4.17.4. Cross Cutting Issues

Given the nature of this OP, it is highly multi-sectoral and is dependent with other Ministry activities which are articulated in the Action Plan of the Strategic Document.

i. Effective Integration of priority nutrition Interventions in the field level at all service delivery points of DGHS and DGFP. OP-MNCAH, ESD, CBHC, HSM, MCRAH, FPFSD

ii. Strengthening HR resources necessary for provision of nutrition services. OP-IST, PSE, TRD, HRM

iii. Establish effective facility and pop based nut surveillance. OP- MNCAH, ESD, CBHC, CDC, HIS-EH, MIS-FP

iv. Providing nutrition education OP- ESD, CBHC, HEP, IEC

v. Strengthening sectoral collaboration regarding nutrition and food safety. MODM, Food Div, MOFLS, MOWCA, MOI and other.

4.17.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health, population & nutrition care for all citizens of Bangladesh. They will help to achieve Result 1.1, increased utilization of essential HPN services; Result 1.3 improved awareness of healthy behavior, and Result 1.4, and improved PHC-CC.

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
1	Number of Vitamin A Capsule distribution among 6-59 months children	90 % +	90 % +	90 % +
2	Number of CC workers trained in nutrition services delivery	NA	27,000 (60 %)	40,500 (100%)
3	Percentage of UHCs having a functional Nutrition Corner established	21	120 (60%)	200 (100%)
4	Number of Health service providers trained in nutrition services delivery	NA	6,000	10,000
5	% of Tertiary Hosp, DHs, MCWC, UHCs, UHFWC, Union Health Sub-Center having a functional Nutrition unit.	NA	60 %	90 %
6	Observance of National Breastfeeding week -? Campaign promoting breastfeeding conducted during National BF week?	50 % unit of DGHS, DGFP & Urban health	75 % unit of DGHS, DGFP & Urban health	90 % unit of DGHS, DGFP & Urban health
7	Exclusive Breast Feeding (EBF) for 6 months	43%	46 %	>50 %
8	Complementary Feeding (CF) for 6-	42 %	46 %	>50 %
9	Number of school/madrasa teachers received orientation on Nutrition education	NA	40 %	>50 %
10	Number/batches of media personnel oriented on Nutrition issues (for dissemination)	NA	60 %	80 %
11	Management of SAM& MAM	NA	60 % of tertiary, District, certain UZ hospital	60 % of tertiary, District, certain UZ level hospital

Sl	Indicators	Baseline with source	Projected target	
			Mid- 2014	Mid 2016
12	Reduction in the prevalence of anaemia in < 5 years children, adolescents and in pregnant women	Children <5 Y: 48%, Adolescent girl: 30% Pregnant women-46% (National Anemia survey 2001-3)	Children <5Y: 32%, Adolescent girl-23% Pregnant women-35%	Reduction in the prevalence of anaemia in < 5 Y children, adolescents and in pregnant women
13	Training of HI/AHI on IDD	NA	50 %	70 %
14	Nutrition implementation committee headed by DGHS established and meetings held to monitor nutrition activities in the concerned LDs (**DAAR Indicator)**	NA	2 meeting/ year	60% CC staffed with trained HA, FWA, CHCPs on nutrition services.

4.17.6. Budget

Component and Year wise physical and financial target of OPs

Agency: DGHS.

Name of the OP: National Nutrition Services, DGHS.

(Taka In lakh)

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Behavior Change Communication (BCC): (BCC material for nutrition, healthy eating/feeding for all age group would be developed and incorporated through mass media and other different channels. BCC -Package for policy maker, managers/implementers, service provider, beneficiary)	Nationwide (LS)	1600.00	4000.00	2000.00	7600.00	Nationwide (LS)	2000.00	Nationwide (LS)	2100.00	Nationwide (LS)	2100.00	Nationwide (LS)	1400.00
Human resource development (HRD):(Preparation of capacity building guideline, training module in relevant cases, formation of master and core trainer team, training of relevant service providers at home & abroad)	Nationwide (LS)	3130.00	4000.00	800.00	7930.00	Nationwide (LS)	1632.00	Nationwide (LS)	1632.00	Nationwide (LS)	1932.00	Nationwide (LS)	2734.00
Control of Vitamin-A deficiency disorder: (Awareness creation about food based approach, training of service provider, supplementation in routine service & in NID among two(2) crore children)	Nationwide (LS)	5200.00	6500.00	2000.00	13700.00	Nationwide (LS)	3400.00	Nationwide (LS)	3400.00	Nationwide (LS)	3400.00	Nationwide (LS)	3500.00

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Control & prevention of Anemia: (Awareness creation about food based approach, training of service provider, supplementation to pregnant women, lactating mother, children, adolescent)	Nationwide (LS)	800.00	4000.00	2000.00	6800.00	Nationwide (LS)	1160.00	Nationwide (LS)	1610.00	Nationwide (LS)	1610.00	Nationwide (LS)	2420.00
Control of Iodine deficiency Disorder: (Awareness creation about food source & consumption of Iodized salt, training of service provider)	Nationwide (LS)	720.00	1200.00	1000.00	2920.00	Nationwide (LS)	560.00	Nationwide (LS)	560.00	Nationwide (LS)	560.00	Nationwide (LS)	1240.00
Other Micronutrient problems of Public Health importance (zinc, vitamin 'D,' calcium etc.): (Awareness creation about food based approach, training of service provider, supplementation to vulnerable group)	Nationwide (LS)	80.00	904.00	1200.00	2184.00	Nationwide (LS)	466.00	Nationwide (LS)	467.00	Nationwide (LS)	467.00	Nationwide (LS)	784.00
Community & facility based management of severe & Moderate acute malnutrition (SAM/MAM): (Development of guideline, training module, manpower trained for SAM & MAM management at all facilities and community)	Nationwide (LS)	5000.00	2000.00	1000.00	8000.00	Nationwide (LS)	2000.00	Nationwide (LS)	2000.00	Nationwide (LS)	2000.00	Nationwide (LS)	2000.00
Institutional Capacity Development (including Pay & Allowances): (Organogram development, deployment of skill manpower, training of deployed manpower in both technical & managerial aspect, establishment of	47 Persons L/S	6500.00	1200.00	1012.00	8712.00	Nationwide (LS)	2000.00	Nationwide (LS)	2073.00	Nationwide (LS)	2073.00	Nationwide (LS)	2566.00

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
nutrition unit at tertiary, district and Upazila level.)													
Infant and Young Child Feeding (IYCF) including BFHI & BMS Code: (Establishing Nutrition corner in facilities from tertiary level to UzHC, Campaign for IYCF up to community clinic & community, breast feeding week and through Mass media campaign)	Nationwide (LS)	570.00	2000.00	13414.00	15984.00	Nationwide (LS)	3472.80	Nationwide (LS)	3472.80	Nationwide (LS)	3472.80	Nationwide (LS)	5565.60
Food fortification: (Salt Iodization, fortification of oil/other food with Vitamin 'A', iron etc.)	Nationwide (LS)	100.00	125.00	1175.00	1400.00	Nationwide (LS)	45.00	Nationwide (LS)	65.00	Nationwide (LS)	65.00	Nationwide (LS)	1225.00
School Nutritional education Program: (Awareness development campaign for teachers, TOT for selected teachers, Small fund allocation for school/madras's)	Nationwide (LS)	480.00	936.00	0.00	1416.00	Nationwide (LS)	452.00	Nationwide (LS)	452.00	Nationwide (LS)	512.00	Nationwide (LS)	0.00
Food Quality and Food Safety: (Raising awareness on food safety, hygienic practices, hand washing etc., developing an action plan, Support to Food Safety Laboratory of IPH and strenthen collaboration with other food safety laboratories.)	IPH, BSTI, INS etc.	240.00	250.00	710.00	1200.00	IPH, BSTI, INS etc.	200.00	IPH, BSTI, INS etc.	500.00	IPH, BSTI, INS etc.	500.00	IPH, BSTI, INS etc.	0.00

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Monitoring, Evaluation, Operations Research, Survey:(Development of Monitoring tool , Establish linkage with central MIS, Establishment of a national resource centre for nutrition, Survey as per program need)	MIS of NNS-01	0.00	800.00	1000.00	1800.00	MIS of NNS-01	300.00	MIS of NNS-01	400.00	MIS of NNS-01	400.00	MIS of NNS-01	700.00
Nutrition Surveillance Program (NSP): (Baseline Survey, mid-term & end evaluation)	Urban slu-60U, Under served-180 U, Hard to Reach-180 U	0.00	1800.00	1000.00	2800.00		600.00		600.00		600.00		1000.00
Establishment of nutrition unit (NU) and strengthening of existing NU: (Planning of nutrition unit at UHC, Functioning of NU)	Tertiary-25, District-59, UHC-427	2628.00	866.00	0.00	3494.00		800.00		900.00		900.00		894.00
Community based Nutrition (CBN) as selected area: (CC would be equipped for nutrition service delivery, introduce growth monitoring, mapping of targeted areas for CBN, review and update CBN package, implementation of package in targeted areas through outsourcing)	Nationwide (LS)	1440.00	53547.26	6115.00	61102.26		9502.26		13400.00		17500.00		20700.00
Consultancy Service: (Implementation specialist, nutrition expert, finance expert)	54 MM	0.00	54.00	0.00	54.00		0.00		27.00		27.00		0.00
Multi -sectoral Collaboration: (Formation of National Nutrition Coordination Committee for coordination among	LS	40.00	873.12	1000.00	1913.12		337.00		350.00		382.00		844.12

Name of the Components/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
ministries, GO- NGOs, DPs and all relevant organization)													
Total		28528.00	85055.38	35426.00	149009.38		28927.06		34008.80		38500.80		47572.72

B. DGFP

4.18. Maternal, Child, Reproductive and Adolescent Health (MCRAH)

4.18.1. Introduction

The MCRAH program is designed to deliver quality safe motherhood, child and reproductive health services along with Family Planning to reduce the maternal mortality and morbidity, neonatal mortality and improve other reproductive and adolescent health care services.

The activities under MCRAH program are being implemented successfully across the country through different service centers ranging from community clinic to national level. There has been a significant improvement reflected in the indicators, such as the maternal mortality ratio (MMR) of 1.94 per thousand live births and a Total Fertility Rate (TFR) of 2.5 per woman (BMMS-2010). During the implementation of the sector program HNPSP, many constraints or bottle-necks were identified, the most prominent being the retention of trained manpower and filling up the vacant position of service providers. Considering the constraints and lessons learnt from the previous sector programs and contribute to achieve the MDG 4 & 5 goals and targets as well as the Vision 2021, two priority activities are designed and considered for implementation such as i) to invigorate the supply side of the services in order to ensure the sustainability and expansion of on-going services and ii) increase demand generation in communities for service utilization resulting to bring an equilibrium on both side of the curve.

In the scenario of decreasing trend of MMR, this operational plan gives emphasis to ensure maximum utilization of service centers under the DGFP by all level of service recipients specially the community people and particularly the poor and vulnerable. For ANC, Safe delivery and PNC services the primary focus is to strengthen and reorganize the union level service centers along with service expansion at urban and hard to reach areas as well as to establish effective referral system from community clinic to different level of service facilities

Existing Service Centers

At national level	:	**1.** Maternal and Child Health Training Institute (MCHTI), Azimpur, Dhaka	**1**
		2. Mohammadpur Fertility Services and Training Centre (MFSTC). Mohammadpur, Dhaka	**1**
At District level	:	**1.** Mother and Child Welfare Centers (MCWC)	**60**
At Upazila level	:	**1.** MCH-FP unit of Upazila Health Complex(UHC)	**427**
		2. Mother and Child Welfare Center (MCWC)	**12**
At Union level	:	**1.** Union Health and Family Welfare Centers (UH&FWC)	**3827**
		2. Mother and Child Welfare Center (MCWC)	**24**
At Community level	:	**1.** Community Clinics	**10723**
		2. Satellite Clinics (Per Month)	**30000**

At present Emergency Obstetric Care (EOC) services are available in MCHTI, Azimpur, MFSTC, Dhaka and 70 MCWCs at district and upazilla level.

With the support of GOB,UN agencies and EC &DFID MNH program have been implemented in 04districts.It will be expanded in another 06 districts to accelerate the on-going program.

For better MCRAH services an effective referral linkage from union to Upazilla/District level will be ensured.

4.18.2. Objectives

- To provide safe delivery at homes and facilities
- To educate adolescent boys and girls on healthy reproductive lifestyle practices



- To ensure healthy life of man and women throughout the whole period of reproductive life.
- To educate community people on nutrition.
- To train service providers to ensure quality of services
- To maintain MSR./logistic supplies to the service centers
- To repair and renovate of service centers
- To introduce evidence based best practices in the program, such as introduction of tab.misoprostol.
- To monitor and supervise for ensuring quality of care
- To ensure safe MR and Post Abortion Care(PAC) in health care centers

4.18.3. Components

Component 1: Services Delivery

Maternal Health Services: It includes

- Registration of all pregnant mothers;
- Increase birth planning and antenatal care (ANC);
- Safe delivery by trained service providers at home and at facilities (MCWCs and Upgraded UH&FWCs) with active management of 3rd.stage of labor.
- Ensure24/7 EOC services in all MCWCs and selected UH&FWCs.
- Use of tab. misoprostol at field level to prevent PPH
- Use of Mg.Sulph. to prevent Eclampsia.
- Postnatal natal care (PNC)
- Performance based financing for the service providers;
- DSF for the service providers and clients; and
- Community mobilization activities;

Reproductive Health Care services: It include

- Reduction of unsafe abortion through safe MR services and Post Abortion Care;
- Syndromes management of RTI/STI through diagnosis and treatment;
- Counseling on RTI/STD, HIV/AIDS and Condom promotion;
- Provide health education for adopting preventive measures against RTI/STTDs with especial emphasis on condom promotion;
- Prevention of unwanted pregnancies through Emergency Contraceptive Pill.
- Early detection of Cervical cancer through Visual Inspection of Cervix with Acetic acid (VIA) and screening for Breast cancer.
- Fertility care services and treatment of infertility.

Adolescent Health Care Services

- Implementation of adolescent health strategies action plans;
- Promotional activities on delayed marriage;
- Counseling and developing awareness of adolescents on personnel hygienic practices, nutrition, puberty, anaemia, RTI/STI, unprotected sexual activities, night wets, drug addiction, accident, violence and sexual abuse;
- Train adolescents on SRH through peer groups;
- Management for minor gynecological problems i.e. dysmenorrhea, and menorrhagia etc;
- Syndromes management of RTI/STDs, awareness creation on HIV/AIDS and condom promotion for married adolescents;
- Providing consultation and treatment for some reproductive health related problems of adolescents;
- Full immunization of adolescent girls with five dose TT vaccination in coordination with EPI Program;
- Initiation for making all service centers adolescent friendly in phases.

Newborn & Child Health Care Service

- Promoting integrated approach to address sick Child through IMCI including ARI/ pneumonia, Diarrhea, malnutrition, fevers etc.
- Growth monitoring
- Providing medication of Deforming
- Routine immunization in coordination with EPI Program and Vit-A supplementation
- Ensuring management of drowning, injuries and accident
- Limited curative care for Eye, Ear, Skin infection/worm infestation etc
- New born care :
  - Health education for mothers on cleanliness, nutrition, danger signs of both mother and baby, Umbilical cord care, Breast feeding, Thermal control, EPI etc.
  - Management of birth asphyxia
  - Routine eye care, and
  - Special care of pre-term and low birth weight baby

Nutrition Services

Maternal, New born nutrition and Child Nutrition activities will be streamlined in the DGFP Program through this OP. The activities are reflected in this-OP but the logistics/supplies will be provided by as part of the "National Nutrition Service" OP. The nutritional activities will be as follows

- Exclusive breast feeding
- Complementary feeding
- Growth monitoring
- Vit-A Supplementation
- Iron Supplementation (Micro nutrient powder)
- Zinc Supplementation
- Deworming
- Iron & Folic acid Supplementation for pregnant & lactation woman
- Early initiation of breast feeding
- Postpartum-Vit-A
- Weight monitoring for pregnant women
- Food intake (Quantity & Quality)

Component 2: Training

- Training of service providers (Doctors and FWV) on Emergency Obstetric Care (EOC) services;
- Midwifery training for FWVs.
- CSBA training for FWAs to ensure safe delivery round the clock at the community level.
- Training on reproductive health activities such as MR, PAC, VIA & CBE etc;
- Training on adolescent health activities to service providers and adolescents and other stakeholders.
- Training on RTI/STI, VAW, Infection Prevention and other RH Services
- Training on Essential Newborn Care

Component 3: Procurement

- DDS kits, RTI/STDs drugs, drugs for conducting safe delivery and other essential drugs; such as Tab.Misoprostol, Inj.Mag.Sulf.
- Micronutrients Powder (MNP);
- Hospital equipments, surgical instruments and MSR such as MR kit, MVA kit, BP machine Stethoscope, weight machine;
- Service procurement for consultancy, maintenance of hospital equipments etc;
- Printing and Publications of different types of forms, registers and IEC materials.



Component 4: Repair and Renovation of service centers

- New construction of one 200 beded MCRH based hospital in the Dhaka City Corporation area.
- New construction of two MCWCs at district level (Gazipur and Sariatpur) and 366 UH&FWC at union level.
- Upgradation and Repair/Renovation of UH&FWCs for Obstetric First Aid/Basic EOC
  Construction works will be done through Physical Facilities Development-OP

4.18.4. Cross Cutting Issues

- Provide necessary HR, Equipment, supplies and budget for renovation and maintenance to all facilities OP-PFD & HRM
- Provide training to doctors, FWVs and paramedics on reproductive health, essential newborn care and adolescent health. OP-IST & TRD
- Introduce local level recruitment and performance based incentives for retention of trained staff in hard to reach areas OP-HRM
- Strengthen MIS OP-HIS-EH & HRM
- Develop system to register all pregnancies and newborns at the community level with linkages to national population and health registries .OP-MNCAH,CBHC, HIS-EH,MIS, MOLGRD and BBS
- Establish maternal and prenatal death review system both at community and facility level OP-MNCAH, ESD, CBHC, HSM, MCRAH & Local Government
- Increasing efficiency through functional co-ordination with MNCH services, incorporating expertise and facility sharing between DGFP and DGHS .OP-MNCAH and MCRAH.

4.18.5. Indicators

The activities planned under this OP will contribute to all the results under Component 1, Result 1.1, increased utilization of essential HPN services, Result 1.2 improved equity in essential HPN utilization, Result 1.3 improved awareness of health behavior and Result 1.4 improved primary health care-community clinic systems.

SL. No	Indicators	Base line with source	Projected Target	
			Mid-2014	Mid-2016
1.	Number of FWVs trained in Midwifery	1492	1792	3292
2.	Number of FWAs & Female HAs trained on midwifery	6029	9029	12629
3.	Number of doctors trained on EOC	323	339	391
4.	Number of UH & FWCs Upgraded	1441	2000	2300
5.	Number of FWVs trained on EOC	511	555	623
6.	Number of Program Personnel trained on PAC	164	344	601
7.	Number of Service providers trained on VIA & CBE	-	1272	2788
8.	Number of ECP distributed	140000	168000	196000
9.	Number of high risk pregnancies identified and referred	14500	175000	350000
10.	Number of Upazila & Union Level service provider trained on Active management of the third stage of labor (AMTSL)	-	2318	5796
11.	Number of ANC First visits by SBAs	1325570	1918914	2630173
12.	Number of women receiving 4 ANC Visits by SBAs	564594	895493	1315086
13.	Number of Deliveries by SBAs	650511	767565	1315086
14.	Number of reported MR done	250000	370000	440000
15.	Number of mothers receiving PNC by SBAs	-	767565	1315086
16.	National situation analysis on adolescent health conducted	None	done	Implemented



4.18.6. Budget

Component and Year wise physical and financial target of OPs

Agency: DGFP

Name of the OP: Maternal, Child, Reproductive and Adolescent Health

(Tk. In Lakh)

Name of the Components/ Major Activities	Total Physical and Financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Maternal, Child Health Care Services													
DDS kits	480000 Pcs	8200.00	33240.00	0.00	41440.00	80000	7006.67	80000	7006.66	80000	6856.67	240000	20570.00
Medicines (RTI/STI, Adolescent Health & others drugs)	700 mil Pcs	0.00	1486.00	0.00	1486.00	140	297.20	140	297.20	140	297.20	280	594.40
MR kit	50000 Pcs	0.00	500.00	0.00	500.00	10000	100.00	10000	100.00	10000	150.00	20000	150.00
MVA kit	1000 Pcs	0.00	34.00	0.00	34.00	700	23.80	300	10.20	0	0.00	0	0.00
Reproductive Health Care Services					0.00								
FWC kit	500 Pcs	0.00	14.00	0.00	14.00	0	0.00	250	7.00	0	0.00	250	7.00
MCH kit	500 Pcs	0.00	14.00	0.00	14.00	0	0.00	250	7.00	0	0.00	250	7.00
BP machine	10000 Pcs	0.00	80.00	0.00	80.00	2000	20.00	2000	20.00	6000	20.00		20.00
Stethoscope	10000 Pcs	0.00	40.00	0.00	40.00	2000	20.00	2000	20.00	6000			
Portable Weighing Machine (Bathroom Type)	10000 Pcs	0.00	150.00	0.00	150.00	2000	40.00	2000	30.00	2000	30.00	4000	50.00
Adolescent Health Care Services					0.00								
Baby Weighing Machine	5000 Pcs	0.00	100.00	0.00	100.00	1000	30.00	1000	30.00	1000	30.00	2000	10.00
Contraceptives (ECP)	0.5 in Mil Pcs	0.00	0.00	750.00	750.00	0	150.00	0	150.00	0	150.00	0	300.00
Micronutrient powder (MNP) Sachet	50 in Mil Pcs	0.00	0.00	1116.00	1116.00	10	223.20	10	223.20	10	223.20	20	446.40
Logistics & Equipment for upgraded UH&FWCs	1800 Center	1500.00	500.00	1000.00	3000.00	500	600.00	500	600.00	500	600.00	1000	1200.00
Establishing Adolescent Friendly Health Service (AFHS) centre & Life Skill Training	23 Center	0.00	0.00	1356.83	1356.83	0	701.83	0	205.00	0	150.00	0	300.00
Fellowship/ Overseas training/ study tour	150 Persons	0.00	0.00	770.00	770.00	30	154.00	30	154.00	30	154.00	60	308.00

Name of the Components/ Major Activities	Total Physical and Financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Orientation/Seminar/ Conference	300 Pcs	0.00	0.00	1050.00	1050.00	60	210.00	60	210.00	60	210.00	120	420.00
Training (EOC, Midwifery, CSBA, Cervical & Breast Cancer Screening, CME etc.)	2500 Persons	50.00	800.00	3700.00	4550.00	500	950.00	500	950.00	500	950.00	1000	1700.00
Repairs and maintenance of Machineries & Equipments		550.00	0.00	280.00	830.00	0	166.00	0	166.00	0	166.00	0	332.00
DAAR related activities	5 low-performing district MCWCs	0.00	1040.00	1000.00	2040.00	0	0.00		500.00		600.00		940.00
Advertising and publicity		75.00	0.00	215.00	290.00	0	58.00	0	58.00	0	58.00	0	116.00
Pay and allowances	77 Persons	564.00	0.00	0.00	564.00	15	112.80	15	112.80	15	112.80	31	225.60
Cleaning Services		505.00	0.00	0.00	505.00		71.00		96.00		96.00		242.00
Security Guard/Sweeper (to recruit according to existing system)		610.00	0.00	0.00	610.00		122.00		122.00		122.00		244.00
Stationery, Seals and Stamps		150.00	0.00	0.00	150.00	0	30.00	0	30.00	0	30.00	0	60.00
Loose medicines for MCWC, UHC, UH&FWC		680.00	0.00	4805.00	5485.00	0	1196.00	0	1196.00	0	1196.00	0	1897.00
Medical and surgical requisites (MSR) for MCWC, UHC, UH&FWC		680.00	0.00	5700.00	6380.00	0	1176.00	0	1176.00	0	1176.00	0	2852.00
Petrol, Oil and Lubricant	100	1225.00	0.00	0.00	1225.00	0	245.00	0	245.00	0	245.00	0	490.00
Research Expenses/Survey		300.00	0.00	500.00	800.00	0	50.00	0	200.00	0	250.00	0	300.00
Municipal Rates & Taxes		404.00	0.00	0.00	404.00	0	60.00	0	86.00	0	86.00	0	172.00
Travel, Overtime, Office rent and Others (Recurrent expenditure)		185.00	0.00	743.00	928.00	0	140.00	0	197.00	0	197.00	0	394.00
Printing and Publication (Forms, Card, Register, Log Book etc)	0.715 in million	1150.00	0.00	1350.00	2500.00	0	420.00	0	520.00	0	520.00	0	1040.00

Name of the Components/ Major Activities	Total Physical and Financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Logistics & Equipment for newly constructed/upgraded MCWCs	new: 10 & upgrd: 3	200.00	400.00	100.00	700.00	new: 2	120.00	new: 2 & upgrd: 1	186.65	new: 2 & upgrd: 1	186.65	new: 4 & upgrd: 1	206.70
JICA Safe Motherhood Promotion Project		0.00	0.00	1000.00	1000.00		200.00		200.00		200.00		400.00
TA for coordinated service		0.00	0.00	300.00	300.00		50.00		50.00		75.00		125.00
Operations & maintenance		505.00	0.00	512.77	1017.77		109.69	0	240.52		319.52	0	348.04
Machineries and Hospital Equipment (OT table-20, OT light-20, A/C-15, Anaesthesia Machnie-30, Diathermai-30, Colposcopy-5 and others-50)	170 Pcs in variable	975.00	0.00	1162.40	2137.40	34	427.48	34	427.48	34	427.48	68	854.96
Motor vehicle (Ambulance- 15 & Four wheel Jeep-4)	19 Pcs	450.00	0.00	1880.00	2330.00	4	490.53	4	490.53	4	490.53	7	858.41
Iron Cot-2500, Bed Side locker-2500, Salane stand-2500, Spot light-2000, Labour table-1500 etc)	11000 Pcs in Variable	450.00	0.00	0.00	450.00	4200	90.00	4200	90.00	4200	90.00	8400	180.00
Furniture and fixture	Lot	200.00	0.00	0.00	200.00	0	40.00	0	40.00	0	40.00	0	80.00
Computer, Laptop, Multimedia, Photocopier etc.	40 Pcs in Variable	120.00	0.00	200.00	320.00	8	64.00	8	64.00	8	64.00	16	128.00
Tubewel and equipment		65.00	0.00	0.00	65.00	0	5.00	0	15.00	0	15.00	0	30.00
Telecommunication equipment		40.00	0.00	0.00	40.00	0	8.00	0	8.00	0	8.00	0	16.00
Electrical equipment		65.00	0.00	0.00	65.00	0	5.00	0	15.00	0	15.00	0	30.00
Others expense		117.00	0.00	0.00	117.00	0	17.00	0	25.00	0	25.00	0	50.00
Total		20015.00	38398.00	29491.00	87904.00		16000.20		16577.24		16632.05		38694.51

4.19. Clinical Contraception Service Delivery (CCSD)

4.19.1. Introduction

The family planning (FP) Program has built a nationwide community based FP service delivery system, relying primarily on non-clinical methods such as oral pills and condoms. The emphasis on short- and long-acting clinical methods, which was relatively high in the 1980s, has faded. The current pattern of temporary contraceptive use, with oral pill users close to 30% of all married couples, is reaching saturation (only two other developing countries exceed this proportion), but other individual methods do not even account for 10% each. With persistent early marriage and low high fertility, many women have completed their childbearing by the mid-late twenties, leaving them with two decades of reproductive life to avoid unwanted pregnancies. However, the proportions of couples relying on long-acting or permanent FP methods (IUD, implants, male or female sterilization) remains very low (less than 15%). Diversified and mass scale FP services will need to be undertaken to bring back the tempo of 1980s and achieve the target of fertility to replacement level. FWAs are providing family planning and MCH services through household visit and they are maintaining FWA register to record their activities during their home visit.

Family Planning Clinical Contraception Services Delivery Program ideals with the following family planning and related services as below:

(1) Permanent methods:

(i) Tubectomy (permanent method for female),

(ii) No-scalpel Vasectomy –NSV (permanent method for male) ,

(2) Longer-term methods :

(i) Intra-Uterine Contraceptive Device- IUCD (Tcu-380A),
(ii) Implants (Norplant/ Implanon /Jadelle /Sino Implant)

(3) Contraceptive related back-up and humanitarian services, like-

(i) Management and treatment of complications/side-effects arise due to use of any modern contraceptive method, and

(ii) Arrangement for reversal operation of NSV and tubectomy (Re-anastomosis operation of fallopian-tubes and spermatic-cords) for those acceptors who might have desire for child either due to death of all of their living children or re-marriage after death of the spouse or divorce.

Therefore, Operational Plan of CCSDP has been designed with the view to deliver permanent (Tubectomy & NSV) and longer-term (IUD & Implant) contraceptive methods along with other backup services i.e. quality control/ introduction of new contraceptives/ management/ treatment of any complication/ side-effect arise due to use of any contraceptive and reversal operation of permanent methods and also ensure LAPM service delivery to Hard to reach area, far-flung, low-performing areas, tribal area and slums of urban area.

The HPNSDP Strategic document has set out several drivers and strategies as follows:

- Addressing population growth with vigorous, fully integrated family planning services, and cross-cutting, multi-sector interventions.
- Revitalize various family planning interventions to attain replacement levels.
- Strengthen contraceptive security and additional staff to improve procurement and distribution.

4.19.2. Objectives

- To promote a more effective method-mix CPR with increased share (20%) / proportion of longer acting and permanent family planning methods through:
    a. Attaining replacement level fertility by 2016 at the earliest and its continuation;
    b. Shifting and increase share of LAPM in CPR.

- To increase male participation specially for No-scalpel Vasectomy (NSV)
- To provide quality of care of family planning methods
- To ensure contraceptive security.

Targets

- To reduce Total fertility Rate (TFR) from 2.5/woman (UESD-2010)to 2.00/women by 2016
- To increase Contraceptive Prevalence Rate (CPR modern methods) from 61.7%(UESD-2010) to 72% by 2016
- To reduce Unmet need from17.1%(BDHS-2007) to **09%** by 2016
- To reduce Discontinuation rate of FP method from 56.5%(BDHS-2007) to 20% by 2016
- To ensure share of LAPM from 7.3% to 20% in CPR.

4.19.3. Components

Component 1: Strengthening LAPM Services.

To provide 20% share of LAPM in CPR-72% and TFR-2.0 by the year 2016 with increase male participation in family planning.

Activities:

- Ensuring availability of LAPM services close-to users
- Shifting contraceptive use patterns towards more effective longer-acting and permanent methods from short-term hormonal and traditional methods;
- Promoting increased male participation specially for No-scalpel Vasectomy (NSV) with 20% share of LAPM in CPR
- Reinvigorating domiciliary visit specially in hard-to-reach, far-flung, low-performing areas slums of urban areas by well informed field staff i.e. FWAs
- Sustaining quality of care of service delivery center, FP clients and service providers by regular supervision and monitoring through FPCST-QAT team.
- Increasing male participation and popularize LAPM services orientation program of satisfied Long Acting and Permanent Method (LAPM) clients are prepared.
- Reducing drop out of long acting method; monthly, quarterly, half yearly and yearly follow up of the LAPM clients has been introduced in the program.
- Introduce reward through lottery among the permanent methods recipients at divisional level twice in a year.

Component-2: Ensuring availability of Contraceptives and MSR of LAPM

Activities:

- Ensure availability of contraceptives (implants and IUD) and other essential commodities like Drugs, MSR, Instrument, Equipment, Surgical apparels, printing materials etc to all service delivery centers, so that steady supply are always maintained whenever and wherever needed.
- Delivery LAPM services to ELCOs, upazila wise children based client segmentation done and projection for contraceptive distribution and service delivery policy prepared by the grass root level service provider for achieving projected CPR & TFR.
- Simplification of routine procurement procedures, training to upgrade the skills of community level workers, filling vacant positions and new recruitments, will be practiced for ensuring FP services and meeting the unmet needs.

Component -3: To Provide quality of care of family planning services

Activities:

- Quality of care of LAPM services of FP clients, service provider and service centers provided by FPCST-QAT team.



- FPCST-QAT Supervise, monitor the morbidity and mortality of LAPM services and insure the quality of care. This service will cover all UH&FWC, UHC, MCWC & other GO & NGO service centers providing LAMP & EOC services. They also monitor the dropout and discontinuation of these services

Component -4: To provide capacity development.

Activities:

- Skill based training to the VSC, IUD and Implant provider's through different training centers to improve their skill.
- 21 days basic 14 days refresher for doctors VSC training; 15 days basic and 7 days refresher training of FWV/SACMO/Staff nurse/Paramedics and 2 days Implant training of the doctors to ensure quality services all over the country.

Component -5: To Provide support to NGOs for LAPM services

Activities:

- Outsourcing the services for LAPM services as part of PPP or GO-NGO collaboration in hard to reach and low performing areas
- NGOs, both national and international, will be selected on the GOB existing financial and procurement rules and regulations. National and locally acting NGOs with experience of similar works will be given priority. Support for service delivery will be considered under this collaboration. However, BAVS will continue to deliver LAPM services as a government administered NGO until further decision of GOB.
- BAVS role to provide LAPM will be reviewed. BAVS will generate their own fund gradually and will be sustainable. BAVS services will be made cost-effective compare to the GOB services.

4.19.4. Cross Cutting Issues

- Information and Communication, OP-IEC
- Recruitment and posting of manpower, OP-HRM
- Training-OP-TRD
- Strengthen MIS –OP-HIS-EH, MIS, SWPMM and DMIS
- Urban services-OP-MNCAH, ESD, MCRAH, CCSD & MOLG
- Inter- sectoral co-ordination-Related with Female education , MOE
- Co-ordination of nutritional services, OP-NNS

4.19.5. Indicators

The activities under this Operation Plan will contribute to ensure the quality and equitable health care for all citizens of Bangladesh. In particular, the activities planned will contribute to all the results under Component 1, Result 1.1, increased utilization of essential HPN services, result 1.2 improved equity in essential HPN utilization

Sl no	Indicators	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
1	Number of VSC performed	234217 (FPCST/QAT report, 2008-2010), DGFP MIS	9,00,000	15,00,000
2	Number of IUDs inserted	260984 (FPCST/QAT report, 2002-2003), DGFP MIS	18,00,000	25,00,000
3	Number of Implants inserted	100652 (FPCST/QAT report, 2002-2003), DGFP MIS	13,00,000	20,00,000
4	Number of UH&FWCs upgraded to perform VSC,IUDs, Implants	1441, HED	2000	2300
5	Number of VSCs performed by Roving teams (e.g. Tribal areas)	29120	1,50,000	2,50,0000



Sl no	Indicators	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
6	Number of personnel trained in clinical contraception	332	1996	3560
7	Number of couples referred by FWAs for LAPM	FWA-278981 S.NSV-223184 NGO-55796	FWA-2177500 S.NSV-1742000 NGO-435500	FWA-3875000 S.NSV-3100000 NGO-775000
8	Number of NSV and IUD acceptors trained as referral agents – as per "Total 15000 satisfied NSV & IUD acceptors	81215	225833	1250000
9	Use of modern contraceptives (LAPM) in low-performing areas	59%	65%	72%
10	Availability of semi-permanent FP methods in Upazila Health Complexes (UHC) in low performing districts with high maternal and child mortality rates (**DAAR Indicator)**	NA, CCSDP	2 UHC in 5 low performing districts	2 UHC in 25 low performing districts

4.19.6. Budget

Component and Year wise physical and financial target of OPs

Agency: DGFP

Name of the OP: Clinical Contraception Service Delivery

(Tk in Lakh)

Name of the Component/Major Activities	Total Physical and financial target (2011-2016)					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty/ Unit	Financial				Physical Qty/ Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/ Unit	Financial	Physical Qty/ Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Strengthening LAPM services													
Permanent methods (Tubectomy & NSV)	1500000 Cases	50,000.00	-	-	50,000.00	300000	10000.00	300000	10000.00	300000	10000.00	600000	20000.00
IUD	2500000 Cases					600000		600000		600000		700000	
Implant	2000000 Cases					400000		400000		500000		700000	
Ensuring availability of contraceptives and MSR of LAPM					-								
Procurement of Contraceptive					-								
a. Implant	2000000 Set	1,562.50	14,625.00	14,982.50	31,170.00	1000000	8780.00	675000	8787.50	700000	7802.50	875000	5800.00
b. IUD	2500000 Pcs					600000		625000		650000		1375000	
Procurement of Drugs	190688855 Lot	2,082.33	-	3,964.43	6,046.76	33844695	600.00	35956783	600.00	38237315	600.00	82650062	4246.76
Procurement of MSR	24755285 Lot	3,538.99	2,180.00	10,019.79	15,738.78	4265696	2000.00	4559402	2300.00	4944184	3650.00	10986004	7788.78
Printings of registers, forms, cards etc.	13960900 Lot	513.81	-	-	513.81	371000	16.00	4392800	133.27	411500	98.00	8785600	266.54
To provide quality of care of family planning services					-								
Consumable item	960000 Lot	508.50	-	-	508.50	192000	101.70	192000	101.70	192000	101.70	384000	203.40
Vehicle	4 Pcs	240.00	-	-	240.00	-	0.00	-	0.00	2	120.00	2	120.00
Upgradation of UH&FWC	1218 Nos	1,000.00	200.00	13,928.43	15,128.43	100	1389.85	200	2279.71	400	4059.42	518	7399.45
Medical Equipment & Machinery		-	-	-	-		0.00		0.00		0.00	0	0.00
Surgical Instrument for Laparoscopic Ligation	32 Pcs	960.00	-	-	960.00	-	0.00	-	0.00	9	270.00	23	690.00

Name of the Component/Major Activities	Total Physical and financial target (2011-2016)					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty/ Unit	Financial				Physical Qty/ Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/ Unit	Financial	Physical Qty/ Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Hystrescope for IUD insertion	100 Pcs	400.00	-	-	400.00	-	0.00	-	0.00	0	0.00	100	400.00
4 Burner Kerosene Stove	1000 Pcs	60.00	-	-	60.00	-	0.00	500	30.00	0	0.00	500	30.00
OT light	1200 Pcs	267.00	-	-	267.00	-	0.00	550	66.00	550	66.00	1125	135.00
Autoclave	1200 Pcs	180.00	-	-	180.00	-	0.00	300	45.00	300	45.00	600	90.00
Dressing Drum	600 Pcs	7.20	-	-	7.20	-	0.00	200	2.40	0	0.00	400	4.80
O.T. Table	1200 Pcs	333.75	-	-	333.75	-	0.00	550	82.50	550	82.50	1125	168.75
Oxygen Cylinder	1500 Pcs	180.00	-	-	180.00	-	0.00	500	60.00	0	0.00	1000	120.00
Oxygen Therapy set with flow meter	2000 Pcs	60.00	-	-	60.00	-	0.00	500	15.00	500	15.00	1000	30.00
IUD sterilizer insertion kit	6000 Pcs	210.00	-	-	210.00	-	0.00	2000	70.00	0	0.00	4000	140.00
Ambu bag	1000 pcs	35.00			35.00			1000	35.00	0	0.00	0	0.00
Instrument Trolley	2000 Pcs	160.00	-	-	160.00	-	0.00	500	40.00	500	40.00	1000	80.00
Hospital/ Clinic Furniture					-		0.00		0.00		0.00	0	0.00
Wooden bench with Arms	8900 Pcs	267.00	-	-	267.00	-	0.00	2225	66.75	2225	66.75	4450	133.50
Chair with Arm steel/class room chair	22250 Pcs	778.75	-	-	778.75	-	0.00	5560	194.60	5560	194.60	11130	389.55
IUD insertion table for UH&FWCs/UHCs/other clinics	500 Pcs	40.00	-	-	40.00	-	0.00	-	0.00	500	40.00	0	0.00
Secretariat Table with side table	12 Pcs	2.40	-	-	2.40	4	0.80	2	0.40	2	0.40	4	0.80
Linen	46675	343.93	-	-	343.93	100	2.00	11610	84.35	11610	84.35	23355	173.23
Repairs and maintenance		332.50	-	-	332.50		33.50		41.00		86.00		172.00
Office operational costs		1,401.69	-	133.85	1,535.54		255.78		252.99		337.74		689.03
Capacity development	4200	505.00	-	485.00	990.00	400	68.00	1000	235.00	1050	235.00	1750	452.00
To provide support to NGOs for LAPM services	0	2,100.00	-	-	2,100.00		600.00		600.00		700.00	0	200.00
Study on effectiveness of NGO services on LAPM	2	100.00	-	-	100.00	1	50.00	0	0.00	0	0.00	1	50.00
Reward for LAPM clients	1000	125.00	-	-	125.00	200	25.00	200	25.00	200	25.00	200	50.00
DAAR indicator related activities	in 5 low performing districts	-	2,000.00	5,000.00	7,000.00		200.00		900.00		3100.00		2800.00
Total		**68,295.35**	**19,005.00**	**48,514.00**	**135,814.35**		**24,122.63**		**27,048.17**		**31,819.96**		**52,823.59**

4.20. Family Planning Field Service Delivery (FPFSD)

4.20.1. Introduction

The Government has recognized that a massive population forms an obstacle to economic development, and has developed the National Population Policy which seeks to reduce fertility to replacement level by 2015. This requires a further TFR decline of 0.5 children per couple. But even at replacement fertility, the country will be adding two million annually to the population, and many in the population field, feel that the decline needs to be greater, with a target of 1.0 below present fertility (i.e., to TFR 1.7), projected to have substantial benefits across many sectors. It will not fall any lower, so all future population growth will be determined entirely by the fertility level.

