TABLE OF CONTENT

ABBREVIATIONS & ACRONYMS iv
EXECUTIVE SUMMARY xiii
CHAPTER I: INTRODUCTION 1
1.1. Background: History of Sector Programme 1
1.2. Progress Made after Sector Programme Taken 2
1.3. Lessons Learnt During Previous Sector Programme 8
1.4. New and Continuing Challenges 9
CHAPTER II: OVERVIEW OF THE PROPOSED SECTOR PROGRAMME (4th HPNSP) 12
2.1. Vision, Mission and Goal 12
2.2. Programme Priorities and Strategies 13
Component 1: Strengthening Governance and Stewardship 13
2.2.1. Strategic Objective 1: *13*
2.2.2. Strategic Objective 2: *18*
2.2.3. Strategic Objective 3: *23*
Component 2: Health Systems Strengthening 28
2.2.4. Strategic Objective 4: *28*
2.2.5. Strategic Objective 5: *32*
2.2.6. Strategic objective 6: *38*
Component 3: Provision of Quality Health Services 42
2.2.7. Strategic Objective 7: *42*
2.2.8. Strategic Objective 8: *78*
GEVA- an Issue Cutting Across All Services 80
2.3. Boundaries of the Sector 82
2.4. Duration and Timing 84
2.5. Location of the Programme 84
2.6. Implementation Priorities 84
2.7. Sponsoring Ministry 85
2.8. Implementing Agency 85
2.9. Estimated Programme Cost 85
2.10. Estimated PA Cost 85
2.11. Source of PA 85
2.12. Financing Pattern 85

2.13. DP's Support for the 4th HPNSP 86
CHAPTER III: MAPPING THE STRATEGY TO THE IMPLEMENTATION STRUCTURE 87
Mapping the strategy to the implementation structure 88
3.1. Introduction 88
3.2. Organizational Structure 88
3.3. Linking Strategic Priorities to Implementation Structure 90
3.4. Issues Relating to Poverty, Environment, Climate Change, Women, Children and Gender etc 99
3.5. Technical Assistance 101
3.6. Procurement Management 102
3.7. Macro-level Considerations in Implementation 102
3.8. Coordination Mechanism between Agencies, Operational Plans etc 103
3.9. Implementation Monitoring 110
3.10. The Proposed Operational Plans and Designated/Proposed Line Directors 113
CHAPTER IV: SUMMARY OF OPERATIONAL PLANS 114
GOVERNANCE AND STEWARDSHIP 115
4.1 Sector-Wide Programme Management & Monitoring (SWPMM) 115
4.2 Planning, Monitoring and Research (PMR) 132
4.3 Planning, Monitoring & Evaluation (PME) 145
4.4 Health Economics and Financing (HEF) 153
4.5 Strengthening of Drug Administration and Management (SDAM) 167
HEALTH SYSTEMS STRENGTHENING 181
4.6 Health Information System and e-Health (HIS & e-H) 181
4.7 Management Information System (MIS) 197
4.8 Procurement, Storage and Supplies Management-HS (PSSM-HS) 209
4.9 Procurement, Storage & Supply Management-FP (PSSM-FP) 219
4.10 Human Resources Development (HRD) 234
4.11 Medical Education and Health Manpower Development (ME&HMD) 247
4.12 Nursing and Midwifery Education Services (NMES) 262
4.13 Training, Research and Development (TRD) 274
4.14 Physical Facilities Development (PFD) 283
4.15 Improved Financial Management (IFM) 311
PROVISION OF QUALITY HEALTH SERVICES 320

4.16 Maternal, Neonatal, Child and Adolescent Health (MNCAH) 320
4.17 Maternal, Child, Reproductive and Adolescent Health (MCRAH) 339
4.18 National Nutrition Services (NNS) 361
4.19 Communicable Disease Control (CDC) 382
4.20 Tuberculosis-Leprosy and AIDS/STD Programme (TB-L & ASP) 408
4.21 Non-communicable Diseases Control (NCDC) 422
4.22 National Eye Care (NEC) 464
4.23 Community Based Health Care (CBHC) 477
4.24 Hospital Services Management (HSM) 498
4.25 Clinical Contraception Services Delivery Programme (CCSDP) 519
4.26 Family Planning Field Services Delivery (FP-FSD) 536
4.27 Lifestyle, and Health Education & Promotion (L&HEP) 547
4.28 Information, Education & Communication (IEC) 567
4.29 Alternative Medical Care (AMC) 579
CHAPTER V: EXPENDITURE PLAN 589
5.1. Introduction 590
5.2. Estimated Budget and Expenditure of the Previous Programme 590
5.3. Background and Basis of Budget Estimation of the Programme 591
5.4. Resource Envelope for the 4th HPNSP 592
5.5. Estimated Development Budget Requirements by the OPs 593
5.6. DP's Support for the Sector Programme 596
5.7. Expected GOB and DP share and the Resource Gap (if any) 597
APPENDIX-I 598
Results Framework for the 4th HPNSP (2017-2022) 599
APPENDIX-II 603
Compliance of the PEC decisions 604

ABBREVIATIONS & ACRONYMS

A&E	Accident and Emergency
ACSM	Advocacy, Communication and Social Mobilization
AD	Auto-Disable
ADP	Annual Development Programme
ADR	Adverse Drug Reaction
ADRM	Adverse Drug Reaction Monitoring
AEFI	Adverse Events Following Immunization
AFHS	Adolescent Friendly Health Services
AHI	Assistant Health Inspector
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
AMC	Alternative Medical Care
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
APIR	Annual Programme Implementation Report
APR	Annual Programme Review
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
ASD	Autism Spectrum Disorder
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Workplan
BAMS	Bachelor of Ayurvedic Medicine & Surgery
BBS	Bangladesh Bureau of Statistics
BCEWG	Bangladesh Country Engagement Working Group
BCPS	Bangladesh College of Physicians and Surgeons
BCS	Bangladesh Civil Service
BDHS	Bangladesh Demographic and Health Surveys
BDS	Bachelor of Dental Surgery
BEmONC	Basic Emergency Obstetric and Newborn Care
BENAP	Bangladesh Every Newborn Action Plan
BFHI	Baby Friendly Hospital Initiatives
BFSN	Bangladesh Food Safety Network
BGMEA	Bangladesh Garment Manufacturers and Exporters Association
BHB	Bangladesh Homeopathic Board
BHE	Bureau of Health Education
BHFS	Bangladesh Health Facility Survey
BHMS	Bachelor of Homeopathic Medicine & Surgery
BLS	Basic Life Support
BLTL	Bi-Lateral Tubal Ligation
BMA	Bangladesh Medical Association
BMDC	Bangladesh Medical and Dental Council
BMMS	Bangladesh Maternal Mortality and Health Care Survey
BMRC	Bangladesh Medical Research Council
BNC	Bangladesh Nursing Council
BNCB	Bangladesh National Council for Blind
BNHA	Bangladesh National Health Accounts
B-NIAMC	Bangladesh National Institute for AMC
BNMC	Bangladesh Nursing and Midwifery Council
BNNC	Bangladesh National Nutrition Council
BPL	Below Poverty Line
BRDB	Bangladesh Rural Development Board
BSCIC	Bangladesh Small and Cottage Industries Corporation
BSMMU	Bangabandhu Sheikh Mujib Medical University
BTEB	Bangladesh Technical Education Board
BU&AB	Board of Unani and Ayurveda Bangladesh

BUHS	Bangladesh Urban Health Survey
BUMS	Bachelor of Unani Medicine & Surgery
CAO	Chief Accounts Officer
CBHC	Community Based Health Care
CC	Community Clinic
CCSDP	Clinical Contraceptive Service Delivery Programme
CCU	Coronary Care Unit
CDC	Communicable Disease Control
CEmOC	Comprehensive Emergency Obstetrical Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CG	Community Group
CGA	Controller General of Accounts
CHCP	Community Health Care Provider
CHSW	Community Health Service Worker
CHT	Chittagong Hill Tracts
CHX	Chlorhexidine
C-IMCI	Community-based Integrated Management of Childhood Illness
CKD	Chronic kidney disease
CME	Centre for Medical Education
CMSD	Central Medical Stores Depot
CMT	Clinical Management Training
cMYP	Comprehensive Multiyear Plan
CNCP	Comprehensive New-born Care Package
COIA	Commission on Information and Accountability
COPD	Chronic Obstructive Pulmonary Diseases
CPR	Contraceptive Prevalence Rate
CQI	Continuous Quality Improvement
CRHCC	Comprehensive Reproductive Health Care Centre
CRS	Congenital Rubella Syndrome
CRVS	Civil Registration and Vital Statistics
CS	Cesarean Section
CS	Civil Surgeon
CSBA	Community Based Skilled Birth Attendant
CSG	Community Support Group
CWH	Central Warehouse
DAAR	Disbursements for Accelerated Achievement of Results
DCC	Drug Control Committee
DDO	Drawing and Disbursement Officer
DFID	Department for International Development
DGDA	Directorate General of Drug Administration
DGFP	Directorate general of Family Planning
DGHS	Directorate General of Health Services
DGNMS	Directorate General of Nursing and Midwifery Services
DH	District Hospital
DHIS2	District Health Information System, version 2
DLI	Disbursement Linked Indicator
DNI	Direction Nutrition Intervention
DNS	Directorate of Nursing Services
DOE	Department of Environment
DOT	Directly Observed Treatment
DP	Development Partner
DPA	Direct Project Aid
DPHN	District Public Health Nurse
DPM	Deputy Programme Manager
DPP	Development Project Proforma
DQA	Data Quality Assurance
DSF	Demand Side Financing
ECD	Early Childhood Development

ECP	Emergency Contraceptive Pill
ELCO	Eligible Couple
EmOC	Emergency Obstetric Care
ENC	Essential Newborn Care
EPB	Export Promotion Bureau
EPI	Expanded Programme on Immunization
EQA	External Quality Assurance
ESD	Essential Service Delivery
ESP	Essential Service Package
ETAT	Emergency Triage Assessment and Treatment
EVM	Effective Vaccine Management
FAPAD	Foreign Aided Project Audit Directorate
FCPS	Fellow of College of Physicians and Surgeons
FCTC	Framework Convention for Tobacco Control
FDI	Foreign Direct Investment
FEP	Filariasis Elimination Programme
FETP	Field Epidemiology Training Programme
FM	Financial Management
FMAU	Financial Management and Audit Unit
FMIS	Financial Management Information System
Forex	Foreign Exchange Account
FP	Family Planning
FPFSD	Family Planning Field Service Delivery
FPI	Family Planning Inspector
FSW	Female sex worker
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FYP	Five Year Plan
GAC	Global Affairs Canada
GATS	Global Adult Tobacco Survey.
GAVI-HSS	Global Alliance for Vaccines and Immunization- Health System Strengthening
GBV	Gender-based Violence
GCP	Good Clinical Practice
GDP	Gross Domestic Product
GES	Gender Equity Strategy
GEVA	Gender, Equity, Voice and Accountability
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Fund Facility
GH	General Hospitals
GHMC	Government Homeopathic Medical College
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GMP	Good Manufacturing Practice
GMP	Growth Monitoring and Promotion
GNI	Gross National Income
GNSPU	Gender, NGO and Stakeholders Participation Unit
GOB	Government of Bangladesh
GOD	Government Outdoor Dispensaries
GPS	Global Positioning System
GSID	Governance, Stewardship and Institutional Development
GUAMC	Government Unani and Ayurvedic Medical College
HA	Health assistant
HBB	Helping Babies Breathe
HCFS	Health Care Financing Strategy
HDC	Hill District Council
HDU	High Dependency Unit
HED	Health Engineering Department
HEF	Health Economics and Financing
HEP	Health Education and Promotion
HepB0	Hepatitis B Vaccine Birth Dose

HER	Electronic Health Record
HEU	Health Economics Unit
HFA	Health for All
HI	Health Inspector
HIS&eH	Health Information System & e-Health
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Programme
HPNSDP	Health, Population and Nutrition Sector Development Programme
HPNSP	Health, Population and Nutrition Sector Programme
HPSP	Health and Population Sector Programme
HPV	Human Papilloma Vaccine
HR	Human Resource
HRD	Human Resource Development
HRH	Human Resources for Health
HRIS	Human Resource Information System
HRIS	Human Resources Information System
HSM	Hospital Service Management
HTA	Health Technology Assistant
HTC	HIV Testing and Counseling
HTN	Hypertension
HTR	Hard-to-Reach
HWF	Health Workforce
HWS	Health Workforce Strategy
IAP	Indoor Air Pollution
IAPB	International Agency for Prevention of Blindness
iBAS	Integrated Budget and Accounting System
ICD 10	International Classification of Disease, Tenth Edition
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
ICM	International Confederation on Midwives
ICM	International Confederation of the Midwife
ICMH	Institute of Child & Mother Health
ICN	International Council of Nurses
ICR	Implementation Completion Report
ICT	Information and Communication Technology
ICU	Intensive Care Unit
ICV	Informed Choice and Voluntarism
IDA	International Development Association
IDH	Infectious Disease Hospital
IEC	Information, Education and Communication
IEDCR	Institute of Epidemiology, Disease Control and Research
IEM	Information, Education & Motivation
IFA	Iron Folic Acid
IFM	Improving Financial Management
IHT	Institute of Health Technology
IMCI	Integrated Management of Childhood Illness
IMED	Implementation Monitoring and Evaluation Division
IMR	Infant Mortality Rate
IMSC	Inter-Ministerial Steering Committee
IPC	Interpersonal Communication
IPGMR	Institute of Postgraduate Medicine and Research
IPH	Institute of Public Health
IPHN	Institute of Public Health and Nutrition
IPV	Inactivated Polio Vaccine
IRS	Indicator Reference Sheet
IRT	Independent Review Team
IST	In-Service Training
IUD	Intra Uterine Device
IUFR	Internal Unaudited Financial Report

IYCF	Infant and Young Child Feeding
JDTAF	Joint Donor Technical Assistance Fund
JICA	Japan International Cooperation Agency
KFW	Kreditanstalt für Wiederaufbau
KMC	Kangaroo Mother Care
KP	Kaiser Permanente
KPI	Key Performance Indicators
LAPM	Long Acting and Permanent Method
LARC&PM	Long Acting Reversible Contraceptives and Permanent Methods
LD	Line Director
LEBC	Lifestyle, Environment and Behavior Change
LGD	Local Government Division
LHEP	Lifestyle and Health & Education Promotion
LMF	Licentiate in Medical Faculty
M&E	Monitoring and Evaluation
M&ETG	Monitoring & Evaluation Task Group
MAM	Moderate Acute Malnutrition
MATS	Medical Assistant Training School
MATS	Medical Assistant Training School
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCH	Maternal and Child Health
MCH	Medical College Hospital
MCH&FP	Maternal, Child Health and Family Planning
MCHTI	Maternal and Child Health Training Institute
MCPS	Member of College of Physicians and Surgeons
MCRAH	Maternal, Child, Reproductive and Adolescent Health
MCWC	Maternal and Child Welfare Centre
MDR	Multi Drug-Resistant
MDV	Mass Dog vaccination
ME	Medical Education
ME&HMPD	Medical Education and Health Manpower Development
MEIT	Medical Education and In-service Training
MESAP	Monitoring & Evaluation Strategy and Action Plan
METG	M&E Task Group
MHV	Multipurpose Health Volunteer
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MIS-FP	Management Information System of Family Planning
MLSS	Member of Lower Subordinate Staff
MMEIG	Maternal Mortality Estimation Inter-Agency Group
MMR	Maternal Mortality Ratio
MNCAH	Maternal, Neonatal, Child and Adolescent Health
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Neonatal Health
MO	Medical Officer
MOA	Ministry of Agriculture
MOCA	Ministry of Cultural Affairs
MOCHTA	Ministry of Chittagong Hill Tracts Affairs
MODMR	Ministry of Disaster Management and Relief
MOE	Ministry of Education
MOEF	Ministry of Environment and Forest
MOF	Ministry of Finance
MOFL	Ministry of Fisheries and Livestock
MOFood	Ministry of Food
MOHPW	Ministry of Housing and Public Works
MOHA	Ministry of Home Affairs
MOHFW	Ministry of Health and Family Welfare
MOI	Ministry of Information
MOIND	Ministry of Industries

MOL	Ministry of Law
MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MOPA	Ministry of Public Administration
MOSW	Ministry of Social Welfare
MOU	Memorandum of Understanding
MOWCA	Ministry of Women and Children Affairs
MPDR	Maternal Perinatal Death Review
MPIR	Mid-term Programme Implementation Report
MR	Menstrual Regulation
MSR	Medical and Surgical Requisites
MtBF	Medium-term Budget Framework
MTR	Mid-Term Review
MWM	Medical Waste Management
MYCNSIA	Mother & Young Child Nutrition Initiative in Asia
NASP	National AIDS/STD Programme
NBR	National Board of Revenue
NCDC	Non-Communicable Disease Control
NCL	National Control Laboratory
NEC	National Eye Care
NEMEMW&TC	National Electro-Medical Equipment Maintenance Workshop & Training Centre
NES	Nursing Education and Services
NFSL	National Food Safety Laboratory
NGO	Non-Government Organization
NHA	National Health Accounts
NHP	National Health Policy
NICC	Nutrition Implementation Coordination Committee
NICU	Neonatal Intensive Care Unit
NID	National Immunization Day
NIDGH	National Institute of Diseases of the Chest and Hospital
NIKDU	National Institute of Kidney Diseases and Urology
NIO	National Institute of Ophthalmology
NIPORT	National Institute of Population, Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
NLEP	National Leprosy Eradication Programme
NMR	Neonatal Mortality Rate
NMES	Nursing and Midwifery Education and Services
NNS	National Nutrition Services
NPAN	National Plan of Action for Nutrition
NSSS	National Social Security Strategy
NSV	No-Scalpel Vasectomy
NTC	National Technical Committee
NTP	National Tuberculosis Control Programme
OCC	One Stop Crisis Centre
ODDC	Oral and Dental Diseases Control
ODDC	Oral and Dental Diseases Control
OOPE	Out-of-Pocket Expenditure
OP	Operational Plan
OPD	Out-Patient Department
OPD	Outpatient Department
OPIC	OP Implementation Committee
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PAC	Post Abortion Care
PAP	Prioritized Action Plan
PBF	Performance Based Financing
PCB	Pharmacy Council of Bangladesh
PCR	Programme Completion Report
PCV	Pneumococcal Conjugate Vaccine

PDD	Pervasive Developmental Disorders
PER	Public Expenditure Review
PFD	Physical Facilities Development
PFM	Public Financial Management
PforR	Programme for Results
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PIP	Programme Implementation Plan
PLHIV	People Living with HIV
PLMC	Procurement and Logistics Management Cell
PLSM	Procurement, Logistics and Supplies Management
PLW	Pregnant and Lactating Women
PM	Programme Manager
PME	Planning Monitoring and Evaluation
PMIS	Personnel Management Information System
PMMU	Programme Management and Monitoring Unit
PMP	Performance Monitoring Plan
PMR	Planning Monitoring and Research
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post Natal Care
PPH	Post-Partum Hemorrhage
PPM	Procurement Procedure Manual
PPP	Public Private Partnership
PSE	Pre-Service Education
PSSM-FP	Procurement, Storage and Supplies Management of Family Planning
PSSM-HS	Procurement, Storage and Supplies Management of Health Services
PT	Procurement Tracker
PV	Pharmacovigilance
PW	Planning Wing
PWD	Public Works Department
PWID	People Who Inject Drugs
QA	Quality Assurance
QAP	Quality Assurance Project
QI	Quality Improvement
QIS	Quality Improvement Secretariat
QIT	Quality Improvement Team
QMS	Quality Management System
RADP	Revise Annual Development Programme
RCHCIB	Revitalization of Community Health Care Initiative in Bangladesh
RFW	Results Framework
RH	Reproductive Health
RHIS	Routine Health Information System
RMG	Ready Made Garment
RMNCAH	Reproductive, Maternal, Newborn, Child & Adolescent Health
RMNCAHFP	Reproductive, Maternal, Newborn, Child & Adolescent Health and Family Planning
RPA	Reimbursable Project Aid
RPIP	Revised Programme Implementation Plan
RSP	Regional Service Package
RTI	Reproductive Tract Infections
RTRL	Regional Tuberculosis Reference Laboratory
SACMO	Sub-Assistant Community Medical Officer
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SBK	Shishu Bikash Kendra
SC	Satellite Clinic
SCANU	Special Care Newborn Unit
SCMP	Supply Chain Management Portal
SDAM	Strengthening of Drug Administration
SDG	Sustainable Development Goal

SDP	Service Delivery point
SIA	Supplementary Immunization Activity
SIAPS	Systems for Improved Access to Pharmaceuticals and Services
SIDA	Swedish International Development Agency
SIP	Strategic Investment Plan
SK-KRC	Surya Kanta Kala-azar Research Centre
SMC	Social Marketing Company
SMF	State Medical Faculty
SmPR	Six-monthly Progress Report
SMTG	Sector Management Task Group
SNME	Strengthening Nursing and Midwifery Education
SOE	Statement of Expenditure
SOP	Standard Operating Procedure
SRHR	Sexual and Reproductive Health Rights
SSFP	Smiling Sun Franchise Programme
SSK	Shasthyo Shuroskha Karmasuchi
STEPS	STEPwise Approach to Surveillance
STH	Soil Transmitted Helminthes
STI	Sexually Transmitted Infection
SVRS	Sample Vital Registration System
SWAp	Sector-Wide Approach
SWPMM	Sector-Wide Programme Management and Monitoring
TA	Technical Assistance
TAC	Technical Assistance Committee
TAG	Technical Advisory Group
TAST	Technical Assistance Support Team
TB	Tuberculosis
TBA	Traditional Birth Attendant
TB-LC & NASP	TB-Leprosy and National AIDS/STD Programme
TC	Technical Cooperation
TEMO	Transport & Equipment Maintenance Organization
TFR	Total Fertility Rate
TG	Task Group
TG	Transgender
THE	Total Health Expenditure
TM/CAM	Traditional Medicine / Complementary and Alternative Medicine
TMIS	Training Management Information System
TOE	Table of Equipment
TQI	Total Quality Improvement
TQM	Total Quality Management
TRD	Training Research and Development
TTI	Transfusion Transmissible Infection
TTU	Technical Training Unit
TVC	Television Commercial
U5MR	Under 5 Mortality Rate
UESD	Utilization of Essential Service Delivery
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Centre
UHC	Universal Health Coverage
UHC	Upazila Health Complex
UHS	Urban Health Survey
UIMS	Upazila Inventory Management System
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPHCP	Urban Primary Health Care Provider
UPHCSDP	Urban Primary Health Care Service Delivery Project
USAID	United States Agency for International Development
USC	Union Sub Centre

VCT	Voluntary Counseling and Treatment
VPD	Vaccine Preventable Disease
WASH	Water, Sanitation and Hygiene
WFHI	Women Friendly Hospital Initiative
WFME	World Federation for Medical Education
WHO	World Health Organization
WIMS	Warehouse Inventory Management System
XDR	Extensively Drug-Resistant

Programme Implementation Plan (PIP)

Volume- I

EXECUTIVE SUMMARY

I. Programme Brief:

(a) Name of the Programme : 4th Health, Population and Nutrition Sector Programme (4th HPNSP)

(b) Duration of the Programme :

Date of Commencement January 01, 2017

Date of Completion June 30, 2022

(c) Location of the Programme : All over Bangladesh

(d) Sponsoring Ministry : Ministry of Health and Family Welfare (MOHFW)

(e) Implementing Agency : MOHFW, DGHS, DGFP, DGNM, DGDA, NIPORT, HED and PWD

II. Programme Cost and Financing Pattern:

(Taka in crore)

Sl. No.	Financing Pattern	Total	% of Grand Total	Source of PA
1.	GOB Non-Development (Revenue)	72,000.00	62.34%	Credits from IDA & JICA and Grants from DPs (DFID, GAC, USAID, SIDA, EKN, WHO, UNICEF, GFATM, Gavi-HSS, WB (GFF), UNFPA, etc.)
2.	GOB Development	24,639.13	21.34%	
3.	Sub-Total of GOB(1+2)	96,639.13	83.68%	
4.	RPA	11,676.07	10.11%	
5.	DPA	7171.16	6.21%	
6.	Sub-Total of PA (4+5)	18,847.23	16.32%	
7.	Total of Development (2+ 6)	43,486.36	37.66%	
8.	Grand Total (1 + 7)	1,15,486.36	100.00%	

Rate of US$ and Date: 1US$ = 78.50 BDT, Date: 11 November 2016

III. Source of PA and Type of Support:

Sl. No.	Source	Amount in million US $	Amount in Lac BDT	RPA (in Lac BDT)	Other than RPA (DPA) (in Lac BDT)
1	IDA Credit	500.00	392500.00	392500.00	0.00
2	World Bank GFF	15.00	11775.00	0.00	11775.00
3	GAC	TBD*	-	-	-
4	JICA Credit	51.71	40592.35	37232.55	3359.80
5	SIDA (200mlcroner)	21.70	17034.50	17034.50	0.00

Sl. No.	Source	Amount in million US $	Amount in Lac BDT	RPA (in Lac BDT)	Other than RPA (DPA) (in Lac BDT)
6	DFID	TBD*	-	-	-
7	USAID	40.00	31400.00	31400.00	0.00
8	UNICEF	15.00	11775.00	0.00	11775.00
9	WHO	30.00	23550.00	0.00	23550.00
10	EKN (7.7 ml. Euro)	8.13	6382.05	6382.05	0.00
11	Gavi-HSS	84.00	65940.00	0.00	65940.00
12	Gavi-ISS+ MR	500.00	392500.00	0.00	392500.00
13	GFATM	146.00	114610.00	0.00	114610.00
14	UNFPA	11.00	8635.00	0.00	8635.00
	Total	1422.54	1116693.90	484549.10	632144.80

* GAC & DFID have expressed their willingness to remain in the 4th HPNSP, but are yet to decide on their probable contributions.

Rate of US$ and Date: 1US$ = 78.50 BDT, Date: 11 November 2016

IV. Programme Background:

The Programme Implementation Plan (PIP) is a plan document prepared to reflect the HNP sector development activities of MOHFW under the SWAp. The purpose of the PIP is to describe broadly GOB's aspiration and targets related to the HNP sector of the Five Year Plan (e.g. 7th FYP). The PIP details out *what* needs to be done and *how* to be achieved through implementation of the 4th HPNSP. The PIP demonstrates how the resources will be allocated to specific programmes and activities.

The first HNP SWAp- the 'Health and Population Sector Programme (HPSP)' (1998-2003), was initiated in 1998 replacing 128 discrete projects in the MOHFW. The second SWAp- the 'Health, Nutrition and Population Sector Programme (HNPSP)' was implemented during 2003–2011. The third SWAp- the 'Health, Population and Nutrition Sector Development Programme (HPNSDP)' (2011–16), was extended to end in December 2016. The fourth SWAp – the 4th HPNSP – is planned to begin in January 2017 through to June 2022.

The development of the PIP (2017-2022) of the 4th HPNSP is guided by Bangladesh's Vision 2021 (transforming the country from a developing into a middle-income country), which acknowledges that improved health is a necessary and critical condition for the achievement of this vision. The 4th HPNSP's articulation and design have been linked to the 7th Five Year Plan (FYP) of the Government. Other guiding principles are drawn from the national policies on health, nutrition and population, various HNP sector related strategies approved by the Government and the experience of implementing three successive sector programmes in Bangladesh. The 4th HPNSP starts at a time of transition from the Millennium Development Goals (MDGs) to the newly agreed Sustainable Development Goals (SDGs) to be achieved by 2030. The MDGs had a major focus on health sector-specific goals whilst the SDGs encompass a much broader agenda for change.

Design of the PIP:

The 4th HPNSP has been designed keeping the above mentioned background in view. It incorporates appropriate strategies and activities for focused improvements in increasing access to, and quality of health care and improving equity along with financial protection in order to meaningfully realize the objectives of universal health coverage (UHC) by 2030. The 4th HPNSP can be considered as the first of three 5-year Programmes contributing to gradual shift towards UHC. However, the challenge is to

prevent ill health and provide better services for all within a heavily constrained resource environment.

The *first chapter* of the PIP contains a brief description on how the SWAp had evolved in the HNP sector; lessons learnt during the last three SWAps with emphasis on achievements of HPNSDP; and a brief discussion on new and continuing challenges to be addresses in the 4th HPNSP. The *second chapter* describes the vision, mission, goal, programme priorities and strategies, boundaries of the sector, implementation priorities, etc.

The *third chapter* focuses on implementation arrangements including organizational structure, linking strategic priorities to implementation structures, issues relating to poverty-environment-climate change-women, children & gender, functional coordination of DGHS and DGFP at the field level, procurement management, implementation monitoring mechanism, technical assistance, etc. The *fourth chapter* provides a summary description of each of the OPs along with component and activity-wise budget. *Chapter five* describes the resource envelope, expenditure plan and financing arrangements from both the government of Bangladesh and Development Partners. Appendix-1 provides details on the Results Framework (RFW) indicators.

V. Main Objectives and Brief Description of the Programme:

Main objectives

The 4th HPNSP is built on existing achievement to improve equity, quality and efficiency with a view to gradually moving towards UHC and achieving health related Sustainable Development Goals (SDGs) through pursuing the following ***strategic objectives (SOs)*** during the next five and half years starting from January 2017:

SO 1 : *To strengthen governance and stewardship of the public and private health sectors*

SO 2 : *To undertake institutional development for improved performance at all levels of the system*

SO 3 : *To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage*

SO 4 : *To strengthen the capacity of the MOHFW's core health systems (Financial Management, Procurement, Infrastructure development)*

SO 5 : *To establish a high quality health workforce available to all through public and private health service providers*

SO 6 : *To improve health measurement and accountability mechanisms and build a robust evidence-base for decision making*

SO 7 : *To improve equitable access to and utilization of quality health, nutrition and family planning services*

SO 8 : *To promote healthy lifestyle choices and a healthy environment*

Brief Description of the Programme

The 4th HPNSP coincides with the adoption of the United Nations' SDGs by world leaders in New York on the 25 September 2015. The 2030 Agenda for Sustainable Development articulates an ambitious set of targets aimed at transforming the world by ending poverty, hunger and inequality, taking action on climate change and the environment and improving health and education. The new Global Goals replace and expand the previously agreed MDGs.

Out of the 17 SDGs, SDG 3 specifically relates to good health and well-being, while several SDGs have bearing on the determinants of health like improvements in hunger, food security and nutrition (SDG 2), inclusive and equitable quality education (SDG 4), water and sanitation (SDG 6), environments (SDG 11 & 16), reducing inequality (SDG 10), gender equity and empowerment of women and girls (SDG 5), etc. SDG 3 aims - among others - to achieve UHC, and provide access to safe and effective medicines and vaccines for all.

The SDG 3 targets are numerous and wide-ranging and cover issues of communicable and non-communicable diseases, lifestyle and healthy environments and provide a holistic framework for development of national responses. The SDGs provide new background to looking at health, nutrition and population in a more holistic and multi-sectoral way and this is reflected in this 4th HPNSP document for Bangladesh.

The 4th HPNSP has been designed with appropriate strategies and efforts for focused improvements in increasing access to, and quality of health care and improving equity along with financial protection in order to meaningfully realize the objectives of UHC.

VI. Vision, Mission and Goal of the Programme:

The PIP is based on the vision, mission, goal, development objectives, strategic objectives and resource envelope as mentioned in the Strategic Investment Plan (SIP) of MOHFW developed in mid-2016.

Vision : *"To see the people healthier, happier and economically productive to make Bangladesh a middle income country by 2021"* (Vision 2021)

Mission : *"To* create *conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health"*

Goal : *"To ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable health care in a healthy environment"*

VII. Development Objective of the Programme:

The development objective of the 4th HPNSP is to have focused improvements in increasing access to quality health care and improving equity along with efficiency by gradually achieving UHC.

VIII. Programme Priorities and Strategies :

On the basis of the experience in the previous health SWAp periods a set of three underlying principles has been identified in preparing the 4th HPNSP. One of these is to ensure that all citizens have access to high *quality* services whether these are obtained from the public or private, modern or alternate medical providers. The other is on *equity*, i.e. all citizens are treated equally and no one is left behind. Finally the Programme aims to gain efficiency by reducing wastage and maximizing the impact of all available resources.

Programme Priorities

During the 4th HPNSP, various innovative approaches will be explored for improving service delivery, which comprise review of existing field-based service delivery; diversification of service provision (inclusive of public-private partnership as referred by the PPP Act) particularly for hard-to-reach areas; development of a functional referral system involving all levels of facilities; ensuring access to

and utilization of quality health services by the poor and the marginalized etc. Moreover, emphasis will be given on- ensuring SBAs at birth; newborn care; CDC and NCD control; adolescent care; health for the tribal population; mental and disability healthcare; climate change and health protection; health regulation: geriatric healthcare; urban healthcare; health research; etc.

Focus will be given to accelerate initiatives in low-performing and hard-to-reach areas as well as to address child marriage, adolescent pregnancies, obstetric fistula, unsafe abortions and a rise in reproductive health cancers/cervical and breast cancers among women and adolescent girls, etc. The existing family planning programme will be strengthened through delivering regional packages in less well performing divisions/pockets. Shifting of existing method-mix of contraceptive use to emphasize long acting and permanent methods (LAPM) will continue to be promoted through informed voluntary choice and counseling. Other FP approaches will be targeting newly-wed couples, particularly adolescents to delay the first birth; addressing the existing unmet need and reducing the discontinuation through improving collaboration with DGHS.

The nutrition programme will continue to be mainstreamed within the DGHS and DGFP service provision. Regular nutritional services will be provided for strengthening IYCF programme, distribution of iron-folic acid supplementation among pregnant and lactating women and adolescent girls, continuation of existing half-yearly Vitamin A capsules distribution programme, scaling up postpartum Vitamin A distribution to improve vitamin A status of neonates through breast milk, monitoring of universal iodization of edible salt, promotion of zinc for treatment of diarrhea, etc. The 4th HPNSP will also strengthen inter- and -intra ministerial coordination; collaboration with the Ministry of Local Government, Rural Development and Cooperatives, and the Ministry of Food to address nutrition and food safety issues within urban contexts.

The 4th HPNSP will continue to strengthen HNP system that may require reorganizing various systems and institutions based on needs of the day. Moreover, the regulatory functions and stewardship role of the MOHFW including the agencies under it will be strengthened.

Strategies

The 4th HPNSP will continue to (a) expand HNP services and (b) improve health systems for programme implementation and oversight. However it is unique in terms of its focus on (a) strengthening MOHFW's stewardship and regulatory roles in the HNP sector; (b) emphasizing service quality both in public and private sectors for achieving equitable healthcare increasingly; and (c) strengthening systems/ institutions for efficient programme delivery.

The challenge for the sector is to prevent ill health and provide better services for all within a constrained resource environment. The Government allocations to health remain low in terms of regional comparisons while performance is high. The MOHFW will concentrate on demonstrating improved performance across the sector and building the investment case for health funding as a foundation for future growth and national prosperity.

Achieving sustainable levels of financing for the sector will depend on a combination of managing demand for health care through prevention and effective treatment, seeking efficiency gains based on reducing wastage and introducing better systems for providing care, and through advocacy with the Government and the development partners for increased financial and technical support. Thus the 4th HPNSP will be translated into actions through implementation of the following strategies:

(i) Building capacities in leadership, management and regulation with stronger governance and stewardship role of the MOHFW for better quality services;

(ii) Restructuring the MOHFW, to increase performance, efficiency and accountability while removing duplication and waste;

(iii) Rolling out an upgraded Essential Services Package (ESP) with greater functional coordination of services at the field level and a functional referral system;

(iv) Developing new approaches and partnerships with the private sector and the community to ensure that basic services reach the poor, the hard-to-reach, the disabled, elderly and those left behind;

(v) Focusing improvement in quality of care, including ensuring the implementation of a comprehensive health workforce strategy and action plan;

(vi) Promoting the importance of public health and increased investment in prevention, primary care and strengthening community engagement;

(vii) Tackling the rising burden of NCDs through cross-sectoral interventions on public health awareness and to establish healthy lifestyles and healthy environment;

(viii) Tackling the burden of established and new communicable diseases;

(ix) Adopting new technologies to strengthen surveillance, data quality and information systems for evidence based decision making; and

(x) Increasing investment in health, ensuring a focus on managing demand, increasing efficiency and creating strong case for health funding.

IX. New Elements or Issues That Would Add More Value to the Programme

The 4th HPNSP is characterized by restructured OPs, implementation mechanism and program contents, activities or focus in OPs. The Program has elements that are different and or add value to the third Sector Program-HPNSDP, particularly in reproductive, maternal, newborn, child & adolescent health; nutrition & food safety; and non-communicable diseases. The objectives of the new elements/focus are to address the unfinished agenda of HPNSDP; challenges posed by demographic and/or epidemiological changes taking place; changing national economy, society and citizen's aspirations; and the Sustainable Development Goals (SDGs) related to health and well-being. Some notable new focuses are stated below:

(i). ***Governance, Stewardship and Institutional Development (GSID):*** *This is an increasingly* critical area for urgent intervention, especially in view of fast expanding and unregulated private sector investment in different branches of the HNP sector in Bangladesh e.g. in laboratory/ clinical service provision, medical education including for doctors, nurses, midwives, paramedics and different categories of technicians etc. and the production/ supply of pharmaceuticals including those of alternative medicine.

(ii). ***Essential Service Package (ESP):*** The new focus will be to restore centrality to ESP in PHC service delivery with a view to emphasizing on equity, gender sensitivity and efficiency in resource use. This is planned to be achieved through greater co-ordination among service providers in health & family planning, co-operation and alignment with the NGOs and other private sector HNP service providers at the District level and below.

(iii). ***Mainstreamed Nutrition:*** Nutrition services and awareness building activities will be expanded, using MOHFW service facilities and through co-operation with NGO stakeholders. This will require recognizing nutrition related services provided by a host of sources like multilateral interventions in water and sanitation, food safety and security, education, welfare and social safety net programs, salt iodization and food fortification, etc.

(iv). ***NCDs*****:** Link needs to be established with existing service providers in the private sector (esp. the not-for-profit organizations). Some non-government actors are playing recognized and important role for a number of NCDs like the Bangladesh Diabetic Association, Heart Foundation for hypertension, Cancer Institute/Ahsanulla Cancer Hospital for cancer, Blind Welfare Society etc. All these organizations receive substantial funds from both MOHFW and MOSW.

(v). ***Urban Health***: The 4th HPNSP focuses on reducing burden of cost of service available to urban dwellers and to expand their access to essential services through additional interventions by MOHFW.

(vi). ***Autism, Mental and geriatric healthcare****:* Given the size of mental health problems and autism spectrum disorders, it will be necessary during the 4th HPNSP to strengthen the public health services for counseling and treatment. Partnership with the media and NGOs will be augmented to raise public awareness about appropriate attitude towards mental and autistic patients.

Evolving socio-economic changes and demographic transition are resulting in rapidly rising number of older population in the country; people over sixty years are expected to grow to 14.4% in 2021. This requires expensive and long-term specialist management for which the country's health system is ill-prepared. During the 4th HPNSP the existing institutional arrangements for health service delivery will be reoriented and incremental investment will be made in developing an appropriate geriatric – friendly healthcare service system.

(vii). ***Community Clinic***: Further consolidating community-supported PHC service delivery as per updated ESP with special emphasis on under-served clientele including those in hard-to-reach areas will be provided by the community clinics.

(viii). ***Field-level supervision*****:** Strengthening of field-level supervision of service delivery at district and below and reporting has been given importance. This will be made effective through (a) development of supervision guideline (Inspection Manual), training of the supervisors and supervised – with special focus on financial integrity; (b) improvement of reporting practice – issuance of guidelines, establishment of reporting chain and providing training; and (c) sensitizing managers and service providers about the legal requirements of Right to Information Act, etc.

(ix). ***Facility management*****:** Importance is given on improved facility management using best practices-e.g. Jhenidah/Chaugacha practices and Narshingdi model for involving community and local government. Special focus is given on asset management; waste management; revisiting complaint handling system; and establishing complaint management to improve two-way communication between service receivers and providers.

X. Priority Indicators with Benchmarks and Targets:

The Government has been following the results-based development approach, as evident from the sixth and the seventh Five Year Plans, as was followed in the HPNSDP. The results-based development approach will also continue in the 4th HPNSP. The Results Framework (RFW) of the 4th HPNSP has set eight goal level indicators to be achieved by the end of the Programme period. Besides, there are 25 intermediate level indicators (outcome/output/process) covering three

components of the programme (e.g., 4 governance and stewardship related indicators: 6 indicators related to stronger health systems; and 15 indicators related to quality health services – annex I shows detailed RFW). The RFW goal level indicators for the 4th HPNSP are shown in the table (Table-1) below:

Table 1: RFW goal level indicators for the 4th HPNSP

Sl. No.	Indicator	Means of verification & timing	Baseline & source	Target June 2022
1	2	3	4	5
Goal 1	Under 5 Mortality Rate (U5MR)	BDHS, every 3 years	46, BDHS 2014	34
Goal 2	Neonatal Mortality Rate (NNMR)	BDHS, every 3 years	28, BDHS 2014	18
Goal 3	Maternal Mortality Ratio (MMR)	BMMS/MPDR/MMEIG, every year	176 WHO 2015	121
Goal 4	Total Fertility Rate (TFR)	BDHS, every 3 years	2.3 BDHS 2014	2.0
Goal 5	Prevalence of stunting among under-five children	BDHS, every 3 years/ UESD, every non-DHS years	36.1% BDHS 2014	25%
Goal 6	Prevalence of hypertension among adult population	BDHS, every 3 years/ NCD-RF, every 2 years	Female 32% Male 19% BDHS 2011	Female32% Male 19%
Goal 7	% of public facilities with key service readiness as per approved Essential Service package (ESP)	BHFS, every 2 years	FP: 38.2% ANC 7.8% CH 6.7% BHFS 2014	FP: 70% ANC 50% CH 50%
Goal 8	% of total health expenditure (THE) financed from public sector	BNHA, every 3 years	23.1% BNHA 2012	26.2%

XI. Major Programme Components:

The 4th HPNSP has three major components - (i) governance and stewardship of the sector; (ii) stronger health systems; and (iii) quality health service. The first component gives priority to addressing issues in the areas of stewardship and governance, regulation of drug administration and quality drug management, legal and regulatory framework, and strengthening roles of the autonomous organizations like BMRC, BMDC, etc. and effective use of the NGOs and public private partnership.

The second component relates to strengthening health system with focus on planning and budgeting, monitoring and evaluation, health sector financing, management information system, research and development, strengthening of human resources for health, pre-service education and in-service training, nursing and midwifery services and training, establishing quality assurance system,

procurement and supply chain management, maintenance of physical facilities, inter-sectoral coordination, financial management, etc. for strengthening the health systems.

The third component aims at improving priority health services in order to accelerate the achievement of the health related SDGs by capitalizing on and scaling up the interventions undertaken under the previous SWAps as well as introducing new interventions. This component supports the priority interventions such as reproductive, maternal, newborn, child and adolescent health; population and family planning services; nutrition and food safety; communicable and non-communicable diseases; alternative medical care; and behaviour change communication related programmes.

XII. Sub-sector wise Brief Description of the Programme:

The 4th HPNSP will be taking action for improving upon the areas of health, nutrition and population sub-sectors as described in the subsequent paragraphs.

Health Sub-sector

***Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH)*:** Given the progress made in the areas of RMNCAH over the last two decades, priority will be given to implementation of approved Maternal Health Strategy and MNH Standard Operating Procedures; making 24/7 normal delivery services available at all upazila and union level (in a phased manner); strengthening of strategically located facilities for BEmONC and CEmONC services; addressing the indirect causes of maternal death, malnutrition, and chronic diseases; implementing special service packages for low - performing and underserved areas; management of sick newborns; etc. Simultaneously, adolescent health improvement activities to be pursued during the 4th HPNSP include - development of a comprehensive Adolescent Strategy and Action Plan; promotion of school health programmes; strengthening response to gender based violence; and prevention of child marriage, etc.

***Non-Communicable Disease Control (NCDC)*:** A transition in the disease pattern is taking place in Bangladesh in the recent past - shifting from communicable to non-communicable diseases (NCDs). The key activities to be pursued during the 4th HPNSP for addressing the NCD related issues include - strengthening capacity of primary health care for early detection, management and referral of NCDs; coordination with other OP services and Ministries/Agencies/Units under MOHFW for promotion of healthy lifestyle and prevention of NCDs; training of health workers on detection/screening of major NCDs (e.g. hypertension, diabetes mellitus, COPD); etc.

***Communicable Disease Control (CDC)*:** Over the last few years, there have been notable achievements in combating diarrheal diseases and addressing Malaria, Tuberculosis (TB), Leprosy, Filariasis, Kala-azar, HIV/AIDS and STDs, etc., these efforts will be continued. The activities to be pursued during the 4th SWAp period include - detection of TB case and its management, strengthening efforts for detection and management and pharmaco-vigilance to control vector borne communicable diseases; creation of mass awareness regarding the sources, symptoms, prevention and management of major communicable diseases; strengthening detection and prevention of cross-border communicable diseases through screening at the entry points of the country; extension of the communicable disease control programmes to cover hard-to-reach and vulnerable population; etc.

Hospital Service Management (HSM): During the past two decades, efforts were made to improve secondary and tertiary level hospital service management. The key activities to be pursued during the 4th HPNSP involve - continuation and expansion of service provided through the hospital service network; introducing/expanding ICU/CCU, NICU, Dialysis Unit, etc.; increasing capacities of hospitals to address the NCD issues; providing focus on autism, mental health, geriatric and palliative

care and accident/violence related injuries; expanding structured referral system; improvement of diagnostic, imaging and other technical services in the hospitals; capacity improvement of the MCHs with harmonized HR, equipment and other logistics; and strengthening follow-up of SOPs in all secondary and tertiary hospitals.

Alternative Medical Care (AMC): Homeopathy, Ayurvedic and Unani are the three streams of AMC being practiced in Bangladesh. One of the achievements of the AMC OP was development of the AMC Strategy during HPNSDP implementation. Way forward activities in the 4th HPNSP involve - strengthening of AMC services in public hospitals in phases; introduction of postgraduate and higher education for AMC practitioners; updating existing curriculum of Unani, Ayurvedic and Homeopathy; continuation of awareness building on AMC, etc.

Revitalizing Community Based Primary Health Care towards UHC in Bangladesh: Significant progress in primary health care (PHC) services has been made with the revitalization of Community Clinic (CC) based services since 2009. Currently, there are 13,136 CCs, functional with the required Community Health Care Providers (CHCP), medical and surgical requisites (MSR) and medicines. The number of CC level service seekers (mostly women and children) has increased over time. The key activities to be implemented during the 4th HPNSP involve - establishment of a field-level functional co-ordination mechanism between DGHS and DGFP; review of job description of CC level staff for rationalizing service providers' workload; review of the drug list for CCs for rational dispensing of drugs; continuation of in-service training for skill development of the CC based service providers; etc.

Urban Health Service*:* PHC services in urban areas are provided by the MOLGRDC and other public sector HNP services are provided by the MOHFW. Currently 60% of the urban population in the country is slum dwellers. During the 4th HPNSP the key activities to be pursued for improving the urban health service delivery involve - continuation of 35 urban dispensaries and 4,000 satellite centres to provide outdoor service for EPI to the urban population; distribution of vaccines for immunization and FP materials in the urban areas in cooperation with the City Corporations through the NGOs; development of a referral system between the urban dispensaries and the secondary/tertiary level hospitals; strengthening of coordination among MOHFW, MOLGRDC, NGOs, and private sector for operationalization of the guidelines of National Urban Health Strategy 2014; strengthening of stewardship role of MOHFW for proper licensing and registrations of the private service providers, etc.

Tribal Health Service*:* In Bangladesh, there are about 45 different tribal/ethnic communities, majority of who live in the Chittagong Hill Tracts. During HPNSDP, a Tribal Health Committee was constituted; a number of health service providers were trained on tribal health; satellite clinics took place in CHT area to address tribal health issues; and an action plan with guideline was developed for provision of PHC services to the districts of CHT. The key activities to be carried out during the 4th HPNSP involve - ensuring equitable access of tribal/ethnic people to HNP services; making service providers available at tribal health facilities; using community leaders in IEC activities; strengthening collaboration among MOHFW, MOCHTA, CHT-RC and HDCs; development of district-specific health service in the CHT in cooperation with HDC and local NGOs; etc.

Public Health, Lifestyle Change and Environment*:* Health promotion, awareness building, community participation, surveillance, research, SBCC activities are the core public heath activities to be pursued under the 4th HPNSP. Other key interventions to be implemented include - development of a comprehensive healthy lifestyle and environment strategy; using ICT platforms including mobile

technology and social media to disseminate SBCC messages; promoting healthy diet; avoiding the hazards of overdose of salt, oil and sugar; promoting adequate intake of fruits and vegetables; stoppage of smoking and substance abuse; etc.

***Pre-service Medical Education*:** There has been rapid expansion in medical education in terms of number of medical/paramedical colleges, especially during the last decade between 2005 and 2015. However, issues needing attention during the 4th HPNSP include quality of medical education; limited capacity of the governing entities; inadequacy of legal framework: parallel bodies in medical education; concerns regarding common appraisal; etc. To address these issues, a number of steps will be taken including improvement of governance and supervision capacity of the stewarding bodies; updating the current laws/enacting new laws as appropriate; introduction of an accreditation system for assessing the quality of medical education; etc.

Nursing and Midwifery Services: One of the significant achievements during 2011-16 was the introduction of the midwifery cadre. The activities to be pursued during implementation of the 4th HPNSP cover: making the Directorate General of Nursing and Midwifery (DGNM) functional; introduction of accreditation system in both public and private sector nursing & midwifery institutes; improvement in quality of nursing and midwifery education; continuation of in-service training of deployed nurses and midwives; filling up the vacant positions with the planned number of nursing professionals; establishment of regular monitoring mechanism at the field level; building mass awareness on midwifery profession; etc.

Nutrition Sub-sector

Nutrition and Food Safety: A shift in implementation of nutrition services by mainstreaming through existing service delivery platforms was made during the HPNSDP. Moving into the 4th HPNSP, nutrition services will be expanded through delivery of the newly adopted ESP, improved inter-OP functional coordination and multi-sectoral collaboration; growth monitoring and promotion, infant and young child feeding counseling, nutrition counseling delivered through ANC and PNC, identification and management of severe and acute malnourished children, vitamin A supplementation, iron folic acid distribution, expansion of, food fortification, promotion of food safety and good hygiene including WASH interventions, etc.

Population Sub-sector

***Population and Family Planning Services*:** There has been a stagnant situation of TFR at 2.3 births per woman since 2011 (BDHS, 2014). The usage of LARC/LAPM, male sterilization and implant also remained very low. The key activities to be pursued during the 4th HPNSP include - making LARC, LAPM and other relevant contraception methods available through strengthening service delivery; strengthening FP services for post-partum and post-MR/PAC; ensuring availability of contraceptives through proper need assessment and procurement planning; continuation of efforts like awareness programmes, orienting newly-wed couples on contraception methods; implementation of regional service package for FP in hard-to-reach locations and low-performing areas; etc.

Issues cutting across Health, Nutrition and Population sub-sectors

***Services for Hard-to-Reach Areas and Vulnerable Population*:** Due to various difficulties, there is limited access for people living in the Chittagong Hill Tract areas, char islands of large rivers, haor and the coastal belt areas to quality HNP services. During HPNSDP, specialized service package was developed for the hard-to-reach areas. In continuation of the existing services, additional steps will be taken during the 4th HPNSP for the hard-to-reach and vulnerable population through adopting

diversification in service delivery; providing functionally coordinated health and FP services; introducing incentives to attract and retain quality workforce in these areas; and collaborating with MOLGRDC, MOCHTA, DPs, NGOs, private sector and others to ensure effective HNP services including the updated ESP.

***Essential Services Package (ESP)*:** Since the beginning of SWAp in 1998, priority was given to extend health care services to the poor people including the vulnerable groups. The central feature of this approach is the funding of an essential service package (ESP) which aims to maximize health benefits relative to per capita expenditure, meet essential needs of the clients, strengthen service delivery, and improve health system management. The MOHFW has recently approved an updated ESP to be provided at nine main delivery sites, from the CC to the UH&FWC/Union Sub-centre, UHC, and to the MCWC and district hospital, including urban facilities. The ESP service components include - maternal, neonatal, child and adolescent health; family planning; nutrition; communicable diseases; nob-communicable diseases; management of other conditions; laboratory diagnosis, radiology and other imaging tools; and pharmacy.

Functional Coordination at the field level: In order to implement the updated ESP, it is essential that a harmonized and cost-effective service delivery system is put in place. There are existing evidences of coordinated service delivery by the field personnel of DGHS and DGFP in certain programme activities being implemented by the Government (e.g., EPI). MOHFW intends to make conscious efforts during the 4th HPNSP to harmonize activities of both the Directorates at the field level. In doing so, the key areas of functional coordination include unified services on maternal health especially EOC, post abortion care, child health and neonatal heath, reproductive and adolescent health; registration of births, couples and pregnancy; training to DGHS personnel on PPFP; exchanging HR especially Anesthetists between DH and MCWC for EmOC; aligning resources of DGHS and DGFP to ensure services of ESP; developing a common guideline for strengthening referral mechanism using existing platform; and developing common service delivery plan for the lagging areas, for implementation and supervision jointly by DGHS and DGFP officials.

***Governance and Stewardship*:** During the 4th HPNSP, major activities for improving governance and stewardship functions of MOHFW involve - updating regulatory instruments; review of the structure, organogram and mandate for regulatory bodies; review Nursing Council Ordinance; amendment of BMDC Act; enactment of proper regulations for SMF; and introduction of an accreditation system for assessing the quality of private and government medical colleges**.** Other governance issues relating to service delivery improvement will also be pursued through the implementation of the 4th HPNSP.

***Drug Administration*:** The key activities to be pursued during the 4th SWAp period include - adoption of a revised policy and a unified law considering the limitations and challenges in the Drug Act, 1940 and Drug (Control) Ordinance, 1982; creation of drug inspector position under DGDA (the drug regulatory authority of Bangladesh) in each district office considering the market size and workload; capacity building of staff through need based trainings; introducing a uniform and online reporting system for field offices; identification of pharmaceutical companies producing sub-standard, fake and adulterated drugs and taking legal actions against them.

***Aid Modality & IPF*:** A new financing operation named Investment ProjectFinancing (IPF) along with the Disbursement Linked Indicators (DLIs), is proposed to be introduced in the 4th HPNSP for financing of US$ 500 million by the IDA of the World Bank. Under the IPF, disbursement is made against achievement of some indicators, known as the DLIs. This new procedure is challenging as it needs to be harmonized with ADP/RADP preparation timing. Notably, if MOHFW fails to achieve

the targeted results (e.g. the DLI) at the stipulated time, there will be no disbursement of the earmarked fund for a DLI. In the 4th HPNSP, an arrangement with adequate TA support will be made for tracking progress and reporting on the DLI's achievement. Also, training will be provided to relevant staff under MOHFW on DLI monitoring and internal verification mechanism.

***Sector-Wide Programme Management and Coordination*:** A variety of mechanisms were identified and practiced in HPNSDP on sector-side programme management, collaboration and coordination. Conscious efforts were made to improve both inter and intra OP coordination and also to strengthen inter-ministerial coordination. For further improvement in sector-wide programme management and monitoring, focus will be given on activities like - strengthening coordination with DPs through establishing 'HNP sector Coordination Forum' with Honorable Minister for MOHFW in the Chair along with reforming the existing TGs against the backdrop of emergence of issues like NCD, governance & stewardship; institutionalization of the Programme Management and Monitoring Unit (PMMU) under the Planning Wing and strengthening of the Planning Units of DGHS & DGFP; and developing M&E capacity of the associated staff during implementation of the 4th HPNSP.

***Technical Assistance*:** GOB led Technical Assistance Committee (TAC) along with joint donor technical assistance fund (JDTAF) managed by DFID was acknowledged as an effective institutional arrangement for TA management and coordination. This arrangement will be continued during the 4th HPNSP with emphasis on - development of a harmonized TA Plan to identify major areas of TA needs and how these will be supported; strengthening of capacity of TA recipients to utilize TAs effectively; accelerating TA procurement; strengthening monitoring/follow-up of TAs at MOHFW level; utilizing TAs to address the technical issues and/or innovations; etc.

***HNP Sector Financing**:* MOHFW's budget for the HPNSDP increased at an average rate of 15% per annum. It is expected that at least the same rate will be sustained during implementation of the 4th HPNSP. However, during the 4th HPNSP more emphasis will be given on activities like allocating resources based on a resource allocation formula; increasing resources in the HNP sector; and enhancing efficiency in resource allocation and utilization.