High rate of population growth and the resultant increase in population size impede the process of achieving the objectives in various sectors of the economy. Therefore, those ministries and agencies whose target population is affected by population growth would have to share the burden of responsibility of population control and family planning, in addition to the targeted interventions of MOHFW.

The development issues relating to the population of Bangladesh are convincing the families of the need and benefits of delayed marriage for their daughters; newly wedded couples should wait before having their first child, especially if the bride is young; small and medium scale employment opportunities for young women be generated in rural areas, so that marriage does not have to follow so closely on school drop-out; high school drop-out rates be reduced; services can be designed to more effectively educate unmarried adolescents on reproduction, and alternative options to early marriage. A social movement to eliminate dowry needs to be encouraged and supported. All these challenges are to be addressed through the interventions of other relevant ministries, in addition to the interventions within MOHFW's jurisdiction.

The family planning (FP) Program has built a nationwide community based FP service delivery system, relying primarily on non-clinical methods such as oral pills and condoms. The current pattern of temporary contraceptive use, with oral pill users close to 30% of all married couples, is reaching saturation (only two other developing countries exceed this proportion), but other individual methods do not even account for 10% each. With persistent early marriage and high fertility, many women have completed their childbearing by the mid-late twenties, leaving them with two decades of reproductive life to avoid unwanted pregnancies. However, the proportions of couples relying on long-acting or permanent FP methods (IUD, implants, male or female sterilization) remains very low (less than 15%). Diversified and mass scale FP services will need to be undertaken to bring back the tempo of 1980s and achieve the target of fertility to replacement level.

As per UESD report-2010, CPR is 61.7% and TFR is 2.5 which were respectively 55.8% and 2.7 in 2007(BDHS-07). Under the HPNSDP, CPR and TFR have been targeted as 72% and 2.00 /women respectively by the year 2016, the following strategies will be followed to achieve the targets: (i) Increasing the contribution of long acting and permanent methods to the method mix ; (ii) Reducing the unmet need from 17.1% (BDHS-07) to 09%; (iii) Ensuring uninterrupted supply of logistics; (iv) Implementing special interventions/programs for the low performing and hard to reach areas; and (v) Massive awareness development program.

On the other hand unmet need for Family Planning was 17.1% (BDHS-07) . The reasons for higher unmet need were as follows: (i) Stock out of contraceptives at the field level; (ii) Shortage of manpower at the field level: (iii) Below par monitoring and supervision; (iv) Inadequate program interventions for the low performing and hard to reach areas. During the last few years, required number of manpower were recruited, contraceptives forecasting and procurement had been made time bound. Special activities were undertaken to ensure effective monitoring and supervision at all levels. In addition, considering the initiatives taken so far, and the program interventions under various OPs of DGFP for the HPNSDP; it will be possible to reduce the unmet need to 9% from 17.1 %(2007).

4.20.2. Objectives

- To reduce Total Fertility Rate (TFR)

- To increase Contraceptive Prevalence Rate (CPR)
- To reduce discontinuation / dropout rate of temporary contraceptive methods (Oral pill, Condom & Injectables)
- To provide health and family planning services through satellite and community clinics.
- To strengthen domiciliary services
- To provide adolescent reproductive health care services
- To reduce early marriage, adolescent pregnancy and unsafe abortion.
- To reduce unmet need of contraceptives to eligible couple.

4.20.3. Components

Component -1: Intensification of FP-FSD program

FP-FSD program is being implemented by manpower like FWAs, FPIs, FWVs, SACMOs, MO(FW)s and MO(MCH-FP), UFPOs at field level through domiciliary visits and at service facilities like Satellite Clinics, Community Clinics, Union Health and Family Welfare Centers (UH&FWCs) and Upazilla Health Complexes (UHC). These personnel are involved in performing, managing and implementing Family Planning Field Services according to the guidance of Line Director (FP-FSDP) under Directorate General of Family Planning.

Field workers are distributing condom, oral pill and injectables to the acceptors at domiciliary and community clinic level. They also counsel, motivate and refer eligible couples for taking longer acting FP methods, care of safe motherhood and child/adolescent health care services to the community clinics and other service centers.

FWAs trained on SBA are providing safe delivery and essential newborn care in the community. They provide health education among the target population on nutrition, food supplementation (Iron & vitamin A capsules) and give advice on personal hygiene, ante-natal care, safe delivery, post natal care, essential newborn care providing by FWAs/ FWVs at domiciliary level and in all service delivery points.

Activities

- Organization of Satellite Clinics
- Services at the Community Clinics
- Recruitment of security guards (Ansar VDP) for the upgraded UH&FWCs
- Maintenance of FWC's
- Supply of logistics

Component -2: Ensuring availability of contraceptives and other supplies (Condom, Oral Pill & Injectables)

Need assessment and procurement of required contraceptives, and other commodities, MSR (Cotton, povidine solution) are processed by LD (FP-FSDP) and procurement is done by the Logistic & Supply Unit of DGFP.

Activities

- Procurement of contraceptives (Oral pill, Condom & Injectables)
- Procurement of MSR (Povidon, cotton)

Component -3: Monitoring & Supervision of the Program

Line Director, FP-FSDP is responsible for monitoring the performances and take follow-up action of GO-NGO family planning activities. Divisional Directors (FP) and Deputy Directors (Family Planning), Assistant Directors (CC)/ (FP), Medical Officer (CC) of Districts & Upazilla Family Planning Officer (UFPO), Medical Officer (MCH-FP)/Medical Officer (FW), Assistant Upazilla Family Planning Officer (AUFPO) and Assistant Family Welfare Officer (AFWO-MCH-FP)&Family Planning Inspectors (FPI) are also directly involved in management and implementation of the Program. For extensive supervision & monitoring, districts & upazilla managers need transport facilities. For strengthening field visits procurement of 45(Forty Five) jeeps, 500(Five Hundred) motorcycles &2100 (Two Thousand one Hundred) Bicycles have been proposed. Jeeps will be supplied on replacement basis at district family planning offices. Motorcycles will be supplied to upazilla



managers & bicycles will be supplied to family planning inspectors of under served & low performing areas. Repair, maintenance and fuel cost of these jeeps and motorcycles will be provided from revenue budget. RH-MCH-Family Planning related other NGO's program activities are being monitored and supervised by family planning field service delivery program under the guidance of the Director General of Family Planning.

Activities

- Supervision of the static service centers, Satellite Clinics and Community Clinics.
- Supervision of the field activities
- Procurement of vehicles (Jeep, Motorcycle &Bicycle)

Component- 4: Capacity Building

Personnel involved in the Field Service Delivery Program implementation to be trained up through regular and & continued refresher training program .

Activities

- Orientation of service providers for developing skills
- Orientation program for newly married couples

Component- 5: Family Planning Services in Urban Slums

Prevalence of contraceptives use has been consistently lower among urban slum dwellers than among the rural population which is now a major concern in reducing fertility rate. With gradual urbanization, City Corporation and Pourashava area increasing with population. Domiciliary and door to door services for distribution of FP commodities and counseling & motivational works for acceptance of contraception are negligible in City Corporation areas. Moreover eligible couples are out of registration because of clinic based service delivery approach by NGOs instead of domiciliary service. So, a large number of eligible couples remained uncovered/ unprotected for FP services in urban areas especially in the slums. Registering eligible couples in the city corporation areas to establish effective communication and counseling will be given priority. Therefore, volunteers through PPP(Public Private Partnership) package program is proposed for starting domiciliary services and registration of eligible couples in urban slums of six city corporations.

Activities

- Registration of eligible couples in urban slums.
- Out sourcing of NGOs
- Counseling & motivational activities for FP services
- Establish referral linkage between urban slum and FP service centers within the City Corporation and Pourashava.
- Technical assistance
- Feasibility study, Piloting and other FP activities in urban areas.

Component- 6: Family Planning Services in Hard-to-Reach Areas

Using different service delivery approaches for different geographical regions is one of the priority interventions of the next sector program. Volunteer through PPP (Public Private Partnership) Package Program for hard-to-reach & underserved areas in Sylhet, Sunamganj, Chittagong including CHTs, other regions such as Mymenshingh, Dinajpur and char areas will be strengthened for domiciliary family planning services.

Activities

- Procurement of Vehicle for field level supervisors (Motor Cycle & Bi-Cycle)
- Maximum logistics support

Component- 7: Services for newly married couple

Orientation and motivational program for newly married couples on family planning methods will be conducted.

Activities:

- Orientation program for newly married couples (Through IEC OP)

Component- 8: GO-NGO Co-ordination

For field level family planning services multi-sectoral efforts and co-ordination to be reinforced. GO-NGO co-ordination and co-operation to be strengthened for field level family planning services.

4.20.4. Cross Cutting Issues

Under population sub-sector of HPNSDP, the strategies are addressed and materialized through three direct FP-MCH services delivery related Operational Plans of DGFP, FP Field Services Delivery Program, Clinical Contraceptive Service Delivery Program and MC&RH Services Delivery Programs; and these three OPs will be supplemented and supported by other OPs of DGFP. Some important cross-cutting issues those would play a pivotal role i.e. public information, motivation and counseling campaigns; human resource development and arranging new human resources; MIS, procurement & supply system etc are also required to be reinvigorated for accelerating the FP- MCH services delivery.

- IEC-OP-IEC
- Recruitment and posting of manpower, HRM-OP-HRM
- Training-OP TRD
- Monitoring and supervision –OP-MIS, HIS-EH, SWPMM and DMIS
- Urban services-OP-MNCAH, ESD, MCRAH, CCSD, MOLG
- Inter- sectoral co-ordination-Related with Female education ,MOE
- Co-ordination of nutritional services,OP-NNS
- Procurement – OP-PSSM-FP

4.20.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. They also work towards achieving all the results under Component 1, Service Delivery Improved.

Indicators	Unit of Measurement	Base line (with Year and) Data Source	Projected Target	
			Mid-2014	Mid-2016
Percentage of Injectable acceptors (method mix)	%	7.0% BDHS.2007	11%	12%
Percentage of Oral pill users (method mix)	%	28.5% BDHS 2007	33%	34%
Percentage of Condom users (method mix)	%	4.5% BDHS 2007	5%	6%
Percentage of Satellite Clinic conducted	%	360,000/ year	100%	100%
Lowest performing (FP) districts monitored	Number	Monthly Report	10 /month	10/month
Unmet need	Rate	17.1% BDHS 2007	12%	9.0%

4.20.6. Budget

Component and Year wise physical and financial target of OPs

Agency: DGFP

Name of the OP: Family Planning Field Service Delivery

(Tk. In Lakh)

Name of the Components/Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit in thousand	FY 2011-16				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1													
Procurement of contraceptive & MSR													
Oral Pill	970 m	0.00	51800.00	25375.00	77175.00	160 m	14850.00	170 m	11900.00	180 m	13650.00	460 m	36775.00
Condom	970m	0.00	11926.00	6480.00	18406.00	150m	1230.00	180 m	2880.00	180 m	3600.00	430 m	10696.00
Injectables	98m	11305.00	20307.00	700.00	32312.00	18 m	4340.00	19 m	6622.00	19 m	6650.00	42 m	14700.00
AD Syringe	107.7m	1877.00	4245.00	120.00	6242.00	19.8m	820.00	20.9 m	1180.00	21 m	1354.00	46 m	2888.00
Safety Box	0.60m	0.00	488.00	0.00	488.00	0.1m	80.00	0.11 m	88.00	0.12 m	96.00	0.27 m	224.00
Povidine Iodine Solution	2m	600.00	0.00	0.00	600.00	0.4 m	120.00	0.4 m	120.00	0.4 m	120.00	0.8 m	240.00
Cotton	2m	400.00	0.00	0.00	400.00	0.4 m	80.00	0.4 m	80.00	0.4 m	80.00	0.8 m	160.00
Sub Total		**14182.00**	**88766.00**	**32675.00**	135623.00		**21520.00**		**22870.00**		**25550.00**		**65683.00**
Procurement of Printing Materials													
Register for Injectables	50	615.00	0.00	0.00	615.00	10	143.00	10	98.00	10	118.00	20	256.00
Register for Oral pill	50				0.00	10		10		10		20	
Register for Condom	50				0.00	10		10		10		20	
Injectables forward Register	50				0.00	10		10		10		20	
Pocket Diary	150				0.00	30		30		30		60	
FWC Manual	4				0.00	4		0		0		0	
Injectables Client Card	5000				0.00	1000		1000		1000		40	
Bag	70	400.00	0.00	0.00	400.00	14	80.00	14	80.00	4	80.00	28	160.00

Name of the Components/Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit in thousand	FY 2011-16				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Umbrella	60	100.00	0.00	0.00	100.00	12	20.00	12	20.00	12	20.00	24	40.00
Uniform (Apron)	150	460.00	0.00	0.00	460.00	30	80.00	30	80.00	0	100.00	60	200.00
Vehicle,(Jeep-46, Motor cycle-500, Bicycle-2100)	46,500 & 2100	4260.00	70.00	0.00	4330.00	5,100,500 pcs	500.00	11,100,400 pcs	1010.00	10,100, 400 pcs	940.00	20,200, 800 pcs	1880.00
Computer & Laptop	14 Pcs	12.00	0.00	0.00	12.00	0	0.00		4.00	0	0.00	0	8.00
Sub Total		**5847.00**	**70.00**	**0.00**	5917.00		**823.00**		**1292.00**		**1258.00**		**2544.00**
Componet-2					0.00								
Organization of Satellite Clinics	1800	3700.00	0.00	0.00	3700.00	360	700.00	360	750.00	360	750.00	720	1500.00
Supply of Furniture for UHFWCs	Existing-3800, New-366	1000.00	0.00	0.00	1000.00	700	200.00	700	200.00	700	200.00	2066	400.00
Tube-well Installation for UH & FWCs	Existing-1200,New-366	100.00	0.00	0.00	100.00	300	20.00	300	20.00	300	20.00	666	40.00
Electrical Equipment for UH & FWCs	Existing-1200,New-366	100.00	0.00	0.00	100.00	300	20.00	300	20.00	300	20.00	666	40.00
Sub Total		**4900.00**	**0.00**	**0.00**	4900.00		**940.00**		**990.00**		**990.00**		**1980.00**
Componet-3					0.00		0.00						
Workshop/Orientation/Refresher	1.83	770.00	0.00	0.00	770.00	16	160.00	16	160.00	16	150.00	32	300.00
Security Guard(Existing Recruitment procedure will be followed)	1.5	6000.00	0.00	0.00	6000.00		1200.00		1200.00		1200.00		2400.00
Improvement/Strengthening of urban Family Planning services		500.00	0.00	5500.00	6000.00		1200.00	0	1200.00	0	1200.00	0	2400.00
Improvement/Strengthening of Family Planning services in Hard to reach areas		1200.00	0.00	0.00	1200.00		200.00		300.00		300.00		400.00
Others		1000.00	0.00	0.00	1000.00		200.00		200.00		200.00		400.00
Sub Total		**9470.00**	**0.00**	**5500.00**	14970.00		**2960.00**		**3060.00**		**3050.00**		**5900.00**
Grand total		**34399.00**	**88836.00**	**38175.00**	**161410.00**		**26243.00**		**28212.00**		**30848.00**		**76107.00**

4.21. Planning, Monitoring and Evaluation of Family Planning (PME-FP)

4.21.1 Introduction

Although Bangladesh is one of the most populous countries in the world, with the highest population density and a low per capita income, the country's demographic and economic indicators have recorded considerable improvement. Overpopulation is one of the main problems in Bangladesh with its limited resources and small land area. Due to population growth, cultivable land is decreasing. From 1981 to 2001, last 20 years cultivable land has been decreasing by approx. 0.98 million hector. Population is doubling in cities in twenty years and in slums in ten years. Replacement level fertility by 2016 is the earliest priority vision of the government. In line with this vision present TFR of 2.7 (in 2007) needs to be reduced to 2.0 to attain Net Reproductive Rate (NRR)=1 by 2016. To achieve replacement level fertility by 2016, corresponding CPR has to be increased to 72% by mid-2016 from 55.8% (in 2007) and also unmet need of eligible couples for FP supplies has to be reduced from 17.1 to 9%. Achievement of replacement level fertility can only be possible by gaining the momentum of the robust FP-MCH program supported by public information and motivation campaigns to bring about overall changes in attitude and awareness creation among all stakeholders which requires multi-sectoral efforts.

The Planning Unit remains, however, responsible for the collection and compilation of the implementation progress of operational plans as an input to the MOH&FW's monthly monitoring of its Annual Development Programs (ADP). As per the Conceptual Framework for HNPSP, the planning Unit of the Directorate General of Family Planning will, during HNPSP, be assuming important additional responsibilities with respect to Local Level Planning /decentralization/de-concentration, support and local-level partnerships for the achievement of sectoral and sub-sectoral goals. Another important aspect of Planning Unit is to assist in conducting Annual Program Review (APR)/Mid Term Review (MTR) by providing information, co-ordination with LDs and Ministry, making suggestions for further improvement of program/project etc .

The Local Level Planning (LLP) for ESP has been introduced during HPSP in order to collect information, make community need assessment, priorities problems and issues at local level. The LLP is also required to strengthen the decision making skill of local level officers & staffs of DGFP and making them capable of preparing their plans. Local-level plans, as prepared annually by local-level managers, will be compiled at the central level. Identified resource requirements and in-service training needs will be incorporated by the concerned Line Director into their Operational Plans as and when necessary. During HNPSP, workshops on local level planning of 64 districts were done.

NGO's are playing an important role for achieving goals of the population sector. In this OP, several steps will be taken to define more precisely how NGO's activities can be integrated into the population sub-sector. About 180 national & local levels NGO's working in the field of RH: FP-MCH service delivery throughout the country. A more effective co-ordination and monitoring mechanism would be developed to achieve the national family planning objectives. Recently DGFP has modified guideline for affiliation & renewal of NGO's with the DGFP.

Family Planning has the vast infrastructure facilities throughout the country. At the end of HNPSDP almost every Union will be covered by UH&FWC with residence facilities from where the rural communities get the RH: FP-MCH services. At district level 61 MCWCs are providing 24 hours RH: FP-MCH services, apart from that 12 Upazila level and 24 Union level MCWC's are situated in different districts.

4.21.2 Objectives

- To facilitate planning process and participate in the formulation of different plans, programs and promote coordination within the sub-sector.
- To monitor program performance in the population sub-sector.



- To strengthen internal co-ordination among different Ops of DGFP to provide timely information required by MOH&FW, Planning Commission, IMED, ERD and other related ministries/agencies for multi-sectoral RH-FP-MCH activities.
- To develop yearly local level plans for hard to reach, low performing and 7 piloting district's Upazilas.
- To develop capacity of the local level managers to accelerate and facilitate the decentralization / deconcentration process.
- To incorporate the budget and activities of the local level plan into the operational/work plans of the relevant OP.
- To monitor the local level plan at the performing Upazilas.
- To strengthen the GO-NGO, stakeholders, public-private partnership and co-ordination with multi-sectoral agencies involved in population and development.
- To improve the capacity of the personnel of DGFP.
- To facilitate better performance of population sub-sector and to enhance efficiency.
- To ensure effective evaluation of the family planning programs under different OPs of DGFP

4.21.3 Components

Component-1: Coordination and preparation of Operational Plans for the population sub-sector

Establishing and maintaining a harmonious relation among the Line Directors and related OP's is the key role of the Planning unit Coordination among the LDs is helpful to find easiest way of solving the problem within the shortest possible time by sharing their knowledge, experience & involvement. Planning unit has been playing its role as a coordinator by organizing regular meetings, workshops, seminars by which it has been considered as a focal point of the development activities of DGFP. This OP is also maintaining liaison on behalf of the DGFP with the MOH&FW, Planning Commission, IMED, ERD and Development Partners related agencies

Following the guideline and assessing the practical need during the course of implementation, different activities have to be incorporated into the OPs to reach the goals within the stipulated time. Hence, designing, preparation, modification of OPs with the related technicalities such as avoiding overlapping, duplication of activities, resources rationalization are part and parcel of the responsibilities.

Component-2: Program Monitoring including APR and MTR

Monitoring is an ongoing process that provides information on whether progress is being made towards achieving the results (output/goals) of the RH: FP-MCH program. This process helps the implementation trends whether it is in right track or not by analyzing the ongoing activities to identify the strength and weakness of the program. It also focuses on input, activities, output and relevance of the program considering current situation. The Planning Unit is also responsible for the collection and compilation of implementation progress of sectoral operational plans & ongoing projects of DGFP as an input to the MOH&FW's monthly monitoring of annual development programs' (ADP) progress. In addition, Planning Unit provides necessary inputs in the Annual Program Review (APR), DAAR indicators and Mid Term Review of the sector Program (MTR).

Component-3: Local Level Planning

Institutionalize a bottom-up planning process for the RH: FP-MCH Services Delivery at upazila- level and below as well as increased decentralization/ de-concentration, mobilize local resources for achieving goals and targets are important to continue activities under this OP. With the present Government's interest to support decentralization as a policy, which is also reflected in the draft national population policy & draft national health policy, 2010 as decentralized planning had found greater acceptance. In this way it can contribute a great opportunity of the local community & stakeholder participation in the preparation of Upazila's plan. Approaches that will be followed for effective local level planning are as follows:

- Planning as per the available local resources and requirements

- Placement of local demand to the respective LDs
- Requesting the LDs to incorporate the LLP requirements to the ADP
- Alignment of the central level budget of DGFP with the LLP
- Ensuring effective monitoring mechanism to get the desired LLP
- Capacity building of the officials, local Govt. representatives and other stakeholders to get desired LLP

Component-4: GO-NGO collaboration

This OP is responsible for the affiliation & renewal of NGO related to RH: FP-MCH Services on behalf of the DGFP. Through this OP better coordination between GO and NGO service delivery at the field level will be established.

Component-5: Strengthening of Planning Unit, DGFP.

Train up and capacity building of the personnel of planning unit, DGFP so that the activities of planning unit can perform better.

Activities:

- Co-ordination/Collaboration with the planning section of the Ministry and Donor Agencies.
- Co-ordination in Preparation of PIP, OPs/Project.
- Contributing in preparation of annual reviews and revisions of Operational Plans for the sub-sector.
- Management of monthly review and monitoring the development program performance in the sub-sector against annual targets of the operational plans.
- Maintaining liaison on behalf of the Director-General (Family Planning) with the Planning Wing, MOH&FW, Planning Commission, IMED, ERD and Development Partners.
- Providing operational support to local level planning and institutionalize a bottom-up planning process for the RH-FP& MCH (Reproductive health, Family Planning & Mother and child health) Services Delivery at upazila-level and below through LLP.
- Updating the LLP Toolkit reflecting the following changes:

  3-year planning cycle;

  - Clearly spelt out responsibilities of the LLP Core Cell in arranging resource envelope and providing feedback to the local-level; budget demands as per OPs;
  - Complementation of goals and activities between the field-level services provided by the two Directorates;
  - Role of the community especially of the elected representatives of local government at Union and Upazila levels.
  - Introduction of changes in the various support systems:
  - Increased delegation of administrative and financial power to the cost centers,
  - Capacity building, including short training on administrative, management and financial management,
  - Developing performance indicators and evaluation mechanism,
  - Guidance and mentoring by the two Directorates and Meeting the needs for human resources, drugs and equipment.
  - Introducing joint review of non-development and development expenditure in the Ministry as well as in the Directorates on a monthly basis.
  - Involving the field level cost centers in the preparation and management of development budget, similar to their current involvement in the preparation of non-development budget.
  - Establishing new coordination section in the MOHFW and at the Directorate level to facilitate preparation and use of single work plan.
  - Incorporation of the budgets and activities of the LLP into the OP/ WP of the relevant LDs.



- Assist in other types of independent financial and activity monitoring, review and evaluation.
- Supporting community-participation, local level co-operation with NGOs, mobilize local resources for achieving set- goals and targets, stakeholder involvement, other public-private partnerships and co-ordination with multi-sectoral agencies involvement in RH-FP-MCH.
- Planning for Medium Term Budget Framework.
- Half-yearly monitoring of the program under different Ops.

4.21.4 Cross Cutting Issues

Linkage & sharing with other LDs about LLP findings & ways to materialize. OP-All of DGFP, PMR-DGHS & SWPMM

- Sharing & preparation of budget of LLP piloting Districts & Upazilas with other LDs. OP- PMR-DGHS, MCRAH, PFD & SWPMM
- Alignment of sector wide program management & monitoring activities done by MOH&FW with DGFP –OP- All DGFP OP & SWPMM.

4.21.5 Indicators

In particular, the proposed activities contribute to Result 2.2 strengthening monitoring and evaluation system and Result 2.8 decentralization through LLP procedures.

Indicators	Unit of Measurement	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
Number of upazilas prepared Local Level Plan (LLP) in Hard to reach & low Performing areas.	Number of Upazila	NA	146 Upazila/year Total 438 Upazilas plan	146 Upazila/year Total 730 Upazilas plan
Number of piloting & functional LLP (7 districts).	Number of District	6 Districts (2009-2010)	7 Districts/year Total 21times	7 Districts/year Total 35 times
Number of Upazilas having functional LLP monitored.	Number of monitoring report	42 Upazilas (2010-2011)	188 Upazila/year Total 564 times monitoring	188 Upazila/year Total 940 times monitoring
% of annual work plans with budgets submitted by LDs by defined time period (July/Aug)	Number of annual work plans	9 Ops (2009-2010)	7 OPs/year Total 21times	7 OPs/year Total 35times
Preparation of Annual Performance Report.	Number of report	9 Ops (2009-2010)	7 OPs/year Total 21times	7 OPs/year Total 21times
Monitoring of financial & physical progress of OPs by reporting formats.	Number of monitoring meeting.	8 (2009-2010)	12 Meeting/year Total 36 times	12 Meeting/year Total 60 times
Monitoring of family planning activities implemented by NGOs/ Private organization.	Number of NGOs/CBOs	NA	40%	50%



4.21.6 Budget

Component and Year wise physical and financial target of OPs

Agency: DGFP

Name of the OP: Planning, Monitoring & Evaluation -FP

(Tk in Lakh)

Name of Components/ Major Activities	Total Physical & Financial Target					Year-1		Year -2		Year-3		Year-4 & 5	
	Physical Unit	Financial				Physical Unit	Finan.	Physical Unit	Finan.	Physical Unit	Finan.	Physical Unit	Finan.
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Components 1: Strengthening of Planning Unit, DGFP													
Pay and allowance of Project Personnel	8 Person	75.00			75.00		13.300		14.45		15.27	0	31.98
Office Operating cost		43.00			43.00		7.050		9.50		7.93	0	18.52
Sub Total		**118.00**	**0.00**	**0.00**	**118.00**	**0.00**	**20.35**	**0.00**	**23.95**	**0.00**	**23.20**	**0.00**	**50.50**
Components 2 : Local Level Planning					0.00							*0*	*0.00*
Toolkit Modification & Finalization Workshop	2 Batch		1.50		1.50	1	0.750			1	0.75	0	0.00
Toolkit Printing	3000 Nos		2.40		2.40	1710	1.360			1290	1.04	0	0.00
Carrying cost of Toolkit & Accessories at upazial level	940 Set		0.75		0.75	188	0.150	188	0.15	188	0.15	376	0.30
Core LLP Team orientation Workshop	1 Batch		1.00		1.00	1	1.000					0	0.00
Upazila stakeholder & plan preparation workshop.	940 Nos		94.00		94.00	188	18.800	188	18.80	188	18.80	376	37.60
Support to community mobilization & participation of LLP activities at community clinic.	6320 ,,		519.00	50.00	569.00	1075	96.920	1135	102.40	1270	114.18	2840	255.50
Workshop on redesigning & Finalization of LLP Monitoring tool.	2 Batch		1.30		1.30	1	0.650	1		1	0.65	0	0.00
Printing of LLP monitoring tool	2000 Nos		0.60		0.60	1150	0.340			850	0.26	0	0.00
Monitoring supervision of LLP activities	1880 ,,		65.00		65.00	285	10.000	430	15.00	415	14.00	750	26.00
Meeting for review & Finalization upazilas plan at district level	110 ,,		4.40		4.40	22	0.880	22	0.88	22	0.88	44	1.76

Name of Components/ Major Activities	Total Physical & Financial Target					Year-1		Year -2		Year-3		Year-4 & 5	
	Physical Unit	Financial				Physical Unit	Finan.	Physical Unit	Finan.	Physical Unit	Finan.	Physical Unit	Finan.
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Data entry & report writing at upazilas plan monitoring tool at H.Q.	5 Nos		3.05		3.05	1	0.650	1	0.60	1	0.60	2	1.20
Dissemination Workshop on LLP report	5 Batch		2.00		2.00	1	0.400	1	0.40	1	0.40	2	0.80
Abroad training on planning & Development.	2 ,,			40.00	40.00					2	40.00	0	0.00
Technical Assistance (TA) for Strengthening LLP*	12MM			10.00	10.00	6	5.000	6	5.00			0	0.00
Sub Total		**0.00**	**695.00**	**100.00**	**795.00**	**4629.00**	**136.90**	**1972.00**	**143.23**	**4229.00**	**191.71**	**4390.00**	**323.16**
Components 3 : Co-ordination & preparation of OPs for the population sub-sector					0.00							*0*	*0.00*
Workshop on preparation of OPs.	5 Batch		2.50		2.50	1	0.500	1	0.50	1	0.50	2	1.00
Sub Total			**2.50**	**0.00**	**2.50**	**1.00**	**0.50**	**1.00**	**0.50**	**1.00**	**0.50**	**2.00**	**1.00**
Components 4 : Program Monitoring including APR & MTR					0.00							*0*	*0.00*
Program Monitoring workshop	5 Batch		2.50		2.50	1	0.500	1	0.50	1	0.50	2	1.00
Sub Total			**2.50**	**0.00**	**2.50**	**1.00**	**0.50**	**1.00**	**0.50**	**1.00**	**0.50**	**2.00**	**1.00**
Components 5 : Procurement of goods					0.00							*0*	*0.00*
Computer & Accessories.	16 Nos	7.50			7.50	7	3.750	3	1.25	3	1.25	3	1.25
Office Equipment & Machineries	6 ,,	6.50			6.50	3	2.000	1	2.00	1	2.00	1	0.50
Furniture	60 ,,	8.00			8.00	15	2.900	6	1.80	21	1.55	15	1.75
Motor Vehicles.	1 ,,	60.00			60.00	1	60.000					0	0.00
Sub Total		**82.00**	**0.00**	**0.00**	**82.00**	**26.00**	**68.65**	**10.00**	**5.05**	**25.00**	**4.80**	**19.00**	**3.50**
		200.00	700.00	100.00	1000.00	4657.00	226.90	1984.00	173.23	4256.00	220.71	4413.00	379.16

* Fund will be provided from SWPM, MOH&FW.

4.22. Management Information Systems of Family Planning (MIS-FP)

4.22.1 Introduction

Bangladesh is the most densely populated country in the world having population around 155 million. Family Planning program was first introduced in this country in the early 1950s through voluntary efforts and the Government took Family Planning as a government program in 1965. Recognizing the importance of reducing fertility rate Government attached priority on Family Planning programs.

During the HNPSP period, MIS system was established for the record keeping and reporting systems at the grass root level to generate RH-FP-MCH performance data. Monitoring and supervision system was implemented for overall FP-MCH services. MIS helps to ensure better monitoring and supervision which helped to achieve Contraceptive Acceptance Rate (CAR) increased from 62 percent to 73 percent and CPR (Contraceptive Prevalence Rate) increase from 52 percent to 58 percent. MIS introduced innovative approaches to strengthen and institutionalize data collection, collation, storage and transmission to the MIS headquarters for publication of analytical reports for dissemination to different national and international organizations. Notable among the steps taken to strengthen reliable data gathering were the distribution of national FP-MCH projection to different upazilas, introduction of a longitudinal data collection mechanism through FWA registers, different clinic registers and reporting formats, periodic couple registration and survey by MIS personnel and performance monitoring in high and low performing areas.

At the verge of completion of Health, Nutrition and Population Sector program (HNPSP), a comprehensive program for better utilization of the data through web-based system was planned in the operational plan. A considerable amount of fund was allocated to execute the planned activities. A country wide internet access was planned to be established by installing web based software. The formulation of Sector Approach OP matching the upcoming 6th Five Year Plan is envisaged keeping fund provision to make the MIS system digital. For family planning service statistics, online database software will be put into the web-server. Accordingly, generated data will be operational through website. A web portal will be a strong communication channel through which an effective feedback system to data providers and data senders will be enhanced. There is a scope to generate PRS/ MDGs related indicators for monitoring the RH-FP-MCH activities. Moreover, the operational plan will help to strengthen the following strategies:

- Reviewing and promoting effective method mix through the generation of routine service statistics data on continuous basis;
- Improving performance monitoring systems through the utilization of services data;
- Identifying the high, medium and low performing areas and take appropriate actions accordingly;
- Generating output/input indicators related to RH-FP-MCH for monitoring program activities
- Measuring the progress of health and population variables related to MDGs through the generation of routine data
- Avoiding duplications with ongoing similar activities under other ministries/agencies such as BBS, MOPA, SICT project etc.

4.22.2 Objectives

- To generate valid, accurate and quality information/data on RH-FP-MCH services, logistics and personnel from all levels of Service Delivery Points (SDPs);
- To develop national plan, formulate, strengthen and evaluate the progress of RH-FP-MCH on the basis of evidence based data;
- To monitor the program and its strengths and weaknesses in a more systematic way.

4.22.3 Components

1 Service Statistics (SS)
2. Logistics Management Information Systems (LMIS)



3. Personnel and Hospital Management Information Systems (PHMIS)

Component –1: Service Statistics (SS)

Service Statistics is the main source of Family Planning performance data at the National level. This component deals with close monitoring of the RH-FP-MCH services. Geographically, the country is divided into 23,500 working units for the purpose of FP services. The field workers unit consists of 5-6 thousand populations with an average of around 1000-1100 eligible couples. Each worker is assigned the task of visiting all the eligible couples in her unit within a period of two months. There was provision for updating eligible couples for three years after initial registration. Field workers keep track of eligible couples in their assigned catchments areas. Data on current use of contraceptives are being recorded continuously in the Field Workers Record Keeping Book (FWA Register). The main feature under this system is the derivation of contraceptive estimates by village, ward/unit (i.e. by workers), union, sub-district, division and national levels. Besides, pregnancy estimates, births and deaths (all deaths) vaccination status of mothers and children and monthly stock balance of contraceptives, etc. are recorded through the system. For reporting of information from the Field Workers Record Keeping Books (FWA Register), five types of reporting forms are used at different levels under the system. This process of reporting system will continue. The main objectives of the Service Statistics are:

- To ensure regular flow of information and facilitate the program monitoring;
- Timely publication of MIS reports;
- Implementation of different types of recording & reporting tools throughout the country;
- To identify low performing areas and causes of low performance to help formulate strategies for improving program performance;
- To strengthen overall capability of MIS in producing periodical reports and statements for meeting the increasing demands of RH-FP-MCH information;
- To enhance data processing capability of MIS;
- Data collection and reporting to be gender-disaggregated whenever relevant from a gender-equity perspective;
- To developing GIS for improving monitoring and HRM; and
- To design an integrated MIS consolidating data from a range of sources of service delivery.

Activities

- Design, develop, print & implement FWA register throughout the country for improved recording and reporting of service statistics
- Validate and improve recording and reporting on sample basis for assurance of quality data;
- Collect, compile, analyze and publish report on couple registration data;
- Procure and install computers with its accessories in phases at different levels
- Provide back-up support to keep computers operational, already installed in the Upazila/District/Divisional Family Planning offices, Directorate of FP and MOHFW through regular maintenance and providing computer consumable items.
- Establish a full-fledged computerized systems and its networking through LAN and WAN (at least HQ to District level) in phases at different level.
- Linking with DMIS

Component – 2: Logistics Management Information Systems (LMIS)

This component deals with the Logistic Information Systems. This sub-system helps to generate key indicators for logistic management and to prepare a computer data base for stock out, Desired Inventory Level (DIL) and shelf life of major life saving drugs and contraceptive etc. Currently data of LMIS (FP) are being collected through web based computerized system. After processing and analyzing, a report on LMIS (FP) is being published monthly. LMIS formats have been redesigned in light of RH-FP-MCH policy to collect information from different levels on LMIS. The main objectives of this sub-system are:

- To publish LMIS monthly report;

- Inventory management of different commodities of family planning directorates
- To verify LMIS data inconsistency at different levels.

Activity

- Implement updated LMIS reporting formats
- Print LMIS reporting formats
- Develop customized software according to program need
- Publish LMIS monthly report regularly

Component – 3: Personnel and Hospital Management Information Systems (PHMIS)

PMIS is one of the important sub-systems of MIS. Based on the previous family planning experiences, a new design of forms and formats for class-I & class-II officers and class III & IV staffs have been developed. These are printed and distributed to the concerned officers and staffs. PDS is being updated on continuous basis. PMIS report to be used for human resources management and other administrative purposes. Under this component MCHTI and MFSTC will be automated to provide better services. The main objectives are:

- To publish yearly PMIS report.
- Utilization of PMIS for human resources management.
- Introduction of automated system for hospital service improvement.

Activities:

- Establishing Personnel Management Information System for management of RH-FP-MCH program;
- Design, develop, print and distribute Personnel Data Sheet (PDS) for class- I to Class-IV for all levels;
- Regular updating of PDS; and
- Introduce computerized automated system at MCHTI and MFSTC (National Level) with automated MIS system.

4.22.4 Cross Cutting Issues

i) Promote training of staffs on Data and IT –OP-TRD & HRM

4.22.5 Indicators

The activities under this OP contribute towards all the results under Component 1, Service Delivery improved, and many of the results under Component 2, Strengthened Health Systems. In particular, the activities will work towards achievement of Result 2.2, strengthened monitoring and evaluation systems, and Result 2.3, improved human resources, planning, development and management.

OP level indicators (Output/Process)

Sl no	Indicators	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
1	MIS reports (FP, Child, Reproductive Health and LMIS) published and disseminated	12 per year	36	60
2	Number of Laptop supplied and used for reporting purpose (HQs 96, Division 7, District 64, UFPO 483 and Union level up-graded UH&FWC 2050)	NA	2650	2700
3	Percentage of district and upazila submitting complete service statistics electronically (web-based reporting) monthly	NA	100%	100%
4	Number of FWA Register (7th & 8th Edition) & Reporting Forms printed and made available	6th Edition, Jan 2010	48000	96000
5	Number of Field Workers & Supervisors trained on FWA Register (7^{th}/8th Edition)and Reporting Forms	NA	32500	65000
6	Number of personnel trained on computer operation (HQs, Districts & Upazilla level)	NA	2000	3000
7	Established hospital automation in MCHTI & MFSTC	NA	2	-

4.22.6 Budget

Component and Year wise physical and financial target of OPs

Agency: DGFP

Name of the OP: Management Information System-FP

(Tk in Lakh)

Name of the Components/Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Service Statistics (SS)													
Training Expenses	68000 Person	260.00	475.00		735.00	650	50.00	33150	215.00	1300	115.00	32900	355.00
Printing and Publication	96000 Pcs	380.00			380.00	48000	150.00		10.00		10.00	48000	210.00
Consultancy	48 Man/month	0.00	40.00		40.00		0.00	1	10.00	1	10.00	2	20.00
Procurement of Vehicle	01 Nos.	80.00			80.00		0.00	1	80.00		0.00		0.00
Procurement of Machinery and other equipment	30 Nos. LCD Monitor=04, Digital Podium=01 CC Camera &TV=01,PhaocopierMachine=04(2Color), Digital Attendances=03,AC, Fridge & Others=17	63.00			63.00	11	26.00	7	19.00	4	6.00	8	12.00
Procurement of Computer and Accessories	8172 Nos. Laptop=2700,Printer=2700, Modem=2700,Server=02, Scanner=08,Color Printer=08, UPS=52,M.Projecter=02	543.00	1378.00		1921.00	1912	450.00	3911	928.00	2111	497.00	238	46.00
Procurement of Computer Software	31 Nos.	155.00			155.00	3	15.00	7	35.00	7	35.00	14	70.00
Developing GIS for improving monitoring and HRM	Countrywide		500.00		500.00				100.00		200.00		200.00
Procurement of Furniture	1001 Nos.	67.00			67.00	1 Set	7.00	250	15.00	250	15.00	500	30.00
Procurement of Tele-communication equipment		0.00		100.00	100.00		0.00		100.00		0.00		0.00
Logistics Management Information System (LMIS)													
Pay and Allowance (Officer & staff)	35 Person	440.00			440.00		20.00		60.00		120.00		240.00
Seminar /Workshop/Conference	20 Nos.	20.00	60.00	20.00	100.00	8	40.00	3	15.00	3	15.00	6	30.00

Name of the Components/Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Computer Consumable Items		30.00	60.00		90.00		10.00		20.00		20.00		40.00
Supply and Services		260.00	200.00	80.00	540.00		30.00		105.00		135.00		270.00
Other Expenses		96.00	0.00		96.00		8.00		22.00		22.00		44.00
Special Expenses		52.00	0.00		52.00		7.00		15.00		10.00		20.00
Personnel & Health Management Information System (PHMIS)					0.00								
Maintenances of Motor Vehicles (3 Vehicles)	03 Nos.	10.00	0.00		10.00	3	2.00	3	2.00	3	2.00	6	4.00
Maintenances of Furniture and Fixture		13.00	0.00		13.00		1.00		3.00		3.00		6.00
Maintenances/Replacement of existing computer and accessories & Others	600 Nos.	100.00			100.00	100	20.00	100	20.00	100	20.00	300	40.00
Other Repair and Maintenance		18.00			18.00		2.00		4.00		4.00		8.00
Automation of MCHTI & MFSTC	2 Nos	0.00	300.00	0.00	300.00		100.00	1	100.00	1	100.00		0.00
Total	**173524**	**2587.00**	**3013.00**	**200.00**	**5800.00**	**50687**	**938.00**	**37433**	**1878.00**	**3779**	**1339.00**	**81974**	**1645.00**

4.23. Information, Education and Communication (IEC)

4.23.1 Introduction

The provision of Information, Education and Communication (IEC) on selected health, family planning and nutrition issues has been one of the key interventions for more than four decades. This program on communication activities has resulted in raising awareness and has contributed to a greater use of key health, family planning and nutrition services in the country.

Since inception, Information, Education and Motivation (IEM) unit, under the then Directorate of Population Control in the late '70s, there had been made quite a good impact through IEC activities in increasing CPR, reducing TFR, IMR, MMR and under 5 mortality, to improve nutritional status and reproductive health status, eliminate social violence against poor specially women and children, establish gender equity and awareness building on HIV/AIDS and STD. But still, we could not achieve our goal at desired level. Realizing the importance of electronic media for strengthening the IEC program, Government established separate population cells under Bangladesh Betar and Bangladesh Television during mid 1970s and early 1980s. From that time Bangladesh Betar and Bangladesh Television have also been working to raise the awareness level on FP-MCH through population cells funded by IEM unit. Now Bangladesh Betar broadcast 460 minutes program on ARH, FP-RH, gender issues, HIV/AIDS etc throughout the country (Dhaka and other 10 sub centers). Bangladesh Television also telecast 25 minutes programs daily on ARH, FP-RH, gender issue, HIV/AIDS etc

Besides these, to narrow the gap between knowledge and practice ; IEM unit produce and disseminate many cinema slides, TV spots, TV magazine, TV talk show, TV dramas, TV serials, short films, music video, audio video cassettes/CDs/DVDs on family planning, mother and child health, adolescent reproductive health, gender issue, violence against women and women empowerment.

To disseminate the message to the target audience, other IEC activities of the unit such as: installation of bill boards, hoardings, banners, festoons, posters, books, booklets, flip charts, leaflets, stickers, brochures, souvenirs, gas balloons, observance of special days, weeks, fortnights, organizing exhibitions and fairs. IEM unit also conducted a number of research activities, developed curriculum for different TOTs, field based orientation and skill development on counseling & interpersonal communication (IPC).

IEM unit regularly disseminate population and FP-MCH related information from field to national level as well as print & electronic media. The in-house production capacity of IEM unit was elevated to meet the needs of field based IEC print materials. IEM unit regularly publish and disseminate manuals and newsletters such as Porikrama (Bangla news letter) etc.

In the next sector program intensive IEC activities will be under taken with special emphasis on IPC and innovative IEC activities such as a) Broadcasting of FP-MCH messages through private TV & radio channels b) Production of TV magazine and telecasting through TV channels c) Country wide awareness building campaign for newborn care, breast feeding, supplementary food, immunization, personal hygiene d) Musical show on FP-MCH & Gender issue in 7 divisions using local team with local dialect e) Motivational Program on FP, MCH, RH & gender issue through street drama in local dialect in 3 hill districts f) Family Planning campaign through foot ball tournament g) Message dissemination on FP & MCH through electronic bill board/television at division level are design to further strengthen the FP-MCH Program and to achieve the goals of next sector Program as well as MDGs & Vision 2021.

The National Communication Strategy for Family Planning and Reproductive Health has been developed and accordingly IEC activities for the year 2011-2016 have been considered. This will promote MCH-FP based services as well as provide need based IEC support and increase community participation in the ongoing family planning Program. Proximate IEC intervention has been incorporated in the next "Health, Population and Nutrition Sector Development Program (HPNSDP)" which will play key role to:

i) Reduce NMR ii. Reduce IMR, iii. Reduce under five mortality rate iv) Reduce MMR, v) Reduce TFR, vi) Increase CPR, vii) Increase Life Expectancy.

4.23.2 Objectives

- To provide IEC support for optimum utilization of FP-MCH-RH and Nutrition services;
- To support in changing attitude among the people on long acting contraceptive methods and prompt male participation.
- To provide IEC support to the users to reduce discontinuation of using contraceptives without valid reasons.
- To create awareness on FP-MNCH-RH, specially contraceptive methods for newlywed and low parity couples.
- To create awareness about the deleterious effect of early marriage among the adolescent/unmarried and develop positive attitude among them towards delayed marriage;
- Capacity development of IEM
- To extend IEC support to hard-to-reach areas (char, haor, baor & hill) and disseminate family planning/reproductive health messages among the inhabitants specially couples of those areas and also among the hard core groups, urban slum dwellers and the disadvantaged groups;
- To address the issues like violence against women and children, Gender equity, and Adolescent Reproductive Health through different IEC interventions;
- Promote community ownership through community participation, collaborate with local govt. agencies/representatives and involve NGOs in various IEC campaign and related activities; and
- To increase IPC skills among the service providers for better counseling, motivation and quality care services.
- Awareness development on using condom to prevent STD/HIV/AIDS

4.23.3 Components

Component-1: Awareness, Sensitization and Motivation

Under this component target audience will be aware on FP, MCH, Nutrition and Gender issues through skill development workshop, meeting, seminar and FP campaign. This will help in creating demand for FP, MCH services and as a result, CPR will increase and TFR, IMR & MMR will be decreased.

Activities

- Awareness building campaign for delayed marriage, delayed first child, birth spacing at district level
- Awareness building campaign for long acting and permanent method, reducing dropout & promotion of service centers to ensure quality services.
- Orientation workshop for stakeholders (elected representatives, different occupational groups and community management groups of community clinic from upazila & union) on FP, MCH, ARH, HIV/AIDS, Nutrition and gender issue etc
- Motivational meeting for Newlywed and Low-parity couples on FP, MCH, RH, safe motherhood, birth- spacing and Nutrition in the low-performing upazila and hard-to reach area
- Skill development workshop on IPC for service providers (FWA, FPI, FWV, SACMO etc.)
- Orientation workshops on adolescent health care and Nutrition at school (Class VIII-X)/youth forum
- Orientation workshop for school and madrasha teachers, marriage registrar and religious leaders/Imams and UP chairman on FP-MCH and Nutrition
- Awareness building campaign for newborn care, breast feeding, complementary/supplementary food, immunization, personal hygiene and nutrition at district level
- Orientation workshop for upazila level all officers on FP-MCH, safe motherhood and Nutrition
- Awareness building campaign for Adolescent health, ANC, safe delivery, PNC, institutional delivery and nutrition
- Observance of World population day, recognition of best manager, service provider, service centers, upazila, union parishad and NGOs etc

- Observance of service week,
- National FP campaign throughout the country
- Campaign on safe motherhood at MCWCs
- Observance of other special events and other National days
- Orientation program on MCH-FP for Sylhet and Chittagong and other hard to reach areas

Component-2: Capacity building and Logistic Support

The communication skills and capacity of the officials of IEM unit of DGFP and field level who are involved with the development, printing and disseminating IEC materials throughout the country with various IEC activities will be developed/ updated. Besides, technical skills of projectionists, mechanics, press staffs on audio-visual equipments, will be improved through various activities of this OP.

Activities

- Procurement of AV van
- Procurement of multimedia & laptop/Computer
- Procurement of digital camera
- Procurement of furniture
- Modernization of IEM press
- Supply and services and maintenance & other recurrent cost
- Orientation for projectionist on multimedia & laptop

Component-3: Production, distribution and Display of IEC materials

Under this component various types of IEC materials such as bill boards, neon signs, electronic boards, trivisions, short films, TV spots, TV drama, TV magazines, posters, leaflets, brochures, prorikroma etc. will be produced and will be displayed throughout the country. These activities will help to create awareness among the people on FP, MCH, Gender and Nutritional issues.

Activities

- Message dissemination on FP & MCH through hoardings/ bill boards at upazila level
- Production of different IEC materials on FP, MCH, ARH, HIV/AIDS and gender issue, violence against women and Nutrition
- Short film
- TV drama (13 episode)
- TV magazine
- TV spots
- Advertise through news paper to disseminate message on FP, MCH & RH/messages dissemination through newspapers
- Message dissemination on FP & MCH through electronic bill board/ trivision in division level
- Designing and printing of posters/ of leaf lets/ booklets/ brochures
- Publication of “Parikroma (Bangla news letter) ” quarterly

Component-4: Media Campaign and Transmission

Organizing media campaign through IEC activities such as broadcasting of FP-MCH messages through TV and radio channels, musical show (folk song/ jari gan) and street drama on FP-MCH & gender issue using local team with local dialect, family planning campaign through football tournament, film show by AV van under this component will create awareness and demand of FP-MCH services and will increase utilization of service centers.

Activities

- Radio program through Population Cell of Bangladesh Betar
- Radio program through all private FM radio channel

- BTV program through Population Cell
- Media campaign through all private TV channels
- Country wide film show program by using audio-visual van
- Motivational program on FP, MCH, RH & Gender Issue through folk song, jarigan & pot singing (Region focused)
- Motivational program on FP, MCH, RH & gender issue through street drama in 3 hill districts & Sylhet
- Family Planning campaign through football tournament at division/district level
- Musical show on FP-MCH & gender issues in 7 divisions using local team with local dialect division

Component-5: Survey, Monitoring and Evaluation of IEC activities

Well organized survey will be carried out under this component to see the impact of the different IEC activities including Program broadcasted by Population Cell of Bangladesh Betar and BTV as well as to see the expected level of behaviour change among the clients those who will receive the services from all service delivery points..

Activities

- Impact survey of IEC activities

4.23.4 Cross Cutting Issues

1) IEC is integral part of all DGFP services OP MCRAH, CCSD & FPFSD
2) Integration with Nutrition services OP NNS

4.23.5 Indicators

Linkage with results FW: The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. In particular, the activities under this OP contribute to achieving Result 1.1, increased utilization of essential HPN services, and Result 1.3, improved awareness of healthy behaviors.

Indicators (s)	Unit of Measurement	Baseline (with year and data source)	Project Target	
			Mid-2014	Mid-2016
1	2	3	4	5
1. Number of FP Campaign organized	Number	950 (2003-2008) LD IEC / DGFP quarterly repot	a) District level - 288 b) Upazila level – 161	a) Distinct level - 576 b)Upazala level - 1127
2. Number of workshop organized	Number	1163 (2003-2008) LD IEC / DGFP quarterly repot	a) Upazila level - 1593	a) Upazala level - 6071
3. Number of IEC materials produced, telecasted, display, disseminated	Number	545 (2008-2010) LD IEC / DGFP quarterly repot	Short film = 03 TV drama = 02 TV magazine : = 01 TV spots =15 Radio Program = 30,600 Folk Song :2,600 (3 years) Street drama =15 TV Program =2,408 - Bill board-500	Short film = 05 TV drama = 02 TV magazine = 02 TV spots = 25 Radio Program =56400 Folk Song = 4,178 Street drama = 45 TV Prog = 3,814 Electronic bill boards = 14 Bill board-534
5. Number of	Number	48 (2008-2010), LD	Advertisement 300	Advertisement 620

Indicators (s)	Unit of Measurement	Baseline (with year and data source)	Project Target	
			Mid-2014	Mid-2016
1	2	3	4	5
advertisement published in the National dailies		IEC / DGFP quarterly repot		
6.Family planning campaign through foot ball tournaments	Number	-	50	Football tournaments 128
7.Musical show on FP-MCH & gender issues using local team with local dialect organized	Number	-	12	Musical show = 28

4.23.6 Budget

Component and Year wise physical and financial target of OPs

Agency: DGFP

Name of the OP: Information, Education and Communication-FP

(Tk in Lakh)

Name of the Components/Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3)		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physica Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Awareness, sensitization and motivation													
Country wide awareness building Campaign on FP, MCH, ARH, HIV/AIDS, Nutrition and gender issue etc,population and adolescent health care etc.	1703	0.00	687.62	396.06	1083.68		0.00	192	205.00	353	272.62	1158	606.06
Orientation workshop for stakeholders (elected representatives, different occupational groups and community management group of community clinic from upazila & union) on FP, MCH, ARH, HIV/AIDS, Nutrition and gender issue etc,population and adolescent health care and Nutrition at school etc.	3413		912.70	396.06	1308.76	232	95.20			635	211.22	2546	1002.34
Motivational meeting for Newlywed and Low-parity couples on FP, MCH, RH, safe motherhood, birth-spacing and Nutrition at low-performing,upazila level all officers on FP-MCH, safe motherhood and Nutrition	1450	96.80		396.06	492.86	242	48.40			242	48.40	966	396.06

Name of the Components/Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3)		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physica Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Skill development workshop on IPC for service providers (FWA, FPI, FWV, SACMO etc.)	1208	99.22		396.06	495.28	242	99.22					966	396.06
Observance of World population day, recognition of best manager, service provider, National FP media award, service centers, union parishad and NGO etc, service week, safe motherhood day at MCWC, special events and other National days	368	114.00	154.00	650.00	918.00	2	74.00	144	186.60	74	155.80	148	501.60
T.A For National IEC Campaign				560.00	560.00			1	150.00	1	150.00	2	260.00
Sub total	**8146**	**310.02**	**1754.32**	**2794.24**	**4858.58**	**718**	**316.82**	**337**	**541.60**	**1305**	**838.04**	**5786**	**3162.12**
Capacity building and Logistic Support													
Salary support of officers and staffs of IEM Unit, Supply and services and maintenance & other recurrent cost	105 Persons	785.38			785.38	105	130.38	105	145.00	105	160.00	105	350.00
Orientation for projectionist on multimedia & laptop	1	4.00			4.00							1	4.00
Procurement of AV van, multimedia & laptop & Computer, camera,furniture	131	1101.00			1101.00	26	220.00	27	225.00	26	220.00	52	436.00
Modernization of IEM press		200.00			200.00				100.00		100.00		
Sub total	**132**	**2090.38**	**0.00**	**0.00**	**2090.38**	**26**	**350.38**	**27**	**470.00**	**26**	**480.00**	**53**	**790.00**
Production, distribution and Display of IEC materials													

Name of the Components/Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3)		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physica Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Message dissemination on FP & MCH through hoardings/ bill boards at upazila level,IEC materials	548	153.86	895.80		1049.66	7	250.00	258	200.00	256	250.00	27	349.66
Advertise through News paper to disseminate message on FP, MCH & RH ,Designing and printing of Posters/ of Leaf lets/ Booklets/ brochures	620	790.00		70.00	860.00	140	125.00	140	150.00	140	175.00	200	410.00
Publication of Parikroma (Bangla news letter) quarterly	500000				0.00	100000		100000		100000		200000	
Subtotal	**501168**	**943.86**	**895.80**	**70.00**	**1909.66**	**100147**	**375.00**	**100398**	**350.00**	**100396**	**425.00**	**200227**	**759.66**
Media Campaign and Transmission													
Radio Program through Bangladesh Betar & private channel	56400	1161.74	250.00		1411.74	11280	305.00	11280	351.00	11280	302.00	22560	453.74
TV Program through pop. Cell & private channel	3814	395.00	1258.00		1653.00	770	357.00	836	287.00	736	338.00	1472	671.00
Film show Program by audio-visual van	22000	154.00			154.00	3000	21.00	3500	24.50	4500	31.50	11000	77.00
Motivational Program folk song, jarigan & pot singing show, street drama in 3 hill districts and sylhet division	4178		689.88		689.88	833	125.00	900	135.00	815	142.50	1630	287.38
Family Planning campaign through football tournament	128			317.88	317.88							128	317.88
Musical show on FP-MCH & gender issues in 7 divisions using local team with local dialect	28			317.88	317.88							28	317.88
Campaign on FP, MCH, RH & Gender Issue through big corporate bodies					0.00								

Name of the Components/Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3)		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physica Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Procurement of machinery & furniture for Population Cell in B.B & BTV	LS	67.00			67.00		2.00	1	56.00		5.00		4.00
Subtotal	**86549**	**1777.74**	**2197.88**	**635.76**	**4611.38**	**15883**	**810.00**	**16517**	**853.50**	**17331**	**819.00**	**36818**	**2128.88**
Survey, Monitoring and Evaluation of IEC activities													
E.Survey, Monitoring and Evaluation of IEC activities	2		30.00		30.00			1	15.00			1	15.00
Subtotal	2	0.00	30.00	0.00	30.00	0	0.00	1	15.00	0	0.00	1	15.00
Grand Total	**595997**	**5122.00**	**4878.00**	**3500.00**	**13500.00**	**116774**	**1852.20**	**117280**	**2230.10**	**119058**	**2562.04**	**242885**	**6855.66**

4.24. Procurement, Storage and Supply Management (PSSM-FP)

4.24.1 Introduction

The Family Planning Program has made remarkable progress over the years due to political commitment, innovative program approach, Government and Non-Government collaboration and commitment of the field functionaries.

Procurement, Storage and Supply Management program (PSSM-FP) of the Directorate General of Family Planning continues to play a vital role in the successful implementation of the entire Family Planning program. It is the responsibility of the unit to procure and supply all the contraceptives and reproductive health commodities to the Service Delivery Points (SDPs) throughout the country in the right time and in right quantity at the least possible cost.

During the HNPSP period PSSM-FP unit has procured contraceptive items like low dose oral pills, condoms, IUDs, Implants and MC-RH commodities such as Drugs and Dietary Kits, Medical and surgical requisites, instruments and equipment etc through international and national competitive bidding process according to the requirement of the concerned Line Directors under DGFP as per their operational plans. In this way PSSM-FP program is contributing in the realization of objectives of various line directors and the overall goals of the DGFP.

In future, keeping in mind the Millennium Development Goals and Vision-2021 PSSM-FP program of DGFP will make all efforts to contribute to the attainment of Reproductive Health Commodity Security in the country. In order to achieve this goal, the program will work as a support service provider to other Line Directors of Directorate General of Family Planning in the execution of their Operational Plans, also aims at introduction of e-procurement and automation of the Procurement and Supply Management System. The PSSM-FP has installed two soft-wares for inventory management namely Warehouse Inventory Management System (WIMS) and Upazila Inventory Management System (UIMS) in all Warehouses and 124 selected upazila family planning stores successfully. To monitor the status of DGFP procurement packages, a web based tool called 'Procurement tracker' and to monitor DGFP national and regional level logistics data another web based tool called 'LMIS'(Logistics Management Information System) have been formally launched in February, 2011.

4.24.2 Objectives

- To ensure proper forecasting and timely procurement of contraceptive commodities required for implementation of the national family planning Program;
- To ensure procurement, storage and supply management of DGFP logistics with due care to economy, efficiency, transparency, accountability and consistency ;
- To establish product quality assurance of the procured items;
- To ensure proper storage and inventory management at different tiers;
- To buildup capacity for procurement management to reduce lead time;
- To ensure timely distribution of contraceptives and RH commodities to the service delivery points particularly in the high fertility areas;
- To ensure monitoring and feedback system to detect stock out and unmet need situations;
- To implement e-procurement and on line procurement tracking system.

4.24.3 Components

- Program Organization for procurement and supply management;
- Procurement planning, monitoring & evaluation;
- Product quality assurance and Material Standardization;
- Commodity shipment, clearing and delivery;
- Supply chain management;
- Record keeping and feedback mechanism;
- Capacity Building and technical assistance
- e-procurement and web based information system

Component – 1: Program Organization for procurement and supply management

The PSSM-FP program has 60 officers and staff based at 22 Warehouses all over the country and Procurement cell at the Logistics and Supply unit of DGFP. It has a fleet of different types of vehicles for distribution of commodities to different destinations. The security of the Warehouses and constructed Upazila stores is ensured through the deployment of either private security personnel (through out-sourcing) or Ansar or Village Defense Party members.

Activity:

- Retention of procurement and supply chain staff
- Re-alignment of roles and responsibilities of desk officers and other staff in accordance with the procurement procedure manual to ensure efficient procurement management
- Improve storage conditions in the Central Warehouse, Regional warehouses and Upazila stores through constructions, extensions, new floors, shelves etc.
- Improve handling of goods through provision of new material handling equipments and other accessories;
- Ensure security of RHWs and Up Stores through deployment of Ansar/VDP members;
- Repair & maintenance of stores, vehicles, forklift, furniture equipments etc

Component- 2: Procurement planning, monitoring and evaluation

PSSM-FP is the most vital operation plan of the DGFP. A set of skilled, experienced and dedicated staff have been procuring contraceptives and other commodities through International/National bidding process as per PPR-2008 and IDA guidelines at a volume of 25-30 Packages each year. Effective procurement planning or lack of it has a very definite impact on the overall attainment of DGFP's objectives. Planning for procurement begins with the estimation of annual requirements of individual RH commodities under the purview of different Line Directors of DGFP. Planning takes into account long term strategies adopted for population containment, including CPR targets, changes to method and product mix and plans and estimates of private sectors. Procurement planning monitoring and evaluation eliminates the risk of emergency orders, complaints, ensure lower purchase, and improves service delivery.

Activity:

- Formation of a Forecasting Working Group under DGFP for preparation of short term and long term procurement plans;.
- Development of forecasting, quantification and supply planning system
- Quarterly meeting of the Logistic Coordination Forum to review progress of implementation of procurement plans and the optimal functioning of the supply chain.
- Continuous monitoring of all procurement related information
- Ensuring that contracts are done in a transparent manner
- Introduction of e-GP and strengthening e-LMIS in the DGFP;
- Evaluate and assess the adequacy of internal control

Component -3: Product quality assurance and material standardization

The quality of health sector goods is a critical factor in safeguarding the health of the population of the country in which the goods are consumed. Poor quality reproductive health commodities are unlikely to fulfill their purpose of controlling fertility. In worst case scenarios they can be detrimental to health. Ensuring product quality is an essential component of the procurement process which can be achieve through preparation of comprehensive technical specification or material standardization, purchasing from qualified manufacturers and suppliers and appropriate testing and surveillance of the goods though out the delivery, customs clearance, warehousing and distribution process. Implementation of PSI will ensure that only quality assured products are shipped in the country.

Activity:

- Application of Pre shipment and Post shipment quality inspection; drawing of batch samples and carrying out of quality checks to be done by reputable independent laboratories;
- Implement a system for post market surveillance to ensure continued maintenance of the quality of products in the supply chain
- Ensure that storage and transportation condition guarantee the quality and integrity of products both in storage and in transit
- Development and regular update of a database of generic specifications for the goods or services as per WHO, local and international standards;
- Specification to be drawn up by the individual line directors responsible for managing different RH commodities, if required assistance to be sought from technical experts to ensure preparation of right specifications
- Develop a database of reliable suppliers and implement a supplier performance appraisal system.

Component -4: Commodity shipment, clearing and delivery

Clearing of commodities from Sea, Air and Land ports are carried out under PSSM-FP Program. In order to monitor the movement of the consignment and ensure timely arrival, the procurement team must be in close contract with the suppliers. Delayed shipment or receiving shipping documents late causes demurrage in the port and disruptions in the program implementation. The appointed C&F Agent would take necessary action for payment of CD VAT, Exemption of Duty(if needed) and clearing of goods on behalf of the LD. Goods received are delivered from Central Warehouse to Regional Warehouses and Upazila Family Planning Stores by government Vehicles as well as private transportation firm via an outsourcing arrangement.

Activity:

- Improve communication to reduce delays in clearing goods and reducing storage fees;
- Increase transport capacity by purchasing new trucks, covered van etc;
- Continue with GOB transport and hire private transportation for distribution of goods;
- Build capacity for expediting contracts management.

Component 5: Supply Chain Management

At present commodities procured by DGFP are delivered from the Central Warehouse (CWH) down to the millions of users through a chain of 21 Regional Warehouses (RWHs), 483 Upazila Family Planning Stores and thousands of Service Delivery Points (SDPs). The Supply chain Management wing under PSSM-FP is currently using two Soft-wares namely (i) Warehouse Inventory Management System (WIMS) and (ii) Web-based LMIS and iii) Upazila Inventory Management System (UIMS). These tools are also used to generate supply plans and monthly LMIS reports which are then aggregated in the web-based LMIS for analysis and reporting Establishment of LAN/WAN and Broad Band Internet connection is vital for the System. All these are great steps toward the digitalization of the Supply Chain Management System. To ensure accountability, Physical Inventory is conducted in all Warehouses twice a year and Commodity Audit is carried out by a third party (contract out) every two years.

Activities:

- Develop additional reports from the various soft-wares to support different situation analysis and evidence based decision making;
- Networking computer system with central file storage;
- Carryout periodic physical inventory and commodity audits through independent firms;
- Implementation of modern warehousing practice;
- Improve condemnation and disposal process;
- Purchase computers and installation of soft-wares at all Upazila levels
- Conduct training and refreshers training on the soft-wares and store management



Component -6: Record keeping and Feedback mechanism

Up to Upazila level the supply situation has been recently quite reliable, while below this level there are intermittent serious unmet need issues. Proper reporting and feedback mechanism can avoid stock out and ensure continuity of services.

Activities:

- Improve system for detection of supply shortages at UP stores and SDP points;
- Establish modern central archives for all documents
- Ensure manual and electronic reporting system from all tiers;
- Ensure accuracy of reporting ;
- Data validation and situation analysis
- Ensure use of information system by officers at all levels

Component -7: Capacity Building & Technical Assistance

To enhance the Efficiency and skill of the Procurement and Supply chain Officers and staff, on the job training and, technical assistance is essential. With support from the USAID funded Strengthening Pharmaceutical System program (SPS), implemented by Management Science for Health (MSH) currently DGFP is developing a "Strategic Framework for Capacity Building in Procurement & Supply Chain Management for DGFP". This framework would serve as a basis for capacity building and training efforts to help address the need of individual personnel and develop skill of the organization. With a view to enhancing the knowledge and skill of the for Upazila level Drawing and Disbursing Officers Procurement workshops are organized in different district venues in order to familiarize the personnel with PPR-2008 and PPA-2006. This would reduce the burden of procuring all requirements at the central level.

Activity:

- Organize trainings , study tours workshops locally and abroad;
- Participate in international courses, conferences, seminars and related networking activities
- Capacity building regarding product quality issues;
- Organize workshops for bidders for reducing the numbers of ineligible bids;

Component -8: e-procurement and Web based information system

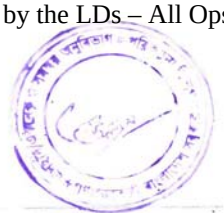
Online procurement management has been introduced in different parts of the world as well as in Bangladesh. Introduction of e-Procurement would help simplification and expedition of procurement process. New contracts models, multi years contracts and frame work contracts for avoidance of annual tendering and reduce the risk of stock out situations is possible through e-procurement. A Web based Supply Chain Information Portal has been launched with the help of USAID funded MSH/SPS program. This SCIP helps to monitor procurement progress through web and provides latest stock situation, archives of documents, latest procurement related news publications etc.

Activity:

- Evaluation of option for selection and implementation of an e-procurement system
- Capacity building on e-procurement process.
- Build capacity for the establishment and management of multiyear framework and indefinite quantity contracts.
- Software developments for e-procurements
- Continued enhancement of the Supply Chain Information Portal

4.24.4 Cross Cutting Issues

- Timely demand & fund placement by the LDs – All Ops of DGFP



- Infrastructure development & maintenance - OP- PFD

4.24.5 Indicators

This OP contributes to improving the service delivery as well as to the strengthening of the health systems. In particular, the activities contribute directly to ensuring Result 2.5, sustainable and responsive procurement and logistic systems.

Sl no	Indicators	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
1	Percentage of contracts awarded within initial Bid Validity period	55% (2006) L&S unit	95%	100%
2	Percentage of service delivery points without stock out of contraceptives	90% (2008, MIS Unit) 58.1% BHFS 2009	95% 65%	100% 70%
3	Percentage of service delivery points without stock out of medicines	90% (2008, MIS Unit 66.1%, BHFS 2009	95% 70%	100% 75%
4	Percentage of procurement is tracked using online system	NA	100%	100%
5	Percentage of usage of online reporting using the software	N/A	100%	100%
6	Percentage of personnel trained on LMIS	(100%,2004-05) L&S unit	100%	100%
7	% of supplies ensured (by private transports)	50% of the country (2004), L&S unit	55%	60%
8	% of Upazila stores ensured with security guards	240 Upazila stores (2007) and 21 Warehouses, L&S unit	290 Upazila stores and 22 Warehouses	320 upazila stores and 22 Warehouses



4.24.6 Budget

Component and Year wise physical and financial target of OPs

Agency: DGFP

Name of the OP: Procurement, Storage and Supplies Management-FP

(Tk in Lakh)

Name of the Components'/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year- 5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	12	12	13	14
Component-1:													
Security of the 22 Warehouses and 281 constructed Upazila FP stores. (Existing Recruitment procedure will be followed)	3030 (persons)	2375.00	0	0	2375.00	606	425.00	606	475.00	606	475.00	1212	1000.00
Maintain officer and staff: pay & Allowance		385.00			385.00		75.00		75.00		77.00		158.00
Maintain Utilities		395.00			395.00		70.00		80.00		80.00		165.00
Repair and Maintenance		207.00			207.00		37.00		30.00		45.00		95.00
Cleaners for 22 Warehouses- (contract out)		40.00			40.00		8.00		8.00		8.00		16.00
Sub total		**3402.00**	**0.00**	**0.00**	**3402.00**		**615.00**		**668.00**		**685.00**		**1434.00**
Component-2													
Honorium for tender evaluation committees, tender opening committees, advertisement cost etc.		125.00			125.00		25.00		25.00		25.00		50.00
TA support (Consultant services continue from Kfw, GFPA).		0.00	0.00	30.00	30.00		30.00		0.00		0.00		0.00
Sub total		**125.00**	**0.00**	**30.00**	**155.00**		**55.00**		**25.00**		**25.00**		**50.00**
Component-3:													
Pre& post Shipment Inspection		0.00	0	122.00	122.00		22.00		30.00		30.00		40.00
Sub total		**0.00**	**0.00**	**122.00**	**122.00**		**22.00**		**30.00**		**30.00**		**40.00**
Component-4:													

Name of the Components'/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year- 5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	12	12	13	14
Procurement of Vehicle*[Jeep-2,Pickup-3,Track-9(Coverdvan-5ton/3ton)]	14(Nos)	245.00	290.00		535.00	3	75.00	5	215.00	2	50.00	4	195.00
Continue GOB Transport (POL) In selected Warehouses & Upazila stores		719.00			719.00		125.00		125.00		130.00		339.00
Continue Private Transport In selected Warehouses & Upazila stores		600.00			600.00		110.00		115.00		125.00		250.00
Clearance of commodities from Sea/Land and Airport,		500.00			500.00		100.00		100.00		100.00		200.00
Customs duty, supplementary taxes, Value Added Tax (CD.ST.VAT) including NIPHP / UBHPP		1500.00			1500.00		350.00		350.00		400.00		400.00
Sub total		**3564.00**	**290.00**	**0.00**	**3854.00**		**760.00**		**905.00**		**805.00**		**1384.00**
Component-5:													
Conduct physical Inventories & Commodity Audit(GOB+Kfw fund)		50.00	0.00	20.00	70.00		20.00		25.00				25.00
Procurement of Computer & Accessories, equipment, furniture etc	273 (Nos)	220.0	0	0	220.00	111(Nos)	25.00	72(Nos)	35.00	40(Nos)	50.00	50(Nos)	110.00
Sub total		**270.00**	**0.00**	**20.00**	**290.00**		**45.00**		**60.00**		**50.00**		**135.00**
Component-6:													
Logistics -MIS(Review, Revise and implement reporting system) Forms & Registers	52368 (Nos)	90.00	0	0	90.00	17456	25.00		0	17456	30.00	17456	35.00
Appointment of Farm for Maintenance repair, trouble shooting and software development.		33.00			33.00		5.00		6.00		7.00		15.00
Sub total		**123.00**	**0.00**	**0.00**	**123.00**		**30.00**		**6.00**		**37.00**		**50.00**
Component-7:													
Training & workshop: Logistics Management, Computer course, Supply Chain Management, Course on Procurement	65 (packages)	30.00	50.00	0	80.00	13	20.00	13	20.00	13	20.00	26	20.00

Name of the Components'/ Major Activities	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year- 5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	12	12	13	14
Sub total		**30.00**	**50.00**		**80.00**		**20.00**		**20.00**		**20.00**		**20.00**
Component-8:													
Capacity building on e-procurement		5.00	0.00	0.00	5.00		1.00		1.00		1.00		2.00
Sub total		**5.00**	**0.00**	**0.00**	**5.00**		**1.00**		**1.00**		**1.00**		**2.00**
Grand Total		**7519.00**	**340.00**	**172.00**	**8031.00**		**1548.00**		**1715.00**		**1653.00**		**3115.00**

C. Other Agencies

4.25. Training, Research and Development (TRD)

4.25.1 Introduction

NIPORT and institutes under NIPORT (12 FWVTI & 20 RTC) have been conducting various types of research & survey, and imparting training to develop knowledge, skills and change attitude of all category of service providers, and managers who are working at various levels of HNP service delivery and M&E under DGFP, DGHS and Ministry of Health and Family Welfare. Another imperative activity of NIPORT is to undertake evaluative, cross-sectional, operations research, conduct collaborative research and surveys as well as efficiently disseminate research findings at different levels to strengthen the reproductive health, child health, nutrition and family planning activities.

4.25.2 Objectives

For Training:

- To impart training to the program managers, medical officers, trainers, paramedics and field workers on reproductive health, child health, nutrition, management and information technology to increase knowledge, develop skills and change behaviors for delivering better services to the people;
- To update existing curricula, develop new curricula and instructional materials to ensure quality of the training program;
- To communicate and share information on new technology and concepts of training to update knowledge of faculty;
- To build capacity to strengthen professionalism and facilities of the institutes; and
- To conduct and coordinate training programs in collaboration with Foreign Countries, GO and NGO.

For Research:

- To conduct research/survey/ rapid appraisal/situation analysis and need assessment for the development of reproductive health, population, family planning program and nutrition ;
- To conduct training evaluation to improve the quality of training;
- To carry out and monitor program, population & development related research and disseminate the findings to stakeholders.
- To strengthen research capacity and extend facilities for research;
- To strengthen coordination, avoid duplication, determine priority research areas;
- To coordinate and conduct collaborative research/studies & surveys with the government & non-government organizations and development partners;
- To disseminate research information for future policy and planning; and
- To fund for research on priority areas.

4.25.3 Components

Component 1: Training

As a National Training Institute, NIPORT has been playing a significant role in improving Health, Reproductive Health, Family Planning and Nutrition program through development of knowledge and skills of Managers, Service Providers, Paramedics, Field Supervisor and Field Workers. NIPORT has been implementing multidimensional training program for Mid-level Managers, Trainers, Paramedics and Frontline Workers. NIPORT's achievement in last 7 years is remarkable and had distinctive provided training to more than 68,600 (Sixty eight thousand six hundred) functionaries of health, nutrition and population program of Bangladesh



working at District, Upazila and Field Level. NIPORT provided these training through Team Training, Management Development Training, Clinical Management Training, Training of Trainers, FWV training, Comprehensive Orientation, Midwifery Training, Refresher Training, computer training, Early Childhood Development training and Subject Oriented other in-country training courses. At the same period, a number of training curriculums were also developed. Under HPNSDP, NIPORT will provide basic training for the newly recruited doctors under DGFP. Strengthening NIPORT's facilities for effective in-service training of the FP personnel is the key intervention for the next sector program. Officials from related sector of Planning Commission and IMED would be given opportunity under the provision of local and foreign training, as applicable.

Activities:

- Basic, Induction & Refresher (Pre-Service & In-Service) Training for program managers, medical officers, trainers, paramedics and field workers
- Midwifery training for FWV
- Reproductive, Child Health and Nutrition training
- Clinical Management, and Nutrition Management training
- Management Development training
- Planning Process training
- Education Information and Communication Technology (EICT) training
- Curriculum & training materials-instructional materials development
- Training Workshop
- Procurement of equipments for training
- Training capacity development through Overseas and In-country training

Component-2: Research

Research is the prime source of information for policy makers, program managers and professionals to develop national policies, program strategies, and design and priority interventions. Apart from that what is known on various subject areas it is necessary to generate new knowledge, apply the knowledge to program, planning and implementation. As such research, evaluation and monitoring activities are being considered as an integral part of the national health, nutrition and family planning program. Under HNPSP, NIPORT has undertaken a number of research studies / surveys including Bangladesh Demographic and Health Survey (BDHS), Utilization of Essential Service Delivery (UESD) Survey, Urban Health Survey, Integration of Reproductive Health Services for Men in Health and Family Welfare Center, Demand Based Reproductive Health Commodity Project, Bangladesh Maternal Mortality and Maternal Health Services Survey (BMMS) etc. From the beginning, the research unit of NIPORT is contributing to further strengthen the national program through various researches activities. Specifically NIPORT research contributes in designing the program interventions, routinely monitoring the program indicators at national and divisional levels, generating useful information on demographic and reproductive behavior, designing and evaluating the human resource development activities etc.