Innovative Approaches to Universal Health Coverage (UHC): During the 4th HPNSP, various innovative approaches will be explored for improving service delivery and ensuring universal health coverage as the long term goal, which may comprise review of existing field-based service delivery; diversification of service provision particularly for hard-to-reach areas; development of a functional referral system involving all levels of facilities; ensuring quality of care, etc. MOHFW will promote multi-sector collaboration with other Ministries, private sector, NGOs, CSOs, etc. for providing health service delivery particularly for hard-to-reach areas, geriatric-friendly health care, and for addressing the disability issues (autism, mental health, etc.) and rehabilitating the disabled.

***Community Participation and Ownership*:** There already exist many good examples of community participation in Bangladesh, e.g., 'Chowgacha model'. Another prominent example of community engagement is demonstrated by the Community Clinic Project (RCHCIB) of the Government, at present, reformed as community based health care (CBHC) OP under DGHS. The good initiatives of encouraging community participation will be continued and expanded, and new initiatives will be explored to increase their participation and empowerment in the 4th HPNSP. Local communities will also be motivated to mobilize local resources for repair and maintenance of community-based infrastructure (including CCs) and cleaning; monitoring of the performance of service providers; and meeting operational expenses of the community level health facilities, etc.

Partnership with Private Sector*:* Over 80% of people in Bangladesh seek care from non-public HNP service providers. Considering that Public private partnership (PPP) models would help reduce expenses as well as improve quality of services, MOHFW has already initiated exploring the possibilities of contracting out non-functional health facilities to private (for profit and not-for profit) providers where the Government will have clearly defined monitoring and supervisory role. Modalities will be determined to mobilize private sector resources to high investment areas like infrastructure development, service centre establishment with high-tech equipment and innovative medical and pharmacological research.

Multi-Sectoral Approaches**:** Achievements in the HNP sector do not solely result from MOHFW's success; other sectors like agriculture, education, information, etc. also contribute enormously. Therefore MOHFW will work closely with other sectors to achieve the HNP related SDG targets. To address the issues that affect access to a safe, affordable and nutritionally adequate diet and impact nutritional status, concerted effort and action across multiple sectors will be taken. Efforts will also be made to strengthen collaboration around healthy lifestyles and healthy environment which will play a major role in keeping the burden of NCDs under control.

Financial Management: Commendable progress over a period of past 15 years was achieved in budgeting procedures, fund disbursement, financial monitoring and reporting systems. The key activities during the 4th SWAp implementation period will be to recruit proficient human resources for the FMAU; develop training manuals and provide regular training on financial management and audit issues; set-up Audit Units at the Directorate levels to track expenditure; and develop an institutional framework for addressing FAPAD led audit objections.

Physical Facilities Development: Over the years, full operationalization and utilization of the health and family planning facilities had been a challenge mostly due to lack of coordination and synchronization of activities among the OPs related to infrastructure development and facility-based service provision (PFD, ESD, HSM and HRM). During the 4th HPNSP, the key activities to be pursued include preparation of a completion schedule to finish the incomplete civil works for priority structures; preparation of a comprehensive construction and maintenance plan for the health and family welfare facilities; enhanced coordination with HRD, PSSM-HS and PSSM-FP OPs to operationalize the already completed structures; synchronization of the Table of Equipment and Table of Organization while planning for new construction and upgrading of infrastructure; asset management mechanisms, etc.

Management Information System (MIS)**:** During HPNSDP, investments were made in hardware as well as increasing connectivity up to the community clinic level. To continue the advancement in MIS, the activities to be implemented during the 4th HPNSP cover - building functional linkage between the information systems of the Directorates for better coordination and harmonization; digitization of entire routine health information system in Bangladesh by 2021; institutionalization of Data Quality Assurance (DQA) mechanism; timely availability of routine, surveillance, civil registration and vital statistics (CRVS) and survey data; collaboration with MOLGRDC and the NGOs for establishing linkage with urban health information system; etc.

Health and FP Research & Training: During the 4th HPNSP, the key activities to be pursued for improvement of health and FP research and training in Bangladesh include - continuation of research and survey on important HNP issues; assessment of the capacity of BMRC; strengthening of skills of research personnel and linking of research with management/policy decisions and techniques for wider dissemination of research findings; conduct research on medical biotechnology, demographic

and epidemiological transition and their implications for public health; environmental and ecological impact on public health, and emerging and re-emerging diseases, etc.

Governance, Equity, Voice and Accountability (GEVA): With the revitalization of community based health service provision, access of the poor, particularly women and children to PHC service has increased considerably. Advancement has been made during HPNSDP in hearing citizen's voices through establishing community support groups and community groups for management of the community clinics. A Gender Equity Strategy (GES) has also been published by MOHFW, acknowledging the significance of gender in improving voice, equity and accountability in the HNP sector. The 4th HPNSP will pursue a number of activities including - expanding service coverage in the hard-to-reach areas; implementation of the Gender Equity Action Plan (GEAP); provision of health care services to survivors of domestic violence as part of comprehensive response to gender based violence; strengthening of collaboration with other relevant ministries and agencies (e.g. MOWCA, MOHA, MOSW and other stakeholders); rolling out women friendly hospital initiative (WFHI); generation of gender disaggregated information; and expansion of social protection schemes (e.g., DSF).

***HNP Sector boundary*:** SWAp is an approach that brings together the Government, DPs and other stakeholders within the sector. However, Bangladesh health SWAps do not include the public sector health interventions implemented outside the MOHFW ((i.e. by MOLGRDC, MOSW, MOWCA, MOCHTA, etc.), nor the health programmes implemented by NGOs, the private sector or DPs' off-budget activities. Neither has it included the discrete projects implemented by MOHFW under ADP. Against this backdrop the MOHFW has been continuously trying to strengthen its coordination and functional relationship with other stakeholders/Ministries/Agencies involved in providing health services.

The provision of quality health services and related outcomes are the result of multi-sectoral interventions and thus not solely the responsibility of MOHFW. During the 4th HPNSP efforts will be made to further improve upon existing platform of coordination between MOHFW and relevant stakeholders including the private sector and explore feasible new modes for maximization of available resources. Key areas of such coordination and collaboration would include - urban health (MOLGRDC) and tribal health (MOCHTA) for resource sharing, programme planning, implementation and review; parallel projects (both GOB and DP) to avoid duplication and develop complementarities; NGO/private sector for management/operation of non-functional facilities and/or providing services in hard-to-reach areas or for exploring feasibility of new services/technology; community, public representatives and local government's involvement in augmenting resources, management and oversight of service facilities in their locality; etc.

XIII. Proposed Operational Plans:

The number of HPNSDP – OPs (32) were reviewed, rationalized and renamed for implementation during the 4th HPNSP. There are now 29 OPs for this PIP distributed across DGHS (14), DGFP (7), and MOHFW (5) and other agencies (one each for DGDA, DGNM and NIPORT), each of which reflects priority areas of the 4th HPNSP. Each OP is led by a Line Director (LD) and has a functional administrative structure including staff, budget and infrastructure. The OPs are prepared for five and half years and will be revised based on the progress of work, the ADP allocation and the recommendations of the Mid-Term Review (MTR), to be conducted during the second half of 2019. The Steering Committee for the 4th HPNSP, comprising of inter-ministerial representations at a senior level and chaired by the Honorable Minister for MOHFW, is responsible for approving all the OPs.

However, a particular OP may need to be revised at any other point of time during the implementation of the 4th HPNSP to rationalize activities and/or budget based on implementation experience.

XIV. Mapping Strategy to Operations and Cross-cutting Issues:

The structure of the 4th HPNSP does not map directly, or simply, onto the OPs. Some strategic priorities require contribution from, and co-ordination with more than one OP. For each strategic area and their priority interventions within the structure of the 4th HPNSP - component 1: strengthening governance and stewardship; component 2: health systems strengthening; and component 3: provision of quality health services – 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 chapter III of the PIP identifies the lead OPs together with the strategic objectives and supporting or linked OPs. The PIP maps these linkages and draws attention to where crosscutting engagement of multiple OPs are required for effective implementation.

XV. Procurement Process:

Central Medical Store Depot (CMSD), DGFP Procurement and Logistics Unit, Health Engineering Department (HED) and Public Works Department (PWD) are considered as agencies with good procurement capacity. The Procurement and Logistics Management Cell (PLMC) set up during HPNSDP implementation period will be continued during the 4th HPNSP for promoting the stewardship role of MOHFW and overseeing procurement process, preparation of procurement plan, tendering documents, tender evaluation, procurement tracking and asset management, etc.

MOHFW will roll out e-GP for all its procurement agencies - CMSD, DGFP Procurement and Logistics Unit and HED. Capacity building of the focal points of procurement is one of the important activities to be pursued during the 4th HPNSP's implementation period. Expansion of supply chain management portal (SCMP); establishment of a coordination mechanism for procurement between DGHS and DGFP; introduction of automated mechanism for stocking and warehouse management; introduction of routine surveillance to ensure quality of goods; and development of a database for trained staff on procurement issues, etc. will also be pursued during the 4th HPNSP.

XVI. Human Resource Management:

The health sector experienced – in different degrees – human resource shortage, mal-distribution of personnel, skill-mix imbalance, negative work environment and weak knowledge base during HPNSDP implementation. As part of HR augmentation, the GOB has already appointed more than 6,000 doctors and 4,100 nurses. Besides, 13,500 CHCPs were recruited to strengthen community based service delivery. Similarly, 3,000 midwifery posts have been created to improve MNH services. It is a challenge for MOHFW to retain health workforce, especially the physicians and nurses, in remote and hard-to-reach areas.

The 4th HPNSP aims to implement the approved Health Work Force (HWF) Strategy; address the issue of skill mix; explore community participation and engagement of private sector to address shortage of human resources; rationalize job descriptions of HWF at different level of services; and develop and operationalize Human Resources Information System (HRIS) to link DGHS, DGFP and DGNM HR platforms. Steps are to be devised for improving the quality of existing workforce in both the formal and the informal sectors. HR retention through financial and non-financial incentives, contracting in & contracting out in HTR/rural areas will be key issues to be addressed during implementation of the 4th HPNSP.

XVII. Monitoring and Evaluation Mechanism:

The PW of MOHFW will be the focal point for M&E in the 4th HPNSP and will continue with its role of monitoring implementation progress of the Programme through tools like, monthly ADP review meeting; review of DLIs; OP Implementation Committee (OPIC); Steering Committee; LCG Working Group on Health; and task groups, etc. for monitoring progress of the 4th HPNSP with assistance from the PMMU established under the HPNSDP, supported by the a technical assistance support team (TAST).

During HPNSDP, a number of activities to support capacity building, streamlining, and scaling up of M&E systems were implemented. The 4th HPNSP is also linked to the achievement of results as defined by the Results Framework (RFW) and a set of OP level indicators to monitor progress of its implementation. The OPs will be formally reviewed to assess progress in implementation and a six-monthly/annually report will be produced. Given the renewed focus on tracking progress under the current global (e.g. SDG) as well as national (e.g. 7th FYP) and ministerial (e.g. disbursement linked indicators) commitments, implementation of the Monitoring & Evaluation Strategy and Action Plan (MESAP) would be a priority activity in the 4th HPNSP. Development of SmPR, APIR & APR to monitor progress of OP implementation and sector performance; and tracking of DLI progress along with capacity building of the staff will be pursued during the 4th HPNSP.

XVIII. Programme 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 3.5% of GDP is spent on HNP sector in Bangladesh, of which about 1% 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 HNP sector demands higher allocation.

The projected MTBF allocation for MOHFW covers the financial years 2017-18, 2018-19 and 2019-20, which may be seen below (Table-2). The budget for FY 2020-21 and 2021-22 has been projected based on an annual increase of 15% over the FY 2019-20 budgets. Following this estimation, the non-development budget and development budget stand around Tk. 92,375.80 crore and Tk. 46,359.70 crore respectively. However, considering the expenditure trend and duration of the programme period, the non-development and development budgets are estimated Tk. 72,000.00 crore and Tk. 43486.36 crore respectively.

Table-2: Allocation in the MTBF for MOHFW Budget (Revenue and Development)

(Tk. in crore)

Budget by Type	Budget for 2016-17	MTBF Projection			15% increase on the projection of 2019-20		Total
		2017-18	2018-19	2019-20	2020-21	2021-22	
Revenue	11,281.51	12,271.40	14,320.84	15,752.93	18,115.87	20,833.25	9,2375.80
Development	6,234.54	6,996.26	6,873.54	7,560.94	8,695.08	9,999.34	46,359.70
Total	17,516.05	19,267.66	21,194.42	23,313.87	26,790.95	30,832.39	138,935.50

Of the total budget requirement (both revenue and development) for the 4th HPNSP, the development budget is estimated at Tk. 43,486.36 crore to be distributed amongst 29 OPs for implementation during the period of five and half years.

A. OP wise Budget Requirement for the Programme:

(Taka in Lakh)

SL	Name of the Operational Plan	GOB	RPA	DPA	Sub-Total PA (4+5)	Total (3+6)	% of Total
1	2	3	4	5	6	7	8
A) Governance and Stewardship							
1	Sector-Wide Programme Management and Monitoring (SWPMM)	2882.00	2342.00	16905.00	19247.00	22129.00	0.51
2	Planning, Monitoring and Research (PMR)	6754.40	3587.80	1385.00	4972.80	11727.20	0.27
3	Planning ,Monitoring and Evaluation (PME)	551.50	1934.50	0.00	1934.50	2486.00	0.06
4	Health Economics and Financing(HEF)	13518.45	7763.20	901.00	8664.20	22182.65	0.51
5	Strengthening of Drug Administration and Management (SDAM)	3160.00	3165.00	0.00	3165.00	6325.00	0.15
	Sub-Total	26866.35	18792.50	19191.00	37983.50	64849.85	1.49
B) Health Systems Strengthening							
6	Health Information Systems and E-Health (HIS& e-health)	52292.00	23466.00	2872.00	26338.00	78630.00	1.81
7	Management Information Systems(MIS)	6068.00	7272.00	0.00	7272.00	13340.00	0.31
8	Procurement, Storage and Supplies Management-HS (PSSM-HS)	82972.00	8776.00	0.00	8776.00	91748.00	2.11
9	Procurement, Storage and Supply Management-FP (PSSM-FP)	14935.00	710.00	0.00	710.00	15645.00	0.36
10	Human Resource Development (HRD)	2737.97	3552.50	0.00	3552.50	6290.47	0.14
11	Medical Education and Health Manpower Development (ME&HMD)	142247.00	26410.00	0.00	26410.00	168657.00	3.88
12	Nursing and Midwifery Education Services (NMES)	9417.00	16570.00	14698.00	31268.00	40685.00	0.94
13	Training, Research and Development(TRD)	9607.51	15280.94	0.00	15280.94	24888.44	0.57
14	Physical Facilities Development (PFD)	1145111.70	22514.31	0.00	22514.31	1167626.01	26.85
15	Improved Financial Management (IFM)	1738.00	1090.00	0.00	1090.00	2828.00	0.07
	Sub-Total	1467126.18	125641.75	17570.00	143211.75	1610337.93	37.03
C) Provision of Quality Health Services							
16	Maternal, Neonatal, Child and Adolescent Health (MNCAH)	60086.96	185812.25	533234.25	719046.50	779133.46	17.92
17	Maternal, Child, Reproductive and Adolescent Health (MCRAH)	38650.80	80738.00	17362.00	98100.00	136750.80	3.14
18	National Nutrition Services (NNS)	7089.45	53717.65	12107.08	65824.73	72914.18	1.68
19	Communicable Diseases Control (CDC)	41292.00	44283.00	13260.00	57543.00	98835.00	2.27
20	TB-Leprosy & AIDS/STD Programme (TBL & ASP)	28426.39	48973.50	88252.83	137226.33	165652.72	3.81
21	Non-Communicable Diseases Control (NCDC)	72765.20	32462.07	6600.00	39062.07	111827.27	2.57
22	National Eye Care (NEC)	2187.00	6098.00	0.00	6098.00	8285.00	0.19
23	Community Based Health Care (CBHC)	358054.45	146533.50	2010.00	148543.50	506597.95	11.65
24	Hospital Services Management (HSM)	150019.00	251153.00	2939.00	254092.00	404111.00	9.29
25	Clinical Contraception Services Delivery Programme (CCSDP)	107073.97	40264.85	2502.98	42767.83	149841.80	3.45
26	Family Planning Field Services Delivery (FP-FSD)	35346.00	109242.00	350.00	109592.00	144938.00	3.33
27	Life Style and Health Education & Promotion (LHEP)	14067.07	6226.00	867.00	7093.00	21160.07	0.49
28	Information, Education and Communication (IEC)	15007.00	13469.00	870.00	14339.00	29346.00	0.67
29	Alternative Medical Care (AMC)	39855.00	4200.00	0.00	4200.00	44055.00	1.01
	Sub-Total	969920.29	1023172.82	680355.14	1703527.96	2673448.25	61.48
	Total	2463912.82	1167607.07	717116.14	1884723.21	4348636.03	100.00

B. Justification for Budget Requirement:

The 4th HPNSP calls for incremental investment during the next five and half years with a view to implementing its strategic objectives into actions. Considering the significance of reproductive and maternal health care (e.g. ANC, PNC, institutional delivery, etc.) and the current status of adolescent and child health care in Bangladesh, the RMNCAH related activities will continue to receive more resources. Coverage of DSF has been included in the Maternal, Neonatal, Adolescent and Child Health Care (MNCAH) of DGHS. Increased funding will also be required to address the non-communicable diseases control (NCDC) related activities and to halt increasing deaths due to the NCDs.

The PHC service provision following the updated ESP will require considerably larger amount of investment for ensuring increased service utilization by the poor at the grass-root level. Nutrition services will continue to be provided throughout the country with emphasis on IYCF, nutrition counseling and food safety. In addition, more resources will be required to improve sector governance and to strengthen the support systems, e.g., establishing M&E, improving HIS, strengthening procurement, etc. All these interventions explain the necessity for higher investment in the HNP sector during the 4th HPNSP.

C. Expected GOB and DP Share: the Resource Gap

The MOHFW's budgetary requirement for implementing the 4th HPNSP, combining development and non-development budgets stands at Tk. 1,15,486.36 crore, equivalent to US$ 14,711.64 million. The GOB bears the entire responsibility of funding MOHFW's non-development budget (Tk. 72,000.00 crore equivalents to US$ 9,171.97 million) and part of the development budget. However, GOB and DP share is about 83.68: 16.32 of the MOHFW's total budget for the Programme.

Out of the total development budget of Tk. 43,486.36 crore (US$ 5,539.66 million), about 57% (Tk. 24,639.13 crore equivalent to US$ 3,138.74 million) will be contributed from GOB's own resources and the rest 43% (Tk. 18847.23 crore equivalent to US$ 2400.92 million) is considered to be the resource gap which will need to be funded externally.

The World Bank including a number of DPs has continuously been funding the HNP sector development efforts of GOB. It is expected that the funding gap will be covered by the DPs (both credits from IDA & JICA and grants from other bilateral DPs). By this time there has been an indication of DP commitment to the extent of Tk. 11,166.93 crore (US$ 1422.54 million) and DFID & GAC are likely to contribute approximately US$ 250.00 million. There remains a resource gap of Tk. 7680.28 crore (US$ 978.38 million). New sources of funding may crop up, e.g., The Gates Foundation, WB's Global Fund Facility and DPs like China & Korea. However, the challenge of resource gap can be further minimized by increasing GOB's contribution as well as gaining efficiency in both rational fund allocation and utilization.

Signature of the Secretary
Ministry of Health and Family Welfare

CHAPTER I: INTRODUCTION

1.1. Background: History of Sector Programme

Bangladesh focused on the development of health services and family planning (FP) through individual development projects since independence in 1971. The Ministry of Health and Family Welfare (MOHFW) recognized by the mid-90s that the proliferation of the projects (over one hundred) was not suited to deliver cost-effective and integrated health services. The Ministry envisaged that a Sector-Wide Approach (SWAp) would meet the identified challenges in three ways: (1) improved coverage of essential health and FP services would be assured through technical support and coordinated financing; (2) service delivery would be more cost-effective by leveraging sector reforms; and (3) involvement of non-government organizations (NGOs and the private sector in service delivery would be promoted. These aspirations motivated the MOHFW to embark on a sector-wide development programme.

The first SWAp known as 'Health and Population Sector Programme (HPSP)' (1998-2003), was prepared jointly by the Government of Bangladesh (GOB) and the Development Partners (DPs) with full ownership and leadership of the Government. HPSP- initiated in 1998- replaced 128 discrete projects in the MOHFW. DPs' funding was through pooled and bilateral funding. The main focus of the HPSP was to decentralize the delivery of the essential service package (ESP) of primary health care (PHC) using a 'one-stop' service model, to deliver basic health and FP services to rural communities.

The second SWAp, titled as 'Health, Nutrition and Population Sector Programme (HNPSP' was designed by a new Government and implemented during 2003–11. The overall objective of the HNPSP was to increase the availability and utilization of user-centreed, effective, efficient, equitable, affordable and accessible quality Health, Nutrition and Population (HNP) services. The Government, led by a new political regime, abandoned the community clinic (CC) programme and reversed the unification of services and structure belonging to Directorate (DGHS) and Directorate general of Family Planning (DGFP) as well as some other reform initiatives like hospital autonomy introduced during HPSP.

In 2011, the MOHFW adopted the third SWAp titled the 'Health, Population and Nutrition Sector Development Programme (HPNSDP)' (2011–16). The focus of HPNSDP was on strengthening health systems and improving health and FP services. The CCs were reintroduced in 2009 as a priority project and was later mainstreamed into the SWAp Programme in 2014.

Bangladesh in its development planning had prioritized a focus on making public health services available and accessible to all its citizens since, at least, the last three decades–through Health for All (HFA), PHC, ESP, etc. The adoption of SWAp further consolidated those efforts and helped to focus on expanding service coverage and access, while strengthening service-related systems to meet the Universal Health Coverage (UHC) goal. During the SWAp periods, significant progress has been achieved in terms of key HNP outcomes, as evidenced by different Bangladesh Demographic and Health Surveys (BDHS). Life expectancy at birth has substantially increased to 70.7 years (Bangladesh Economic Review 2016) – a massive 15.9 year increase during 1981–2016.

Based on the successes and lessons learned in the previous SWAps and to move towards the development goal of Vision 2021, the MOHFW has prepared the 4th SWAp (2017-22) which would serve as the first, and the foundation stone, of three subsequent SWAps for realizing the global health targets of the Sustainable Development Goals (SDGs) by 2030. It is consistent with GOB's 7th Five

Year Plan (2016-20) and its policy framework on health, nutrition and population. The 4th HPNSP is aligned to the goal of achieving UHC which highlights the right of every citizen to gain access to quality health care without incurring economic hardship. It articulates a set of objectives, strategies and activities to move the country towards achieving the UHC by 2030.

1.2. Progress Made after Sector Programme Taken

This sub-section briefly summarizes the trend of improvement in different service outcomes and the supporting core health systems during the three SWAps spanning over last 18 years. Table 1 at the end of this sub-section presents the status of achievement of the goal level RFW indicators of HPNSDP.

***Health Service Utilization*:** The Contraceptive Prevalence Rate (CPR) among married women in Bangladesh increased from 8% in 1975 to 62.4% in 2014 —and CPR for modern methods increased from 5% to 54.1% during this period (BDHS 2014). In the last decade, contraceptive use has increased by 4 percentage points from 58% in 2004 to 62% in 2014, while use of modern contraceptive methods increased by 7 percentage points from 47% to 54% during the same period (BDHS 2014).

The proportion of births delivered at health facilities has continued to increase from <4% to 27% during 1992-2009 to 29% in 2011, and to the current level of 37% in 2014 (BDHS 2014). In terms of maternal health services utilization, delivery by a medically trained provider increased from 31.7% in 2011 to 42.1% in 2014 (BDHS 2014), mostly driven by an increase in facility delivery.

The emergency obstetric care (EmOC) facilities established in the pre-SWAp period, became functional during the SWAp as the Sector Programmes ensured better availability of human resources for health (HRH), drugs and equipment. In the 2014 BDHS, 15% of births to women in the lowest wealth quintile were delivered in a health facility compared with 70% of births in the highest wealth quintile.

***Maternal, Neonatal and Child (MNC) & Adolescent Health (AH), MNCAHFP and Nutrition*:** Consistent and continued progress in Maternal, Neonatal, Child and Adolescent Health (MNCAH) was observed over the previous SWAps. Over 40% decline in maternal mortality ratio (MMR) between 2001 and 2010 and further (model estimated) decline to 170 (in 2015) indicate remarkable progress in maternal health. This could principally be attributed to contribution of fertility reduction and, access to qualified maternal health care; and overall improved care seeking during the antenatal period (ANC4: 26 % to 31%) and during delivery (skilled birth attendant- SBA delivery: 32% to 42%, facility delivery: 29 % to 37%).

Bangladesh has been able to reduce the Under 5 Mortality Rate (U5MR) below the Millennium Development Goal (MDG) 4 target, which now stands at 46 (against the target of 48) per 1000 live births by the year 2014 (BDHS 2014). Bangladesh also achieved the MDG 1 target of reducing under nutrition one year in advance. Vitamin A supplementation coverage among under-five children increased from 60% in 2011 to 62% in 2014 (BDHS 2014).

Progress has been observed in addressing newborn complication and deaths due to birth asphyxia, prematurity and infection through establishing Special Care Newborn Units (SCANU) in 6 medical colleges and 20 District Hospitals (DHs) covering 26 districts; rolling out of Emergency Triage Assessment and Treatment (ETAT); sick newborn care and Helping Babies Breathe (HBB) initiative training; and equipping over 28,000 SBAs; and rolling out 7.1% chlorhexidine for umbilical cord care. The neonatal mortality rate (NMR) came down to 28% in 2014 from 32% in 2011. Progress on

expanded programme on immunization (EPI) and introduction of new vaccines has progressed well and scaling up of Community-Based Integrated Management of Childhood Illness (C-IMCI), IMCI & nutrition corners is taking place. About 81% of children aged 12-23 months received all scheduled vaccines by 12 months of age.

Adolescent health has been highlighted frequently during HPNSDP as a priority area. Training modules have been developed by the DGHS and service providers, school teachers and adolescent peers were trained in 10 districts and, adolescent friendly health services (AFHS) have been established in 9 districts and two city corporations. Nurses have also been providing menstrual regulation (MR), post abortion care (PAC) and FP services following training, thereby indicating the efficacy of task-shifting and task sharing from doctors to mid-level providers.

The GOB's strong political, financial and programmatic supports to the national FP programme from its inception till present have resulted in reduction of the total fertility rate (TFR) to 2.3 births per woman. The national public sector network of health care infrastructure, including the CCs, has facilitated the distribution of FP information and methods, particularly to low income populations. Social and behavioral change communication (SBCC) campaigns and activities by Government and NGOs have increased public awareness and knowledge of FP methods and availability, contributing to an increased CPR and reduced TFR.

Introduction of the midwifery programme is a bold and timely initiative towards achieving quality maternal-newborn care. The GOB recently introduced a 3-year midwifery diploma course facilitating creation of a midwifery cadre for the first time in the country. 3000 posts have also been created in the facilities where the midwives will be working.

Bangladesh has given considerable importance to nutrition since the mid-1990s. The National Nutrition Policy was approved in 2015 during the HPNSDP implementation period. HPNSDP targets for both stunting and wasting (38% and 33% respectively) have been achieved and stunting is now below the World Health Organization (WHO) 'critical' threshold of 40%. The prevalence of exclusive breastfeeding of infants up to 6 months in 2014 was 5 percentage points higher than the HPNSDP target of 50% of exclusive breastfeeding by 2016 (BDHS 2014).

Food hygiene and sanitation standards remain poor and widespread diarrhea remains a public health concern. Fifteen ministries and twenty agencies of the GOB are involved in food safety activities. The MOHFW is playing a pivotal role in the areas of food analysis, food inspection and enforcement, food-borne illness surveillance, food safety emergency response and information, education and communication (IEC), which are important building blocks of food safety. Establishment a state-of-the-art National Food Safety Laboratory (NFSL); a modern risk-based food inspection system, food-borne illness surveillance system, IEC activities and an institutionalized consumer awareness system with establishment of Bangladesh Food Safety Network (BFSN) are some of the achievements on improving food safety during the 3rd Sector Programme.

Communicable Disease Control (CDC): Bangladesh has achieved significant success in preventing and controlling communicable diseases and elimination of diseases. During the last SWAps the country scaled up interventions for prevention and control of communicable diseases and established an effective response system across the health system. Human Immunodeficiency Virus (HIV) - Acquired Immune Deficiency Syndrome (AIDS), Tuberculosis (TB) and Malaria are on track to achieve targets as planned. Diseases targeted for elimination (Filaria, Kala-azar) have achieved desired targets as per strategic goals. The Leprosy elimination target has been achieved and the programme is in its post elimination phase. Quick detection and appropriate response for emerging

and re-emerging diseases have been improved and capacity of rapid response teams enhanced. Other sectors' involvement in various aspects of disease prevention and control has been promoted. Attempts have been taken to introduce integrated surveillance system and institutionalized surveillance for strengthening evidence-based decision making in the area of disease prevention and control. Bangladesh is now at an advanced stage of epidemiologic transition, from acute, infectious, and parasitic diseases to non-communicable, chronic diseases.

Non-Communicable Diseases Control (NCDC)*:* The Non-Communicable Diseases (NCD) Country Profile (WHO, 2014) reported that NCDs account for 59% of total deaths in Bangladesh (17% cardiovascular diseases, 11% chronic respiratory diseases, 10% cancers, 9% injuries, 3% diabetes and 10% other NCDs). Low awareness on healthy lifestyle and structural/environmental factors particularly among urban residents are contributing to the NCD burden. As the country is suffering from a double burden of diseases, more attention needs to be provided to the management of NCD. Screening and referral of hypertension (HTN) are ongoing in the CCs of 300 Upazilas and 236 UHCs. To create awareness on neuro-development disorder like Autism, a special initiative called 'Lighting of the Blue Lights' has been undertaken in all health facilities. To help build capacity of service providers, training was undertaken on emergency preparedness and response (EPR), climate change, air pollution and occupational health safety. The GOB enacted a tobacco control act in 2005, and amended it in 2013 to comply with the Framework Convention for Tobacco Control (FCTC). The Government adopted the Strategic Plan for Surveillance and Prevention of NCDs in Bangladesh 2011-2015.

Alternative Medical Care (AMC)*:* Alternative medicine has been in use in Bangladesh from generation to generation, and traditionally the rural communities use these drugs most. Currently, 225 Medical Officers (MO) or equivalent care providers have been recruited in the DGHS to strengthen the services under AMC. There are one private Homeopathic Medical College, 15 Unani, 08 Ayurvedic, and 50 homeopathic diploma institutes. Nearly 80,000 different categories of AMC doctors are practicing and about 498 industries are producing Unani, Ayurvedic & Homeopathic drugs. Recently a national strategy on AMC has been developed. Yet, significant challenges in the institutional and regulatory environment for AMC remain with no proper system to register AMC professionals and standardization of regulation of AMC drugs.

Human Resources for Health (HRH): There has been considerable recruitment during the HPNSDP with vacancy rates declining to around 15% in 2014 from 20% in 2011. Over 7,000 doctors and 4,100 nurses were recruited during the period and in total over 42,000 positions across the sector have been filled. However, the doctor nurse ratio continues to be skewed. A Human Resource Strategy has been approved and development of human resource information system (HRIS) has started. During implementation of the SWAps, especially in HPNSDP, building capacity and skills within the workforce has been an area of much activity and a large number of training courses and workshops were held annually.

There exists a high level of commitment from the GOB to bringing health care as close to the communities as possible and channelling resources to PHC level. Revitalization of community based health care service provision addresses the health of grass root populations, creating increased access of the poor to PHC services. Recruitment of 13,500 CHCPs); making the CCs (currently 13,136) operational; distributing adequate medicines and contraceptives; and providing care from a single service delivery point have created opportunities to deliver preventive, screening, educational, primary and referral care closer to the community. This was made possible by establishing CCs nationwide and prioritizing PHC for increased budget allocation.

Procurement: During the implementation of HPNSDP, significant progress has been made in strengthening the procurement and supply chain functions of MOHFW as compared to the last two Sector Programmes. The mid-term review (MTR) of HPNSDP reported no stock-outs, an indication of improvements in the procurement planning and management. During the HPNSDP, a Procurement and Logistics Management Cell (PLMC) was formed to ensure effective and efficient procurement and supply chain management. A Supply Chain Management Portal (SCMP) was also introduced with the assistance of PLMC in order to monitor the procurement management of MOHFW.

Other notable improvements supported by PLMC include: drafting of Procurement Procedure Manual; activating the process of condemnation (de-commissioning of old equipment); expanding the DGFP Logistics MIS up to the service delivery point; developing Table of Equipment (TOE) for facilities with in-patient capacity of 10, 50, 250 and 500-bed; preparing standard technical specifications for 58 core medical equipment; preparing a draft bio-medical device guideline; developing a template for Framework Agreement (for single stage national competitive tender). There have also been some gains in efficiency in the procurement process. The overall lead time for procurement of equipment and tender processing by Central Medical Stores Depot (CMSD) has been reduced from 46 months in 2008 to 26.5 months in 2012 respectively. There, however, remain gaps in the process where efficiency gains can further be achieved.

***Sustainable Financing for Health*:** The Government has shown commitment in ensuring sustainable financing for health care. A Health Care Financing Strategy (HCFS) was approved and embedded in the National Social Security Strategy (NSSS) 2015. The HCFS proposes a substantial change in the current payment system from direct payment i.e. Out-of-Pocket expenses made at service point to paying for services through pre-paid risk pooled schemes. During HPNSDP, the Government initiated pilot interventions such as Shasthyo Shuroskha Karmasuchi (SSK), a health protection scheme for the poor and the ready-made garment (RMG) workers' scheme. Social health protection scheme for the formal sector is being designed along with the required law and a supporting communication strategy. However, in absolute terms, there was considerable escalation in budgetary allocations for the MOHFW during the SWAp periods from the Annual Development Programme (ADP), but the rate of growth failed to increase MOHFW's share of the overall national budget which grew at a faster pace.

The MOHFW is financed by a combination of GOB non-development and development budgets, and external finance from DPs for supporting development expenditure. The MOHFW being a service delivery organization, the major portion of the cost is borne out of revenue budget of the Government for the service providers. The MOHFW's fund absorption capacity also increased during the 3rd SWAp implementation period. Utilization of the development budget increased from an average rate of 72% in the pre-SWAp period to around 80-85% during the three SWAp periods. Utilization of the non-development budget allocations has consistently remained high because of the permanent nature of its expendable items (95%).

An analysis of non-development budget by line item shows that in addition to provision of salary and operational costs of the service providers, a portion of the GOB non-development budget allocations is spent every year for small equipment, medical and surgical requisites (MSR), as well as maintenance of public and autonomous hospitals (e.g., Bangabandhu Sheikh Mujib Medical University). Besides, private sector organizations such as the Diabetic Association and the various national foundations on heart, kidney and ear, nose and throat (ENT), and international organizations like International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) get regular grants from MOHFW's non-development budget for provision of HNP services in the country. Moreover, considerable amount of funds are allocated annually to NGOs as special grants through the non-

development budget. All these added together form a significant development expenditure borne out of MOHFW's non-development budget from GOB source.

***Financial Management (FM) and Audit*:** The three SWAps shaped and strengthened Government's health systems and supported its implementation technically and financially. There have been positive developments in budgeting procedures, planning of Operational Plan (OP) -wise resource allocations, capacity and capability building including the Medium-term Budget Framework (MtBF), fund disbursements, financial monitoring and reporting systems.

Further improvements in FM and Audit during HPNSDP period include finalization and approval of Financial Management and Audit Unit's (FMAU's) approved organizational structure along with revised recruitment rules by the Ministry of Public Administration (MOPA), drafting of an audit and FM strategy, training of FM officials, outsourcing of internal audit, strengthening of the management of revenue budget and audit functions by putting them under the FMAU of MOHFW, etc.

Programme Coordination, Management and Monitoring: The MOHFW's role in sector coordination and management strengthened over time. The MTR 2014 recognized that there had been considerable progress in management and coordination. The 2012, 2013, 2015 Annual Programme Reviews (APRs) and 2014 MTR were functionally managed by the MOHFW.

Under HPNSDP, conscious efforts were made to improve both inter-and intra- OP coordination. For example, coordination in maternal, neonatal and child health (MNCH) services through the MNCAH and MCRAH OPs of the DGHS and DGFP has improved. Mainstreaming of nutrition services through the regular channels of DGHS and DGFP during HPNSDP implementation has not only made service provision cost-effective but also leading to improved coordination at different stages of service delivery including at the CCs (where Health Assistants (HA) and Family Welfare Assistants (FWAs) work together with the CHCPs.

Under the HPNSDP, a coordinated technical assistance (TA) approach was put in place supported by a multi-year, integrated and consolidated TA plan to mobilize resources in support of selected reforms. The pooled TA fund titled 'Joint Donor Technical Assistance Fund (JDTAF)' as a new initiative of HPNSDP implementation proved itself as an effective institutional arrangement for sector management and TA coordination. On behalf of the DPs, the JDTAF was financed, coordinated and managed by Department for International Development (DFID). A Technical Assistance Committee (TAC) headed by Joint Chief (Planning), MOHFW comprising of MOHFW, agencies under it and DP representatives, reviewed and recommended TA proposals for endorsement by the Government.

During HPNSDP, a number of activities to support capacity building, streamlining, and scaling up of monitoring and evaluation (M&E) systems was implemented. Improvements also took place in the MIS of DGHS and DGFP. A Programme Management and Monitoring Unit (PMMU), assisted by a TA support team (TAST) was set up in 2011 in order to provide technical support to the Planning Wing of MOHFW in monitoring & evaluation, coordination work and in tracking the performance of HPNSDP. The PMMU produced Six-monthly Progress Reports (SmPR) and Annual Programme Implementation Reports (APIR) on a regular basis, which fed into the APRs of HPNSDP. The PMMU also prepared the Mid-term Programme Implementation Report (MPIR) 2014 for conducting the MTR 2014 and the APR 2015. These activities produced useful results in gaining management efficiency for the implementers, the policy planners and possibly the DPs as well.

Development of the Monitoring & Evaluation Strategy and Action Plan (MESAP) for the HNP sector in 2015 was a milestone achievement of HPNSDP. Moreover, a pilot to strengthen the Routine Health Information System (RHIS) of the MOHFW started in January 2015 in Tangail and Habiganj districts.

The experience of Tangail and Habiganj revealed that RHIS initiatives had achieved complete business process automation of routine health workers.

Policy formulation and planning: A series of Five Year Plans (FYPs) guided the GOB's policy directions in the health sector during the pre-SWAp period. Major policy and programmatic steps during the late '80s focused on delivery of core maternal and child health (MCH) services to rural population through secondary and primary-level facilities and field-level workers. Later in the 1990s, GOB initiated an EmOC programme that focused on upgrading existing Government facilities in phases with specific support from the DPs. With HPSP, the focus of health service delivery was realigned from home-based service delivery to the provision of services from fixed site clinics and the expansion of EmOC services from health facilities. Each SWAp outlined specific interventions directly linked to resources within designated OPs—this ensured actual delivery of MCH and other planned services under the SWAp.

Reform initiatives: Improving health sector efficiency through innovations and policy as well as institutional reforms has been a focused area under the SWAps. Major policy reform areas identified in the successive plans include, among others, introducing an ESP, diversification of services by involving stakeholders including NGOs, review and development of various policies and strategies (e.g. gender strategy; drug policy; etc.). Major institutional reforms tried under the SWAps include integration of services provided through two different Directorates, decentralization, and local level planning, improving FM and procurement systems, outsourcing of services and setting up NGO contracting system.

There were mixed results in achieving planned reforms during the SWAps —reforms like integration of health and FP services, diversification of service delivery and modernization of the health sector through decentralization and local level planning faced insurmountable obstacles from different pressure groups during implementation. On the other hand, improvements in programme implementation, strengthening of M&E, procurement and FM processes registered notable success.

Reform initiatives were also undertaken during the 3rd SWAp period to suit the needs of the changing policy environment. A matrix of policy issues was developed during HPNSDP preparation to ensure MOHFW's ownership and commitment to the reforms. During the first 3 years of HPNSDP, notable progress was made in 6 out of 11 major reform activities highlighted in the policy matrix. These include: allocating resources for scaling up EmOC and FP services in lagging regions; mainstreaming nutrition; improving coordination between DGHS and DGFP; developing a health care financing strategy; revitalizing CCs and strengthening the fiduciary capacity of the MOHFW.

Gender, Equity, Voice and Accountability (GEVA): GEVA is a central theme of the Sector Programme of the MOHFW aimed at enhancing availability of quality services to women and creating a congenial environment for women and adolescent girls where they get health services with dignity, respect and privacy. Women-friendly hospitals (28) render specialized psychosocial counseling to women survivors of violence and link them with legal aid agencies. Specific progress in GEVA issues includes a situation analysis of GOB Initiatives (Attaining Gender Equity in HNP Sector), approval of the Gender Equity Strategy (GES) 2014 and the Gender Equity Action Plan (2014-24). The HPNSDP, through implementation of CC-based services, provision of separate toilets, breast feeding corners and other facilities in the women friendly hospitals, provision of nutrition corners and establishment of SCANUs in public hospitals, etc. have contributed to increasing access among poor women to HNP services.

Ministry of Women and Children Affairs (MOWCA) in collaboration with other Ministries such as MOHFW, Ministry of Social Welfare (MOSW), Ministry of Home Affairs (MOHA), and Ministry of Law (MOL) started the multipurpose project called 'One Stop Crisis Centre (OCC)' to provide services to survivors of Gender-based Violence (GBV) in 7 divisions.

Infrastructure Development: Despite the huge expansion/construction of physical facilities, the access and utilization of public health facilities by the poor remains a challenge. Due to supply-side barriers such as inadequate availability of human resources, drugs and supplies, as well as various management inadequacies including attitudes of the service providers towards the clients/service seekers etc., health facilities remain underutilized. The MOHFW initiated the task of developing a master plan of civil works (for up-gradation and new construction) along with their maintenance under the HPNSDP. As for other initiatives, MOHFW developed Tables of Equipment for 10-, 50- and 250-bed hospitals and is currently developing the same for 500-; 1000- and 1500-bed hospitals. A TA is working to develop Table of Organization for different types of health facilities. The outcome of these inputs will help synchronize physical construction with supply of equipment and human resource in a timely manner.

Results Framework (RFW): It has been observed that since the introduction of SWAp, gradual improvements in performance measurement have taken place in the HNP sector of Bangladesh. The GOB's thrust to achieve RFW indicators of HPNSDP helped to expedite the process. The updated RFW table of HPNSDP below summarizes achievement of the goal level indicators. Out of eight goal level indicators, five have been fully achieved/on track while the remaining three are challenging.

Table 1: Update of HPNSDP Results Framework (RFW) Indicators

Sl #	Performance Indicator	Means of Verification & Timing	Baseline & Source	Update 2016	Target 2016	Results
Goal: Ensure quality and equitable health care for all citizens of Bangladesh.						
GI 1	Infant mortality rate (IMR)	BDHS every 3 yrs	52 BDHS 2007	38 BDHS 2014	31	On track
GI 2	Under 5 mortality rate (U5MR)	BDHS every 3 yrs	65 BDHS 2007	46 BDHS 2014	48	Achieved
GI 3	Neonatal mortality rate (NMR)	BDHS every 3 yrs	37 BDHS 2007	28 BDHS 2014	21	Challenging
GI 4	Maternal mortality ratio (MMR)	BMMS, every 5 yrs	194 BMMS 2010	170 MMEIG 2013	<143	Challenging
GI 5	Total fertility rate (TFR)	BDHS every 3 yrs	2.7, BDHS 2007	2.3 BDHS 2014	2.00	Challenging
GI 6	Prevalence of stunting among under-5 children	BDHS every 3 yrs	43.2%, BDHS 2007	36.1% BDHS 2014	38%	Achieved
GI 7	Prevalence of underweight among under-5 children	BDHS every 3 yrs	41.0%, BDHS 2007	32.6% BDHS 2014	33%	Achieved
GI 8	Prevalence of HIV in MARP	Sero-Surveillance (SS), every 2 yrs	<1% SS 2007	0.7% SS 2011	<1%	Achieved

1.3. Lessons Learnt During Previous Sector Programme

In 1998, the first SWAp in the HNP sector marked a shift from multiple projects to a single Sector Programme, which created an opportunity for better coordination, harmonization and alignment of

multiple donor funded projects and resources. The SWAps helped to focus on critical development objectives like equity and access and enabled the Government to establish connections between identified objectives, strategies, activities, resources and outcomes. It also reduced, for the Government, transaction costs involved in dealing with multiple agenda and numerous official missions fielded by the DPs for projects funded by them. These changes led to considerable efficiency gains.

All three SWAps laid high focus on pro-poor ESP, which contributed to the reduction of the gap between rich and poor with respect to health outcomes in rural areas. While achievement against some of the indicators is satisfactory in general, there are pockets of underachievers geographically – which are linked to the socio-cultural as well as topographic features of the given areas. For example, FP achievements are better in the western Divisions of the country than in the Eastern Divisions.

The health SWAps in Bangladesh brought desired results over the last decade and the continuity of policy, as well as commitment towards SWAp, irrespective of Government changes, remained consistent. This is one of the key factors which contributed to the success of health SWAp in Bangladesh in spite of it working within a complex administrative structure.

During HPNSDP, significant improvement took place in the health systems and services, particularly in the areas of life expectancy at birth; reduction in fertility, child and maternal mortality, immunization coverage, stunting, underweight, procurement and MIS. However, there remains much to be done. Based on SWAp experience for the last 18 years in the HNP sector, especially of HPNSDP, it is learnt that continuous efforts are needed to maintain and improve functioning of the SWAp modality in Bangladesh.

1.4. New and Continuing Challenges

Many challenges still remain in the HNP sector along with some unfinished agenda of the HPNSDP. Ensuring skilled attendance at birth, addressing the epidemiological transition and the double burden of communicable and non-communicable diseases- including detection, prevention and control of emerging and reemerging diseases, improving overall nutritional situation including underweight and stunting, improving quality and safety of food and drugs, providing adolescent health care along with ensuring sexual and reproductive health rights (SRHR), adequate health response to gender-based violence, increasing contraceptive prevalence and promoting Long Acting and Permanent Method (LAPM) of contraception, ensuring urban primary health care service delivery particularly for the poor, improving health care for mental and neurological disorders and geriatric population, service expansion to hard-to-reach (HTR) areas, assuring quality of care, etc., are some important and continuing challenges for improving HNP services.

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; aging and geriatric diseases; the spread of infectious diseases such as Hepatitis B and C, as well as emerging and re-emerging diseases; and the health effects of geo-climatic disasters and arsenicosis. There is also concern for the rising incidence of NCDs, recognizing that diabetes, cardio-vascular diseases and cancer have become leading causes of morbidity and mortality requiring more concerted policy attention at primary and secondary prevention.

Despite improvements in the health system, particularly in the areas of procurement and MIS, much remains to be done. Ensuring availability of skilled human resource (HR) following an effective and efficient Health Workforce Strategy (HWS); utilizing full capacity of the existing and upgraded public

facilities at the district and Upazila level; synchronizing expansion of physical facilities with equipment and HR; further improving supply chain management and management of information systems; addressing proper asset management; strengthening governance, stewardship and regulatory functions; mobilizing more resources for the HNP sector and reducing out-of-pocket expenditure; ensuring equity, efficiency and equality for women and vulnerable population; etc. are some key challenges to be overcome.

Expansion of city areas up to upazila level, rural-urban migration and a rising urban population pose new challenge for effective urban PHC service delivery. With the demographic transition taking place it has become urgent to review the present urban health services delivery arrangement and take measures to improve and expand the coverage with supplies and services in the urban areas through existing HR, keeping in view the needs of the urban poor.

There are issues of inadequate and ineffective service delivery in the hilly, char and the coastal areas where provision of human resources remains a problem. Settlements in those areas are quite dispersed due to geographical reasons making it difficult for service seekers to access facilities miles apart.

The challenge still remains with regard to defining a boundary of the HNP sector. The MOHFW implements 29 parallel projects included in its development budget (e.g., ADP) but outside the SWAp programme. Moreover, there are projects under the responsibility of other Ministries/Divisions, which contribute to the HNP sector development. For effective SWAp implementation, better coordination and functional relationship is required with other Ministries/Agencies/stakeholders. In addition, steps are needed to be taken to maximize in-house financial resources of the MOHFW to spread over both revenue and development budgets and within the development budget, between the discrete projects and OPs of the Sector Programme.

MOLGRDC

The need for strengthening the stewardship role of the MOHFW is assuming increasing importance in view of the fast expanding private sector and the focus on capacity and quality of service provision by both public and private sectors. This would require updating existing laws/rules relating to oversight and governance as well as improving the systems and the institutional structures for ensuring compliance with these laws/rules. Given the sensitivity of the involved issues, making meaningful progress in this area would require consistent support from policy makers, professional bodies and from an organized civil constituency defending public interest.

A large number of dynamic elements pose challenges to the current set-up of service focus, resource allocation and service delivery. These elements include: the growing NCD burden and continuing trend of urbanization, the expanding private sector investment in health and the growing per capita income of Bangladesh citizens – both of which are contributing to the trend of increasing out-of-pocket expenditure (OOPE), and the expanding demand for quality service by a population which is riding tide of rising expectations.

The new Programme faces a situation where conflicting demands for resources – both financial and human resources –will need to be balanced to be able to continue existing focus on priority areas-for example, on rural areas and on CDC-while at the same time developing a response to new trends, like the needs of urban health, NCDCs and the broader SDGs. Given the expected mismatch between demand for and the supply of resources, the 4th Sector Programme intends to set up a platform for orderly response to the conventional as well as new health challenges. That is why new focus areas have been included, e.g., on stewardship and on lifestyle changes, while new avenues of financial augmentation and greater community participation have been planned.

The Programme simultaneously lays emphasis on the continuation of efforts to strengthen core systems to support overall improvement in service efficiency, e.g., the reorganization of the FMAU, and the proposed restructuring of CMSD as the major procurement unit. It continues the emphasis on PHC, EPI, MNCH, FP and nutrition etc., on consideration of achieving the equity goal and plans to implement an updated ESP as part of its strategy to achieve the UHC as proposed in SDG (Goal-3). The Programme will therefore need adequate financial and technical support to implement, monitor and manage the multifarious challenges posed by the ambitious health goals within the dynamic development process of Bangladesh.

CHAPTER II: OVERVIEW OF THE PROPOSED SECTOR PROGRAMME (4th HPNSP)

The GOB aspires to ensure that all citizens enjoy a quality of life assured with basic health care and adequate nutrition as provided in Article 15a of the Constitution. Vision 2021 aims to transform Bangladesh into a globally competitive and prosperous country with a high quality of life by 2021 by transitioning the country from a developing country into a middle-income country. The Government is also committed to achieving the universally agreed goals in specific areas as set out in the declarations of various world summits including the SDG to be achieved by 2030.

The development of the Programme Implementation Plan (PIP) is guided by Bangladesh's Vision 2021, which acknowledges that improved health is a critical driver to the achievement of this vision. The PIP is also linked with the 7th FYP which outlines new strategies, institutions and policies to complete the remaining agenda of achieving the social and economic outcomes of the Vision 2021.Other guiding principles of the PIP are set for the national policies on Health, Nutrition and Population; and various strategies as well as the experience of implementing successive three Sector Programmes in Bangladesh. The country is also committed to achieving the universally agreed goals in specific areas as set out in the declarations of various world summits and the SDG.

2.1. Vision, Mission and Goal

Vision

"To see the people healthier, happier and economically productive to make Bangladesh a middle income country by 2021" (Vision 2021)

Mission

"To create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health"

Goal

"To ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable health care in a healthy and safe living environment"

Development Objective

"To have focused improvements in increasing access to quality health care and improving equity along with efficiency by gradually achieving UHC"

Strategic Objectives

The HNP sector analysis by the MOHFW, through consultation with Government, DPs and other stakeholders, for the 4th HPNSP included an assessment of progress under HPNSDP as well as emerging health issues across the country. Based on this analysis, a set of eight strategic objectives has been formulated to be pursued over the five and half-year period (FY 2017 to 2022). The development objective of the 4th HPNSP will be attained through pursuing the following strategic objectives:

Strategic objective 1	➢ To strengthen governance and stewardship of the public and private health sectors
Strategic objective 2	➢ To undertake institutional development for improved performance at all levels of the system
Strategic objective 3	➢ To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage
Strategic objective 4	➢ To strengthen the capacity of the MOHFW's core health systems (Financial Management, Procurement, Infrastructure development)
Strategic objective 5	➢ To establish a high quality health workforce available to all through public and private health service providers
Strategic objective 6	➢ To improve health measurement and accountability mechanisms and build a robust evidence-base for decision making
Strategic objective 7	➢ To improve equitable access to and utilization of quality health, nutrition and family planning services
Strategic objective 8	➢ To promote healthy lifestyle choices and a healthy environment

2.2. Programme Priorities and Strategies

The 4th HPNSP will take a holistic approach to tackle the continuing and emerging sector challenges. The Program will be unique in terms of its focus on (a) strengthening MOHFW's governance and stewardship roles in the HNP sector; (b) strengthening systems/ institutions for efficient service delivery; and (c) expanding HNP services and emphasizing service quality both in public and private sectors. A focus on these achievements will lead to an achievement of more equitable health care. The strategic objectives under the three program components cover all aspects of the HNP sector.

Priority program areas under each of the Program components as well as challenges to be addressed in certain areas are highlighted in this chapter. This chapter also highlights major practices and key activities to be pursued under the 4th HPNSP.

Component 1: Strengthening Governance and Stewardship

2.2.1. Strategic Objective 1:

To Strengthen Governance and Stewardship of the Public and Private Health Sectors

Strengthening of governance and stewardship involves a substantial evolution in the way the sector is managed. There needs to be considerably more focus on stewardship and regulation on the part of the MOHFW and more emphasis on developing partnerships between the public and private sectors in ensuring high quality care for all as the country works towards UHC. This will require a review of capacity in key areas of stewardship and regulation at different levels of the Government system combined with a range of institutional changes in function and structure. The program areas of the 4th HPNSP to achieve this objective are as follows:

2.2.1.1. Governance and Stewardship

Stewardship in health is the very essence of good governance and encompasses the task of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. From a developing country perspective, stewardship also focuses on

managing external resources in ways that promote national leadership, contribute to the achievement of agreed policy goals, and strengthen reasonable national management systems. Good governance mandates adherence to the principles of participation, and being responsive to citizens' view and encouraging decisions on the basis of consensus.

The MOHFW, to perform its responsibility, relies on entities directly under its control like the DGHS, the DGFP and the Directorate General of Drug Administration (DGDA) as well as on different statutory/autonomous bodies like the Bangladesh Medical and Dental Council (BMDC), the State Medical Faculty (SMF), the Pharmacy Council of Bangladesh (PCB), the Bangladesh Nursing Council (BNC), the Board of Homeopathy Bangladesh (BHB), and the Board of Unani and Ayurveda Bangladesh (BU&AB). Though Directorates are directly accountable to the MOHFW, the statutory/autonomous bodies, however, have separate boards and separate governance arrangements.

DGHS and DGFP have elaborate structures for service delivery around the country. However, apart from the public sector, there is a widespread network of private sector service providers for health care in Bangladesh and a significant portion of the people is dependent on these service providers. Despite this reliance, private sector health care is characterized by commercialization and there are complaints about induced investigations, unnecessary procedures and use of costly intensive and cardiac care units. Many private clinics rely on Government physicians and lack qualified nurses and auxiliaries. The Private Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982, still continues to be the operating law governing the establishment of private clinics and hospitals in the private sector.

Six autonomous professional regulatory bodies under the MOHFW have responsibilities for dealing with doctors, nurses, medical assistants and pharmacists and alternate medical practitioners - BMDC, BNC, PCB, SMF, BHB, and BU&AB. BMDC is the regulatory body providing registration functions to the doctors, dentists and medical assistants. It is responsible for ensuring quality of medical education and practice. BMDC is required to deal with the cases of medical negligence, malpractice or professional misconduct and is expected to promote openness and transparency.

BNC regulates nursing education and practice which includes affiliation of institutions, conducting examinations and maintenance of nursing and allied professionals register. A new cadre of midwifes added lately would also be regulated by the BNC (or BNMC later). However, steps are already underway to strengthen and restructure the Nursing Directorate with consequences for improved operation of BNC as well.

SMF is responsible for affiliation of Medical Assistants Training School (MATS) and Institute of Health Technologies (IHT) which produce medical assistants. The body is responsible for the quality of their education and acts as a body for conducting their examinations. BHB regulates homeopathic education and practice and BU&AB regulates Unani and Ayurvedic education and practice. Both these bodies are working under laws of 1982, and have limited relevance in the present context. Both these organizations function as bodies of examinations as well as professional regulation.

Some services provided by the MOHFW are complemented by health-related services provided by other ministries and agencies for which inter-ministerial coordination is required. Some of these include urban health (in which coordination is required with the Ministry of Local Government Rural Development and Cooperatives (MOLGRD&C), tribal health (with the MOCHTA), Gender (with the MOWCA), nutrition and food safety (Local Government Division (LGD), the Ministry of Food (MOFood), the Ministry of Agriculture (MOA), the Ministry of Fisheries and Livestock (MOFL) and the Ministry of Environment and Forest (MOEF).

The challenges in governance and stewardship are:

***Regulatory Instruments**:* As mentioned before, laws, as well as executive orders and instructions constitute regulatory instruments for the MOHFW in governance and stewardship. However, many of these instruments need updating. For example, the law regarding private practice and clinics date back to 1982. DGDA operates under a 1982 ordinance. SMF does not have any applicable legal instrument. Because of the out-dated nature, these instruments are inadequate to meet the present context, which pose challenges to establishing good governance in the HNP sector.

Institutional Capacity: The HNP sector experienced a major expansion in last decade or so; however, the institutional capacity of the regulatory bodies has not increased at the same pace in terms of human and other resources. For example – DGHS structure for monitoring private medical colleges is the same for the last twenty five years, although the number of such colleges increased four times during this period. Similar shortages of manpower and capacity are visible in most regulatory bodies.

Grievances Redressal Procedure: Though the right to health care is constitutionally guaranteed in Bangladesh, there are allegations of patient's rights being compromised. Complaint or grievance redressal procedures either do not exist or do not function to the satisfaction of the service seekers.

Coordination Mechanism: To assume the appropriate stewardship role, the MOHFW needs to strengthen/establish coordination with other ministries, agencies and stakeholders both at the policy level as well as at the execution level. Inter-ministerial consultation or wider consultation with different groups is usually arranged during the process of approval of major policies or plans. Wider reforms require substantial support from the influential stakeholders in order to succeed. At the apex, there are the National Health Council and the National Population Council, both headed by the honorable Prime Minister. There are also a number of Committees headed by the honorable Health Minister. Executive level Committees at different levels and for different purposes, however, meet more frequently, with differential results.

During the 4th HPNSP period the following key activities will be pursued for overcoming the challenges described above and for improving governance and stewardship functions of the MOHFW:

- Regulatory instruments will be updated during the 4th HPNSP Sector Program. This will include laws for regulating private medical and dental colleges, private clinics and private practice as well as legal provision relating to service recipients and the providers.
- The structure, organogram and mandate for regulatory bodies like DGHS and DGDA will be reviewed to cater to their expanded responsibilities.
- The existing nursing council ordinance will be reviewed to allow space for BNC to function as an autonomous regulatory authority. BMDC Act will be amended to incorporate, among others, a section on professional conduct and other issues. The disciplinary committee in BMDC will be activated. The system of registration will be automated. There will be publicity campaigns about the role of BMDC and the legal provisions for addressing professional complaints.
- Proper regulations for SMF will be enacted. The courses offered by the BTEB and SMF will be reviewed for achieving convergence and equivalence. The requirement of licensing and registration of all paramedical professionals will be assessed.
- An accreditation system will be gradually introduced for assessing the quality of private medical colleges which will be extended to Government medical colleges as well**.**
- A broad coalition in support of changes in laws and relevant institutions would be built by MOHFW with the professional associations, different stakeholders and the civil society for regular periodic review of developments and introducing needed adjustments.

2.2.1.2. Drug Administration

The Directorate General of Drug Administration (DGDA) being the drug regulatory authority of the country supervises and implements all prevailing Drug Regulations and regulates all activities related to import, procurement of raw and packing materials, production and import of finished drugs, export, sale, pricing, etc. of all kinds of medicine including those of Ayurvedic, Unani, Herbal and Homoeopathic systems. At present, there are 278 Allopathic, 206 Ayurvedic, 266 Unani, 32 Herbal and 79 Homeopathic drug manufacturing companies in the country. The DGDA is also empowered by the Government to act as the Licensing Authority of drugs for the purpose of issuing licenses to manufacture, store, sell, import and export drugs and medicines.

The DGDA initiated Pharmacovigilance (PV) - in Bangladesh through operationalizing the Adverse Drug Reaction Monitoring (ADRM) Cell in 2013. ADRM Cell acts as the National Drug Monitoring Centre in Bangladesh. 32 different hospitals in Bangladesh were brought under the monitoring activities of the ADRM Cell and awareness building programs were conducted in these hospitals by the Cell. Apart from these, all the Government hospitals were brought under the PV activities and initiatives were taken to establish ADRM Cell in the respective hospitals. As per the recommendation of the Cell, registration for all drugs under Pioglitazone (30 and 45 mg) and Rosiglitazone were cancelled and withdrawn from the market.

A Memorandum of Understanding (MOU) was signed between DG, DGDA and Secretary, MOHFW in 2015 to guarantee human and animal health through ensuring safe, effective and quality drugs. A draft of "Bangladesh Medical Device Registration Guideline" was developed, which is in the process of finalization. The MOHFW approved the Guideline for Good Clinical Practice (GCP) for trialing pharmaceuticals products in Bangladesh. This guideline sets standards for Bioequivalence Studies, Clinical Trials and Pharmaceutical Research and ensures safety of human subjects. The updated website of DGDA acts as a vital source of information for citizens regarding important information about different medicine and pharmaceutical products in Bangladesh. The fourth edition of Bangladesh National Formulary was published and circulated in 2015, which provides important information on registered drugs in Bangladesh.

Given the progress in drug administration, there still remain some challenges which are described below:

***Regulatory Framework*:** The Drug Act, 1940, the Drug (Control) Ordinance, 1982, the Drug Rules, 1945, and the Bengal Drug Rules, 1946, provide the legal framework for functioning of DGDA. As they date back to many years in the past, some of the provisions of these laws are quite outdated and need updating.

Manpower and Funding: The DGDA has to fulfill its mandate and oversee the local pharmaceutical industry, given the rapidly growing pharmaceutical market, large number of registered products, and large population size. Budget for its activities – both under Revenue and Development, need to match with their scope and extent. Fees charged for regulatory services adjusted by gross national income (GNI) per capita are significantly lower than in other countries. A comprehensive costing analysis can inform the DGDA on the adequate level of resources including staffing required to effectively implement its responsibilities.

***Governance and transparency measures*:** There is potential for conflict of interest in the memberships of committees as some members have multiple roles. The civil society, particularly the consumer groups feel under-represented in DGDA committees. Other missing key elements of governance measures include lack of formal communication channel with customers including industry, inadequate tracking of key performance indicators, and gaps in information sharing.

***Quality management system (QMS)*:** A quality manual and quality policy have been developed, but implementation of a Quality Management System (QMS) is weak. Regulatory registers and an inventory of standard operating procedures (SOPs) and guidelines are lacking that would enable the DGDA to track, update, and identify critical gaps.

***Regulatory compliance and enforcement*:** The legal basis to enforce compliance and implement sanctions for violations is in place, including drug courts. The DGDA needs to strengthen administrative measures such as publicly posting information on violators.

Product evaluation and market authorization: Delay in registration for new products is often due to infrequent and irregular scheduling of Drug Control Committee (DCC) meetings, lack of manpower, and lack of an electronic information management system, etc. Other challenges include application forms not in compliance with the common technical document format, inadequate registration fees (registration fee index less than 0.3), indications for use not included in the registration certificate, and delays attributed to reviewing application packages sequentially instead of using a parallel process.

Licensing and Inspection: An electronic system to keep and update the register is absent. For example, the list of retail pharmacies and wholesalers is not publicly available. Significant shortage of inspectors and inadequate time spent during inspections could compromise the quality of the inspections. The lack of use of risk-based inspection strategies further strains the limited resources. It is estimated that 440-660 inspectors are needed to conduct the type of inspections that would comply with Good Manufacturing Practice (GMP) guidelines. The current number of inspectors is significantly less than the required number.

Import and export control: The DGDA has a critical role to support the growth of the pharmaceuticals industry by ensuring that local manufacturers comply with global quality standards. Cooperation needs to be formalized with key stakeholders including the Ministry of Commerce, the National Board of Revenue, and the Export Promotion Bureau (EPB).

Quality control: The DGDA is currently collaborating with the World Health Organization (WHO) to strengthen the capacity of the National Control Laboratory (NCL) to become a WHO pre-qualified facility. Achieving WHO prequalification or global GMP standards is critical also for local manufacturers, which will ensure the quality of products in the local market and also help them export quality products.

***Clinical trials*:** Absence of law and regulation that provide explicit guidelines for the conduct of clinical trials can lead to inadequate control of clinical trials thereby exposing vulnerable trial participants and generating unreliable data. Currently limited information is shared on clinical trials between the Bangladesh Medical Research Council (BMRC) and DGDA and there are no guidance documents or regulation on approval of new investigational drugs.

Pricing: The DGDA's pricing policy and regulation contributes to keeping the prices of pharmaceuticals low in Bangladesh, particularly for the primary health care listed medicines. Also, the price marked in the packing materials is another good mechanism to control prices of medicines. However, there is no systematic price-monitoring system in Bangladesh. Introducing a robust price monitoring system, such as barcodes in product packages, can ensure the affordability of medicine and prevent counterfeiting.

Key activities to be pursued for overcoming the challenges described above and for improving the situation of rational use of drugs include:

(i). A revised policy and a unified law will be adopted considering the limitations and challenges in the Drug Act, 1940, and Drug (Control) Ordinance, 1982. The revised law would provide for the following –

- Medical devices, food supplements, and cosmetic products are covered;
- The time of gazette notification of drug pricing is specified;
- The structure and working procedure of different drug administration related committees are specified and incorporated; and
- Inconsistencies in terms of punitive measures for different offenses are eliminated and commensurate punishment is included.

(ii). Drug inspector position will be created in each district office considering the market size and workload and the vacant positions of each tier will be filled.

(iii). Training based on need assessments to develop the capacity of staff will be arranged.

(iv). Different types of information including registration of drugs and pharmaceutical companies will be updated and incorporated. A uniform and online reporting system for field offices will also be introduced.

(v). Pharmaceutical companies producing sub-standard, fake and adulterated drugs will be identified and legal actions will be taken against them as part of a regular sustained process.

2.2.2. Strategic Objective 2:

To Undertake Institutional Development for Improved Performance at All Levels of the System

Clear institutional roles and responsibilities are fundamental to improved performance across the HNP sector. Ensuring that designated functions are taking place at the appropriate level of the system, that the institutional arrangements are effective and that there is strong coordination and harmonization at all levels will enable the efficiency and equitable use of resources. The current institutional set up at national and sub-national levels would be reviewed early in the new program with a view to rationalization, removal of duplication, establishment of new functions and an overall clarity of roles and responsibilities. Organizational Capacity Assessments (OCAs) of all key institutions will provide a mechanism for self-assessment and capacity planning and monitoring for continuous improvement. The program areas of the 4th HPNSP to achieve this objective are as follows:

2.2.2.1. Sector Wide Program Management and Coordination

During HPNSDP, implementation of sector wide management and coordination involved activities in the areas of (i) coordination and collaboration across a wide range of stakeholders; (ii) sector wide planning & budgeting; (iii) governance and stewardship; (iv) sector-wide monitoring and evaluation; and (v) coordination of different TAs provided by the DPs.

Steps were taken to improve both inter and intra OP coordination. Mainstreaming of nutrition services through the regular channels of DGHS and DGFP required improving coordination between various OPs involved in service delivery like Community Based Health Care (CBHC), Essential Service Delivery (ESD), Family Planning Field Service Delivery (FPFSD), Health Education and Promotion (HEP) & IEC etc. Another example is MNCH services through MNCAH OP of DGHS and MCRAH OP of DGFP including resource sharing (e.g., creating delivery rooms in selected CCs including training of CSGs under CBHC OP with support from MNCAH OP).

Various Inter-Ministerial committees like the inter-ministerial and Urban Primary Health Care Provider (UPHCP) Steering Committee between the MOHFW and the MOLGRD&C under the leadership of MOHFW were formed during HPNSDP to serve as a forum for coordinating the related inter-ministerial activities. To deliver mainstreamed nutrition service at all service delivery points of DGHS and DGFP with the CC being the first contact point, a Nutrition Implementation Coordination Committee (NICC) headed by DG, DGHS and a Steering Committee for Nutrition Implementation

(SCNI) headed by Secretary, MOHFW, were formed to provide overall guidance. Existence of the operation of these committees showed that provision of co-operation mechanisms need purposeful leadership and considerable mentoring to bring desired results.

The MTR 2014 found the LCG WG on Health performing well. Besides, nine Task Groups (TGs), were formed with representation from all stakeholders including DPs for dealing with technical aspects in nine thematic areas, namely- Monitoring & Evaluation TG, Financial Management TG, Procurement TG, Nutrition TG, Human Resources TG, Gender, Equity, Voice and Accountability TG, Health Financing Resource TG, MNCH&FP TG, and Sector Management TG. Formal interactions between the DPs and the MOHFW were conducted through the LCG Working Group on health and nine issue-based technical TGs. The MTR 2014 opined that the TG system was one example that was variable in effectiveness. Some TGs appeared to work well and the members were content with the level of information sharing, discussion and agreements made; while other TGs provided a different picture due to inadequate participation, readiness of participants and management.

As part of its Planning and Budgeting functions, the Planning Wing -following MTR recommendations - reviewed the HPNSDP and revised the PIP and the 32 OPs including OP level indicators and RFW indicators. It was evident in MTR 2014 that the percentage of OPs spending more than 80% of their annual budget had increased from 50% in 2012 to 69% in 2014. It also revealed that all the OPs were timely submitting annual work plans (AWPs) with budget, which indicated notable success in HPNSDP planning and budgeting. There has been an average annual growth of 12.6% in the total ADP allocations throughout the HPNSDP. Utilization of the development budget also increased during the 3rd SWAp period compared to the first two SWAps.

In terms of sector wide monitoring & evaluation (M&E), focus was on improvement in the routine MIS of the DGHS and DGFP especially in terms of expanding connectivity. Monthly monitoring of OPs of HPNSDP took place in the ADP review meetings at MOHFW chaired by the Secretary. OP level activities were also reviewed by the OP Implementation Committee (OPIC) chaired by Joint Chief (Planning) and the Steering Committee chaired by Hon'ble Minister for MOHFW. Piloting for the development of an automated and computerized RHIS is under implementation in two districts during the program period.

An institutional arrangement introduced in HPNSDP was the setting up of the Program Management and Monitoring Unit (PMMU) under the PW which - assisted by a TA Support Team (TAST) (sourced from MEASURE Evaluation-)- provided technical support to the PW in M&E, and in tracking and management of program implementation. The development of a Results Framework Performance Monitoring Plan (PMP), Indicator Reference Sheets and an M&E Strategy and Action Plan (MESAP) contributed to strengthened M&E in the HNP sector. The MESAP seeks to strengthen progress monitoring of the HNP sector and to promote evidence-based decision making.

A coherent multi-year integrated and consolidated technical support plan was developed in the PIP of HPNSDP for stronger TA coordination. The pooled TA fund titled 'Joint Donor Technical Assistance Fund (JDTAF), was managed and funded by DFID and proved itself as an effective institutional arrangement for sector management and TA coordination. A TA Committee (TAC) was formed comprising of MOHFW, agencies under it and DP representatives to oversee the TA proposals, review and recommend for endorsement by the Government. The MTR 2014 acknowledged TA progress in HPNSDP and recognized that some TAs were well aligned to the HPNSDP and had provided useful and valued support to the MOHFW.

A new aid modality - Program for Results (PforR) was introduced in the last year of HPNSDP for additional financing of US$ 150 million by the World Bank. This modality will be continued in the 4th HPNSP. Under the PforR, disbursement is made against verified achievement of the Disbursement Linked Indicators (DLIs) agreed between the World Bank and MOHFW at the beginning. This new procedure of fund reimbursement would be challenging as it needs to be harmonized with the timing of the preparation of ADP. It also calls for a feasible and robust monitoring and verification protocol. It is thus crucial to develop effective field-level supervisions of the DLI activities and establish a dedicated review mechanism for ascertaining progress on the DLIs, based on factual in-house routine data.

In spite of the progress gained during the last 18 years in sector wide program management and coordination, there is room for further improvement in all constituent components of sector-wide program management and monitoring. The key activities to be pursued during the 4th HPNSP to improve sector co-operation, sector management including planning and budgeting and M&E include:

A) Sector wide management, coordination and collaboration:

(i). Efforts will be made to acknowledge the inputs of the MOHFW/other Ministry/DP parallel projects contributing to the development of the HNP sector through improved coordination and collaboration. In the case of the MOHFW, conscious efforts will be made to maximize use of available resources through close coordination between investments in the discrete projects under the Ministry's ADP and the OPs in the Sector Program and between use of revenue and development budgets. An 'HNP sector Coordination Forum' will be established with Honorable Minister, MOHFW in the Chair for stronger coordination at a higher level.

(ii). LCG Working Group on Health meetings will be continued on a quarterly basis, as had been done during HPNSDP for program appraisal, policy discussion and guidance.

(iii). A review of the existing TGs will be undertaken to ensure their relevance and effectiveness. Formation of TGs on emerging issues like NCD, Governance & Stewardship will be given preference. Guidelines will be jointly developed with the DPs to improve their task orientation, regularity and follow-up.

(iv). Effective coordination mechanism in the areas of program designing, planning, review and budgeting will be established with the MOLGRD&C and MOCHTA for improving urban health and tribal health services respectively. Similar coordination panels will be established with the relevant Ministries, agencies and other stakeholders to improve sharing information and strategy as well synchronizing actions on health aspects related to traffic accidents (SDG 3.6), substance abuse and narcotics (SDG 3.5), and pollution of air, water and food (SDG 3.9) - all three of which are included as targets of goal-3 in the SDGs.

(v). A harmonized coordination mechanism among the PW and Planning Units of DGHS & DGFP will be developed through SWPMM OP. Steps will be taken to strengthen both the Planning Units of DGHS and DGFP with necessary technical support.

B) Planning and budgeting:

(i). Steps will be taken to ensure that all the OPs continue to submit timely Annual Work Plan (AWP) with budget.

(ii). Efforts will be made to ensure that all the DPs submit reports on on-budget activities (direct project aid activities) regularly. This will help OP's AWP to avoid duplication and at the same time allow all the stakeholders to achieve complementarity in interventions and investments.

(iii). Training/orientation will be provided on planning, budgeting, fund release, monitoring, coordination etc. to the LDs and their teams involved with OP implementation.

C) Monitoring and Evaluation:

(i). Efforts will be made to generate coordinated data, reduce duplication of efforts and provide adequate funding for M&E activities etc. M&E offices will be provided with specialized skilled personnel (e.g. in IT, public health, epidemiology, etc.).

(ii). Capacity of the relevant MOHFW staff will be strengthened in reviewing and reporting performance for results (in the form of DLIs). An effective and harmonized review mechanism for ascertaining progress on the DLIs will need to be developed.

(iii). The MOHFW will develop a plan to institutionalize the PMMU under the Planning Wing, so that the activities of PMMU are continued uninterruptedly during the 4th HPNSP. The MOHFW will also take necessary steps to deploy skilled personnel in the PMMU on a full-time basis. M&E capacity of the PW including PMMU and the Planning Units of DGHS & DGFP will be strengthened through TA support, training and logistics.

(iv). Steps will be taken to implement the MESAP. Coordination and harmonization of MISs of the Directorates will be established for implementation of the MESAP.

D) TA *Coordination*: A separate note on Technical Assistance has been presented at sub-section 3.1.2.3.

2.2.2.2. Aid Modality & IPF

A) Aid modality:

Bangladesh remains one of the top 10 recipients of aid to the health sector. The total estimated cost of the HPNSDP revised RPIP stood around US$ 6.6 billion, inclusive of the development and non-development budget, where, US$ 2.5 billion was set as the estimated development budget. The contribution from the DPs in the development budget was estimated to be US$ 1.5 billion, which was 57% of the total development budget. However, by combining the development and non-development budget of the MOHFW, the Government's share stood at 78% and the DP share at 22%. In HPNSDP, aid in the form of credit was provided by the World Bank (IDA) and Japan International Co-operation Agency (JICA); whereas, DFID, JICA, Swedish Interntional Development Agency (SIDA), Global Affairs Canada (GAC) , United States Agency for International Development (USAID), WHO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Kreditanstalt für Wiederaufbau (KFW), Deutsche *Gesellschaft für Internationale Zusammenarbeit-(*GIZ), Joint United Nations Program on HIV/AIDS (UNAIDS), The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Global Alliance for Vaccines and Immunisation-Health System Strengthening (GAVI-HSS), etc. provided grants.

In HPNSDP, out of the total DP funding, the World Bank and nine other DPs put their money (US $ 699.34 million) in a pooled fund administered by the World Bank. GOB maintained a designated foreign exchange account (Forex) at Bangladesh Bank and based on IFR, money was reimbursed to the Forex in the Bangladesh Bank. Any individual DP could maintain a separate Forex as well (e.g. JICA). From this Forex, funds were deposited to the Government's Consolidated Fund or treasury. In the GOB system, this DP resource was recognized as the Reimbursable Project Aid (RPA) allocation.

Some DPs of HPNSDP provided funds through the DPA mechanism. The fund was mostly spent by the DPs directly, if not spent by the LDs. Paucity of information on DPA spending hampered proper planning and execution of many OPs of HPNSDP. Lack of an established mechanism to inform OP

wise actual contribution or commitment regarding DPA each year in a timely manner- hindered proper planning and budgeting.

B) Investment Project Financing (IPF)

During the preparation process of the 4th HPNSP, a new program financing operation was discussed and agreed upon between the co-financing partners (World Bank and other DPs) and the Government of Bangladesh (GOB), through which pool funds in the form of reimbursable project aid funds would be disbursed based on results known as DLIs. IPF - DLI is a financing mechanism of the World Bank that ties funding directly to the delivery of results. The IPF-DLI instrument is designed to shift the GOB's focus from inputs based financing towards program results and to divert the World Bank's attention to macro management of program financing instead of day-to-day management of transactions. But at the same time it is to be ensured that fiduciary and safeguards oversight is maintained through up-front assessment and agreement on system improvements during implementation. Clear definition, measurement criteria, independent assessment and verification of program results are the basis of the IPF-DLI.

Under the IPF-DLI modality, funds are disbursed upon achievement of some preset DLIs. DLIs are a set of tangible, transparent and verifiable performance indicators/results that provide the basis for fund disbursement. DLIs articulate the key program milestones that GOB must achieve to demonstrate and improve performance of their program. DLIs have been set on the basis of the 4th HPNSP's objective, systems, strengths and performance (through systems' assessment), results framework and programme activities. The number and specification of DLIs, amount allocated per DLI, verification process and disbursement mode have also been determined jointly by co-financing partners (World Bank and other DPs) and the GOB.

However, it is to be noted that there will be either full or partial disbursement of the earmarked fund for a DLI from the World Bank as the Administrator of the pooled funds, if the MOHFW achieves fully / partially targeted results (e.g. the DLI) at the stipulated time. This new procedure is challenging as it needs to be harmonized with the timing of the preparation of ADP. Annual review of results for reimbursement in the DLI-based financing mode may call for annual revisions of OPs (at least some of those) in response to the review results. It, therefore, calls for a feasible and robust monitoring and verification protocol. The exact nature of the relationship between achievement or partial achievement of results and amount/proportion of fund disbursement would depend on prior agreement reached on this issue between the MOHFW and the World Bank/DPs.

It is thus crucial to develop an effective and harmonized review mechanism for ascertaining progress on the DLIs, which would regularly produce factual routine data at minimal cost. Capacity of the relevant MOHFW staff will need to be strengthened in reviewing and reporting performance for results (in the form of DLIs).

2.2.2.3. Technical Assistance

The need for overall coordination and management of TA was recognized in the past SWAp reviews. A coherent multi-year integrated and consolidated technical support plan was thus developed in the PIP of HPNSDP as well as in the SWPMM OP. This plan was a consolidation of TA/TC supports, provided separately by the parallel DPs, with the aim of ensuring effectiveness and responsiveness of technical supports to the diverse and evolving program needs. Accordingly, the TA at the Ministry level was reflected in the SWPMM OP while those on specific program areas were reflected in the respective OPs.

The JDTAF formed in 2012 was coordinated and managed by DFID on behalf of the DPs. The Technical Assistance Committee (TAC) under the GOB leadership oversaw the TA proposals,

reviewed and recommended for endorsement by the Government. A database of national and international consultants was also developed. The MTR 2014 acknowledged TA progress in HPNSDP and recognized that some TAs were well aligned to the HPNSDP and had provided very useful and valued support to the MOHFW. In view of the progress made by MOHFW in handling TA under HPNSDP, the Government decided that this mechanism of implementing and monitoring JDTAF TA through the GOB-DP TAC will be continued in the 4th HPNSP and efforts will be made to expand the number of partners contributing to the JDTAF.

However, still there remain some challenges which need to be addressed for better results from TA. The MTR 2014 revealed that though progress had been made and considerable TA was provided, there remained a need for an overall plan for use of the resources. More coordination and better dissemination of reports and key findings would be useful. Challenges are there in procuring consultants, e.g., (i) getting consultants with the right kind of skills; (ii) availability of the consultant as per the required timing; and (iii) a limited consultant database. Moreover, effective coordination and tracking of different TAs provided by the DPs in the health sector continue to remain as a challenge for the MOHFW.

Key activities to be pursued for overcoming the challenges during the 4th HPNSP are that :

(i). A Harmonized TA Plan will be prepared to identify major areas of TA needs and how these will be supported.

(ii). Effectiveness of the TAC will be increased through extensive follow-up from the PW to assist the LDs to send the proposal well ahead of TAC meeting.

(iii). Effectiveness of TAs received will be increased through (i) establishing a knowledge management system/repository by collecting all the TA reports and performance briefs of TA projects for future use and reference; and (ii) through taking necessary follow-up actions on relevant recommendations in the reports.

(iv). TA Procurement will be accelerated by (i) extending PW's assistance to LDs in developing TOR; (ii) expediting TA approval process after endorsement by the TAC; and (iii) extending the consultant database; etc.

(v). TA monitoring/follow-up at MOHFW level will be strengthened through the TAC and TA performance status will be reviewed in the Monitoring & Evaluation Task Group (M&ETG) and Sector Management Task Group (SMTG) meetings on a six monthly basis.

(vi). TA coordination and tracking will be strengthened by (i) introducing a simple and brief reporting template for TA tracking; and (ii) submission of TA Performance Report by the parallel DPs on an annual basis.

(vii). TA will be utilized to address the challenges of the MOHFW which most relate to technical issues and/or innovations, rather than shouldering the routine workload of the officials of the MOHFW and agencies under it.

2.2.3. Strategic Objective 3:

To Provide Sustainable Financing for Equitable Access to Health Care for the Population and Accelerated Progress towards Universal Health Coverage

A major focus over the next 5 years will be to increase the total health funding available for essential health care services. This will be achieved through demonstrating the positive economic gains of investment in health as well as ensuring efficient, effective and equitable resource allocation. Financing of the sector will come under increasing pressure from the rise in population, the ageing of the population and the rapid rise of non-communicable diseases. While economic growth continues,

per capita investment in health by the GOB remains low and the prospect of a proportionate rise in resources from the GOB is uncertain. Growth and sustainability in finances for health will be a combination of managing demand for services, the efficient use of available resources, and establishing a convincing investment case for Government, DPs and the private sector. The priority program areas of the 4th HPNSP to achieve this objective are as follows:

2.2.3.1. Financing the Health Sector

Fund absorption capacity of the MOHFW and the agencies under it has increased during the three SWAp implementation periods (1998 - 2016) with increased efficiency in resource allocation and utilization of funds. Private sector organizations such as the National Foundations on Heart, Kidney and ENT, and international organizations like icddr,b also get regular grants from the MOHFW's budget allocations for the provision of HNP services in the country. Moreover, a considerable amount of funds are allocated to NGOs as special grants (one time) in each year from the MOHFW's budget. Fund utilization capacity (on average 90% +) places an argument for more resources to be given for the HNP sector development. The MOHFW's budget during the past five years increased at an average rate of 15% and, it is rationally assumed that the budget will be increased by at least 15% per annum during the next five years as well.

The MOHFW needs to achieve efficiency gains through improved budget management, which in turn can yield some additional financial resource. Efficiency gains can also be realized from improved procurement process, needs-based infrastructure development, and appropriate maintenance of equipment. Deciding on new methods of payment may help enhance efficiency in resource allocation. Moreover, allocating resources based on an agreed and rational resource allocation formula can enhance efficiency in resource use. Improving availability and access of staff, ensuring an appropriate staff-mix and enhancing quality of care can also contribute to efficiency gains.

Sustainable health financing, as identified in the Health Care Financing Strategy (HCFS) 2012 of Bangladesh, is crucial in providing financial risk protection and promotion of equity in the context of achieving UHC which is one of the overarching goals of the 4th HPNSP (2017-22). There is a high level of commitment from the GOB to bringing health care as close to the communities as possible. National commitment and policy support are reflected in (a) 7th Five Year Plan; (b) National Health Policy-2011; (c) Bangladesh Population Policy 2012; and (d) Concept Paper and Strategic Investment Plan for the new Health, Nutrition and Population Sector Program. All these call for incremental public financing in the health sector in a sustainable way. Although public financing in health has been increasing steadily, its relative share to gross domestic product (GDP) and national budget has been on the decline.

Managing the due health needs of a huge population requires resources which are currently clearly inadequate. Moreover, emerging and re-emerging diseases, health hazards due to natural calamities, environmental degradation, rapid urbanization and threat to people's health, and rising incidence of NCDs (cardio-vascular diseases, cancer, diabetes, etc) are putting constant pressure on available resources. High out-of-pocket expenditure for health care (63.3%, BNHA 2015), gaps in PHC coverage of urban areas, health spending disparities across wealth quintiles and inadequate pre-payment mechanisms to protect the population from catastrophic spending reflect inequity in health financing and resource use.

During the 4th SWAp implementation period, efforts will be made to realize the objectives of (i) increasing resources in the HNP sector; (ii) achieving equitable access to services and financial protection; (iii) enhancing efficiency in resource allocation and utilization; and (iv) improving

financial management and governance. Key activities to be pursued for overcoming the challenges as well as achieving the objectives described above include:

(i). Increase resources in the HNP sector by:

- Pursuing with the Ministry of Finance (MOF)-an increase in the share of the MOHFW's budget to national budget (both revenue and development).
- Negotiating with the MOF to ensuring that tobacco taxes are earmarked and channeled to the MOHFW's budgetary allocation.
- Scaling up community participation activities in operating hospital and community health facilities in a structured way following the Chougachha Model.
- Utilizing global funds (e.g., WB-GFF, GFATM, GAVI-HSS, Bill & Melinda Gates Foundation) fully.

(ii). Achieve equitable access to services and financial protection by:

- Ensuring proper implementation of the Health Care Financing Strategy 2012 to strengthen financial risk protection and to extend health services and population coverage with the aim of achieving universal coverage.
- Determining suitable institutional arrangements to manage social health protection schemes for different groups (e.g., garment workers, Government employees).
- Prioritizing public resources to cover people in the bottom 25% (people living below the poverty line) through pre-payment models like SSK and move towards purchasing of quality health services.
- Setting standards for allocating resources that are sensitive to indicators like the extent of poverty, disease incidence and prevalence, population size and peculiarities of the localities and topographies.

(iii). Enhance efficiency in resource allocation and utilization by:

- Defining an affordable, acceptable and effective service package and delivery at different tiers of facilities with agreed quality standard.
- Reducing wastage through appropriate procurement planning and implementation, and rationalizing budget for infrastructure construction.
- Freeing up public resources and providing more fiscal space for health through pooling mechanisms via contributions from the formal sector and the middle and upper-middle classes.
- Contracting out non-functional health facilities to private (for profit and not-for profit) entities with the provision of a strong stewardship role of the Government.
- Designing and pilot innovative service delivery models such as e-health, 24-hours call centres for consultation and referral advice.
- Improving health systems efficiency through linking allocations of financial resources to achievement of pre-defined performance targets.
- Working with the MOF for reviewing/revising the public finance management rules/regulations for efficiency improvement.
- Carrying out costing exercise of the programs and interventions more methodically for cost effectiveness and efficiency improvement.

- Developing mechanism for health technology assessment for introducing suitable and efficient new technology and medicines.

(iv). Improve financial management and governance by:

- Improving financial management, especially on planning and budgeting, and procurement capacity to achieve efficiency in resource use and absorption capacity.
- Improving co-ordination between the revenue and development parts of MOHFW budget to avoid duplication in the use of resources and to increase efficiency.
- Improving co-ordination through structured institutional arrangements between the DPs and MOHFW planners to maximize outcome of investments made by both the parties.
- Improving governance and stewardship role of MOHFW to lessen wastage in fund use and to strengthen transparency and accountability.

The above mentioned plan of activities on health financing has been developed based on the fiscal space study and it will be reviewed periodically for exploring any further scope of expansion. These activities (if put in practice collectively) are expected to increase efficiency in the use of existing resources. This, in turn, can positively orient the decision makers to invest more in health as the value for money will become more evident.

2.2.3.2. Innovative Approaches to UHC

Various innovative approaches will be explored for improving service delivery, which would include review of existing field-based service delivery; diversification of service provision (inclusive of public-private partnership) particularly for HTR areas; development of functional referral systems involving all levels of facilities; ensuring quality of care, etc. Ensuring access and utilization of quality health services by the poor and the marginalized will be at the heart of an improved health service delivery system and ensuring UHC is the long term goal.

After proper mapping of existing Comprehensive Emergency Obstetrical Care (CEmOC) services, new initiatives will need to be undertaken to ensure access of CEmOC, particularly for hard to reach areas. Newborn care will be strengthened and expanded through building strategic partnerships with NGOs and private sector to leverage the resources for intensification of newborn care promotion.

Further consolidation of on-going efforts to reduce the effects of communicable diseases along with intensified health promotion and prevention for non-communicable diseases will be undertaken through increased investment and multi-agency co-ordination. Gender and AFHS together with availability of proper information for adolescents will have to be ensured to protect them from health hazards.

Assistance will be provided in the Hill District Councils (HDCs) in the Chittagong Hill Tracts (CHT) to develop district-specific health service in co-operation with MOCHTA and with interested DPs. Steps will be taken for providing improved health services to the tribal populations residing in plain lands (pocket areas) of the country.

Disability issues (autism, mental health, etc.) will also be properly addressed in collaboration with various actors (public, private, NGOs) through preventive and curative services including expansion of services to cater the need of those who are physically or mentally challenged.

There is a need for reorienting the existing institutional arrangements for health service delivery and to increase investment – both financial and human resources – in developing an appropriate geriatric health care service system. MOHFW will promote multi-sector collaboration with other ministries (e.g., Ministry of Social Welfare), private sector, NGOs, CSOs, etc. for providing geriatric- friendly health care in the country.

The possibility of utilizing the existing vast informal sector of health service delivery, particularly for hard to reach areas and ensuring proper quality of care and health promotion will be explored. Moreover, various mechanisms for promotion and protection of service recipients including their rights under the Right to Information Act will be promoted as part of strengthened accountability.

***Community participation and ownership*:**

There already exist many good examples of community participation in Bangladesh. Among them, one is the "Chougachha model," based on experiences of the Chougachha model. From this model, a new model emerged from Jhenaidah DH in 2012. The characteristics of these two models are: 1) *Hospital centreed* approach, meaning community mobilization initiated by hospital leaders for hospital improvement; 2) strengthening record keeping for generating data and use of data for decision-making; and 3) building up a participatory accountability mechanism for hospital management involving local administration, elected local Government representatives and community leaders. Another prominent example of community engagement is a structured community engagement framework consisting of a Community Group (CG) for each CC and 3 Community Support Groups (CSG) around each CC. The CGis responsible for the daily management of CC operation and resource mobilization while CSGs are engaged in promotion of CC services, providing support to patients/clients, and raising awareness on health among community people.

These good initiatives of encouraging community participation will be continued and expanded in the 4th HPNSP with strengthened CGs. At the same time, new initiatives will be in co-operation with other stakeholders, explored to increase their participation and empowerment in HNP issues for the local communities.

Partnership with private sector:

In Bangladesh, the private service providers are often the first responders, especially in urban slums and HTR areas. These service providers cater to more recipients, providing round-the-clock services as per the recipients' convenience. There is an increasing emphasis on the complementary role of the private sector through PPP.

Collaboration with the private sector may be expanded in the 4th HPNSP by preparing a database of private service providers (drug stores, diagnostic service providers, etc.) working in HTR areas and with vulnerable populations. The accreditation systems will also be introduced for both public and private service providers to ensure standards of services. Modalities will be determined to mobilize private sector resources to high investment areas like infrastructure development, service centre establishment with high-tech equipment and innovative medical and pharmacological research.

2.2.3.3. Multi-Sectoral Approaches

As the SDGs begin to gain traction in national level discussions on development it is clear that the HNP sector needs to work closely with other sectors. The MOHFW has a role to engage with other Ministries whose work has a bearing on HNP sector development. For example, given that much remains to be done to bring the rates of stunting and micronutrient deficiencies down, issues that affect access to a safe, affordable and nutritionally adequate diet and impact nutritional status need to be addressed. This will require concerted effort and action across multiple sectors e.g., food, agriculture (including fisheries and livestock sub-sectors), social protection, education and health in order to improve dietary diversity, food quality and safety, and dietary practices. Additionally, close linkages with Water, Sanitation And Hygiene (WASH) and women's sectors need to be strengthened. Similarly, it is essential that convergence and coherence in nutrition and food safety across sectoral

policy domains and linkages with mechanisms having adequate cross sectoral governance and coordination be in place.

There is also scope for health-related evidence to inform decisions on issues such as air and water pollution, food safety and agricultural practices, urban health and its relation to city planning incorporating green space and provision for physical exercise facilities, issues such as road traffic accidents, harmful substances and narcotics, etc. Efforts will be made to strengthen multi-sectoral collaboration around healthy lifestyles and healthy environment which will play a major role in keeping the burden of NCDs under control.

Component 2: Health Systems Strengthening

2.2.4. Strategic Objective 4:

To Strengthen the Capacity of the MOHFW's Core Health Systems (Financial Management, Procurement, Infrastructure Development)

The core systems that underpin administration and operations of the sector are highlighted under this objective.

2.2.4.1. Financial Management

Commendable results over a period of past 15 years was achieved in shaping and strengthening Government's health systems and supporting their implementation, both technically and financially. There have been developments in budgeting procedures, planning of Operational Plan (OP)- wise resource allocation, capacity building, more efficient preparation of the medium-term budgetary framework (MTBF), fund disbursement, financial monitoring and reporting systems.

Further improvements in Financial Management (FM) and Audit during HPNSDP period include restructuring of the FM and Audit Unit (FMAU) including revised recruitment rules and its approval by the Ministry of Public Administration (MOPA), engagement of qualified FM Consultants to support FMAU and LDs as a temporary measure, drafting of FM and Audit Strategy, strengthening of the management of revenue budget and audit functions by putting them under the FMAU of MOHFW, timely presentation of accurate Interim Unaudited Financial Reports (IUFRs), outsourcing of internal audit to private audit firms, etc. Extensive trainings were provided to more than 2,500 officials from different agencies under MOHFW on FM issues by the end of 2015.

The key challenges that need to be addressed in the FM of the 4th HPNSP are as follows:

Public Financial Management (PFM): Apart from the MOF, the reforms and improvements in PFM in line ministries, including the MOHFW, were very limited and remain weak. It has yet to implement adequate FM arrangements in line with the GOB's policy that supports effective and efficient fiscal management and oversight functions. At the Directorate level, PFM functions are carried out in a fragmented manner by different units with limited coordination amongst them. Due to the lack of clear assignments of FM responsibilities in OPs and cost centres, capacity building efforts from theIFM OP remained incomplete partly aggravated by shifting responsibilities among concerned personnel.

Fund Flows and Treasury Management: Drawing down of funds from the FOREX account to reimburse the MOHFW for quarterly (pre-financed) expenditure remains a challenge. Delays occur in the various offices involving the Chief Accounts Officer (CAO), Controller General of Accounts (CGA) and the Bangladesh Bank in issuing authorization to process the fund transfer to the GOB's consolidated fund. Due to delay in the release of fund from the FOREX account, spending agencies cannot make proper expenditure planning and consequential result is under spending. A rush of

expenditure at the end of the financial year increases risk of wasteful expenditure and or financial irregularities.

Expenditure Tracking: Automating the expenditure tracking process remains a critical improvement action if reliable financial monitoring of foreign aid funds- advanced for program implementation- is to be achieved in a harmonized manner. Replacing parallel and manual systems with integrated budget and accounting system (iBAS) to generate financial reports for the HNP sector has not materialized. Internal audit is still being outsourced and is not yet an integral and strategic function within the MOHFW. Delayed response from the Foreign Aided Project Audit Directorate (FAPAD) is one of the reasons regarding timeline in settling audit observations. At the same time LDs find it difficult to meet the FAPAD audit objections on DPA expenditures, as these are incurred from DP's end and LDs have no access to vouchers and other relevant papers for meeting audit objections.

Accounting and Reporting: The FMAU finds it challenging to submit financial reports on time (within 45 days after the quarter-end) because they need to reconcile the closing balance in the *Internal Unaudited Financial Report (*IUFR) with records at the CAO and the CGA. From accounting point of view, another important issue relates to recording of advance drawn by the LDs as final expenditure before adjustment. This means that, when money is drawn as advance to meet emergencies, no voucher is required and it is recorded under a temporary head until it is adjusted for final expenditure by producing relevant vouchers. This in effect creates scope for spending without any evidence to substantiate. There is a general lack of understanding at the operational level about the internal control framework and its implementation to establish propriety in public spending.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above include:

(i). As FMAU structure and recruitment rules have been approved by the Government, capable human resource will be recruited at the earliest convenience.

(ii). The existing training modality of FMAU will be enhanced and extended (in duration and on relevant issues). Training manuals will be developed and distributed, not only among the trainees, but also among other OP officials so that these can serve as references.

(iii). There will be regular training and capacity building of officials at different levels regarding financial management and audit issues.

(iv). Operational Plans will have provision to engage capable personnel with relevant educational background and experience in Government financial management and audit system, and relevant public financial rules and regulations to support in financial management related issues.

(v). Audit Units may need to be set up at the Directorate level to track expenditure and to support the respective implementers in addressing audit issues. Such a Unit is already established in one of the Directorate General's Office of MOHFW, which can be followed as a role model.

(vi). MOHFW will closely work with FAPAD in terms of reducing the frequency of audit through synchronization. Moreover, an institutional framework will be developed for getting time bound response from the LDs on FAPAD led audit objections and for resolving those through holding regular tripartite and bipartite meetings with concerned stakeholders.

2.2.4.2. Procurement & Supply Chain Management

Procurement under in the HNP sector in Bangladesh encompasses procurement of goods, services and civil works. These procurements are done using Government funds (revenue and development) and

funds of DPs through Reimbursable Project Aid (RPA) and/or Direct Project Aid (DPA). For the Government's own procurement, the national regulations (Public Procurement Rules and Public Procurement Act) are applied and there are provisions for decentralized procurement by the users. Procurement is also done using Japan International Cooperation Agency (JICA) fund, and in that case the JICA guidelines for procurement apply.

The CMSD of the DGHS and the Logistics and Supply Unit of the DGFP are the entities for Goods procurement. Works procurement is carried out by the Health Engineering Department (HED) of MOHFW and the Public Works Department (PWD) of Ministry of Housing and Public Works. Service procurement is done by the LDs. The JDTAF financed by DFID which the LDs can use to obtain required TA. JDTAF follows DFID guideline for procurement. Besides JDTAF, other DPs also provide specific TAs to the MOHFW, following respective DP guidelines for procurement.

The challenges that need to be addressed in 4th HPNSP include the following:

Improper Procurement Planning*:* Actual needs of the users in the HNP sector have not yet been formalized and linked with the prevailing stock and projected requirements. Duplication in procurement by the DGHS and the DGFP is also visible in many cases due to limited coordination between the procuring entities of these two directorates. There appear lag in synchronizing physical facilities development (PFD) with timely supply of equipment and human resources.

Issues in Procurement Process and Distribution*:* In spite of the improvement in procurement process, still there are areas of improvement due to the prevailing issues like- delayed submission of procurement plans, duplication in procurement, not generalizing technical specification of high-end equipment and bundling of procurement packages towards the end of the fiscal year. The mechanism for stock control and distribution is yet to be automated.

Capacity Issues*:* The CMSD is dealing with a significant portion of the entire procurement of the MOHFW. The NEMEMW&TC is entrusted with the responsibility to repair and maintain medical equipment. The existing tender evaluation committees need to strengthen their capacity to identify irregularities and red flags in procurement as well as to evaluate packages of medical equipment.

Key activities of the 4th HPNSP to be pursued for overcoming the challenges described above and for improving the situation of procurement and supply management in Bangladesh HNP sector include:

(i). A mechanism for need-based procurement will be adopted in which procurement plan will be developed on the basis of actual needs of the users. For similar procurement, multi-year contract and/or framework contract will be introduced.

(ii). Supply Chain Management Portal (SCMP) will be expanded to capture the total procurement plans of the Government

(iii). A coordination mechanism will be established for procurement coordination between the DGHS and the DGFP to avoid duplication in procuring common goods

(iv). Warehousing of medicine and vaccines will be improved with proper storage conditions and environmental control.

(v). Automated mechanism will be introduced for stocking and warehouse management

(vi). High-tech equipment will be procured centrally. For high-tech/proprietary equipment, provision for comprehensive maintenance contracts will be introduced in the tender document. This will be included as one of the evaluation criteria in the tender documents so that the tenders can be evaluated for this.

(vii). A "life-cycle cost" approach will be adopted for high-tech medical equipment so that the required corrective and preventive maintenance can be performed. The log history will also be maintained so that proper maintenance can be ensured.

(viii). Routine surveillance will be introduced to ensure quality of goods. Pre and post shipment inspection will also be done.

(ix). The restructuring of the CMSD will be undertaken following the study recommendations.

(x). There will be mechanism planned to make the PLMC more effective and sustainable.

(xi). The NEMEMW&TC will be enhanced for capacity as per the study recommendations.

(xii). Capacity of the existing tender evaluation committee will be enhanced.

(xiii). A database for trained staffs on procurement issues will be developed so that they can be called upon as needed.

2.2.4.3. Physical Facilities Development

There is a time lag between investment made on construction, and making those operational as service centres for the health-seeking public. Over the years, it has been seen that the completed infrastructure could not be operationalized due to supply side barriers like provision of equipment and HR. The PFD's work is independent of other OPs of HPNSDP, but it has linkages with related OPs like HSM, ESD and HRM. Due to limited coordination, HRM, HSM and ESD often do not have adequate planning or resources to make supply of required equipment and HR.

The uniform decision of upgrading 31 bed hospitals to 50 bed did not reflect or meet the need of all upazilas. Significant number of these hospitals remains underutilized, while some of the upgraded hospitals may still have excessive patient pressure and require further expansion. Moreover, the construction of 10/20 bed facilities in many cases has left the MOHFW with the unresolved problem of how to make those functional. In contrast, the need for construction of the upazila health complexes (UHC) in the tribal areas or the urgency of meeting central/regional warehouses for family planning or having facilities for drug storage in the hospitals etc. have failed to receive the attention that these deserve. This calls for the need for adopting objective criteria for deciding on prioritization for construction/maintenance. On the implementation side, questions have been raised about the quality and capacity of the implementing agencies, i.e. the HED/PWD to complete construction within a Program-period.

The PFD activities face different challenges like (a) absence of policy direction for maintaining balance between new construction, up gradation and repair; (b) infrastructure development is not necessarily linked to systematic need assessment; (c) lack of coordination among OPs related to infrastructure development and facility-based service provision (PFD, ESD, HSM and HRM); (d) lack of emphasis on repair and maintenance; (e) limited capacity of the infrastructure developing entities (HED and PWD) to maintain timeline; (f) inadequate stewardship and supervision for operationalizing completed physical structures; and (g) lack of emphasis on the needs of women and the physically challenged in accessing and using of public health facilities, etc.

Not all civil works of MOHFW are synchronized with plans for human resource deployment and procurement of medical goods so that health facilities can be made fully operational as soon as the civil works are completed. There is also a need to ensure that there is a systematic mechanism with adequate funds for ensuring routine maintenance of physical facilities and medical equipment.

Key activities of the 4th HPNSP to be pursued for overcoming the challenges described above and development of the HNP sector of Bangladesh include:

(i). A completion schedule will be prepared by the MOHFW in co-ordination with theHED and the PWD to finish the incomplete civil works for priority structures. There will be improved supervision and follow-up from the MOHFW on the HED and the PWD to ensure completion of these structures within the agreed time period.

(ii). Emphasis will be put on the structures in HTR areas, underserved areas, structures related to medical/FP commodities storage and distribution and structures that are meant for serving specific interest groups (e.g. tribal people).

(iii). There will be increased coordination with HRD, Procurement, Logistics and Supplies Management (PLSM-CMSD), and Procurement, Storage and Supplies Management (PSSM-FP) OPs to operationalize the already completed structures through supply of required human resources and equipment thereby making those into active service centres.

(iv). A comprehensive maintenance plan will be prepared for the health and family welfare facilities for regular preventive and periodic curative maintenance of the structures.

(v). There will be a comprehensive construction plan developed upon execution of a construction need assessment and development of a detailed new construction action plan along with timeline. Priority for new construction will be focused on less attended areas, e.g. tribal areas, FP warehouses, CCs remaining to be constructed, CCs for the erstwhile enclaves, and stores for hospital drug and FP materials with appropriate temperature and humidity control.

(vi). Gender perspective will be incorporated into the construction and maintenance of physical facilities so that these can provide women-friendly services (e.g. separate functional toilet, privacy of examination room, breast-feeding corners, etc.). Attempt will be made to make the facilities user-friendly for older patients and the physically challenged.

(vii). Infrastructure for different service providers like Nursing Institutes, Medical Assistant Training School (MATS), Institute of Health Technology (IHT), etc. are closely related to the evolving HR Strategy and HR Action Plan. Hence, decision of such construction will be synchronized with the finalized HR Strategy and HR Action Plan.

(viii). The Table of Equipment developed for different sizes of health facilities and Table of Organization to be developed by HRM during HPNSDP will be synchronized so that these can be used while planning for new construction and upgrading of infrastructure in future.

2.2.5. Strategic Objective 5:

To Establish a High Quality Health Workforce Available to All through Public and Private Health Service Providers

This objective includes specific objectives related to the roles and responsibilities of all cadres at all tiers of the system, recruitment and retention, quality, efficiency and medical education. It includes all public, private and AMC health workers. The priority program areas of the 4th HPNSP to achieve this objective are described below.

2.2.5.1. Human Resources Management (HRM)

The key Human Resource Management (HRM) functions assumed by the MOHFW include institutional education of Health Workforce (HWF), in-service training and development, as well as recruitment and retention. Entities like medical and dental colleges, nursing colleges and nursing institutes, homeopathy, ayurvedic and uniani colleges, medical assistants' and FWVs' training institutes and institutes of health assistants provide institutional or pre-service education (PSE) for the HWF in the country. These institutes, both from public and private sectors, play a vital role in producing the required number of the HWF. However, there are issues regarding quality of education

of some of these institutes posed by insufficient number of teaching faculty, inadequate laboratory/clinical facilities, teaching methods and inadequate supervision by the governing entities. Medical Education section of the PIP further illustrates these issues.

The sanctioned posts of the MOHFW and its agencies are close to 140,000 (Health Bulletin, 2015). The DGHS and the DGFP are the principal recruiters, employing 56% and 29% of the total HWF respectively. The Directorate General of Nursing and Midwifery Services (DGNMS) also manages around 13% of the HWF. Considerable recruitments were made (42,000 positions) during the HPNSDP period, which include recruitment of 7,000 doctors and 4,100 nurses. However, some of the recruitment rules and policies were formulated in 1980s and 1990s and have not been updated in recent years. In spite of significant number of recruitment in recent times, there is still considerable shortage of human resources, especially in terms of nurses, medical technicians and ancillary workers. Shortage of manpower also impacts on maintenance of infrastructure and equipment, more so for regular preventive maintenances, including cleaning.

Retention of the HWF, especially the physicians and nurses in remote and HTR areas has been a challenge for the MOHFW. Location of the facilities, lack of proper infrastructure and utilities, insufficient logistics and social support system discourage the retention of the human resources in the HTR areas. Staffing pattern of the HWF traditionally depends on the category of the health facility rather than on service utilization status, disease pattern, demographic distribution or geographic location. As a result, position of the HWF in urban areas is more skewed than in the rural areas. This creates imbalance in workload distribution in different geographic locations. Due to different nature of work in the HNP sector in comparison with other sectors, the performance appraisal system followed for the HWF is not always appropriate. The career progression path for the HWF is not clear for different categories of human resources. The action plan of the approved the HWF strategy – now under development will address these issues to improve service delivery to be able to achieve the goal of UHC.

Monitoring of the HWF is a challenge for the MOHFW partly due to lack of information. The DGHS, the DGFP and the DGNMS use separate information platform to record the HR information. The aforementioned three platforms have different protocols and are at different levels of implementation. The absence of a common and integrated Human Resources Information System (HRIS) challenges proper HR planning. A TA was recently provided to HRM unit of MOHFW for designing and implementing a central HRIS. After development of the HRIS, it is expected that the MOHFW will have a clearer picture to improve the HR interventions like career planning, capacity development and deployment.

Key activities to be pursued for overcoming the challenges described above and for improving the situation of Human Resource Management in Bangladesh HNP sector include:

(i). The approved HWF Strategy will be implemented through the 5-year comprehensive Health Workforce Action Plan, costed and prioritized.

(ii). The organogram of all health and family planning facilities will be reviewed and updated.

(iii). Steps will be taken to address the shortage of human resources and the issues of skill mix, including that of ratio imbalance in the light of the HWF strategy and the HR action plan.

(iv). Community participation and engagement of private sector will be explored in addressing shortage of human resources and provision of quality service through expanding the Chaugachha and Jhenaidah model.

(v). Public and private pre-service health workforce education system (including for AMC providers) will be improved through the steps as mentioned in the “Medical Education” section.

(vi). IST will be based on an approved training master plan and IST will be linked with career development.

(vii). Job descriptions of the HWF at different level of services will be rationalized based on changing needs.

(viii). Recruitment and retention planning, including incentives (non-financial) will be addressed to overcome distribution issues particularly for underserved/disadvantaged areas, appraisals and through career planning.

(ix). The HRIS will be developed and operationalized, and will be linked with the DGHS, the DGFP and the DNS HR platforms.

2.2.5.2. Pre-service Medical Education

This section covers the pre-service medical education, covering doctors and medical technicians. Pre-service education status of nurses and midwives are stated in "Nursing and Midwifery Services" section of this PIP document. In-service training of the medical professionals are illustrated in various sections of this document, including "Human Resources Management", "Nursing and Midwifery Services", and "Alternative Medical Care". The challenges remaining in the medical education are as follows:

Quality Concerns: There has been rapid expansion in medical education in terms of number of medical colleges, especially during the last decade between 2005 and 2015. However, essential elements of medical education like quality faculty could not be developed during this period, since cadre development requires significant time, and also for the fact that medical faculty has lower incentives than other branches of medical professionals. Shortage is especially seen for faculty in basic subjects. Newly established public medical colleges and a significant number of non-Government medical and dental colleges lack required physical facilities and often operate in improvised structures. Non-Government MCHs often lack adequate number of patients, resulting in insufficient clinical practices for the students. Similar is the case for paramedical education. The growth of MATS and IHT, especially in private sector has been very fast in the last decade, resulting in a situation where faculty development and provision of appropriate teaching facilities, laboratory facilities and clinical facilities could not keep pace. This mismatch has raised concerns regarding the overall quality of education in various new medical teaching institutions.

Limited Capacity of the Governing Entities: The Directorate for Medical Education and Health Manpower Development (DME&HMD) in the DGHS is responsible for monitoring quality of education in Government and private medical and dental colleges. It is also responsible to supervise the adequacy and quality of human resources, physical facilities and other amenities in the medical and dental colleges. Although the number of medical and dental colleges increased 10 times between 1990 and 2015, the organizational structure and capacity of the DME&HMD remained the same. Manpower capacity of the BMDC and respective universities (Dean and Inspector of Colleges) has not also increased significantly during this period. Similar scenario can be seen in case of the SMF, and respective boards of Unani, Ayurveda and Homeopathy education. With limited capacity of the monitoring and governing entities, providers of medical education remain inadequately supervised for their quality and adequacy.