Activities:

- Conduct demographic behavioral aspects of family planning, reproductive health and nutrition program focused research / survey to strengthen the national program;
- Undertake human resource (HR) and training related research;
- Conduct and monitor operations research on HNP program improvements;
- Carry out survey / rapid appraisal / situation analysis and need assessment for the development of HNP program;
- Conduct national surveys: BDHS, BMMS, UESD surveys, Facility survey, Urban Health Survey, etc;
- Strengthen research capacity through higher education and training (in country and abroad) and extend facilities for research;



- Co-ordinate and conduct Research on improvement of Reproductive Health and Demand based Reproductive Health Commodity, ANC, PNC with other government and non-government organizations involved in conducting health, nutrition and population related research;
- Disseminate the research findings to policy makers, program managers and researchers.

Component -3: Administration and Management

- Personnel management of NIPORT and institutes under NIPORT (12 FWVTIs, 20 RTCs);
- Facility development for NIPORT
- Establishing new training institutes at more Districts and Upazila, (To be constructed through HED);
- Procurement of logistics and equipments.

4.25.4 Cross Cutting Issues

Coordination with other agencies related with training, research information system. OP-MNCAH, IST, PMR-DGHS, NNS, HIS-EH, MCRAH, PME-FP, MIS, NES.

4.25.5 Indicators

The activities planned under this OP will increase the number of health providers competent and available to provide health services and should therefore contribute to Result 1.1, increased utilization of essential HPN services.

Indicators(s)	Unit of Measurement	Base line (with Year and Data Source)	Projected Target	
			Mid- 2014	(Mid-2016)
1	2	3		4
Basic Training (18-months FWV, 2-months FWA, 10-days FPI, 2-years Community Paramedic)	batch	102 batches in 7 years LD (TRD)	284 batches	308 batches
Induction Training- 10 days (MO, FPO, SACMO/MA, SSN & Midwife)	batch	250 batches in 7 years LD (TRD)	49 batches	56 batches
Refresher Training- 5 days (FWV, SACMO/MA, HA, FWA & FPI)	batch	1917 batches in 7 years LD (TRD)	344 batches	440 batches
Reproductive and Child Health Training- 5 days (IUD & IP, ENC, ELCD)	batch	370 batches in 7 years LD (TRD)	313 batches	385 batches
Clinical Management Training (6-months Midwifery, 5-days other training)	batch	80 batches in 7 years LD (TRD)	38 batches	74 batches
Management Development Training (Program Management, Financial Management, BCC, Monitoring, Supervision and Follow-up etc.)	batch	48 batches in 7 years LD (TRD)	35 batches	50 batches
Education, Information & Communication Technology- 5/10/15 days (Computer Training, etc.)	batch	11 batches in 7 years LD (TRD)	15 batches	25 batches
Environment and Nutrition Management Training (5 days)	batch	NA	7 batches	53 batches
Gender and Organizational Development Training (5 days)	batch	NA	6 batches	20 batches
Instructional System Design Training- 5/10 days (Basic TOT, Curriculum & Instructional Material Development, etc.)	batch	7 batches in 7 years LD (TRD)	18 batches	25 batches
Short-Term Overseas training for NIPORT professionals, concern wing of the ministry	Batch	5 Batches	10 Batches	20 Batches

Indicators(s)	Unit of Measurement	Base line (with Year and Data Source)	Projected Target	
			Mid- 2014	(Mid-2016)
1	2	3		4
including concern sector of the planning commission				
Long-Term Overseas training (Masters/Diploma) for NIPORT professionals, concern wing of the ministry including concern sector of the planning commission	Persons	NA	10 Persons	18 Persons
In-country Collaborative Training & Other Activities	batch	10 batches in 7 years LD (TRD)	3 batches	5 batches
Pre-service training (Community Paramedic etc)	Batch	-	18 batch.	30 batch.
Curriculum and Instructional Material Development	number	26 nos. in 7 years LD (TRD)	18 nos.	23 nos.
Technical Assistance	number	NA	5 months	40 months
Training Workshop	number	27 nos. in 7 years LD (TRD)	30 nos.	48 nos.
Procurement of Training Equipment & Material	number	1090 nos. in 7 years LD (TRD)	3866 nos.	4573 nos.
Research studies / surveys (including BDHS, BMMS, UESD surveys, facility survey, Urban Health Survey, etc.) conducted	number	**103**	10	101
Seminar/workshops conducted	number	**84**	40	60
Annotated bibliography/ research briefs/ newsletter published	number	**106**	30	50
Conducted Research Methodology Training Course (Local)	batch	**3**	6	10

4.25.6 Budget

Component and Year wise physical and financial target of OPs

Agency: NIPORT

Name of the OP: Training, Research and Development (TRD)

(Tk in Lakh)

Name of the Components/Major Activities	Total Physical and Financial Target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical	Financial	Physical	Financial	Physical	Financial	Physical	Financial
		GOB	RPA	DPA	Total	Qty		Qty		Qty		Qty	
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1: Training													
Basic Training (FWV, FWA, FPI)	308 batch	834.68	610.74	685.11	2130.53	134	794.42	67	476.26	64	429.4	43	430.45
Induction Training (MO, SACMO/MA, etc.)	56 batch	0.00	162.25	20.19	182.44	6	27.02	31	100.02	12	35.21	7	20.19
Refresher Training (FWV, SACMO/MA, HA, FWA & FPI)	440 batch	114.74	116.51	334.28	565.53			191	279.05	131	173.46	89	113.02
Reproductive and Child Health Training (ENC, ELCD)	385 batch	499.50	52.69	28.46	580.65	82	122.84	85	130.98	104	153.55	114	173.28
Clinical Management Training (Midwifery Skill Practice, etc.)	74 batch	0.00	112.32	114.42	226.74			5	12.92	21	107.14	48	106.68
Management Development Training (Program Mgmt., Financial Mgmt., BCC, Monitoring, Supervision and Follow-up etc.)	50 batch	81.82	133.24	5.17	220.23	26	50.79	39	71.2	28	54.74	17	43.5
EICT (Computer Trg., etc.)	25 batch	15.21	38.88	15.50	69.59	3	12.22	10	22.55	5	11.48	17	23.34
Environment and Nutrition Management	53 batch	0.00	29.51	71.22	100.73			8	20.22	14	24.35	31	56.16
Gender and Organizational Development	20 batch	0.00	12.92	38.76	51.68	1	2.58	3	7.75	4	10.34	12	31.01
Instructional System Design Training (Basic TOT, Curriculum & Instructional Material Development, etc.)	25 batch	0.00	70.22	17.31	87.53	6	25.1	9	32.86	4	12.26	6	17.31
Overseas Training (Long/Short-Training on Demography, Population & Dev. Studies, Research, Evaluation, Monitoring, Clinical management, Trg. Tech. ,	20 batch	0.00	742.00	60.00	802.00	4	172	5	220	5	220	6	190

Name of the Components/Major Activities	Total Physical and Financial Target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical	Financial	Physical	Financial	Physical	Financial	Physical	Financial
		GOB	RPA	DPA	Total	Qty		Qty		Qty		Qty	
1	2	3	4	5	6	7	8	9	10	11	12	13	14
MDT. etc.)													
In-country Collaborative Training & Other Activities	5 batch	11.11	37.15	10.00	58.27	1	13	1	13.11	1	13	2	19.15
Pre-service Training (Community Paramedic, etc.)	30 batch	0.00	130.32	32.58	162.90	6	32.58	6	32.58	6	32.58	12	65.16
Curriculum & Instructional Material Dev.	23 Nos	32.50	25.75	4.50	62.75	6	16.5	6	16.5	6	16.5	5	13.25
Technical Assistance	40 Nos	0.00	0.00	100.00	100.00			10	25	10	25	20	50
Training Workshop	48 Nos	36.00	85.50	36.00	157.50	10	33	10	33	10	33	18	58.5
Procurement of Training Equipment	4543 Nos	174.44	115.00	51.50	340.94	2628	166.94	623	48.5	615	44	677	81.5
***Sub Total=**		**1800.01**	**2475.00**	**1625.00**	**5900.01**		**1468.99**		**1542.51**		**1396.01**		**1492.50**
Component-2: Research and Development													
Program Focused ORs /Studies (Family Planning, Reproductive Health, Maternal and Child Health etc.)	47 Nos.	330.00	300.00	0.00	630.00	6	120	11	190	10	160	20	160
Research Dissemination (including Bibliography, Research brief, News letter)	73 Nos.	0.00	120.00	100.00	220.00	15	30	14	50	15	50	29	90
NASCOPOR Activities (including Training Evaluation, commissioned research studies, workshop)	73 Nos.	390.00	200.00	0.00	590.00	11	100	16	170	15	170	31	150
Research Methodology Training Courses /Capacity Building	10 Nos.	230.00	0.00	0.00	230.00	2	60	2	60	2	60	4	50
Collaborative Survey and Research Activities (including BDHS, BMMS, UESD, Facility Survey, Urban Health Survey)	13 Nos.	0.00	1160.00	1477.00	2637.00	2	110	3	470	3	670	5	1,387.00
Studies through BIRPERHT	5 Nos	0.00	100.00	0.00	100.00	1	20	1	20	1	20	2	40
Sub Total		**950.00**	**1880.00**	**1577.00**	**4407.00**		**440.00**		**960.00**		**1130.00**		**1877.00**
Component-3: Administration and Management													
Supplies & Services	5300 Nos	53.80	8.30	10.00	72.10	900	8.3	19	14.3	1200	14.5	2000	35

Name of the Components/Major Activities	Total Physical and Financial Target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical	Financial	Physical	Financial	Physical	Financial	Physical	Financial
		GOB	RPA	DPA	Total	Qty		Qty		Qty		Qty	
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Repair & Maintenance	1009 Nos.	51.20	11.75	0.00	62.95	309	11.75	300	15.7	150	10.5	250	25
Equipment, Computer, laptop, IPS, Printer, Multimedia projector, Freezer, Photocopier etc. and Furniture	1016 Nos.	75.00	44.95	45.00	164.95	38	34.95	273	45	263	45	364	40
Vehicles (Jeep-1, Car-1, Microbus -13)	15 Nos.	95.00	305.00	120.00	520.00	4	140	11	380	0			
Sub Total		**275.00**	**370.00**	**175.00**	**820.00**		**195.00**		**455.00**		**70.00**		**100.00**
Total		**3025.00**	**4725.00**	**3377.00**	**11127.00**		**2103.99**		**2957.50**		**2596.01**		**3469.50**

4.26. Nursing Education and Services (NES)

4.26.1. Introduction

Bangladesh Nursing Council has registered 26,644 nurses in January 2011. There are 17,605 posts in the public nursing services and education. Out of which 15,086 nurses are working in the public sector and 2,513 posts are vacant (DNS: Jan 2011).

Total number of nursing institutes are 72 (public 43: 1550 seats and private 29:1090 seats) providing 3 years Diploma in Nursing Science and Midwifery course. There are 18 nursing colleges (public-7:700 seats; private-11:340 seats) offering 4 years B.Sc in Nursing Course. In addition there are 12 (public 4: 500 seats and private 8:245 seats) post basic nursing colleges where Bachelor of Nursing Science course are provided for the diploma nurses (BNC 2011). Master degrees are still not conferred in Bangladesh, although there are about 200 Master graduates in the country. Very few of them having Master in various nursing specialties, rest of Masters are in public health from Bangladesh. There is only one graduate who is currently doing his PhD. This data concludes that the human resource in nursing education/ management is still not adequate to run the quality nursing education.

It is found that seat capacity is inadequate to fulfill the current demand of human resource development in nursing and midwifery. So seat capacity will be increased with infrastructure including teaching and human resources. In educational management institutions there are 460 posts of teachers in public sector out of which only 72 teachers are in position; so there is acute shortage of teachers. Most of the teaching institutions run by the deputed nursing staff. Thus faculty preparation and recruitment rules/deployment policy need to be considered.

The present nurse: bed ratio is 1: 13 in the morning shift; doctor: nurse ratio is 2: 1 and population: nurse ratio is 5000:1 in Bangladesh (HRD data sheet 2010). This has to be seen against an international standard of one nurse for four patients in general beds and 1 nurse for one patient in intensive care units in a shift. So there is acute scarcity of nurses for providing services to the hospital patients. Nursing service aims at strengthening of the public sector nursing by creating adequate posts and filling-up the same, so that existing mismatch of physicians: nurses, nurses: patients, nurses: bed and nurses: population ratios can be improved substantially. Considering the present number of nurses in this country which is 26,644, the demanding number of nurses will be 2,60,000 according to this estimation. Several studies have shown, on the other hand, that nursing services in particular in the public hospitals in Bangladesh are inefficient and ineffective.

It is mentioned that nurses have entered in the govt. sector as class three employees. These nurses are working for promoting the health of the people and reducing mortality, morbidity and fertility rate which ultimately help to achieve the target of MDG 4 and 5. In considering this, present Government have declared nurses entry point as 2nd class and 4000 midwives will be produced by 2016. A policy (Strategic) direction paper has been developed by the Directorate of Nursing Services (DNS) and Bangladesh Nursing Council (BNC) for enhancing the contribution of nurse-midwives (NMs) in addressing the maternal, child and neonatal health issues which is approved by the MOHFW and implementation phase is going on.

Nursing service needs to be expanded to cover specialist nursing services like in cardiology, pediatric, community, psychiatric, gerontology, trauma & orthopedic, nephrology, neurology, etc. Nursing and midwifery education is expected to be expanded for training more nurses both in public and non-public sectors covering diploma and bachelor courses.

The quality of nurses to record and report in English, which is practiced in the hospitals, has also been found to be poor. Interaction with the patients and their attendants has scope of improvement.

Directorate of Nursing Services (DNS) and Bangladesh Nursing Council (BNC) are two salient organizations for managing nursing education and services. No regular director of nursing was ever posted since 1993 in the DNS. The first recruitment rule for the nursing service was made in 1977, then in 1979, 1984 and in1985 for all posts under DNS. Reviewing of the job descriptions of the different categories of nurses is warranted. Since its inception in 1977 to till now, no independent building was ever established for the Directorate of Nursing yet.

The physical structures of hospitals are not nurse friendly, e.g. there are no facilities for rest room or space for nurses to change dress or study or even separate wash room for nurses.



Specific activities need to be taken up for strengthening capacity of nursing education and services like establishment of national nursing research cell; introduction of performance audit system through monitoring and evaluation. DNS, BNC and all educational institutions have no internet facilities. These organizations also suffer from the absence of an effective MIS.

The main issues that need to be addressed in the nursing are: establishment of career planning, development and introduction of quality assurance and accreditation system, enhancement of leadership and management skills, development of tools and guidelines for institutionalization of in service training, establishment of mechanism of supervision, monitoring and evaluation, training on different specialty areas, arrangement for post graduate course, facilitating research, further up-gradation of senior level nursing services, construction of directorate of nursing building and continued education center for teachers' development, production of newsletter and development, amendment and introduction of nursing acts, legislations and regulations.

4.26.2. Objectives

- To ensure the quality of Nursing & Midwifery Education and Services;
- To establish, upgrade and strengthen the directorate, Nursing Institutes and Colleges.
- To develop and strengthen human resource plan in nursing and midwifery;
- To strengthen nursing & midwifery education for producing competent and efficient nurse-midwives.
- To develop the capacity of nurses in specialized areas and also in leadership, management and administration.
- To establish a national nursing research council by strengthening the Nursing Research Cell (NRC) for evidence-based practice.
- To strengthen networking within National and International Bodies.
- To develop and strengthen the Nursing Management and Information System (NMIS)

4.26.3. Components

Component 1: Ensuring Quality of Nursing and Midwifery Education

Strengthening nursing & midwifery education, training and practices for producing competent and effecient nurse-midwives for delivering/ensuring holistic care depending on agreed roles and responsibilities.

Activities

Ensure the quality of nursing services through establishing monitoring and evaluation system.

- Establishing mechanism for monitoring & evaluation system.
- Establishing monitoring and evaluation cell within the DNS or DGN to ensure quality of services for providing better patient care.
- Ensuring well balanced NMs (nurse-midwives) ratio in different areas.
- Ensuring required resources for providing NMs services.
- Introducing policy for incentive package a) for posting in remote places & b) to encourage women to enter into nursing.

- Established curriculum cell for curriculum development and review.

Up-gradation of DNS with required manpower to uphold and ensure quality of nursing & midwifery education & services

- Up-grading position of DNS and to facilitating smooth functioning that help improving the quality of services on the basis of GOB decision
- Construction of **'Nursing Bhaban'**
- Modification of existing recruitment rules



Component 2: Nursing Education and Services Improvement and Training

Strengthening nursing & midwifery education for producing competent and efficient nurse-midwives and specialized nurses.

Activities

Faculty preparation: Develop Nursing Faculty to strengthen nursing and midwifery education.

- By the end of 2016, at least 300 nurses are trained in abroad as 1. Master Trainers of Clinical Specialists in fifteen identified areas (Total 15X20=300) who start in country training.
- Develop a master plan for subject-wise teachers' preparation.
- Develop one teachers training colleges for the nurse-midwives to prepare faculty with subject based competency.
- Strengthen nursing colleges for introducing Post-graduation program

Expansion of the Nursing institutes and colleges

- **Vertical expansion** of the existing nursing institutes and colleges
- Establishing a set of well equipped Laboratory (Total 8 lab): **4 nursing lab, one midwifery lab, one science lab, one English lab & one computer lab** for each of all individual nursing educational institutions.
- Ensuring the availability of vehicle for the nursing officials and for each individual nursing educational institution to facilitate teaching learning activities.
- Establishing one staff development college at national level for capacity building of Nurses as continuing education program (CEP)

Regulation: Establish the system to ensure safeguard for the client & care provider in collaboration with Bangladesh Nursing Council (BNC).

- Developing & reviewing nursing act, regulation & accreditation.
- Developing Comprehensive Exam for Licensing for RN, RM and Specialized nurses
- Training of nurse educators regarding licensing exam
- Developing mechanism for renewal of registration.
- Training nurses on code of professional conduct/practice

Research on nursing education and practice: Upgrade the existing Nursing Research Cell to open the avenue for evidence based nursing education and practice.

- Establishing a structure of Bangladesh Nursing & Midwifery Research Council (BNMRC).
- Training of nurses on research methodology & Statistics.
- Conducting small scale research.
- Publishing a journal to disseminate the research paper

Component 3: HR Administration and Management

Develop comprehensive human resources plan (HRP) to ensure workplace safety for the nurses and for the benefit of the people.

Activities

Human Resources planning & implementation for equitable distribution and utilization for the benefit of the people through developing the capacity of nurses in specialized areas and also in leadership, management and administration.

- Establishing the policy & mechanism of post creation at all levels in relation to expansion of services.
- Developing career plan
- Developing recruitment rules for nurses and midwives
- Enhance production Junior Nurse-Midwifery production through 2 year Junior Nursing midwifery course (Target 3000)
- Enhance production of midwifes (Target 4000)

- Enhance production of Aide-nurse (Target 2000)

Component- 4. MIS and Monitoring

Establishment of computer-based Nursing and Midwifery Management and Information System (NM-MIS).

Activities

Establishment of phase-wise distribution and installation of computers and computer programs for MIS at head office, Nursing Institutes and Nursing Colleges or College of Nursing.

- Set up a MIS Structure. Organogram of NMMIS
- Develop and install Web-Based software and training to the concerned persons.
- Procurement of computer and its accessories.
- Provide Internet connection at all level
- Maintaining Webpage of DNS and updating NMMIS

4.26.4. Cross Cutting Issues

- Human resources development and planning. OP-HRM,
- Monitoring and evaluation of nursing education and services. OP-PSE, HIS-EH
- Development of physical facilities like Establishment of own building for nursing directorate, exam hall, expansion of educational institutions, libraries. OP-PFD
- Management information system.-OP-HIS-EH

4.26.5. Indicators

The activities planned under this OP will contribute to improving service delivery and in particular, will help achieve Result 1.1, increased utilization of essential HPN services, and Result 1.4, improved PHC-CC systems.

Sl	Indicators	Baseline (source)	Projected Target	
			Mid 2014	Mid 2016
1	Established curriculum cell and functional	DNS/BNC	Done	-
2	BSc Nursing curriculum Modified	BNC /DNS	Done	-
3	Number of BSc. Nurses Produced	1400, DNS	2000	2500
4	Developed MSc Nursing curriculum	NA, DNS	Done	-
5	Number of MSc. Nurses Produced	100, DNS	200	400
6	Developed Diploma in Nursing and Midwifery course	NA	Done	-
7	Number of Diploma Nurses Produced	26644, DNS	36000	40000
8	Number of Nurses trained on specialized course	200, DNS	400	-
9	Established Monitoring and evaluation cell	NA,DNS	Done	-
10	Job description of Nurse and Midwifes reviewed	NA, DNS	Done	-
11	Finalized Nursing and Midwifery master plan	NA, DNS	Done	-
12	Published Newsletter and Nursing Journal	NA, DNS	6 (2/year)	6 (2/year)
13	Accreditation guideline and regulations updated and approved	NA, BNC	done	-
14	Accreditation visits conducted with updated guideline and measures taken	NA, BNC	Done	-
15	Nursing MIS established and reported with updated information	NA, DNS	Done	-
16	Number of additional mid wives recruited and trained	NA, DNS	1500	3000

4.26.6. Budget

Component and Year wise Physical and Financial target of OP

Agency : Directorate of Nursing Services

Name of the OP : Nursing Education and Services

(Taka in Lakh)

Name of the Components & Major Activities	Total Physical and Financial Target					Year 1		Year 2		Year 3		Year 4 & 5	
	Physical Qtty. (no)	Financial				Physical Qtty.	Financial	Physical Qtty.	Financial	Physical Qtty.	Financial	Physical Qtty.	Financial
		GOB	RPA	DPA	Total								
(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	*(10)*	*(11)*	*(12)*	*(13)*	*(14)*
1. Pay and Allowances	26	300.00		145.00	445.00	5.2	89.00	5.2	89.00	5.2	89.00	10.4	178.00
2. Curriculum development and review (MSc, BSc, Diploma, Specialized training, subject based training, orientation etc)	4040 No	0.00	0.00	1080.00	1080.00	808	216.00	808	216.00	808	216.00	1616	432.00
3. Capacity Development for clinical instructor	550 No		0.00	1092.00	1092.00	110	218.40	110	218.40	110	218.40	220	436.80
4. Develop midwife	3000		2750.00	850.00	3600.00	600	720.00	600	720.00	600	720.00	1200	1440.00
5. Develop subject based nurse	500			600.00	600.00	100	120.00	100	120.00	100	120.00	200	240.00
6. Training on health assessment, nursing process, holistic nursing, critical nursing, ethic legal issue, QA, infection control, respiratory diseases, IT etc.	19790		466.00	4101.00	4567.00	3958	913.40	3958	913.40	3958	913.40	7916	1826.80
7. Regional training on policy formulation, nursing care provision, hospital management, Disaster management	40		160.00	0.00	160.00	8	32.00	8	32.00	8	32.00	16	64.00
8. Develop faculty by Preparing required number of Master graduate (abroad)	200		4000.00	0.00	4000.00	40	800.00	40	800.00	40	800.00	80	1600.00
9. Prepare required number of PhD Nurses	25		875.00	0.00	875.00	5	175.00	5	175.00	5	175.00	10	350.00

Name of the Components & Major Activities	Total Physical and Financial Target					Year 1		Year 2		Year 3		Year 4 & 5	
	Physical Qtty. (no)	Financial				Physical Qtty.	Financial	Physical Qtty.	Financial	Physical Qtty.	Financial	Physical Qtty.	Financial
		GOB	RPA	DPA	Total								
(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	*(10)*	*(11)*	*(12)*	*(13)*	*(14)*
10..Establish a monitoring & evaluation cell	1 unit			176.00	176.00		35.20		35.20		35.20		70.40
11. Study tour to neighboring countries for mid-level and front line managers on management	40			160.00	160.00	8	32.00	8	32.00	8	32.00	16	64.00
12. Orientation Training	450			54.00	54.00	90	10.80	90	10.80	90	10.80	180	21.60
13. Basic training on English, Arabic language	320			100.00	100.00	64	20.00	64	20.00	64	20.00	128	40.00
14. Training for nurses on nursing and midwifery standards				50.00	50.00	0	10.00	0	10.00	0	10.00	0	20.00
15. Prepare master trainer from abroad on adult nursing, paediatric nursing, oncology, oro-dental nursing, Trauma and emergency nursing, psychiatry nursing, Geriatric nursing, etc,	260		680.00	360.00	1040.00	52	208.00	52	208.00	52	208.00	104	416.00
16. Finalize NM master plan and HR policy for preparing specialist Nurse, Administrator, Teachers and Clinicians, and review organogram and recruitment rules.				459.00	459.00	0	91.80	0	91.80	0	91.80	0	183.60
17. Procure and supply furniture required for NIs, Nursing Colleges	for 20 CON and 10 NI	1293.00		660.00	1953.00		390.60	0	390.60	0	390.60	0	781.20
18. Procure and supply vehicle and fuel	MB-25, B-32	1100.00	358.00	660.00	2118.00	11	423.60	11	423.60	11	423.60	24	847.20
19. Repair and maintain all the physical facilities of Nis (CIDA will help repair about 15 NIs) and Nursing Colleges	38 NI's	180.00		360.00	540.00		108.00	0	108.00	0	108.00	0	216.00
20. Purchase, collect and supply the books/resource material for Library for NIs and Nursing Colleges.	L/S	231.00		69.00	300.00	L/S	60.00	L/S	60.00	L/S	60.00	L/S	120.00

Name of the Components & Major Activities	Total Physical and Financial Target					Year 1		Year 2		Year 3		Year 4 & 5	
	Physical Qtty. (no)	Financial				Physical Qtty.	Financial	Physical Qtty.	Financial	Physical Qtty.	Financial	Physical Qtty.	Financial
		GOB	RPA	DPA	Total								
(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	*(10)*	*(11)*	*(12)*	*(13)*	*(14)*
21. Purchase, collect and supply the resource equipments/ material for eight Lab for NIs and Nursing Colleges	L/S	901.00		2283.00	3184.00	L/S	636.80	L/S	636.80	L/S	636.80	L/S	1273.60
22. Postal. Telephone, WASA, Electricity, Gas, POL, Stationary , Bedding, cookeries and d others	L/S	1200.00		0.00	1200.00	L/S	240.00	L/S	240.00	L/S	240.00	L/S	480.00
23. Management, Labor, Cleaning, Security Guard	L/S	525.00		0.00	525.00	L/S	105.00	L/S	105.00	L/S	105.00	L/S	210.00
24. CD & VAT	L/S	300.00		0.00	300.00	L/S	60.00	L/S	60.00	L/S	60.00	L/S	120.00
25. MIS for DNS and BNC with web dev	L/S		369.00	540.00	909.00	L/S	181.80	L/S	181.80	L/S	181.80	L/S	363.60
26. Review and update Accreditation Guidelines, BNC Rules, ACT, Regulations on Nursing and Midwifery Education and Services	L/S			22.00	22.00	L/S	4.40	L/S	4.40	L/S	4.40	L/S	8.80
27. Strengthen the Research cell	20			125.00	125.00	4	25.00	4	25.00	4	25.00	8	50.00
28. Network workshop, seminar at divisional and national and international level	L/S			366.00	366.00	L/S	73.20	L/S	73.20	L/S	73.20	L/S	146.40
Total		6030.00	9658.00	14312.00	30000.00		6000.00		6000.00		6000.00		12000.00

4.27. Strengthening of Drug Administration and Management (SDAM)

4.27.1. Introduction

The Directorate of Drug Administration was established in the year 1976 as a Drug Regulatory Authority (DRA) under the Ministry of Health and Family Welfare. The organization has been upgraded to Directorate General of Drug Administration in the year 2010. This organization is entrusted with the responsibilities of overall control and management of the pharmaceutical sector of the country. It regulates and performs various activities related to manufacture, quality control, storage, distribution, sale, post-marketing surveillance, import and export of drugs in the country. In addition, the Director General of the Directorate acts as the Licensing Authority and issues Licenses for the manufacture, distribution, export, import and sale of drugs and vaccines. The Directorate is also responsible for implementation of the National Drug Policy in order to establish discipline in production, distribution and use of drugs at all levels of health care delivery system. It also ensures Good Manufacturing Practices (GMP) in production and quality control of drugs manufactured and used in the country.

Since the introduction of the Drug Policy, in the last three decades, there have been spectacular changes in the socio-economic sectors nationally and internationally. Implementation of "National Drug Policy (NDP) 1982" resulted tremendous positive effect leading to rapid development of the pharmaceutical industries in Bangladesh. Production of allopathic and other traditional medicines increased substantially. The National Drug Policy of 1982 was updated in 2005, to make the country a producer and exporter of good quality medicines and to strengthen the DGDA into an effective regulatory authority. Bangladesh has recently turned to a quality medicine exporting country. The updating of National Drug Policy 2005 is on process. The recent upgrading of the office into a Directorate General was responding to the provisions of the policy. The DGDA currently has about 65% of its posts vacant.

The Directorate General of Drug Administration will be substantially strengthened and its capacity will be built to carry on its responsibilities efficiently and effectively. This will result in improved drug manufacturing, better quality and safety management and curbing spurious drug manufacturing and marketing, less drug-abuse, and more rational use of drugs. Thus essential drugs will be available at affordable price and can be accessed by the poor nation-wide.

But counterfeit, spurious and substandard drugs smuggled in to the country from outside are now creating serious problems and hindering availability of safe and efficacious drugs and medicine to the people. A strong Drug Regulatory Authority is a pre-requisite for appropriately dealing with these drugs and for production, trade, distribution and use of safe, efficacious and good quality drugs and medicines in the country. In order to protect the general people from ignorant misuse of drugs and from exploitation of the unscrupulous drug manufacturers and traders, strengthening and up-gradation of the Drugs Administration Directorate is absolutely essential. A strong Directorate of Drug Administration is also needed to compete efficiently with other drug producing and exporting countries of the world. This would in turn consolidate our achievements, and would ensure good control over the drug market and also rational use of drugs. The DGDA, in consultation with the expert committee shall update from time to time the list of essential medicines in line with the current EDL of WHO.

To ensure drug safety and pricing in the country will require collaboration between the DGDA and other regulatory agencies/stakeholders in the Health Sector. DGDA will need substantial funds to train the officers and staff of the DGDA including drug testing laboratories in monitoring drug quality. In addition, DGDA will have to establish an effective drug testing laboratory of International standard. The vacant posts of DGDA should be immediately filled up for effective functioning. The existing laboratories need to be modernized. The irregular retail trade of drugs and medicines, the sales of spurious drugs or below standard drug and the dispensing of drugs by unauthorized sellers needs to be controlled by deploying more staff at district levels and at possible 'DGDA outlet stations'.

Pharmaceutical companies will be monitored and checked for functioning of a quality control and quality assurance systems and for practice of WHO recommended GMP guidelines for manufacturing drug and



vaccines and ensure the quality of marketed drugs through post-marketing surveillance by testing randomly collected samples in drug testing laboratories.

To keep pace with the changed global circumstances, it has become imperative to modernize and expand our pharmaceutical sector aiming beyond national horizon to the international export markets and also to attract the foreign investment in this sector.

Through the implementation of this OP the peoples of Bangladesh will have better health care facility through quality medicine at affordable price. Moreover, Bangladesh will be an export oriented medicines producing country in addition to its self sufficiency and the sector will create lot of employment opportunity for the concerned personnel.

4.27.2. Objectives

- To support the pharmaceuticals industries to produce quality drugs;
- To strengthen and build capacity of the National Regulatory Authority for Drugs.
- To enhance Post Marketing Surveillance Activities.
- To improve the capacity and standard of Govt. Drug Testing Laboratory for Quality Control of Drugs.
- To facilitate the Rational Use of Drugs
- To update and implement the drug regulatory functions.

4.27.3. Components

Component-1: Establishing Modern drug/vaccine testing laboratory

In order to ensure the quality standard of drugs and vaccines, the government needs to evaluate the quality standard of each drug / vaccine available in the market on a routine basis. Expansion of these testing laboratories at the divisional level would be considered on the basis of priority.

Activities:

- Procurement of Laboratory Equipment
- Repair & Renovation of Drug Testing Laboratory
- Repair and Maintenance of Laboratory Equipment

Component 2: Updating the National Drug Policy for ensuring quality drugs in the market

Up gradation of national drug policy 2005 is needed

- To ensure the essential drugs for all at affordable price.
- To support the national Drug Manufacturing Industry to keep pace with the changed global scenario.
- To modernize and expand our pharmaceutical sector aiming beyond national horizon to the international export markets.
- To attract the foreign investment in this sector.

Activities:

- Committee meetings
- Workshops / Seminars

Component-3: Establishing Drug Information and Adverse Drug Reactions Monitoring Cell

- To make available all the information related to drugs such as marketing authorization procedure, Registered Drugs, Licensed Manufacturing Unit, Licensed drug Outlets, related drugs law and policies etc.
- To collect the information about Adverse Drug Reaction, evaluation of ADR and awareness dissemination



- To ensure Rational Use of Drug to minimize side effects and avoid misuse of drugs

Activities:

- Printing and Publications ADR Bulleting, Awareness Poster, etc.
- Procurement of Office Equipment
- Procurement of Machinery and Other Equipment
- Awareness and Sensitization for RUD
- Procurement of Computer and Accessories
- Training on Computer and ICT

Component-4: Strengthening field monitoring and quality assurance of drugs

A strong Drug Regulatory Authority is essential for evaluation of manufacturing facilities of drugs and for ensuring use of safe, efficacious and good quality medicine in the country through post marketing surveillance. The Directorate General of Drug Administration needs strengthening and building capacity to carry on its responsibilities effectively.

Activities:

- Automation in the drug administration and management system
- Construction of Office Building
- Procurement of Vehicles
- Procurement of Furniture and Fixture
- Procurement of Telecommunication equipment
- Training for DGDA Officers on GMP, **QMS, EMS, Accreditation System,** Quality Control and Quality Assurance of Drugs and Vaccines

4.27.4. Cross Cutting Issues

i) Public private partnership OP-HEF

4.27.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. The proposed activities will contribute to the strengthening of health systems (Component 2). In particular, the activities will help achieve Result 2.5, sustainable and responsive procurement and logistic system, and Result 2.7, sector management and legal framework.

Sl	Indicators	Base line (Year and Source)	Projected Target	
			Mid-2014	Mid-2016
1	Drug/vaccine testing laboratory modernized and functional	NA	2	2
2	National Drug Policy revised and approved	NA	Done	Done
3	Adverse drug reaction (ADR) cell established	NA	Done	Done
4	Number of Drug samples tested as per standard	3500/year (2010)	5000	10000
5	Number of drug companies inspected and adhered to quality production of drugs	1200/year (2010)	2200	3000
6	Number of Batches of staff receiving training on GMP, QMS, Accreditation, quality control and vaccines	NA	25	20

4.27.6. Budget

Component and Year wise physical and financial target of OPs

Name of Agency: DGDA

Name of the OP : Strengthening of Drug Administration and Management

Taka in Lakh

Name of the Components/Major Activities	Total Physical and Financial Target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Repair and Renovation of Drugs Testing Laboratory, and Vaccine Wing	2 Units	800.00			800.00	1 Unit	500.00	1 Unit	300.00				
Repair and Maintenance of Equipment for DTL & CDL	75 No.	45.00			45.00							75	45.00
Printing and Publication	Lump-sum		18.00		18.00			Lump-sum	3.00	Lump-sum	5.00	Lump-sum	10.00
Computer Training	100 Person/ 4 Batches	20.00			20.00			25 Person	5.00	25 Person	5.00	50	10.00
Stationary & Stamps	Lump-sum	24.00			24.00	Lump-sum	4.00	Lump-sum	4.00	Lump-sum	5.00	Lump-sum	11.00
Petrol and Lubricant	Lump-sum	28.00			28.00	Lump-sum	4.00	Lump-sum	4.00	Lump-sum	6.00	Lump-sum	14.00
Foreign Training for GMP, QMS, Accreditation, QA, QC and Vaccine, etc	45 person		20.00	160.00	180.00			10 person	40.00	10 person	40.00	25	100.00
Local Technical Training	60 person		10.00	40.00	50.00			15 person	12.00	15 person	12.00	30	26.00
Seminar/Workshop	3 workshop	5.00			5.00	3 workshop	5.00						
Committee Meeting	15 meetings	3.00			3.00	10 meeting	2.00	5 meeting	1.00				
Procurement of Laboratory Equipment	10 No.		130.00		130.00					10 No.	130.00		
Procurement of Computer and Accessories	155 No		96.00		96.00			105 No.	46.00			50 No.	50.00

Name of the Components/Major Activities	Total Physical and Financial Target					Year-1		Year-2		Year-3		Year-4 & 5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Procurement of Office Equipment (Photocopier, Biometric Access Attendant, CCTV)	45 No	30.00	50.00		80.00	10 No.	25.00			10 No.	25.00	25	30.00
Procurement of Machinery and Other Equipment (Window type Air cooler , Split type Air cooler, Generator)	34 No	30.00	24.00		54.00	14 No.	12.00			14 Nos.	12.00	6	30.00
Procurement of Vehicles	28 (Jeep-5,Micro3,Mot Cycle-20)		450.00		450.00	28	450.00						
Procurement of Furniture and Fixture	Lump	10.00	29.00		39.00			lump	29.00			lumpsum	10.00
Construction of Office Building	3 Office		690.00		690.00					3 office	690.00		
TA for Automation of SDAM		-	-	423.00	423.00		200.00		223.00				
Revision and updating of Drug Policy	1		10.00		10.00		3.00		7.00				
Procurement of Telecommunication Equipment	2 Intercom, Sets	10.00			10.00			1 set	5.00			1 set	5.00
Total		**1,005.00**	**1,527.00**	**623.00**	**3,155.00**		**1,205.00**		**679.00**		**930.00**		**341.00**

D. MOHFW

4.28. Physical Facilities Development (PFD)

4.28.1. Introduction

Bangladesh is a small country with a vast Population of about 150 million. In other words within a total area of 147570 sq.km as many as 150 million Populations are presently residing. The density of Population per sq.km is about 1016 which is one of the highest in the world. Furthermore, the population is presently increasing at a rate of 1.48%. The existing facilities under the MOHFW are inadequate to cater to the increasing Health and Family Planning needs of the people. In view of the rising trend in population, it is apprehended that unless the government goes for a large scale of construction of new facilities, up-gradation & remodeling of existing facilities, it would indeed hardly be possible to provide required Health & Family Welfare Services to the People of the country.

In order to meet the increasing Health and Family Planning needs of the people and to provide them better and/or modern services, Bangladesh will have to construct new facilities with a suitable design. We should inter alia include such facilities as (i) Crèche, prayer room, (ii) Child corner (iii) Breast feeding corner (iv) Changing and washing room for duty nurses (v) Comfortable waiting room (vii) Suitable conference room (viii) Facility for cleaning/washing clothes and drying by the patients & their care takers (ix) Cafeteria with modern amenities, etc. Facilities will be designed taking into consideration the scarcity of land and wherever possible, vertical extension will be given priority to minimize land requirement. In addition, feasibility of construction of all administrative offices under different agencies of MOHFW may be in the same premise depending on the availability of land and other conditions. Construction of hospital, residential and other facilities would be as a complex, as and where possible.

The existing establishments which have no such facilities as mentioned shall be supported through Upgrading, Conversion, Re-construction, Remodeling, Renovation, etc. While designing new facilities, due consideration will be given to demographic and geographic characteristics with special focus on building disaster resilient structures. New and upgraded facilities construction will be synchronized with the provision of manpower, equipment, logistics and supplies for those facilities.