Inadequacy of Legal Framework*:* The laws governing medical education in Bangladesh are out-dated and partly because of that, these do not capture the changing context. An updated "Private Medical College Act" is still at draft phase. Respective boards of Unani, Ayurveda and Homeopathy are using acts dating back to 1982. The SMF, as a matter of fact, is operating without any legal

instrument. Because of such inadequacy in legal framework, governing entities also face problem in exercising their oversight responsibilities.

Parallel Bodies in Medical Education: A single entrance examination is conducted by the DME&HMD from which the qualified students get admitted into Government and non-Government medical colleges. However, six medical colleges belonging to the Armed Forces are outside of this and conduct their own entrance examinations. Paramedical education of medical technologist is provided by entities under the SMF, as well as by those under the BTEB. There is little co-ordination among these parallel bodies responsible for medical education. Hence, there remain concerns regarding uniformity and consistency in quality of medical education in the country.

Concerns Regarding Common Appraisals: Admission in medical colleges are done through a common entrance examination, which raised controversies from time to time. There were cases in which students failing the entrance examination could be enrolled in private medical colleges. Existing law empowers the BMDC to decide about the procedures of conducting examination and other matters related to registration. However temporary registration for internship is awarded without examination to the graduates who pass from the BMDC approved medical colleges. Permanent registration is awarded upon completion of internship. However, lack of specific appraisal for registration leave scope for raising concern regarding uniform quality of the professionals.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above and for improving the situation of medical education in Bangladesh include:

(i). Steps will be taken to ensure full compliance of the criteria for establishment of medical colleges both in Government and non-Government.

(ii). Governance and supervision capacity of the stewarding bodies will be assessed and actions will be taken to improve capacity

(iii). Existing laws of boards for Unani, Ayurveda and Homeopathy will be updated. Appropriate law for the SMF will be enacted.

(iv). An accreditation system will be introduced for assessing the quality of medical education in Bangladesh

(v). Need for licensing/registration of all technology courses offered in the country will be evaluated and the capacity of SMF as the licensing authority will be assessed.

(vi). Steps will be taken to establish uniformity in technical educations and job opportunities for courses offered by institutes officiated to BTEB and those with the SMF.

2.2.5.3. Nursing and Midwifery Services

According to Human Resources Report of DNS, 2016, there are 24,632 sanctioned posts for nurses and allied professionals. However, 18,905 of these positions could be filled up, which means around 23% of the sanctioned posts are still vacant. The situation is especially critical in Sylhet division where 49% of the nursing posts are vacant. The vacancy is 29% in Chittagong and 24% in Dhaka divisions. 45% of the occupied positions are filled up with personnel in current charge, additional charge, own pay or deputation. Hence, the real vacant positions might be higher than the reported figures. In addition to this, DGNMS predicts a total of 10% of the recruited nursing staff to retire during 2017-22 period. To address this, Government is in the process of recruiting 10,000 nurses in the subsequent years, among which 4,100 nurses have already been recruited during HPNSDP period.

Already there have been initiatives from Government with support of the DPs to introduce quality midwifery in Bangladesh, including introduction of three year Diploma in Midwifery program, faculty development and curriculum development for Diploma in Midwifery, certificate programs for

nursing staff, in-service training and orientation for the managers, etc. As there were no graduates in Diploma in Midwifery, NES trained 1,541 nursing professionals on specialized six month post basic midwifery training. Till now 660 professionals completed the three year "Diploma in Midwifery" degree and earned their professional license from BNC. Government created 3,000 midwifery positions and the first two batches of 600 certified midwives were deployed in November 2015 and July 2016 respectively to the UHCs and union health facilities. Private sector hospitals are also recruiting registered midwives. The challenges remaining in nursing and midwifery services include the following:

Imbalanced Skill Mix: Considerable efforts were put in Bangladesh over the last two decades to increase the number of physicians, which paid off with 5 physicians for every 10,000 citizens of the country. However, the increase of nursing professionals was not at the same pace, resulting only 2 nurses for every 10,000 people. This means, the nurse-doctor ratio is 1:0.4, whereas, according to the WHO standard, this was supped to be 1:3. Such imbalance of skill mix affects the quality and extent of health care.

Shortage of Deployed Nurses: The number of nursing professional deployed is not sufficient with the increasing need of the country. Hospital bed to available nurse ratio is 4:1 for upazila level and 3:1 for secondary level. 23% of the total nursing professional positions are vacant. The vacancy is especially high in health facilities located in HTR areas like hill tract areas, haor regions and remote rural places – evident from the 49% vacancy in Sylhet and 29% in Chittagong divisions. The planned recruitment of 10,000 nurses needs to be initiated immediately to address this issue, along with designing mechanisms to encourage nurses working in HTR areas.

***Quality of Nursing and Allied Education Programs*:** There are ample opportunities to improve the quality of nursing, midwifery and other allied education programs – both in public and private sector. The physical facilities of education, including laboratory arrangements, lodging facilities and clinical practices requires improvement. Already there have been initiatives to improve the teaching quality improvement, which should be further enhanced. There is no institute for continuous faculty development on modern teaching methodology. Teaching medium for community level nursing professionals (e.g. community paramedics) is English and Arabic, which hampers the knowledge intake. At the same time, the capacity of BNC requires to be strengthened to properly monitor quality of the nursing and midwifery education service providers.

Regulatory Instruments: The BNC is currently being operated under BNC Act, 1983, which is quite outdated and not entirely matched with the current context. A draft of updated Bangladesh Nursing and Midwifery Council Act was developed aligned with the modern requirement, which is yet to be approved.

Midwifery Education Facilities: A recent study conducted by the UKAID in 2015 identified inadequate resources for midwifery students training in terms of classroom and hostel accommodation and laboratory facilities, as these are being shared with nursing students at respective nursing institutes and colleges. Although the curriculum of midwifery is quite a standard in Bangladesh, there needs extensive faculty development to deliver the curriculum. Development is required in developing and utilizing relevant teaching materials and methods, since the faculty are mostly with nursing background. There were initiatives in the HPNSDP for midwifery faculty development with the support from DPs, which require further expansion.

Awareness of Midwifery: Midwifery, as a professional cadre, is still new in Bangladesh. The awareness regarding this profession is still low among the service recipients. In cases, the field level managers also have limited awareness, which affects the training and deployment of midwives,

although there is awareness building programs and orientation training going on for the managers. Mass awareness building is required for the recipients for further improvement in RMNCAH area.

Deployment of Midwives: Significant numbers of recently deployed midwives are currently working at either DH or UHC. Although these positioning is crucial, however, in comparison, rural areas require more coverage of midwifery services. The DNS is currently conducting an assessment of where the midwives are and their constraints and challenges.

The key activities to be pursued for overcoming the challenges described above and for improving the situation of medical education in Bangladesh include:

(i). Approval of the DGNMS is in the process. Upon approval, DGNMS will be made functional through necessary recruitment and resources.

(ii). Initiatives will be taken for introducing accreditation system in both public and private sector nursing & midwifery institutes for ensuring quality of nursing and midwifery education.

(iii). The present efforts for improving quality of nursing and midwifery education will be continued and strengthened further. The BNC will be strengthened with resources for better monitoring of nursing and allied education service providers. The curriculum development cell will continue working on updating both nursing and midwifery curriculum so that the quality is in line with the international standard.

(iv). Faculty development in midwifery will be continued and expanded to cover all institutes offering midwifery education. Designated midwifery faculty will be deployed. Scope for higher education for midwives will be created and certified midwives will be encouraged for higher studies.

(v). Resources in the nursing and midwifery education institutes will be increased, including skill lab equipment and computer lab accessories. Classroom and accommodation facilities for midwives will be reviewed for their adequacy.

(vi). In-service training of deployed nurses and midwives will be continued. Training will focus on specialized areas, as well as on teaching methodology for the teaching faculty and senior nursing instructors. Senior nursing managers will be oriented on leadership and human resources management including monitoring and supervision.

(vii). Job description of the nursing staff will further be reviewed to encourage them working at HTR areas through incorporating incentives (non-financial) like scope of higher studies and career upgradation, etc. Nursing staff will be oriented with their career progression and job responsibilities.

(viii). Necessary steps will be taken to fill up the vacant positions with the planned number of nursing professionals. Vacant midwives positions will also be gradually filled-up with certified diploma midwives.

(ix). There will be strategic deployment of midwives to ensure comprehensive coverage of midwifery services in priority locations.

(x). A regular monitoring mechanism will be established in the DNS to better supervise the nursing and midwifery staff working at field level. The MIS of the DNS will further be strengthened to aid management efficiency. Upon completion of the HRIS at the MOHFW, harmonization will be made with Personnel Management Information System (PMIS).

(xi). Efforts will be taken in upgrading the existing Nursing Research Cell to open the avenue for evidence based nursing education and practice. A structure of Bangladesh Nursing & Midwifery Research Council (BNMRC) will be established, and nurses & midwives will be

trained on research methodology and statistics. Researches will be encouraged on different nursing and midwifery specialties.

(xii). Mass awareness will be built on midwifery profession. Community engagement of midwives under direct supervision from the DNS will be introduced in this regard.

2.2.6. Strategic objective 6:

To improve health measurement and accountability mechanisms and build a robust evidence-base for decision making.

Based on the experience, situation assessments and comprehensive analyses of the HNP Sector Program's annual reviews in the past years, appropriate and strategic advocacy will need to be carried out so that the management and the implementers of the SWAp at different levels make better use of data and evidence in the HNP planning and decision making. The key principles of national HIS and e-Health would be building on existing resources, standardization, interoperability, harmonization, integration and efficiency in data collection, selection of software and hardware, engagement of human resources, and effective data sharing and use by all relevant stakeholders. The priority program areas of the 4th HPNSP to achieve this objective are described below.

2.2.6.1. Management Information System (MIS)

During the third SWAp-the HPNSDP - a number of activities to support capacity building, streamlining, and scaling up of M&E systems were implemented. These included carrying out a complete review of the studies and work done during the HPSP and the HNPSP along with lessons learned. The HPNSDP in adopting a results framework required generation of comprehensive, high quality and timely information on health outcomes, delivery of health services and the tracking of administrative inputs.

In the HPNSDP, the first phase of routine health information system (RHIS) was completed during which, technical support was provided to the DGHS and the DGFP MIS units to streamline and standardize paper-based tools. Digitization of some data collection tools was initiated for periodic reports generated at the health facility and community levels. A review of its experience suggested that full benefit would come from automating the business process. The second phase of the RHIS being piloted in two districts- Tangail and Habiganj, developed a comprehensive digital system for both the DGHS and the DGFP, which could be replicated nationwide to bring improvement in the way the health workers perform their work.

Utilizing the ***District Health Information System***, version 2 (DHIS2) platforms by both the DGHS and DGFP would ensure interoperability of the systems and facilitate data exchange and use. Heavy investments were made in hardware through Health Information System & e-Health (HIS & e-Health) and Management Information System of Family Planning (MIS) OPs respectively. Progress was also made towards strengthening National Civil Registration and Vital Statistics (CRVS) system. CRVS would be beneficial towards achieving UHC. The hospital automation program was on-going as planned. The launch of an electronic health records (EHRs) system was also underway.

The challenges remaining in the MIS services include the following:

Organizational Structure: Currently, the routine health information system in the MOHFW is bifurcated between the DGHS and the DGFP. Integration of existing MISs of both the Directorates with the RHIS and rolling out of RHIS throughout the country remains a challenge in terms of policy and resources.

Duplication of efforts: Several routine data collection systems operate in parallel. Health facilities are overburdened with different reporting forms and formats, sometimes for the same indicators,

stretching/overloading the system's capacity at all levels due to 'seasonal' collection of relevant data, e.g. APIR and other periodical reports.

Capacity Development: For routine data collection, MIS Units of the DGHS and the DGFP use their respective channels – for MIS/DGHS, statisticians at district- and upazila-level facilities compile aggregate data and send to central level. For MIS/DGFP, union level supervisors and office assistants at upazila-level compile population and facility level service statistics. Given the ongoing progress towards MIS automation and web-based data entry up to the community clinic-level in both the Directorates, there is need for training on the web-based platforms and software currently being used.

Weak culture of data utilization: The primary focus of MISs had been on collection and compilation of service statistics only, with no established mechanism to appraise performance and weak learning agenda based on evidence. The MPIR 2014 found that inadequate supervision system was reported as one of the major challenges faced by the LDs during the HPNSDP implementation.

Key activities to be pursued for improving the MIS of Bangladesh HNP sector as identified under the M&E Strategy and Action Plan approved in 2015 by the MOHFW include:

(i). Coordination and harmonization of MIS of the Directorates and programs will be improved by building towards functional linkages between the information systems (including non-governmental and private sectors).

(ii). The entire routine health information system in Bangladesh will be fully digitized by 2021 to build a robust evidence-base for decision making. This will eventually avoid duplication of efforts.

(iii). Timely availability of routine, surveillance, civil registration and vital statistics (CRVS) and survey data will be ensured.

(iv). Multi-year, comprehensive training and program implementation plans will be in place for capacity building of program managers and field staff for effective implementation;

(v). Multi-sectoral collaboration with the MOLGRDC and the implementing NGOs will be ensured for linkage with urban health information system.

2.2.6.2. Monitoring & Evaluation (M&E)

The 3rd Sector Program HPNSDP (2011-2016) emphasized on strengthening the overall health system and governance by establishing a sustainable M&E system as one of the key drivers. The RFW of HPNSDP having eight goal levels, sixteen service delivery level and sixteen systems strengthening level indicators was the main tool for monitoring and evaluating the progress of the HPNSDP. It was observed in APIR 2016 that progress in achieving the targets of RFW indicators could be considered satisfactory after five years' of Program implementation – out of 8 goal-level indicators and 32 intermediate outcome-level indicators, progress in 5 goal-level indicators and 19 outcome-level indicators were in line with the respective targets. The 3 goal level indicators which are off-track and need to be pursued vigorously in the next program are: neonatal mortality rate, maternal mortality ratio and total fertility rate.

There were OP level indicators for each of the OPs aligned with the RFW to monitor and evaluate OP wise implementation progress. Each year's APIR covered analyses of progress of the OP level indicators. Out of the 158 indicators used at the OP-level, 98 indicators (62%) were fully achieved, 40 indicators (25%) were partially achieved and twenty indicators (13%) were found "not achieved" against the targets set for mid-2016. The centrality of indicators for monitoring implementation was further emphasized through the Performance Based Financing (PBF) framework that provided Disbursements for Accelerated Achievement of Results (DAAR).

The MTR observed good progress in overall M&E and concluded that MOHFW's M&E capacities were greater than the previous SWAps. Considering USAID's TA support to MOHFW for monitoring and assessment performance of HPNSDP, it is expected that USAID would continue to assist in monitoring and assessing the performance of the 4th HPNSP including e-MIS and assistance to implement the national surveys and selected implementation research. GOB has also asked USAID to provide PMMU/TAST type TA with focus on M&E at both the Planning Units of DGHS and DGFP.

Given the renewed focus on tracking progress under the current global (e.g. SDG) as well as national (e.g. 7th FYP) commitments, and built on the on-going progress in M&E in the recent years, implementation of the MESAP of the MOHFW would be a priority activity in the 4th HPNSP to attain an effective and harmonized M&E system for the HNP sector of Bangladesh. The MESAP, with a focus on the on-going and future HNP Sector Programs, was developed to ensure that key MISs are able to operate complimentarily. It seeks to strengthen progress monitoring of the HNP sector and to promote evidence-based decision making at the policy level. For ensuring proper implementation of the MESAP, many activities need to be pursued over the next five years. Some of the key activities are as follows:

(i). Coordination and harmonization of the various MIS will be established for implementation of the MESAP.

(ii). PMMU will be institutionalized and deployment of adequate skilled personnel will be made.

(iii). M&E capacity of the PW including PMMU and the Planning Units of DGHS & DGFP will be strengthened through capacity training, logistics and TA.

(iv). Systems for regular training and updating of skills for data collection and reporting by various categories of health workers will be established. Multi-year, comprehensive training and program implementation plans will be in place for capacity building of PMs and field staff for effective implementation of the 4th HPNSP.

(v). Mechanisms of data sharing by all MISs and enhancing data use through provision of timely analysis and effective dissemination will be established.

(vi). The goal of fully digitizing the entire routine health information system by 2021 will be pursued as a target to help build a robust evidence-base for decision making;

(vii). Conducting monthly ADP Review meeting on the OPs' to monitor financial and physical progress and a system of Annual Program Review will be continued. The SmPR and APIR will be prepared and disseminated on time to feed into the APR.

(viii). Mechanism for monitoring progress of DLI-related activities and targets will be established.

(ix). Emphasis will be given on evaluation/research, particularly on BMRC for conducting health related research and on NIPORT for research in population and family planning. Evaluation/research gaps will be identified to ensure that evaluation/research studies are relevant to the needs. Utilization of research activities undertaken by different agencies and professional bodies will also be promoted. The Research/Evaluation Committee chaired by Additional Secretary, MOHFW will be re-energized and made more functional. An inventory of completed and ongoing evaluation and research studies will be developed.

(x). Efforts will be taken to generate coordinated data, avoid duplication of efforts and provide adequate funding for M&E activities etc. M&E offices will be provided with specifically skilled personnel (e.g. in IT, epidemiology, etc.).

(xi). A Data Quality Assurance (DQA) mechanism will be institutionalized.

(xii). Appropriate and strategic advocacy will be carried out for the sector managers and decision makers to prioritize information management and evidence-based decision making in the HNP sector.

2.2.6.3. Health and FP Research & Training

Health and family planning research is essential to improve design of HNP intervention and systems, service delivery and pro-poor policies. Health and FP research was, therefore, an integral part of the Strategic Investment Plan (SIP) of the HPNSDP and it was expected to 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 in the HNP sector. In the MOHFW structure, the Health Economics Unit (HEU) of MOHFW, Director (Planning and Research) under the DGHS, Director (Planning) under the DGFP and the National Institute of Population Training and Research (NIPORT) assume primary responsibilities for health and FP research.

Outside the Ministry, the BMRC is the leading point of health and FP research in the country. Established in 1972, this is an autonomous body having representation from post-graduate medical institutes, medical colleges, universities, learned societies, medical institutions, health related organizations, various divisions and departments of ministries dealing with medical education, services and research. The main activities of the Council include: organization and promotion of scientific research in various fields of Health Science, training of manpower in the field of health research and dissemination of research results for proper utilization. The Institute of Child & Mother Health (ICMH) is a national institution in Bangladesh committed to being a centre of excellence in the South-East Asia. The Institute is working for the improvement of health and nutrition of children and mothers in the country through its three objectives: human resource development, conducting research, and patient-care. The Institute of Epidemiology, Disease Control and Research (IEDCR) conduct studies in collaboration with national and international public health institutions and universities. It has also a good number of PhD researchers. He IEDCR conducted fifteen researches and studies in 2014-15. The National Institute of Preventive and Social Medicine (NIPSOM), attached to the University of Dhaka, was established in 1978 with the aim of producing postgraduates in public health, capable of satisfying the needs of the community in promoting and restoring health The Institute is also supporting various health policy formulations of the Government and community health programs through research, training, and services.

Challenges in the health and FP research are as follows:

Limited Resource Allocation*:* Resource allocation for research in HNP sector is limited in comparison to the actual requirement. Cumulative allocation of budget for the four important OPs responsible for health and FP research was only 1.34% of the total allocation of the HPNSDP during 2011-14. Bulk of the allocation in the respective OPs is spent for non-research related activities. For example – only 19% of the fund allocated for the PMR OP was actually allocated for research. The BMRC provides 50 to 60 block grants every year, however, the size of the grants is not large and may not be adequate in many cases.

Inadequate Capacity of the Research Entities*:* The entities responsible for health and FP research need to strengthen. The NIPORT outsources all the major researches if financed by the TRD OP. Each of the PMR and PME structures has provisions for one Program Manager (Research) and one Deputy Program Manager (Research), which were, filled with Government officials on deputation. Although there were trainings on research methodology, partly because of rapid changes of personnel in these institutions, the trainings could not develop institutional capacities for these entities.

Lack of Coordination in Research Initiatives*:* Though there are quite a few entities conducting health and FP research, but there is absence of mechanism for overall coordination among these units. This results in duplication and inappropriate prioritization of research subjects. Dissemination of research findings are not necessarily done, which obstructs the full benefits of their potential utilization. The MOHFW took cognizance of the problem of co-ordination and need for dissemination of research findings and set up a Research Monitoring Committee (RMC) in September, 2014, under the Chairmanship of Additional Secretary of the MOHFW to address these issues. The Committee is to meet at least twice a year.

Limited use of Evidence in Decision Making*:* There have been significant numbers of research and studies in HPN sector. Lack of capacity of the researchers and the management in linking research findings to relevance for policy and/or management can be attributed as one of the reasons behind this. During the HPNSDP, however, policy briefs had been prepared and disseminated following major national surveys like the Maternal Mortality Survey, the BDHS and the Urban Health Survey. Moreover, steps were taken to produce list of all reports of consultancies financed under JDTAF with brief summaries and their findings.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above and for improving health and FP research and training in Bangladesh:

(i). Research and survey on important HNP issues (e.g. BDHS, Health Facility Survey, PER, BNHA, etc.) will be continued.

(ii). Capacity of the BMRC as focal point to organize, promote and coordinate health research will be assessed and subsequent actions will be taken based on the recommendations, which might involve extensive capacity building and/or restructuring of the BMRC.

(iii). Steps will be taken to strengthen skills of research personnel regarding research methodology as well as focusing on prioritizing research needs, linking research with management/policy decisions and techniques for wider dissemination of research findings.

(iv). There will be sensitization for policy makers regarding the importance of research based decision making (i.e. utilizing research findings to make important policy decisions).

(v). There will be execution of researches on demographic and behavioral aspects of family planning, reproductive health, and other important aspect of FP and population.

(vi). Medical biotechnology related researches will be conducted which will be in line with National Biotechnology Policy and National Guidelines on Medical Biotechnology.

(vii). Operational research on potential efficiency gains within the system will be undertaken on issues like rationalization of HRH, including reducing absenteeism and introducing task shifting; use of IT solutions; more multi-sectoral collaboration and PPP options; reduction in duplication and variable methodologies.

(viii). There will be researches related to: demographic and epidemiological transition and their implications for public health; environmental and ecological impact on public health, and emerging and reemerging diseases, etc.

Component 3: Provision of Quality Health Services

2.2.7. Strategic Objective 7:

To Improve Equitable Access to and Utilization of Quality Health, Nutrition and Family Planning Services

This strategic objective includes the main service delivery component of the 4th HPNSP. It captures primary, secondary and tertiary services including preventive and curative services. It is the major cost driver of the sector where the majority of human resources and supplies are focused. A major focus would be on achieving improved service integration while ensuring individual services are of a high quality and accessible to all. There is a clear emphasis on the need to scale up and strengthen community-based public health interventions towards achieving the goal of equity and to enhance the quality of health services. Innovative approaches to improving efficiency are essential as is ensuring motivated staff present at their designated posts to deliver quality care to all of the population. Collaboration between the public and private sector will be a key element of ensuring access to specialist services as well as functional care in hard to reach areas and for vulnerable groups. The priority program areas of the 4th HPNSP to achieve this objective are described below:

2.2.7.1. Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH)

During the era of MDGs, Bangladesh achieved remarkable reduction in maternal and under-five mortality. This has set the stage from where Bangladesh can now ambitiously look forward to attaining the Sustainable Development Goals (SDG) through ensuring universal health coverage (UHC). Expanding and strengthening the country's comprehensive RMNCAH services, is therefore maintained as a priority in the 4th HPNSP to incrementally reduce morbidity and mortality and to ensure the well-being of the population. The strategic focus is to consolidate and sustain the achievements gained so far, through strengthening health systems and ensuring continuous improvement in service quality. An important proposition underlying this HNP Sector Program is that MOHFW has strategic stewardship and management roles that extend beyond the services it finances or provides directly. It calls for strengthening public care services in order to increase utilization by the poor and those living in geographically challenged areas, while exercising the stewardship role to ensure the quality and equity of services in the private and NGO sectors.

The 4th HPNSP proposes the following strategies to overcome some of the remaining cross-cutting challenges for improving RMNCAH outcomes:

- ***Improve service delivery at primary and secondary levels****:* Upgrade and strengthen existing facilities at union and upazila levels in phases to provide round-the-clock delivery care, essential care for all newborns, family planning, and adolescent health and nutrition services. Strategically located facilities will be strengthened for BEmONC and CEMONC services, to be determined using the existing comprehensive GIS map. Strengthen the referral linkages between different levels of care, including provision of emergency transport facilities in the public as well as in the private sector.
- ***Focus on quality of care****:* There is a steady improvement in the coverage of key interventions in public and private sector. There an urgent need to strengthen the quality of care to ensure impact. Expedite the implementation of the National Quality Improvement Strategic Framework through all health service delivery systems of MOHFW. Develop and implement an action plan for implementation of national standards for RMNCAH service component by level of service delivery point. Establish QI system at different levels with functioning accountability framework and system support for improving quality of RMNCAH services. Emphasize on quality, respectful care that promotes dignity and empathy. Strengthen the functionality of national/ divisional/ district and sub-district level QI committees and implementation structures. Strengthen the supervision, monitoring and measurement of quality of care, including through periodic independent assessments.

- ***Improve coordination among implementing agencies****:* Functional integration between DGHS and DGFP will be strengthened at all levels of service provision and management. Develop and implement an urban RMNCAH package with proper engagement of MOLGRDC, NGOs and private sector in a coordinated way.
- ***Harmonize and strengthen information systems for RMNCAH****:* Strengthen the information systems to support the service delivery process, improve tracking and follow up and improve efficiency in program management for all RMNCAH interventions. Harmonize the MIS using electronic systems and strengthen Community Clinic as the hub for RMNCH data compilation and data transfer.
- ***Address workforce gaps****:* Analyze the workload of staff at various levels and redefine the staffing norms for different levels of service provision. Improve planning and coordination at all levels to ensure better working conditions and motivation of the health workforce at all levels of care.
- ***Mobilize local level ownership and resources****:* Promote local level flexibility for resource mobilization and use at district and upazila levels. Earmarked Union *Parishad* funds for health will be tapped for supporting health service delivery. Strengthen community engagement in management of health service delivery by strengthening management committees and local Government representation.
- ***Implement comprehensive SBCC strategy****:* The national SBCC strategy has been endorsed, which will be implemented using innovative, efficient and multiple channels of communication to reach target population. Develop and implement a comprehensive framework for community engagement embarking on CG and CSG model and learning from in-country *experiences*.

A). Maternal Health and Newborn Health

Despite the tremendous efforts in reduction of maternal deaths, the country still loses 14 mothers a day due to complication of pregnancy delivery and post-partum period and largely due to delivery by unskilled birth attendants at home and lack of appropriate care for obstetric complications from a skilled provider at facilities. Experiences show that if women-friendly services can be made available nearer to the communities, the utilization of services is high. Significant inequities exist across geographical regions and between different wealth quintiles. MMR is the highest in Sylhet division (425 per 100,000 live births) and the lowest at 64 per 100,000 live births in Khulna division (BMMS 2010). The increase in facility delivery is mostly in the private sector. Notably, 23% of all deliveries are conducted through caesarean section. About four fifths of the deliveries in the private sector are by CS which is very expensive for the poorest and quality of care in these facilities is yet to be monitored. The burden of maternal morbidities continues to be high as pregnancy and delivery complications bring an unacceptable burden on women in Bangladesh. Obstetric Fistula (OF) affects 71,000 women. Dyspareunia and chronic pelvic infections cause disability, marital disharmony and loss of working ability. Uterovaginal prolapse is another common complication which needs to be addressed by proper management of labor and postpartum period, and better family planning.

Achieving the SDG target of NMR 12/1,000 live birth by 2030 would require accelerating the annual rate of reduction from its current level of 3.4% to over 4.6%. More than 80% of the neonatal deaths occur within 7 days, 50% within first 24 hours of life and most of these deaths are at home without the care by an SBA and are often unregistered. More than 80% of all newborn deaths stem from three largely preventable and treatable conditions – complications due to prematurity, intrapartum-related deaths (including birth asphyxia) and neonatal infections. Estimated 438,800 babies are born preterm, of which 23,600 die due to complications, making it the leading cause of under-five mortality in the country. Estimated number of still births is similar to the number of early neonatal deaths. With an

estimated 83,000 stillbirths annually, Bangladesh is ranked seventh among countries with the highest number of stillbirths.

The absence of round-the-clock services in district and sub-district level facilities continues to be a concern. Both availability and accessibility to Basic and Comprehensive Emergency Obstetric Care (EmOC) is very low in the country and hence clients seek higher level of care for even normal deliveries. Health facilities at upazila level and below are not ready to meet the increasing demand for quality MNH services. A large number of union level facilities exist (4,461), but a significant proportion of them (41%) are not ready or are not providing normal delivery care services. The union level facilities offer an actionable opportunity to strengthen the provision of life-saving care to mothers and newborns during and at the time of birth.

In order for Bangladesh to achieve the SDG 3.1, the maternal mortality ratio has to be reduced from the level of 170 (per 100,000 live births) to 59 by 2030. Increasing access to SBA is one of the highest priority interventions that can contribute towards significant reduction of maternal mortality and morbidity. Concerted efforts will be made by the public sector, in the rural and under-served areas, to ensure increased access to facility delivery by the poor and marginalized groups. Care during labor, around birth and the first week of life; and care for the small and sick newborn- have the greatest impact on ending preventable neonatal deaths and stillbirths. Thus universal coverage of high quality interventions before, during and after delivery could bring us triple return in saving most newborn lives (74,000/year) as well as prevent maternal deaths (5,500/year) and stillbirths (83,000/year). As stated in the SIP, 'The Bangladesh Every Newborn Action Plan (BENAP), 2016-2020, identifies a set of priority newborn interventions for scaling up in next five years with achievable results and accountability framework.

The priority areas of strengthening MNH during the 4th HPNSP include:

(i). ***Strengthen the union level facilities for MNH care***: The large network of union level facilities, (including UH&FWCs, USCs and RDs) will be strengthened to provide normal delivery care and essential newborn care on round-the-clock basis24/7 normal delivery services will be made available at all upazila and union level, in a phased manner. A well-coordinated effort is required between the various agencies of MOHFW to ensure readiness of these facilities, including infrastructure, staffing, equipment, supplies and local level ownership and management mechanisms. Special emphasis will be given on improving the readiness of labor rooms at all levels with necessary amenities and privacy. Continue the training, deployment and support for diploma midwives to strengthen midwifery services at upazila and union levels. Increase the ratio of nurses and midwives with skills in safe delivery and newborn care at all levels, including the deployment of midwives to union level facilities that are equipped to conduct normal deliveries. An assessment will be conducted to determine the additional training required to upgrade existing eligible FWVs as midwives and eligible FWVs will be trained as midwives. A subset of union level facilities will be focused for the provision of BEmOC services, depending on the availability of trained midwives and other preparedness parameters.

(ii). ***Strengthen basic and comprehensive emergency obstetric services*****:** All district and upazila level facilities will be strengthened top provide EmONC on a 24/7 basis. Strategically located facilities at upazila levels and all district level facilities to provide CEmONC services. Rationalization of the number of CEmONC at UHC through appropriate mapping exercise based on the principle of availability of EmONC services within 2 hours travel time from any location – would be a priority consideration. Establish contracting model for engaging

anesthetists from private sector for CEmONC facilities. A detailed assessment is proposed to determine the readiness of primary and secondary level facilities to provide BEmONC and CEmONC services as relevant to the level. In order to address the chronic shortage of specialists, establish a contracting model for engaging anesthetists from private sector for CEmONC facilities. NGO, private and informal providers, especially retired Government officials will be engaged in hard to reach areas.

(i) ***Address the indirect causes of maternal death:*** including communicable diseases, other sexually transmitted infections, malnutrition (both under-nutrition and obesity), and chronic diseases (e.g., high blood pressure, diabetes, cardiac disease).

(iii). ***Prevention and management of maternal morbidities:*** Capacity for managing OF will be developed. Rehabilitation program in different sectors of Government/private sector will be mainstreamed through public-private partnerships. Prevention of complications such as fistula and uterovaginal prolapse will be fully integrated into management of normal labor and delivery. New treatment and rehabilitation centres for obstetric fistula will be established. Technology and operational research to be promoted on maternal and reproductive related morbidities. Scale up of Women Friendly Hospital Initiative (WFHI) to ensure medical service, psychosocial counseling and linkage with legal support for the women victim of violence

(iv). ***Effective scale up of evidence-based newborn interventions****:* Institutionalize the implementation of priority newborn interventions with high quality, like essential newborn care including early initiation and exclusive breastfeeding; 7.1% chlorhexidine and resuscitation using HBB, KMC, antenatal corticosteroids and management newborn sepsis from primary care level.

(v). ***Improved delivery of facility-based newborn care:*** In line with the vision of increasing facility delivery in the SIP, quality facility based newborn care through scale-up of SCANU in all 64 districts and Newborn Stabilization Units (NSU) in all UHCs for management of sick newborn. So far only 40 districts are covered with SCANU, thus additional resources are required to cover rest 24 districts. Coverage of sick newborn care need to be rapidly scaled up in all 480 UHCs with provision of Newborn Stabilization Unit (NSU) in order to immediately stabilize the sick newborn with provision of referral of severe cases to district level hospitals. Quality newborn care as per the national guidelines should be integrated in the private sector facilities under an effective regulatory framework with provision of newborn referral transport at district and Upazila level through PPP mechanism.

(vi). ***Prevention of stillbirths:*** There are large numbers of still births, 230 every day in Bangladesh, which still remains unrecognized and not properly addressed in the current health sector program. Thus evidence based interventions for prevention and management of still births will be prioritized through quality improvement of care during the time of delivery including quality pregnancy care.

(vii). ***Special service packages****:* for low- performing and underserved areas will be implemented in partnership with NGOs and private sector for difficult to reach and urban areas.

(viii). ***Develop and implement quality improvement plan for MNH:*** QI initiatives will be institutionalized through development of a national strategy and operational plan, concerted action by the implementing agencies; strengthen and support QI structures at national, divisional, district, upazila and union level facilities. Disseminate the MNH standard operating procedures (SOP) in tandem with the national QI Strategic Framework. Standardize

the services at each level, applying the national SOPs for MNH and internationally recognized standards. MOHFW will create an enabling environment for gradual accreditation of all facilities through establishment of accreditation body. Monitor and measure quality of care on a routine basis; and recognize improvement in quality and performance standards. Enforce stronger regulatory mechanism for the private sector through revising the Private Clinics and Hospitals Act with proper procedures for renewal of licensing. MOHFW will engage with the professional bodies to minimize irrational use of C-Section deliveries.

(ix). ***Address behavioral, social, and cultural barriers for MNH:*** Greater citizen participation to address disempowerment, "voiceless-ness" and social exclusion of women and the poor. Revitalize facility SMS based complain system, Health Service User Forum. Design and implement effective and innovative communication strategies, including the engagement of NGOs/private sector in communication services.

B). Child health

Despite the reduction in mortality over time, continued disparities are observed between the richest and the poorest quintiles, urban and rural areas and between divisions (e.g. Khulna, Sylhet).Mothers' education was found to be associated with U5MR, with the highest mortality rate (82/1,000) noted among mothers with no education compared to 39 among mothers with secondary education or higher. As for under-five deaths, pneumonia, neonatal causes and drowning are major causes. Diarrheal deaths among under-five has decreased substantially over the last few years (2%), however pneumonia remains the single most important cause (21%) of under-five mortality followed by neonatal causes. Although deaths due to preventable communicable diseases continued to decrease over times, the share of deaths due to drowning has resulted in a sharp rise from 26%t in 2007 to 42% in 2011 among the age group of 1-4 years. Currently, a clear multi-sectoral strategy to address child drowning is absent. The current child health interventions mainly focus on mortality, with limited emphasis on child development. Sustaining the already achieved high coverage for EPI and reaching the unreached to further increase the coverage remain a challenge.

During the 4th HPNSP, prioritized child health interventions based on the evidences from morbidity and mortality data, with special attention to addressing regional disparities will be as follows:

(i). ***Develop a comprehensive costed Child Health Strategy****:* and implementation plan and to guide the country towards 2030. The strategy will focus on a shift towards more comprehensive and inclusive programming with focus on survival, growth and development, including ECCD, disability, drowning and other child health issues. Child development, disability prevention and management interventions in the existing child health program will need to be integrated. Strategic shift towards more comprehensive and inclusive child health programming with focus on survival, growth and development with special strategies to reach the unreached.

(ii). ***Strengthen IMCI both at community and facility levels****:* with priority focus on pneumonia and diarrhea prevention and case management, including the functioning of nutrition corners. Universal coverage of pneumonia case management in IMCI program to address leading cause of child deaths. Strengthen provision of care both in public/private sector including effective referral system; enforce regulatory mechanism including pharmacies.

(iii). ***Financial sustainability of EPI program:*** Gradually move towards financial sustainability of the EPI program with gradual transition to revenue budget for vaccine procurement. Introduction of rotavirus vaccine and improve the coverage with equity of all life-saving vaccines

(iv). ***Improve quality of child health care:*** Implement the national QI strategic framework, with focus on development and adherence to standards for in-patient hospital care for sick children and outpatient care.

(v). ***Develop and implement a multi-sectoral plan for child drowning prevention:*** with the involvement of Ministry of Education, MOWCA, MOLGRDC and other relevant ministries, and focusing on building community awareness as well as capacity

C). Adolescent Health

The Program endorses the 'Adolescence Reproductive Health Strategy 2006' and related 'National Plan of Action 2011-2017' and recognizes that insufficient progress has been made on prevention of child marriage, early pregnancy, unsafe abortion, violence and promotion of healthy reproductive behaviors among adolescents. Combined action by all sectors is needed to ensure that legal, educational social and cultural issues are addressed. ICT and social networks will be used to disseminate information and promote healthy behaviors. Besides being a serious reproductive health issue, child marriage is a children's and women's rights issue, since it has deep social implications on female education and overall status. Priority actions to be carried out during the 4th HPNSP for addressing adolescent health include:

(i). *Develop and implement a comprehensive costed Adolescent Health Strategy and Action Plan:* taking lesson from Adolescent Reproductive Health Strategy 2006. Integrate and mainstream AH into existing MNCH platform. Adolescent-focused strategies including information about AFHS, nutrition, family planning, care-seeking will be updated along with promotion of ASRH and Rights.

(ii). Increase access to adolescent health services by establishing linkages with schools through school health program, adolescent clubs, etc. Develop new guidelines and protocols for ASRH, including syndromic management, based on lessons learned from current guidelines, and build capacity for improved management of PAC at DGHS, DGFP and private facilities

(iii). Start and scale up Human Papilloma Virus (HPV) vaccine for the adolescent girls to prevent cervical cancer. Integrate selected adolescent health interventions with HPV.

(iv). Scale up multi-level and multi-channel SBCC interventions, with focus on adolescent sexual and reproductive health and rights

(v). Implement an action plan for health sector response to gender based violence including prevention of child marriage will be strengthened.

2.2.7.2. Nutrition and Food Safety

Bangladesh is now experiencing a high burden of under nutrition, to which a rapidly increasing burden of NCDs driven by overweight and obesity (known as nutrition-related NCDs) is being added. It is recognized that NCDs are preventable and a stronger focus on nutrition will reduce the burden of NCD specifically related to heart disease, hypertension and diabetes. Despite a significant reduction in under nutrition over the last 20 years, driven partly by sustained income growth and partly by greater coverage of health and education services, under nutrition levels still remain very high. Further progress would require significant change in the level and scope of current investment for nutrition, as well as the quality of nutrition governance and service delivery. Persisting high levels of under nutrition, combined with rising levels of nutrition-related NCDs, will add to economic cost, dampening potential growth and draining national resources. Concerted prioritized action on nutrition under the 4th HPNSP will continue to ensuring that Bangladesh reaches middle-income country status quickly.

Poor nutritional status is one of the most important health and welfare problems in Bangladesh. Young children and women of reproductive age are especially vulnerable to nutritional deficits and micronutrient deficiencies. The 1,000 days between pregnancy and a child's second birthday are the most critical time for positive impact on a child's cognitive and physical development. The health and well-being of a pregnant and lactating woman is directly connected to the growth and health of her infant. The right nutrition for the mother and for the child during this time can have a profound impact on the child's growth, development and reduce disease risk, and also protect the mother's health. Child under nutrition results from sub-optimal breastfeeding and complementary feeding or Infant and Young Child Feeding (IYCF), poor dietary diversity, and other aspects of food, health and care practices. Maternal under nutrition results from poor dietary diversity and gender and culture related care and practices. Focusing nutrition efforts on evidence-informed interventions targeting this critical window can have lasting implications across the lifecycle. The combination of good health and reduced disease risk for both mothers and their children can also have a powerful, lasting effect on a country's prosperity. At the individual level, inadequate or inappropriate feeding patterns lead to malnutrition. Numerous socioeconomic and cultural factors influence patterns of feeding and nutritional status.

Achievements in child nutrition have been mixed in Bangladesh. Some outcome indicators are declining, with underweight decreasing from 36% in 2011 to 33% in 2014 and wasting decreasing from 16% in 2011 to 14% in 2014, but the priority indicator stunting (low height for age) still remains near the WHO emergency level at 36% according to BDHS 2014. Exclusive breastfeeding (no liquids or foods other than breast milk to be fed up to six months of age) rates remained static for the last two decades with a drop in 2014 to 55% from 64% in 2011. Complementary feeding practices beginning at six months of age are far from satisfactory leading to high level of under nutrition in early childhood and continue to remain challenging at 23% in 2014. Food diversity, as reflected in calories derived from cereals in adults, is poor, although the total energy intake has shown an upswing.

Some social risk factors of nutrition are discomforting (such as age at marriage, age at first birth, school dropout rate among girl students). The anaemia and night blindness rates have decreased, but "hidden hunger" due to the deficiency of micronutrients is still common. People do not possess enough knowledge about nutrition and the best sources of micronutrients. While under nutrition shows some decline, overweight school-aged children and women are becoming more prevalent. Nutrition-related NCDs are becoming more common. These diseases are associated with maternal under nutrition and nutritional deficiency in infants during the intrauterine period and LBW. Overall 13% of ever-married women fall below the cut-off of 145 centimeters in height. Given the relationship between maternal stature and pelvic size, women's height can be useful in predicting the risk of difficulties in delivery. The risk of giving birth to low-weight babies is also higher among women of small stature and poor nutritional status. The body mass index (BMI) is used to measure thinness and obesity. About 1 in 4 ever-married women age 15-49 years are undernourished or thin BMI and 17% are overweight or obese. High level micronutrient deficiency exists in Bangladeshi population (MOHFW 2014). Four in 10 women age 15-49 years are anemic (NIPORT 2013).

Contamination and adulteration of food have been long standing challenges in the country. Unsafe food poses a serious public health risk leading to increased prevalence of food borne diseases. Consumption of contaminated food causes damage to the intestinal flora leading to mal-absorption and hamper nutritional gain of the consumers. Contamination along the food chain is mostly due to not following the good practices from production level to consumption. Food hygiene and sanitation standards remain poor and widespread diarrhea remains a public health concern. Establishment a state-of-the-art National Food Safety Laboratory (NFSL); a modern risk-based food inspection

system, food-borne illness surveillance system, IEC activities and an institutionalized consumer awareness system with establishment of BFSN are some of the achievements that were gained on improving food safety during the third Sector Program. The efforts, however, need to be continued and strengthened.

Key interventions defined as direction nutrition interventions (DNIs) were prioritized for implementation under HPNSDP. There were clear, significant milestones achieved under this Sector Program including revised job descriptions with clear, roles and responsibilities for all health care workers at every level of the health system. The adoption of the National Nutrition Policy and preliminary development the National Plan of Action further highlights the importance of nutrition as a key strategy for improving overall health and development of particularly adolescent, pregnant and lactating women and children under the age of five. However, challenges listed below limited implementation of nutrition services through an integrated approach including:

- a mismatch between the scale and scope of activities under NNS and the capacity of the institutions mandated to oversee the mainstreaming of nutrition services in the health sector;
- insufficient attention to maternal nutrition and the nutrition of adolescent girls, and data and programs on low birth weight;
- insufficient coverage and quality of programs for the promotion, protection and support of breastfeeding and complementary feeding'
- limited dietary diversity, particularly amongst the poorest wealth quintiles, due to the unavailability and/or unaffordability of nutritious food, and/or lack of awareness;
- challenges in the detection and management of acute malnutrition at all levels;
- insufficient attention to the nutrition situation and interventions in urban areas, particularly slums;
- insufficient attention to water, sanitation and hygiene and their relationships with nutrition;
- insufficient attention to, and resourcing of, community-based nutrition activities involving citizens; and
- the growing challenge of obesity and nutrition related NCDs.

Moving into the 4th HPNSP, mainstreaming of nutrition will be strengthened through delivery of the MOFHW's clearly defined essential services package which will provide nutrition services through RMNACH platforms. Improved functional co-ordination of nutrition through RMNACH services is critical to promoting healthy pregnancy and safe deliveries for women. The first one thousand days of a child's life (during a woman's pregnancy through a child's second birthday) is globally agreed as the window of opportunity to most significantly prevent and reduce stunting and affect positive overall survival and development outcomes for a child and will only be successful if nutrition services are functionally co-ordinated.

The vital entry point for nutrition will be the community clinic serving as the hub of preventive and promotive health, extending services to the domiciliary/household level. An effective behavior change communication strategy and materials specific to nutrition and integrated through RMNACH messaging will be critical to increase awareness on the importance of nutrition to promote maternal survival as well as child survival and development and increase demand for nutrition services. Partnership with NGOs and the private sector specifically pharmacies working in the areas will be critical to expand the reach of the community clinic in rural areas. These partnerships are even more critical in urban areas to address urban nutrition with targeted emphasis on slum areas.

Key actions that will be prioritized in the 4th HPNSP will be implementation of functionally co-ordinated RMNACH, family planning and nutrition services. Priority will be placed on key services such as:

(i). Growth monitoring and promotion, infant and young child feeding counseling (which includes early initiation and exclusive breastfeeding counseling);

(ii). Identification and management of children who are severely and acutely malnourished;

(iii). Broader behavior change communication interventions and Vitamin A supplementation for children under 5 through EPI and IMCI platforms at healthy facilities and through outreach/satellite sessions at community/household level for children under 2.

For adolescent and pregnant women, activities will include:

(i). Iron folic acid distribution and nutrition counseling delivered through ANC and post natal care (PNC) visits as well as through routine community outreach sessions by existing public health care workers specifically health assistants, family welfare assistants and optimizing the use of community clinic support group members;

(ii). Development of clear standard operating procedures linked to quality of care and supportive supervision including review of data for quality will serve as model for implementation of integrated programming under the ESP.

Steps will also be taken to ensure that-

(i). all health care workers are aware of their roles and responsibilities for delivery of the essential services package, but specifically for nutrition which is a relatively new area of responsibility for health care workers;

(ii). Training of all health care workers on nutrition will link to a comprehensive training plan linked to the ESP;

(iii). Clearer nutrition leadership within the MOHFW will be prioritized for stronger mainstreaming and functional co-ordination through RMNCAH platforms.

The MOHFW as the Secretariat for the Bangladesh National Nutrition Council (BNNC) serves in a leadership role for multi-sectoral coordination as defined by the National Plan of Action for Nutrition (NPAN). Moving forward in the 4th HPNSP the NPAN will help to guide the implementation of multi-sectoral nutrition programming across the Government with the MOHFW leading the coordination efforts.

Nutrition sensitive activities will be continued and expanded through multi-sectoral collaboration, including food safety program, promotion of good hygiene, including WASH interventions, school nutrition program, food fortification, etc. An effective monitoring and evaluation (M&E) system will be established in link with the existing systems to monitor coverage, progress, program performance and also for evidence based planning/decision making. Nutrition surveillance system will be strengthened and institutionalized. Survey/ surveillance will be conducted on relevant and important nutrition issues to assess/ monitor progress of key nutritional outcomes.

NNS OP will continue supporting the state-of-the art National Food Safety Laboratory (NFSL) established at Institute of Public Health (IPH) with required resources. Risk-based inspection planning and implementation across the country will be strengthened along with food borne Illness Surveillance. Awareness raising program for food safety will be prioritized.

2.2.7.3. Population and Family Planning Services:

Bangladesh, with a population of approximately 160 million is one of the most densely populated countries in the world. The male/female ratio is 104.9/100.0 and the annual growth rate is 1.37% (SVRS, 2011). According to UN prediction Bangladesh will face one of the most rapid demographic transitions as country's population will peak at 203.7 million in 2059 *(Population Division of DESA,UN Secretariat: World Population Prospects-The 2012 Revision)*. The reduction in the total fertility rate (TFR) from 6.3 births per woman in 1975 to 3.4 in 1994 and to 2.3 in 2011 is very encouraging, although this is stagnant at 2.3 births per woman since 2011 (BDHS, 2014). However, regional variation also exists: The TFR in rural areas is higher (2.4) than in urban areas (2.0). Sylhet and Chittagong Divisions lag behind with the highest TFRs of 2.9 and 2.5, respectively. With one third of the country's population, Dhaka division has a TFR of 2.3.

Early childbearing extends the reproductive period and subsequently increases fertility. This is also a social and health concern. As per BDHS, 2014, there are approximately three million married adolescents in Bangladesh and around 31% of girls of age group 15 to 19 are childbearing. The adolescent (15-19) fertility rate in Bangladesh is 113 per 1000 women (BDHS 2014) and has not decreased significantly for decades. Use of modern contraceptives among married teenage girls (15-19) is low at 47% and with 42% of them spacing their second birth less than the recommended time period of three years after the first birth. The overall contribution of adolescent fertility to TFR is 25% which means approximately 750,000 adolescents are giving birth annually.

Due to rapid urbanization, providing FP services to urban population was a priority in HPNSDP. FP services were included in the Clinical Contraceptive Service Delivery Program (CCSDP), Family Planning Field Service Delivery Program (FPFSDP) and Essential Service Delivery (ESD) Operational Plans (OPs) targeting urban population – specifically urban slums. Some of these services include i) registration of couples and counseling ; ii) domiciliary visits and contraception distribution ; iii) establishing referral linkages with FP service centres ; iv) arranging FP package programs and v) orientations/ training. Health Care Services Delivery Project (UPHCSDP: 2012-2017) is being implemented by Local Government Division (GD) through 25 local NGOs. The NGO Health Service Delivery Project (NHSDP), also known as "*Surjer Hashi*", funded by USAID and DFID is also providing FP services in different areas, including urban areas. FP is one of the priority areas of this project. Besides this UPHCSD project, there are number of NGOs providing FP services in cities throughout the country. Point to be noted that the FP logistics (condoms, injectables, pills, etc.) are provided by MOHFW to these NGOs for effective service delivery.

The Challenges of the population and family planning services are as follows:

Readiness of FP Service Facilities: The Bangladesh Health Facility Survey (BHFS, 2014) revealed that overall, only 25% of the public facilities that offer FP services are ready to provide quality FP services. At the District and Upazila level, half of facilities are fully 'ready' to provide such services, and at Union level, only one in three. Half of the NGO facilities were found to be ready but situation of the private sector is extremely weak as only 5% facilities are ready to offer quality FP services. A recent study by icddr,b (2015) titled "Contribution of MOHFW for Urban Health Services" (2015) revealed that very limited LARC/PM services are available in District Hospitals and Medical Colleges.

Shortage of Human Resources: Shortage of human resources is still a concern in FP sector. Around 14% of the total DGFP sanctioned positions are vacant. Majority of these vacancies are in the positions of medical officers and FWVs, which are vital for services like clinical contraception. The

vacancy situation is high in facilities located in hard-to-reach areas, including coastal belt, chars, hill tracts, etc.

Use of Contraception Methods: Although CPR is high in the country, the reliance is more on short term methods like condoms and pills. Utilization of long acting and permanent methods continue to be low. Limited awareness of the users is one of the possible reasons, and at the same time, availability of these methods is relatively low. Recipients have apprehension regarding these methods – e.g. potential side effects. Also, the decision of contraceptive usage is often not an informed decision. Male participation in contraception usage is relatively low.

Fragmented MIS: Bifurcated MIS for DGFP and DGHS coupled with lack of control on information of private facilities is a major impediment to organize FP services nationwide.

Menstrual Regulation (MR) and Post-abortion Care (PAC) Services: Information on MR and PAC is not readily available in health facilities, especially regarding post-MR care. There is a need for counseling the recipients of MR services.

During the 4th HPNSP, the following key activities will be pursued for overcoming the challenges described above and for improving population and family planning services in Bangladesh:

(i). *Strengthen FP service delivery* including long Acting Reversible Contraception (LARC) and permanent methods (PM) and other contraception methods will be made available through strengthening service delivery through: strengthening satellite clinics, UH&FWCs, UHCs and MCWCs through provision of necessary equipment, drugs, MSR and other supplies; technical training on LARC& PM and PPFP for doctor and paramedics; motivation, Counseling, referral, client segmentation for volunteers, FWAs, Has, FPIs, SACMOs; reinvigorating domiciliary visit especially to hard-to-reach, far-flung, low-performing areas slums of urban areas by well-informed field staff i.e. FWAs and Paid volunteer/community volunteer; recruiting volunteers in the hard-to-reach areas and deploying roving team; Strengthen clinical supervision through expansion of Quality Improvement Team (QIT); Follow up service recipients for any complications and side-effects; and Strengthen counseling and management of Reproductive Health issues (STI/RTIs, HIV/AIDS) in relation to LARC & PM. There will be greater emphasis with DGHS for accountability in the provision of FP services in its facilities in close collaboration with DGFP.

(ii). *Implement the National PPFP Action Plan*, including post-partum, post-MR and PAC. FP information and services for post-partum and post-MR/PAC will be strengthened through capacity enhancement of the field staff, ensuring counseling for the recipients and providing relevant medicine and logistics.

(iii). *Intensify demand generation for FP services:* through continued efforts on registering and orienting newly-wed couples on contraception methods. Implement systematic information dissemination and service provision for female garments workers on FP issues. Mobilize advocacy meetings and orientation programs with the garment owners, buyers including general managers, production managers and supervisors on FP services, personal hygiene and reproductive right based working environment. A wide network of stakeholders such as local Government representatives, journalists, religious leaders, marriage registers, cultural activists, women groups and civil society representatives will be engaged for awareness creation.

(iv). *Improve the quality of FP counseling and service delivery:* Framework for Quality Improvement (QI) will be followed in service delivery at all levels. Training on motivation, FP Counseling (during premarital, marital, ANC and post-partum periods), referral, Client

segmentation for volunteers, CHCPs, HAs, FWAs, FPIs, FWVs, SACMOs and midwives will be prioritized. FP services will be integrated in the MNCH platform, with added focus on family planning counseling and services for first time young mothers.

(v). *Regional service package for FP:* will be implemented in hard-to-reach locations and low-performing areas.

2.2.7.4. Non-Communicable Disease Control (NCDC)

Bangladesh is experiencing a major transition in disease pattern, shifting from Communicable Diseases to NCDs in the recent past. NCDs primarily include cardiovascular diseases (heart disease and stroke), cancers, Chronic Obstructive Pulmonary Diseases (COPD) and diabetes mellitus. These are linked to four shared risk factors - tobacco use, unhealthy diet, low physical activity and harmful use of alcohol. These risk factors contribute to maturation of the NCDs through a few intermediary risk factors, including obesity, high blood pressure, abnormal glucose tolerance, and abnormal blood lipids. According to the NCD Country Profile, 2014, NCDs account for 59% of total death in Bangladesh. 17% of total deaths are caused by cardiovascular diseases, while chronic respiratory diseases, cancers, accidents and diabetes cause 11%, 10%, 9% and 3% of total deaths in the country, respectively.

Awareness building programs were carried out during HPNSDP implementation period on anti-tobacco use, drowning, blindness and other NCDs. Trainings were conducted on diabetes, hypertension, heart disease, COPD, cancer, arsenicosis, thalassemia, clinical algorithm, injury prevention/ trauma prevention, health emergency preparedness and response, post disaster health management for doctors, climate change and occupational health safety. National level surveys were also completed on NCD issues like COPD, diabetes, violence against women, road traffic injury, thalassemia, stroke, epilepsy, ocular injury and behavior risk factor.

A WHO study (conducted in 2007) suggests that tobacco related disorders in Bangladesh cost around USD 44 million annually. For low-income groups, direct costs associated with diabetic care could drain up to 24.5% of annual household income. Around half of the rural households experiencing an accident become poor due to medical expenses and cost of rehabilitation. Thus the NCDs have a huge impact on financial vulnerability, particularly for the poor and overall impact on the economy.

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. The prevalence of mental disorders including mood, sleep, anxiety and substance related disorders is on the rise. A community survey in Bangladesh conducted in 2009 showed prevalence of child mental disorders to be 18.35%, epilepsy 2.02%, mental retardation 3.81% and substance abuse 0.78%. Given the emerging size of mental health problems amid changing life styles, it will be necessary to strengthen the public services for counseling and treatment of mental health and partnerships with the media and non-Government actors to raise public awareness about appropriate attitude towards mental patients.

Autism spectrum disorders (ASDs) includes (i) Classical Autism, (ii) Asperger's Syndrome (iii) Pervasive developmental Disorders (PDD). Exact figure for people with ASD is not available, though different available guestimates shows concerning numbers. The general attitude of mass people towards ASD is not very positive and it is still considered to be a social burden. Lack of proper knowledge regarding ASD is quite common, even among health professionals. Often, children with ASD are misdiagnosed and given antipsychotic drugs. The mainstream education system in the country cannot cater to the need of the children with ASD and specialized education facility for them is very limited.

During HPNSDP, control of NCDs was given priority, although the resource allocation could not be matched with its significance. A detailed situation analysis was conducted for ASD and other neurodevelopment disorders. Based on this, National Strategy for Autism and Neurodevelopment Disorder has been recently drafted, which sets objectives and activities for Government to address ASD related issues in the upcoming years. Bangladesh is the first developing country adopting such a detailed strategic plan. The strategy focuses on tackling ASDs with lower cost solutions, using existing resources. A mass awareness program regarding autism was developed and implemented in all the health complexes, civil surgeon offices, medical college hospitals and other health facilities. There was an important research conducted on autism and several books, booklets and IEC materials were distributed on increasing awareness of the condition.

As Bangladesh economy improves further, it expected to experience a lower incidence of impairments. However, the gains due to improved health care is likely to be outweighed by the triple effects of increased numbers of impaired children surviving; increased numbers of people incurring impairments due to old age (e.g. cataracts and arthritis) and widespread malnutrition. A lack of consistent oxygen supply at the hospitals beyond the district level means that, a newly born child, especially suffering a prolonged labor, not necessarily gets the required oxygen soon after birth. This alone starves the brain of the required oxygen supply, resulting in conditions like cerebral palsy, or intellectual disabilities. Compounded by natural calamities and a constant occurrence of road traffic accidents and victims of violence, this implies that the prevalence of impairments in Bangladesh is likely to rise over-time, although the nature and distribution of impairments are likely to change considerably.

Increasing rate of road accident is a growing concern for the country. A WHO study report of 2015 indicates an annual fatality of 21,316 due to traffic related accidents. There is no exact figures for the injured persons for road accidents in Bangladesh, as these are not often reported, however, a study conducted by Bangladesh University of Engineering and Technology indicate an estimate of around 64,723 serious injuries resulted from road accidents, which often results in permanent physical disabilities. Other forms of increasing injuries resulting fatalities include burns, electrocution, poisoning and act of violence. Health bulletin 2014 indicates injuries causing 9% of total hospitalized patient deaths. Experts in road safety are increasingly emphasizing on mass awareness on emergency response, as a significant portion of the fatality can be addressed through proper emergency response and quick hospitalization. At the same time, accident and emergency (A&E) care of hospitals needs to be strengthened to provide proper emergency response to the injury patients.

Population aging is an inevitable consequence of fertility decline and the demographic dividend in Bangladesh. People over sixty years constituted over 11% of total population in 2011 and are estimated to grow to 14.4% in 2021 and to 21.3% in 2031 (UNFPA Demographic Impact Study, 2014). Health is a major component for addressing the challenges posed by the increasing proportion of an aging population. It is high time to create geriatric-friendly health care system in the country.

Government's role in NCDs has been traditionally limited to providing health education at primary level and clinical treatment at tertiary level, with less focus on preventive clinical care at primary and secondary level. NGOs, private providers (formal and informal) and traditional medicine play a large role in service delivery of NCD. Specifically private sector providers are the lead in treatment services of NCDs in the country. NCD treatment drugs have recently been included in the list of essential drugs, which are produced and distributed by the private sector providers.

There are many challenges associated with NCD which include:

Strengthening Regulatory Framework: Government took some major regulatory steps to address NCD issues, including enacting Smoking and Tobacco Product Usage (Control) Act, 2005, which was amended in 2013. A guideline was also developed for control of somking and tobacco product usage in 2015. However, the enforcement is not as strong as expected. The National Tobacco Control Cell (established in 2007 and headed by Additional Secretary (PH & WHO), MOHFW lacks the staff and resources for proper enforcement. Coordination with relevant entities, especially law and enforcement agencies need to be strengthened for proper enforcement of laws. Effective governance is also required to oversee the activities and quality of the private service providers, as they are the first line providers of NCD treatment medication and services.

Limited Coordination across Sectors: Several NCD interventions exist in public and non-Government sectors with limited national coordination. NCD activities from MOHFW were carried out from NCDC OP, which has no formal institutional location with DGHS. As a result, currently, there is no clear leadership or coordinating entity at this moment to bring all the NCD interventions on a common platform.

Weak Surveillance: Major surveys like Demographic and Health Surveys and Utilization of Essential Service Delivery do not include NCD related information. There is currently no specific surveillance of NCD morbidity and/or mortality. Routine hospital based surveillance system need to capture NCD related information for urban slum dwellers, who are almost one third of the urban population.

Focus on treatment: NCDs are tackled at secondary and tertiary levels mainly through treatment in specialized facilities. There is less emphasis on prevention at the primary care level and on readily available low-cost treatment. Some of the investment for treatment of the NCDs in the specialized facilities could be saved if interventions for their preventions were scaled up. Although some NCD drugs have been recently included in the essential drug list, their supply is not yet ensured.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above and for improving the situation of non-communicable diseases in the country include:

(i). Coordination with other OPs, agencies/units under MOHFW, with other relevant ministries, non-public entities and private sector will be strengthened for mass awareness promoting prevention and control of NCD issues (through living healthy lifestyle, improving environment and reducing abusive substances).

(ii). Capacity of PHC will further be strengthened for early detection, management and referral of NCDs. Health Workers will be trained for detection/screening of major NCDs (e.g. hypertension, diabetes mellitus, COPD). The cases of NCDs identified in the community and community clinic level will be referred to Upazila Health Complex for further action.

(iii). Arrangement will be made to ensure supply of the diagnostics and drugs available as per ESD package (antihypertensive, insulin and other diabetic medicine, affordable asthma inhalers, nebulization equipment and solutions).

(iv). Surveillance of NCDs will be strengthened through routine hospital surveillance system as well as through important national surveys

(v). Efforts will be taken to facilitate approval of draft "Mental Health Act", and "National Strategy for Autism and Neurodevelopment Disorder"

(vi). Early detection and referral of Autism Spectrum Disorder (ASD) will be established for addressing autism

(vii). Multi-sectoral approach will be promoted for creating an enabling environment for neurodevelopment.

(viii). Capacity for providing psychosocial 'first aid' will be strengthened and early detection of depression cases will be promoted.

(ix). Helpline for suicide prevention will be established at MOHFW and suicide prevention campaign will be organized in collaboration with MOSW, MOWCA, MOCA, MOE, etc.

(x). Capacity for treatment, counseling and rehabilitation of substance abuse will be improved

(xi). Capacity for prevention and management of injury will be strengthened ER will be strengthened at the hospitals for better A&E care. Trained HR and logistics (drugs, oxygen, cardiac monitor, defibrillator, etc.) will gradually be provided to all hospitals for increased ER. Feasibility for introduction of a new postgraduate degree on Emergency Medicine will be assessed. Patients with injuries will be put priorities in the structured referral system to be expanded in the hospital service management. Mass awareness will be created, in coordination with other relevant ministries and departments, on ER of injuries.

(xii). Capacity for management of cataract (adult and childhood), refractive error and diabetic retinopathy will be strengthened

(xiii). Efforts will be taken for provision of Quality care for NCDs at the level of PHC (community clinic, Union Health and Family Welfare Centre (UH & FWC)/Union Sub Centre (USC), Upazila Health Complex (UHC); Secondary level (District Hospital); Tertiary level (Medical College Hospital & Specialized Institutes).

(xiv). There will be steps to strengthen the capacity of the National Tobacco Control Cell in implementing "Smoking and Tobacco Substance Usage (Control) Guideline, 2015".

2.2.7.5. Communicable Disease Control (CDC)

There were notable achievements over the last few years in prevention and control of some of the major communicable diseases. Malaria is in pre-elimination state in nine out of the total 13 malaria endemic districts. Early diagnosis and prompt treatment in the community and prevention of exposure to vector through insecticide treated nets were the main intervention in controlling malaria in the country. There is success in TB case notification and treatment rate. However, many Multi Drug-Resistant (MDR) patients are still outside this coverage which requires to be brought under the coverage of National TB program. Leprosy cases are also in decline, although continuous efforts still require for further increase in future. Bangladesh also achieved significant progress in eliminating filariasis. By 2014, the country had achieved eliminating this disease from 18 out of 19 districts through filariasis elimination program (FEP) and started to concentrate its attention on morbidity control for those persons who had developed deformity and disfiguration. Bangladesh is on the verge of achieving elimination of Kala-azar during the 3rd Sector Program, reducing the number of cases and endemic upazilas by over 90%.

There are scopes for improvement in management and control of some other infectious diseases. Rabies was a neglected disease in Bangladesh before 2010, which has become quite prominent these days with more than two thousand annual rabies cases. Bangladesh has started the program for elimination of rabies from the country by 2020. The re-emergence of dengue in Bangladesh has established it as a public health problem especially for the growing urban population. Though the country has been able to contain mortality but transmission remains an issue of concern, especially in urban areas. Bangladesh is one of the few countries of the world that continues deworming a huge number of children, due to the prevalence of Soil Transmitted Helminthes (STH). Along with regular deworming, safe water, sanitation and hand hygiene are important components for achieving elimination of STH, which require multi-sectoral collaboration and coordination. Influenza is another infectious agents causing repeating pandemic in the country since 2009. Programs for influenza needs

to include intervention for preventing and managing seasonal influenza and also prevention and control of novel influenza virus including response to impending pandemic. Also, the country needs to vaccinate the pilgrims, expatriate workers and member of peace contingents against influenza.

Despite economic progress, diarrhea, a preventable disease has remained as one of the leading causes of illness and death among children in Bangladesh. Limited access to safe drinking water and safe sanitation especially in slum areas and fecal contamination in water during natural disaster leads to a high prevalence of diarrheal diseases in this region. The disease has a huge impact on public health including malnutrition, under nutrition, stunting of growth as well as national economy. Development of awareness regarding personal hygiene, drinking safe water, access to improved sanitation, along with proper management can reduce incidence and severity of diarrheal episodes.

Among the emerging infectious diseases, Nipah is unique for Bangladesh, as the only country having endemicity of the disease. Consumption of raw date palm sap has been identified as the primary mode of transmission. The disease is also transmitted from man to man. It is manifested as encephalitis, ARS or as both. Awareness regarding the causes of the diseases and improvement of patient care in isolation is critical for managing the cases. Viral hepatitis is the seventh leading cause of death globally, accounting for 1.4 million deaths per year – more than HIV/AIDS, TB or malaria. In Bangladesh, more than 10 million are living with viral hepatitis and 20,000 die per year. Government is working for prevention and control of Viral Hepatitis through a series of interventions. Creation of effective national inter-sectoral task forces will be pivotal to the success of implementation and monitoring of interventions.

Typhoid fever caused by Salmonella typhi produces systemic infection and remains an important public health problem in Bangladesh. The country is in the region of typhoid high endemic area. Multiple factors including improper hygiene practice, exposure to unsafe water quality and sanitation, and improper food handling have a huge impact on transmission of the enteric pathogens of S. Typhi. In addition, emergence of single or multi-drug resistance strain of S. Typhi against common antibiotics for treating the disease is also potentiating clinical severity and outcome of the disease.

Bangladesh is consistently a low-prevalent country with regard to HIV/AIDS and STDs and the increase in infestation is comparatively low. However, continuation of effort in creating awareness among the high risk group, including sex workers, prison inmates and transgender (TG) people is important. The vast working class population living abroad also requires to be brought under the preventive net of the National HIV/AIDS program. At the same time, access to antiretroviral drugs among the population with advanced HIV infection requires further improvement.

Communicable diseases requires continuous attention in the context of the demographic transition, changing pattern of the diseases due to rapid urbanization and climate change and the risk behavior of the country's population. CDC has direct linkage with living conditions, poverty and other macroeconomic indicators. Effective management of communicable disease control interventions is also important for equitable delivery of ESP. So, disease control interventions for major communicable diseases in the 4th HPNSP will have direct linkage to policy and strategic documents of the Government and to larger economic goals.

The challenges remaining in this area are as follows:

Disease Surveillance: A satisfactory and well-functioning disease surveillance system, which is vital for proper planning and implementation of effective CDC interventions, is yet to be achieved. Capacity of the IEDCR will need further strengthening alongwith adequate funding to take the lead role in integrated disease surveillance. Effective collaboration and coordination is required with other public and non-public institutes. Continuation and further strengthening of capacity development

programs like Field Epidemiology Training Program (FETP) is required for effective CDC interventions. Behavioral and sero-data are also required to be updated regularly and made available for effective program design.

Supply Chain Management of Drugs and other Logistics: One of the major challenges in CDC is the interruption of logistical supplies, especially for drugs against HIV/AIDS and TB. Proper inventory and transportation is vital to prevent quality deterioration of essential CDC drugs. Supply is also required to be rationalized according to the geographic and demographic variance. HTR areas and vulnerable population are prone to major communicable diseases and hence ensuring uninterrupted supply of quality drugs and other logistics is a priority issue.

Disease Diagnosis: Early detection is important for management of major communicable diseases. Public diagnostic facilities are not adequate in providing investigative services for the growing population in the country. Private sector has been expanding their investment in establishing diagnostic facilities, thereby improving access to diagnostic services for the recipients. However, there are growing concerns regarding professionalism, equality of services, and commercialization in service pricing. A strong monitoring mechanism requires to be established. Establishing a system of accreditation of investigative services may improve the situation.

Rational Usage of Drugs: A growing concern in disease control is the irrational use of drugs, especially antibiotics, which results in increasing trends of MDR-TB, drug resistant typhoid and a few other communicable diseases in the country. Limited awareness of the patients regarding proper dosage, reliance on over the counter availability of prescription drugs and import and distribution (legal or illegal) of drugs of doubtful quality are the principal challenges in establishing continuing rational use of drugs.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above and for improving the situation of CDC include:

(i). Efforts will be continued and strengthened for vector control, disease and vector surveillance, detection and management and pharmacovigilance to control vector borne communicable diseases.

(ii). Capacity of IEDCR and other relevant entities will be strengthened for disease surveillance and increasing availability of behavioral and sero-data.

(iii). There will be mass awareness regarding the sources, symptoms, prevention and management of major communicable diseases.

(iv). Bangladeshi citizens working in foreign countries will be covered under the awareness campaign through innovative use of electronic media. Awareness will include the rationale usage of drugs, especially antibiotics.

(v). Screening will be strengthened at the entry points of the country (air, sea and land ports) to detect and prevent cross-border communicable diseases

(vi). Extent of the National AIDS/STD Program (NASP) and other communicable disease control programs will be enhanced to cover HTR and vulnerable population

(vii). Efforts will be continued to complete the elimination state for malaria and filariasis and sustain elimination state for kala-azar through scaling up morbidity management, active case search, case-based camp approach and blanket house to house search approach.

(viii). There will be strengthened efforts to control STH through stronger collaboration with stakeholders in ensuring proper WASH facilities and ensuring nutrition for children,

continued deworming of children, through scaling up of the Little Doctors' Program for mass awareness of population, and strengthening surveillance.

(ix). Timely procurement will be done to ensure supply of essential drugs and other logistics for prevention and control of communicable diseases. Priority will be given to HTR areas and vulnerable population.

(x). Capacity of the public service providers will be strengthened for early detection of communicable diseases and their proper management

(xi). Monitoring from the MOHFW on private sector entities will be strengthened to ensure effective diagnosis and proper management of communicable diseases. Collaboration will be made with professional bodies, NGOs and private sector for increasing professionalism, ensuring quality and expanding service delivery.

2.2.7.6. Hospital Service Management and Quality Improvement

Hospital Service Management (HSM)

The scope of hospital service management (HSM) under the Sector Programs covers the services provided from secondary and tertiary health care facilities of DGHS spanning from DHs to MCHs, and other tertiary hospitals. These facilities provide more advanced and specialty care than those offered in the primary health facilities at upazila and below.

Hospital Service Network: Hospital service network in the country consists of 64 DHs, 21 MCHs, 13 chest hospitals, 11 specialty-care postgraduate institutes and hospitals, and 23 other hospitals. In combination, the hospital service network has roughly 29,278 bed availability – around 45% of which are located in Dhaka division. Besides the network of DGHS, private sector has significant contribution in hospital based service delivery. As of November, 2015, 4,280 private hospitals and clinics got registration from DGHS, having combined bed availability of 74,620.

Government's hospital service network provides in-service care, as well as out-patient and emergency services. Data from 94 Government secondary and tertiary hospitals shows such service delivery to 21,079,314 patients – 85% of which were out-patients. Health Bulletin, 2015 indicated an increase in service utilization of Government secondary and tertiary hospitals for both admitted and out-door patients (8.8% in case of out-door and 22.8% for admitted patients). In addition to DGHS hospital network, BSMMU has a functional 1,500 bed hospital that had 31,025 admitted patients and 866,400 outdoor patients in 2014. Since hospital service management works mostly in urban areas, there are other actors providing services, including LGD through the local Government institutions and NGOs. Service extent and management of these actors are detailed in the "Urban Health" section of the PIP document.

Hospital Management: The office of the Director (Hospitals and Clinics), DGHS is responsible for the management of the hospital service network. The Director (Hospital and Clinics) is the head of the HSM and monitors and supervises the service quality and effectiveness of the hospitals, including the secondary and tertiary hospitals. However, each specialized hospital and MCH hospital is managed by a dedicated Director who is responsible for service provision in respective hospitals. At district level, Civil Surgeon (CS) is the district health manager responsible for delivering secondary and PHC services. Some DHs are headed by a Superintendent, while others are managed by the CS.

Medical Waste Management: Traditionally, medical waste used to be mixed with municipal wastes from the bins and disposed of, using the conventional disposal methods like burying or incineration. The issue of medical waste management (MWM) is becoming important gradually as the amounts of hazardous/ infected waste is increasing This has necessitated more attention to blood safety, disposal

of needles, syringes and other infectious wastes. To address the issue - the MWM program was introduced during the second Sector Program. Till June, 2015, 14 MCH, 15 DH and 8 specialist hospitals introduced standard in-house medical waste management. An action plan for MWM was developed and rule for MWM and handling was issued.

Blood Transfusion: Legislation for safe blood transfusion is in place but its implementation is a challenge, as most of the blood screening centres and private health institutions requires equipping with updated blood screening facilities. To prevent the spread of Transfusion Transmissible Infections (TTIs), the Safe Blood Transfusion Program was introduced during first Sector Program. Up to June, 2015, safe blood transfusion was introduced in 219 health facilities, including UHC, MCH, DH and a few other tertiary hospitals. Under this program, blood screening kits and other relevant equipment were provided and capacity building of medical technologists and medical officers was done on safe blood transfusion. This need to be expanded to cover all hospital, including the private sector hospitals where there are growing concerns regarding safety in blood transfusion.

Women-Friendly Hospitals: To ensure availability of services for women and to create a suitable environment for them, "Women Friendly Hospital" initiative was taken in selected hospitals. These hospitals put especial emphasis on treating women with respect, dignity and equity, timely and affordable service delivery, providing required information and listening to the voice of women. As of June, 2015, 28 DHs were declared as women friendly hospitals.

Referral system: Referral system is a process, which ensures the accessibility to higher levels of medical care to the patients from the community or primary level health care facility. Referral is usually pursued in order to obtain expert professional advice, undergo a diagnostic technique, seek a therapeutic intervention or receive in-patient care when these are not available at the referring facility. The presence of well-established referral system is important for the proper functioning of the health system based on PHC. A common tendency in Bangladesh on the part of the patients is to bypass the PHC facilities to secondary and tertiary levels hospitals. A JDTAF funded study on medical colleges (conducted in 2015) found that around half the patients in MCH Outpatient Department (OPD) come with issues which can be mitigated at primary level. This overburdens the secondary and tertiary level hospitals, while the primary level facilities remain underutilized. To address these issues, HSM initiated a structured referral system involving primary health care facilities and secondary and tertiary hospitals. As of June, 2015, these facilities were linked with 21 DHs. However, the referral system has not yet been institutionalized to the system and there are ample scopes for scaling up the initiative.

Harmonization of physical structures with human resource and equipment for hospitals is a concern, without which expanded and newly constructed structures remain underutilized. Skill mix ratio in hospitals also needs to be ensured, which is skewed in favor of doctors instead of medical technicians and nurses. There are also issues with vacancy in crucial technical positions at hospitals. (The HR related issues are further discussed in HRM sections of this PIP document.)

As Bangladesh is in transition phase of disease burden from CDCs to NCDs, the hospital readiness to address NCD issues needs to be enhanced. Services for mentally challenged persons and children with ASD should be expanded in the DH level. As the aging population in Bangladesh is increasing, special geriatric care should be introduced at all levels of hospitals. With the rise in patients with injuries (especially due to road accidents and violence), emergency responses at the hospitals should be reorganized. There is a need to create more professionals in the fields of emergency medicine. Emergency response trainings and care need to be institutionalized throughout the hospital structure.

Referral system from primary to upper level should prioritize the accident patients. These issues are further illustrated in the "NCD" section of this PIP document.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above and for improving the hospital services in Bangladesh include:

(i). Service provided through the hospital service network will be continued and expanded and proper human resources, equipment, drugs and other logistics supply will be ensured. Specialized services like Intensive Care Unit (ICU), Coronary Care Unit (CCU), Neonatal Intensive Care Unit (NICU), dialysis unit, etc. will be introduced and/or expanded based on priority and resource availability.

(ii). Capacities of hospitals will be increased to address the NCD issues. Steps identified as way forward in "NCD" section of the PIP document will be introduced in hospitals in this regard. Focus will be given on mental health, geriatric and palliative care and accident/violence related injuries.

(iii). The structured referral system will be expanded from primary level facilities to all secondary and tertiary level hospitals on a phase-by-phase manner.

(iv). Gradually the environment of hospitals will be made friendlier towards children, women and elderly population. The Women Friendly Hospital Initiative will be expanded to other facilities in the hospital service network.

(v). Diagnostic, imaging and other technical services in the hospitals will be improved. Emphasis will be put more on regular and preventive maintenance of equipment. Users will be trained on equipment maintenance. National Electro-Medical Equipment Maintenance Workshop & Training Centre (NEMEMW&TC) and Transport & Equipment Maintenance Organization (TEMO) will be strengthened with capacity to ensure proper curative maintenance and repair of hospital equipment and vehicles.

(vi). Patient intake capacity of DHs will further be increased in phased manner.

(vii). Existing capacity of the MCHs will be strengthened with harmonized HR, equipment and other logistics. National Institutes will be strengthened as National centre of excellence for providing stewardship role for specialized services at all levels of facilities. These will be enabled with capacities to provide technical support to the respective national programs for standard setting and quality assurance, development of Protocol and SOP, training, assist monitoring and conducting research.

(viii). High Dependency Unit (HDU) in Medicine, Pediatrics, Surgery and Obs & Gynae dept. will be provided in MCH (upon priority and availability of resources) for providing immediate supervised clinical care in absence of adequate Critical care bed/ICU

(ix). TQM approach will be expanded to cover the entire hospital service network on a phased manner

(x). MWM system will be introduced to all facilities under hospital service network on a phased manner.

(xi). Hospital standard operating procedure will be introduced for all secondary and tertiary hospitals for management, service delivery, support service standard, infection control, hygiene, waste management, patient safety and hazard free working environment.

(xii). Effective monitoring mechanism will be established to monitor the quality of services at private hospitals and diagnostic centres. Public-private collaboration will be enhanced in this regard.

(xiii). Procurement, Store Management, Asset management and Financial Management of hospitals will be strengthened

(xiv). Innovative use of modern technology and IT will be introduced in hospitals for evidence generation, monitoring and research.

Improving Quality of Care

Quality is one of the major dimensions of modern health care services and an important aspect of Universal Health Coverage. The quality of health care services in Bangladesh is generally perceived as not satisfactory. Different surveys, media reports and other reviews consistently tend to confirm the general perception. However, there have been initiatives to address this important aspect of health service. "Quality Assurance Project (QAP)" was undertaken (1994 – 1998) and some Standard Operating Procedures (SOPs) were developed and piloted in some of the hospitals. Later, utilizing the experience of this pilot project, Quality Assurance (QA) program was included in HPSP (1998-2003) to ensure quality health care in every sphere of health service delivery. Subsequently, QA activities continued during the HNPSP period (2003-2011) and QA Program of DGHS was mainly involved in awareness building among health care providers and managers of the public sector.

During the HPNSDP, Total Quality Management (TQM) was included the primary quality improvement initiative (in addition to QA). The Hospital Service Management (HSM) OP implements TQM in several medical college hospitals, district hospitals and upazila health complexes. The National Strategic Plan for Quality of Care in Health Services in Bangladesh was launched in July 2015, which sets the basis for a focused and coordinated framework for implementing quality improvement activities in the country. A national Quality Improvement Secretariat (QIS) was established in January 2015 at the Health Economics Unit (HEU) to facilitate coordination of the QI efforts. Key Performance Indicators (KPI) of quality of care, facility level indicators were set for readiness of facilities. The MOHFW has also approved the Standard Operating Procedures (SOPs) for maternal and newborn health in 2016. Maternal and Perinatal Death Surveillance and Response (MPDSR), HEU/MOHFW has approved National MPDSR Guideline which paves the pathway for nationwide scale up in 4th HPNSP.

At the national level, a Steering Committee headed by the Secretary, a National Committee headed by Additional Secretary and a Technical Committee headed by DG, DGHS have been formed. In addition, QI Committees have been formed in seven divisions and 64 districts, covering facilities from tertiary level to UHCs. A QIS has been established. Stock taking for quality of care activities in both public and private sector has been done by the QIS and based on that inventory, a mapping exercise has been conducted for better engagement of the service provider organizations (GO, NGOS, DPs). Pilot initiatives for QI have been initiated to test out the QI processes and develop a model for quality improvement. The development of standards, guidelines, protocols and implementation tools in all service areas is in progress, aligned with the WHO framework for quality improvement in maternal and newborn health. The national Standard Operating Procedures (SOP) for MNH has been developed and approved by the MOHFW for country-wide implementation.

Despite efforts to improve quality of care over the past decade, several challenges remain to be tackled. Common among the issues raised by clients include: unfriendly attitudes by service providers, long waiting time, poor communication with patients, lack of privacy, high cost of care and informal charges and near absence of avenues to raise grievances. The numerous inputs provided through pre-service and in-service training, supervision and mentoring to improve the professional competence of health care providers, these have not translated into improved quality of care. From the providers/ program implementers perspective, there are issues of unfavorable work environment,

shortage of resources, inadequate skills and competencies, unavailability and lack of adherence to standard protocols etc. Many service providers describe working condition to be difficult and demoralizing. Shortage of qualified human resources and equipment, consumable supplies and drugs, etc. undermines facility functioning, damage reputation, inflate out-of-pocket expenditure and fuel a spiral of distrust and alienation. The absence of automated information systems at hospitals limits the ability to gather data on quality of care. There is scope to improve coordination among different units of HNP service delivery system for improving the clinical quality of care as well as to improve satisfaction of the clients.

Harmonization of structures with human resources and equipment for hospitals is another concern, without which expanded and newly constructed structures remain underutilized. Skill mix ratio in hospitals also needs to be ensured, which is at this moment skewed in favor of the doctors instead of medical technicians and nurses. Also efforts need to be taken to address issues with vacancy in crucial technical positions at hospitals. These HR related issues are further discussed in HRM sections of this PIP document.

Quality of care is one of the three guiding principles for progressing towards the ambition of UHC under the HNP Sector Program. Consumer care programs and patient-centreed services will be introduced in the health facilities. There will be inclusion of clients and general population in improvement of these services through provision of information on service providers and representation in the management of health services. Facilities will have system for informed-consent for medical and surgical procedures. Patient safety will be provided through development of appropriate safety standards, establishing adverse event management system, establishing risk management systems, strengthening Infection Prevention and Control (IPC) system and establishing effective medical waste management system. Developing and implementing standard operating procedures, protocols and guidelines in all areas of service provision will be a high priority. Side by side, clinical/death audit system will be established and structured referral system will be improved. TQM will be introduced at a wider scale, covering all major health facilities. Formation of facility QIC and work improvement teams (WIT) is a pre-requisite of initiation of all quality related activities at the facility. Regular internal and external assessments will be facilitated to assess progress and to support improvements. All facilities will establish procedures for death and clinical audits. The QICs will establish Plan-do-check-act (PDCA) cycle for continuous improvement of each facility.

The 4th HPNSP will prioritize the QI implementation within the structures of the major implementing agencies – DGHS and DGFP. The implementation structures at national, divisional, district and health facility levels will be strengthened, with ownership and leadership of the implementing agencies. The Program will establish resource pools at national and divisional levels to lead and coordinate the implementation of QI activities at all levels. Monitoring and measurement of quality of care will be a priority. The development of standards, guidelines, protocols and implementation tools in all service areas will be a high priority, along with capacity building of service providers, supervisors and managers to implement effective quality improvement interventions and to monitor and support adherence to the standard protocols. A national action plan for improving quality of care in RMNCAH will be developed and implemented along with the national QI action plan. The implementing agencies, viz DGHS and DGFP, will incorporate QI activities in their operational plans. Capacity building will also address community engagement, provider attitudes and communication skills. Training will also focus on clinical and non-clinical supervision skills, and use of monitoring tools and guidelines also need to be conducted. The HNP program will initiate the introduction of automated patient information systems that allow regular collection of data on quality of care. A national web-based learning system will be created to facilitate access to technical resources

materials, documentation of progress, and real-time exchange of best practices and problem solving In addition, periodic assessments and quality of care measurements, including patient satisfaction surveys, will be conducted.

Inputs in ensuring quality will be provided in terms of infrastructure, staff training, equipment, adequate and essential drugs and other necessary logistics. Importantly, effective outcome measurement system for QI will also be developed and implemented. The 4th HPNSP will establish a hospital accreditation system, covering both the public and private sectors.

2.2.7.7. Alternative Medical Care

Alternative Medical Care (AMC) is an age-old mode of health care using medicinal items derived from herbal, animal and mineral origin. There are primarily three streams of AMC being practiced in Bangladesh – homeopathy, Ayurvedic and Unani. As treatment cost is relatively low, people living in lower income groups and rural area show significant acceptance of AMC in the country. Realizing the importance, upgrading and modernization of AMC is one of the objectives under the National Health Policy, 2011.

HPNSDP included dedicated OP on AMC. One of the achievement of the AMC OP was the development of first ever AMC strategy of Bangladesh, which is in the process of approval by the Government. Extensive awareness campaign was conducted under this OP to enhance public awareness regarding AMC. Challenges in AMC include:

Ensuring Quality of Care: An effective supervision system needs to be developed for ensuring quality of AMC in public sector facilities. Currently, MOs of homeopathy, unani and ayurved are deployed in different public facilities. They work under administrative control of allopathy physicians, who are not in a position to supervise AMC medical officers technically. In the DGHS, Director (AMC) is also staffed with allopathic physicians. Appropriate posts of AMC professionals needs to be created within AMC directorate to ensure quality of care.

Regulatory Framework: Bangladesh Homeopathic Practitioner Ordinance, 1983 governs the activities of homeopathic professionals, while Bangladesh Unani and Ayurvedic Practitioner Ordinance, 1983 does the same for Unani and Ayurvedic professionals. Both the laws require update as the contexts have significantly changed after the enactment.

Institutional Capacity: Capacity of both BUSM and BHB needs strengthening to ensure professionalism among the AMC professionals. A JDTAF funded study in 2014 found AMC professionals practicing allopath, and non-registered practitioners practicing AMC services, as well as malpractices in AMC.

Absence of a Statutory Body: At present, there is no statutory body to maintain education standard of AMC education and to recognize the AMC qualifications in Bangladesh. BUSM and BHB plays a wide array of activities including certification of AMC professionals, curriculum development, providing education, maintaining standard in education, monitoring examination, etc. Some of these activities may create conflict of interest – if being carried out by a single entity. Director (AMC), DGHS certifies the graduate AMC professionals, which is a violation of the existing laws. A separate statutory body is required (similar to BMDC or BNMC) to ensure standard of education and maintain professionalism among the practitioners.

AMC Education: Currently, there is no postgraduate level education institute for AMC professionals. The scope for in-service education is also quite limited for the practitioners. At institutional level, there is no research centre to further strengthen the technicalities or up bring innovation in AMC education in the country. BSMMU mandate includes establishment of a faculty for AMC (Unani, Ayurvedic and Homoeopathy). However, this is yet to be materialized.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above and for improving AMC education and services in Bangladesh include:

(i). AMC services in public hospitals will be strengthened in a phased manner. This will be done through appointing the suggested number of AMC professionals in all medical colleges, as indicated in the proposed "National AMC Strategy". MOs at UHCs will arrange OPD camps in the CCs under the vicinity of the respective upazila. Medicine, MSR and other AMC logistics will be ensured through timely and efficient procurement.

(ii). Postgraduate and higher education will be introduced for AMC practitioners through establishment of Bangladesh National Institute for AMC (B-NIAMC) as an autonomous institution under BSMMU.

(iii). Existing curriculum of Unani, Ayurvedic and Homeopathy will be updated in line with modern treatment methods and changing context of Bangladesh

(iv). Maternal, neonatal and childcare services will be introduced in the GUAMCH and GHMCH- to widen the service provision and to strengthen the clinical education and practice for the students.

(v). Research units will be established in GUAMCH, GHMCH and other major education institutes to encourage collaborative research for a) Testing efficacy of AMC in handling public health issue and b) developing integrated protocols for major communicable and NCDs. A national ethics committee will be established for research. Options will be explored to set up a AMC research challenge fund to encourage research in AMC.

(vi). Awareness building on AMC will be continued and expanded through mass awareness campaigns and usage of innovative communication tools

(vii). Institutional capacity will be built in DGHS, BUSM and BHB for better monitoring and regulatory functions. Feasibility of setting up a separate body to ensure AMC education standard and encourage professionalism among practitioners will be assessed for taking further necessary education.

2.2.7.8. Revitalizing Community Based Primary Health Care towards UHC in Bangladesh

Primary Health Care (PHC)

Globally, Primary Health Care (PHC) is recognized as a key feature of an effective health system that can be adapted in various country contexts to achieve sustainable and equitable health gains for all. Basically, WHO has identified five key elements for achieving health for all:

- Reducing exclusion and social disparities in health (universal coverage reforms);
- Organizing health services around people's needs and expectations (service delivery reforms);
- Integrating health into all sectors (public policy reforms);
- Pursuing collaborative models of policy dialogue (leadership reforms); and
- Increasing stakeholder participation.

With the new SDG targets for health and the goal of universal health coverage UHC, the main principles of equity and social justice that underpins PHC are more relevant than ever. Successful PHC interventions which demonstrated the use of health system approach and inter-sectoriality is similar to the SDG principles of universality, integration and "no one is left behind". The need to address social determinants of health through partnerships beyond the health sector and promoting community empowerment are essential in the march towards the goal of UHC.

In 1978, Bangladesh signed the Alma Ata declaration on PHC. Thirty eight years since this historic event, the country has achieved significant progress in health outcomes even with low per capita spending (THE=$27/capita in 2012). The Government renewed its commitment to PHC in its various national policies and stated as principle "To make essential PHC services reach every citizen in all geographical regions within Bangladesh". Thus, it has established CCs nationwide per 6,000 populations to bring health care to the doorstep of the people. This is a flagship program of the GOB and is recognized globally as a model for PHC in a low-middle income country.

PHC services were delivered through several OP including the OP called ESD. Other additional Operational Plans were MNC&AH; Maternal, Child, Reproductive and Adolescent Health (MCRAH); CBHC; FPFSD; and National Nutrition Services (NNS). Under the HPNSP, the prime importance of PHC is highlighted 4th as a strategy for improving service provision and increasing utilization of services by the population.

Essential Service Package (ESP)

The central feature of the SWAp is the funding of an essential service package (ESP) which aims to maximize health benefits relative to per capita expenditure, meet essential needs of the clients, strengthen service delivery, and improve health system management. An ESP is defined as a limited list of public health and clinical services that will be provided at primary and/or secondary care level. It is a powerful tool to define in practical terms access to a guaranteed minimum package of services for the population, thus enhancing equity. The MOHFW intends to use the ESP for three complementary purposes:

- Associated with the UHC initiatives, the ESP represents the GOB commitment to ensure the right to health and that the whole population has access to the most essential health services.
- The ESP will become the basis to define the set of standards by type of health facility. A minimum set of services is defined as a requirement for a public facility to be considered within a level. While all required services are part of the ESP, some may be qualified as "extra" services for some facilities with the capacity to do so.
- The package, common to the whole territory, is to be used for resource allocation, in a way that promotes equity and increases efficiency.

An ESP was developed while introducing the first SWAp (HPSP) in 1998, which continued till the third SWAp (HPNSDP) implementation period. With the change of epidemiological disease pattern and the need for expanding scope of PHC services, the ESP has been updated by the MOHFW with assistance from the WHO in consultation with all stakeholders for implementation during the 4th HPNSP. The ESP will be delivered through the health & FP service facilities from community to the upazila level with a functioning referral system. DHs are included in the ESP only for the services classified as PHC and for attending the referred cases from below level. The revision of the ESP and its revitalized implementation is a key towards achieving UHC with priority to HTR areas and vulnerable population.

Composition of the ESP: The Bangladesh ESP has been structured in five core services complemented by another one which includes some common conditions, and three support services. The ESP is to be provided at the delivery sites mentioned below, from community to district hospital, including urban facilities. Social and behavioural change communication (SBCC) activities are integrated in each of the services. The core services and their components include:

1. *Maternal, Neonatal, Child and Adolescent Health Care*
    - Maternal and Newborn Care

        - Maternal care: pre-conception, antenatal, delivery, postnatal
        - Newborn care: during delivery, after delivery
        - Obstetric and neonatal care
    - Child Health and Immunization
        - Integrated Management of Child Illnesses (IMCI)
        - Expanded Programme of Immunization (EPI)
    - Adolescent Health
        - Adolescent Sexual and Reproductive Health
        - Adolescent Nutrition
        - Adolescent Mental Health
        - Risk taking behaviour

2. *Family Planning*
    - Pre-Conception
    - Post-partum
    - Post-abortion
    - Post-MR
3. *Nutrition*
    - Child Nutrition: assessment of nutrition status, prevention of malnutrition, management of malnutrition
    - Maternal Nutrition
    - Adolescent Nutrition
4. *Communicable Diseases*
    - Tuberculosis
    - Malaria
    - HIV/AIDS
    - Neglected Tropical Diseases: Kala-Azar, Lymphatic Filariasis, Leprosy, Dengue, Rabies, Intestinal Parasites
    - Other Communicable Diseases
5. *Non-Communicable Diseases (NCD)*
    - Hypertension
    - Diabetes Mellitus
    - NCD screening and management based on total risk assessment
    - Cancer: breast, cervical
    - Other NCDs: Arsenicosis, Chronic Obstructive Pulmonary Disease (COPD)
    - Mental Health, Autism and Neurodevelopment Disorder
    - Sexual and Gender-Based Violence (SGBV)
6. *Management of other common conditions*
    - Eye care
    - Ear care
    - Dental care

- Skin care
- Emergency care
- Geriatric care

The three support (non-clinical) services are:

1. Laboratory diagnosis
2. Radiology and other image tools
3. Pharmacy

The sites where the ESP is provided are:

1. Users' homes
2. Satellite Clinics and Outreach Sites
3. Community Clinics (CC)
4. Union-level facilities (combination of Union Health and Family Welfare Centres (UHFWC) and Union Health Sub-Centres (USC))
5. Upazila Health Complexes (UHC)
6. District Hospitals (DH)
7. Maternal and Child Welfare Centre (MCWC)

In urban areas, different settings and networks of facilities coincide. Urban PHC services are the responsibility of City Corporations and Municipalities and are provided through their own facilities or through services contracted to NGOs. In addition to specific PHC services, which include the public Urban Dispensaries and others, some public higher-level facilities –District, Medical College and Specialized Hospitals also provide services included in the ESP. A mapping of the ESP components by OPs of the 4th HPNSP is given in the table below.

Table 1: Bangladesh Essential Service Package Mapping by OP

ESP COMPONENT	LEAD OPERATIONAL PLAN(S)	Associated OP(s)	Support OP(s)
MATERNAL, NEONATAL, CHILD AND ADOLESCENT HEALTH CARE	MNCAH, MCRAH	CBHC, NNS, HSM, NCDC, CDC	IEC, LHEP, CCSDP, FPFSD, CDC
FAMILY PLANNING	CCSDP, FPFSD	MNCAH, MCRAH, CBHC, HSM	IEC, NNS, LHEP
NUTRITION	NNS	MNCAH, MCRAH, CBHC, HSM	IEC, LHEP, CDC, NCDC
COMMUNICABLE DISEASES	CDC	CBHC, HSM, MNCAH, MCRAH, NCDC	IEC, LHEP
NON-COMMUNICABLE DISEASES (NCD)	NCDC	CBHC, HSM, MNCAH, MCRAH, CDC	LHEP, IEC, NNS, CCSDP, FPFSD, HRD, ME
MANAGEMENT OF OTHER COMMON CONDITIONS (e.g. eye, ear, dental and skin	CBHC, NCDC	HSM	LHEP, IEC,

ESP COMPONENT	LEAD OPERATIONAL PLAN(S)	Associated OP(s)	Support OP(s)
conditions etc.)			

Community Clinic Based PHC Services:

The country has made remarkable progress in improving the health status of its population, mainly through PHC approach and improvements in the social determinants of health. The CCs deserve a special mention as the cornerstone of PHC strategy in Bangladesh providing basic health care to the population. Currently, there are 13,136 independent CCs which have been made functional with the required CHCPs, MSR and medicines. In addition to the CHCPs, the existing domiciliary staff members of the DGHS and DGFP also provide service to the CCs three working days a week alternately. By April 2014, all the CCs received internet connection through a laptop and wireless modem to help collection of local health-related data, provide telemedicine service, community health education, and certain other ICT-based health solutions. The amount of allocation per CC for medicine supply was about BDT 0.11 million in each CC from 2014-2015 with about 30 items.

Number of CC level service seekers has increased over time gradually during HPNSDP implementation period and it is estimated that an average of 38 patients/day, receive service from each CC and since re-inception in 2009, about 15 million patients were served from the CCs. The CC is an unprecedented instance of community participation and public-private partnership. On the whole, the CCs have taken off as the first-contact facility providing PHC and MNH services. CC based service provision has led to increasing access of the poor (particularly women) to public HNP services and community participation. Steps would be taken for strengthening and further consolidating the functioning of the upazila health complexes, union health and family welfare centres/sub-centres through providing adequate human resources, drugs, and other medical aids.

There is ample scope for further improvement in institutional coordination between health, population and nutrition to avoid duplication, wastage and missed opportunities. Although the CCs have constituted the first tier of the PHC system, still there exist some outstanding issues to be resolved for proper functioning of the CCs. During implementation of the 4th HPNSP required steps will be taken for sustenance of the CC-based PHC system. Some important ones are mentioned below:

- The need for improved co-ordination between CHCPs and the other two categories of service providers at the CC i.e. FWA and HA is essential. The elaborate guidance jointly issued by DGHS and DGFP for field-level co-ordination and supervision therefore need better compliance for turning the CC into an effective first service-contact.
- The drug list for CCs will be reviewed to ensure rational dispensing of drugs by service providers at CCs.
- The CBHC initiative will need to be mainstreamed with the PHC system of DGHS's regular service delivery mechanism.
- The female CHCPs – who constitute more than 50% of the total number – offer a potential pool of qualified personnel to undertake CSBA training and thereby lead to filling in the current gap of skilled birth attendants in the rural homes.
- Community empowerment needs to be pursued through involvement of mass and electronic media, communication materials on health entitlements, utilizing existing Government field workers to inform people of their entitlements and the elected local Government administration.

- Providing the ESP also requires upgradation of health facilities, for which additional investments would be needed.
- Union Sub-centre/UH&FWC facilities would need to be improved to act as the first referral from the CCs for some of the service components (e.g., diagnostic and prescription for NCD patients, who may be followed up and prescription refilled at CC level). The UHCs having provision of CEmONC will continue to provide services and other UHCs will concentrate on referral activities to DH.

2.2.7.9. Urban Health Service

Bangladesh is experiencing a rapid urbanization over the last decade or so. This is evident from the proportion of urban population, which was 31%, 33% and 34% respectively in 2011, 2013 and 2015. At this rate the urban population is expected to increase up to 56% by 2050. A large number of slums were created in the last two decades to accommodate large scale rural migrants to urban areas and currently 60% of the urban population in the country is slum dwellers. More than two third of urban population is out of the coverage of piped water supply and three fourth of the slum population do not have access to hygienic latrine facilities. 21% of the urban population lives below the poverty line. The combined effect of inadequate access to water, sanitation and poverty associated with urban slums creates significant public health hazards, causing excessive pressure on the existing health care services.

Health, Nutrition and Population services in urban areas are provided broadly by three categories of service providers – public, NGOs (supported by DPs and often collaborated with public service providers) and private providers. The public sector HNP services are provided by the MOHFW and Ministry of Local Government, Rural Development and Cooperatives (MOLGRD&C).

MOHFW has an extensive network of health service delivery throughout the country. Currently there are 14 MCHs, 13 general hospitals (GH), 59 DHs /sadar hospitals, 21 specialized hospitals, 425 upazilla health complexes, 14 TB hospitals, 3 leprosy hospitals under the DGHS located in the urban settings. These public facilities under MOHFW are providing primary, secondary, tertiary and specialized health care services to urban, peri-urban and rural population. In addition 35 urban dispensaries and 4000 satellite centres under the DGHS are providing outdoor service through EPI and MCH to the urban population. Moreover, under the DGFP, two Maternal and Child Health Training Institutes (MCHTI) and 62 out of 96 MCWCs are located in district headquarters (serving the urban population) and functioning across the country.

MCH and DH/Sadar hospitals provide a wide range of curative care services including delivery care, post abortion care, immediate newborn care, treatment under-5 (IMCI), neonatal sepsis management, birth asphyxia management, communicable disease management, non-communicable disease management, etc. These hospitals also provide full range of preventive care services, including antenatal care (ANC), postnatal care, immunization, essential newborn care, adolescent care, health education, control of micronutrient deficiency, de-worming of children under 10, etc. The UHCs also provide similar curative care services, although some of the preventive care services are not available in all UHCs. Specialized hospitals provide services on specific areas (e.g. cardiovascular diseases, eye care, renal diseases, etc.). Maternal and Child Health Training Institutes (MCHTIs) and Maternal, Child Health and Family Planning (MCH&FP) units of UHC provide all the major family planning related services. These facilities also provide immunization and IMCI services. MCWCs also provide important FP services. MOHFW operated Government Outdoor Dispensaries (GOD) in large city corporations also provide services on various communicable and NCDs. In the urban areas, all the

commodities (vaccines and contraceptives) of immunization and family planning respectively, being distributed by the City Corporations through the NGOs, are provided by MOHFW.

MOHFW is responsible for policy development and reform initiatives in the HNP sector. Moreover, the stewardship and regulatory responsibilities (both in urban and rural areas) in HNP sector fully lies on MOHFW, including setting standards of services, ensuring quality medical education, regulating and monitoring quality and standard of drug production and management, regulation of clinics and diagnostic centres, and regulation of professional practices. MOHFW carries out its responsibilities through the executing agencies and statutory bodies under it.

According to Local Government (City Corporation) Act, 2009 and Local Government (Municipalities) Act, 2009, city corporations and municipalities are responsible to provide PHC to city dwellers. MOLGRD&C renders these services in 5 city corporations through 11 hospitals and 29 dispensaries. In addition, under the Urban Primary Health Care Service Delivery Project (UPHCSDP), Essential Service Package Plus (ESP+) is being delivered in 11 city corporations and 5 municipalities through 161 Primary Health Care Centres (PHCCs), 24 Comprehensive Reproductive Health Care Centres (CRHCCs), 644 satellite clinics, 24 Voluntary Counseling and Treatment (VCT) centres, 92 Directly Observed Treatment (DOT) centres, and 24 primary eye care centres.

There are also parallel programs implemented by NGOs with support from DPs in urban areas for provision of PHC services. The earlier Urban Primary Health Care Project (UPHCP), the Smiling Sun Franchise Program (SSFP), BRAC Manoshi Program in urban slums, and facility and community-based NGO programs such as Marie Stopes Clinics are some of such important ongoing urban health programs. Private sector also plays an important role in providing urban PHC mainly through graduate private practitioners, pharmacies, and private clinics. Other private health care providers include private hospitals, pathology laboratories, diagnostic centres and networks of unqualified private practitioners. In slums, pharmacies/ drug stores were the first point of care followed by private hospitals/ clinics.

Because of the extensive network of facilities from different service providers, health care services are quite available for urban population. Urban Health Survey (UHS), 2013 revealed that 95% of communities in slum and 90% of those in other urban areas have a health facility available within two kilometers. UHS, 2013 indicated good progress in child health of urban areas. Under 5 mortality rate was reported to be declined by 30% in slum areas. Substantial increase was seen in exclusive breastfeeding. There was also improvement in nutritional status. Improvement was also noticed in family planning issues in urban areas with declining TFR and increased CPR, although a pattern of early childbearing was observed during 2009-13 period.

The Urban Health Strategy was finalized in 2014. The strategy targets creating environment for urban people (especially poor) to have equitable access to public and private sector health services and improve overall health indicators of the country through strengthened essential health care system for the urban population.

Although there have been significant improvements in urban health achieved over the past few years, however, further developments are challenged due to some constraints, which are discussed in this section.

Gap in Coordination among Public Service Providers: As mentioned before, urban health is the joint responsibility of both MOHFW and MOLGRD&C as far as public health care service is concerned. However, recent studies show significant gap in coordination among these two ministries in this regard. Because of the limited capacities of LGIs, PHC in urban areas suffer from both service quality and extent. Such coordination issue also constraints the quality of FP services in urban areas. Both

DGFP and City Corporations are providing FP services in urban areas and in many cases (e.g. supply of contraceptives) entities under UPHCSDP have to rely on DGFP officials. However, the coordination between DGFP and City Corporation is not very strong. At the same time, some of the partner NGOs under UUPHCSDP lacks the capacity in providing long acting contraception services. Because of the limited coordination, DGFP neither can enhance their capacities, nor can extend services on its own in areas where the NGOs are working. The lack of coordination among agencies of these two ministries resulted in weaker expanded program on immunization (EPI) in urban areas in comparison to the rural areas. Such limited coordination between these two ministries also constraints the collection of routine HNP information in urban areas, which possess barrier in taking proper evidence-based decision for urban population. HPNSDP initiated a coordination mechanism between these two ministries through inter-ministerial and Urban Primary Health Care Provider (UPHCP) Steering Committees, however, there is hardly any evidence suggesting this being significantly successful.

Accessibility of Services: The formal service providers (MOHFW, MOLGDR&C and NGOs) provide non-emergency health care services during day-time, which is not convenient for the service recipients (especially those from slum areas) due to their engagement with income earning activities. There are also issues with convenience of location, mainly in slum areas. Majority of the slums are located on private or disputed lands, which bars the possibility of establishing permanent or static health care points. This sometimes constraint the accessibility for slum dwellers. As mentioned before, legal framework bars the placement of field level staff of MOHFW in urban slums. The limited HR capacities and quality of LGI staff constraints the possibility of proper service from health professionals for HNP services in urban areas.

Quality and coverage of Public service providers: GOD is a vital point of HNP services offered by the public service providers in urban areas. Quality and extent of services from these GODs are severely hampered by limited HR, poor infrastructure and shortage of equipment, instruments and logistics. MCH and DH, although located in urban vicinities, however are open to all categories of patients. Due to the lack of a strong referral system with the PHC providers, secondary and tertiary level hospitals in urban areas are often overpopulated with patients requiring non-specialized treatments which could have been resolved at the lower level. This creates unnecessary pressure on the limited resources of these hospitals and bars the quality and outreach of services.

Quality of the Private service Providers: Due to the convenience of time and location, urban population, especially the slum dwellers rely on private service providers for health care services. In many cases, these are informal private service providers in the form of drug vendors, frontline workers, itinerant health professionals, and traditional healers. Small private clinics and diagnostic centres in the vicinity of the slums also provide vital health care services, often at a much lower cost than mainstream private service providers. In spite their convenience and cost, these service providers are quite unregulated and not monitored for their service. Unauthorized medical treatment, over the counter provision of prescription drugs, unnecessary dispensing of drugs and selling of spurious quality drugs are quite common in these areas and can be detrimental to health and wealth, disease transmission and drug resistance. There are even evidences of exploitation of urban slum dwellers by mainstream private service providers (doctors, hospitals and diagnostic centres) in the interest of maximizing income and profit.

MOHFW will continue to function for policy development and stewardship and regulatory responsibilities in the HNP sector, including setting standards of services, ensuring quality medical education, regulating and monitoring quality, standard fordrug production and management,

regulation of clinics and diagnostic centres, and regulation of professional practices (both in urban and rural areas).

Key activities to be pursued for overcoming the challenges described above and for improving the urban health service delivery in Bangladesh include:

(i). The facilities under MOHFW (14 MCH, 13 GHs, 59 DHs/Sadar Hospitals, 21 SHs, 425 UHCs, 14 TB hospitals, 3 leprosy hospitals) will provide primary, secondary, tertiary and specialized health care services to urban, peri-urban and rural population. Specialized hospitals will provide services on specific areas (e.g. cardiovascular diseases, eye care, renal diseases, etc.). MOHFW operated GODs in large city corporations will also provide services on various communicable and NCDs.

(ii). 35 urban dispensaries and 4,000 satellite centres will provide outdoor service for EPI and MCH to the urban population. Two MCHTIs and 62 MCWCs (located in the HQs) will provide immunization, important FP services and IMCI services.

(iii). MOHFW will continue to provide all the commodities (vaccines and contraceptives) of immunization and family planning respectively in the urban areas, being distributed by the City Corporations through the NGOs.

(iv). Further expansion of urban dispensaries will be made for quality PHC services (including services for reproductive health, nutrition and health education). A referral system will be developed and implemented between the urban dispensaries and the secondary/tertiary level hospitals. The General Practitioner (GP) system will be piloted in this regard.

(v). Coordination between MOHFW and MOLGRDC will be strengthened through operationalizing the guidelines of National Urban Health Strategy 2014. Coordination and collaboration will also be strengthened with the private sector and NGOs in extending the existing health care service network in urban slums.

(vi). Capacity of the various service providers under MOHFW, MOLGRD&C, NGOs and private sector working in urban slum areas will be strengthened to enhance service quality.

(vii). Stewardship role of MOHFW will be strengthened for proper and updated licensing and registrations of the private service providers and for standardized service quality and service charge.

2.2.7.10. Tribal Health Service

There are around 45 different tribal/ethnic communities in Bangladesh inhabiting mostly in the districts of Chittagong Hill Tracts (CHT), and Rajshahi, Rangpur, Sylhet & Mymensing divisions. A scattering of them also lives in Barisal division. Most of them inhabit in HTR areas such as hilly terrains or the forest areas where access is generally difficult. The proportion of the tribal/ethnic population in the 64 districts varies from less than 1% in majority of the districts to 56% in Rangamati, 48.9% in Khagrachari and 48% in Bandarban in the CHT. It is believed that the tribal/ethnic population ranges between 1.5-2.5 million.

The tribal/ethnic communities are burdened with various types of diseases. Malaria, diarrhea, and Acute Respiratory Infection (ARI) are the most common diseases in the CHT. In the CHT, about 52% of the girls get married before their eighteenth birthday, which increases the risk of morbidity due to complications related to early pregnancy. In the CHT, Maternal mortality still remains high and the number of deliveries assisted by medically trained personnel is low.

Traditional healers are still popular among the tribal population in Bangladesh. Gender and age also play a role in making decisions in tribal households in relation to health matters and treatment-seeking

behavior. There exist distinct differences among different tribes concerning their knowledge of health, awareness, and treatment-seeking behavior.

Due to variations in culture and socio-economic situations, the GOB recognizes the need to approach these communities differently in order to ensure that the health care delivery system is accessible and acceptable to them. The MOHFW under the third Sector Program HPNSDP (2011-16) took steps to implement HNP services to the tribal/ethnic communities through the ESD OP. The ESD OP highlighted in making provision to implement HNP services to the tribal communities through 'Tribal/Ethnic Health Population and Nutrition Plan for the HPNSDP (THNPP 2011)'. The THNPP was first adopted in 2004 during implementation of HNPSP (2003-2011) - the second Sector Program. However, little progress was made in the implementation of THNPP between 2005 and 2011. The THNPP was thus upgraded in 2011 and the HPNSDP made provision to implement HNP services to the tribal communities through this THNPP 2011. One of the objectives of the ESD OP was to ensure accessibility of effective health care service to the tribal people.