There is no denying the fact that for shortage of adequate Nurses, Medical Technicians, Paramedics, etc. in the Health and Family Welfare Sector, the Govt. objective of providing modern and latest health services to its people might remain a myth. Construction of some Institutions/Colleges (NC, MATI, IHT, etc), alongside hospitals shall also be necessary. It will not be out of place to mention here that establishment of new training Institutes/Colleges will not only help provide skilled and qualified manpower to the public sector owned hospitals, but also be a source of meeting the need of technical personnel in the private sector. Besides, persons achieved degrees or certificates from these institutions/ colleges might as well be a source of earning valuable foreign exchange for the country by rendering their services abroad.

A huge number of populations about 76% are living in the villages. Govt. has, therefore, attaches a high priority to the Construction, Upgrading, Repair, & Maintenance of facilities in the rural areas in particular. To this end, the Govt. has decided to set up physical facilities even at the level of village/ward. By now as many as 10,723 Community Conics (CC) have been set up at different villages/wards of the country. The govt. plans to set up one such Clinic for 6000 population in the rural areas of the country and a total number of 13,500 CCs shall be established all over the rural areas of the country.

In the above situation, it is proposed to go for a large scale of construction of new facilities, alongside upgrading and renovation of existing facilities from the village to the National level to render required and better Health and Family Welfare facilities to the people in the country under this Operational Plan(OP) covering the period from 2011-2016.

Most of the works related to new construction, up-gradation, repair and maintenance under MOHFW shall be executed by HED. PWD along with Department of Architecture will be involved in the execution of works under MOHFW as per decision of the Ministry.

4.28.2. Objectives

- To establish new facilities aiming at providing essential health and family welfare services ;



- To upgrade and renovate existing facilities such as Union Health & Welfare Centers (UHFWCs), sub-centers, Upazila Health Complexes (UHCs), District Hospitals (DHs), Nurses Training Institutes (NTIs) etc;
- To develop a user and gender friendly physical design for hospitals such as children's corner attached to pediatric department, breastfeeding corner, adolescent corner, nurses dress changing room, cafeteria for patients, family members and care takers' clothes washing and drying facilities and conducive to disabled persons;
- To develop need based standard designs for various levels of care as per the population, demographic characteristics. disease patterns of the particular area and consideration of the scarcity of land;
- To build capacity of human resources (e -procurement, management, designing etc.) as well as in the field with a view to obtain optimum benefits;
- To establish Procurement and Logistic Management Cell (PLMC) for promoting the stewardship role of the MOHFW to ensure quality and oversee procurement plan preparation, bidding documents preparation, bid evaluation etc.

4.28.3. Components

Component-1: Upgrading Facilities

Considering the inadequacy of health care facilities and their inequitable distribution between urban and rural area, a huge number of infrastructures had been constructed from the national to the remote village level. By now about 3835 UHFWCs, 415 UHCs and 59 District Hospitals of various capacities have been established in the country. The prototype facilities have been established in union, upazila and district levels respectively though population and catchment area are not identical. As a result populations now being served under many facilities are not proportionate and need to be rationalized. Considering population bed ratio, bed utilization and inconvenient communication links, remaining UHCs and DHs are required to be upgraded.

Upgrading UHFWCs

UHFWC is the grass root institution built for providing integrated health and family welfare services to the rural people at the union level. At the moment, UHFWCs headed by Medical Officers renders only outdoor treatment facilities. There is no indoor treatment facility either for mothers & children or for other patients needing emergency treatment. A large number of patients are rushing to the UHFWCs creating an additional pressure on the existing facilities of the UHFWCs. Because of lack of adequate physical facilities, UHFWCs are, failing to provide such required health and family welfare services as expected by the people.

In order to make the UHFWC as vital and effective centre for providing coordinated health and family welfare services including MCH services to the rural people, it has been proposed to upgrade UHFWCs. Meanwhile 1441 UHFWCs have already been upgraded; remaining 1218 FWCs need to be upgraded in phases.

Activities:

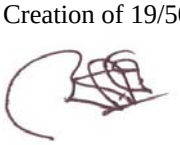
- Construction of a MCH ward and delivery room.
- Construction of office room for MBBS Doctor.
- Construction of protective boundary walls around the upgraded UHFWCs and creating separate, improved toilets for female clients.

Upgrading Upazila Health Complex (UHCs)

By now a total of 415 UHCs have been established in the country with 31 bed facilities having floor area of 14500-17500 sft and housing facilities covering floor area around 12000 sft varying from centre to centre. The UHC with its present bed strength of 31 beds, however, finds it extremely difficult to properly serve the population around its catchment areas. As of now 303 UHC have been upgraded. Govt. plans to upgrade the remaining 112 UHCs in phases for better and expanded health service to meet the growing needs of the people particularly in rural areas. Adequate space for storage of medicines and medical requisites will be ensured, and if required, additional storage place will be constructed.

Activities:

- Creation of 19/50 additional bed facilities.



- Construction of ramp for disabled persons.
- Establishment of 3 (three) modern OTs, labor room and other related facilities..
- Construction of store to stock vaccines, drugs, other supplies.
- Spacious waiting place for male & female clients/attendance separately at OPD.
- Provision of cleaning facilities.
- Creation of Nurses rest room/dress change room.
- Separate dispensing counter for male & female patients.
- Separate, improved toilets for female clients.
- Residential accommodation for consultants and doctors and other officers and staff.
- Remodeling, Repair & Renovation of the existing facilities.
- Safe medical waste disposal system.

Up-gradation of District Hospitals (DHs)

The secondary health care is provided at the district level through district hospitals where the bed strength now varies from 50-250 beds. Most of these district hospitals were constructed quite a long back without adequate provision for future needs and as such most of them presently are not in a position to serve properly the fast growing population. There are only sixteen 250 beded district hospitals in the country. The existing health facilities being inadequate to serve the present needs of the people, there is an imperative need to carryout upgradation of many of these facilities, while remodeling and/or renovation would be necessary in others. Considering the present health needs of the people, the Government has taken a decision to upgrade the existing hospitals up to 250 beds. Upgrading District hospitals will help them treat better the referral cases coming from UHCs/UHFWCs. Adequate space for storage of medicines and medical requisites will be ensured, and if required, additional storage room will be constructed. Strengthening District hospitals will contribute to deliver essential health and family welfare services to the people more effectively and the load of tertiary care level will be reduced. It is, therefore, proposed to upgrade 18 DHs under the Next Sector Program.

Activities:

- Creation of 50/150/200 additional bed facilities.
- Construction of ramp for disabled persons.
- Establishment of modern OTs, labor room and other related facilities.
- Construction of store to stock vaccines, drugs, other medical supplies.
- Spacious waiting space for male & female patients separately at OPD.
- Provision of cleaning utility.
- Nurses rest/dress change room.
- Separate drug dispensing counter for male & female.
- Additional improved toilet facilities for the male & female patient separately.
- Residential accommodation for consultants and doctors and others officers and staff.
- Remodeling, Repair & Renovation of the existing facilities.
- Establish safe medical waste disposal system
- Strengthening emergency, diagnostics services and blood transfusion
- Strengthening services of six selected hospitals on pilot basis.

Component-2: Construction of UHFWCs / Up-gradation of Rural Dispensaries into UHFWCs.

Primary Health Care has been identified as an essential element to ensure sound health to the people. In order to bring the essential Primary Health Services at the doorsteps of the people living in rural areas, Government has decided to construct UHFWCs in all over the country.

In the country so far about 3835UHFWCs (including RD upgrading) have been constructed. But still there are 366 Unions where UHFWCs are yet to be constructed/RDs to be upgraded. In the next sector Program, out of 370 UHFWCs, about 200 FWC/RDs are planned to be upgraded in phases. Adequate space for storage of medicines and medical requisites will be ensured, and if required, additional storage place will be constructed.



Activities:

- Two storied brick building about 3600 sft shall be constructed.
- Providing improved toilet facilities for the male & female patients separately.

Construction of MCWCs

The establishment of MCWCS is required to facilitate the Delivery of Health & Family Welfare Services to Mothers & Children and to enable them to have an easy access to such essential service facilities. In view of above, a total of 98 MCWCs have since been established in the country out of which 62 are in the District Head Quarters and still 02 Districts are yet to be covered. Considering the inadequacy of Mother & Child Care Health Facilities and their inequitable distribution of services, establishment of 14 MCWCs have been proposed under the next Sector Program.

Activities:

- Construction of Clinic building, with FWV & Doctors quarter
- Providing improved toilet facilities for the male & female patients separately.

Establishment of Nursing Facilities

Nursing profession is an indispensable segment of health system. There are 17,605 posts in the public nursing services and education. Out of which 15,086 are working in the public sector and 2,513 posts are vacant (DNS: Jan 2011). About 3000 are working in abroad. For maintaining the minimum standard 76000 more nurses in the country will require to be produced. At present the government has a plan to raise the number of nurses to 33000. There are 8 Nursing Colleges (NC) and 43 Nursing Training Institutes (NTI) all over the country in public sector and 22 NTI in private sector. But there is a negative balance between need and supply of Nurses. Hence more NC need to be established to meet the existing acute shortage of Nurses in the country. The establishment of NCs aims at providing higher education in the field of Nursing so that they can provide better health care services to the people. These qualified Nurses will be of the International Standard and will also be able to get employment at abroad. Furthermore, these will considerably help Government aim of empowering women in Bangladesh. More new 6 nursing colleges and 15 NTIs upgraded into 15 Nursing Colleges are proposed to be constructed during HPNSDP period.

Activities:

- Establishment of Nursing College (Academic Building & Admin. Bldg. Hostel Bldg. Staff Quarter, Guest House, Car Garage, Pump House and Sub-Station, Guard Room etc.)
- Establishment of Nursing Bhaban in Dhaka,

Establishment of IHT

Establishment of IHT shall help production of Laboratory Technicians. These will on the one hand help reduce the existing shortage of laboratory technicians in the country and on the other hand the technicians will be a source of remitting foreign exchanges to the country by getting jobs in abroad. Consequently unemployment & poverty to some extent be reduced. In view of above, so far 3 IHTs have been established 2 are under construction. More 10 (ten) IHTs are proposed to be constructed during HPNSDP period.

Activities:

- Construction of academic building with separate male & female hostel and other residences for principal, professor and staff.

Establishment of 20-Beded Hospitals

It is observed that in a number of cases some pockets or clusters have naturally been formed with a part of a Upazila and parts of other surrounding Upazilas. These pockets are generally far away from the Upazila Health Complex and difficult to reach during all seasons particularly during the monsoon. The people living in such pockets or clusters are mostly poor and poverty stricken and can't easily have essential health services from the Upazila Health Complexes which are far away from their houses/homes. The present democratic Govt. attaches a high priority to the improvement of health status of the people and is committed to bring essential health services to the door steps of the people living in the rural remote and hard to reach areas of the country. Further, some Upazila Health Complexes

have been set up at places which are far away from Upazila head quarters. As a consequence, inhabitants of the Upazila Head quarters including govt. semi govt. & private officials and employees of different commercial enterprises are presently being deprived of essential health services from such upazila health complexes. The Govt. has, therefore, taken a plan to establish 20-beded hospital in the different pockets or head quarters of the Upazilas so that people living in those areas may get health services close at their door. It is proposed to construct forty-six 20-beded Hospitals during HPNSDP period.

Activities:

- Construction of hospital, RMO & EMO quarter, Consultant's & Doctors Dormitory, Nurses dormitory and class-II & class-III dormitories. Construction of ramp for disabled persons. Establishment of 2 (two) modern OTs, labor room and other related facilities. Adequate space for storage of medicines and medical requisites will be ensured.

Component-3: Strengthening of Health Engineering Department (HED)

Ministry of Health and Family Welfare, established Construction and Maintenance Management Unit (CMMU) in 1992 for construction, upgrading, remodeling and maintenance of different Health and Family Welfare Facilities, merging Construction Maintenance Cell (CMC) established in 1979 for family planning wing and the Building Planning & Design Unit (BPDU) established in 1974 for health wing. CMMU has been reorganized now as the Health Engineering Department (HED) with the status of a full-fledged directorate under the Ministry of Health and Family Welfare. The present strength of manpower in different categories as well as available logistics is inadequate compared to their work load. As a result the strengthening of HED is urgently called for. During the period of HPNSDP (2011-2016), the work load of the HED is supposed to increase as they would be entrusted with most of the construction, upgrading, remodeling & repairing/maintenance of different facilities under Ministry of Health and Family Welfare (MOHFW). In handling the expected enhanced work load, there would be need for further strengthening of HED engaging more personnel in design section as well as at the supervisory level with more logistic support. Furthermore, proper training to the existing manpower will also have to be provided.

On line services will have to be introduced which would include procurement & installation of computer and other accessories. Presently HED has no office building of its own. For better management of the overall assignment of the HED, construction of HED Bhaban at Head quarter and Circle & Division offices at the Circle/Division level will be required.

Activities:

- Establishment of HED Bhaban and Office Bhaban for Circles & Divisions.
- Procurement of vehicles, computer and others necessary requisites.
- Introducing online services to HED including e-procurement.
- Arrangement of training facilities at home and abroad.

Component-4: Other Health and Family Welfare Facilities

Besides the above mentioned facilities, it is proposed to undertake some other facilities such as Construction of 50-Beded Hospitals, Upgradation of BCPS at Mohakhali, Dhaka (2nd phase), Construction of Health Bhaban (2nd phase), New construction of Shishu Hospitals, Construction of Medical Assistant Training Institute (MATI), Supply of Medical Gas, Dead House and Autoclave room in District Hospitals, Construction of Divisional offices for Directorate of Health Services, Construction of Civil Surgeons Offices (where needed), Construction of Central Warehouse to preserve EPI vaccine, Construction of Divisional Family Planning office, Construction of Family Planning offices at District Level in phases, Construction of Bhola Regional Warehouse, Remodeling & capacity build-up of Central Warehouse (CWH) at Mohakhali, Dhaka, Construction of Multipurpose Building at NIPORT Premises, Dhaka (1st phase), Construction of FWVTI and RTC in phases, Conversion of Nurses Training Institute to Nursing College, Construction of a HED Inspection Banglow at Cox'sbazar. Remodeling and renovation of existing Upazila family planning stores to meet efficiently the increasing need of Heath and Family Welfare Services of the people across the country.

Further, in the future it might be necessary to undertake different other project/works as well depending on demands from higher authorities of GOB, after the assessment of their needs.

Component-5: Periodical Maintenance of Infrastructures

Till date about 16000 different health infrastructures have been constructed and more than 900 are under process of completion. But due to lack of regular maintenance and cleaning many of the completed facilities are failing to serve the people as per expectation. For regular maintenance and repairing, some allocation is made mainly through the revenue budget every year which is highly inadequate. Therefore, in many of the structures some components such as electric fixtures, water supply and sewerage system are indeed in a dilapidated condition. Furthermore, facilities are not often kept in neat and clean condition, thus the situation now prevailing in those facilities are not favorable for providing quality care. The allocated revenue budget is not sufficient to complete a cycle of maintenance and cleaning of facilities. Day to day cleaning and up-keeping and periodic maintenance at least once in every 2-3 years are of utmost necessity to keep these facilities up to mark.

A comprehensive maintenance plan would be prepared for the health and family welfare facilities for smooth maintenance, to avoid repetition and attain cost effectiveness. The plan would have a total repair and maintenance of all existing facilities in phases, inclusive of adequate maintenance budget for effective implementation.

All civil works, financed by the pooled funds, will be done in compliance with the guidelines indicated in the Social Management Framework and Environmental Management Plan.

Component -6: Procurement and Logistic Management Cell (PLMC)

CMSD, DGFP Procurement and Logistics Unit and HED are considered agencies with good procurement capacity based on the experience in HNPSP as well as number of procurement-proficient staff in those agencies. The MOHFW will also procure and execute contracts - with the establishment of PLMC. The role of the PLMC is to promote the stewardship role of the MOHFW to provide quality assurance and control to procurement plan preparation, bidding documents preparation and bid evaluation and overseeing for works, goods and services with terms of reference agreed with the DPs. The PLMC is also required to support the contracting out of consultants and non-consultancy services.

Component -7: Procurement Audit

Procurement audit by the Ministry of Health and Family Welfare will be carried out to ensure effective periodic monitoring of procurement activities in the OP. Two audits will be carried out- one at the end of second year and another at the closing of HPNSDP. IMED may be engaged for procurement audit according to existing rules and regulations.

Component-8: Miscellaneous

Consultancy services

To ensure proper design, supervision, timely completion, quality of works, etc. it is proposed to engage architectural and engineering Consulting Firms. They will assist Health Engineering Department (HED) for the overall quality implementation of the works. Government expertise particularly from PWD, HED and Dept of Architecture would be considered for the preparation of design and drawing as well as supervision instead of recruiting consultants in large scale. Numbers of consultants would be kept minimum as possible throughout the course of implementation and existing PPR/PPA and other related guidelines to be followed for the consultants' recruitment.

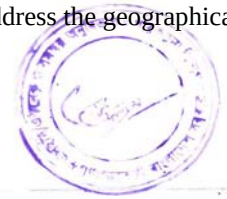
Line management

There will be two program managers one from Public Works Department and one from Health Engineering Department under the Line Director PFD. One officer at the status of Deputy Secretary from the ministry will coordinate the two departments.

Scheme Summary: For large and proto-type structures, a scheme summary will be prepared as per PIP budget provision which will be approved by competent authority under MOHFW.

Mapping out the need for new constructions and that for upgrading of health facilities

A survey shall be conducted for the need assessment of new construction and up-gradation of facilities. All the information from the survey report shall be represented through mapping. Previously a base line survey had been conducted by HED (former CMMU) which will have to be updated and enhanced. Besides, a master plan will be developed based on GIS for all construction to address the geographical variation of the physical facilities.



4.28.4. Cross Cutting Issues

Coordination regarding construction and maintenance of facilities, OP-MNCAH, ESD, CBHC, MCRAH, FPFSD, TRD, NES.

4.28.5. Indicators

The activities under this OP will work towards the strengthening of the health system. Namely, they will contribute to Results 2.6, improved infrastructure and maintenance.

Sl.	Indicators	Baseline (source)	Projected Target	
			Mid 2014	Mid 2016
1	Number of Hospitals/health facilities constructed/renovated to make them gender and disability friendly (ramp, separate commode toilet and sitting arrangement)	NA	50%	100%
2	Percentage of Contracts awarded within initial Bid validity period	NA	70%	85%
3	Percentage of procurements used “online procurement system”	NA	70%	100%
4	Number of existing FWC physically upgraded to UHFWCs for improved MCH services	1441 (2010)	400	800
5	Number of UHCs upgraded from 31 – 50/ 50 to 100 bed hospitals	303 (2010)	30	81
6	Number of Hospitals upgraded to 250 bed hospitals	16 (2010)	4	18
7	Number of Union newly FWCs constructed /RDs constructed/ upgraded	3835 (2011)	75	200
8	Number of MCWC constructed	98	4	14
9	Number of 20 bed hospital constructed	21 (2010)	15	46
10	Health Engineering Department (HED) Building constructed	NA	-	Done
11	Number of Nursing College Upgraded/ constructed	43(2010)	4	21
12	Number of Facilities maintained / repaired by category	Not Avail	CC: 1500 FWC: 1500 UHC:75 DH: 30	CC: 3000 FWC: 2500 UHC: 150 DH: 50

*Along with other criteria gender and disability friendly hospitals/ facilities also include provision of Ramp, improved toilet facilities, separate sitting arrangements etc.

4.28.6. Budget

Component and Year wise physical and financial target of OPs

Name of Agency: MOHFW in collaboration with HED, PWD & MES (for DGHS, DGFP, NIPORT, DGDA, HED, DNS)

Name of the OP : Physical Facilities Development

(Tk in Lakh)

Name of the Components'/ Major activities	Total Physical and financial target					Year - 1		Year - 2		Year - 3		Year - 4 & Year - 5	
	Physical Qty./unit	Financial				Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component-1: Construction & Upgradation of works :													
Activity-1: Upgradation :													
Upgradation of Existing Union Health and Family Welfare Centers(UH&FWCs)	800	13830.00	14170.00	0.00	28000.00	100	3640.00	200	7000.00	300	8400.00	200	8960.00
Upgradation of Upazila Health Complex from 31 to 50 Beds	81	43870.00	30650.00	0.00	74520.00	-	9687.60	20	18630.00	29	22356.00	32	23846.40
Upgradation of Upazila Health Complex from 50 to 100 Bed (Syedpur, Charfesion & Chowgacha)	3	6000.00	0.00	0.00	6000.00	-	780.00	1	1500.00	1	1800.00	1	1920.00
Upgradation of District Hospitals from 50/100/200 to 250 Bed	18	23200.00	28000.00	2800.00	54000.00	-	7020.00	2	13500.00	8	16200.00	8	17280.00
Upgradation of BCPS at Mohakhali, Dhaka (2nd phase)	1	1500.00	0.00		1500.00	-	195.00	-	375.00	-	450.00	1	480.00
Upgradation of Nurses Training Institutes into Nursing Colleges (including Manikgonj).	15	7900.00	12600.00	500.00	21000.00	-	2730.00	5	5250.00	5	6300.00	5	6720.00
Upgradation of FWVTI through Vertical extension .	8	7200.00		0.00	7200.00	-	936.00	3	1800.00	4	3024.00	1	1440.00
Upgradation of RTC through Vertical extension .	6	4200.00		0.00	4200.00	-	546.00	2	1050.00	4	1764.00		840.00
Upgradation of Bangladesh - Korea Friendship Hospital from 30 to 50 Beds	1	2000.00		0.00	2000.00	-	260.00		500.00		600.00	1	640.00

Name of the Components'/ Major activities	Total Physical and financial target					Year - 1		Year - 2		Year - 3		Year - 4 & Year - 5	
	Physical Qty./unit	Financial				Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Upgradation of District Hospital from 50 to 100 bed at Rangamati district.	1	2000.00	0.00	0.00	2000.00	-	260.00	-	500.00		600.00	1	640.00
Establishment of 500 Beds Hospital at Kurmitola, Dhaka (2nd phase).	1	0.00	0.00	2000.00	2000.00	-	260.00	-	500.00	-	600.00	1	640.00
Remodeling & capacity buildup of Central Warehouse (FP) at Mohakhali, Dhaka.	1	400.00	0.00	0.00	400.00	-	52.00	-	100.00	-	120.00	1	128.00
Upgradation works of Upazila Health Complex from 31 to 50 Bed (2nd phase) at (i) Putia, Rajshahi, (ii) Tanore, Rajshahi, (iii) Tetulia, Panchagore & (iv) Boda, Panchagore (v) Kamarkhand, Sirajgonj.	5	1325.00	0.00	0.00	1325.00	-	172.25	3	331.25	2	397.50		424.00
Conversion of 100 Beds General Hospital into 200 Beds Specialized Hospital at Sylhet.	1	2000.00			2000.00		260.00		500.00	1	1040.00		200.00
Remodeling & Renovation of Existing Family Planning Stores.	100	1000.00			1000.00	25	130.00	25	250.00	25	520.00	25	100.00
Remodeling & Renovation of Existing HED Assistant Engineer's office at Cox's Bazar.	1	100.00			100.00		15.00	1	70.00		15.00		0.00
Remodeling & Renovation of District Hospitals	10	500.00			500.00	1	50.00	2	100.00	4	200.00	3	150.00
Sub-Total :	**1053**	**117025.00**	**85420.00**	**5300.00**	**207745.00**	**126.00**	**26993.85**	**264.00**	**51956.25**	**383.00**	**64386.50**	**280.00**	**64408.40**
Activity-2: Construction :													
Construction of Union Health & Family Welfare Centre (UH&FWCs) and Upgradation of RDs into UH&FWC.	200	20000.00	0.00	0.00	20000.00	-	2600.00	60	5000.00	70	6000.00	70	6400.00
Construction of 50-Bed Upazila Health Complex in New Upazilas (Including 3 Nos. UHCs at Ashugonj, Dhanbari & Juri and 50-Bed Hospital at Khadimnagar, Sylhet).	12	24000.00	0.00	0.00	24000.00	-	3120.00	3	6000.00	4	7200.00	5	7680.00
Expansion of UHC (Upazila Health Complex) for Upazila Family Planning office cum store and services.	100	7500.00	0.00	500.00	8000.00	13	1040.00	25	2000.00	30	2400.00	32	2560.00

Name of the Components'/ Major activities	Total Physical and financial target					Year - 1		Year - 2		Year - 3		Year - 4 & Year - 5	
	Physical Qty./unit	Financial				Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Construction of 20 bed MCWCs (Including Re-construction of MCWCs at Sunamgonj, Moulovibazar & Lalmonirhat) .	14	9100.00	0.00	0.00	9100.00	-	1183.00	3	2275.00	6	2730.00	5	2912.00
Construction of Bhola Regional Warehouse for FP.	1	100.00			100.00		15.00		50.00	1	35.00		0.00
Construction of Satkhira 250 Bed Hospital at Polashpole , Satkhira. & expansion of sadar hospital, Satkhira	1	9674.00			9674.00		1241.50		2387.50		2865.00	1	3180.00
Construction of 20-Bed General Hospitals including MCH Services.	46	37780.00	2700.00	0.00	40480.00	-	5262.40	4	10120.00	22	12144.00	20	12953.60
Establishment of. Institute of Health Technology (IHT) at Joypurhat (2nd phase)	1	1500.00	0.00	0.00	1500.00	-	195.00	-	375.00	-	450.00	1	480.00
Construction of Health Bhaban (2nd phase)	1	3500.00	0.00	0.00	3500.00	-	0.00	-	0.00	-	1750.00	1	1750.00
Establishment of Institute of Health Technologys (IHTs) (Including IHTs at Chandpur & Keshobpur).	10	22500.00	2500.00	0.00	25000.00	-	3250.00	2	6250.00	4	7500.00	4	8000.00
Construction of Govt. Shishu Hospitals at Barisal & Rajshahi.	2	2500.00	0.00	1500.00	4000.00	-	520.00	-	1000.00	1	1200.00	1	1280.00
Construction of Medical Assistant Training Institutes (MATIs)	5	4200.00	2800.00	0.00	7000.00	-	845.00	1	1625.00	2	2200.00	2	2330.00
Supply & Installation of Medical Gas Pipe Line System at ICU, CCU, OT, Post Operative & Peadiatice ward in Different District Hospitals	8	1600.00	0.00	0.00	1600.00	2	208.00	2	400.00	2	480.00	2	512.00
Construction of Central Warehouse to preserve EPI vaccine at Mohakhali, Dhaka.	1	3000.00	0.00	0.00	3000.00	-	325.00	-	625.00	-	1000.00	1	1050.00
Construction of Mother and Child & Chest Hospital at Rangpur (50 Beds for MCH & 50 Beds for Chest)	1	0.00	3000.00	0.00	3000.00	-	325.00	-	625.00	-	1000.00	1	1050.00
Construction of Multipurpose Building for NIPORT at Mohakhali, Dhaka.	1	500.00	0.00	0.00	500.00	-	65.00	-	125.00	-	150.00	1	160.00
Construction of Regional Training Centers (RTCs) (1 at Cox's Bazar and 2 other District).	3	3000.00			3000.00		390.00	1	750.00	1	900.00	1	960.00

Name of the Components'/ Major activities	Total Physical and financial target					Year - 1		Year - 2		Year - 3		Year - 4 & Year - 5	
	Physical Qty./unit	Financial				Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Construction of Nursing Colleges .	6	14100.00	0.00	0.00	14100.00	-	1833.00		3525.00	3	4230.00	3	4512.00
Construction of Nursing & Midwifery Bhaban	1	2000.00	0.00	500.00	2500.00	-	325.00	-	625.00	-	750.00	1	800.00
Construction of Health Engineering Department (HED) Bhaban (1st phase)	1	3000.00	0.00	0.00	3000.00	-	390.00	-	750.00	-	900.00	1	960.00
Construction of different Offices :													
Construction of Different offices in a common premises for Health, Family Planning and HED at Division/District level. a. HED Circle offices at Khulna, Rajshahi & Chittagong (3), b. HED Division offices at Tangail, Dinajpur, Jessore & Noakhali (4), c. HED Assistant Engineer's offices at Chandpur & Joypurhat (2), d. Divisional offfices for Directorate of Health Services (2). e. Civil Surgeon Offices (10), f. Family Planning offices at District & Division Level(25).	46	6426.00	0.00	600.00	7026.00	6	913.38	15	1756.50	15	2132.12	10	2224.00
Construction of HED Inspection Banglow at Cox's Bazar.	1	300.00	0.00	0.00	300.00	-	39.00	-	75.00	1	150.00		36.00
Construction of Nursing College at Khulna (2nd phase).	1	250.00	0.00	0.00	250.00	-	32.50	-	62.50	1	75.00	-	80.00
Construction of Boundary wall including Retaining wall and Gas connection of FWVTI at Sylhet (2nd phase).	1	150.00	0.00	0.00	150.00	-	19.50	-	37.50	1	83.00	-	10.00
Construction of Tibbiya College at Sylhet (2nd phase).	1	500.00	0.00	0.00	500.00	-	65.00	-	125.00	1	150.00	-	160.00
Construction of Male & Female Hostel in Medical College & Hospitals at Pabna, Cox's Bazar, Jessore, Noakhali,Comilla, Barisal & Chittagong.	7	4400.00		500.00	4900.00		637.00	1	1225.00	4	1470.00	2	1568.00
Establishment of National Fistula Centre at Dhaka Medical College and Hospital, Dhaka.	1	200.00			200.00		26.00	1	50.00		124.00		

Name of the Components'/ Major activities	Total Physical and financial target					Year - 1		Year - 2		Year - 3		Year - 4 & Year - 5	
	Physical Qty./unit	Financial				Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Construction of Dead Body House at different District & Medical College & Hospital (Including Narayangonj District Hospital and Shahid Sohrawardi Medical College & Hospital , Dhaka).	4	200.00			200.00		20.00	2	100.00	2	80.00		
Construction of Boy's Nurses Hostel	3	150.00			150.00		19.50	1	37.50	2	93.00		
Construction of Trauma Units in identified UHCs	10	1000.00			1000.00	1	150..00	2	250.00	3	300.00	4	300.00
Repair and Maintenance of different physical facilities	L/S	1500.00			1500.00	L/S	375.00	L/S	450.00	L/S	450.00	L/S	225.00
Sub-Total :	**490**	**184630.00**	**11000.00**	**3600.00**	**199230.00**	**22**	**25429.78**	**123**	**48676.50**	**176**	**60991.12**	**169**	**64132.60**
Activity-3: Remaining works of HNPSP	**232**	**55935.00**	**3565.00**	**500.00**	60000.00	**142**	**40000.00**	**90**	**20000.00**				
Component-2: Procurement of goods													
Activity-1: Office & Construction equipment of HED	L.S	300.00	0.00	0.00	300.00		100.00		150.00		50.00		
Activity-2: Operational Expense of HED	L.S	300.00	0.00	0.00	300.00		100.00		100.00		50.00		50.00
Activity-3: Furniture of HED and Others Facilities	L.S	1300.00	0.00	0.00	1300.00				500.00		400.00		400.00
Activity-4: Vehicles (Jeep/Pickup-39, Car-1, Microbus-2 & Motor Cycle-100) Nos for HED.	142	2000.00	0.00	0.00	2000.00	42	200.00	50	1600.00	50	200.00		
Sub-Total :	**142**	**3900.00**	**0.00**	**0.00**	**3900.00**	**42.00**	**400.00**	**50.00**	**2350.00**	**50.00**	**700.00**	**0.00**	**450.00**
Component-3: Capacity Building													
Activity-1: Training (Local & Foreign)		50.00	350.00	0.00	400.00		100.00		150.00		100.00		50.00
Activity-2: Workshop/Seminar		50.00	0.00	0.00	50.00		10.00		10.00		15.00		15.00
Sub-Total :		**100.00**	**350.00**	**0.00**	450.00	**0.00**	**110.00**	**0.00**	**160.00**	**0.00**	**115.00**	**0.00**	**65.00**
Component-4: Procurement of Services													

Name of the Components'/ Major activities	Total Physical and financial target					Year - 1		Year - 2		Year - 3		Year - 4 & Year - 5	
	Physical Qty./unit	Financial				Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial	Physical Qty./unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Activity-1: Consultancy services for works, updating and enhancement of Baseline Survey of different Health & Family Welfare facilities, Preparation of Master Plan for different Health Facilities and online services including e-procurement.	8	1150.00	3750.00	0.00	4900.00	5	980.00	3	1400.00		1300.00		1220.00
Activity-2: Baseline Survey for equipment and utilization of infra Structure in different hospitals across the Country.	1	0.00	300.00	0.00	300.00	1	75.00		100.00		100.00		25.00
Sub-Total :	**9**	**1150.00**	**4050.00**	**0.00**	5200.00	**6.00**	**1055.00**	**3.00**	**1500.00**	**0.00**	**1400.00**	**0.00**	**1245.00**
Component-5: Operational Expenses of PLMC			200.00	400.00	600.00		100.00		200.00		200.00		100.00
Component-6: Procurement Audit		0.00	200.00		200.00				50.00		50.00		100.00
Component-7: Block Allocation	L.S	4200.00	0.00	0.00	4200.00		375.00		1000.00		1250.00		1575.00
Sub-Total :		**4200.00**	**400.00**	**400.00**	**5000.00**		**475.00**		**1250.00**		**1500.00**		**1775.00**
Grand-Total :	**1926**	**366940.00**	**104785.00**	**9800.00**	**481525.00**	**338**	**94463.63**	**530**	**125892.75**	**609**	**129092.62**	**449**	**132076.00**

4.29. Human Resources Management (HRM)

4.29.1. Introduction

Human resource is a critical element in the effective delivery of health services. The Bangladesh Health Workforce Strategy will address the issues of shortages, mal distribution of personnel, skill-mix imbalance, negative work environment and weak knowledge base. Steps will be devised for improving the quality of existing workforce in both the formal and the informal sectors. The public sector HRD strategy will, among other things, involve establishing career plans for specific lines of specialization, based on competence and experience, and clear principles for promotions, posting and transfers. Moreover, the following are some of the important areas of focus for health sector's human resources development and management:

- Developing and implement a long term comprehensive Health Workforce Master Plan which has the provision of short, medium and long term interventions taking public, private and NGO sectors in perspective
- Scaling up production of the critical health workforces including midwives to minimize the immediate gaps as well as ensure service of such personnel.
- The existing anomalies of career planning in health cadre having two separate channels of progression for teachers and rest will be streamlined to remove injustice and resentment.
- To overcome shortage of required human resources "contracted-in" will be explored at all levels by delegating authority for smooth service delivery and gaining management efficiency in operating the Program.
- Undertaking periodic comprehensive assessment of health workforce availability, requirements and gaps in all sub systems; measure geographic, skill mix and gender inequalities; and gather data on national and international migration, and accordingly balance production and deployment of required health workforce in all places
- The marked imbalance in the skill-mix of service providers needs to be addressed on an urgent basis. Priority will be given to the post creation, developed / Review & update job description of various categories of workforces, recruitment rules and capacity building of additional Nurses, Midwives, Paramedics, technicians and C-SBAs to meet existing shortage and improve service delivery.
- Personnel management procedures will be reviewed and updated as required. The updates will include introduction of incentives for service providers working in remote and hard-to-reach areas and modifications of the transfer-posting practices for field level managers.
- Performance management (supervision and annual performance evaluations) of individual staff will be strengthened. This will include application of merit-based incentives as well as disciplinary measures in response to absenteeism or misuse of public-sector resources for private gain.
- The large and critical role of the informal health care providers will have to be recognized and appropriate strategies developed with a view to managing and improving their practices to minimum levels of acceptable care. Guideline will be prepared for need based capacity development program of different durations at both public and non-state facilities, particularly on appropriate drug use and prevention of drug resistance, routine curative care management and referral of complex cases to the appropriate facility.
- Bangladesh needs to take more initiatives to accelerate the reduction of infant and maternal mortality. Broad agreement is reached with respect to the following points: (1) the need to formulate and pass the Midwifery Act. (2) Reconstitution of the Bangladesh Nursing Council as the Bangladesh Nursing and Midwifery Council with separate nursing and midwifery boards. (3) A 6 month refreshers training in midwifery to Diploma nurse midwives and a direct entry diploma and Bsc in Midwifery is initiated according to International Confederation of Midwives standard. (4) Upgrade existing and create training sites where necessary for midwifery training across the country. (5) The Government of

Bangladesh will develop recruitment rule, job description and create 3000 new positions for midwives over the next five years with a focus on serving area with a greater need. A system of supervision will be established to regulate the quality of their service.

4.29.2. Objectives

- To accelerate production and recruitment of health workforce as needed to implement HPNSP objectives properly, by increasing the production capacity, rationalizing the recruitment rules and coordinating the recruitment process.
- To improve the management of existing workforce with clear and updated TO&E, job description, career planning, performance management system, etc and consideration of gender and equity issues in order to increase their performance/productivity and availability.
- To improve the quality of education and training through monitoring, coordination and evaluation of training programs and accreditation of training institutions both in public and private sectors.
- To provide accurate and up-to-date HRH information to policy makers, health managers and other stakeholders through an integrated HRIS for better planning and monitoring

4.29.3. Components

Component 1: HR Policy, planning and coordination

Activities:

- HR planning (2011-16)
- HR projection (2011-21)
- Interfacing with other Ministries and professional bodies
- Developing an effective and fair HRM policies particularly policies on recruitment, deployment, transfer and promotion
- Implementation of Bangladesh Health Workforce Strategy

Implementation of the policy recommendations related to HR in areas of financial and non-financial incentives, contracting in & contracting out of HR in hard-to-reach/rural areas also related to Component-2: Acceleration of production and recruitment to address HR shortage and Component-3: Improved management of existing health workforce

Component-2: Acceleration of production and recruitment to address HR shortage

Activities:

- Increase the production of health professionals
- Upgrading the recruitment rules incorporating best practices of HRM
- Monitoring and coordination of the recruitment processes

Component-3: Improved management of existing health workforce

Activities:

- Standardization of TO&E of the health facilities and organizations
- Developing and updating job descriptions
- Improving implementation of the career planning
- Individual and institutional performance management system
- Increasing retention of health workforce (including developing financial and non-financial incentive packages for hard-to-reach/rural areas)

Component-4: Capacity development /Enhanced quality of education and training

Activities:

- Monitoring, evaluation and coordination of training components of various OPs relating to HRH



- Capacity development of individual and facilities / institutions responsible for HRM (e.g. Individual & Institutional performance management , organization building, Monitoring & Evaluation, stewardship & governance and other relevant HRM issues
- Implementation of accreditation of training institutions

Component-5: HR information system

Activities:

- Developing HRIS establishment and maintenance, automated HRH management process for policy, planning & management through coordinated mechanism.
- Monitoring gaps and progress in HR Foster evidence-based planning and decision making

Component-6: Governance

Activities:

- Reviewing, updating and revitalizing mandate and structure of the regulatory bodies, to increase their effectiveness in strengthening government's stewardship functions.
- Exploring requirements of setting new entities like accrediting bodies for medical education, hospital service delivery, Nursing & Midwifery services and for ensuring food safety.
- Constituting a Taskforce to assess the need for (1) new law/ordinance, (ii) revise any existing ones, and (iii) determining measures to improve existing legal framework
- Reviewing and updating the existing health related legal frameworks to include the health consumer's rights in the Consumer Rights Protection Act (2009)
- Strengthening MOHFW's regulatory and supervisory roles through revising the mandates of the regulatory bodies and capacity building for enforcement of standards.

4.29.4. Cross Cutting Issues

- Scaling up some categories of workforce such as midwifes. OP –MNCAH, MCRAH, NES
- Developing linkage with HIS. OP-HIS-EH, MIS

4.29.5. Indicators

The OP will contribute towards all the results under Component 1, Service Delivery improved, and many of the results under Component 2, Strengthened Health Systems. In particular, the activities will work towards achievement of Result 2.3, improved human resources, planning, development and management.