To attain the objective, a number of activities was taken: a Tribal Health Committee was constituted; a number of health service providers were trained on tribal health; workshops at national level as well as in Rangamati, Bandarban and Khagrachari Hill Districts were held on advocacy and multi-sectoral meeting to develop special measures and adjustments in delivery mechanism of tribal health for ethnic people; satellite clinics took place in CHT area to address tribal health issues; an action plan with guideline was developed for provision of PHC services to the districts of CHT; training of field workers and workshops on micro planning for satellite and mobile medical team in HTR areas of the three hill districts were completed; participation of local traditional leaders in tribal health was ensured. During MTR of HPNSDP in 2014, 'ensuring HNP services available and accessible to the tribal populations' was included as an action in the Prioritized Action Plan (PAP). In APIR 2015 it was revealed that HNP services were in place at all UHCs of the three CHT districts.

A review of tribal health revealed that the 'Para' Centres with good arrangement and infrastructure were effective for health and education. 'Para'-wise recruitment of female Community Health Service Worker (CHSW) and arrangement of satellite clinics provided HNP services with emphasis on treatment of malaria, diarrhea, ARI and maternal health service which were found effective. However, still there remain many challenges in achieving expected results in HNP services to the tribal communities.

Scarcity of health service providers: In tribal areas the management of health care remains the responsibility of the local Governments of the Hill Districts as per law. Provision of human resources remains a problem for the local bodies. Under a project implemented by UNDP, some personnel including CHSWs were recruited to provide HNP services to the tribal communities. Some CHSWs had the common tendency of leaving their communities after selection and training. After completion of the project, funding for these personnel was provided by USAID. In the ESD OP, an allocation was preserved for these personnel which could not be spent due to non-establishment of expenditure mechanism. However, a few of the CHSWs are still continuing services under different mechanism of payment. Though the HNP program coverage had improved over the past few years, however, many of the health facilities in the CHT remained underused, suffering from severe shortage of technical staff, especially doctors.

Dependence on traditional healers: Many of the tribal communities living in HTR areas usually seek health services from traditional healers and TBAs. They prefer the drug sellers for treatment who are mostly untrained.

***Communication and referral system*:** Settlements in the hills are quite dispersed due to geographical reasons making it difficult for service seekers to access facilities miles apart. It is therefore difficult to transfer a patient from a rural village to a health facility when needed. Referral cost is also a hindrance to seek HNP services from health facilities.

***Monitoring and Supervision**:* Weak monitoring and supervision reduces utilization of the existing human resource and affects service. The local Government's strong administrative role assisted by supportive supervision by MOHFW is crucial to ensure HNP services to the tribal communities.

***Coordination**:* Tribal health involves inter-ministerial and inter-agency coordination requiring both administrative and policy coordination while there is an absence systematic institutional linkage between the MOHFW and the MOCHTA and the HDCs. Also there is lack of coordination among several vertical programs covering tribal populations. Sometimes these also lead to duplication of services in the same areas.

IEC activities: The IEC activities are not in tune with the tribal vocabulary, beliefs and practices. There is also lack of confidence among patients about the curability of the disease. Tribal culture specific IEC activities and involvement of traditional healers with strong community participation need proper attention.

***HPN service to the plain land tribal/ethnic communities*:** The HPN programs had so far focused mostly on the three hill districts, but there is a number of small concentrations of different tribal population in the plain lands outside the tea garden areas also. HPN service for the plain land ethnic people needs to be geared up in the 4th HPNSP.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above include:

(i). Equitable access of tribal/ethnic people to HNP services without compromising their cultural/ traditional norm will be ensured through service delivery and establishing a strong referral system in the CHT area and other tribal population.

(ii). Efforts will be made to make available adequate number of service providers at tribal health facilities and involve community leaders in IEC activities.

(iii). Policy initiative from the MOHFW will be taken to establish institutional mechanism for inter-ministerial and inter-agency coordination. The MOHFW will strengthen collaboration with the MOCHTA, CHT-Regional Council and HDCs to address service delivery issues in tribal areas. Agency level (joint) strategy and planning on tribal health will be developed.

(iv). District-specific health service will be developed in the CHT in cooperation with HDC. Assistance (e.g., HR, funds) will be provided to the HDC for providing improved health services to those living in the CHTs. Tribal-friendly health services will also be ensured for tribal populations residing in plain lands (pocket areas) of the country.

(v). Coordination with the Ministry of Cultural Affairs (MOCA) will be established to create awareness among the tribal communities to seek health care service from health facilities.

(vi). A mapping of tribal communities in the CHT and plain land for planning and implementing HNP services will be carried out to identify available community health services/providers (including NGOs/private sector) in hill and plain land for wider use.

(vii). Improving human resource management; developing social mobilization strategies; implementing culturally sensitive IEC programs; and strengthening of research, monitoring and evaluation will be addressed for the tribal population.

(viii). The Para centres involving the CHSWs will continue to be utilized for HNP services. Mobile/satellite clinics will be ensured in HTR areas.

(ix). An action plan in cooperation with all stakeholders will be developed involving all related institutions/establishments, on the specific elements of who should do what specific activities for guiding line-staff, managers, administrators, and tribal communities so that each level of accountability supports the other in a coordinated way.

(x). The MOHFW and MOCHTA will work together for providing the service providers and their managers' ethnic culture specific training, orientation on CHT/HDC rules and regulation, etc.

2.2.7.11. Services for Hard-to-Reach Areas and Vulnerable Population

Though the geographical conditions in Bangladesh are quite homogenous throughout the country, there are areas which have difficult accessibility. Hill tract areas, char islands of large rivers, haor region and the coastal belt are some of the HTR areas. People living in these areas have limited access to quality HNP services, as the service providers face significant challenges in providing services. At the same time, there are population groups having limited access to HNP services, not for geographical accessibility, but for specific socio-cultural reasons. Tribal population (including those living in plain lands), prison inmates, nomadic ethnic groups, urban floating population, transgender people, and people living in the recently merged enclaves, etc. are examples of vulnerable population which lack quality HNP services.

From service providers' point of view, extending services in HTR areas involve significant challenges. Absence of proper accommodation, lack of basic amenities (e.g. electricity, safe water), difficult and/or costly transportation, wide dispersion of service recipients and frequent natural disaster in the case of "coastal belt" hinder retention of quality health workforce in these areas. Access of the service providers to other vulnerable population is challenged by floating nature of the service recipients, physical distance and cultural barriers. Extending services to HTR and vulnerable population require different strategies and additional resources. Resource constraints of MOHFW in terms of quality staff, equipment, drugs and other logistics also adversely affect service coverage among these population groups.

Developing policy and introducing service package for hard-to-reach/rural areas is one of the specific initiatives conducted during the 3rd Sector Program from the MOHFW. Motorcycles and bicycles have been distributed to upazila level managers and family planning inspectors (FPI) to intensify the supervision and monitoring. With a view to enhancing CPR and reducing TFR in HTR areas DGFP has been filling up vacant positions and ensuring supplies. Regional service packages have been introduced for Chittagong, Sylhet and Barisal divisions under DGFP. Progress has been reported, however only for temporary methods but not for LAPMs.

NGOs have been working with DP support in hard to reach areas for delivery of quality health care services at a reasonably affordable price. Admittedly, the NGOs are filling up gaps in public sector delivery. CCs have also been providing services in these areas.

Present efforts of service delivery in HTR areas and to vulnerable population will be reinforced in the 4th HPNSP. Diversification of service provision (including public private partnership) will be adopted in service delivery. Special incentive packages will be adopted to attract and retain quality workforce in these areas. Institutional arrangements of collaboration and cooperation among MOHFW, MOLGRDC, DPs, NGOs, private sectors and others will be improved to ensure effective HNP services for the HTR population. Possibility of utilizing the vast informal sector of health service delivery will also be explored. PHC centres, including CC will be extended to as many HTR areas as feasible on a priority basis. In line with the CHT agreement which treats health as a transferred

subject, the respective Hill District Councils will be provided in cooperation with the interested DPs and UN agencies.

2.2.8. *Strategic Objective 8:*

To promote healthy lifestyle choices and a healthy environment

Investments in lifestyle choices and healthy environments can reduce the future costs of treating the rapidly expanding incidence of chronic NCDs. The projected increase in the NCDs if unchecked will require huge investment in specialist medical centres, diagnostic equipment, highly trained specialist health staff and expensive pharmaceuticals treating the patients suffering from cancer, diabetes, hypertension etc. Given the funding gap that exists in the health sector, this will be a financial burden that the country will find difficult to afford. Reaching the young with effective public health messages will be a key to averting NCDs.

2.2.8.1. Public Health, Lifestyle Change and Environment

Health programs in Bangladesh are credited with many notable achievements. However, many challenges still remain. Lack of adequate awareness of healthy lifestyle and structural/environmental factors (e.g. lack of green spaces and sidewalks in urban areas) are contributing to NCD burden, e.g. diabetes, cerebro- and cardio-vascular diseases, cancers, etc. – (such behavior ranges from smoking, chewing of betel nuts, lack of physical exercise, prolonged hours of sitting, etc.) Inadequate awareness of healthy and balanced food contributes to under-nutrition as well as to over-nutrition from increased consumption of junk food and excessive consumption of carbohydrate, salt, sugar, etc. Also food adulteration in recent years has become a major public health concern. Poor water and sanitation conditions and hygienic practices; lack of proper disposal of waste continue to result in water- and food-borne diseases, and seasonal outbreaks like dengue. Environment pollution especially air, sound, water can lead to illnesses (viz. neurological, orthopedic, eye, mental stress, etc.) resulting from poor environment. Bangladesh is already at an advanced stage of epidemiologic transition from acute, infectious, and parasitic diseases to non-communicable, chronic diseases. This on-going shift in disease burden and risk factors warrants re-prioritization of public health interventions to achieve national and global objectives for improved health status under the SDG agenda.

There is increasing recognition that healthy lifestyle expressed as individual decisions about diet, exercise, and smokings are of critical importance. Physical environment, including infrastructure, market forces, pollution, urbanization and other factors also influence people's physical, mental and social well-being. The complex relationships between environmental factors and human health, taking into account multiple pathways and interactions, should be seen in a broader public health context. Among the key elements of public health, health education and communication to inform, educate, and empower people about health issues and lifestyle are of crucial importance.

Core public heath activities under the HNP Sector Program in Bangladesh are mostly comprised of health promotion, awareness building, community participation, surveillance, and research. SBCC activities in Bangladesh are aimed at fostering behavioral changes among the people towards increase in health seeking behavior, promoting family welfare, healthy lifestyle, and safe nutrition practices. These activities are managed or overseen primarily through two OPs under HPNSDP –HEP within DGHS and IEC within DGFP.

HEP OP housed in Bureau of Health Education (BHE) of DGHS conducts communication and health education and promotion activities through existing national, divisional and district offices with audio-visual capacity and DH-based staff for imparting health education to the patients, their relatives and attendants. Preparation of communication materials, e.g., audio-visual messages and material, interpersonal communication (IPC), indoor and outdoor display devices, posters, fliers, handbills,

folders etc. are important functions of BHE. BHE also plans, designs and develops program for both electronic and print media. Features films have been developed and short drama, telop, discussion and folksongs for TV ads and radio jingles produced.

IEC OP within the Information, Education & Motivation (IEM) Unit of the DGFP has a long history of creating awareness throughout Bangladesh on topics including family planning; maternal, newborn and child health; and population and development issues. Since Bangladesh's independence, the IEM Unit has been designing, developing, producing, distributing and disseminating SBCC materials (posters, booklets, pamphlets, training manuals, SBCC strategies, flip-charts, policy briefs, fact sheets, etc.), and entertainment-education products (TV spots, short films, drama serials, music videos, theme songs, etc.).

In order to raise awareness on nutrition among the pregnant and lactating mothers and caregivers of children under 5 years of age, NNS OP organized nutrition-related SBCC activities, which are implemented by the service providers at the CC and household level (i.e. CHCP, HA, FWA). Presently, different type of SBCC tools are used for strategic communication on nutrition like poster, brochure, flip Chart, booklet, leaflets, TV spot, talk show, etc. covering components on maternal and child nutrition, IYCF, growth monitoring and promotion (GMP) and early childhood development (ECD), micronutrient supplementation, adolescent and elderly nutrition, and food safety and hygiene (e.g. hand washing). SBCC activities, supportive of healthy lifestyle changes, are spread over multiple OPs e.g. under other OPs like NNS, NCD, CBHC, MNC&AH, MCRAH, NASP, and TB-LC implemented SBCC activities. However, the challenges remaining in this area are:

SBCC Planning and Management: In spite of development of the national SBCC strategy, fragmented interventions from different entities still continue: because of inadequate coordination among agencies like BHE (DGHS) and IEC (DGFP). A clear and specific SBCC plan is absent, resulting in activities based on resource availability rather than need based activities. There is no clear mechanism set to monitor the effectiveness of a specific SBCC intervention and design the subsequent ones accordingly. The approval process of the annual 'Procurement Plan' leaves little time to implement the yearly SBCC plan, and results in SBCC that is deadline-driven rather than strategic.

Regional Variation: Regional variation in uptake of certain services indicates the need for effective communication interventions specific to low performing areas – SBCC activities need to be implemented nationally with a strategic focus to capture the differential needs of regions with varying socio-economic determinants (e.g. low-performing areas, different target groups, vulnerable populations, ethnic variation, cultural practices, etc.).

Weak Coordination: Changing lifestyles of the citizens and promoting environmental awareness require strong coordination among different stakeholders, including local Government agencies, ministries like Food (MOFood), Environment and Forest (MOEF) Industries (MOIND), MOHFW, Education (MOE), Information (MOI) and others. As a result, there is limited synchronization of SBCC activities, although all the stakeholders have some investment on these activities. In many cases, SBCC interventions of one agency are not complemented by actions from others, resulting limited effectiveness of SBCC interventions in areas like tobacco/substance abuse, food safety and adulteration, road safety, etc.

Capacity Issues: Most public agencies in HNP sector (e.g. BHE, IEC, etc.) need institutional and personnel support for proper planning and implementation of SBCC interventions. As a result, the interventions are either designed by DPs, NGOs or outsourced from agencies outside the Government, raising potential issues of ownership and sustainability. Quite often the public agencies lack the

capacity to monitor effectiveness of the SBCC interventions and to redesign subsequent activities accordingly.

Lack of Innovation: Official SBCC interventions often lacked innovation in message design and presentation and depended on traditional media like TV, radio and press. While there is a revolution in the use of mobile phone based technology, use of text message, voice message, email and mobile applications, these have not been extensively utilized as message dissemination platform.

Key activities to be pursued during the 4th HPNSP for overcoming the challenges described above and for improving public health, lifestyle changes and environment in Bangladesh include:

(i). A comprehensive lifestyle and environment strategy will be developed in collaboration with relevant ministries, departments, private entities and other stakeholders;

(ii). There will be innovative use of mobile technology, other ICT platforms and social media to disseminate SBCC messages;

(iii). Capacities of PH&WHO Wing at MOHFW will be strengthened for multi-sectoral coordination including with the line agencies, NGOs and the DPs to avoid duplication in SBCC initiatives and promote the practice of sharing best practices related to SBCC planning, design, coordination, implementation, monitoring and evaluation;

(iv). Capacity of agencies under MOHFW like IEM and BHE will be strengthened to adopt data-driven, theory-based and audience-focused strategic communication;

(v). Accuracy and depth of interpersonal health counseling, to frontline fieldworkers (FWAs, HAs, FWVs, CHCPs) will be enhanced by providing them access to smart phone or tabs loaded with all needed SBCC information;

(vi). There will be promotion around healthy diet, the hazards of overdose of salt, oil and sugar, and need for adequate fruit and vegetable intake. There will also be promotions on stopping smoking and substance abuse. Actions will be taken in coordination with other relevant ministries and agencies to reduce their usage.

(vii). Extensive public education campaigns about the benefits of physical exercise and healthy lifestyle will be conducted;

(viii). Campaigns on road and waterway safety will be promoted in co-operation with all stakeholders to reduce death and disability from traffic accidents.

(ix). Appropriate campaigns will be designed and implemented to increase awareness of food and water safety at community level, urban slums and other relevant areas of the country.

(x). The need for green space and space for sports and games for the communities, with special focus on urban populations: men, women and children would be advocated through building common platform with city planners and relevant civil advocacy organizations.

GEVA- an Issue Cutting Across All Services

Gender has important health implications. In spite of the remarkable achievements over the past several years in many aspects of HNP sector in Bangladesh, major inequities in health outcomes still exist and need to be addressed. In general, women and girls have less access to health care and their health status is relatively worse than their male counterparts. The vulnerability of women is particularly pronounced in the area of reproductive health. It is to be noted here that the overwhelming majority of women do not have access to safe delivery as 63% of births take place at homes. More than 60% of mothers do not get postnatal checkup, while only 31% of pregnant women receive the recommended four or more ANC visits.

The Women Friendly Hospital Initiative (WFHI) was included in the Sector Program specifically to address discriminations suffered by women/girls. The objectives were to provide health care to women & children to achieve gender equity, managing women victims of violence, rendering psychosocial counseling and linking victims to legal aid agencies, and providing quality of care. Technical and financial assistance were arranged to support health officials in implementing interventions at selected public facilities. 28 women friendly hospitals render specialized psychosocial counseling to women survivors of violence and link them with legal aid agencies. Among these, 10 DHs have been accredited as Women-Friendly Hospitals. Local community and elected representatives mobilize local resources (in kind and cash) to support cleanliness of hospital, establishing public toilets within hospital premises, funding for local recruitment of staff and facility renovation. WFHI is currently the only program in health sector having an accreditation system. A Gender Equity Strategy (GES) was also finalized and published by Health Economics Unit (HEU), which houses a dedicated unit looking after GEVA issues. A Gender Equity Action Plan was also developed to implement the GES. As a follow up of GES, capacity development initiatives on Gender and Voice related issues were undertaken. The revitalization of the CCs has provided a woman-friendly platform where more than 90% of service seekers are women availing various PHC services near at home. According to the Bangladesh Health Facility Survey 2014, 47.6% of the public health facilities excluding CCs had separate improved toilets for female patients.

Limited fund allocation to support implementation of WFHI in new hospitals constrained the scale up of WFHI. Limited capacity in LD-HSM, DGHS, inadequate number and skilled staff for counseling of victims and providing quality treatment, etc. are key challenges in rolling out the WFHI initiative throughout the country. Violence against women and sexual abuse of children (especially adolescents) are major challenges to the attainment of gender parity, in spite of the existence of stringent laws – e.g. Prevention of Repression on Women and Children Act 2002, Acid Crime Control Act 2002 and Dowry Prohibition Act 1980. Enforcement of those instruments remains weak and need to be strengthened.

Equity is one of the guiding principles for the 4th HNP Sector Program. Equity means fairness and justice in the distribution of benefits and responsibilities among all citizens regardless of gender, race, and economic, social and cultural situation. The remarkable progress in achieving MDG related health outcomes in Bangladesh sets the stage from where Bangladesh is now ambitiously looking forward towards attaining the SDGs including UHC – meaning an end to inequity in health care. Establishing efficient, transparent and accountable services, as well as reducing wastage and maximizing impact of all available resources thus become important. Collaborative approach with different stakeholders, including private sector is required for reducing the burden of high out-of-pocket-expenditure, especially for the lowest two quintile income groups in order to enhance equitable access to universal health care. MOHFW is exploring modalities to ensure equity, including pooling mechanism via contributions from formal sector and middle and upper-middle class; determination of an equitable resource allocation formula; and expanding the safety net programs like Demand Side Financing (DSF). MOHFW is implementing a pilot social health protection scheme known as “Shasthyo Shuroksha Karmasuchi (SSK) under which free hospital services are being provided to the poor-below poverty card holders. Continuation of piloting along with scale up of the SSK will be pursued during the 4th HPNSP. However, in addition to income inequalities, there are other equity issues involving geographical, ethnic, gender and other forms of marginalization. Gradual expansion of service coverage in the HTR areas, effective implementation of tribal health plan and efficient supply chain and health workforce management are called for in mitigating such disparities.

GOB has created a credible framework for the exercise of accountability and for hearing citizen's voices. This combines the well-established vertical approaches of the MOHFW (sometimes in combination with other ministries) with the roles of local democratic structures (at union and upazila levels), as well incorporating a space for NGOs and CBOs to work with communities and help them raise their voices. The community clinic model is an example of participation and accountability of local communities in HPN service delivery (e.g. community support groups and community groups for management of the CCs). There are other such examples, such as the "Chaugaccha Model" and "Jhenaidah Model" which have been discussed in different sections in this document. While these models encourage people's participation and strengthen their oversight role, systemic approaches are required to associate community and the people's representatives with management of service and resources at each level of service delivery.

Keeping in view the aforementioned, the key activities to be carried out during the 4th HPN Sector Program include:

(i). Activities as indicated in the Gender Equity Action Plan will be implemented on the basis of priority and availability of resources.

(ii). Gender based violence and female empowerment will be addressed as part of a comprehensive response. MOHFW's role in providing health care services to survivors of domestic violence, especially related to rape and sexual assault, will be enhanced and continued through a multi-sectoral response involving effective collaboration with other relevant ministries and agencies (e.g. MOWCA, MOHA, MOSW and other stakeholders).

(iii). More health care facilities will be added offering women friendly environment, including specific breastfeeding corners, separate toilet facilities and waiting rooms.

(iv). The updated ESP to be implemented during the 4th HPNSP will ensure better access of women to quality health care.

(v). Generation of gender disaggregated information will be facilitated and gender data management will be strengthened.

(vi). Extent and quality of service provision in HTR areas will be enhanced on priority basis.

(vii). Potential expansion of SSK will be considered upon extensive assessment of the pilots.

(viii). Social protection schemes (including DSF) will be expanded in line with provision in the 7th FYP and the National Social Security Strategy.

(ix). Implementation of Tribal Health Plan will be continued and expanded on a priority basis. Increased community participation will be encouraged to address voice and accountability, which is further detailed in the "Community Participation and Empowerment" section of this document.

(x). Initiatives will be taken for introduction/institutionalization of a system for lodging client views/ feedback/ complaints and responding to these at local and national levels.

(xi). Initiatives will be taken to activate management committees at different tiers of health facilities by involving civil society and elected public representatives with a view to sustaining demonstrated effective models.

2.3. Boundaries of the Sector

The characteristics of a SWAp are that 'all significant funding for the sector supports a single sector policy and expenditure programme, under Government leadership, adopting common approaches across the sector, and progressing towards relying on Government procedures to disburse and account

for all funds'. The GOB follows a specific definition of sector boundary as far as sector financing for development is concerned: the whole economy is divided into 17 economic sectors covering 56 Ministries/Divisions for allocation of development fund by the Planning Commission and a couple of Ministries fall under one sector. .

However, it is a difficult task to come up with a defined sector boundary as far as implementation of development activities is concerned, as the implementation responsibilities are guided by GOB's "Rules of Business" for each Ministry, wherein a Ministry-wide sector boundary has been defined. Accordingly, each Ministry prepares development programmes, implements the programme along with supervision and over sight. As for overlapping activities and aligned subjects, the GOB system operates through inter-ministerial cooperation, coordination and alignment with concerned Ministries under the leadership of the lead Ministry primarily responsible for the Programme.

The challenge still remains with regard to defining a boundary of the HPN sector. The MOHFW implements 29 parallel projects included in its development budget (e.g., ADP) but outside the SWAp programme. Moreover, there are projects under the responsibility of other Ministries/Divisions, which contribute to the HNP sector development. Health related projects (urban health, water, sanitation and food safety) of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC); mother and child care projects of MOWCA; district level diabetic hospitals and NGO-led health and social welfare programmes of MOSW; and tribal health projects of the Ministry of Chittagong Hill Tracts Affairs (MOCHTA) constitute responses to a variety of health needs within the HNP sector. Besides, health education and promotion related projects of the Ministries of Education and Primary & Mass Education; efforts of the Ministries of Agriculture, Food and Fisheries and Livestock in production and promotion of safe and nutritious food; food fortification activities of Ministry of Industries also need to be considered as associate contributors and active partners to the HNP sector development.

It is relevant to point out that the various APRs carried out in the past did not limit themselves to the OPs of the MOHFW but took a broader view in their evaluation and their assessment of achievement of targets. The goal level indicators and targets, as set in the SWAp Results Framework of HNPSP (2005) as well as those in the RFW of HPNSDP (2011), however, reflected the HNP sector as a whole, rather than the limits of programme contents of HNPSP and HPNSDP. Various national surveys like BDHS, Utilization of Essential Service Delivery (UESD) Survey and Bangladesh Maternal Mortality and Health Care Survey (BMMS) also capture the performance of the HNP sector as a whole. It is relevant to recognize that a broader view of the HPN sector as a whole is meaningful within the wide socio-economic context of the country within which the sector operates.

The SWAp modality in Bangladesh's health sector can be considered a hybrid between a project approach and a SWAp in the sense that it finances a specific set of MOHFW activities, agreed between the GOB and the DPs during the Programme design. The choice of a SWAp modality as practiced by the MOHFW has also allowed having parallel projects implemented by non-state actors, funded and supervised directly by the DPs outside the SWAp (known as off-budget DP support). These projects and activities also contributed to achieving the results of the SWAps, but have not been formally accounted for by the MOHFW. Same applies for the MOHFW's parallel investments in discrete projects which constitute a considerable portion of its ADP, but do not form part of the SWAp formally.

However, a key message from the experience so far is that the SWAp is, as the name implies, an approach rather than a blueprint. Most programmes, even quite well established ones, are in the midst of a process for moving over time towards broadening support to different sources of funding, making

the coverage of the sector more comprehensive, bringing on-going projects into line with the SWAp, and developing common procedures and increased reliance on the Government. Recent examples of this process in Bangladesh include the mainstreaming of the HIV/AIDS, nutrition and the CC projects, to form part of MOHFW's Sector Programme. The provision of quality health services and related outcomes are the result of multi-sectoral interventions and thus not solely the responsibility of the MOHFW. That is why the MOHFW has been trying-over time-to strengthen its coordination and functional relationship with other stakeholders Ministries/Agencies involved in providing health services.

However, efforts are needed to be made to improve upon existing platform of coordination between the MOHFW and relevant stakeholders including the private sector for maximization of available resources. Areas of such coordination and collaboration would include, among others, (a) development and revenue budgets of MOHFW for the purpose of budget planning, allocation of resources, and joint review of SWAp performance;(b) parallel projects (both GOB and DP) to avoid duplication and develop complementarities;(c) urban health (MOLGRDC) and tribal health (MOCHTA) for resource sharing, programme planning, implementation and review; (d) NGO/private sector for management/operation of non-functional facilities and/or providing services in HTR areas or for exploring feasibility of new services/technology etc.; and (e) community, public representatives and local governments involvement in augmenting resources, management and oversight of service facilities in their locality.

Therefore, the 4th HPNSP will also put increased focus on the issues like- (i) pursuing multi-sectoral approaches to establish better linkages with other components of human development (viz. education, social protection); (ii) establishing stronger coordination and collaboration among multiple sectors affecting health outcomes (e.g. malnutrition, NCDs); (iii) developing a long-term, phased plan for broader sector-wide coverage, inclusive of the role of non-state actors addressing issues like PHC coverage in urban areas; (iv) setting up effective supervision mechanism through functionally integrated information systems ; (v) strengthening MOHFW's stewardship and regulatory role to reap the full benefits of a sector-wide approach; and (vi) promoting healthy lifestyles and environment through comprehensive SBCC in collaboration with all relevant Government agencies, private sector participants, DPs and other stakeholders.

2.4. Duration and Timing : January 2017 – June 2022

2.5. Location of the Programme : All over the Bangladesh

2.6. Implementation Priorities

The 4th HPNSP is characterized by restructured OPs, programme contents, the context of the new elements/focus are defined by the changing national as well as international context of health. The national context is defined by the need to formulate responses to the unfinished agenda of HPNSDP; challenges posed by demographic and/or epidemiological changes taking place; changing national economy, society and rising citizen's aspirations; and the fast expanding role of the private sector in service provisioning and education etc.

The international context is set by the SDGs related to health and well-being. Some notable new focuses are: (i) governance, stewardship and institutional development; (ii) implementation of the updated essential service package (ESP); strengthening of the mainstreamed nutrition service; (iii) increased investment on preventing NCDs; (iv) development of appropriate response to the needs of autistic, mental and geriatric population; (v) provision of functionally coordinated PHC service

delivery through the community clinics; (vi) development of supervision guideline (Inspection Manual), training of the supervisors & supervised and improvement of reporting practice; and (vii) facility management involving the community and the local government.

2.7. Sponsoring Ministry : Ministry of Health and Family Welfare

2.8. Implementing Agency : MOHFW, DGHS, DGFP, DGNM, DGDA, NIPORT, HED and PWD

2.9. Estimated Programme Cost : (Taka in crore)

(a) Revenue Cost	72,000.00
(b) Development Cost	43,486.36
(c) Total Cost (=a+b)	1,15,486.36

2.10. Estimated PA Cost : Taka 18,847.23 crore

2.11. Source of PA : Credits from IDA & JICA and Grants from DPs (DFID, GAC, USAID, SIDA, EKN, WHO, UNICEF, GFATM, GAVI-HSS, WB (GFF), UNFPA, etc.)

2.12. Financing Pattern :

(Taka in Crore)

Sl. No.	Financing Pattern	Total	% of Grand Total	Source of PA
1.	GOB Non-Development (Revenue)	72,000.00	62.34%	Credits from IDA & JICA and Grants from DPs (DFID, GAC, USAID, SIDA, EKN, WHO, UNICEF, GFATM, Gavi-HSS, WB (GFF), UNFPA, etc.)
2.	GOB Development	24,639.13	21.34%	
3.	Sub-Total of GOB(1+2)	96,639.13	83.68%	
4.	RPA	11,676.07	10.11%	
5.	DPA	7171.16	6.21%	
6.	Sub-Total of PA (4+5)	18,847.23	16.32%	
7.	Total of Development (2+ 6)	43,486.36	37.66%	
8.	Grand Total (1 + 7)	1,15,486.36	100.00%	

Pattern of Programme's Development Financing:

Source of Fund	in crore BDT	in million USD	% of Total
GOB-Development	24,639.13	3138.74	57%
Project Aid	18,847.23	2400.92	43%
Total (dev.)	43,486.36	5539.66	100%

Rate of US$ and Date: 1US$ = 78.50 BDT, date: 11November 2016

2.13. DP's Support for the 4th HPNSP

An amount of Taka 18,939.46 crore equivalent DP support is being estimated for the 4th HPNSP. However, as of now there has been an indication of BDT 11166.93 crore given by the DPs. Indication of DP-wise contribution is given below (Table-2).

Table-2: Indicative DP Contribution for HPNSP

Sl. No.	Source	Amount in million US $	Amount in Lac BDT	RPA (in Lac BDT)	Other than RPA (DPA) (in Lac BDT)
1	IDA Credit	500.00	392500.00	392500.00	0.00
2	World Bank GFF	15.00	11775.00	0.00	11775.00
3	GAC	TBD*	-	-	-
4	JICA Credit	51.71	40592.35	37232.55	3359.80
5	SIDA (200mlcroner)	21.70	17034.50	17034.50	0.00
6	DFID	TBD*	-	-	-
7	USAID	40.00	31400.00	31400.00	0.00
8	UNICEF	15.00	11775.00	0.00	11775.00
9	WHO	30.00	23550.00	0.00	23550.00
10	EKN (7.7 ml. Euro)	8.13	6382.05	6382.05	0.00
11	Gavi-HSS	84.00	65940.00	0.00	65940.00
12	Gavi-ISS+ MR	500.00	392500.00	0.00	392500.00
13	GFATM	146.00	114610.00	0.00	114610.00
14	UNFPA	11.00	8635.00	0.00	8635.00
	Total	1422.54	1116693.90	484549.10	632144.80

*GAC and DFID have expressed their willingness to remain in the 4th HPNSP, but are yet to decide on their probable contributions.

Rate of US$ and Date: 1US$ = 78.50 BDT, date: 11November 2016

CHAPTER III: MAPPING THE STRATEGY TO THE IMPLEMENTATION STRUCTURE

Mapping the strategy to the implementation structure

3.1. Introduction

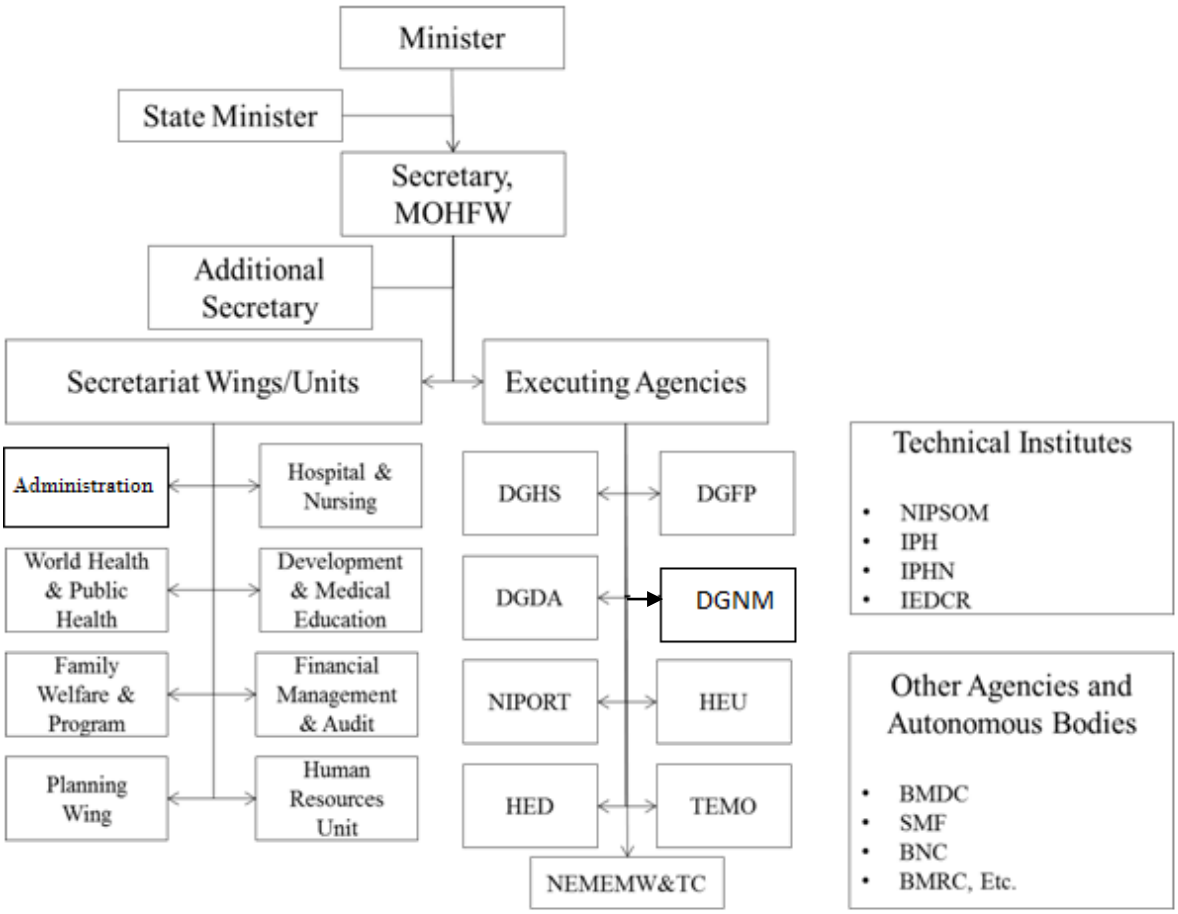
This chapter identifies how the PIP of the 4th HPNSP, maps on to the implementing structures of the MOHFW. The primary implementing unit of the MOHFW is the "Operational Plan" (OP). There are 29 OPs in the 4th HPNSP distributed across the DGHS, DGFP, and the MOHFW. Each OP, a summary of which is provided in Chapter 4, is meant to effectively implement some part of the HNPSP. The structure of the 4th HPNSP, 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. The Chapter begins by providing an overall structure of the MOHFW which has the responsibility for implementing the 4th HPNP. It then follows by mapping the 4th HPNSP structure – component 1 - Srtengthening Governance and Stewardship; component 2 - Health Systems Strengthening; and component 3- Provision of Quality Health Services -- and the priority activities within these components, to the primary implementing OPs. 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 section identifies the methods for monitoring implementation of the 4th HPNSP. Finally, the proposed OPs along with designated LDs have been mentioned in this chapter.

3.2. Organizational Structure

MOHFW's Organizational Structure

The MOHFW is responsible for implementation, management, coordination and regulation of national health, family planning and nutrition related policies, programmes and activities. The MOHFW organizational structure (Figure 1) comprises 2 main groupings: (i) the Secretariat responsible for policy and administration comprising eight functional Wings/units; and (ii) executing agencies through which the MOHFW implements its policies comprising nine Directorates/Units/Institutes. Both groups are supervised by the Secretary of the Ministry who works as the Chief Executive. The Minister, assisted by State Minister, heads the Ministry.

Figure 1: MOHFW's Organizational Structure



The lead technical Directorates include one for the Health Services (DGHS and that for Family Planning (DGFP, each led by a Director General (DG). DGHS and DGFP have separate management and delivery structures from national to field level. Other technical Directorates are: DGDA, Directorate General of Nursing and Midwifery Services (DGNM), Health Economics Unit (HEU) and Health Engineering Department (HED). Other technical and implementing agencies include: National Institute of Population, Research and Training (NIPORT), NIPSOM, IPH, Institute of Public Health and Nutrition (IPHN) and Institute of Epidemiology, Disease Control and Research (IEDCR). Transportation & Equipment Maintenance Organization (TEMO) and NEMEMW&TC are specialized entities of MOHFW located centrally in Dhaka with the responsibility of maintenance of medical equipment and vehicles.

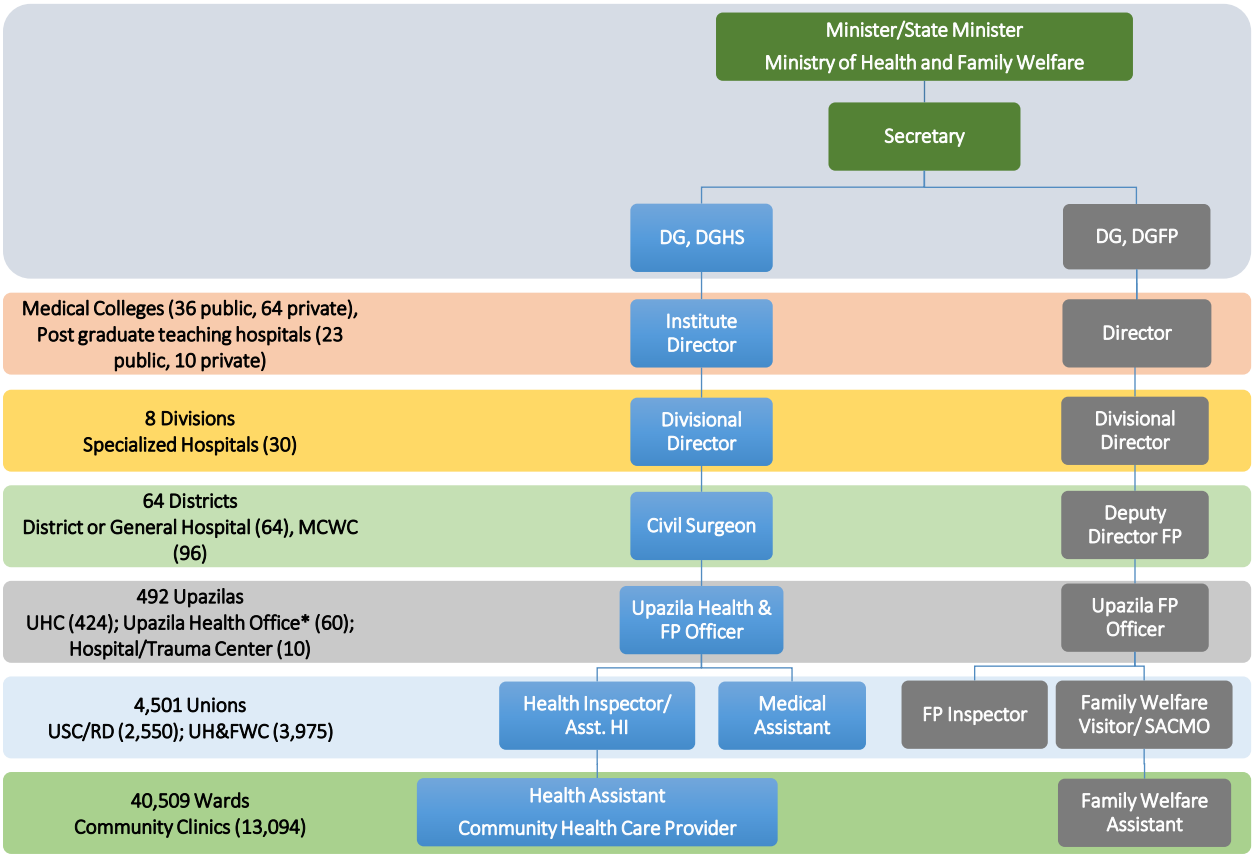
The DGHS, DGFP and DGDA have a separate presence at the divisional level, exercising administrative and regulatory oversight. Technical agencies provide specialized services, including capacity development, disease surveillance and research. Autonomous bodies shown in figure-1 exercise specified governance and stewardship functions for different professional groups in the HNP sector within MOHFW structure, as envisaged by law.

MOHFW's Service Delivery Structure

The field level HNP service delivery has multiple layers of service provision entities corresponding to different administrative tiers. The grass-root service point of the MOHFW is the CC at ward level,

serving approximately 6,000 people. At union level, there are UH&FWCs, Union Sub-Centres/RD with an average coverage of 30,000 people. UHCs are located at the upazila headquarters. These three layers provide PHC service. The secondary layer of service provision is delivered from the DHs, which also provide primary care and work as a referral for the UHC. On top of these, there are specialized hospitals, mostly located at divisional headquarters and in Metropolitan cities. The medical college hospitals and specialized institutes offer tertiary care services. Figure-2 below shows health service delivery structure of the MOHFW.

Figure 2: MOHFW's Structure of Health Services Delivery



* situated at '*sadar upazila*' which do not have indoor facilities because it's headquarter is co-located at the district town.

Under the MOHFW, the DGFP is primarily responsible for managing and ensuring FP services in collaboration with other directorates and departments, particularly DGHS. At the domiciliary level the Family Welfare Assistants (FWAs) are involved in providing FP information through household visits, registering the eligible couples, provide counseling and distributing condom and oral pills. At the community level approximately 30,000 Satellite Clinics (SC) are organized every month to provide family planning, maternal and child health services for the rural population.

3.3. Linking Strategic Priorities to Implementation Structure

A linkage between the component & strategic objective-wise priority activities and the lead & supporting OPs has been established in the following tables (Tables: 2, 3 & 4)

Table 2: Component 1 - Strengthening Governance and Stewardship

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
Strategic objective 1: To strengthen governance and stewardship of the public and private health sectors	• Organizational capacity of key Directorates, Departments, Agencies and Professional bodies • Capacity strengthening programme (staff and skills) • Strengthen regulatory bodies and clarification of roles and responsibilities • Introduce mentoring scheme for senior managers	SWPMM, SDAM, HRD	PMR, PME and other OPs with training components	MOHFW, BMDC, BMRC, SMF, BNMC and relevant other Ministries
	• Enact / amend laws, including - law for regulating private medical and dental and nursing colleges; amend Private Clinic Act; BMDC Act • Develop introduce standards and accreditation systems for the public and private sectors.	SWPMM, HSM, HEF	PMR, PME	MOHFW, BMDC, BMRC, SMF, BNMC , Professional Bodies and relevant other Ministries
	• Build capacity in governance and accountability across local levels of health system • Expand local accountability, transparency and governance mechanisms • Scale up active community participation in operating hospital and community health programmes (learning from existing models such as the Chougachha Model)	SWPMM, SDAM, HEF, CBHC	MNCAH, MCRAH, HIS & E-H, HSM, CCSDP, FPFSD, PME, PMR	LGIs, NGOs
	• Inclusion of public health in inter-ministerial policies through evidence based advocacy • Capacity building amongst national and local decision-makers on the role of public health • Agency level (joint) strategy and planning on important inter-Ministerial issues: tribal health, nutrition, food safety, climate change, use of chemicals in agriculture. • LCG and Health Council meetings consider health related inter-ministerial issues	SWPMM, HEF	CBHC, LHEP, NNS, IEC, PME, PMR, HIS & E-H, MIS	MOHFW, MOLGRDC, MOA, MOEF, MOCHTA, MOFOOD
Strategic objective 2: To undertake institutional development for improved	• Assess organizational capacities, structure, operational plans, and related resourcing to maximize efficiency and effectiveness • Implement agreed action plans from assessments (e.g. reorganization of	SWPMM, IFM	PME, PMR	MOHFW, MOPA, MOF, ERD

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
performance at all levels of the system	FMAU) • Strengthen aid effectiveness arrangements, practices and reporting • Review existing coordination mechanisms including use and functioning of committees.			
	• Improve management and administrative structures and functioning at all facilities from district hospitals down to Community Clinics. • Set up institutional arrangements for engaging communities at all levels from District to Community Clinic, including feedback mechanisms.	SWPMM, CBHC, HSM	MNCAH, MCRAH, FPFSD, CCSDP, PMR, PME	MOHFW, LGIs, NGOs
	• All laws in light of human resource needs • Institutional strengthening in support of Health workforce strategy and planning	HRD, NMES	SWPMM, PME, PMR	MOHFW and relevant other Ministries
	• Review regulatory and accreditation bodies and develop new competencies and entities for specialized activities • Establish mechanisms for development and monitoring of health standards • Collaborate with LGD and a permanent institutional mechanism on urban health	HEF, HSM, SDAM	SWPMM, CBHC, PME, PMR	MOHFW, MOLGRDC, Urban Health Network, CSOs
Strategic objective 3: To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage	• Evidence based advocacy for increased Government budget allocation for the health sector (based on regular PER and NHA) • Explore new and innovative sources of financing for the health sector: tobacco tax ('sin taxes') allocation to health; new taxes on environmental pollutants; a trust fund in line with the NHFS; private sector investment in health systems; public private partnerships to mobilize resources; research into innovative financing • Evidence based advocacy for increased on and off budget funding from Development Partners.	HEF, SWPMM	IFM, PMR, PME	PMO, MOHFW, MOF (FD), ERD, Planning Commission
	• Implement the Health Care Financing Strategy through close coordination with the NSSS - national social health protection scheme - to strengthen financial risk protection and extend health services and population coverage with the aim to achieve universal health coverage. • Explore pooling mechanisms, as part of the national social health protection scheme, via contributions from the formal sector and the middle and upper-middle classes.	HEF,	SWPMM , PME, PMR	PMO, MOHFW, MOSW, Planning Commission (GED)

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
	• Complete pilot and implement the resource allocation formula			
	• Increase budget allocation to public health/PHC activities. • Increase supervision and monitoring systems across all tiers of the health system • Reduce wastage across procurement practices, especially in area of infrastructure development. • Explore contracting out (including PPP) highly specialist services, non-functional facilities, and facilities for underserved hard to reach populations to the private (for profit and not-for profit) sector. • Promote results-based financing as a strategy used to improve health systems efficiency • Improve coordination between Sector Programme and DP-supported off-budget programmes	HEF, SWPMM, PFD	IFM, PSSM-HS, PSSM-FP and other relevant OPs HIS & E-H, MIS	MOHFW, MOF, DGHS, DGFP, DGNM, LCG WG on Health

Table 3: Component 2 - Health Systems Strengthening

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
Strategic objective 4: To strengthen the capacity of the MOHFW's core health systems (Financial Management, Procurement, Infrastructure development)	• Strengthen procurement planning, process, distribution and contract management • Improve quality and efficiency of procurement • Strengthen capacity of CMSD and other departments • Improve regulation of the pharmaceutical sector	PFD, PSSM-HS, PSSM-FP, SDAM,	HSM, PMR, PME and other relevant OPs	MOHFW, CPTU, DGHS, DGFP, Bangladesh Association of Pharmaceuticals Industries (BAPI)
	• Improve coordination between different departments involved in infrastructure development • Make the completed physical structures into active service centres • Prioritize new construction to be focused on areas that lack facilities • Develop comprehensive maintenance plans for both infrastructure and equipment	PFD	MCRAH, HSM, PMR, PME, HRD, NMES, PSSM-HS, PSSM-FP	MOHFW, HED, PWD, DGHS, DGFP, DGNM, Professional Bodies, NGOs,
	• Strengthen Financial Management at individual, processes and systems levels • Increase capacities of the OP management and directorates • Strengthen the Audit System • Establish advisory role of FMAU • Quickening fund release	IFM	SWPMM, PMR, PME	MOHFW, MOF, C&AG

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
Strategic objective 5: To establish a high quality health workforce available to all through public and private health service providers	• Finalize and implement integrated Health Workforce Strategy • Finalize and implement 5-Year comprehensive Health Workforce Action Plan, costed and prioritized. • Review the organogram of all health and family planning facilities and entities • Address shortage and skill mix, including ratio imbalance, task shifting (see HWF strategy) • Develop and implement policy on outsourcing service delivery.	HRD, NMES, ME&HMD	SWPMM, PMR, PME	MOPA, MOF, MOHFW, DGHS, DGFP, DGNM, Professional Bodies,
	• Improve quality of public and private pre-service health workforce education system (including for AMC providers) • Integrate in-service training, linked with career development. • Capacity development to ensure better management within district level and below • Introduce and/or strengthen quality assurance of medical education at both private and public sector institutions through licensing and accreditation • Review professional licensing and accreditation of health professionals	HRD, ME&HMD, NMES, AMC	HSM, CBHC, TRD, PMR, PME and other relevant OPs	MOHFW, DGHS, DGFP, NIPORT, DGNM, BCPS, SMF, BAPI, Prefessional Bodies
	• Rationalize job descriptions of HWF at different level of services based on changing needs • Recruitment and retention planning, including incentives to address distribution issues particularly for underserved/disadvantaged areas, appraisals and career planning. • Introduce innovative, unbiased and decentralized health workforce deployment and transfer system. • Gender sensitive HWF planning and implementation	HRD, NMES,	HEF, PMR, PME	MOPA, MOF (FD), MOHFW, DGHS, DGFP, DGNM,
	• Establish one HRIS that is linked to national HIS • Establish monitoring framework for implementation of HWF Action Plan	HRD	HIS&e-H, MIS	PMO (A2I), MOHFW, DGHS, DGFP, DGNM
Strategic objective 6: To strengthen the evidence base for health sector decision-	• National scale up of the electronic tracking system of citizen's health • Improve integration of the health information and eHealth platforms existing amongst different agencies and stakeholders. • Strengthen the use of ICD-10 coding system in healthcare facilities • Make routine mechanism for evidence	HIS&e-H, MIS	SWPMM, PME, PMR, TRD	PMO (A2I), MOHFW, DGHS, DGFP, DGNM

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
making	based decision making in MOHFW			
	• Implement the M&E Strategy and Action Plan (MESAP) • Monthly OP-wide ADP Review, both on financial and physical progress. • Prepare SmPR and APIR • Conduct Annual Programme Reviews (APR) by Independent Review Team (IRT) and ensure use of APIR data generated by PMMU in APR • Institutionalize Data Quality Assurance (DQA) mechanisms • Improve coordination and harmonization of population based health surveys • Develop inventory of survey and research publications	SWPMM	PME, PMR, HIS &e-H, MIS, TRD and other relevant OPs	MOHFW, DGHS, DGFP, DGNM, BBS, NIPORT, BMRC, NIPSOM, icddr,b,
	• Establish Indicator Reference Group • Promote innovations in data production and utilization • Strengthen community engagement and feedback through data and information sharing for promoting transparency and accountability.	HIS&e-H, MIS	SWPMM, PME, PMR, CBHC	MOHFW, DGHS, DGFP, DGNM, NIPORT, BMRC, NIPSOM, icddr,b
	• Develop and implement multi-year, comprehensive training plans • Conduct orientation of LDs and core OP staff in Planning, Monitoring and Coordination; • Conduct organizational assessment and restructure and strengthen the MIS units on all required dimensions of national HIS.	SWPMM,	PME, PMR, HIS & e-H, MIS and other relevant OPs	MOHFW, DGHS, DGFP, DGNM, NIPORT, NIPSOM, icddr,b
	• Allocate sufficient and adequate funds to sustain, expand and further strengthening HIS, e-Health and M&E activities • Support specific agencies, organizations and institutions under MOHFW to conduct planned surveys in a timely manner • Develop resource mobilization strategy for sustaining and increasing budget for HIS, e-Health and M&E activities.	SWPMM, HEF	HIS &e-H, MIS, PMR, PME, TRD	MOF (FD), MOHFW, NIPORT, NIPSOM, HEU, BMRC, IEDCR
	• Strengthen key research institutions • Strengthen BMRC to play its desired role as the competent focal national health research institution • Strengthen NIPORT to play its desired role as the competent focal national FP research institution • Strengthen the coordinating role of Planning Unit in DGHS for research	PME, PMR, TRD	SWPMM, HIS & e-e-H, MIS	MOHFW, NIPORT, NIPSOM, NIPORT, HEU, BMRC, IEDCR, IHE (DU), icddr,b, JPG SPH (bracu)

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
	• Review and update the National Health Research Strategy 2009 • Mainstream academic/operational research with national health priorities • Build up capacity of the policy makers, health managers and health professionals on utilization of data and research findings.			

Table 4: Component 3 - Provision of Quality Health Services

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
Strategic objective 7: To improve equitable access to and utilization of quality health, nutrition and family planning services	• Define and implement Essential Health Service Package (ESP) as per service delivery tiers • Implement a functional integration of services approach, including collaboration with private sector providers • Establish an effective referral system including ambulance services	MNCAH, MCRAH, CBHC, HSM, AMC, CCSDP, FPFSD, CDC, NCDC	SWPMM, PMR, PME	MOHFW, DGHS, DGFP, NIPORT, NIPSOM, HEU, BMRC, IEDCR
	• Upgrade UH&FWCs to provide 24/7 normal delivery and primary care for sick newborns • Endorse National Adolescent health strategy and implement action plan • Endorse Maternal Health Strategy, prioritize facility delivery, PNC and PPFP • Implement BENAP (including new interventions) • Implement national midwifery strategy, and increase facility delivery • Continue and expand of safety net programmes (e.g. DSF)	MNCAH, MCRAH, NNS, NMES	SWPMM, PFD, HEF	MOLGRDC, MOHFW, MOSW, DGHS, DGFP, DGNM, NIPORT, NIPSOM, HEU, BMRC
	• Strengthen FP services for post-partum, post MR/ PAC • Implement regional service package for FP (HTR, CHT, urban poor and low performing areas) • Raise awareness regarding method mix including LARC&PM, delay of first pregnancy and birth spacing among adolescents	CCSDP, FPFSD	MCRAH, MNCAH, CBHC IEC, SWPMM, PME, PMR	MOHFW, MOCHTA, DGHS, DGFP, DGNM, NIPORT, NIPSOM, HEU,
	• Implement National Nutrition Strategy • Strengthen strategic leadership and investment required to complete and consolidate mainstreaming of nutrition services • Increase coverage and quality of preventive community outreach services • Increase facility readiness to deliver nutrition services including monitoring • Pay attention to severe acute malnutrition • Strengthen inter-ministerial and multi-sectoral collaboration on nutrition and food safety (e.g. institutionalization of NPAN)	NNS	LHEP, IEC, SWPMM, PFD, CBHC, HSM	MOHFW, MOLGRDC and other relevant Ministries, DGHS, DGFP
	• Develop and implement effective, integrated, sustainable, and evidence-based public policies for non-	NCDC, CBHC	LHEP, IEC, SWPMM,	MOHFW, DGHS, DGFP,

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	Supporting OPs	Agencies Concerned
	communicable diseases • Strengthen the capacity and competencies of the health system for the integrated early detection, management of non-communicable diseases and their risk factors. • Develop and strengthen capacity for surveillance of non-communicable diseases Provide services for conventional and non-conventional NCDs, in particular, mental health, GBV, suicide, injuries and poisoning		HIS & EH	DGNM and relevant other Ministries/Agencies, NGOs, CSOs, CBOs
	• Intensify programme for control, detection and management of tuberculosis, especially MDR-TB • Develop and implement special programme on rational use of antibiotics • Strengthen programme on vector borne diseases, including elimination programmes for malaria, kalaAzar, filariasis • Strengthen priority programmes, e.g. hepatitis, typhoid, dengue, HIV/STDs	CDC, TBL & ASP	CBHC, HSM, AMC, LHEP, IEC, SWPMM	MOHFW, HEU, DGHS, DGFP, DGDA, DGNM, NIPSOM, IEDCR
	• Endorse and implement the AMC Strategy and Action Plan • Strengthen AMC regulatory authority to regulate practitioners through a certification/registration system • Raise awareness about AMC and treatments especially for NCDs	AMC	CBHC, HSM, NCDC, CDC	MOHFW, DGHS, DGDA
Strategic objective 8: To promote healthy lifestyle choices within a healthy environment	• Evidence based advocacy for enforcement of legislation • Introduce appropriate measures in line with legislation e.g. no smoking zones • Develop guidance and health related evidence for promotion of green urban spaces and recreation areas for the public • Support legislation on air standards and controls in Industrial areas	LHEP, IEC	SWPMM, PME, PMR,	MOHFW, MOEF, MOE, MOLGRDC, DGHS, DGFP, BELA, Urban Planners, NGOs, CSOs, Mass Media, etc.
	• Capacity development, including pre and in-service curricula, on lifestyle choices, public health and school health • Promote around healthy diet, the hazards of salt, oil and sugar, and need for high fruit and vegetable intake • Lead actions to stop smoking and substance abuse • Implement public education campaigns about the benefits of exercise	LHEP, IEC, ME&HMD	SWPMM, NNS, PME, PMR, NCDC	MOHFW, MOEF, MOE, MOLGRDC, DGHS, DGFP, BELA, Urban Planners, NGOs, CSOs, Mass Media, etc.