Sl	Indicators	Base line with Source	Projected Target	
			Mid-2014	Mid-2016
1	HR plan for 2011-2016 developed (by 2012) and implemented (by 2015).	NA	Developed and implemented	Implemented
2	HR projection for 2011-2021 developed (by 2012) and utilized (by 2013).	NA	Developed and utilized	Utilized
3	Recruitment rules upgraded (by 2012) and implemented (by 2013).	Available (BCS RR 1981)	Recruitment rules updated	Implemented
4	Number of health professional increased (from number by category in baseline year to number by category	Doctor: 5000 NS: 2700 MW: 0	Doctor: 5500 NS: 3700 MW: 1500	Doctor: 6000 NS: 4000 MW: 4000
5	TO&E for health facilities and organizations developed (2013) and implemented (by 2014).	NA	Developed and implemented	Implemented
6	Job description (JD) of all categories updated (by2012) and implemented (by 2012).	JD developed in 2008	Updated and Oriented	Implemented

Sl	Indicators	Base line with Source	Projected Target	
			Mid-2014	Mid-2016
7	Career planning scheme improved (by 2012) and implemented (by 2014)	NA	Developed	Implemented
8	Performance Management Systems reviewed (by 2012) and implemented (by 2013).	Implemented in limited offices under DGHS	Existing system reviewed and improved	Implemented
9	Incentive packages (financial and non-financial) for hard-to-reach/rural areas developed and implemented	Policy options developed by the HEU in 2010.	Incentive packages approved.	Incentive scheme implemented
10	Transfer policy implemented	Transfer policy available	Barriers identified	Transfer policy implemented
11	Number of accredited training institutes increased.	NA	Accreditation system developed	Utilized
12	Human Resources Information System (HRIS) established and utilized.	NA	HRIS established and data entered	HRIS is utilized for HRM

4.29.6. Budget

Component and Year wise physical and financial target of OP-HRM

Agency: MOHFW

Name of the OP: Human Resource Management, MOHFW

(Taka in Lakh)

Name of the components / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
(1) HR planning (2011-16) & HR Projection (2011-2021)	20 Meeting & workshop/ 4 Reports/ study/ Consultant	15.00	80.00	260.00	355.00	12 Meeting & workshop/ 2 Reports/ study/ Consultant	250.00	8 Meeting & workshop/ 2 Reports/ study/ Consultant	105.00	--	0.00	--	0.00
(2) Strengthen HRM (Pay of Officers & Establishment, allowances)	19 Persons	450.00			450.00	19 persons	65.00	19 persons	74.00	19 persons	92.00	19 persons	219.00
(3) Vehicle Procurement & Maintenance, Computer accessories	2 Vehicle & Maintenance / Equipments	90.00	200.00	547.00	837.00	Maintenance / Equipments	170.00	1 Vehicle & Maintenance / Equipments	170.00	1 Vehicle & Maintenance / Equipments	175.00	Maintenance / Equipments	322.00
(4) Interfacing with other Ministries and professional bodies on workforce & career planning	20 workshops & reports		120.00	300.00	420.00	4 workshops & reports	0.00	8 workshops & reports	100.00	8 workshops & reports	150.00		170.00
(5) Implementation of Bangladesh Health Workforce Strategy	Implementation plan/ Strategy document	15.00	85.00	250.00	350.00	Implementation plan/ Strategy document	50.00	Implementation plan/ Strategy document	70.00	Implementation plan/ Strategy document	80.00	Implementation plan/ Strategy document	150.00

Name of the components / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
(6) Implementation of the policy recommendations related to HR in areas of financial and non-financial incentives On performance based piloting, contracting in & contracting out of HR in hard-to-reach/rural areas [also related to 2. HR shortage and 3. Improved HR management]	Plan of Action document/ TA	0.00	200.00	400.00	600.00	Plan of Action document	60.00	Plan of Action document	110.00	Plan of Action document	130.00	Plan of Action document	300.00
(7) Replication of Chowghacha model in selected Upzillas-10		400.00	100.00	1000.00	1500.00	1 UZ	100.00	3 UZ	300.00	3 UZ	500.00	3 UZ	600.00
(8) Upgrading the recruitment rules for Doctors, Nurse, Midwives, and Paramedics etc. incorporating best practices of HRM	10 recruitments rules / Resource Person	20.00	150.00	200.00	370.00	continue	0.00	3 recruitments rules / Resource Persons	120.00	4 recruitments rules / Resource Persons	150.00	3 recruitments rules / Resource Persons	100.00
(9) Monitoring and coordination of the recruitment & promotion processes	20 meeting & workshop/ 4 Reports/ study/ TA post creation,	25.00	100.00	170.00	295.00	3 meeting & workshop/ 1 Reports/ study/ Consultant	0.00	continue	70.00	8 meeting & workshop / 1 Reports/ study/ Consultant	130.00	4 meeting & workshop/ 1 Reports/ study/ Consultant	95.00
(10) Standardization of TO&E of the health facilities and organizations	15 Report / record develop/TA	20.00	120.00	250.00	390.00	2 Report / record develop	0.00	5 Report / record develop	110.00	3 Report / record develop	120.00	5 Report / record develop	160.00
(11) Developing and updating job descriptions Doctors, Nurse, Midwives etc.	15 job description	10.00	90.00	200.00	300.00	3 job description	40.00	5 job description	70.00	4 job description	78.00	3 job description	112.00
(12) Improving implementation of the career planning	20 career planning	10.00	50.00	145.00	205.00	5 career planning	20.00	5 career planning	60.00	4 career planning	60.00	6 career planning	65.00

Name of the components / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
(13) Individual and institutional performance management system Increasing retention of health workforce (including developing financial and non-financial incentive packages for hard-to-reach/rural areas)	6 study/ reports / Resource Persons	0.00	145.00	205.00	350.00	continue	0.00	continue	60.00	2 study/ reports / Resource Persons	120.00	4 study/ reports / Resource Persons	170.00
(14) Developing an effective and fair HRM policies particularly policies on recruitment, deployment, transfer and promotion	9 Policies	10.00	50.00	150.00	210.00	1 Policies	20.00	2 Policies	50.00	3 Policies	70.00	3 Policies	70.00
(15) Monitoring, evaluation and coordination of training components of various OPs relating to HRH	15 workshop seminar & reports	10.00	75.00	185.00	270.00	2 workshop seminar & reports	20.00	4 workshop seminar & reports	50.00	5 workshop seminar & reports	60.00	4 workshop seminar & reports	140.00
(16) Capacity development of individual and institutions responsible for HRM.	1250 persons Capacity development through local & foreign												
i. Long course (Local) on hospital management	290 persons		400.00	600.00	1000.00	40 Persons	120.00	60 Persons	180.00	70 Persons	230.00	120 Persons	470.00
ii. Long Course (Overseas)	46 Persons		400.00	300.00	700.00	8 Person	80.00	10 Persons	100.00	13 Persons	180.00	15 Persons	340.00
iii. Short Course (Local)	150 batch	10.00	400.00	350.00	760.00		120.00		120.00		200.00		320.00
iv. Short Course (Overseas)	20 batch		500.00	900.00	1400.00	3 batch	150.00	4 batch	260.00	7 batch	360.00	11 batch	630.00
Fellowship (Long & short)	50 persons		150.00	350.00	500.00	continue	0.00	10 Persons	130.00	15 Persons	110.00	30 Persons	260.00
Exposure Visit	15 batch		200.00	300.00	500.00	1 batch	50.00	2 batch	120.00	4 batch	180.00	8 batch	150.00

Name of the components / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
(17) Implementation of accreditation of training institutions & Individuals.	5 workshops & recommendation/ resource persons		40.00	160.00	200.00	1 workshops & recommendation/ resource persons	20.00	1 workshops & recommendation/ resource persons	20.00	1 workshops & recommendation/ resource persons	50.00	2 workshops & recommendation/ resource persons	110.00
(18) Developing Human Resources Information System (HRIS) and automation of HR management process	1 (HRIS) System & 5 automation	20.00	300.00	350.00	670.00	1 (HRIS) System & 5 automation/ planning	50.00	1 (HRIS) System & 5 automation/ developed	80.00	continue	150.00	continue	390.00
(19) Monitoring gaps and progress in HR	1 Report	20.00	100.00	160.00	280.00	--	0	continue	50.00	continue	80.00	1 Report	150.00
(20) Foster evidence-based planning and decision making	2 study	15.00	80.00	150.00	245.00	continue	0	continue	35.00	1 study	60.00	1 study	150.00
(21) Reviewing, updating and revitalizing mandate and structure of the regulatory bodies, to increase their effectiveness in strengthening government's stewardship functions.	5 reports/ study	40.00	100.00	180.00	320.00	1 reports/ study	80.00	2 reports/ study	110.00	2 reports/ study	130.00	continue	0.00
(22) Exploring requirements of setting new entities like accrediting bodies for medical education, hospital service delivery, Nursing & Midwifery services and for ensuring food safety.	5 reports/ study	30.00	120.00	150.00	300.00	continue	0	1 reports/ study	50.00	2 reports/ study	110.00	2 reports/ study	140.00
(23) Constituting a Taskforce to assess the need for (1) new law/ordinance, (ii) revise any existing ones, and (iii) determining measures to	5 reports/ study	25.00	80.00	250.00	355.00	continue	0	1 reports/ study	80.00	2 reports/ study	100.00	2 reports/ study	175.00

Name of the components / Major Activities	Total physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
improve existing legal framework													
(24) Reviewing and updating the existing health related legal frameworks to include the health consumer's rights in the Consumer Rights Protection Act (2009)	4 reports/ study	20.00	100.00	250.00	370.00	1 reports/ study	100.00	1 reports/ study	120.00	2 reports/ study	150.00	continue	
(25) Strengthening MOHFW's regulatory and supervisory roles through revising the mandates of the regulatory bodies and capacity building for enforcement of standards.	4 study/ reports	20.00	100.00	125.00	245.00	2 study/ reports	45.00	1 study/ reports	100.00	1 study/ reports	100.00	continue	
Grand Total		**1275.00**	**4635.00**	**8837.00**	**14747.00**		**1610.00**		**3074.00**		**4105.00**		**5958.00**

4.30. Sector-Wide Program Management and Monitoring (SWPMM)

4.30.1. Introduction

With the provision in National Constitution as umbrella and guiding principles like Vision 2021, MDG, draft 6th FYP and National Strategy for Accelerated Poverty Reduction – NSAPR II as driving force, the sector wide program planning and management initiatives of the Ministry of Health and Family Welfare (MOHFW) signifies an attempt to preparation of Bangladesh Health, Population and Nutrition (HPN) sector strategy, and Program Implementation Plan for the next sector program from July 2011- June 2016- titled as Health, Population and Nutrition Sector Development Program (HPNSDP). The entire preparation process widely upholds and accumulates all the related sectors, agencies under the ministry and development partners in consultations, considers the experience and lessons from previous two SWAps. The first SWAp (HPSP 1998-2003) marked a shift from a multiple project approach to a single sector program. This has not only ensured Government's leadership in preparing and implementing the program that was sustainable but also created opportunity for coordination, harmonization and alignment of multiple donor funded projects and resources.

The Government has introduced the sector wide approach to effectively manage the Health, Population and Nutrition Sector. The overall purpose of SWAp and its Management is to improve the performances of the HNP sector hence improving the health of the people of Bangladesh. Uniform financial accounting procedure has been developed and implemented. Significant progress was made in standardizing and unifying disbursement procedures and reducing transaction costs associated with managing multiple donor funds. Increased predictability of the amount and timely disbursement of development partner's support should be a major goal for sector program if partnership is to be made meaningful. With the signing of Joint Cooperation Strategy- JCS between GOB and DPs as a continuation of Paris and Accra Declaration, the MOHFW took decision to continue the SWAp during 2011-16 as well.

The Sector Boundary: There are 32 operational plans under the MOHFW and a number of projects included in the HPN sector. MOHFW is implementing several parallel projects included in its ADP, which are outside the SWAp program. The boundaries of the sector extend beyond the mandate of the MOHFW. A true SWAp would encompass both urban and rural health services (i.e. MOLGRDC, MOHFW, and MOCHTA), as well as the buy in and participation from other players, including the Ministry of Finance (MOF). However, MOHFW is not in a position to change the mandate of either this ministry or others. Health being an outcome of multi-sectoral interventions is not also desirable to be handled by the MOHFW alone. In the next sector program MOHFW will try to strengthen its coordination and functional relationship with other ministries involved in providing health services. In addition it will try to bring gradually new and existing parallel projects of MOHFW under the SWAp modalities. It would include a clear strategy for working with the private sector – something which is essential given that more than half of all health expenditure in Bangladesh takes place within the private sector. It would also include a formal mechanism with the large NGO sector in the country that fills the gap where the MOHFW services are either inadequate or cannot be reached.

The MOHFW is playing the role for strengthening public health sector management and stewardship capacity through development of pro-poor targeting measures as well as strengthening sector-wide governance mechanism. Appropriate measures as per agreed results framework will be undertaken with regard to sector management and stewardship role of MOHFW.

The MOHFW has recently adopted the Strategic Plan for Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-2016 with the intention to reforming the HNP system and of pro-poor health service provision. The goal of HPNSDP is to ensure quality and equitable health care for all citizens by improving access to and utilization of health, population and nutrition services and the development objective is to improve both access and utilization of such services, particularly for the poor.

The new SWAp identifies 32 Operational plans (OP), and amongst these Sector Wide Program Management is one of them and implemented by the Planning Wing of MOHFW. The main purpose of Sector wide management is – coordinating and preparing the plan, financing and budgeting, managing, reviewing, monitoring and evaluating the SWAp.

Planning and budgeting procedures are yet to provide adequate flexibility for revision of Operational Plans (OP) revisions with regard to certain percentages of approved PIP enhancement and inter-OP and intra-OP cost adjustment. Due to the bifurcated structure in the MOHFW, adequate and timely monitoring of sector performance is yet to take a sustainable shape for using routine information for decision-making.

The PW has established coordination and collaboration with other relevant sectors, agencies and participating stakeholders to ensure financial and performance reporting. Similarly, various projects funded directly by several DPs are also coordinated by the PW for their reporting on implementation progress along with a few GOB funded vertical projects within MOHFW.

4.30.2. Objectives

- To develop equitable and diverse health population and nutrition sectors' strategies, 5-year plan, program implementation plan (PIP), improve budget management through an MTBF process and roll out for the period of 2011- 2016.
- To assist and coordinate with the implementing agencies to prepare operational plans in line with Strategic plan of the health, population and nutrition sector development program (HPNSDP) for the period of 2011- 2016 and implemented according to agreed performance indicators.
- To broaden the scope of existing M&E unit through establishing a program management and monitoring unit (PMMU) for strengthening monitoring and evaluation of the sector, equipped with adequate skilled professionals and logistics in the PW of MOHFW for management, coordination, monitoring and evaluation and to track progress of HPNSDP
- To develop an M&E Strategy and Work Plan and operationalise a sustainable M&E system in MOHFW.
- To improve all MIS, including regular collection and dissemination of quality data by entities and establish connectivity of those with Data Management and Information System- (DMIS).
- To support and create enabling environment for sector modernization, good governance and participation of non-state actors in the health service delivery
- To coordinate with development partners, implementing agencies, other actors for harmonization, financing and research for better implementation of the project.
- To mobilize resources for HPN sector with DP coordination and enhance the efficiency of resource utilization.

4.30.3. Components

Component-1: Planning and Budgeting

The Planning function under SWAp of the MOHFW oversees to a certain extent the planning and budgeting process of the whole ministry and as such fulfills an essential role in the systems that support timely and adequately submitting of the Operational Plans (OPs) and their budgets. The This responsibilities involve a range of the activities related to (i) Sector wide policy, strategy and planning/budgeting, (ii) Sector wide coordination/collaboration, (iii) Processing of program and projects and (iv) Monitoring and evaluation of program and projects.

A health sector Strategic Plan for HPNSDP has been developed through a consultative process with all relevant stakeholders. This strategic plan of HPNSDP has been translated into a Program Implementation Plan (PIP). Following the PIP, Operational Plans are to be developed for all the components by their respective LDs. The PW revised and standardized formats for the OPs and provided guidance in the development of OPs. OPs will be made for 5 years with reflection of 3-years detailed budget (terminal 2-years budget will be kept as block allocation) by the Line Directors, responsive to the overall planning cycle of GOB and taking into account (i) the results of the earlier year's activities, (ii) changing needs and budget provision as stipulated in the PIP (iii) Local level planning (LLP) inputs from two directorates collected through LLP tool kits, where



applicable. **Introduction of changes in the various support systems such as increased delegation of administrative and financial power to the cost centers to make effective local level planning and implementation of the essential field level activities.** It is expected that a Mid-Term Review will take place at the middle of the PIP implementation. These OPs can then be further revised after MTR.

PW of MOHFW, as a technical wing, providing expert support to LDs, guiding them to appropriately design standardized plans and budgets, strengthen their management and implementation mechanism, and produce reports relevant to OPs, especially with respect to the achievements in their respective Results Framework (RFW) and other sectoral progress reports.

The planning and budgeting functions also include preparation of five years plan, identify health financing and prepare budget accordingly. Improve budget management through an MTBF process. Assist the Directorate Generals, Agency Heads, and Line Directors to prepare the Operational plans. Ensuring that PIP and all OPs are reflected with sectoral polices, HPNSDP priorities and strategies, cross cutting issues equity and gender. Provide secretariat services for the approval of the Operational Plans.

Activities are:

- Preparation of Program Implementation Plan (2011- 2016) according to available resources.
- Finalize PIP and make available for dissemination;
- Explore and mobilize foreign aid for sector program
- Rationalize PIP/OP budget according to sectoral priority;
- Preparation and management of ADP budget within framework to achieve sectoral / program goal;
- Assist and coordinate with Line Directors for preparation of OP based on PIP budget.
- Facilitate timely approval of OP with review of OP components;
- Collaboration with Planning Commission for the preparation and update of Sixth Five Year plan (2010-2015);
- Introduce joint review of non-development and development expenditure in the Ministry as well as in the Directorates on a monthly basis;
- Prepare annual work plan linking with ADP allocation at the beginning of each financial year
- Initiate Single Work Plan for the preparation of annual budget (both development and Non-development budget) in the light of MTBF on a pilot basis;
- Practice adequate flexibility by MOHFW in revising the OPs based on each year's APR and in inter and intra allocation and reallocation of development budget amongst the OPs.
- Facilitate and processing of OP revision wherever needed; and
- Communication of HPNSDP across the organization of MOHFW (fact sheet, reports etc).

Component-2: Monitoring and Evaluation

Under the current health sector program HNPSP, PW with the TA of GIZ (former GTZ), manages the monitoring and evaluation unit (MEU) and the data management information system (DMIS). MOHFW's current M&E system is inadequate and MEU was not in a position to function properly due to lack of capacity and capability, logistics, etc. As NSAPR II categorically mentions to "strengthen capacity of ministries and divisions to monitor and evaluate progress of development projects", there is an urgent requirement of broadening the scope of work of the existing MEU and institutionalizing it as a permanent structure for sustainability, under the direct responsibility of the PW of MOHFW to provide professional, sustainable support to the Ministry, to monitor progress of HPNSDP and to strengthen the monitoring capacities within MOHFW and the Directorates to efficiently use the routine data systems for decision making. This will call for a wide range of activities including coordination and management of activities that span several LDs. Monitoring and evaluation of the sector program requires an overall M&E strategy and work plan, based on a thorough assessment at local and central levels, to guide the improvement of the system, especially the quality and capacity of the routine data collection systems (which includes development of registries, routine data collection forms, type and frequency of reports) and outline specific activities required for strengthening the organizational capacity to conduct effective M&E (including HIS) activities.

The process of translating RFW from program level to the Operational Plan (OP) level indicators has been undertaken for the next sector program will help to set strategic targets and objectives for the Ops. Then at the implementation level periodic review of the OP level indicators will strengthen the monitoring culture within the MOHFW and its Directorates. Developing an M&E framework and system for the HPNSDP is essential to provide convenient and timely information to policymakers as they track its performance in order to make necessary adjustments over its course.

The MOHFW, in collaboration with the DPs, will jointly review the sector program in the third quarter of every year to review implementation progress, called Annual Program Review (APR). The review will: (i) evaluate the effectiveness of the implementation mechanisms and the efficiency of the organizational structures; (ii) assess the impact of the sector program on access to poor, equity, and gender; (iii) assess the sector program's contributions to the improvement of the quality of health services; (iv) assess implementation performance against agreed upon indicators in the program framework and adjust indicators as needed; (v) identify health policy issues; (vi) assess the performance of budget execution; (vii) assess the effectiveness of the sector program's strategies; and (viii) assess the progress on implementing the actions related capacity building and systems strengthening related to governance and fiduciary reforms. An Independent Review Team (IRT) will undertake the APR and assist GOB and DPs during policy dialogue. A joint GoB-DP APR Steering Committee headed by Joint Chief (Planning), MOHFW with representation among other from the socio-economic Division, Planning Commission, ERD and IMED will be responsible for finalizing the priority areas of APR, composition / TOR of IRT and the engagement of the consultants (local and international).

A coordination committee headed by the Secretary/Additional Secretary, MOHFW will be framed to institutionalize the M&E functions in the MOHFW. The coordination committee will also establish a coordination mechanism with the MOLGRDC in relation to birth and death registration, and with Bangladesh Bureau of Statistics (BBS) in relation to decennial census, Sample Vital Registration Survey (SVRS), Multiple Indicators Cluster Survey (MICS), Health Economics Unit, NIPORT, etc.

During the HPNSDP's implementation, it is envisaged that at least five surveys (Bangladesh Demographic and Health Survey in 2011 and 2014, Utilization of Essential Service Delivery (UESD) survey in 2011, 2013 and 2015, and a Bangladesh Maternal Mortality Survey (BMMS) in 2015 will be carried out along with three facility surveys and three integrated bio-behavioral surveys in 2011, 2013 and 2015 to track the Program's performance. SWPM will maintain close liaison with respective funders and implementers of the surveys in pipeline and follow up the progress of each of the activities so that information is available on time to feed into the APR process on regular intervals.

The activities to improve M&E system will include:

- Establishing a program management and monitoring unit (PMMU), equipped with adequate skilled professionals and logistics in the PW of MOHFW for management, coordination, and monitoring and evaluation to track progress in HPNSDP.
- Developing M&E Strategy and Work Plan to identify gaps, duplications and areas for improvement and streamlining the existing routine M&E system.
- Improvement of the routine information of all MIS, including the regular production of meaningful quality data by all health facilities in the country and ensuring an effective involvement of all Directorates and the DMIS.
- Developing a comprehensive capacity building plan comprised of courses and workshops to build M&E skills and capabilities at the central and OP levels.
- Conduct Joint GOB - DPs APR and MTR.
- Conducting studies, evaluations and operation research.

Program Management and Monitoring Unit (PMMU)

An effectively functioning unit in the name of Program Management and Monitoring Unit (PMMU), equipped with adequate skilled professionals and logistics, within a GoB structure, to work on program management and monitoring in the Ministry would be instrumental for management, coordination, monitoring and evaluation to

track progress in the HPNSDP. The proposed PMMU in the Planning Wing of the MoHFW will assist in monitoring the overall performance of HPNSDP and at specific Operational Plans; fund availability, disbursement and utilization; and assessment of the health situation in the country. The PMMU will manage the annual review of the Program and will advise the Government on essential steps to take with respect to overall health, population, nutrition and related actions. It will have an authorized strength of professionals to perform its functions, and will be assisted by a Technical Committee of a pool of experts from international and in-country public/private institutions. In addition, short term experts will be procured for undertaking specific technical tasks. The PMMU will also have secretarial support in the form of personal assistants/clerks. USAID and GIZ are expected to be supportive for providing with the TA for the PMMU.

An organizational chart along with short description of means of operationalization of PMMU has been shown in the organizational chart -B (Page- 277).

The specific activities identified are as follows:

- Six monthly and annually monitoring and review of the implementation progress of the Operational Plans,
- Coordinate with MIS directorates and other LDs to develop a coordinated routine information system and provide technical support to prepare and periodically revise/update the Results Framework with appropriate indicators for PIP/OP.
- Publish a six-monthly performance report on progress on the key indicators from the Results Framework and the PIP/Operational Plan, based on routine information and latest evaluation survey data,
- Coordinate with relevant MOHFW entities, technical partners, and development partners in the design and implementation of an appropriate evaluation plan, including periodic national surveys on specific topics/questions, e.g., BDHS, UESD, BMMS, UHS, BHFS, MICS, etc
- Preparation of Six monthly and annual performance review reports for OPs indictors and publish those accordingly,
- Prepare Annual Program Implementation Report (APIR) and other documents to support Annual Program Review (APR) and provide technical support to the APR/MTR process.
- Provide technical support to MOHFW and the DPs to regular update the status of Results Based Financing (RBF) through Disbursement of Accelerated Achievements of Results (DAAR) indicators, which would be linked to fund disbursement
- Provide technical guidance to efficiently manage the newly established data warehouse- Data Management Information System (DMIS).
- Support the MOHFW to review and monitor legal frameworks and to develop strategies and policies in regard to improve the service delivery in the health sector and to manage emerging health issues ;
- Development and monitoring of plan for capacity building in policy making and updating program documents.
- Develop and implement study tours - with the intent to learn from other country experiences
- Develop and implement a continuous technical capacity assessment process, and support technology transfer policies and mechanisms.
- Conduct meeting of the M&E coordination committee headed by the Additional Secretary/Joint Chief (Planning) and provide support for the smooth functioning of the committee.

Component-3: Governance and Stewardship for Health Sector

The GOB has established different professional regulatory and statutory bodies with the objectives of overseeing the development of a competent professional workforce, ensuring provision of standardized and quality health services and protecting the people's right to health. Instead, the governance system is characterized by weak internal monitoring and oversight mechanism. The Citizen's Charter for health service delivery has already been put in practice in the public hospitals and other health facilities. Practicing of the Charter will be monitored and strict adherence to its implementation will be ensured.



PW, MOHFW will also establish a continuous feedback mechanism with various health watches groups and along with them review the progress on effective implementation of the citizen's charter.

In the next sector program, the MOHFW proposes to increase the effectiveness and functionality of the various national regulatory bodies (BMDC, BNC, BPC, etc) through revision of their mandates, structures and building their capacity. The existing structure and capacity of the MOHFW Directorates (DGHS, DGFP and DGDA) need to be reviewed and strengthened to increase their supervisory capacity and enhance institutional management.

Local Level Planning to explore the real need of the demand side and some delegations of administrative and financial authority will be chalk out to expedite the management to be considered in the next sector Program. Reform and new policy matters will be identified and coordinated through activities under this OP. Priority Interventions will be:

- Coordinate Local Level Planning (LLP) with the respective line agencies and reflect LLP in operational plans in order to allocate fund and implement the activities at local level;
- Review, update and revitalize mandate and structure of the regulatory bodies in strengthening government's stewardship functions.
- **Facilitating and strengthening MOHFW's engagement with the NGO and private sector based on comparative advantage.**
- Publish (web page, printing) and disseminate the reports generated from M&E, studies, reviews and others.
- **Assuming strategic stewardship and governance roles by MOHFW for policy management and setting up a coordinating system for synergistic, effective and efficient contribution from public and non-public including private sector and health related NGOs.**
- Establishing a new Coordination Section in the MOHFW and at the Directorate level to facilitate preparation and use of single work plan.

Component-4: Coordination and Collaboration

One of the roles of the SWPM is coordination across wide range of stakeholders, including inter and intra-ministerial coordination, development partners and different actors, inter sector/OP coordination during implementation of the program. It requires direct involvement, interaction and collaboration with policies and programs of other ministries, agencies and a variety of different role players, viz., (a) government ministries and agencies, (b) private and other non-state health service providers, and (c) professional associations, mass media, community organizations and various other non-governmental actors contributing to health sector's development. The feasibility of such collaboration will be addressed during the next sector program with TA support.

Programs of a number of relevant ministries reinforce health outcomes, e.g., Ministry of Local Government, Rural Development & Cooperatives (MOLGRDC), Ministry of Education (MOE), Ministry of Primary and Mass Education (MOPME), Ministry of Food & Disaster Management (MOF&DM), Ministry of Women & Children Affairs (MOWCA), Ministry of Social Welfare (MOSW), Ministry of Agriculture (MOA), Ministry of Fisheries & Livestock (MOFL), Ministry of Information (MOI), Ministry of Commerce (MOC), Ministry of Finance (MOF), Ministry of Law, Justice and Parliamentary Affairs (MOLJPA), etc. To ensure better coordination an inter-ministerial committee under the chairmanship of the honorable Minister for Health and Family Welfare would be formed to serve as a forum for coordinating the activities of all ministries.

The Joint Cooperation Strategy (JCS) will be institutionalized through GOB – DP Local Consultative Group (LCG) meetings. The LCG sub-group on Ministry of Health has already been constituted which will be the meeting point of the senior management of the MOHFW and representatives of the DP. The LCG Working Groups replaces the previous HNPSP Coordination Committee. MOHFW and the DPs should work together to make the LCG sub-group more effective.



Various joint task groups and technical committees operate under the current sector program HNPSP. The outcome of those task groups are thought to be effective. The most important Task Groups are: MNCH, Nutrition, Public Health, M&E, HRH, HFRG, Procurement, Financial Management and Gender, Equity and Voice and QM. These arrangements may continue to work during the next sector program with additional task groups if required.

MOHFW together with the DPs will develop a Code of Conduct that specifies the responsibilities and obligations of both partners, their way of communication and doing 'business' together during the implementation of the program and bringing in more aid effectiveness. One of such ways could be to reach a joint financing arrangement (JFA) which would clearly articulate the vision, principles, objectives, roles and responsibilities for the DPs and GOB.

The DP coordination mechanism will focus on aid management responsible for the co-ordination of aid proposals, the proper use of pooled aid funds, Disbursement of Accelerated Achievement of Results (DAAR), management of funds, JFA and the provision of activity and expenditure reports to and from Development Partners (including pooled, non-pooled and parallel). One of the major roles of SWPM will be to accelerate the system of aid-effectiveness, alignment, harmonization and enhancing stewardship role the ministry. This function also includes facilitating GOB-DP coordination, formation of Pooled Fund Committee, holding Policy dialogue, dissemination and communication of the HPNSP activities.

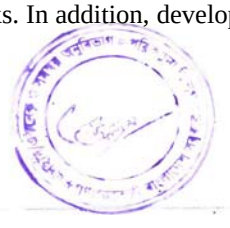
A strong coordination mechanism will be established under the PW, MOHFW during the implementation of the HPNSDP. The important activities will be as follows:

- Ensure coordination across wide range of stakeholders, including inter and intra-ministerial coordination, development partners and different actors to manage the Program. An inter-OP coordination mechanism among the PFD, HSM, HRM and SWPM –OPs would be in place under Joint Chief (Planning) to ensure synchronization of new/upgraded facilities with provision of manpower, supplies and logistics. An inter-ministerial committee under the chairmanship of the honorable Minister for Health and Family Welfare would be formed to serve as a forum for coordinating the activities of all ministries.
- Identification and discharge duties as focal point / person for inter-ministerial activities e,g. urban health, international health etc.
- Mobilizing and ensuring funds, and implementation of the program.
- Facilitating GOB-DP coordination
- Ensure aid management and proper use of pooled aid funds
- Prepare activity and expenditure reports to Development Partners
- Convene HPNSP coordination committee/LCG meeting
- Form and coordinate different task groups
- Develop a code of conduct between MOHFW and DPs
- Establishment of a Pooled Funding Committee including GOB- Pooled funders representative with an appropriate TOR

Component-5: TA Coordination

A coherent multi-year integrated and consolidated Technical Assistance Plan (including technical cooperation) will be developed to support the MOHFW in program implementation and in carrying out the agreed upon policy reforms. This consolidated technical support plan will be supported separately by several DPs with the aim of coordination with the MOHFW to ensure the effectiveness and responsiveness of various technical supports to the various and evolving the program needs.

The TA mapping in terms of related technical / innovative areas, appropriateness or justification, in time placement or availability will be the critical tasks. In addition, development of TORs in connection with the key



issues of assignment including transfer of technology with specific technical expertise and experience, recruitment process and conducting agreements with appropriate conditionality is to be coordinated with DPs.

Based on past experiences, it was deemed reasonable to have a focal point for all types of technical support and cooperation planned by the Partners to enable better coordination, management, follow up and build accountability of both TA provider and recipient. It was agreed by all concerned that DFID will act as the focal point for technical cooperation for the next sector Program.

It was shared that some DPs plan to carry out long term technical cooperation through engaging directly while others will do so through contracted agencies. Some will finance the agencies individually while others would like to pool the TA funds and channel through an identified entity engaged by DFID. Besides the above, the Government will also field some technical assistance through HPNSDP budget to support and strengthen various aspects.

A TA/ TC sub- committee, chaired by the GOB and consisting of the concerned GOB and DP members would be created to coordinate the overall issues.

4.30.4. Cross Cutting Issues

- Coordination for birth and death registration. OP-ESD, MOLG
- Coordination with all form of health information system. OP-CDC, HIS-EH, MIS, TRD.
- Governance, stewardship and legal framework. OP-HRM, IFM, HEF.

4.30.5. Indicators

The activities under this OP contribute to ensuring the quality and equitable health care for all citizens of Bangladesh. They will help to ensure the achievement of Result 2.2 strengthened monitoring and evaluation systems, and Result 2.9, SWAp and improved DP coordination.

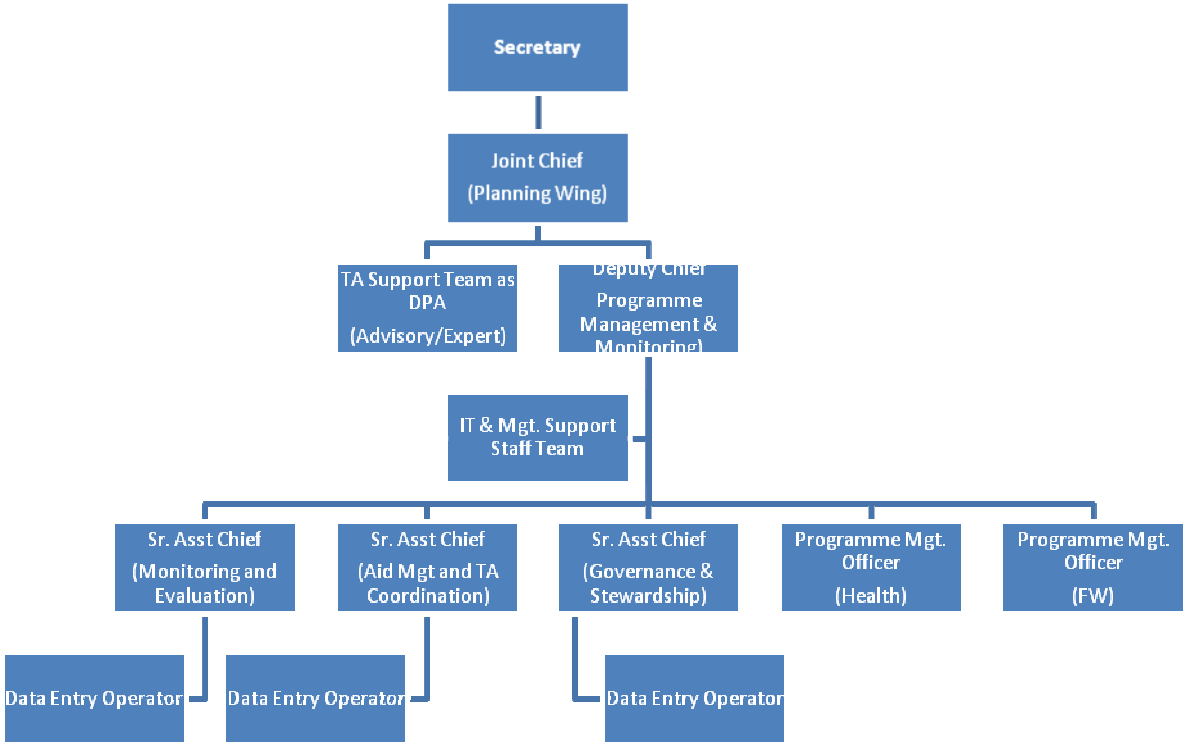
Sl	Indicators	Unit of measurement	Baseline (with year & data source)	Projected target	
				Mid-2014	Mid- 2016
(1)	(2)	(3)	(4)	(5)	(6)
	Component 1: Planning and Budgeting				
	Strategy: *Ensure equitable and diverse health population and nutrition sectors' strategies, effective program planning, and efficient use of resources*				
	% of total National budget allocated to MOHFW	% of MOHFW in the MTBF budget	6.83% National Budget Annually	8 %	10%
	PIP Approved and Published	Number of PIP distributed and published in the website	Not Applicable PW, MOHFW	15 June 2011	March, 2014
	Annual Work Plan with budget allocation submitted quarterly expenditure	% of LDs submitted AWP within selected time line	Not App Planning Wing Annually	90% by July each year	100%
	No of Joint Reviews (DPs & MOHFW) of OP to identify DPs share to support the eligible expenditures.	Number of review meetings	Not Applicable LD, SWPM	6	10
	Resource Allocation Formula reviewed, adopted and piloted	Adopted and piloted	NA PW, MOHFW	Adopted in 2012-13	Piloted in 2014-15
	o **Component 2: Monitoring and Evaluation**				
	Strategy: Establish a sustainable M&E system in MOHFW for management, coordination, and monitoring and evaluation to track progress in HPNSDP				

Sl	Indicators	Unit of measurement	Baseline (with year & data source)	Projected target	
				Mid-2014	Mid- 2016
(1)	(2)	(3)	(4)	(5)	(6)
	Facilitate the joint GOB-DP Annual Program Review (APR)	# of APR Steering Committee meeting/workshop/policy dialogue	NA	3	5
	Program Management and Monitoring Unit established and Functional	Adequate skilled staff with TA and clear mandate in place	Processing initiated since appraisal 2010	Skilled staff & TA in place by --- 2011	Skilled staff will run the system
	Functional Data Management and information System (DMIS) at MOHFW	DMIS feed data from all sources of MOHFW/others and publish report	TA of DMIS in place since 2009 PW, MOHFW	July, 2012 and yearly	Yearly
	Monitor OP indicators quarterly	Status of core OP indicators reported (no of reports) quarterly	Not Applicable PW, MOHFW	12	20
	M&E Coordination Committee formed and meets at least once quarterly.	Number of M&E coordination committee meeting held	M&E task group formed and meeting held regularly	3 meetings per year	3 meetings per year
	Component 3: Governance and Stewardship for Health Sector				
	Strategy: Support for sector modernization and good governance to enhance stewardship role of the ministry				
	Task group on priority areas formed	No of Task Group meeting held bimonthly/ quarterly	Not App	2/ 3 meetings per year	2/ 3 meetings per year
	Coordinate Local Level Planning (LLP)/Upazilla Health System pilot initiative.	TA engaged No of OPs reflected LLP/UHS recommendations	Not app	6 OPs (service delivery OPs)	12 OPs
	Conduct study to Review and update the mandate and structure of the regulatory bodies	No of study	Not App	3	5
	Follow on APR action plan	No of LCG sub-group held	Not App	3 meetings per year	3 meetings per year
	HPNSDP steering committee (with updated TOR) formed for flexible OP approval/revision	Number of HPNSDP meeting held and decisions executed	HNPSP Steering committee formed	4 meeting per year	4 meeting per year
	# of studies conducted, by topic,	Study findings reviewed	Not App	Not App	Not App
	Component 4 :Collaboration and Coordination				
	Strategy 4: *Ccoordinate with development partners, implementing agencies, other actors for harmonization and better implementation of the project*				
	Mobilizing and ensuring PA for HPNSDP	Number of aid agreement signed	Not app	2	4
	Joint Financing Arrangement prepared and adhered to by the GoB and DPs in line with Paris Declaration	Availability of signed Joint Financing Arrangement			

Sl	Indicators	Unit of measurement	Baseline (with year & data source)	Projected target	
				Mid-2014	Mid- 2016
(1)	(2)	(3)	(4)	(5)	(6)
	# of policy dialogues with different stakeholders (by topic, by stakeholders)	Number of Policy Dialogue held	PW management minutes/reports, 2x/yr -	6	10
	No of LCG meeting held	No	Not app	5	10
	Number of decisions taken in LCG working group meetings of the health sector	Number of decisions executed	Not app	2 meeting per year	2 meeting per year
	Pooled fund committee meetings held quarterly	No of meetings held	Not App	4 meeting per year	4 meeting per year
	Component 5: TA Coordination				
	Strategy 5: To support the MOHFW in program implementation and in carrying out the agreed upon policy reforms.				
	% of TA completed as per plan	Percentage	Not Applicable	30%	100%

Organinizational Chart-B

Organogram of Program Management and Monitoring Unit (PMMU) for HPNSDP (2011-2016) MOHFW



- Joint Chief (Planning Wing) of MOHFW will be the team leader of PMMU.TA Support and IT Management Team will be provided by Development Partners as DPA with the request of MOHFW. A post for Deputy Chief (Program Management & Monitoring) will be created newly under revenue budget, Planning Division will be requested to depute an Officer belonging BCS (Economic) Cadre for this position. If creation of a new position for Deputy Chief takes more time then Planning Division will be requested to attach a Deputy Chief from BCS (Economic) Cadre. The Official (Deputy Chief) will have to be well conversant in preparation, management and monitoring of Sector-wide Development Program(s) of MOHFW. IT& Management Support Team will be under the supervision of Deputy Chief (Program Management & Monitoring), the team will comprise a senior IT professional with skill in various aspects of computer software and MIS to assist PMMU. A number of IT professionals will work in the team. Deputy Chief will assign the responsibilities of the professionals.
- Management Support Team will be under the leadership of Deputy Chief (Program Management & Monitoring), the team will comprise of one Administrative Associate, one Finance Associate, six Senior Attendants and five Drivers.
- Post for three Computer Operators will be created in GOB Development/Revenue Budget.
- Three positions for Senior Assistant Chief will be created through restructuring the organogram of Planning Wing.
- Two Program Monitoring Officer (not below the level of Sr. Asst. Chief/Sr. Asst. Secretary) will be deputed from DGHS and DGFP.