Strategic Objective	Priority Activities	Implementation Structure		
		Lead OP	**Supporting OPs**	**Agencies Concerned**
	• Develop lifestyle and environment strategy in collaboration with other Ministries and stakeholders • Establish youth reference group for creative development of strategies to connect with young people • Develop and implement social media strategy • Roll out targeted knowledge products via media platforms	LHEP, IEC	SWPMM, PMR, PME	MOHFW, MOY&S, MOEF, MOE, MOLGRDC, DGHS, DGFP, BELA, Urban Planners, NGOs, CSOs, Mass Media, etc.
	• Promote safe and healthy environments within health facilities, household, workplaces and schools, including overall cleanliness, ordinary and medical waste management, sanitation facilities, • Improve protection of water sources at community level and in urban slum environments • Promote the importance of air quality especially involving cooking fuels and urban air controls especially linked to vehicle emissions • Promote value of urban green spaces including in new urban developments. Promote the importanance of biodiversity and health • Promote Road and Waterway safety	LHEP, IEC, HSM	SWPMM, CBHC	MOHFW, MOLGRDC, MOY&S, MOEF, MOE, DGHS, DGFP, BELA, Urban Planners, NGOs, CSOs, Mass Media, and relevant other Ministries/Agencies, etc.

It is important to note that the lead OP while discharging its responsibilities, by interacting with the supporting linked OPs as mentioned above, will also need to have linkages and communication with relevant Government Ministries/Agencies/Professional and Statutory bodies/NGOs and private sector institutions for realizing desired results.

3.4. Issues Relating to Poverty, Environment, Climate Change, Women, Children and Gender etc

The 2030 Agenda for Sustainable Development articulates an ambitious set of targets aimed at transforming the world by ending poverty, hunger and inequality, taking action on climate change and the environment and improving health and education. The targets of SDG 3 are numerous and wide-ranging and cover issues of communicable and non-communicable diseases, lifestyle and healthy environments and provide a holistic framework for development of national responses.

***Poverty*:** Promoting human development involves ensuring education and training, improving and sustaining health and nutrition, and planning population. Health and poverty share a bi-directional relationship, wherein, health is both a cause and effect of poverty. The incidence of ill health among the poor can be attributed to a number of interlinked causes. Poor nutrition weakens immunity and thus makes human being more vulnerable to various diseases. Ill health imposes a higher level of risk on the poor relative to the wealthier population. Good physical and mental health is essential for effective production and reproduction.

The health and nutrition link to poverty and growth has important policy implications in the HNP sector. The Government recognizes the severity of this issue and has emphasized the human dimension of poverty, i.e. deprivation in health, deprivation in nutrition including water and sanitation, as well as related gender gaps. The 4th HPNSP, therefore, emphasizes reducing severe malnutrition, high mortality and fertility; promoting healthy lifestyles; and reducing risk factors to human health from environmental, economic, social and behavioural causes with a sharp focus on improving the health of the poor. All these are expected to reduce poverty and improve the human development index of Bangladesh, and contribute to attaining the middle income country status by 2021.

Environment and Climate Change: Despite laudable improvement in health and social sectors in Bangladesh over the past few decades, the engagement of the MOHFW in environmental health and climate change issues has remained limited, although there is growing concern about environmental pollution (air, water, and land). Indoor Air Pollution (IAP) remains almost entirely ignored. Inhaling smoke from burning biomass, wood, dung and other traditional fuels can have both temporary and permanent consequences for health, and recognition of the health impacts of IAP is growing worldwide. Moreover, poor water and sanitation conditions and hygienic practices, and lack of proper disposal of waste continue to result in water and food-borne diseases, and seasonal outbreaks like dengue in Bangladesh. Insufficient green spaces and sidewalks in urban areas, are also contributing to NCD burden including diabetes, cerebro and cardio-vascular diseases, cancers, etc. In addition, environmental and health risks due to arsenic contamination, abuse of formalin, pesticides, and other preservatives (chemicals) in foods, fruits, fishes deserve focusing. Children, women and elderly people are likely to be more affected by the environmental health hazards.

Increasing salinity in the costal belt areas due to climate change leading to compromised safe water is posing threat to increased diarrhoea related morbidity and mortality. Acute effects of storms and flooding in the form of injury and death, and indirect effects of compromised sanitation leading to increased incidence of diarrhoeal diseases are always seen. Warmer humid conditions also accelerate vector breeding contributing to increased vector borne diseases. Higher temperature might cause propagation of new pests and disease vectors, while common diseases such as dengue, malaria and water borne diseases (such as cholera) will take significant toll on human health conditions.

The complex relationships between environmental factors, climate change and human health, taking into account multiple pathways and interactions, should therefore be seen in a broader public health context, and warrants re-prioritization of public health interventions to achieve national and global objectives for improved health status under the SDG agenda. The epidemiological transition has huge direct impact on the financial vulnerability of the patients, especially the poor and has long term implications for health budget. The existing capacity of the public health system needs to be strengthened to prevent and manage the rising NCD threats through increasing mass awareness regarding conserving environment and adopting a healthy lifestyle. The existing policy, practices and resource allocations including HR may have to be revisited and realigned to address the new challenges.

The health sector's involvement in environmental and climate change issues will be further strengthened together with expansion of medical waste management to cover all medical installations and programmes of public and non-public sectors. The MOHFW will find out which type of diseases is more likely to spread as a result of climate change within Bangladesh. A comprehensive study regarding the detrimental impacts of environmental and climate change on human health as a whole will be conducted. Appropriate initiatives will be undertaken to manage the emerging and re-

emerging health problems together with strengthening emergency preparedness and response capacity.

Greater emphasis will be given by the MOHFW to environmental pollution (air, water, land). The MOHFW will take a lead for raising mass awareness and advocate for developing/ updating multi-sectoral national policies and strategies in order to combat health hazards due to environment and climate change. The 4th HPNSP has been designed to address the above mentioned issues/ tasks through implementation of the OPs like CDC, NCDC, LHEP, and CBHC.

***Women, Children and Gender*:** There has been increasing recognition of the importance of improved gender equity in health sector plans and programmes. More generally, there is a growing consensus that no equity in health care will be achieved until there is equity in inputs including but not limited to gender, geography, poverty, illiteracy, etc. The implementation of policies and plans to improve gender equity was limited mainly due to weak institutional mechanisms and leadership. However, continuous effort is going on to improve gender equity.

The Women Friendly Hospital Initiative (WFHI) was included in the HPNSDP specifically to address discriminations suffered by women/girls. 28 women friendly hospitals render specialized psychosocial counseling to women survivors of violence and link them with legal aid agencies. Among these, 10 DHs have been accredited as Women-Friendly Hospitals. Local community and elected representatives mobilize local resources (in kind and cash) to support cleanliness of hospital, establishing public toilets within hospital premises, funding for local recruitment of staff and facility renovation.

A Gender Equity Strategy (GES) was also finalized and published by Health Economics Unit (HEU). The revitalization of the CCs has provided a woman-friendly platform where more than 90% of service seekers are women availing various PHC services near at home. According to the Bangladesh Health Facility Survey 2014, 47.6% of the public health facilities excluding CCs had separate improved toilets for female patients. In spite of the achievements over the past several years, major inequities in health outcomes still exist and need to be addressed. In general, women and children have less access to health care and their health status is relatively worse than their male counterparts.

Keeping in view the aforementioned, the activities as indicated in the Gender Equity Action Plan will be implemented during the 4th HPNSP. More health care facilities will be added offering women and children friendly environment, including specific breastfeeding corners, separate toilet facilities and waiting rooms. The updated ESP will be implemented to ensure better access of women to quality health care. Generation of gender disaggregated information will be facilitated and gender data management will be strengthened.

3.5. Technical Assistance

Recognizing the necessity for effective and responsive technical assistance support to the diverse and evolving needs of HPNSDP, a joint donor technical assistance fund (JDTAF) was formed in 2012 to pool interested DPs for TA support to HPNSDP. A Technical Assistance Committee (TAC) under the leadership of Joint Chief (Planning), MOHFW was formed in 2012 comprising of MOHFW, agencies under it and DP representatives to oversee the TA proposals, review and recommend for endorsement by the Government. The JDTAF was acknowledged as an effective institutional arrangement for sector management and TA coordination since TAs were well aligned to the HPNSDP and had provided very useful and valued support to the MOHFW. However, there remain some areas of challenges to get better results from TAs which include: TA plan; TA procurement; TA tracking; TA effectiveness; etc.

To overcome the challenges, the 4th HPNSP emphasizes on- development of a harmonized TA Plan to identify major areas of TA needs and how these will be supported; strengthening of capacity of TA recipients to utilize TAs effectively; accelerating TA procurement; strengthening monitoring/follow-up of TAs at MOHFW level; utilizing TAs to address the challenges of MOHFW which most relate to technical issues and/or innovations; etc.

3.6. Procurement Management

The MOHFW spends significantly large amount of funds in procurement of medicines, medical equipment, services, capacity building etc. Central Medical Store Depot (CMSD), DGFP Procurement and Logistics Unit, Health Engineering Department (HED) and Public Works Department (PWD) are considered as agencies with good procurement capacity. Focus on procurement system has been there since the beginning of the first SWAp, which has contributed to reduce processing time, make more trained personnel available, putting up a web-based procurement system in place, etc. For promoting the stewardship role of the MOHFW and to ensure quality and oversee procurement process, the Procurement and Logistics Management Cell (PLMC), staffed with both MOHFW officials and TA staff, was set up during HPNSDP implementation period. The PLMC will continue to support MOHFW's procurement functions in the 4th HPNSP. However, there are some challenges that need to be addressed in the 4th HPNSP which include- improper procurement planning; issues in procurement process and distribution; quality and efficiency; capacity issues; etc.

The key activities that will be pursued to overcome the challenges in the 4th HPNSP involve - adoption of a mechanism for need-based procurement including development of a procurement plan; expansion of supply chain management portal (SCMP); establishment of a mechanism for procurement coordination between DGHS and DGFP; introduction of automated mechanism for stock-taking and warehouse management, asset management; introduction of routine surveillance to ensure quality of goods; development of a database for trained staff on procurement issues, etc.

3.7. Macro-level Considerations in Implementation

The timeline for the implementation of the 4th HPNSP is critical, as some of the SDGs are closely related to the determinants of health. The SDGs underscore new challenges and opens up new opportunities for the MOHFW and its partners to take coordinated actions on various factors which contribute to better health for a prosperous society.

The main burden of ill health and mortality in Bangladesh is changing with a clear rise in the prevalence of NCDs. This transition has huge direct impact on the financial vulnerability of patients, especially the poor, and has long term implications for the health budget. The existing capacity of the public health system needs to be strengthened to prevent and manage the rising NCD threats through increasing mass awareness regarding conserving the environment and adopting a healthy lifestyle. The existing policy, practices and resource allocations, including HR, may have to be revisited and realigned to address the new challenges.

In order to effect the changes outlined by the strategies of the 4th HPNSP, a more prominent role in governance and stewardship will have to be assumed by the MOHFW to ensure that all health sector stakeholders including the expanding for-profit private sector, adhere to policies, procedures and quality standards. This will, in turn, require improving capacities in governance and management across Government entities, introducing and updating relevant legislative frameworks, building partnership-based relationship with the non-government sector, encouraging professionalism among the practitioners and widening the scope for community participation and ownership.

One of the challenges for the HNP sector is to ensure better service within a significantly constrained financial environment. The Government allocation to health remains low in terms of regional comparisons while the sector's performance has been high, which has led to recognition of Bangladesh experience as one of "good health at low cost". The MOHFW will concentrate on demonstrating improved performance across the sector and building the investment case for higher health funding as a foundation for future national prosperity. Achieving sustainable levels of financing for the HNP sector will depend on a combination of managing demand through prevention and effective treatment, seeking efficiency gains based on prioritization, reducing wastage, introducing better ways of providing care, and through advocacy with the Government and the DPs for increased investment.

3.8. Coordination Mechanism between Agencies, Operational Plans etc

Functional Co-ordination of the Field Level Activities of DGHS and DGFP

The Government of Bangladesh (GOB) is committed to providing quality health care services to the community through efficient and effective service delivery system that is accessible, equitable, affordable and sustainable. Presently DGHS and DGFP under MOHFW are providing health, family planning and nutrition services at different levels through using the same platform in certain cases and separate platforms in other cases of service delivery. This type of bifurcated service delivery has resulted in duplication & fragmentation of services, inappropriate use of HR, wastage of resources, poor accessibility and minimization of quality of care.

To embrace the challenges of the upcoming SDGs and UHC with limited resources, the MOHFW has developed an updated essential service package (ESP) for provision of quality health, nutrition and FP services from the community to the district level. In order to implement the updated ESP cost-effectively, it is imperative that a harmonized service delivery system (*a structured process of functional coordination for provision of HNP services without affecting the organizational structure of DGHS, DGFP,* DGNM *and other stakeholders*) is put in place during the implementation of the 4th HPNSP.

Human resources - Health Assistants of DGHS and FWA of DGFP) - available from two sources provide domiciliary services at the household level. These services include maternal and child health, FP, Community IMCI, adolescent health, social awareness creation, EPI (outreach site), couple and pregnancy registration, death notification and referral.Assistant Health Inspector (AHI) and Health Inspector (HI) from DGHS and FPI from DGFP are the first line supervisors respectively for the supervision of domiciliary services. This two-stream of service delivery modality for similar services to the same clientele leads to avoidable wastage of resources due to duplication and lack of an appropriate coordination mechanism for functioning at the field level.

At the ward level, one Community Clinic (CC) is providing ESP for more or less 6000 population. The Community Health Care Provider (CHCP) offers ESP especially focusing on PHC on a full-time basis while the HA and FWA provide health and FP care according to their Job description, skill and capacity. This platform was created and revitalized for providing integrated health, FP and nutrition services with proper referral linkage.

The service outlet under DGFP situated at the ward level is Satellite Clinic and at the union level is UH&FWC and that under DGHS is Rural Dispensary/Union Sub-centre. The staffing pattern of UH&FWC of DGFP is not the same as that of the RD/Sub-centre of DGHS, but the type of service delivery is similar. The line of supervision is also different. The referral linkage from Satellite Clinic and CC to UH&FWC is irregular and sometimes the service providers from UH&FWC send patients to MCWC at the district level bypassing the UHC, as do the CC bypass the Union facilities to refer to

the UHC. The infrastructure of RD/Sub-centre is not conducive for conducting normal deliveries in comparison with UH&FWC, although these may be staffed with Medical Officer and Paramedics. Presently, DGFP is carrying out regular activities for ensuring 24/7 normal delivery service care at a large number of UH&FWCs, in addition to other FP services.

The bed strength of UHC varies from 31 to 50 beds. Presently specialized services are also being provided by a group of Consultants in addition to general, emergency care and investigation. There is also a MCH unit under DGFP providing maternal and child care in addition to PPFP and other FP services. DGHS service providers are providing EOC, IMC, STD and other RH services, post abortion care, EPI, nutritional care, health education and counseling, outdoor and indoor services, emergency services, dental services, investigation, specialized services and referral service. In respect of MCH care it seems to be a duplication of services.

Opportunity therefore exists to strengthen harmonized service delivery system giving emphasis on EOC, Post MR Family Planning, PAC, PPFP, EPI, IMCI, newborn care, adolescent health, combined reporting on MNCRH and MPDRS by both DGHS and DGFP service providers. In respect of low performing and hard to reach areas evidence based combined local planning needs to be introduced with sharing of HR and other logistics from both the Directorates.

Under DGFP almost every district has one MCWC providing MCH, new born care FP, MR, PAC and adolescent care (although a few MCWCs are situated at the Upazila level). Quite often the MCWC at the district HQs is located at a short distance from the DH in the same town/city. These MCWCs provide comprehensive EOC with trained manpower. Usually complicated patients are referred to DHs which are better manned and equipped to handle such cases. There is scope for mutually beneficial coordination between these service facilities of MOHFW at the district level.

The DHs ranging from 100 to 250 beds provide a wide range of services including some specialized ones. The DH is also earmarked to provide ESP in addition to being the referral centre for UHC and MCWC. Both DH and MCWC provide comprehensive EOC and sometimes are struggling for skilled manpower due to non-existence of a structured system for sharing available human resources between DGHS and DGFP for providing EOC from these service delivery facilities.

Over the past decade there has been an increasing awareness of improving efficiency in service provision, and of achieving optimal outcomes for the communities from the fragmented nature of health service provisions. MOHFW intends to make conscious efforts during the 4th HPNSP for implementation of a harmonized, functionally coordinated approach of service delivery.

The main purpose of harmonization of activities or functional coordination is to have a congruent plan of action for various fsield level operating units in order to achieve greater value out of the service delivery system. Harmonization of functions at the service delivery levels require coordination of service delivery activities provided mainly by DGHS and DGFP field personnel involving sharing of available HR, facility and logistics. The following strategies will be adopted to make the harmonized approach of field level functional coordination effective:

- Review job description of HA, FWA, CHCP and their immediate supervisors to reflect harmonized functional coordination;
- Formation of joint committees at different levels comprising of and keeping provision for co-chairmanship of DGHS and DGFP officials at different levels;
- Hold regular meetings of the coordination committees including yearly planning for working together at different levels of service delivery and follow-up of the decisions;

- Provide unified services on maternal health especially EOC, post abortion care, child health and neonatal heath, MPDRS, reproductive and adolescent health, registration of births, couples and pregnancy;
- Provide EPI, IMCI, CDD, Nutrition, Reproductive Health (RH) and FP services at community and facility level and especially Post Partum Family Planning (PPFP) including Post MR Family Planning and PAC at UH&FWC, UHC, DH and MCWC along with training of DGHS personnel on PPFP;
- Exchange of HR especially Anaesthetist between DH and MCWC for EmOC and align resource of DGHS and DGFP to ensure services of ESP;
- Conduct community awareness activities and joint response to gender based violence and prevention of child marriage;
- Make joint/coordinated response by DGHS and DGFP service providers to reach and address the needs of the adolescents and the youths;
- Develop a common guideline for strengthening referral mechanism using existing platform;
- Refer from the CCs and Satellite Clinics to the higher tiers of service facility (e.g., UH&FWC, UHC, DH and MCWC) and attain a minimum standard of care and improve quality of care;
- Exchange and share information by comprehensively capturing data and using local level data for decision making on reproductive including FP, maternal, neonatal, child and adolescent health (RMNCAH) and create a common database with the active involvement of MIS of DGFP and DGHS;
- Assess the skill and training needs of the service providers (level wise) and develop capacity for implementing harmonized activities. The HR of DGHS and DGFP will be involved in the need assessment and conduct of joint training programmes;
- Distance based learning and using ICT for training may be jointly developed by DGHS and DGFP training units;
- Advocate with the professional bodies, NGOs and private sector for involving these entities and supporting to make the harmonized functional coordination approach effective;
- Develop an inclusive, comprehensive and consistent IEC/BCC/SBCC messages under the leadership of MOHFW for distribution through the channels of DGHS and DGFP. The IEC Technical Committee at MOHFW and the joint IEC/BCC Working Group has been functioning with joint leadership of BHE, IEM and IPHN supported by the NGOs. This arrangement would be utilized to implement the recently approved Comprehensive SBCC Strategy;
- The field workers of DGFP and DGHS have started using Tablets for community awareness raising activities. The Tablets would be loaded with the comprehensive IEC/BCC/SBCC e-messages toolkit.
- Different materials of interest and announcements related to HNP would be jointly shared on the websites of DGHS and DGFP. The websites would be jointly monitored through the IEC/BCC Working Group.
- Develop common service delivery plan for the lagging areas, particularly for Dhaka, Sylhet and Chittagong Divisions including areas for implementation and supervision jointly by DGHS and DGFP officials;
- Carry out all preventive health care functions of NCDs, pregnancies, nutrition, etc. jointly by the providers and field workers of both DGHS and DGFP; and

- Encourage to undertake/develop innovative activities by the local level providers and mangers of DGHS and DGFP for implementation on a joint basis.

Effective implementation of a functionally coordinated service delivery mechanism both by DGHS and DGFP is a challenging task. However, there are existing evidences of coordinated service delivery by the field personnel of DGHS and DGFP in certain programme activities being implemented by the Government (e.g., EPI). Similarly, field activities related to MNCH, nutrition, SRHR, etc. run by the DP-led off-budget programmes in certain parts of the country are also the examples of joint functions of DGHS and DGFP personnel from the community to the district level.

MOHFW, based on the lessons learnt, would be issuing government office orders identifying the areas of functional coordination and their compliance by both the DGHS and DGFP field personnel. Office order will also be issued to this effect that DGHS facility will accept any referred case by the DGFP personnel and vice versa. Job descriptions of the field personnel will be reviewed to accommodate task shifting responsibilities along with accountability framework of field personnel of both the organizations (DGHS and DGFP), so that each HR becomes well aware of his/her clear mandated responsibility.

In addition to the Maternal, Neonatal, Child Health and FP (MNCH-FP) Task Group, a coordination mechanism will be set up through formation of a Committee at the national level with two Directors of DGHS and DGFP as the Chair and Co-chair respectively for continuous supervision and monitoring of the status of functionally coordinated service delivery. This Committee, in addition to representations from various service delivery related OP personnel of DGHS and DGFP, will also include relevant representatives from the DPs, NGOs, Private Sector and Professional Bodies. Designing, developing and implementing the common service delivery plan for the lagging areas, and their overall reporting to the MNCH-FP Task Group will be a prime responsibility of this Committee. Joint supervision and monitoring of field activities along with reporting will also be done by this Committee. However, both DGHS and DGFP will need TA in various areas mentioned above in order to make the functionally coordinated service delivery meaningful and effective.

The expected results of harmonized activities under DGHS and DGFP are increased accessibility of care, provision of quality and coordinated care, minimization of wastage of resources, unified MIS for effective monitoring and supervision, strengthened linkages and formal sharing of care between health, FP and nutrition service providers, and more client satisfaction through providing standard package service delivery at a single outlet.

Coordination mechanism between OPs

The primary implementing unit of the MOHFW in the SWAp is the OP. The number of OPs in the 3rd Sector Programme was 32, distributed across the DGHS, DGFP, DGDA, DGNM, NIPORT and the MOHFW. The number of OPs in the 4th HPNSP has been reduced to 29 for better coordination and management. Some of the OPs of HPNSDP have been merged and/ or renamed without affecting the programme areas. Each OP implements specific activities of the Programme keeping linkages with other OPs, and supports activities of other actors for achieving the strategic objectives of the 4th HPNSP (Table-5).

Table 5: Coordination linkage between OPs & other actors

Sl. #	Operational Plans (OPs)	Designated OP lead	Agencies concerned with implementation/ coordination	Linked/ Supporting OPs

Sl. #	Operational Plans (OPs)	Designated OP lead	Agencies concerned with implementation/ coordination	Linked/ Supporting OPs
Component 1 – Strengthening Governance and Stewardship				
1.	Sector-Wide Programme Management and Monitoring (SWPMM)	JC (Planning), MOHFW	MOHFW, DGHS, DGFP and other agencies	All the OPs of the 4th HPNSP
2.	Planning, Monitoring and Research (PMR)	Director (Planning and Research), DGHS	DGHS, DGFP, MOHFW	SDAM, SWPMM and all the OPs of DGHS
3.	Planning, Monitoring and Evaluation (PME)	Director (Planning), DGFP	DGFP, DGHS, MOHFW	SDAM, SWPMM, TRD, and all other OPs of DGFP
4.	Health Economics and Financing (HEF)	DG, HEU, MOHFW	MOHFW, DGHS, DGFP and other agencies	SWPMM, PMR, PME
5.	Strengthening of Drug Administration (SDAM)	DG, DGDA	MOHFW, DGHS, DGFP and other agencies	SWPMM, PMR, PME, PFD, PSSM-HS, HIS & e-H, MIS
Component 2 – Health Systems Strengthening				
6.	Health Information Systems & e-Health (HIS & e-Health)	Director (MIS), DGHS	DGHS, DGFP, MOHFW	SWPMM, PFD, MIS, all other OPs of DGHS
7.	Management Information System (MIS)	Director (MIS), DGFP	DGFP, DGHS, MOHFW, Register General of CRVS, BBS, MOPA	SWPMM, HIS & e-H, TRD, HRD, PFD, and all other OPs of DGFP
8.	Medical Education and Health Manpower Development (ME& HMD)	Director (Medical Education), DGHS	DGHS, with linkage to specific OPs for IST activities	SWPMM, PMR, HRD,
9.	Procurement, Storage and Supply Management – Health Services (PSSM-HS)	Director (CMSD), DGHS	DGHS, MOHFW, MOPA, MOF	SWPMM, PFD and all other OPs of DGHS
10.	Procurement, Storage and Supply Management – Family Planning (PSSM-FP)	Director (Logistics), DGFP	DGFP, MOHFW	SWPMM, PFD and all other OPs of DGFP
11.	Physical Facilities Development (PFD)	Addl. Sec./Joint Sec. (Development), MOHFW	MOHFW, DGHS, DGFP, DGNM	SWPMM, HSM, CBHC, NMES, HRD, MCRAH, TRD, SDAM, PSSM-HS, HIS & e-H, PSSM-FP , MIS
12.	Human Resource Development (HRD)	One Addl. Sec. MOHFW	MOHFW and agencies under it	SWPMM, PMR, PME, ME&HMD, NMES, AMC, TRD
13.	Improving Financial Management (IFM)	Addl. Sec./Joint Sec.(FMA), MOHFW	MOHFW and agencies under it	All the OPs of the 4th HPNSP
14.	Training, Research and Development (TRD)	DG, NIPORT	DGFP, MOHFW,	SWPMM, PMR, PME, HIS & e-H, MIS, IEC, CBHC, MCRAH, HSM, MNCAH,

Sl. #	Operational Plans (OPs)	Designated OP lead	Agencies concerned with implementation/ coordination	Linked/ Supporting OPs
				CBHC, HRD, NMES, PFD
15.	Nursing and Midwifery Education and Services (NMES)	DG, DGNM	DGHS, DGFP, MOHFW	SWPMM, HIS & e-H, CBHC, MNCAH, MCRAH, HSM, MIS, HRD, TRD
Component 3 – Provision of Quality Health Services				
16.	Maternal, Neonatal, Child and Adolescent Health (MNCAH)	Director (PHC), DGHS	DGHS, DGFP, DGNM	SWPMM, PMR, MCRAH, NNS, CBHC, HSM, LHEP, IEC, HIS & e-H, MIS, HRD, PSSM-HS, ME&HMD
17.	Maternal, Child, Reproductive and Adolescent Health (MCRAH)	Director (MCH), DGFP	DGFP, DGHS, DGNM	SWPMM, PME, MNCAH, NNS, CBHC, LHEP, IEC, MIS, HRD, PSSM-FP, TRD, FPFSD, CCSD
18.	National Nutrition Services (NNS)	Director (IPHN), DGHS	DGHS, DGFP, MOHFW, and other concerned Ministries/Agencies	SWPMM, PMR, LHEP, IEC, MNCAH, CBHC, CDC, TB-L&ASP, NCDC, HSM, MCRAH,
19.	Communicable Diseases Control (CDC)	Director (Disease Control), DGHS	DGHS, IEDCR, NIPSOM, IPH, BITID, IDH	SWPMM, PMR, CBHC, HIS & e-H, HSM, PSSM-HS, LHEP
20.	TB-Leprosy and AIDS and STD Programme (TB-L & ASP)	Director, MBDC, DGHS	DGHS, IEDCR, NIPSOM, IPH, BITID, IDH	SWPMM, PMR, CBHC, HIS & e-H, HSM, PSSM-HS, LHEP
21.	Non-communicable Diseases Control (NCDC)	Director, DGHS	DGHS, MOHFW, and other concerned Ministries/Agencies	SWPMM, PMR, HIS & e-H LHEP, HSM, CBHC
22.	National Eye Care (NEC)	Director, NIO, DGHS	DGHS, IEDCR, NIPSOM, IPH,	SWPMM, PMR, CBHC, HIS & e-H, HSM, PSSM-HS, LHEP
23.	Community Based Health Care (CBHC)	ADG, DGHS	DGHS (including IPH), DGFP, DGNM, HED,	SWPMM, PMR, MNCAH, MCRAH, NNS, HSM, CDC, NCDC, CCSDP, FPFSD, LHEP, IEC, HIS & e-H, MIS, HRD
24.	Hospital Services Management (HSM)	Director (Hospitals and clinics), DGHS	DGHS (including CMSD), HED, PWD, BSMMU, Private Medical Colleges, Diagnostic Lab, Local Govt. Institutions, DFDA, MOWCA	SWPMM, PMR, PSSM-HS, CDC, NCDC, MNCAH, ME&HMD, SDAM, HIS & e-H
25.	Clinical Contraceptive Services Delivery Program (CCSDP)	Director, DGFP	DGFP, DGHS, MOHFW,	SWPMM, PME, FPFSD, MCRAH, PSSM-FP, MNCAH, CBHC, HSM, IEC, MIS, LHEP

Sl. #	Operational Plans (OPs)	Designated OP lead	Agencies concerned with implementation/ coordination	Linked/ Supporting OPs
26.	Family Planning Field Services Delivery (FP-FSD)	Director, DGFP	DGFP, DGHS, MOHFW,	SWPMM, PME, CCSDP, MCRAH, PSSM-FP, MNCAH, CBHC, HSM, IEC, MIS, LHEP
27.	Lifestyle, and Health Education & Promotion (LHEP)	Director (BHE), DGHS	MOHFW, DGHS, DGFP, IPH and other relevant Ministries	SWPMM, PMR, NNS, IEC, CBHC, CDC, NCDC, HSM, HIS & e-H
28.	Information, Education and Communication (IEC)	Director (IEM)	MOHFW, DGFP, DGHS, LHEP and other relevant Ministries	LHEP, MCRAH, MNCAH, FPFSD, CCSDP, CDC, NCDC, NNS
29.	Alternative Medical Care (AMC)	Director (Homeo and Indigenous Medicine)	MOHFW, DGHS, DGFP and other relevant Ministries	HSM, CBHC, NCDC, SWPMM

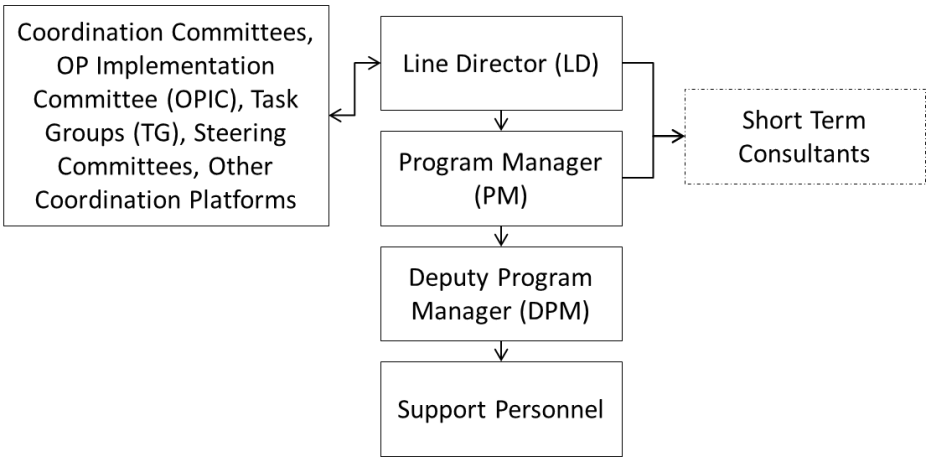
The financial and administrative lead in an OP will be the LD. S/he will be the overall supervisor of the implementation carried out in the respective OPs. S/he will maintain liaison with other OPs, units/wings of MOHFW, implementing agencies, DPs and with other relevant stakeholders. Financial management and control in the OP will also be his/her responsibility. S/he will be the focal person to disseminate the latest status of implementation and hence should have sound ideas about the execution of activities under different OP components. In this regard, s/he will be required to report progress in the form of periodic report or other documentation modality. LDs will take the initiative in strengthening capacity of the OP or its personnel. S/he will also initiate the process of engaging short term consultant(s) through TA, if required.

The LDs will be supported by PM(s). Depending on the number of OP components, the number and extent of activities under the components and their priority, there can be more than one PM in an OP. Under the leadership and regular guidance of the LD, PMs will carry out the day-to-day activities of the respective OP component(s). S/he will also coordinate, as needed, with other PMs, LDs of other OPs or other agencies depending on the nature of activities. S/he will regularly update the LD regarding physical progress and will support him/her in the required documentation process. PMs will be supported by Deputy Programme Managers (DPMs). Depending on the nature, extent and number of activities, there can be more than one DPM in any component of the OP. DPMs will be responsible for implementation of the respective activity or group of activities in a particular OP component. They will support the respective PMs in assuming and documenting the progress of activities and will suggest for any modifications or corrective actions. DPMs will also support the PMs and the LD in drafting required reports or in other required documentation, such as SmPR, APIR.

Each OP receives an annual allocation of funds from the ADP, which may be re-appropriated at the end of the 3rd quarter based on need and efficiency of fund absorption. Depending on the number of cost centres and the volume of funds allocated, there can be one Accountant assisted by an Accounts Officer for an OP. The Accountant will be supervised by one of the DPMs assigned with the responsibility of financial management. The Accountant will make expenditure as per the prior approved plan; maintain proper records of the expenditures; and will help the LD to monitor and ensure the required level of internal control in expenditure. S/he will support the LD in developing

annual budgets and periodic expenditure as well as audit reports for the OP. The following figure shows the OP implementation structure.

Figure 3: OP Implementation Structure



OPs will undergo revision following the MTR of the 4th HPNSP and the resultant revised PIP (RPIP) will be submitted for approval by the ECNEC. Following approval of the RPIP, the process of approval of the OPs through the inter-Ministerial Steering Committee will be followed. However, a particular OP may need to be revised at any other point during the implementation of the 4th HPNSP to rationalize activities and/or budget based on implementation experience.

The LD will remain accountable for presenting the performance and challenges of the respective OP in the OPIC, various coordination committees, annual reviews and other periodic appraisals. S/he may also take support from these committees in rationalizing activities and budgets in line with the performance and challenges faced in smooth implementation of the OP.

The Agency heads will be the overall supervisors of the LDs as well as the OPs, wherein, inter OP coordination takes place. The Planning Units of the DGHS and DGFP will coordinate among own agency's OPs. The Sector-Wide Programme Management and Monitoring OP will play the key coordinator's role with all the OPs. Activities of the OPs will also be co-ordinated by the thematic area based relevant Task Groups (TGs). RMNCAH-FP activities being the largest programme area in the 4th HPNSP, will be co-ordinated by both the DGs of DGHS and DGFP through the MNCAH TG. The existing inter OP coordination mechanisms (e.g. Nutrition Sterring Committee headed by Secretary, MOHFW; IEC-BCC Coordination Committtee headed by Additional Secretary (PH&WHO), MOHFW, etc.) will continue in the 4th HPNSP.

3.9. Implementation Monitoring

The Government has been following the results based development approach, as evident from the 6th and the 7th FYPs, as was followed in the HPNSDP. The results based development approach will also continue in the 4th HPNSP. The Monitoring and Evaluation (M&E) framework for the 4th HPNSP is primarily based on the RFW approach, underpinning the idea that achieving results at different levels will lead to desired health impact. The RFW of the 4th HPNSP consists of specific indicators and logical sequences between input, output, outcome and impact as mentioned below.

The eight strategic objectives of the 4th HPNSP have been categorized under three components, viz., (1) Governance and Stewardship; (2) Stronger Health Systems; and (3) Quality Health Services. Component-wise indicators, milestones and targets have been developed in the RFW of the 4th

HPNSP (Appendix-1 of the PIP). The RFW has set eight goal level indicators to be achieved by the end of the Programme period. Besides, there are 25 intermediate level indicators (outcome/output/process) covering three components of the programme (e.g., 4 governance and stewardship related indicators: 6 indicators related to stronger health systems; and 15 indicators related to quality health services). The RFW goal level indicators for the 4th HPNSP are shown in the table-6.

Table 6: Goal-level indicators of the RFW

Sl. No.	Indicator	Means of verification & timing	Baseline & source	Target June 2022
Goal 1	Under 5 Mortality Rate (U5MR)	BDHS, every 3 years	46, BDHS 2014	34
Goal 2	Neonatal Mortality Rate (NMR)	BDHS, every 3 years	28, BDHS 2014	18
Goal 3	Maternal Mortality Ratio (MMR)	BMMS/MPDR/MMEIG, every year	176, WHO 2015	121
Goal 4	Total Fertility Rate (TFR)	BDHS, every 3 years	2.3, BDHS 2014	2.0
Goal 5	Prevalence of stunting among under-five children	BDHS, every 3 years/ UESD, every non-DHS years	36.1%, BDHS 2014	25%
Goal 6	Prevalence of hypertension among adult population	BDHS, every 3 years/ NCD-RF, every 2 years	Female 32% Male 19%	Female32%
Goal 7	% of public facilities with key service readiness as per approved Essential Service package (ESP)	BHFS, every 2 years	FP: 38.2% ANC 7.8%	FP: 70% ANC 50% CH 50%
Goal 8	% of total health expenditure (THE) financed from public sector	BNHA, every 3 years	23.1%, BNHA 2012	26.2%,

In addition, there are process/output indicators at the OP level covering all the OPs for monitoring OP-wise progress of work on a six-monthly/annual basis. A number of tools will also be used to document and track outputs and indicators, for regular monitoring of the Programme, as illustrated in the table (Table-7) below.

Table-7: Various Implementation Monitoring Tools of the 4th HPNSP

Sl. #	M&E Tools	Responsibility	Frequency
1.	Annual Development Programme (ADP)	MOHW	Monthly
2.	Six Monthly Progress Report (SmPR)	PMMU/PW	Six Monthly
3.	Mandated Implementation Reports to Implementation Monitoring and Evaluation Division (IMED) in Forms 3 and 5	PW	Monthly (Form 5) Quarterly (Form 3)
4.	Review of Prioritized Action Pan (PAP)	PW	Six Monthly
5.	Review and Update RFW and OP level Indicators	PW	Periodically
6.	Annual Programme Implementation Report (APIR)	PMMU/ PW	Annually
7.	Review of DLIs	PMMU/FMAU/PW/World Bank	Six-monthly/ Annually

Sl. #	M&E Tools	Responsibility	Frequency
8.	Annual Programme Review (APR)	Jointly by MOHFW and DPs	Annually
9.	OP Review	OPIC	Periodically
10.	National ADP Review	National Economic Council (NEC)	Quarterly
11.	National representative sample surveys	BBS	Periodically
12.	End-line Evaluation of Sector Programme	IMED/	Once
13.	Programme Completion Report (PCR) to Planning Commission	PW	Once

The Parliamentary Standing Committee on the MOHFW exercises oversight over the functioning of the MOHFW, including the Sector Programme, reviewing specific aspects of health periodically and may like to issue guidance or recommendation.

Data collected from multiple sources will be utilized for M&E activities. Some of these are – (i) data on service contacts collected by different service delivery facilities (from CCs to tertiary level hospitals); (ii) routine data from specialized programmes carried out by DGHS and DGFP (immunization, IMCI, etc.); (iii) administrative data on health inventories, logistics, procurement, financial management, human resource management, trainings, etc.; (vi) data on physical progress of the OP activities; (iv) national surveys, including Bangladesh Health Facilities Survey (BHFS), BDHS, National Health Accounts (NHA), UESD Survey, Bangladesh Maternal Mortality Survey (BMMS), Multiple Indicator Cluster Survey (MICS), Coverage Evaluation Survey, etc.; (v) civil registration and sample vital registration system (SVRS); and (vi) population and household census. Monitoring data will be disseminated in the form of electronic reporting, monthly/bimonthly MIS reports, annual MIS reports, Survey reports, SmPRs, APIRs, quarterly IMED reports, etc.

The PW of the MOHFW will be the focal point for M&E and will take the leading role to coordinate with all MISs. In addition, the PW will enable the M&E Task Group (METG) to carry out its responsibilities which includes:– (i) oversee M&E functions of the MOHFW and MIS Units of its Directorates in relation to the 4th HPNSP; (ii) strengthen routine health information systems of the MOHFW in collaboration with the MIS Units, DPs and other agencies; (iii) review and endorse performance management plans and M&E frameworks for the 4th HPNSP; (iv) coordinate survey and research activities including need assessment for additional surveys/ research; (v) review and follow up APR priority actions and report back to LCG Working Group on Health, etc.

Improvement in the M&E system was done through establishing the PMMU by the MOHFW during implementation of the 3rd SWAp HPNSDP. The PMMU comprises of GOB staff as well as a TA Support Team (TAST) consisting of long-term national advisors and specialists along with Joint Chief, PW, as the head of the Unit. GOB staff included one Deputy Chief, three Senior Assistant Chiefs/ Assistant Chiefs, and two Programme Management Officers from DGHS and DGFP. The TA part was supported mainly by USAID and also by DFID through the JDTAF. The TAST consisted of a Chief Technical Advisor, two advisors, and two specialists on planning & coordination and monitoring & evaluation respectively. There was also a support service team provided through SWPMM OP to assist the GOB and the TAST of PMMU. The MOHFW has decided that in the 4th

HPNSP, the PMMU fully staffed with the designated GOB personnel and TA support, will be continued with its special focus on building M&E capacity within the PW.

3.10. The Proposed Operational Plans and Designated/Proposed Line Directors

The table- 5 under section 3.8 of this chapter shows the OPs along with the designated Line Directors. Notably, based on implementation experience, the designated LDs may undergo change during implementation.

Sl. #	Operational Plans (OPs)	Designated OP lead
Component 1 – Strengthening Covernance and Stewardship		According to the decision of the ECNEC and sub-sequent circular issued by Planning Division, Line Director(s) of the proposed OPs will be selected /appointed by the committee formed under MOHFW.
1.	Sector-Wide Programme Management and Monitoring (SWPMM)	
2.	Planning, Monitoring and Research (PMR)	
3.	Planning, Monitoring and Evaluation (PME)	
4.	Health Economics and Financing (HEF)	
5.	Strengthening of Drug Administration (SDAM)	
Component 2 – Health Systems Strengthening		
6.	Health Information Systems & e-Health (HIS & e-Health)	
7.	Management Information System (MIS)	
8.	Medical Education and Health Manpower Development (ME& HMD)	
9.	Procurement, Storage and Supply Management – HS (PSSM-HS)	
10.	Procurement, Storage and Supply Management – FP (PSSM-FP)	
11.	Physical Facilities Development (PFD)	
12.	Human Resource Development (HRD)	
13.	Improving Financial Management (IFM)	
14.	Training, Research and Development-NIPORT (TRD)	
15.	Nursing and Midwifery Education and Services (NMES)	
Component 3 – Provision of Quality Health Services		
16.	Maternal, Neonatal, Child and Adolescent Health (MNCAH)	
17.	Maternal, Child, Reproductive and Adolescent Health (MCRAH)	
18.	National Nutrition Services (NNS)	
19.	Communicable Diseases Control (CDC)	
20.	TB-Leprosy and AIDS/ STD Programme (TB-L & ASP)	
21.	Non-communicable Diseases Control (NCDC)	
22.	National Eye Care (NEC)	
23.	Community Based Health Care (CBHC)	
24.	Hospital Services Management (HSM)	
25.	Clinical Contraceptive Services Delivery Programme (CCSDP)	

Sl. #	Operational Plans (OPs)	Designated OP lead
26.	Family Planning Field Services Delivery (FPFSD)	
27.	Lifestyle, and Health Education & Promotion (LHEP)	
28.	Information, Education and Communication (IEC)	
29.	Alternative Medical Care (AMC)	

CHAPTER IV: SUMMARY OF OPERATIONAL PLANS

GOVERNANCE AND STEWARDSHIP

4.1 Sector-Wide Programme Management & Monitoring (SWPMM)

1. Name of the Operational Plan: Sector-Wide Programme Management & Monitoring (SWPMM)

2. Implementing Agency: MOHFW

3. Introduction

The experience of implementation of three successive health SWAps in Bangladesh leads one to recognize that sector wide coordination and management reduces duplication & lowers transaction costs; increases equity and sustainability; and improve aid effectiveness and HNP sector efficiency. SWAp management requires involvement, interaction and collaboration with policies and programs of Government Ministries and agencies, private and other non-state health service providers, professional associations, mass media, community organizations and various other non-Governmental actors contributing to health sector's development.

Within the first few years of HPSP, significant progress in developing the MOHFW's management capacity in the Directorates and at upazila-level was observed. The gradual improvement in management capacity of the MOHFW is also evidenced by the presence and performance of the MOHFW during the HNPSP (2nd SWAp period). Each year, the Program was reviewed by an independent review team (IRT) comprising of international/national consultants. The 2012 and 2013 annual program reviews (APRs) and 2014 mid-term review (MTR) by the IRT were functionally managed by the MOHFW (Ahsan et al., 2015). This was acknowledged in the MTR 2014 with the remark that there has been progress in SWAp management and coordination over the implementation of the 3rd SWAp HPNSDP.

During HPNSDP, implementation of **sector-wide management and coordination** involved activities in the areas of (i) coordination and collaboration across wide range of stakeholders; (ii) sector wide planning & budgeting; (iii) governance and stewardship; (iv) sector-wide monitoring and evaluation; and (v) coordination of different TAs provided by the DPs.

Steps were taken to improve both inter and intra OP coordination. Mainstreaming of nutrition services through the regular channels of DGHS and DGFP required improving coordination between various OPs involved in service delivery like CBHC, FPFSD, HEP & IEC etc.

Various Inter-Ministerial committees like the inter-ministerial and Urban Primary Health Care Provider (UPHCP) Steering Committee between the MOHFW and the MOLGRD under the leadership of MOHFW were formed during HPNSDP to serve as forum for coordinating the related inter-ministerial activities. To deliver mainstreamed nutrition service at all service delivery points of DGHS and DGFP with the CC being the first contact point, a Nutrition Implementation Coordination Committee (NICC) headed by DG, DGHS and a Steering Committee for Nutrition Implementation (SCNI) headed by Secretary, MOHFW were formed to provide overall guidance. Existence of the operation of these committees showed that provision of co-operation mechanisms need purposeful leadership and considerable mentoring to bring desired results.

The LCG Working Group on Health works as the highest forum for GOB-DP policy discussions replacing the previous HNPSP Coordination Committee. MTR 2014 found the LCG WG on Health

performing well. Besides, nine Task Groups (TGs), were formed with representation from all stakeholders including DPs for dealing with technical aspects in nine thematic areas, namely- Monitoring & Evaluation TG, Financial Management TG, Procurement TG, Nutrition TG, Human Resources TG, Gender, Equity, Voice and Accountability TG, Health Financing Resource TG, MNCH&FP TG, and Sector Management TG,. Formal interactions between the DPs and the MOHFW were conducted through the LCG Working Group on health and nine issue-based technical TGs. The MTR 2014 opined that the TG system was one example that was variable in effectiveness. Some TGs appeared to work well and the members were content with the level of information sharing, discussion and agreements made; while other TGs provided a different picture due to inadequate participation, readiness of participants and management.

Since the adoption of SWAp in the HNP sector by the MOHFW in 1998, '**planning and budgeting**' has always been one of the key focused areas of the MOHFW. The evaluation report of the first Sector Program-Health and Population Sector program (HPSP) (1998-2003)- prepared by the Implementation Monitoring and Evaluation Division (IMED), acknowledged that the planning functions of the Ministry under SWAp increased to a great extent and the program operations in these respect became more effective. However, IMED's evaluation report on the second Sector Program-Health, Nutrition and Population Sector Program (HNPSP) (2003-11) pointed to areas of weak co-ordination in the planning and budgeting process at the MOHFW. Consequently in the third sector program- Health, Population and Nutrition Sector Development Program (HPNSDP) (2011-16) 'planning and budgeting' was considered as a key priority area for strengthening the health system.

In the development of the HPNSDP strategic plan, the number of OPs was reduced to 32. This was a step forward to both reducing the complexity of budgeting and planning as well as a modest rationalization of functions to remove elements of duplication. Under HPNSDP, planning and budgeting was a component of the SWPMM OP. The Planning Wing of MOHFW-through planning and budgeting activities under the SWPMM OP of HPNSDP- provided expert support to LDs, guiding them to appropriately design standardized plans and budgets, strengthened their management and implementation mechanism, and produced reports relevant to OPs, especially with respect to the achievements in their respective Results Framework (RFW) and other sectoral progress reports. The Planning Wing with support from PMMU also organized three orientation workshops during HPNSDP period on how to prepare allocation proposals for the ADP, meaning of column wise terminologies reflected in the ADP format, coordination and reporting requirements and overall management issues in planning and budgeting to the Line Directors and other key OP managers and staff.

There has been an average annual growth of about 15% in the total Annual Development Program (ADP) allocations of MOHFW during the last five years. As for HPNSDP, average annual growth in total ADP allocation was 16.04% during 2011-16, increase in GOB allocation was about 20% and that for PA was 14.84%. This shows an increasing trend in development financing by the government for the HNP sector. The average ADP utilization rate of last five years of HPNSDP implementation stood at around 85%. However, the proportionate budget of MOHFW as percentage of national budget is not encouraging, even though there has been an absolute average increase of Tk. 460.65 crore (US $ 57.58 million) annually in ADP allocations for HPNSDP from the level of FY 2011-12.

The MTR 2014 adjudged the HPNSDP as having made 'good progress' in planning and budgeting. It also revealed that all the OPs were submitting timely AWPs with budgets.

In terms of sector wide monitoring & evaluation (M&E**)**, focus was on improvement in the routine MIS of the DGHS and DGFP especially in terms of expanding connectivity. Monthly monitoring of OPs of HPNSDP took place in the ADP review meetings at MOHFW chaired by the Secretary. OP level activities were also reviewed by the OP Implementation Committee (OPIC) chaired by Joint Chief (Planning) and the Steering Committee chaired by Hon'ble Minister for MOHFW. Piloting for the development of an automated and computerized Routine Health Information System (RHIS) is under implementation in two districts during the program period.

An institutional innovation introduced in HPNSDP was the setting up of the Program Management and Monitoring Unit (PMMU) under the PW which- assisted by a technical assistance support team (TAST) (sourced from MEASURE Evaluation) provided technical support to the PW in M&E, and in tracking and management of program implementation. The PMMU regularly produced six-monthly progress reports (SmPR), and annual implementation progress reports (APIR) which fed into the preparation of independent annual program reviews (APRs) of HPNSDP. All these indicate MOHFW's increasing institutional capacity in M&E. Follow up of prioritized action plans (PAP) of each year's APR was also done on regular basis. These activities also created useful results in gaining SWAp management efficiency.

The development of Results Framework Performance Management Plan (PMP), Indicator Reference Sheet and an M&E Strategy and Action Plan (MESAP) contributed to strengthened M&E in the HNP sector. The MESAP seeks to strengthen progress monitoring of HNP sector and to promote evidence-based decision making.

A coherent multi-year integrated and consolidated technical support plan was developed in the PIP of HPNSDP for stronger TA coordination. The pooled TA fund titled 'Joint Donor Technical Assistance Fund (JDTAF)' was managed and funded by DFID and proved itself as an effective institutional arrangement for sector management and TA coordination. A TA Committee (TAC) was formed comprising of MOHFW, agencies under it and DP representatives to oversee the TA proposals, review and recommend for endorsement by the Government. The MTR 2014 acknowledged TA progress in HPNSDP and recognized that some TAs were well aligned to the HPNSDP and had provided useful and valued support to the MOHFW.

There were some achievements in governance and stewardship during the HPNSDP in terms of identifying the prevalent constraints and taking the initiative of a few regulatory reforms. In HPNSDP, stewardship issues and governance issues were looked at more closely and limited progress was acknowledged in the MTR. A Governance and Steradship Action Plan (GSAP) was developed during the MTR. However, the MTR identified that many challenges like regulatory instruments, institutional capacity, coordination mechanism need to be addressed properly. The MOHFW's stewardship role in the matters of urban and tribal health also seeks priority.

In spite of the progress gained during the last 18 years in sector wide program management and coordination, there is room for further improvement in all constituent components of sector-wide program management and monitoring. focus needs to be given in the areas of multi-sectoral and institutional coordination; inter and intra op coordination with special focus on training; funding and utilization; non-functional health facilities; aid effectiveness, aid alignment and harmonization, transparency; SWAp arrangement; GOB-DP coordination; DPA expenditure; DPs' commitment on project aid; implementation of MESAP; institutionalization of PMMU; TA plan; TA tracking and effectiveness; TA procurement through JDTAF; TA tracking and effectiveness; dependency on TA and TA effectiveness; monitoring of DLIs and health related SDG indicators; etc. Activities for

further improvement in sector-wide program management and monitoring will be pursued through implementation of the SWPMM OP in the 4th Sector Program.

4. Objectives

The general objective of SWPMM OP is to improve the performance of HNP sector through appropriate planning, budgeting and monitoring for coordinated and efficient utilization of resource.

The specific objectives are:

(i) To develop equitable and diverse health, nutrition and population sector strategies, 5-year plan, PIP, OPs, and improve budget management;

(ii) To monitor, manage, coordinate and evaluate the 4th HPNSP;

(iii) To support implementation of M&E Strategy and Action Plan (MESAP) and operationalize a sustainable M&E system in the MOHFW;

(iv) To strengthen the PMMU of the Planning Wing, MOHFW for strengthening planning, monitoring, coordination and evaluation activities of the 4th HPNSP;

(v) To assist and coordinate with the implementing agencies to prepare OPs in line with the SIP of the 4th HPNSP and implement according to agreed result framework/performance indicators/OP level indicators.

(vi) To strengthen and build capacity of the PW, MOHFW including the Planning Units of DGHS, DGFP and other planning activities of the agencies under MOHFW;

(vii) To coordinate with the implementing agencies, other actors for harmonization, financing and research for better implementation of the program; and

(viii) To coordinate with the development partners (DPs) for overall aid harmonization; sustainable DP financing; TA effectiveness; and review and study with a view to improving the HNP sector development process.

5. Components

During the 4th HPNSP implementation period, activities of the SWPMM OP will be pursued under six components including the previous five components and one new compnent : (i) Sector-wide management, coordination and collaboration; (ii) Planning and Budgeting; (iii) Monitoring and Evaluation; (iv) Technical Assistance Coordination; (v) Governance and Stewardship; and (vi) Stengthening ICT capicaty of MOHFW to implement e-governance. A brief description of the components is mentioned below:

Component-1: Sector-wide management, coordination and collaboration:

One of the key responsibilities of the SWPMM OP is coordination across wide range of stakeholders, such as - within the Wings/Agencies of MOHFW and with other relevant Ministries/Divisions; DPs of the HNP sector. The key activities under the Sector-Wide Management, Coordination and Collaboration component will be as follows:

(i) Efforts will be made to acknowledge the inputs of MOHFW/other Ministry/DP parallel projects contributing to the development of the HNP sector through improved coordination and collaboration. In the case of MOHFW, conscious efforts will be made to maximize use of available resources through close coordination between investments in the discrete projects

under the Ministry's ADP and the OPs in the Sector Program and between use of revenue and development budgets. 'HNP sector Coordination Forum' will be established with Honorable Minister, MOHFW in the Chair for stronger coordination at higher level.

(ii) Steps will be taken to facilitate the LDs to coordinate within the components of their own OPs as well as with other OPs.

(iii) Special emphasis will be given on coordination of training activities of the OPs. In this regard, a Training Coordination Committee chaired by Additional Secretary, MOHFW will be formed with Joint Chief (Planning) as co-chair. The PW will provide secretarial support to the Committee.