4.30.6. Budget

Component and Year wise physical and financial target of OP-HRM

Agency: MOHFW

Name of the OP: Sector wide Program Monitoring and Management

(Taka in Lakh)

Name of the Components[1]/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Component :													
01. GOB DP Coordination & Other related activities (LCG-Health, M&E coordination committee, Different task groups, Pool fund Committee meetings, JFA meetings, Sub committee on TA, other meetings etc.)	L/S	0.00	10.00	0.00	10.00	L/S	2.00	L/S	2.00	L/S	2.00	L/S	4.00
02. Preparation and Revision, Publishing of PIP, OP & other reports.	L/S	0.00	20.00	20.00	40.00	L/S	7.00	L/S	9.00	L/S	14.00	L/S	10.00
03. Conduct Annual Program review (APR), Mid Term Review (MTR) & Policy Dialogue relating to monitor HNP	4 APR, 1 MTR	0.00	185.00	30.00	215.00	1	20.00	1	50.00	1	60.00	2	85.00
04. Strengthening Program Planning & monitoring system in the MOHFW, Directorate level, Concerned Sector of Planning commission and IMED	5 Units	0.00	40.00	20.00	60.00	2	6.00	2	8.00	2	12.00	4	34.00
05. Survey, Study, Research on various issues of SWM (Conduct study to review and update the structure of the regulatory bodies, review resource allocation formula and others)	30 No	0.00	300.00	100.00	400.00	10	50.00	20	100.00	30	100.00	40	150.00
06. Capacity Development & logistic for MOHFW (Planning Wing, Concerned Sector of Planning Commission, IMED, ERD etc).					0.00								
(a) Work shop Meeting/Seminar etc.	50	0.00	200.00	30.00	230.00	10	30.00	10	50.00	10	70.00	20	80.00
(b) Local & Foreign training	20 batches	0.00	290.00	50.00	340.00	5	80.00	5	80.00	5	80.00	10	100.00
(c) Stationary/ Equipment, vehicle (3 no.) & other support	25	325.00	25.00	0.00	350.00	2	70.00	2	75.00	2	100.00	4	105.00

Name of the Components[1]/ Major Activities[2]	Total Physical and financial target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
(d) MPH for the officials of Planning wing/Public Health Wing of MOHFW, Planning Commission (Concern wing)	2 Batch (30 Persons)		60.00		60.00	15.00	30.00	15.00	30.00				
07. Establish & Operational Expenditure of Program Management & Monitoring Unit(PMMU)					0.00								
(a) Meeting/Seminar, Workshop, Stationary, Equipments vehicle (2 no.) & other Supports including DMIS	10	75.00	300.00	100.00	475.00	4	50.00	4	50.00	4	100.00	8	275.00
(b) Local & foreign training	20 batches	0.00	100.00	93.00	193.00	4	30.00	4	40.00	4	60.00	8	63.00
08. Coordinate Local Level planning (LLP)/Upazilla Health System Pilot Initiative through Meeting/ Seminar/ Workshop/ Dialogue with concerned stakeholders	L/S	-	20.00	-	20.00	L/S	2.00	L/S	3.00	L/S	5.00	L/S	10.00
09. TA Support for MOHFW.	L/S	0.00	100.00	4557.00	4657.00	L/S	500.00	L/S	1000.00	L/S	1200.00	L/S	1957.00
Pay and Allowances	17 Persons	150.00			150.00		20.00		50.00		50.00		30.00
Total		550.00	1650.00	5000.00	7200.00	53.00	897.00	63.00	1547.00	58.00	1853.00	96.00	2903.00

4.31. Improved Financial Management (IFM)

4.31.1. Introduction

The Financial Management and Audit Unit (FMAU) of the MoHFW has been established to provide a more complete financial picture of Ministry's activities by capturing all expenditure in formation of all sources in support of the needs of the Principal Accounting Officer, that is the Secretary of MoHFW. The GoB had taken up 1st Population Program from 1975 with the financial assistance of International Development Association (IDA) -IDA Cr No. 533-BD and as such, other eight credits launched by DPs have been implemented successfully till 2003. Presently, FMAU (IFM-MoHFW) is administering with. IDA credit No 4052 BD & TF No. 05610.

The Public Financial Management System in Bangladesh is required for further improvement of managing public funds based on reimbursement and monitoring effectively with economy, efficiency and accountability which is not well understood or practiced at all levels of the system. In recent years, GOB has made considerable progress in public financial management. The Financial Management Reform Program (FMRP) and introducing MTBF and Strengthening Financial Accountability Project' under the umbrella program 'Strengthening Public Expenditure Management Program' (SPEMP) initiatives supported by developments partners demonstrate GOB's continuous thrust to improve public expenditure management and financial accountability that requires more transparency, sound internal controls at all levels, accounting, information on service provided and timely action where mismanagement as well as irregularity in safeguarding assets is observed. MoHFW is one of the pilot ministries for MTBF.

To strengthen internal audit in the Ministry and to ensure effective periodic monitoring of financial and operational activities in the sector. FMAU may outsource internal audit as desired by DP for the next sector program till the capacity building of MoHFW is ensured. There is need for GOB officials to be involved in order for capacity development to start in-house internal audit at the later part of the program and internal auditors hired from the private sector will have the advantage of getting proper access to GOB records. FMAU will coordinate with and facilitate the performance of the internal audit and follow-on and implement internal audit recommendations

The number of unsettled audit observations raised by the C&AG (FAPAD) continues to be a matter of concern. This is due in part to lack of understanding in responding to audit objections by spending offices at district and Upazila level and proved to be extremely time consuming. Non availability of supporting documents for expenditure incurred directly by DP remained another major concern throughout HNPSP implementation which has resulted in a number of unsettled audit observations. FMAU will intensify the resolving effort by holding bipartite and tripartite meeting with the taskforce and with the Audit Committee of the MoHFW.

4.31.2. Objectives

- To ensure transparency and accountability in financial activities;
- To implement funding mechanism agreed for the development funds.
- To improve Management Accounting, Financial reporting & resource tracking;
- To minimize financial risk like financial irregularities.
- To establish automated FMIS that will reflect complete picture of Government expenditures.
- To conduct internal audit and help settlement of audit observations to the Implementing Agency.
- To strengthen internal audit for effective, efficient and economic performance of all the activities
- To build capacity of the related financial and audit personnel.

4.31.3. Components

Accounting and Reporting: The formal as well as the actual HNPSP funds release and reporting procedures need to be strengthened in HPNSDP to ensure that there is clear understanding within the Ministry of Health and family Welfare and LDs. First of all, the use of dual reporting sources needs to be discontinued, requiring a



phased approach to bring gradual improvements in the timeliness of the reporting, the reconciliation process and the use of IBAs across over thousand cost centers. FMAU will intensify efforts that will ensure the use of IBAS budget and accounting modules that created the opportunity to produce management accounting reports for monitoring the health sector program, expenditure monitoring by components and sub-components, resource tracking, reviewing budget variances, analyzing financial information.

Development of Accounting and Asset Management System: Under the IFM operational plan a computerized accounting and asset management system will be developed to bring improvement in timely reporting from field level. In consultation with the MOF and IBAs consulting team linkage/bridge software can be developed to feed timely information for IBAs and for tracking the Asset. The current system of asset and inventory recording, maintenance and verification in MOHFW and LDs is as weak as in other public sector institutions. Neither the LDs nor the DDOs at district and upazila offices maintain an up-to-date asset register. There is no system to ensure that fixed assets are properly recorded at the time of procurement or immediately thereafter.

Internal Control and Audits: To strengthen internal audit in the Ministry and to ensure effective periodic monitoring of financial and operational activities in the sector, FMAU will continue to outsource internal audit function with TOR acceptable to DP to carry out half yearly audit for the program. There is need for GOB officials to be involved in order for capacity development to start in-house internal audit at the later part of the program and internal auditors hired from the private sector will have the advantage of getting proper access to GOB records. FMAU will liaise with and facilitate the performance of the internal audit and follow-on and implement internal audit recommendations.

The number of unresolved audit objections raised by the C&AG continues to be a matter of concern. This is due in part to lack of understanding in responding to audit objections by spending offices at district and Upazila level and proved to be extremely time consuming. Non availability of supporting documents for expenditure incurred directly by DP remained another major concern throughout HNPSP implementation which has resulted in a number of unresolved audit objections. FMAU will intensify the resolution effort by holding bipartite and tripartite meeting with the taskforce and with the Audit Committee of the MoHFW.

Long Term Strategic Approach for Institutional Capacity Development: The main problem of MOHFW financial management relates to the failure of establishing the basic institutional framework required for sustainable systems management and development. Financial Management in Line Directorates is not so strong due to lack of FM staff with appropriate skills, enforcement of financial rules and regulations in maintaining accounts and records. This has led to huge reconciliation problems in accounting office making accurate SOE preparation difficult for the sector. The FMAU of MoHFW under IFM operational plan will be responsible for strengthening and institutionalize the Financial Management operations and Auditing under HPSDP. The implementation experience from the HNPSP has shown clearly that while program specific measures help to mitigate fiduciary risks in the short term, the recurrence of these issues over the years clearly point to the need for addressing the underlying institutional issues relating to financial management. To address the institutional constraints, following initiative will be taken during implementation of HPSDP for 2011-2016:

(i) **Improving the efficiency of Expenditure Management Processes in the Health Sector:** These relate to steps necessary to strengthen the core public expenditure management process in the Health Sector viz planning, budgeting, funds flow and reporting. With the assistance of IDA, as part of the new PFM reform program (SPEMP) and its Components 3, 5, and 6 which deal with strengthening the expenditure management systems and processes, above mentioned areas in MoHFW could be strengthened by linking and coordinating the activities with MOF and SPEMP –project a implementation Team. The institutional strengthening efforts under the new program will need be coordinated through a core group, to be proposed by MOHFW.

(ii) **Strengthening the Monitoring, Oversight of Expenditure Management and Financial management:** A critical weakness that has been brought out in the analysis of the implementation experience of HNPSP relates to the weak monitoring of expenditure incurred by the spending units as well as a weak framework for the timely audit (internal and external) follow ups . Along with strengthening the reporting systems and procedures of the spending units, it is also necessary to strengthen the capacities and systems of the MoHFW for efficient and rigorous monitoring of financial and performance including improvement on action



plans. This could be addressed through the preparation of an "**Audit Strategy"** for the Health Sector which will help to take a holistic and coordinated approach to issues like instituting timely external audits, strengthening internal audits, and ensuring robust follow up of audit recommendations. The other action that MOHFW is to devise is a structured monitoring framework for ensuring improved and efficient oversight, leadership and monitoring of financial management functions.

(iii) **Capacity Building and HR development**: A clear underlying cause for the weaknesses in financial management in the Health Sector relates to the weak staff capacities in terms of necessary skills as well as numbers. The staff and skill gaps in the FMAU have prevented it from exercising the required leadership on FM issues in the Health Sector. At the same time the absence of a systematic **training program** in financial management for the LDs and DDOs (who are health specialists) have also resulted in weak financial management at the spending units. Recognizing these weaknesses, the MoHFW need to prepare a policy paper stating the staffing need across the sector, training plan and an integrated approach to FM capacity building in the Health Sector as well as support the MoHFW to implement the policy decision through one Operational Plan (OP) instead of three uncoordinated and inadequate FM capacity building focused OPs. As an interim measure MOHFW will hire FM staff and consultants following the PPR/PPA immediately after the inception of HPNSDP.

Coordination – A clear underlying cause that impedes better expenditure management is gap of coordination between Planning Wing and FMAU. In the next sector program FMAU will try to establish a better coordination with the planning wing that will enable FMAU for better management of expenditures and reporting. In addition, coordination with LDs would be strengthened for in time reporting in connection with reconciliation and reimbursement.

Aid Modality and Fund Management

In the current mechanism, World Bank (WB) administers the pooled funds on behalf of all the pool donors. Ministry of Finance (MoF) uses the current FOREX account with Bangladesh Bank. The aid modality for HNPSDP will follow the current mechanism with some modifications considering the experiences to date, and at the same time further discussion will continue to find out alternative options of fund management to increase government ownership in the program. The modified version (Option – 1) will encompass joint analytical work, joint financing arrangement (JFA) between DPs and GOB, the establishment of a Pooled Funding Committee including GOB representatives, open eligible expenditure criteria, modified performance-based financing arrangement and procurement pre-review with threshold revisited and streamlining the process. A TA should be engaged from the beginning to manage the fund and develop the capacity of the FMAU.

The process for fund release, expenditure, accounting and reporting of the pooled fund and the subsequent replenishment of the pooled fund will remain same as HNPSP, i.e. FMAU will compile and verify the reconciled SoE sent by the Line Directors and send to the disbursement office for reimbursement.

Activities

A. MOHFW:

- Improvement of Financial Management at all levels of HPNSDP
- Collection of Reconciled SOEs from 32 LDs.
- Preparation and maintenance of Central FMRs reflecting Sector Accounts.
- Submission of FMRs to DPs and Withdrawal Application to DPs
- Reimbursement of expenditure of RPA through GOB funds of HPSDP
- Maintenance of Financial Records, Monitoring and Reporting
- Internal Audit of development funds through outsourced Internal Audit
- Completion of 100% development of audit and accounts and non- development under MOHFW through core audit teams of MOHFW
- Strengthening internal control and Financial Management through spot check.
- Financial Management Support services to anchor LDs by hiring FM staff and build capacity



- Settlement of audit observations of HPNSDP and other projects of MOHFW raised by CAG's audit Directorates.
- Strengthening IFM and LD by filling vacant posts and contracting in additional staff if required.
- Technical Assistance to strengthen FMAU capacity and oversight function.
- A long term technical assistance program needs to be designed both government and DPs. The management of the fund can be contracting- out to a specialist TA management authority. This will help in strengthening the TA procurement process and make it more transparent.. This will help in strengthening the existing system and the overall system strengthening plan can be made more comprehensive and predictable.
- Software development for computerized accounting system and asset management
- Developing mechanism for publishing annual report, financial statement etc. in MOHFW website

Financial Management Personnel for Anchor OPs:

- A number of Financial Management Personnel will be required in the Operational Plan 2011-2016. The categories of Financial Management personnel would be Financial Management Manager, Financial Management Supervisors and Financial Management Officer. Financial Management Officers. They will be dedicated to anchor LDs. The TOR would be finalized and procurement would be made with the approval of the Secretary, MOHFW.

Training Program:

A need assessment will be carried out to develop the curriculum taken into consideration across MOHFW; PFM context and build systematic training module as follows:

- Training on preparation of facilitating Audit (e.g. documentation) and preparation of broadsheet replies and evidence for settlement of audit observations.
- Training on Financial Management and Reporting (FMR) of HPNSDP
- Training on Internal Control of accounts and expenditure management of development funds.
- Training on IBAS and associated with bridge/linkage of software for MOHFW.
- Study tour and Foreign Training on Financial Management, Monitoring, Internal Control System, Procurement and reporting under IDA aided Project.
- Workshop on Financial Management of HPNSDP relevant to Audit Issues
- Training of Financial Management for DDOs and accounts personnel at all levels
- Workshop on Financial Management for LDs, PM, DPM and accounts personnel
- Workshop on Improved Budgeting System (MTBF) for Development and Non Development of all Directorates and Delegation of Financial Powers of MOHFW
- Workshop on Reconciliation of Accounts for LDs under HPSDP
- Workshop on Expenditure Reporting Format for PDs of Projects outsides HPSDP
  Financial Management Training Program for Members of Hospital Management Committee
- Workshop on Monthly Reporting System for LDs and accounts personnel at all levels
- Workshop for Monthly Reporting System for Non- development for Directorates

B) **DGHS and DGFP*:***

- Strengthen FMIS for Realistic Budgeting and Need based Allocation
- Appropriate preparation of Financial Monitoring Report
- Introduction of E-Governance
- Strengthening of internal audit
- Develop computerized accounting system
- Capacity building through Training/Workshop.
- Need assessment for implementation of short and long term activities.
- Preparation of Annual & Revised Operation plan.
- Maintain liaison with FMAU, MOH&FW, Planning Unit, IMED and other related Ministries/Units/Sections for realistic Budgeting.



- Rational allocation of fund considering program and geographical circumstances.
- Preparation of FMR
- Collection of FMR and Compilation.
- Reconciliation with C&AG office and timely Submission.
- Monitoring and Supervision of the expenditures from NHQ to grass root level.
- Co-operation and Co-ordination for preparation of budget and SOE from NHQ to grass root level.

Strengthening Internal Audit:

- Special Audit/inquiry / inspection of financial irregularities, collection of audit objections.
- Co-operate and coordinate to prepare broad sheet reply with C&AG office, NHQ, Divisional, District, and Upazila and below level cost centers.
- Action for audit mitigation.
- Conduct Qualitative performance Audit.

Developing a Computerized Accounting System:

- Establish FMIS (Financial Management Information System) to ensure transparency and accountability.
- Establish Network Based IT and also E-Mail facilities to facilitate data flow.
- Establish Network Based IT and also E-Mail facilities for audit and audit objections status of all offices (Dist. Upazilla and HQ)

Training/Workshop:

- Computer Hardware and Trouble Shooting training.
- Day long workshop for preparation of budget, SOE and reconciliation.
- Database management Training for persons working in Finance Unit of DGFP.
- Training on Internal Audit.

Acquisition of Assets:

- Procure Server, Computers, Printers, and related IT accessories to build up FMIS.
- Procure office equipments for strengthening of Improved Financial Management-FP.

4.31.4. Cross Cutting Issues

Financial management personnel effectively linked with anchor OPs. OP-Anchor OPs of both DGHS, DGFP

4.31.5. Indicators

The OP will specifically contribute to the strengthening the health system, and in particular will help to achieve Result 2.10. “Strengthening financial management systems (funding and financial reporting)”, and also Result 2.1. “Strengthening Planning and budgeting procedures”

Sl	Indicators	Base line (Source)	Projected Target	
			Mid-2014	Mid-2016
1	Software developed and all LDs use Computerized Accounting System	NA, IFM	50%	100%
2	Number of financial reports prepared annually	NA, IFM	2	5
3	Strengthening Internal Audit (Outsourcing) – rephrase as a measurable indicator and make consistent with target	NA, IFP	50%	100%
4	Number of FM personnel trained at all levels	1800, FMAU	3000 (45 Batch)	6000 (90 Batch)
5	IBAS/FMR adopted and used for financial management	38, FMAU	Done	-

Sl	Indicators	Base line (Source)	Projected Target	
			Mid-2014	Mid-2016
6	Number of batches of Refresher courses on Audit and financial Management System organized, by agency	NA	15	30
7	Number of workshops conducted on Audit & Financial Management System organized	NA	25	52
8	GOB IBAs customized to meet health sector financial reporting **(DAAR Indicator)**	NA	Customized and used	TBD

4.31.6. Budget

Component and Year wise Physical and financial target of Ops

Agency : Financial Management and Audit Unit-MOHFW, Audit Unit DGFP, Finance Unit DGHS

Name of the OP: Improved Financial Management

(Taka in Lakh)

Name of the Components/ Major Activities	Total Physical and Financial target					Year-1		Year-2		Year-3		Year 4 & 5	
	Physical Qty/unit	Financial				Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial	Physical Qty/Unit	Financial
		GOB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Operating cost of the IFM-MoHFW (i) Salaries and Allowances		187.45			187.45		30.50		33.50		39.10		84.35
(ii) Supplies and Services	L/S	245.15			245.15	L/S	45.50	L/S	49.00	L/S	48.80	L/S	101.85
(iii) Repair and Maintenance	L/S	52.80			52.80	L/S	9.50	L/S	9.50	L/S	11.50	L/S	22.30
(iv) Acquisition of Assets (Computer, furniture & 1 Vehicle)		127.10			127.10		14.50		65.00		18.60		29.00
Institutionalizing of the IFM (i) Training for DDOs & Accounts Personnel at all Level.	120 (Batch)	49.00	104.00		153.00	40 (Batch)	50.00	13(Batch)	17.00	14(Batch)	18.00	53(Batch)	68.00
(ii) Foreign training on Financial Management Monitoring, internal control system,	21 (person)	-	96.00		96.00			7	32.00	7	32.00	7	32.00
Out Sourcing of FM Personnel for FMAU-MoHFW and LDs Support	32 (person)	-	750.00		750.00	32	100.00		200.00		200.00		250.00
Out Sourcing of Audit firm for internal audit	1(Firm)	-	400.00		400.00	1	40.00		100.00		100.00		160.00
Technical Assistance for IT Support, website of FMAU & LDs e.g. customization of IBAS		-	300.00	950.00	1,250.00		250.00		300.00		300.00		400.00
Workshop Seminars & conference of officials of various level.	52 (Batch)	64.50	250.00		314.50	9 (Batch)	55.00	12 (Batch)	75.00	10 (Batch)	60.00	21 (Batch)	124.50
Total		**726.00**	**1,900.00**	**950.00**	**3,576.00**		**595.00**		**881.00**		**828.00**		**1,272.00**

4.32. Health Economics and Financing (HEF)

4.32.1. Introduction

Health Economics Unit (HEU) was established in 1994 under the Fourth Population and Health Project (FPHP) of Ministry of Health and Family Welfare. The project was established with the support of Department for International Development (DfID) of UK. The Health Economics Project aimed at developing an overall health economics capacity in the country. This capacity was necessary to ensure delivery of cost-effective health care services, efficiency in providing health care services and providing policy guidance to the government. The major activities of the project included training (local & overseas), research and research findings dissemination and networking with National, Regional and International Health Economics Institutions/Organizations. The Government of Bangladesh also established the Institute of Health Economics during the Fourth Population and Health Project (FPHP) period to institutionalize health economics in Bangladesh with support from the then DfID.

With about 160 million populations Bangladesh faces a big challenge of how to extend health care services to the people, especially the most vulnerable and disadvantaged groups – women, children, the poor and elderly. Keeping in mind the Millennium Development Goals (MDGs) and the need and importance of developing a pro-poor strategy for directing health resources and services, the health sector is receiving increased attention from policymakers. For this reason, the MOHFW requires in-house capacity for conducting health policy research, understanding the economic implications of current health care initiatives, proper utilization of pay backs of research and converting research outputs into appropriate policy and actions.

The Government of Bangladesh has made it a priority to eliminate discrimination against women and girls and promote gender equity. Various disparities between girls and boys, women and men has been reduced in Bangladesh, such as life expectancy, primary school enrollment rates, and early childhood mortality but still there are differences regarding access to health services which has resulted a number of areas with serious inequalities and discrimination for girls and women. This is manifested in the high mortality rates, malnutrition rates, incidences of violence, and lack of access to health services.

Government has initiated different mechanisms to promote voice of the stakeholders, for instance the National Health Users' Forum, the Health Advisory Committee; and the Citizen's Charter of Rights. But all these mechanisms provide very limited contribution to ensure incorporation of voice and accountability in the health system, due to non-functionality and/or follow up of planned activities.

There is a greater need/scope of further policy-oriented researches to address these policy issues. The Health Economics and Financing OP can play a vital role in identifying the cheaper interventions; reducing gender discrimination and raising voice of different stakeholders with innovative approaches to address the issues of cost effective health services delivery for the poor and vulnerable.

4.32.2. Objectives

- To conduct policy oriented research on health economics and GNSP issues in the Health Sector and to provide policy support to the Ministry
- To provide policy guidance for cost-effective, gender responsive, efficient health care service delivery;
- To develop health financing framework for the country and explore health financing options;
- To develop resource allocation formula;
- To Institutionalize health expenditure tracking process
- To build overall Health Economics and GNSP capacity in the country; and
- To identify the programs and activities where NGO, stakeholders participation and PPP can be utilized to improve efficiency, enhance accountability and transparency in the health sector.

4.32.3. Components

Component 1: Health Economics

Since its inception in 1994, the role of HEU is to identify efficient and effective policies, strategies for health services to enhance accessibility of health care to the poor and most vulnerable groups, to improve the quality of services as well as to ensure equity.

The HEU can play a vital role in identifying the cheaper interventions; exploring health care financing options, institutionalizing health expenditures tracking process, disease of the poor, innovative approach to address the issues laid down in the different national policy documents.

Activities:

Conduct policy relevant studies

- Developing a national health financing strategy that would guide the nation in adopting and choosing from amongst a variety of options
- Review and reach agreement on the resource allocation formula
- Review different health financing instruments/approaches (demand side financing, role of pre-payment mechanism, community health financing, Tax based financing; reallocation of health tax revenue for health sector)
- Expenditure tracking studies (Public Expenditure Review, National Health Accounts, etc)
- Costing of ESD and other issues
- Facility Efficiency Study
- Benefit incidence analysis
- Make available various health financing and health-economics related research/ studies/ policy notes based on other (inter-ministerial) agencies requirement

Capacity Building in Health Economics Issues

Local Training: Organize Professional Development Training on different aspects of Health Economics (Health Financing, Costing of health services, Economic Evaluation of health services, inequity and poverty, and other issues like: Epidemiology, Research Methodology, Health Services Management , Planning of Health Services, etc.)
Link and Promote HEU website with as many relevant agencies and data warehouse as possible

Foreign Training: Short and long term foreign training on health economics, health care financing, health insurance, National Health Accounts, Economic Evaluation & costing of health care and others,
Dissemination Workshop:

- Organize local seminars, workshops and conferences
- International seminars, workshops and conferences

Procurement: Desktop computers and Laptop, photocopier, multimedia and scanner, Vehicle

Component 2: Gender, NGO and Stakeholders Participation Including PPP

GNSP Unit, under the new program, will reinvigorate its roles to strengthen Bangladesh health system in the area of equity, gender, voice, NGO participation and PPP (EGVNP) related issue as identified in the Strategic Document. MOHFW has already transferred all activities of the erstwhile Gender Issues Office (GIO) to GNSPU. Through this, GNSPU has been entrusted with the implementing role along with the exiting technical and policy support role. In line with this, GNPPU will redefine its purview to implement the program priorities. It will be assigned with the role of focal point/secretariat of EGVNP; especially the NGO Unit will be reconstituted as NSPU (NGO and Private Sector Unit).

GNSPU will continue the role of policy support, policy research, capacity development, and knowledge dissemination and networking. It will provide technical support and help MOHFW (i) to develop relevant policy options and (ii) to design and implement strategies, programs and activities to make HPN sector more



responsive to and mainstream EGV issues. It will also identify the programs and activities where NGO participation can be utilized to improve the efficiency of the sector. This Unit will categorize the areas for stakeholder participation and determine policy strategies to enhance accountability and transparency as well. In this respect, priority focus will be to reconstitute and reactivate the Gender Advisory Committee, and to constitute an Advisory Committee on NGO and PPP issues to guide, identify and implement appropriate actions in the relevant areas.

As a part of policy support, existing Gender Equity Strategy will be updated, a new strategy to facilitate NGO and PPP participation will be formulated and EGVNP related innovative interventions will be piloted. Responding to the needs of the victims of VAW will be a priority issue to develop policy options. Piloting will be initiated for making health centers responsive to victims. In addition, networking and coordination with One-stop Crisis Centre and Women Friendly Hospital Initiative will be strengthened. GNSPU will undertake policy research/studies to guide and develop evidence based policy options for HPN sector on EGVNP issue.

To strengthen sector's knowledge base, GNSPU will regularly communicate with its policy and field level stakeholders and disseminate acquired and available information. It will also develop and maintain formal networks with relevant stakeholders/experts on EGVNP issues. GNSPU will revitalize its role in capacity building of the HPN policy planners, managers, service providers and stakeholders on EGVNP issues through arranging long as well as short term training/research opportunities, workshops and seminars.

Activities

Policy and technical support

- Redefining roles as focal point/secretariat for EGVNP issues
- Reconstituting and activating the Gender Advisory Committee
- Constituting an Advisory Committee on NGO and PPP
- Updating existing Gender Equity Strategy
- Developing Strategies for facilitating NGO and stakeholder participation and PPP
- Developing EGVNP responsive policy options, programs and activities
- Designing and piloting EGVNP related innovative interventions
- Sensitization on collection and use of sex disaggregated data

Conduct policy relevant studies

- Identify and conduct research/studies which have significant policy implications
- EGVNP related research/studies topics and areas will be identified in consultation with relevant stakeholders
- Mechanism for deployment and retention of service providers especially female (doctors, nurses, paramedics) will be designed.
- Legal and administrative procedure for monitoring private sector health services will be reviewed and made effective
- Violence against women: measuring the gap between incidence and reporting
- Measure of Unmet need of RH
- Situation analysis of female service providers
- Analysis of different committees of stakeholders' contribution in policy

Capacity Building on EGVNP Issues for policy planners, managers, providers and stakeholders:

- Local short training, workshops and seminars
- Local long courses for postgraduate and research degrees
- Short and long term foreign training

Knowledge dissemination and networking:

- Organize local and international level dissemination seminars/workshops/ conferences
- Attend national and international seminars/workshops/conferences



- Develop and maintain formal and informal networks with national and international stakeholders/experts
- Establish a resource center on EGVNP issues
- Publish newsletter/periodicals/policy briefs/journals

Procurement of Equipments and Vehicle: Desktop computers and Laptop, photocopier, multimedia and scanner, Vehicle

4.32.4. Cross Cutting Issues

(i) Managing activities with the overall PPP policy and strategy. OP-NGO bureau, OP-TB-LC, NASP, CDC, NCD, HSM, PSE, NNS, PME-FP, SDAM

(ii) The OP will have cross cutting issues linked with service delivery OPs particularly MNCAH, ESD, HEP, MCRAH, IEC.

(iii) The research activities will have interfaces with Planning and Research OP

4.32.5. Indicators

The activities under this OP will contribute to the strengthening of the health system and, in particular, Result 2.1, strengthened planning and budgeting procedures, and Result 2.10, strengthened financial management systems.

Sl	Indicator	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
Health Economics				
1	Number of training conducted (by batch, local) on health financing	Local training – 04 course – 01 post graduation, HEU	20 Local batches Foreign Training-10 Local long training-2	30 Local batches Foreign Training-20 Local long training-2
2	Number of study/ research conducted on health financing	09 researches/ studies HEU (20100	15 Studies with report	25 Studies with report
3	Number of workshops/ seminars conducted on health financing	09 dissemination workshops HEU (2010)	15 workshops/ seminars	27 workshops seminars
4	Health care financing framework designed and implemented	NA, HEU, 2010	Designed	Implemented
5	Health insurance Piloted and results disseminated	NA, HEU, 2010	Piloted	Implemented
6	Advisory committees on health financing constituted and activated	NA, HEU, 2010	2 committees 4 meetings at least 2 decisions	2 committees 8 meetings at least 4 decisions
GNSP				
7	EGV strategies developed	NA	2	3
8	Number of training conducted (EGV)	Local training – 04 course	15 Local training courses (250 participants) Foreign training (6 participants)	25 Local training (400 participants) Foreign training (10 participants)
9	Policy research conducted (EGV)	1, HUE, 2010	8 studies with reports	15 studies with reports
10	Workshops conducted (EGV)	5, HEU, 2010	15 workshops	25 workshops



Sl	Indicator	Base line (with Year and Data Source)	Projected Target	
			Mid-2014	Mid-2016
11	EGVNP and stakeholders issues piloted	NA, HEU, 2010	Piloting started	Piloting completed
12	Analyzed Health expenditure, service utilization, HR etc from gender and equity perspectives	NA, HEU, 2010	1	5

4.32.6. Budget

Component and Year wise physical and Financial target of OP

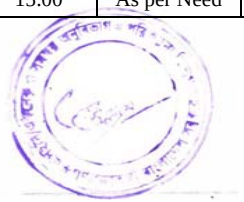
Agency: Ministry of Health and Family Welfare

Name of OP: Health Economics and Financing

(Taka in Lakh)

Name of the Components/Major Activities	Total Physical and Financial Target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
Component - 1: Health Economics & Financing													
1. Capacity building													
1.1 Short local training	30 batches	20.00	25.00	0.00	45.00	6 batches	9.00	6 batches	9.00	6 batches	9.00	12 batches	18.00
1.2 Long local training	2 persons		40.00		40.00	1	8.00	1	8.00	2 persons	8.00	4 persons	16.00
1.3 Foreign training	20 Persons		20.00	80.00	100.00	4	20.00	4	20.00	4	20.00	8	40.00
2. Policy Advice													
2.1 Conduct Research (Broad areas: BNHA, PER, Insurance related studies, BIA, FES, RAF, Costing of ESD & Non-ESD, HIES, etc.)	25 studies		125.00	767.00	892.00	09 studies	300.00	4 studies	146.00	4 studies	146.00	08 studies	300.00
2.2 Development of Policy briefs, strategies & options	10 Nos.	10.00			10.00	2 Nos.	2.00	2 Nos.	2.00	2 Nos.	2.00	4 Nos.	4.00
3. Dissemination													
3.1 National	20 Nos.	8.00		25.00	33.00	4 Nos.	6.00	4 Nos.	6.00	4 Nos.	7.00	8 Nos.	14.00
3.2 International	05 Nos.			25.00	25.00	1 No.	5.00	1 No.	5.00	1 No.	5.00	2 Nos.	10.00
3.3 Publication	As per Need	5.00	5.00		10.00	As per Need	2.00	As per Need	2.00	As per Need	2.00	As per Need	4.00
4. Pilot Health Financing/Insurance issue	Pilot in 2 Upazilas			700.00	700.00	Pilot in 2 Upazilas	200.00	Pilot in 2 Upazilas	100.00	Pilot in 2 Upazilas	150.00	Pilot in 2 Upazilas	250.00
5. Different meetings	As per Need	15.00			15.00	As per Need	3.00	As per Need	3.00	As per Need	3.00	As per Need	6.00
6. Consultancy													
6.1 National	60 MMs* 2per			240.00	240.00	24 MMs	48.00	24 MMs	48.00	24 MMs	48.00	48 MMs	96.00
6.2 International	60 MMs			900.00	900.00	12 MMs	180.00	12 MMs	180.00	12 MMs	180.00	24 MMs	360.00
7. Capital													

Name of the Components/Major Activities	Total Physical and Financial Target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
7.1 Purchase of Vehicle	01 Vehicle	31.50			31.50	01 Vehicle	31.50						
7.2 Computer & access.	03 PCs & 02 Laptops	3.00			3.00	01 PC & 01 Laptop	1.20			01 PC & 01 Laptop	1.20	01 PC	0.60
3.3 Photocopier	1	2.00			2.00			1 No.	2.00				
7.4 Scanner	1	0.50			0.50			1 No.	0.50				
7.5 PA system		1.00			1.00	1 set	1.00						
7.6 CD/VAT	1 vehicle	31.00			31.00	1 vehicle	31.00						
7.7 Others	Lump	2.50			2.50	Lump	2.50						
8. Repair & Maintenance	2 vehicles, 15 PC & Laptop	20.45			20.45	2 vehicles, 15 PC & Laptop	2.75	2 vehicles, 15 PC & Laptop	3.25	2 vehicles, 15 PC & Laptop	4.70	2 vehicles, 15 PC & Laptop	9.75
9. Office Running Cost	As per Need	88.55			88.55	As per Need	20.60	As per Need	15.70	As per Need	16.55	As per Need	35.70
Sub Total of component 1:		**238.50**	**215.00**	**2737.00**	**3190.50**		**873.55**		**550.45**		**602.45**		**1164.05**
Component - 2: GNSP													
1. Pay & allowances	14 Nos.	414.00			414.00	14 Nos.	59.30	14 Nos.	64.43	14 Nos.	75.83	14 Nos.	214.44
2. Capacity building													
2.1 Short local training	30 batches	20.00	25.00		45.00	6 batches	9.00	6 batches	9.00	6 batches	9.00	12 batches	18.00
2.2 Long local training	15 Persons		25.00	40.00	65.00	3 persons	13.00	3 persons	13.00	3 persons	13.00	6 persons	26.00
2.3 Training on EGV	25 batches		30.00	100.00	130.00	05 batches	26.00	05 batches	26.00	05 batches	26.00	10 batches	52.00
2.4 Foreign Training	10		25.00	25.00	50.00	2	10.00	2	10.00	2	10.00	4	20.00
3. Policy Advice	47.00												
3.1 Conduct Research (Broad areas: Gender, EGV, VAW, Stakeholder Participation, etc.)	15 studies		150.00	500.00	650.00	03 studies	130.00	03 studies	130.00	03 studies	130.00	06 studies	260.00
3.2 Development of Policy briefs, strategies & options	10 Nos.	10.00			10.00	2 Nos.	2.00	2 Nos.	2.00	2 Nos.	2.00	4 Nos.	4.00
4. Dissemination													
4.1 National	20 Nos.	10.00	10.00	5.00	25.00	4 Nos.	5.00	4 Nos.	5.00	4 Nos.	5.00	8 Nos.	10.00
4.2 International	05 Nos.			30.00	30.00	1 No.	6.00	1 No.	6.00	1 No.	6.00	2 Nos.	12.00
4.3 Publication	As per	5.00	5.00	5.00	15.00	As per Need	3.00	As per	3.00	As per	3.00	As per	6.00



Name of the Components/Major Activities	Total Physical and Financial Target					Year-1		Year-2		Year-3		Year-4 & Year-5	
	Physical Qty/Unit	Financial				Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial	Physical Qty/unit	Financial
		GoB	RPA	DPA	Total								
1	2	3	4	5	6	7	8	9	10	11	12	13	14
	Need							Need		Need		Need	
5 Pilot EGV issues	Pilot in selected areas		45.00	287.00	332.00	Pilot in selected areas	60.00	Pilot in selected areas	65.00	Pilot in selected areas	65.00	Pilot in selected areas	142.00
6. Different meetings	As per Need	15.00			15.00	As per Need	3.00	As per Need	3.00	As per Need	3.00	As per Need	6.00
7. Consultancy													
7.1 National	28 MMs*2 Per		40.00	100.00	140.00	08 MMs	20.00	12 MMs	30.00	12 MMs	30.00	24 MMs	60.00
7.2 International	36 MMs			540.00	540.00	12 MMs	180.00	12 MMs	180.00	12 MMs	180.00		
8. Capital													
8.1 Purchase of Vehicle	01 Vehicle	31.50			31.50	01 Vehicle	31.50						
8.2 Computer & access.	03 PCs & 02 Laptops	3.00			3.00	01 PC & 01 Laptop	1.20			01 PC & 01 Laptop	1.20	01 PC	0.60
8.3 Photocopier	1	2.00			2.00	1 No.	2.00						
8.4 Multi-media	1	2.00			2.00			1 No.	2.00				
8.5 Scanner	1	0.50			0.50	1 No.	0.50						
8.6 CD/VAT					0.00								
8.7 Others	Lump	3.60			3.60	Lump	1.75	Lump	0.40	Lump	0.65	Lump	0.80
9. Repair & Maintenance	1 vehicle, 10 PCs & Laptops	12.05			12.05	1 vehicle, 10 PCs & Laptops	1.75	1 vehicle, 10 PCs & Laptops	2.25	1 vehicle, 10 PCs & Laptops	2.25	1 vehicle, 10 PCs & Laptops	5.80
10. Office Running Cost	As per Need	74.85			74.85	As per Need	13.45	As per Need	13.70	As per Need	14.55	As per Need	33.15
Sub Total of component 2:		**603.50**	**355.00**	**1632.00**	**2590.50**		**578.45**		**564.78**		**576.48**		**870.79**
Grand Total:		**842.00**	**570.00**	**4369.00**	**5781.00**		**1452.00**		**1115.23**		**1178.93**		**2034.84**

CHAPTER V: EXPENDITURE PLAN FOR HPNSDP (2011-2016)

5.1 Introduction

Currently public and private sources of health finance combined are insufficient to achieve full coverage of health services. On an average, about 3.2 per cent of GDP is spent on health, population and nutrition (HPN) sector in Bangladesh, of which about one percent of GDP is allocated by the public sector. This share is low for ensuring a sustainable development of the sector. Although there is scope for improved utilization of available funds and achieving greater equity, but the HPN sector is a case for demanding higher allocations in every fiscal year. The share of HPN allocation to national budget therefore needs an upward rise year by year and should be reached 10% of the national budget by the year 2016. This also calls for incremental funding from the Development Partners (DPs), who have been providing support to the development of the HPN sector in Bangladesh.

5.2 Estimated Budget and Expenditure of HNPSP

The Health, Nutrition and Population Sector Program (HNPSP) outlines activities from 2003-11 and a total of Tk. 37,384.11 crore (US$ 5,417.98 million) was estimated to be spent for the implementation of HNPSP. Out of this Tk. 20,817.64 crore (US$ 3,017.04 million) is non-development budget (55.7%) and Tk. 16,566.47 crore (US$ 2,400.93 million) is development budget (44.3%). Out of the total development budget to be spent through 38 OPs, 38 % is GOB contribution (Tk. 6,299.11 crore or US$ 912.91 million) and 62% is DP contribution (Tk. 10,267.34 core or US$ 1,488.02 million).

Considering 100 % utilization of 2010-11 ADP allocation for HNPSP, the total development budget expenditure in June 2011 will stand at Tk. 13,541.00 crore. This implies that the fund utilization rate of the development budget during HNPSP period will stand at 82 % of the estimated budget. The rate of utilization is even lower for the DP contribution (79.4%) during the same period as estimated expenditure is Tk. 8,156.03 crore (US$ 1182.03 million) against the commitment of Tk. 10,267.34 crore (US$ 1488.02 million). However, the rate of utilization of GOB development budget is higher (85.87%) during the same period. At the closure of HNPSP period, the GOB development expenditure will stand at Tk. 5409.31crore (US$ 783.96 million) against the estimated budget of Tk. 6299.11 crore (US$ 912.91 million).

The main reasons for low utilization of funds are (i) non-availability of resources from DP's end and consequent reduction in GOB's matching fund as per the estimate, (ii) delay in procurement due to the complex procedural steps and (iii) reduction in absorption of fund due to frequent changes of the LDs. The absorption capacity varied significantly by OPs during HNPSP implementation. The expenditure trend of the non development or revenue budget shows that the rate of utilization is higher (ranging from 95 to 100 per cent) than that of the development budget. The fund utilization rate of non development budget will stand at 97 % assuming 100 % utilization of revenue budget of 2010-11. This gives the evidence that MOHFW's absorption capacity has increased during the SWAp implementation period over the last ten years.

5.3 Background of Budget Estimation of HPNSDP

According to National Health Accounts, total health expenditure in Bangladesh was Tk. 16,089.9 crore in 2007. Assuming that the growth rate of the total health expenditure is equal to 16.33 % (the average of the growth rate of 2004-07), the estimated total health expenditure stands at Tk. 266,741.61 crore for the period of 2011-16. Therefore, the financing gap between what is needed and what is actually spent on health is considerably high. Assuming that the share of the public spending of the total health expenditure in the country will remain same (26%), the required public spending is Tk. 30,614.01 crore for achieving MDG 4, 5 and 6, which only includes child health, maternal health, HIV/AIDS, malaria and tuberculosis, by 2015.

The results of the MDG needs assessment and costing study show that US$ 19 per capita (US$ 4.38 for child health, US$ 1.72 for maternal health, US$ 3.14 for HIV/AIDS, Malaria and TB, and US$ 10.56 for health

systems) and a total of Tk. 145,915.80 crore is required to achieve the health related MDGs (2009-2015). The data disaggregated by year shows that the total resources needed for 2011-15 is Tk. 117,746.2 crore.

Considering the above phenomenon budgeting of the next sector program for 2011-16 has been initiated. The data available from various sources (MOF, MOHFW, etc.), budget request from the LDs, government's document and strategies and trend analysis of budget allocations and absorption capacity of previous years were used to estimate an indicative budget for the next health sector program. The OP-wise projected budget using MTBF projections and on the actual capacity to utilize the fund during HNPSP.

The projection of development budget of MOHFW for HPNSDP had widely been disseminated and the MOHFW received significant feedback from the stakeholders. On the basis of the comments and the substantial difference between the requested budget by the various LDs, the available budget indicated by MOF in the MTBF and absorption capacity of the implementing agencies, the MOHFW estimated the budget for HPNSDP and revised the OP-wise budget distribution based on (i) the trend estimated expenditure (ii) the budget requests by the LDs and (iii) the main 'drivers' of the new program (e.g. CC, PHC through UHS, etc), along with putting more resources in the areas emphasized for priority interventions.

5.4 Resource Envelope for HPNSDP

MTBF projection shows that the estimated non development budget for 2011-12 is Tk. 5,387.00 crore and for 2012-13 is Tk. 6,161.03 crore. Using the MOF's MTBF allocation projected for next three years (2013-2016) it is observed that non development budget earmarked for the year 2013-14, 2014-15 and 2015-16 is Tk. 6,915.66 crore, Tk. 7,746.27 crore, and Tk. 8666.92 crore respectively. The projection depicts that the total estimated non development budget for 2011-16 is Tk. 34,816.88 crore (US$ 4,704.98 million). The MOHFW has decided to set the development budget ceiling according to the available resource envelope (with a limited resource gap) of Tk. 22,176.66 crore. Therefore, the total estimated budget for the MOHFW is Tk. 56993.54 crore (US$ 7701.83 million) for the next sector program, inclusive of the development and non development budget requirement.

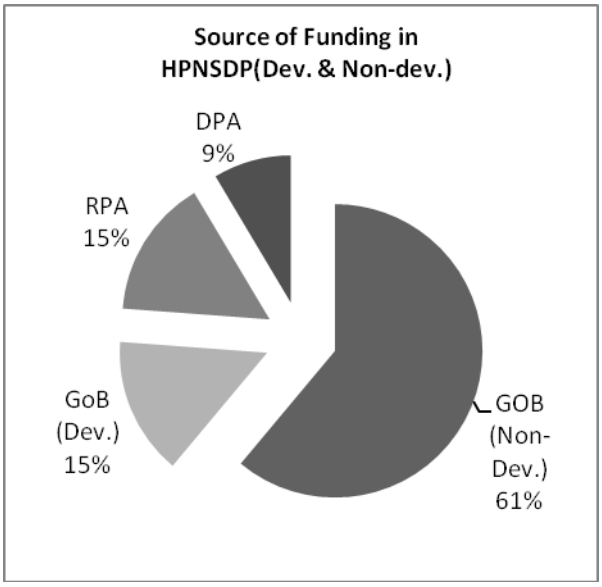
The MTBF projection of the development budget of MOHFW considers not only the budget spent under the OPs but also some parallel projects outside the OPs. Therefore, finally Tk. 22,176.66 crore (US$ 2996.85 million) has been set as the estimated development budget requirement of HPNSDP to be spent through the OPs assuming that development budget allocation will increase incrementally over the proposed program period.

As mentioned earlier, the yearly non development budgets of MOHFW have been set according to the MTBF projection. However, the yearly development budget of MOHFW has been estimated by multiplying the average absorption capacity (82%) and the yearly projected amount by MTBF. The projected trend of the non development and development budget shows that the share of estimated non development budget has gradually increased from 59.9 % in 2011-12 to 63 % in 2015-16. On the other hand, during the same period the share of the development budget has decreased from 40% to 36 %. The average share of the non development budget (61 %) is higher than the average share of the development budget (39 %).

Table 5.1: Allocation in the MTBF (2011-2016) for MOHFW (Revenue, Development)

(In Crore Tk.)

Budget by Type	2011-12	2012-13	2013-14	2014-15	2015-16	2011-16
Non development budget	5327.00	6161.03	6915.66	7746.27	8666.92	34816.88
Non Development Budget % of total MOHFW	60%	62%	63%	63%	63%	62%
Development budget	3561.75	3698.40	4097.31	4555.22	5073.85	20986.53
Development budget as % of total	40%	38%	37%	37%	37%	38%
Total budget of MOHFW (in crore Tk.)	8888.75	9859.43	11012.97	12301.49	13740.77	55803.41
Total budget of MOHFW (in million US$)	1201.18	1332.36	1488.24	1662.36	1856.86	7541.00



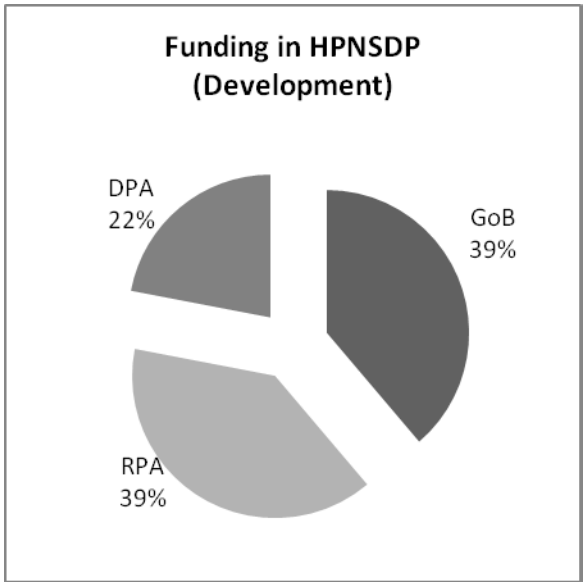


Table 5.2: Summary of estimated budget for HPNSDP (2011-2016) by sources of Financing

(In Crore Tk.)

Financing Pattern	2011-2016	% of Total
GOB Non-Development (Revenue)	34816.88	61%
GOB Development	8,603.50	15%
Sub-Total of GOB	43,420.38	76%
Pool Fund/RPA	8,697.91	15%
DPA	4,875.25	9%
Sub-Total of PA	13,573.16	24%
Total of Development (GOB Dev.+ PA)	22,176.66	39%
Grand Total (Non-Dev. + Dev.)	**56,993.54**	**100%**

5.5 Estimated Development Budget Requirement by the OPs

The MOHFW has decided to reduce the number of OPs in the HPNSDP to 32. The ongoing 38 OPs have been rearranged in to 31 OPs and one new OP, which is Community Based Health Care, has been proposed. The activities of the next sector program will be broadly similar in nature with new elements based on needs of the time. For that purpose, the suggested total budget has been arranged by 32 OPs including the amount required for the new OP.

The OP-wise distribution of the development budget of HPNSDP has been derived by the following steps. Firstly, it is assumed that the yearly average estimated budget for the next program will at least increase by 100 % than the yearly average expenditure of the current program considering the incremental demand due to population growth, inflation and inclusion of new interventions along with activities. In some cases the increase is assumed to be 150 % and even more due to drastic increase in budget request of few OPs compared to previous expenditure with a view to giving new thrust and increasing coverage countrywide. Therefore, total estimated budget for each OP is calculated from the yearly average estimated budget and it is derived from the yearly average expenditure of HNPSP using some assumptions. Secondly, in order to derive the OP-wise distribution of development budget of HPNSDP based on budget requests, the budget request of each OP is reduced to 49 % to match the estimated budget of Tk. 22176.66 crore. Finally, the budget for each OP is estimated taking 50 % from the distribution based on expenditure trend and 50 % from the distribution based on

budget request. The strength of this approach is that it is considering both previous expenditure trend and budget request reflecting the future need (Table 2).

According to this OP-wise distribution as suggested in Table below, the estimated budget is highest for Physical Facilities Development (22%) followed by Maternal, Neonatal and Child Health Care[2] (14%). Community Based Health Care and Hospital Services Management has received 8 %, National Nutrition Service (NNS) and Family Planning Field Services Delivery also has received 7 %, and Clinical Contraception Services Delivery has received 6% of the estimated budget.

Table 5.3: Operational Plan (OP) wise estimated cost of the PIP of HPNSDP

(Taka in Lakh)

Sl. No.	Name of the Operational Plan	GoB	RPA	DPA	Sub-total PA	Total	% of Total
1	2	3	4	5	6	7	8
DGHS							
1	Maternal, Neonatal, Child and Adolescent Health (MNCAH)	38,263.10	161,857.87	101,804.02	263,661.89	301,924.99	13.61%
2	Essential Services Delivery (ESD)	9,589.27	29,266.56	5,700.10	34,966.66	44,555.93	2.01%
3	Community Based Health Care (CBHC)	41,391.00	68,388.12	55,940.00	124,328.12	165,719.12	7.47%
4	TB and Leprosy Control (TB-LC)	3,300.86	4,635.14	24,248.00	28,883.14	32,184.00	1.45%
5	National AIDS And STD Program (NASP)	1,300.00	20,605.00	5,386.90	25,991.90	27,291.90	1.23%
6	Communicable Diseases Control (CDC)	13,826.55	17,965.50	28,550.00	46,515.50	60,342.05	2.72%
7	Non-Communicable Diseases (NCD)	13,824.00	27,787.00	10,300.00	38,087.00	51,911.04	2.34%
8	National Eye Care (NEC)	1,094.50	718.00	400.00	1,118.00	2,212.50	0.10%
9	Hospital Services Management (HSM)	84,962.07	85,553.50	15,700.00	101,253.50	186,215.57	8.40%
10	Alternate Medical Care (AMC)	7,105.00	800.00	-	800.00	7,905.00	0.36%
11	In-Service Training (IST)	9,437.00	19,411.00	4,900.00	24,311.00	33,748.00	1.52%
12	Pre-Service Education (PSE)	23,485.00	31,515.00	4,500.00	36,015.00	59,500.00	2.68%
13	Planning, Monitoring and Research (PMR-DGHS)	1,000.00	3,100.00	1,200.00	4,300.00	5,300.00	0.24%
14	Health Information Systems and E-Health (HIS-EH)	20,014.42	22,972.95	17,900.00	40,872.95	60,887.37	2.75%
15	Health Education and Promotion (HEP)	4,225.00	4,240.00	6,150.00	10,390.00	14,615.00	0.66%
16	Procurement, Logistics and Supplies Management (PLSM-CMSD)	40,474.00	1,300.00	2,000.00	3,300.00	43,774.00	1.97%
17	National Nutrition Services (NNS)	28,528.00	85,055.38	35,426.00	120,481.38	149,009.38	6.72%
	Sub-total(DGHS)	**341,819.77**	**585,171.03**	**320,105.02**	**905,276.05**	**1,247,095.86**	**56.23%**
DGFP							

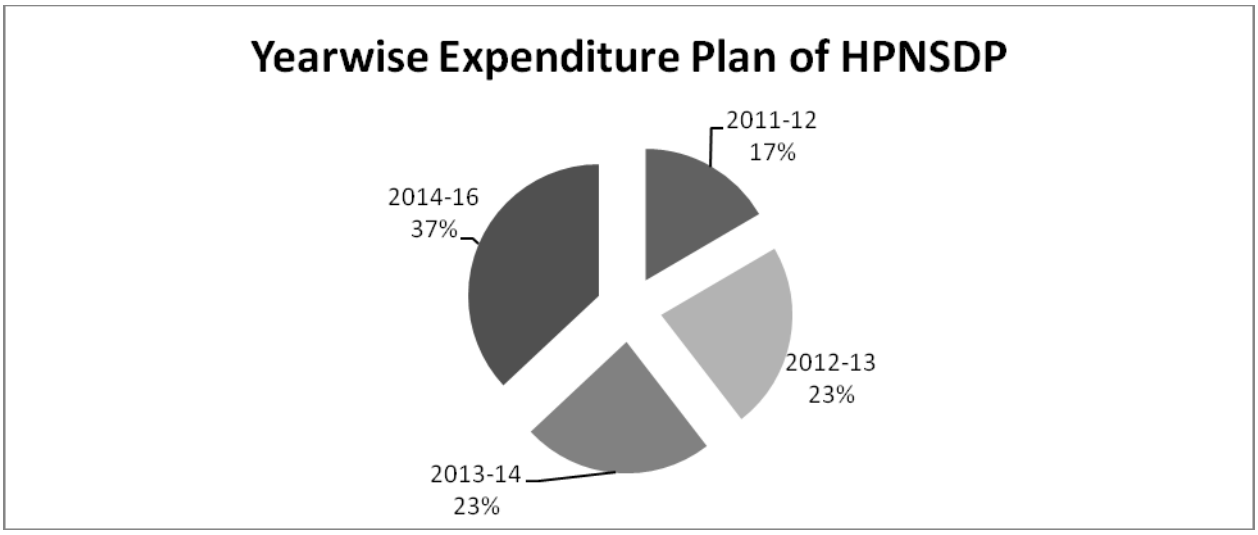
Sl. No.	Name of the Operational Plan	GoB	RPA	DPA	Sub-total PA	Total	% of Total
1	2	3	4	5	6	7	8
18	Maternal, Child, Reproductive and Adolescent Health (MCRAH)	20,015.00	38,398.00	29,491.00	67,889.00	87,904.00	3.96%
19	Clinical Contraception Services Delivery (CCSD)	68,295.35	19,005.00	48,514.00	67,519.00	135,814.35	6.12%
20	Family Planning Field Services Delivery (FPFSD)	34,399.00	88,836.00	38,175.00	127,011.00	161,410.00	7.28%
21	Planning, Monitoring and Evaluation of Family Planning (PME-FP)	200.00	700.00	100.00	800.00	1,000.00	0.05%
22	Management Information Systems (MIS)	2,587.00	3,013.00	200.00	3,213.00	5,800.00	0.26%
23	Information, Education and Communication (IEC)	5,122.00	4,878.00	3,500.00	8,378.00	13,500.00	0.61%
24	Procurement, Storage and Supplies Management (PSSM-FP)	7,519.00	340.00	172.00	512.00	8,031.00	0.36%
	Sub-total(DGFP)	**138,137.35**	**155,170.00**	**120,152.00**	**275,322.00**	**413,459.35**	**18.64%**
Other							
25	Training, Research and Development (TRD)	3,025.00	4,725.00	3,377.00	8,102.00	11,127.00	0.50%
26	Nursing Education and Services (NES)	6,030.00	9,658.00	14,312.00	23,970.00	30,000.00	1.35%
27	Strengthening of Drug Administration and Management (SDAM)	1,005.00	1,527.00	623.00	2,150.00	3,155.00	0.14%
	Sub-total(other)	**10,060.00**	**15,910.00**	**18,312.00**	**34,222.00**	**44,282.00**	**2.00%**
MOHFW							0.00%
28	Physical Facilities Development (PFD)	366,940.00	104,785.00	9,800.00	114,585.00	481,525.00	21.71%
29	Human Resources Management (HRM)	1,275.00	4,635.00	8,837.00	13,472.00	14,747.00	0.66%
30	Sector-Wide Program Management and Monitoring (SWPMM)	550.00	1,650.00	5,000.00	6,650.00	7,200.00	0.32%
31	Improved Financial Management (IFM)	726.00	1,900.00	950.00	2,850.00	3,576.00	0.16%
32	Health Economics and Financing (HEF)	842.00	570.00	4,369.00	4,939.00	5,781.00	0.26%
	Sub-total(Ministry)	**370,333.00**	**113,540.00**	**28,956.00**	**142,496.00**	**512,829.00**	**23.12%**
	Grand Total(HPNSDP)	**860,350.12**	**869,791.03**	**487,525.02**	**1,357,316.05**	**2,217,666.21**	**100.00%**

Table 5.4: Year wise estimated cost of 32 Operational Plans (OPs) of HPNSDP

(Taka in Lakh)

Sl. No.	Name of the Operational Plan	Total 2011-16	2011-12	2012-13	2013-14	2014-16
1	2	3	4	5	6	7
DGHS						
1	Maternal, Neonatal, Child and Adolescent Health (MNCAH)	301924.99	52653.55	58837.24	64431.85	126002.35
2	Essential Services Delivery (ESD)	44555.93	8169.44	8715.64	9800.38	17870.47
3	Community Based Health Care (CBHC)	165719.12	6086.59	19805.00	30400.00	109427.53
4	TB and Leprosy Control (TB-LC)	32184.00	6968.56	7396.06	5859.68	11959.71
5	National AIDS And STD Program (NASP)	27291.90	5151.18	5942.18	5882.18	10316.36

Sl. No.	Name of the Operational Plan	Total 2011-16	2011-12	2012-13	2013-14	2014-16
1	2	3	4	5	6	7
6	Communicable Diseases Control (CDC)	60342.05	15356.90	18448.30	11079.10	15457.75
7	Non-Communicable Diseases (NCD)	51911.04	11349.06	15988.90	14797.71	9775.37
8	National Eye Care (NEC)	2212.50	404.63	647.97	495.42	664.48
9	Hospital Services Management (HSM)	186215.57	24338.98	53285.14	50887.90	57703.55
10	Alternate Medical Care (AMC)	7905.00	1545.00	2315.00	2125.00	1920.00
11	In-Service Training (IST)	33748.00	6140.78	8336.35	8040.62	11230.25
12	Pre-Service Education (PSE)	59500.00	15100.00	15075.00	15000.00	14325.00
13	Planning, Monitoring and Research (PMR-DGHS)	5300.00	1044.00	1058.00	1078.00	2120.00
14	Health Information Systems and E-Health (HIS-EH)	60887.37	5850.00	19834.86	12364.41	22838.10
15	Health Education and Promotion (HEP)	14615.00	2061.23	2611.23	2511.23	7431.31
16	Procurement, Logistics and Supplies Management (PLSM-CMSD)	43774.00	8215.00	8434.00	9053.00	18072.00
17	National Nutrition Services (NNS)	149009.38	28927.06	34008.80	38500.80	47572.72
	Sub-total(DGHS)=	**1247095.86**	**199361.96**	**280739.67**	**282307.27**	**484686.95**
DGFP						
18	Maternal, Child, Reproductive and Adolescent Health (MCRAH)	87904.00	16000.20	16577.24	16632.05	38694.51
19	Clinical Contraception Services Delivery (CCSD)	135814.35	24122.63	27048.17	31819.96	52823.59
20	Family Planning Field Services Delivery (FPFSD)	161410.00	26243.00	28212.00	30848.00	76107.00
21	Planning, Monitoring and Evaluation of Family Planning (PME-FP)	1000.00	226.90	173.23	220.71	379.16
22	Management Information Systems (MIS)	5800.00	938.00	1878.00	1339.00	1645.00
23	Information, Education and Communication (IEC)	13500.00	1852.20	2230.10	2562.04	6855.66
24	Procurement, Storage and Supplies Management (PSSM-FP)	8031.00	1548.00	1715.00	1653.00	3115.00
0	**Sub-total(DGFP)=**	**413459.35**	**70930.93**	**77833.74**	**85074.76**	**179619.92**
Other						
25	Training, Research and Development (TRD)	11127.00	2103.99	2957.50	2596.01	3469.50
26	Nursing Education and Services (NES)	30000.00	6000.00	6000.00	6000.00	12000.00
27	Strengthening of Drug Administration and Management (SDAM)	3155.00	1205.00	679.00	930.00	341.00
	Sub-total(other)=	**44282.00**	**9308.99**	**9636.50**	**9526.01**	**15810.50**
MOHFW						
28	Physical Facilities Development (PFD)	481525.00	94463.63	125892.75	129092.62	132076.00
29	Human Resources Management (HRM)	14747.00	1610.00	3074.00	4105.00	5958.00
30	Sector-Wide Program Management and Monitoring (SWPMM)	7200.00	897.00	1547.00	1853.00	2903.00
31	Improved Financial Management (IFM)	3576.00	595.00	881.00	828.00	1272.00
32	Health Economics and Financing (HEF)	5781.00	1452.00	1115.23	1178.93	2034.84
	Sub-total(Ministry)=	**512829.00**	**99017.63**	**132509.98**	**137057.55**	**144243.84**
	Grand Total(HPNSDP)=	**2217666.21**	**378619.51**	**500719.89**	**513965.59**	**824361.21**



5.6 DP's Support for the HPNSDP

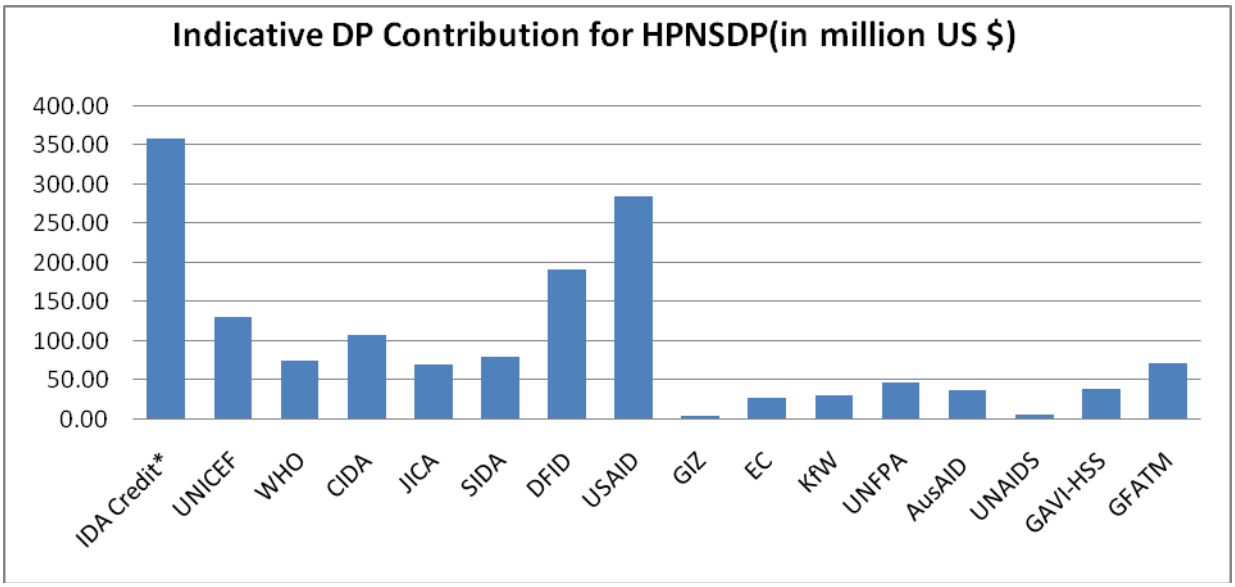
An amount of Taka 13,573.16 crore equivalent DP support is being expected for the HPNSDP. However, as of now there has been an indication of BDT 11515.36 crore given by the DPs. Indication of DP-wise contribution is given below:

Table 5.5: Indicative DP Contribution for HPNSDP

Sl. No.	Source	Amount in Million US $	Amount In BDT Crore Taka**
1	IDA Credit*	358.90	2655.86
2	UNICEF	130.00	962.00
3	WHO	75.00	555.00
4	CIDA	106.76	790.02
5	JICA	70.00	518.00
6	SIDA	80.00	592.00
7	DFID	191.00	1413.40
8	USAID	285.00	2109.00
9	GIZ	3.60	26.64
10	EC	27.00	199.80
11	KfW	30.71	227.25
12	UNFPA	46.00	340.40
13	AusAID	36.64	271.14
14	UNAIDS	6.00	44.40
15	GAVI-HSS	37.67	278.76
16	GFATM	71.85	531.69
	Total:	**1556.13**	**11515.36**

*There is also a provision of receiving an additional credit fund of US$ 43.08 million under Disbursement for Accelerated Achievement of Results (DAAR) in the last year of the program, based on performance.

** US $ 1.00 = BDT 74.00



5.7 Expected GOB and DP Share: the Resource Gap

The total development budget of Tk. 22176.66 crore (US$ 2996.85 million) is to be spent through the OPs during the next five years starting from July 2011. As mentioned earlier, due to fund constraint the GOB is currently in a position to contribute a maximum of 38.8% (Tk. 8603.50 crore equivalent to US$ 1162.64 million) of the resources needed for implementing the HPNSDP while the rest 61.2% (Tk. 13573.16 crore equivalent to US $ 1834.21 million) is considered to be the funding gap, and needs to be ensured from external sources. There has been significant contribution of the DPs in the development programs of the HPN sector of Bangladesh. Therefore, the expected contribution from the DPs is Tk. 13573.16 crore (US$ 1834.21 million). However, combining the development and non development budget of the MOHFW, the GOB share stands at about 76.18% and the DP share is expected to cover 23.82 % of MOHFW's budgetary requirement for implementing HPNSDP during 2011-16.

As of today, there has been an indication of DP contribution to the extent of TK. 11515.36 crore (US $ 1556.13 million). However an additional amount of US$ 43.08 m is expected to be received from IDA under Disbursement for Accelerated Achievement of Results (DAAR). Besides, there is a probability of receiving additional fund from JICA, EC and GAVI-HSS. Kuwait and IDB has also initiated discussion and shown willingness to provide fund in HPNSDP. All these indicate that the resource gap of US $ 278.08 million (about 9%) can be minimized with additional external resources.

Appendix

RESULTS FRAMEWORK FOR HPNSDP 2011-2016

RESULT	INDICATOR	MEANS OF VERIFICATION & TIMING	BASELINE	TARGET 2016
Goal: Ensure quality and equitable health care for all citizens of Bangladesh	Infant mortality rate (IMR)	BDHS, every 3 yrs	52, BDHS 2007	31
	Under 5 mortality rate	BDHS every 3 yrs	65, BDHS 2007	48
	Neonatal mortality rate	BDHS, every 3 yrs	37, BDHS 2007	21
	Maternal mortality ratio	BMMS, every 5 yrs	194, BMMS 2010	<143
	Total fertility rate (TFR)	BDHS, every 3 yrs	2.7, BDHS 2007	2.00
	Prevalence of stunting among children under 5 years of age	BDHS, every 3 yrs	43.2%, BDHS 2007	38%
	Prevalence of underweight among children under 5 years of age	BDHS, every 3 yrs	41.0%, BDHS 2007	33%
	Prevalence of HIV in MARP	Sero-Surveillance Survey (SS), every 2 years	<1%, SS 2007	<1%
Program Development Objective: Increase availability and utilization of user-centered, effective, efficient, equitable, affordable and accessible quality HPN services. **Strategic Objective:** To improve access to and utilization of essential health, population and nutrition services, particularly by the poor				
Component 1: Service delivery improved				
Result 1.1 Increase utilization of essential HPN services: maternal, neonatal, and child health family planning	% of delivery by skilled birth attendant	BDHS, every 3 yrs	26%, UESD 2010 18%, BDHS 2007	50%
	Antenatal care coverage (at least 4 visits)	BDHS, every 3 yrs	19.9%, UESD 2010 20.6% BDHS 2007	50%
	Postnatal care within 48 hours (at least 1 visit)	BDHS, every 3 yrs	20.9%, UESD 2010 18.5% BDHS 2007	50%
	Contraceptive prevalence rate (CPR)	BDHS, every 3 yrs	61.7%, UESD 2010 55.8%, BDHS 2007	72%
	Unmet need for FP	BDHS, every 3 yrs	17.1%, BDHS 2007	9.0%

RESULT	INDICATOR	MEANS OF VERIFICATION & TIMING	BASELINE	TARGET 2016
and reproductive health nutrition services communicable diseases	Measles Immunization Coverage by 12 months	CES, annual	82.4%, CES 2009	90%
	% of children (0-59 months) with pneumonia receiving antibiotics	BDHS, every 3 yrs	38.0%, UESD 2010 37.1%[3], BDHS 2007	50%
	% of children (6-59 months) receiving Vitamin A supplementation in the last 6 months	BDHS, every 3 yrs	82.6%, UESD 2010 88.3%, BDHS 2007	90%
	TB case detection rate	NT Program, annual	74%, NTP 2009	75%
Result 1.2 Improve equity in essential HPN service utilization (MDGs 1, 4, 5 and 6)	Proportion of births in health facilities by wealth quintiles	BDHS, every 3 yrs	Q1:Q5=8.0:59.5, UESD 2010 Q1:Q5[4]=4.4:43.4, BDHS 2007	Q1:Q5 = <1:4
	Use of modern contraceptives in low performing areas	BDHS, every 3 yrs	Syl: 35.7%, Ctg: 46.8%, UESD 2010 Syl: 24.7%, Ctg: 38.2%, BDHS 2007	Sylhet & Chittagong: 50%
	# of upazilas with women targeted by improved[5] voucher scheme for having institutional deliveries	DSF Monitoring Reports, annual	31 (+9 universal)	50[6]
Result 1.3 Improved awareness of healthy behavior (MDG 1, 4, 5)	Rate of exclusive breastfeeding in infants up to 6 months	BDHS, every 3 yrs	43%, BDHS 2007	50%
	% of children 6-23 months fed with appropriate Infant and Young Child Feeding (IYCF) practices	BDHS, every 3 yrs	41.5%, BDHS 2007	52%
Result 1.4 Improved PHC-CC systems	# of Community Clinics (CC) with increasing number of service contacts over time	CC Project/MIS/MOHFW	NA[7]	13,500
	% of upgraded[8] union-level facilities able to provide basic EmOC services	Health Facility Survey (BHFS), every 2yrs	15.5%[9]	50%
Component 2: Strengthened Health Systems				
Result 2.1 Strengthened planning and	% of MOHFW budget allocated to Upazila level or below	Public expenditure review, annual	52%, PER 2006/7	60%

[3] Proxy used as % of children with pneumonia taken to medical doctor/health facility, to be estimated in BDHS 2011
[4] Q1: Bottom 20% and Q5: Top 20% of wealth quintiles to represent socioeconomic status of households
[5] Note for definition of improved: DSF upazilas that are "means-tested," i.e. women need to meet specific criteria to be eligible for the voucher program
[6] Target provisionally set as 50, ad would be revised after MOHFW's review on DSF
[7] Set as Not Available as service registers are not yet to the CCs [CHECK]
[8] In 2006, MOHFW decided to upgrade 1,495 UH&FWCs to provide basic EmOC [Source: Mridha et al. (2009) Public-sector Maternal Health Programs and Services for Rural Bangladesh, J Health Popul Nutr 27(2):124-138]
[9] % of UnH&FWC (upgraded) able to provide vacuum and forceps delivery

RESULT	INDICATOR	MEANS OF VERIFICATION & TIMING	BASELINE	TARGET 2016
budgeting procedures	% of annual work plans with budgets submitted by LDs by defined time period (July/Aug)[10]	Planning Wing, annual	NA[11]	100% (achieved by 2013)
Result 2.2 Strengthened monitoring and evaluation systems	MIS reports on service delivery published and disseminated[12] annually	MIS of all agencies, annual	NA[13]	100%
	Performance report of OPs reviewed with policy makers, MOHFW, Directorates and DPs, six monthly and annually	Planning Wing, six monthly (Jul-Dec->Feb), (Jul-Jun -> Aug)	Not Available	100% (achieved by 2013)
Result 2.3 Improved human resources – planning, development and management	Proportion of service provider positions functionally vacant at Upazila/District level and below, by category	DGHS/DHFP MIS, annual BHFS, every 2yrs	Physicians: 45.7% Nurses: 29.9% FWV/SACMO/MA:16.9%, BHFS 2009	Physicians: 22.8% Nurses: 15% FWV/SACMO/MA:8.5%[14]
	# of additional providers trained in midwifery at Upazila health facilities	HRD/MOHFW, annual	NA	3,000
	No. of comprehensive EmOC facilities with functional 24/7 services covering all districts	MIS/EOC BHFS, every 2yrs	120[15]	204[16]
Result 2.4 Strengthened quality assurance and supervision systems	Case fatality rate among admitted children with pneumonia in Upazila health complex	DGHS MIS	8%[17], Health Bulletin 2009	6.2[18]
Result 2.5 Sustainable and responsive procurement and logistic system	% of health facilities, by type, without stock-outs of essential medicines at a given point in time	BHFS, every 2yrs	66.1%[19], BHFS 2009	75%
	% of facilities without stock-outs of contraceptives at a given point in time	LMIS, annual BHFS, every 2yrs	58.1%[20], BHFS 2009	70%
Result 2.6 Improved infrastructure and maintenance	% of facilities (excluding CCs) having separate, improved toilets for female clients	BHFS, every 2yrs	51.0%, BHFS 2009	75%

[10] Refers to Single Work Plan
[11] Baseline set **Not Applicable** as this was not practiced in HNPSP
[12] Defined as distributed to, and discussed with relevant stakeholders
[13] Naseline set as **Not Applicable** as the current practice by MISs is to publication on time and distribution (no stakeholder discussion)
[14] Target set as reduction by 50%
[15] Approximated figure – to be updated
[16] DGHS MIS Voice of MIS Feb 2009
[17] Calculated from sex distribution of causes of death in each age cluster of children who attended outpatient and emergency departments of IMCI facilities
[18] Calculated as the reduction of the case fatality rate after the implementation of the WHO's standard acute respiratory infection (ARI) case management guidelines found to be 23% [Source: Theodoratou et al (2010) "The effect of case management on childhood pneumonia mortality in developing countries." *International Journal of Epidemiology* 39: i155–i171]
[19] Notes for definition: at least 75% of union level essential drug kit (10 drugs) available in the facilities at district level and below
[20] Notes for definition: four family planning supplied (condom, oral pill, DMPA, IUD) available in the facilities at district level and below

RESULT	INDICATOR	MEANS OF VERIFICATION & TIMING	BASELINE	TARGET 2016
Result 2.7 Sector management and legal framework	Regulatory framework for accreditation of health facilities including hospitals (both in the public and private sectors) reviewed and updated[21]	MOHFW	1982 Regulatory Act	Reviewed (by 2012)
Result 2.8 Decentralization through LLP procedures	# of Districts/Upazilas having functional LLP procedures	Respective agencies, annual	NA	Piloting completed and reviewed for scaling up
Result 2.9 SWAp and improved DP coordination (deliver on the Paris Declaration)	# of non-pool DPs submitting quarterly expenditure reports	Planning wing	Irregular	100%
Result 2.10 Strengthened Financial Management Systems (funding and reporting)	% of project aid fund (e.g. development budget) disbursed annually and quarterly	FMAU	79.4%[22], FMAU 2009/10	100% (by 2013)
	% of OPs with spending > 80% of ADP allocation (annually)	FMAU/Planning Wing	44.7[23], FMAU 2003-11	100%[24] (by 2013)
	% of serious audit objections settled within the last 12 months	FMAU	7%, FMAU 2007/8[25]	>80%

[21] Notes for definition: Start with a framework for facilitating accreditation of public hospitals and then extend to private hospitals
[22] Baseline taken from HPSDP Strategic Document, p.57
[23] Baseline taken from HPSDP Strategic Document, p.71-72
[24] Target set as 100% to ensure efficient fund utilization
[25] Baseline used from APIR 2009

Annexes –Volume -II