(iv) To strengthen GOB-DP coordination, LCG Working Group on Health meetings will be continued on a quarterly basis as had been done during HPNSDP for program appraisal, policy discussion and guidance.

(v) A review of the existing TGs will be undertaken to ensure their relevance and effectiveness. Formation of TGs on the emerging issues like NCD, Governance & Stewardship will be given preference. Guidelines will be jointly developed with the DPs to improve their task orientation, regularity and follow-up.

(vi) Effective coordination mechanism in the areas of program designing, planning, review and budgeting will be established with the MOLGRDC and MOCHTA for improving urban health and tribal health services respectively. Similar coordination panel will be established with the relevant Ministries, agencies and other stakeholders to improve sharing information and strategy as well synchronizing actions on health aspects traffic accidents (3.6), substance abuse and narcotics (3.5), and pollution of air, water and food (3.9)-all three of which are included as targets of goal-3 in the SDGs.

(vii) Current mechanisms for health sector policy and strategy dialogue between MOHFW (and other Ministries) and the DPs will be revisited with a view to achieving greater relevance and synergy. Inter-ministerial coordination will be strengthened through the Secretary's committee meetings with regular inter-ministerial meetings.

(viii) A harmonized coordination mechanism among the PW and Planning Units of DGHS & DGFP will be developed through SWPMM OP. Steps will be taken to strengthen both the Planning Units of DGHS and DGFP with necessary technical support.

Moreover, the MOHFW needs to respond to the threats of climate change on health in a number of different ways, by developing programmatic activities that address key priority areas (e.g., early warning systems, desalinization) or by strengthening the health systems in a horizontal manner (e.g., to build resilience in areas such as supply chains or health facility infrastructure). Given all of the possible elements of climate change and health that could be addressed, it is important to define the results that the country wants to achieve in this area and to be strategic in identifying the most critical activities to deliver these results. To do this, an evidence-based plan will be developed by the Climate Change and Health Promotion Unit (CCHPU) under the directives of the Planning Wing of MOHFW that addresses the health impacts of climate change. The plan will include a set of priority results and a clear theory of change for how to attain them. To complement this, guidelines will be developed that will enable the relevant Operational Plans to be adjusted so as to include priority activities.

Component-2: Planning and budgeting:

The SWPMM OP is responsible for planning, coordinating and preparing the SWAp program along with budgeting, managing, reviewing, monitoring and evaluation. The planning and budgeting functions include preparation of five year plan; identification of health financing and preparing budget

accordingly; improving budget management through the Medium-term Budgetary Framework (MBF) process; assisting the Directorate Generals, Agency Heads, and LDs to prepare the OPs; ensuring that PIP and all OPs reflect sectoral polices, program priorities and strategies, cross cutting issues-equity and gender; etc. Also, allocating budget to OPs while preparing Sector Program, as well as allocating budget annually to OPs to implement development activities is also functions of planning and budgeting component of SWPMM OP. For effective and quality use of resources, it is essential to have a strong linkage between planning and budgeting. The key activities under this component include:

(i) Steps will be taken to ensure that 80% of the OPs spend over 80% of ADP allocation.
(ii) Necessary steps will also be taken to ensure that all the Non-pool DPs submit quarterly/annual expenditure reports on on-budget (direct project aid activities) activities regularly.
(iii) Efforts will be made to encourage the DPs to submit annual performance reports on off-budget activities.
(iv) All the OPs would continue to submit timely AWP with budget.
(v) Training/orientation will be provided on planning, budgeting, fund release, monitoring, coordination etc. to the LDs and others related with OP implementation.
(vi) The PW and the DPs will continue collaboration to ensure that the committed/indicated fund from the DPs is channeled to the Sector program.
(vii) Steps will be takn to ensure that the available funding out of DLI achievements is matched with timing of ADP/RADP preparation.
(viii) Efforts will be made to get ADP/RADP allocation as per requirement to implement the 4th HPNSP.

Component-3: Monitoring and Evaluation:

The PW, under the monitoring and evaluation (M&E) component of SWPMM, acts as the focal point for M&E of MOHFW. During the 4th HPNSP, the PW will take the leading role to coordinate with all MISs and facilitate reform process to improve harmonization. The key activities to be undertaken during the 4th HPNSP are as follows:

(i) Efforts will be made to generate coordinated data, reduce duplication of efforts and provide adequate funding for M&E activities etc. M&E offices will be provided with specialized skilled personnel (e.g. in IT, public health, epidemiology, etc.).
(i) Steps will be taken to implement the MESAP. Coordination and harmonization of MISs of the Directorates will be established for implementation of the MESAP.
(ii) An effective and harmonized review mechanism for ascertaining progress on the DLIs will be developed Capacity of the relevant MOHFW staff will be strengthened in reviewing and reporting performance for results (in the form of DLIs).
(iii) Efforts will be taken to monitor implementation of health related SDG indicators.
(iv) A plan will be developed to institutionalize the PMMU under the PW, so that the activities of the PMMU are continued uninterruptedly during the 4th HPNSP Sector Program.
(v) The PMMU will continue to produce the SmPR, APIR reports as well as monitoring of the RFW and OP-level indicators.
(vi) M&E capacity of the PW including PMMU and the Planning Units of DGHS & DGFP will be strengthened through TA support, training and logistics.
(vii) Review and endorse performance management plans and M&E frameworks for HNP Sector Program;

(viii) Quarterly meetings of OP Implementation Committees (OPIC) and bi-annual meetings of the Steering Committee will be ensured.

(ix) Field visit for monitoring field level activities by the officials of the PW including PMMU and the Planning Units of DGHS & DGFP will be ensured.

(x) APR will be conducted in each year and APR Prioritized Action Plan (PAP) will be closely monitored to ensure timely completion of activities.

(xi) A website of PMMU will be developed with archived resources.

Component-4: Technical Assistance Coordination:

The need for overall coordination and management of TA was recognized in the past SWAp reviews. During the appraisal process of HPNSDP it was agreed that TA on various issues/subjects would be needed to achieve expected results as well as to mitigate anticipated risks in the Sector Program. To augment the implementation of HPNSDP, it was deemed that proper sourcing of TA (including technical cooperation (TC)) from national and international consultants would be essential. Considering the progress made in TA coordination and its significance in the HNP sector, the TA coordination component will be continued in the SWPMM OP of the 4th Sector program with the following key activities:

(i) The mechanism of implementing and monitoring JDTAF TA through the GOB-DP TAC will be continued in the 4th Sector Program and efforts will be made to expand the number of partners contributing to the JDTAF.

(ii) A Harmonized TA Plan will be prepared to identify major areas of TA needs and how these will be supported.

(iii) Capacity of TA recipients will be strengthened to utilize TAs effectively through- (a) organizing orientation for LDs, PMs and DPMs about the purpose, approaches and guiding principles of TA; and (b) organizing skill development training for them on needs assessment, proposal writing, TA monitoring and follow-up process.

(iv) Effectiveness of the TAC will be increased through extensive follow-up from the PW to assist the LDs to send the proposal well ahead of TAC meeting.

(v) TA procurement will be accelerated by (a) extending PW's assistance to LDs in developing TOR; (b) expediting TA approval process after endorsement by the TAC; and (c) extending consultant database; etc.

(vi) TA monitoring/follow-up at MOHFW level will be strengthened through the TAC and TA performance status will be reviewed in the Monitoring & Evaluation Task Group (M&ETG) and Sector Management Task Group (SMTG) meetings on six monthly basis.

(vii) TA coordination and tracking will be strengthened by (a) introducing a simple and brief reporting template for TA tracking; and (b) submission of TA Performance Report by the parallel DPs on an annual basis.

(viii) TA will be utilized to address the challenges of MOHFW which most relate to technical issues and/or innovations, rather than shouldering the routine workload of the officials of MOHFW and agencies under it.

Component-5: Governance and Stewardship:

Apart from the MOHFW, many actors, *viz*., public, private, NGOs, CSOs, etc. are working for the betterment of health of the Bangladeshi population. But, their roles, responsibilities and accountabilities on diverse health issues (urban, nutrition, food safety, arsenicosis, HIV/AIDS, and emerging environmental health & demographic issues) are still not well coordinated.

Six autonomous professional regulatory bodies under the MOHFW have responsibilities for dealing with doctors, nurses, medical assistants and pharmacists and alternate medical practitioners - BMDC, BNC, PCB, SMF, BHB, and BU&AB. These bodies have separate governance arrangement, which reduce the MOHFW's influence over them. There is a strong and widespread network of private sector service which is characterized by commercialization, induced investigations, unnecessary and costly procedures. Unregulated non-formal providers with poor quality of services are also a major concern. Issues concerning governance and stewardship in the HNP sector also include enforcement of the Private Practice and Private Clinics and Laboratories (Regulation) Ordinance, 1982; awareness of managers of field level tiers about their stewardship roles. Though right to healthcare is constitutionally guaranteed in Bangladesh, patient's rights are compromized on many occasions. Inadequate availability of trained and skilled staff, physical absence, compounded by staff resistance to serving in remote areas result in inadequate access to quality RMNCH&FP services at all levels. Shortage is more acute in case of anesthetists, medical officers for FP services, nurses, midwives and FWV trained in skilled delivery.

To strengthen the governance and stewardship role of the MOHFW, the SWPMM OP will facilitate/support the MOHFW/relevant agencies in implementing the following key activities:

(i) Implementation of the Governance and Stewardship Action Plan in line with milestoness;

(ii) Establishment of accreditation body for gradual accreditation of all facilities.

(iii) Strengthening and regularization of systematic inter-ministerial coordination or the services complemented by other Ministries/Agencies.

(iv) Providing necessary support to the DGHS for further enhancement of grievence redress system for greater responsiveness and transparency to the public.

(v) Enforcement of stronger regulatory mechanism for the private sector through revising the Private Clinics and Hospitals Act with proper procedures for renewal of licensing.

(vi) Review of existing acts regulating the establishment and functioning of clinics, laboratories, and diagnostic centres, as well as a review of the drug policy and development of an Act to ensure safe blood transfusions.

(vii) Developing a culture through orientations of the Ministry, Directorates and their Managers at different levels to familiarize the need of stewardship role to be played.

(viii) Updating Private Practitioners Act, Drug Administration Act) Regulatory instruments

(ix) Review and updte the relevant laws of BNC, PCB, BHB and BU&AB

(x) Review the structure, organogram and mandate for regulatory bodies like DGHS and DGDA.

(xi) Reiew and if necessary, update the Medical Colleges (Governing Bodies) Ordinance, 1961 for the management of the government medical colleges and hospitals.

Component-6: Strengthening ICT capacity of MOHFW to implement e-governance

Over the past years, the Organizations under the MOHFW developed several ICT systems - of which some are automated and some manual. These systems were develoed parallelly without having any coordination between them and thus, they do not provide integrated or unified report. Moreover, the GOB is introducing e-governance as a move towards digital Bangladesh.

Expand and diversify the use of ICTs to establish a transparent, responsive and accountable e-government; develop skilled human resources; strengthen ICT capacity of Ministry of Health and Family Welfare to ensure quality service; and support the national goal of becoming a middle-income country within 2021 and join the ranks of the developed countries of the world within 2041. The key activities to be undertaken during the 4th Sector program are as follows:-

(i) Conduct a mapping of the current ICT systems landscape.
(ii) Conduct a needs assessment of the MOHFW's ICT activites and develop an ICT Guideline for MOHFW.
(iii) Improve ICT infrastructure with necessary equipment, and establish network with Agencies under MOHFW and relevant ministries focusing on Digital Bangladesh Vision 2021.
(iv) Strengthening ICT Capacity of the MOHFW through human resource development.
(v) Develop a software for the Planning Wing for ADP review
(vi) Publication (e-Book , Report etc)

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc:

Cross-cutting with poverty, environment, climate change, women and children: The 4th HPNSP has been designed to lay out the foundation to achieve the health related SDG targets. The targets will be achieved through proper implementation of all the OPs. The SWPMM OP is linked with all the OPs. Through its planning and budgeting activities, SWPMM OP will allocate necessary resources to RMNCAH activities of the relevant OPs to ensure women and children's right to health care. The same effort will be given to NCDC OP to address environmental pollution related diseases. Further, through implementation of the activities of the Component-7, a plan as well as guidelines will be developed to address health impacts of climate change. This will enable the relevant OPs to take appropriate measures to address adverse health impacts of climate change. Through proper monitoring of the OP-level indicators, RFW indicators & DLIs of the 4th HPNSP and health related SDG indictors, the SWPMM OP will provide overall guidance to the OPs in achieving their targets which will ultimately lead to poverty reduction of the country.

Cross-cutting with other OPs: Due to the nature of its objectives, SWPMM OP requires close coordination with all the OPs for almost all the major activities. Table below shows the name of the cross-cutting OPs and the coordination mechanism required.

Sl. #	Activity	Name of cross-cutting OP	Co-ordination mechanism
1.	Component-1 activities	PME, PMR, SWPMM	Task Group Meetings, LCG Working Group on Health, OPIC meeting, ADP Review meeting, HNP sector Coordination Forum.
2.	Component-2 activities	PME, PMR, IFM, HEF, HRD	Task Group Meetings, LCG Working Group on Health, coordination meetings, ADP review meeting
3.	Component-3 activities	HIS-eHealth, MIS, TRD, IFM	Task Group Meetings, LCG Working Group on Health, Coordination meetings, ADP review meeting, Quarterly Meetings, OPIC

Sl. #	Activity	Name of cross-cutting OP	Co-ordination mechanism
4.	Component-4 activities	PMR, TRD	TA Committee meeting, LCG Working Group on Health.
5.	Component-5 activities	SDAM, HEF, PMR, PME	SC meeting, Coodination meeting with other Ministries,
6.	Component-6 activities	HIS & E-H, MIS, DGNM	coordination meetings

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services: Annexed in Volume-II

9. Indicators

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1	Percentage of OPs submitting Annual Work Plan (AWP) with budget on time (by August)	Percentage (Admin record)	100% (APIR 2016)	100%	100%
2	Increase in the number of OPs with annual budget execution over 80%	Number (Admin record)	13, (APIR 2015)	18	21
3	Prepare annual program implementation reports (APIR)	Number (Progress report available)	1 report/year	3	5
4	LCG health meetings organized quarterly and decisions followed up	Number (Meeting minutes available)	2 Nos. (July-Dec. 2016)	14	22
5	Improved coordination mechanism focusing on PHC in urban areas	An agreed action plan (yes/no)	NA	An agreed action plan developed	75% of the action plan is implemented

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
2882.00	2342.00	16905.00	19247.00	22129.00	

10.2. Component and activity wise physical and financial target of OP: SWPMM

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
i) Sector Coordination:													
1	GOB-DP Coordination (LCG-Health, Different Task Groups, TAC and other committees)	LS		61.00	45.00	10.00	6.00	3.00	12.00	11.00	11.00	12.00	12.00
2	Interministerial Coordination	LS		43.00	27.00	10.00	6.00	2.00	8.00	8.00	9.00	8.00	8.00
3	Inter-Agency Coordination	LS		11.00	5.00	4.00	2.00	1.00	2.00	2.00	2.00	2.00	2.00
	Sub-Total			115.00	77.00	24.00	14.00	6.00	22.00	21.00	22.00	22.00	22.00
ii) Printing and Publication of SWAp related documents													
1	Publicize and Disseminate HNP Sector Program,	LS		56.00	47.00	7.00	2.00	12.00	15.00	15.00	7.00	4.00	3.00
2	Publish PIP and other SWAp related documents.	LS		18.00	8.00	7.00	3.00	4.00	4.00	2.00	2.00	2.00	4.00
3	Revision of PIP & Operational Plans	LS		13.00	5.00	5.00	3.00	0.00	0.00	0.00	5.00	5.00	3.00
	Sub-Total			87.00	60.00	19.00	8.00	16.00	19.00	17.00	14.00	11.00	10.00
iii) Program Review, Monitoring and Evaluation													
1	Monthly Progress Review Meetings	60	Nos	25.00	25.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
2	Six Monthly Progress Review (SmPR)	9		222.00	22.00	2.00	198.00	42.00	45.00	45.00	45.00	45.00	0.00
3	Annual Program Implementation review/Annual Program Review (APIR & APR)	14		450.00	80.00	20.00	350.00	30.00	105.00	105.00	0.00	105.00	105.00
4	Mid-term Program Implementation Review/Mid-Term Review (MPIR & MTR)	1		120.00	40.00	10.00	70.00	0.00	0.00	0.00	100.00	20.00	0.00
5	Policy Dialogues relating to monitoring of HPN Sector Program	21		111.00	80.00	20.00	11.00	20.00	20.00	20.00	20.00	20.00	11.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
6	Review and monitor DLIs achievement	LS		1220.00	110.00	10.00	1100.00	0.00	244.00	244.00	244.00	244.00	244.00
7	SDG (Health related Goals) Monitoring	LS		60.00	15.00	15.00	30.00	3.00	11.00	12.00	12.00	11.00	11.00
8	End-line Evaluation of the Program (Through IMED or MOHFW itself)	1		150.00	50.00	72.00	28.00	0.00	0.00	0.00	0.00	70.00	80.00
	Sub-Total			2358.00	422.00	149.00	1787.00	95.00	430.00	431.00	426.00	520.00	456.00
iv) Strengthening Capacity of the Planning Wing of MOHFW and Concern sectors of Planning Commission													
1	Logistics (Stationary, Equipment, Furniture and Other supports).	LS		195.00	150.00	45.00	0.00	5.00	40.00	45.00	50.00	45.00	10.00
2	TA Supports	LS		264.00	0.00	34.00	230.00	12.00	47.00	50.00	55.00	55.00	45.00
3	Training, Workshops, Seminars/Symposium/meetings	LS		100.00	70.00	20.00	10.00	2.00	18.00	20.00	20.00	20.00	20.00
	Sub-Total			559.00	220.00	99.00	240.00	19.00	105.00	115.00	125.00	120.00	75.00
v) Capacity Development of MOHFW along with the Implementing Agencies and Concerned Sectors of Planning Commission													
1	Local Training/Orientation	LS		70.00	40.00	20.00	10.00	0.00	15.00	20.00	20.00	15.00	0.00
2	Foreign Training	3 Batches		150.00	100.00	50.00	0.00	50.00	50.00	50.00	0.00	0.00	0.00
3	MS in Public Health/Health Economics/ Supply Chain Management/other relevant disciplines for the Officials of Planning Wing of MOHFW and Concern Sectors of Planning Commission.	20 persons		140.00	0.00	140.00	0.00	0.00	35.00	35.00	35.00	35.00	0.00
4	Advanced Studies in Public Health, Health Economics and other related disciplines	8 batches (8 persons /batch)		200.00	0.00	200.00	0.00	0.00	50.00	50.00	50.00	50.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Program Support and Facilitation (to the Health Wing of the Planning Commission)	LS		1000.00	200.00	300.00	500.00	0.00	200.00	200.00	200.00	200.00	200.00
	Sub-Total			1560.00	340.00	710.00	510.00	50.00	350.00	355.00	305.00	300.00	200.00
vi) Strengthening of Program Management & Monitoring Unit (PMMU)													
1	Manpower (Pay and Allowances)	LS		480.00	0.00	200.00	280.00	41.00	84.00	86.00	88.00	90.00	91.00
2	Stationeries, Equipment & Other Supports	LS		272.00	246.00	20.00	6.00	32.00	48.00	48.00	48.00	48.00	48.00
3	Meetings/Seminars/Workshops/Orientation	LS		60.00	24.00	30.00	6.00	3.00	12.00	11.00	11.00	11.00	12.00
4	Vehicles	1 Jeep, 2 Microbus		200.00	0.00	200.00	0.00	0.00	130.00	70.00	0.00	0.00	0.00
5	Repair & Maintenance (Equipment & Vehicles)	LS		44.00	24.00	20.00	0.00	4.00	8.00	8.00	8.00	8.00	8.00
6	Technical Assistance Support (Under DP Execution]	LS		1500.00	0.00	0.00	1500.00	150.00	300.00	300.00	300.00	300.00	150.00
	Sub-Total			2556.00	294.00	470.00	1792.00	230.00	582.00	523.00	455.00	457.00	309.00
vii) TA Support (Conducting Studies, Surveys etc.)													
1	TA Support (Under MOHFW Execution)	LS		40.00	0.00	0.00	40.00	0.00	5.00	10.00	10.00	10.00	5.00
2	TA Support (Under DP Execution/JDTAF, WHO etc.)	LS		10500.00	0.00	0.00	10500.00	0.00	1500.00	2500.00	2500.00	2500.00	1500.00
3	Implementation of M&E Strategy and Action Plan	LS		100.00	25.00	45.00	30.00	0.00	23.00	20.00	20.00	20.00	17.00
4	Establish and maintain Resource Centre (Archive) at Planning Wing (PMMU)	1		105.00	15.00	45.00	45.00	0.00	30.00	30.00	20.00	20.00	5.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Pay and Allowances of Staff (PW, MOHFW)	LS		390.00	310.00	0.00	80.00	30.00	62.00	67.00	72.00	77.00	82.00
6	**Preparation of 5th HNP Sector Program.**												
6.1	Preparation of Concept Paper, Strategic Document etc.	LS		123.00	65.00	28.00	30.00	0.00	0.00	0.00	23.00	50.00	50.00
6.2	Stakeholders' Consultations at different levels (Meetings, Workshops, Seminars, Policy Dialogues etc.)	LS		105.00	47.00	18.00	40.00	0.00	0.00	0.00	20.00	60.00	25.00
6.3	Exposure visits related to preparation of the Next HNP Sector Program	50		215.00	50.00	125.00	40.00	0.00	0.00	0.00	70.00	75.00	70.00
6.4	Retreat	LS		70.00	10.00	20.00	40.00	0.00	0.00	0.00	0.00	35.00	35.00
6.5	Conduct Studies/Surveys (Need based)	LS		180.00	0.00	50.00	130.00	0.00	25.00	25.00	50.00	50.00	30.00
	Sub-Total			11828.00	522.00	331.00	10975.00	30.00	1645.00	2652.00	2785.00	2897.00	1819.00
viii	**Strengthening ICT capacity of MOHFW to implement e-governance**	LS		275.00	80.00	195.00	0.00	25.00	50.00	50.00	50.00	50.00	50.00
	Sub-Total			275.00	80.00	195.00	0.00	25.00	50.00	50.00	50.00	50.00	50.00
ix) **Gavi-HSS Programme**													
a	Meetings/Seminars/Workshops/Orientation	LS		110.00	0.00	0.00	110.00	15.00	15.00	20.00	20.00	20.00	20.00
b	Pay and Allowances	6 persons		121.00	0.00	0.00	121.00	11.00	22.00	22.00	22.00	22.00	22.00
c	Recruitment of External Audit Firm	6 nos		47.00	0.00	0.00	47.00	5.00	7.00	8.00	9.00	9.00	9.00
d	Survey (Need based)	As per need		230.00	0.00	0.00	230.00	10.00	20.00	50.00	50.00	50.00	50.00
e	Office Equipment & Machineries, Furniture, Computer and Accessories etc	LS		55.00	0.00	0.00	55.00	5.00	10.00	10.00	10.00	10.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
f	Foreign Training	7 batch		350.00	0.00	0.00	350.00	0.00	50.00	50.00	50.00	100.00	100.00
g	Operating Cost (Fuel, Gas, maintenance of vehicles etc)	LS		55.00	0.00	0.00	55.00	5.00	10.00	10.00	10.00	10.00	10.00
	Sub-Total			968.00	0.00	0.00	968.00	51.00	134.00	170.00	171.00	221.00	221.00
x)	**Climate Change adaptation(preparedness and Mitigation (Prevention)**	LS		440.00	0.00	0.00	440.00	40.00	80.00	80.00	80.00	80.00	80.00
	Sub-Total			440.00	0.00	0.00	440.00	40.00	80.00	80.00	80.00	80.00	80.00
xi)	**Stewardship and Governance**												
1	Review and support implementation of the governance and stewardship action plan in phases	LS		50.00	30.00	20.00	0.00	5.00	10.00	10.00	10.00	10.00	5.00
2	Expedite the approval process of laws already updated.	LS		55.00	55.00	0.00	0.00	5.00	10.00	10.00	10.00	10.00	10.00
3	Revitalize different committees under MOHFW and extend necessary support for holding meeting on regular basis	LS		800.00	500.00	200.00	100.00	0.00	100.00	175.00	175.00	200.00	150.00
4	Enact a law for regulating private medical and dental colleges, amend the Private Clinic Act, Organ Transplantation Act, introduce a new Act (by replacing the Act of 1940 and ordinance of 1982)for DGDA.	LS		60.00	60.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00	10.00
5	Expedite the approval of BNMC Act and improve the functioning of BNMC	LS		14.00	12.00	0.00	2.00	2.00	2.00	2.00	2.00	2.00	4.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
6	Strengthen coordination with MOSW, MOLGRDC, MOWCA etc, private sector, NGOs, CSOs.	LS		60.00	30.00	25.00	5.00	5.00	15.00	10.00	10.00	10.00	10.00
7	Review the capacity of Agencies (DGHs, DGFP, DGDA, DGN&M etc,) and statutory bodies (e.g. BMDC,SME,PBC,BNC etc,) for exercising their stewardship role and support for capacity development.	LS		300.00	140.00	100.00	60.00	0.00	75.00	75.00	50.00	50.00	50.00
8	Maintain coordination with Agencies and OPs for implementation of different Strategy/ Action Plan.	LS		18.00	18.00	0.00	0.00	3.00	3.00	3.00	3.00	3.00	3.00
9	Support implementation of others activities related to governance and stewardship.	LS		26.00	22.00	0.00	4.00	2.00	4.00	4.00	4.00	4.00	8.00
	Sub-Total			1383.00	867.00	345.00	171.00	32.00	229.00	299.00	274.00	299.00	250.00
	Total			22129.00	2882.00	2342.00	16905.00	594.00	3646.00	4713.00	4707.00	4977.00	3492.00

11. Budget support from other Operational Plan: Not applicable

4.2 Planning, Monitoring and Research (PMR)

1. Name of Operational Plan: Planning, Monitoring and Research (PMR)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

Situation Assessment

Director, Planning and Research in the DGHS is mandated to take-care planning activities within the DGHS and ensure necessary research for feeding the proper planning. As Line Director of the Planning, Monitoring and Research Operational Plan (OP), the responsibilities are expanded to encompass monitoring of the implemented activities as per the plan and if required make necessary changes in the plan to achieve the desired objective. Thus PMR OP supports the DGHS in planning, monitoring and research. As part of the planning function, it supports in the preparation/revision of OPs, Program Implementation Plan (PIP), Development Project Proforma/Proposal (DPP), Technical Assistance Project Proforma (TAPP), Feasibility Study/Survey Proposal, Preliminary Development Project Proforma/Proposal (PDPP), and Preliminary Technical Assistance Project Proforma/Proposal (PTAPP) within the DGHS. It also provided need based support to the Project Evaluation Committee (PEC), Departmental Project Evaluation Committee (DPEC), Special Project Evaluation Committee (SPEC), Departmental Special Project Evaluation Committee (DSPEC), Project Scrutiny Committee (PSC), Project Steering Committee (PSC), and Project Implementation Committee (PIC). It also works very closely with the Planning Wing of the MOHFW. Considerable experience has been gained through the lessons of a number of pilot initiatives on local level planning (LLP) in the last two SWAp periods. However, upon recommendation from MTR 2014 the LLP program has been changed into Evidence Base Health Planning (EBHP). PMR OP has conducted EBHP program at division and district level on WHO proposed six area of health system in which a substantial number of field level managers being capable to solve their problem at field. Previous experience suggested that coordination with other government offices and NGOs, limited decentralization in resources reallocation within district, monitoring of Government and non-Government health activities and community engagement in district health plan, EBHP will be more successful.

For monitoring, it supports the LDs under DGHS for regular monitoring of their activities, particularly keeping conformity with the indicators and results framework. It also supports DGHS for periodical monitoring of the OPs under DGHS. It supports the Planning Wing/Program Monitoring and Management Unit (PMMU) for preparing six monthly reports, annual/midterm program implementation reports (A/MTPIR) and conduction of annual/midterm program review (AP/MTR) of the sector program. Monitoring of field activity was limited in previous sector program which was the key factor for better performance.

For research it works in collaboration with the Bangladesh Medical Research Council (BMRC) for building capacity to conduct research and allocate funds for conduction of research. However due to capacity constrains neither planning, nor monitoring and research activities were able to carry out up to mark. Moreover activities are mostly at central level and support particularly for planning and monitoring were not expanded to other level of managers like division, district or upazila.

Challenges

1. With the adaptation of Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC), planning context has changed. PMR OP has to adopt the new changed context through building its own capacity and supporting the other LDs together with their Program Managers

(PMs) and Deputy Program Managers (DPMs) to be acquainted fully with the SDGs and UHC agenda.

2. The 4th Health, Population and Nutrition (HPN) Sector Program has adopted many new directions like governance, stewardship, efficiency, equity, quality etc. PMR OP need to make other OPs personnel fully aware of these new dimensions of the program for their proper planning and monitoring while implementing. Not only at DGHS level, but also managers at other levels like division, district and upazila etc. need to be fully internalizing these new dimensions so that they are in better positioned for contributing towards materializing those priority dimensions.
3. PMR had been mostly engaged at DGHS level, however its engagement at other levels (like divisional, district and upazila, City Corporation, municipalities etc.) for planning and monitoring particularly to take forward stewardship, efficiency, equity, quality will add more value to the sector program.
4. Driving the research agenda to make evidence based decision at different levels of health system in collaboration with different research institutions including BMRC are another challenge.
5. Capacity building of the PMR unit to adequately deliver its mandates and responsibilities.
6. To bring desired changes in health, nutrition and family planning activities at urban areas, a strong coordination mechanism is necessary between MOHFW and Urban Local Government Institutions, PMR can play vital role in it.
7. Non-government organization (NGOs) play on important and vital role in rendering health services in urban areas. Coordination and proper planning is a must to avoid duplication of services as well as resources

4. Objectives

i. Enhance planning capacity at different levels of DGHS for the materialization of the 4th HPN sector program

ii. Strengthen monitoring at different tiers of DGHS for effective implementation of the program to achieve its objectives

iii. Ensure need based researches are conducted and evidences are used for making decisions at different levels of DGHS

iv. Capacity enhancement

5. Components

Component-1: Planning

Planning is a powerful management tool. Only robust plan prepared based on evidence and priorities can support in achieving the sector program's objectives. PMR will support at different levels within DGHS to internalize the priorities of the sector program and make plan accordingly based on evidences for achieving the objectives of the sector program.

Activities:

1. Orientation trainings for the LDs, PMs, DPMs, Divisional Directors, Civil Surgeons, Upazila Health and Family Planning Officers about the SDGs, UHC, priorities and principles of the 4th HPN Sector Program.

2. Orientation trainings for the newly appointed LDs, PMs and DPMs about the sector program and on the respective and other cross-cutting OPs
3. Supporting managers at divisional, district and upazila level to prepare coordinated plan for effective (avoiding duplication and wastage and imparting stewardship roles), equity and quality service delivery within respective jurisdiction
4. Supporting managers at different levels for proper planning for the achievements of Disbursement Linked Indicators (DLIs)
5. Prepare and support other OPs within DGHS for the required PIP/OP preparation and revision. Also planning, preparation and revision of development projects (DPP, TPP, TAPP, PDPP, DPR etc.)
6. Supporting OPs/Managers within the DGHS for proper reflection of gender and community engagement ensuring voice and accountability

Component-2: Monitoring

Monitoring is essential for proper implementation of the program. Timely monitoring allows making necessary management decision to ensure proper implementation of the program and thus achieve the program's objectives.

Activities

1. Periodic monitoring of the progress of the OPs under DGHS and supporting DGHS and ADG (Planning) with the information for holding regular monitoring meetings
2. Orientation trainings of the LDs, PMs, DPMs including new appointees for the regular monitoring of the program implementation
3. Facilitating collection of information from the OPs for the preparation of AP/MTIR and AP/MTR processes.
4. Supporting managers at divisional, district and upazila level to monitor coordinated plan for effective (avoiding duplication and wastage and imparting stewardship roles), equity and quality service delivery within respective jurisdiction
5. Supporting managers at different levels for proper monitoring for the achievements of Disbursement Linked Indicators (DLIs)
6. Supporting OPs within the DGHS for proper monitoring of gender and community engagement ensuring voice and accountability

Component-3: Research

Research helps to generate evidences based on which appropriate management decisions can be taken. Unfortunately managers are not familiar with the research findings and thus decisions taken by them may not reflect evidences. Managers seldom undertake research. Researchers are happy in publishing results and not concern about the proper dissemination for the use of policy makers, planners and managers.

Activities

1. BMRC will be a cost centre under this OP and receive grant allocation for building research capacities and conducting research.

2. Research capacities, particularly of the managers/clinicians at different levels will be developed
3. In consultations with the LDs, PMs, DPMs and managers at different levels issues/topics for research will be identified and those are then supported for conduction to generate evidences for making decisions.
4. Scanning of research to be conducted for generation of evidences which will be disseminated to the policy makers, planners and managers for appropriate usages.

Component-4: Capacity enhancement

Strengthen capacity of different level health managers is the crucial issue to well governs the health delivery system. This activity will mainly focus on health planning and implementation, effective and efficient use of resources, supervision and monitoring, managing the health facility, coordination with DGFP and other Government and Non-government organization and primary health care activity.

Increase the capacity of planning and research wing personals of DGHS on planning, monitoring and supervision will help to deliver proper plan and strengthen the monitoring and supervision system.

Activities

1. Capacity building on Planning, Monitoring and Research
2. Views Exchange in different levels
3. Support to planning and research unit, DGHS

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.:

PMR OP will contribute significantly in poverty reduction. Through proper planning based on evidences generated by researches and effective monitoring health services will be better positioned to contribute in poverty reduction. Promotional and preventive initiatives will ensure preservation of health; curative and rehabilitative efforts will takecare restoration of health and thus both contributing for participation in economic development activities and restrict draining of resources due to sickness.

Effective planning, monitoring and research will contribute in conservation of environment through proper management of healthcare wastes. Also support in mitigating health risks of environmental pollution of soil, water and air.

Proper planning, monitoring and research will ensure better health adaptability due to climate change effects and also make sure adequate healthcare for the climate change affected population.

Access and utilization of promotive, preventive, curative and rehabilitative health services by the women and children and thus improving their health status and also addressing gender issues in health service delivery can be properly taken care by adequate planning, monitoring and research.

7. Proposed Manpower : Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

SL #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1	Orientation trainings conducted on priorities of the sector program	No. of trainees trained (office records)	0	300	600
2	Prepare plan for improved service delivery to supporting managers at different levels	No. of managers at different levels prepared plan (plans , admin record)	0	200	400
3	Monitoring meetings for OPs	No. of meetings held (meeting minutes)	12/year	42	66
4	Number of brief prepared and disseminated on research conducted	No. of briefs prepared(available in admin record)	0	25	60

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
6754.40	3587.80	1385.00	4972.80	11727.20	

10.2. Component and activity wise physical and financial target of OP: PMR

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
Component 1: Planning												
a.	Orientation of field level managers about the SDGs, UHC, priorities and principles of the 4th HPN Sector Program											
1	Development of module	1	20.00	20.00	0.00	0.00	15.00	1.00	1.00	3.00	0.00	0.00
2	Organize orientation workshop for field level managers at division and district level	67	167.50	105.00	62.50	0.00	5.00	90.00	50.00	22.50	0.00	0.00
b	Orientation of the newly appointed LDs PMs and DPMs about the SDGs, UHC, priorities and principles of the 4th HPN Sector Program and on the respective and other cross-cutting Ops											
1	Development of workshop materials	1	20.00	20.00	0.00	0.00	15.00	1.00	1.00	3.00	0.00	0.00
2	Organize orientation workshop for the newly appointed LDs, PMs and DPMs at central level	12	12.00	7.00	5.00	0.00	5.00	2.00	1.00	2.00	1.00	1.00
c	Supporting managers at divisional, district and upazila level to prepare coordinated plan for effective (avoiding duplication and wastage and imparting stewardship roles), equity and quality service delivery within respective jurisdiction											
1	Health System Operationality assessment at different level	168	400.00	280.00	60.00	60.00	50.00	70.00	70.00	70.00	70.00	70.00
2	Planning and Implementation module and guideline for all level	1	30.00	20.00	2.00	8.00	12.00	18.00	0.00	0.00	0.00	0.00
3	Formation of District health Planning and Implementation team	240	14.40	14.40	0.00	0.00	0.00	1.44	2.16	2.88	3.60	4.32

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
4	Coordination between Ops within DGHS and DGFP for identifying resource allocation/ activity to avoid duplication, provide equitable services and proper implantation	12	10.00	6.00	4.00	0.00	1.00	1.00	2.00	2.00	2.00	2.00
5	Capacity building of Health Mangers on Planning and Implementation	84	176.00	84.00	60.00	32.00	8.00	40.00	48.00	40.00	20.00	20.00
6	Workshop for plan preparation at selected district	84	25.20	25.20	0.00	0.00	1.20	2.40	3.60	4.80	6.00	7.20
7	Support to upazilla manager via District manager	2410	1000.00	1000.00	0.00	0.00	0.00	200.00	200.00	200.00	200.00	200.00
d	Supporting managers at different levels for proper planning for the achievements of Disbursement Linked Indicators (DLIs)											
1	Coordination with respective LDs and situation analysis relating to DLIs	102	6.00	0.00	6.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00
2	Assessment of DLI activity in field and feed back to LDs	80	39.00	0.00	39.00	0.00	0.00	10.00	10.00	10.00	9.00	0.00
e	Planning, preparation and revision of development projects and PIP/OPs within DGHS											
1	Feasibility study of the proposed projects and digital survey	50	300.00	200.00	100.00	0.00	10.00	70.00	60.00	60.00	60.00	40.00
2	Organize meeting with different stakeholders/Subject experts to identify the cross cutting issues/opinions	50	10.00	10.00	0.00	0.00	1.00	2.00	2.00	2.00	2.00	1.00
3	Organize meeting with different stakeholders to finalize the draft project proposal.	50	10.00	10.00	0.00	0.00	1.00	2.00	2.00	2.00	2.00	1.00
4	Prepare final project proposal	50	40.00	40.00	0.00	0.00	4.00	8.00	8.00	8.00	8.00	4.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
5	Revision of PIP/Ops/Project Proposals	6	5.00	5.00	0.00	0.00	0.00	0.00	1.00	2.00	2.00	0.00
6	Planning and Preparation of PIP and Ops	1	30.00	30.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	30.00
f.	Supporting Ops/Managers within the DGHS for proper reflection of gender and community engagement ensuring voice and accountability											
1	Identify the reflection of Community engagement, Gender and accountatibilty issues in Ops	102	16.00	10.00	6.00	0.00	1.00	1.00	1.00	1.00	11.00	1.00
2	Field activity assesment of issues and feedback	80	26.00	0.00	26.00	0.00	13.00	0.00	0.00	13.00	0.00	0.00
g.	Establish and operate legal support system		2000.00	2000.00	0.00	0.00	0.00	400.00	400.00	400.00	400.00	400.00
	Sub-Total		4357.10	3886.60	370.50	100.00	143.20	920.84	863.76	849.18	797.60	782.52
Component 2: Monitoring												
a.	Periodic monitoring of the progress of the Ops/ Development projects under DGHS and supporting DGHS and ADG (Planning) with the information for holding regular monitoring meetings											
1	ADP monitoring meeting	66	18.00	18.00	0.00	0.00	1.50	3.00	3.00	3.50	3.50	3.50
2	Development project monitoring	66	17.30	17.30	0.00	0.00	0.80	3.00	3.00	3.50	3.50	3.50
3	DPA activity monitoring	89	62.95	7.95	0.00	55.00	5.65	11.30	11.50	11.50	11.50	11.50
4	Periodic visit of OPs/Development projects activity	132	8.80	8.80	0.00	0.00	0.80	1.60	1.60	1.60	1.60	1.60
5	Feedback to relevent manager	LS	2.75	2.75	0.00	0.00	0.25	0.50	0.50	0.50	0.50	0.50
b	Capacity building of the LDs, PMs, DPMs new appointees for the regular monitoring of the program implementation											
1	Program Implementation Monitoring Guideline and Check list	1	5.15	5.15	0.00	0.00	4.00	0.00	0.00	0.00	1.15	0.00
2	Training on program monitoring at central and field level and feed-back	14	14.00	9.00	5.00	0.00	0.00	3.00	3.00	3.00	3.00	2.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
c	**Facilitating collection of information from the OPs for the preparation of AP/MTIR and AP/MTR processes.**											
1	Data collection from all OPs	LS	10.00	10.00	0.00	0.00	0.00	5.00	0.00	5.00	0.00	0.00
2	Support and Coordination with Review team	LS	10.00	10.00	0.00	0.00	0.00	0.00	0.00	5.00	0.00	5.00
d	**Supporting managers at divisional, district and upazila level to monitor coordinated plan for effective equity and quality service delivery within respective jurisdiction**											
1	Develop Monitoring Guideline and checklist for field managers and orientation	1	5.15	5.15	0.00	0.00	4.00	0.00	0.00	0.00	1.15	0.00
2	Coordination meeting with counterpart of DGFP managers and NGOs at field	LS	300.00	180.00	0.00	120.00	0.00	60.00	60.00	60.00	60.00	60.00
3	Feed-back to central level	LS	27.00	0.00	27.00	0.00	2.00	5.00	5.00	5.00	5.00	5.00
4	Coordination at central level with DGHS, DHFP and NGOs	16	6.00	0.00	6.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00
5	Monitoring at field level	2100	105.00	80.00	17.00	8.00	5.00	20.00	20.00	20.00	20.00	20.00
e	**Supporting managers at different levels for proper monitoring for the achievements of Disbursement Linked Indicators (DLIs)**											
1	Record Review from MIS and Other data sources	10	5.00	0.00	4.00	1.00	0.00	1.00	1.00	2.00	0.00	1.00
2	Periodic Meeting with Managers and Feed back	10	25.00	12.50	12.50	0.00	0.00	5.00	5.00	5.00	5.00	5.00
f.	**Supporting OPs within the DGHS for proper monitoring of gender and community engagement ensuring voice and accountability**											
1	Field Visit and data collection	40	12.00	7.20	4.80	0.00	0.00	2.40	2.40	2.40	2.40	2.40
2	Yearly meeting with community peoples in health issues and find solutions	40	80.00	0.00	80.00	0.00	0.00	16.00	16.00	16.00	16.00	16.00
3	Periodic Meeting with LDs and Feed back	12	5.00	0.00	5.00	0.00	0.00	1.00	1.00	1.00	1.00	1.00
g.	Monitoring and supervision-create a monitoring team		1000.00	300.00	500.00	200.00	20.00	200.00	200.00	200.00	200.00	180.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Sub-Total (Component 2)		1719.10	673.80	661.30	384.00	45.00	338.80	334.00	346.00	336.30	319.00
Component-3: Research												
a.	BMRC will be cost centres under this OP and receive grant allocation for building research capacities and conducting research.	LS	3000.00	500.00	2000.00	500.00	200.00	600.00	600.00	600.00	600.00	400.00
b.	Developed research capacities of the managers and clinicians at different levels											
1	Training on research Methodology for researcher	80	140.00	54.00	86.00	0.00	10.00	30.00	30.00	30.00	10.00	30.00
2	Awareness workshop on research activities for researchers	30	48.00	30.00	18.00	0.00	8.00	8.00	8.00	8.00	8.00	8.00
3	Short term training of research methodology on health system and policy research	10	50.00	50.00	0.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
4	Long term training of research methodology on health system and policy research	5	50.00	50.00	0.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
5	Fellowship program for researcher (regional)	3	120.00	120.00	0.00	0.00	0.00	40.00	40.00	40.00	0.00	0.00
6	Participation on seminar/ conference presentation/ health assembly at international level	10	20.00	7.00	7.00	6.00	0.00	4.00	4.00	4.00	4.00	4.00
c	In consultations with the LDs, PMs, DPMs and managers at different levels issues/ topics for research will be identified and those are then supported for conduction to generate evidences for making decisions.											
1	Coordination with different Ops	6	1.50	1.50	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25
2	Identify the thematic area	6	1.50	1.50	0.00	0.00	0.25	0.25	0.25	0.25	0.25	0.25
3	Implementation Research	10	300.00	90.00	120.00	90.00	0.00	120.00	60.00	60.00	60.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
4	Clinical, Basic, applied, Heath system, Epidemiological Research	80	400.00	85.00	315.00	0.00	25.00	75.00	75.00	75.00	75.00	75.00
5	Survey on DLI, Gender issues etc	4	70.00	70.00	0.00	0.00	0.00	35.00	0.00	0.00	0.00	35.00
d	Scanning of research to be conducted for generation of evidences which will be disseminated to the policy makers, planners and managers for appropriate usages.											
1	Review and Update the National Health Research Strategy	LS	13.00	9.00	0.00	4.00	1.00	7.00	5.00	0.00	0.00	0.00
2	Strengthening of the e- library and Research Policy Communication Cell (RPCC) and establishment of meta analysis research centers (MARC)	9	18.00	18.00	0.00	0.00	2.00	4.00	4.00	4.00	4.00	0.00
3	Journal publication	10	25.00	15.00	5.00	5.00	0.00	5.00	5.00	5.00	5.00	5.00
4	Dissemination of research findings at policy level	5	25.00	15.00	5.00	5.00	0.00	5.00	5.00	5.00	5.00	5.00
5	Formation of Institutional Review board (IRB) and DSMB at under Planning and Research, DGHS	1	17.00	17.00	0.00	0.00	2.00	3.00	3.00	3.00	3.00	3.00
	Sub-Total (Component 3)		4299.00	1133.00	2556.00	610.00	248.50	956.50	859.50	854.50	794.50	585.50
Component-4: Strengthening of Planning and Research Unit of DGHS												
a.	Capacity building on Planning, Monitoring and Research											
1	Capacity building of health professionals on Health Diplomacy	6	150.00	100.00	0.00	50.00	10.00	30.00	30.00	30.00	30.00	20.00
2	Mid and long term fellowship program on planning, monitoring and research in collaboration with national and international institutes.	14	300.00	270.00	0.00	30.00	0.00	60.00	60.00	60.00	60.00	60.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
3	Short Term Training on planning, monitoring and research in collaboration with national and international level	22	400.00	400.00	0.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
b.	Exchange of views in different level											
1	Exchange of views and ideas among health professional and health diplomats by organizing and attending national and international conferences and seminars and Linkage with Global forum	25	60.00	60.00	0.00	0.00	0.00	30.00	30.00	0.00	0.00	0.00
2	Formation of health forum and organise policy dialogue	27	42.00	26.00	0.00	16.00	2.00	8.00	8.00	8.00	8.00	8.00
c	Support to planning and research unit of DGHS											
1	Support for office management	LS	200.00	200.00	0.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
2	Formation of a Technical Group to achieve SDGs by formulating Policies and directives (Support to planning and research Unit)	240	200.00	5.00	0.00	195.00	20.00	40.00	40.00	40.00	40.00	20.00
	Sub-Total (Component 4)		1352.00	1061.00	0.00	291.00	92.00	288.00	288.00	258.00	258.00	168.00
	Grand Total		11727.20	6754.40	3587.80	1385.00	528.70	2504.14	2345.26	2307.68	2186.40	1855.02

11. Budget support from other Operational Plan: Not applicable

4.3 Planning, Monitoring & Evaluation (PME)

1. Name of the Operational Plan: Planning, Monitoring & Evaluation (PME), DGFP

2. Implementing Agency: Directorate General of Family Planning (DGFP)

3. Introduction

During the period of the MDGs Bangladesh has made remarkable progress in improving health outcomes particularly reducing maternal mortality (MDG 5) and child mortality (MDG 4). Still, there are some challenges in reducing Maternal Mortality Rate (From 176 to 121 by 2021), Neonatal Mortality Rate (From 28 to 18 by 2021) and Child Mortality Rate (From 46 to 34 by 2021). Substantial progress has been made in reducing population growth through implementation of an effective family planning program across the country. Total Fertility Rate (TFR) reduced from 6.3 births per woman in 1975 to 3.4 in 1994 and to 2.3 in 2014. Use of contraceptive increased from 8 % in 1975 to 62% in 2014. High political commitment from the government as well as factors like quality service delivery, strong BCC activities improved infrastructure with supply of commodities and logistics, strong collaboration with government and no-government organizations have contributed in reducing TFR. However present TFR of 2.3 (in 2014) needs to be reduced to 2.0 to attain Net Reproductive Rate (NRR) =1 by 2021. To achieve replacement level fertility by 2021, corresponding CPR has to be increased to 75% by 2021 from 62.4% (in 2014). Achievement of replacement level fertility can only be possible by gaining the momentum of the robust FP–MCRAH program supported by public information and motivation campaigns to bring about overall changes in attitude and awareness creation among all stakeholders.

In order to achieve the health related targets of Sustainable Development Goals (SDGs) by 2030, government has developed the new Health, Nutrition and Population Sector Strategic Investment Plan (HNPSIP) 2016-21 with the aim to provide new strategic directions to increase access to health services for the poor, strengthening its core systems to move the country towards its goal of Universal Health Coverage (UHC) by 2030.

The 4th HNP Sector Program (2017-2022) has been developed based on the new strategic directions and core values (quality, equity and efficiency) of HNP Strategic Investment Plan (SIP) and is very much in alignment with GOB's Vision 2021, 7th Five Year Plan (FYP) and its policy framework on health, population and nutrition. Focus areas like Maternal, Neonatal, Child and Adolescent including Sexual Reproductive Health and Family Planning are being prioritized to reduce morbidity and mortality. To achieve the health related targets of SDGs by 2030, the 4th Sector Program (2017-2022) would be considered as the foundation for the next three successive SWAPs.

Planning Unit has been providing support to coordinate Planning and M&E activities among all the OPs of DGFP. It assists i) in preparation of the PIP/RPIP, OPs/ROPs, ii) conducting Performance Monitoring of the OP's, iii) providing information and co-ordination support to LDs to conduct Annual Program Reviews (APR), iv) reviewing Progress of Disbursement Link Indicator (DLI) v) assisting Mid Term Review (MTR). It also provides suggestions for further improvement of program/project etc upon completion of the Annual Program Reviews/ Mid Term Review. Upon completion of the reviews (APR/MTR), making suggestions on programmatic improvements is one of the responsibilities of the Planning Unit. Mentionable coordination with the Planning Wing (PW) of MOHFW regarding M&E issues of the DGFP is done through Planning Unit.

Substantial progress has been made during last SWAP as the PME-OP has provided adequate support to other OPs in Planning and M&E activities and builds capacity of the managers, supervisors and field workers to develop local level plans through Local Level Planning (LLP) initiative. Large number of field level staff both from DGFP and DGHS were capacitated on local level planning process. However, as per recommendations from MTR of 2014, some strategic changes have been made on LLP initiative, like Field Program Performance Monitoring activities have been included in this OP. From January 2014 to June 2016, 137 Central, Divisional & District level workshops were conducted. Now in these workshops the Divisional, Districts Managers & other staff present their own Division & Districts' Performances, activities & local problems and recommendations. The performances of NGO's and HED activities are also presented in this workshop. All Managers share their valuable comments regarding the presentation. Gaps of the performance of the Field Level are identified to ensure the follow-up action through effective monitoring. It helps to build the capacity/Action Plan of Field Level Managers for dealing Monitoring in a systematic manner. Finally, at the central level, the way out & decision making for future improvement of FP-MCRAH programs are planned.

NGO's are the key alternative to supplement and complement the Government activities especially in Health Sector Program. Considering the flexibility and relaxation feature of NGOs, Directorate General of Family Planning has already decided to involve the NGOs to extend Reproductive Health Services including Family Planning particularly for the HTR, low performing and urban areas. About 225 national & local levels NGO's affiliated with DGFP have been providing FP-MCRAH services throughout the country. The DGFP has also formulated a standard guideline for affiliation & renewal of NGO's for better co-ordination and performance monitoring and reporting of the NGOs.

Directorate General of Family Planning has systematic good network of infrastructural facilities in the grass root level. Almost every Union of the country (around 4000) has a Union Health & Family Welfare Centre (UH&FWC) with residential facilities and providing FP-MCRAH services to the rural people. Besides, 61 District level, 12 Upazila level and around 100 Union levels Maternal Child & Welfare Centre (MCWCs) are also providing FP-MCRAH services to the community.

High performing staffs are very much required to plan and implement quality FP-MCRH programs. Capacity building through different training programs (Local and Overseas) would be one of the priority activities of the PME OP. Local trainings like on Planning & Development, Demography, e-filing, PPP, Management, Computer training etc. and Overseas trainings on Planning, Monitoring & Evaluation, Planning & Development, Demography etc. will be organized. Mentionable necessary training needs assessment and follow-up mechanism will be developed.

4. Objectives:

(i). To facilitate effective planning process and develop plans and programs in coordination within different OPs of the sub-sector;

(ii). To monitor field level program performance of different OPs under DGFP;

(iii). To strengthen internal review and 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 FP-MCRAH activities;

(iv). To strengthen collaboration with the GO-NGO and private sector including partnership with selected garments' authorities;

(v). To facilitate better performance of population sub-sector and to enhance efficiency;

(vi). To ensure effective evaluation of the family planning programs under different OPs of DGFP;

(vii). To provide petty infrastructural support and demands of DGFP to the MOHFW;

(viii). To build capacity of the personnel of the Planning Unit.

5. Components

Component-1: Coordination and preparation of Operational Plans for the population sub-sector

Establishing and maintaining a harmonious relation among the Line Directors is the key role of the Planning Unit of DGFP. Coordination among the LDs will help to find the easiest way of solving the problems within the shortest possible time by sharing their knowledge, experience & involvement. Planning Unit has been playing its role as a coordination unit by organizing regular meetings, workshops, seminars through which it has been considered as a focal point of the development activities of DGFP. Mentionable, this OP has been maintaining liaison on behalf of the DGFP with the MOH&FW, Planning Commission, IMED, ERD Development Partners and related agencies also.

Following the guidelines 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, preparation and modification of OPs with the related technicalities such as avoiding overlapping, duplication of activities, resources rationalization is the prime responsibilities.

Activities:

1. Coordinate with LDs to develop the OPs as per the guideline
2. Organize review and experience sharing meetings with the LDs to finalize the OPs
3. Coordinate with Planning Wing and /PMMU of MOHFW in preparation of PIP/RPIP, OPs/ROPs;
4. Maintaining liaison on behalf with the Planning Wing, MOH&FW, Planning Commission, IMED, ERD and Development Partners.

Component-2: Program Monitoring of OPs including Annual Program Review (APR) & Mid Term Review (MTR).

Monitoring of all OPs of DGFP is a continuous process that provides information on whether progress is being made towards achieving the results (output/goals) of the FP-MNCRAH program. So, to monitor all the OPs, monitoring meetings chaired by Director General of Family Planning with all the LD's and concerned personnel of all OPs are arranged. This process helps to analyze the implementation trends whether it is on right track or not and to identify the strength and weakness of the program. 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 MOHFW's monthly monitoring of its Annual Development Programs (ADP). In addition, Planning Unit provides necessary inputs in the OP Implementation Committee (OPIC)/Project Steering Committee Meeting of OPs of DGFP, Annual Program Review (APR), Disbursement Link Indicator (DLI) and Mid Term Review (MTR) of the Sector Program. Moreover, assisting PW/PMMU (MOHFW) in implementing the M&E Strategy and Action Plan-2015 is also one of the key responsibilities of the Planning Unit.

Activities:

1. Assist LDs in preparation of Annual Program Review (APR) and Mid Term Review (MTR) for the sub-sector

2. Review the progress of the different OPs against the set targets
3. Assist LDs in reviewing progress of the OP level indicators including DLIs.

Component-3: Field Program Performance Monitoring

To review the Field Program Performance, Central, Divisional & District level workshops are included in this OP. These Divisional & Districts workshops will be held yearly two times where Division's, District's Managers & other staff present their own Division's & District's Performances, activities & local problems and demands. The performances of NGO's and HED activities are also presented in this workshop. Field level performance gaps are identified and follow-up mechanism developed through effective monitoring. It helps to build the capacity of the Field Level Managers to develop effective Action Plans using different monitoring tools in a systematic manner. Finally, it helps at the central level the decision making and planning process for further improvement of the FP-MCRAH programs.

Activities:

1. Organize meetings/workshops to review/share field level performances at the Central Level.
2. Organize Divisional/District level experience sharing workshops involving Mangers, Supervisors and Field Workers at the Divisional & District Level.
3. Assist Field Level Managers to develop different monitoring tools and plan of action for strengthening FP-MCRAH services.
4. Provide feedback (Monitoring Report) to LDs for effective decision making

Component-4: GO-NGO/Garments Collaboration

This OP is responsible for the affiliation & renewal of NGO related to FP-MCRAH Services on behalf of the DGFP. Thus it will contribute to the better coordination between GO and NGO service delivery at the field level. At present, DGFP has signed a MOU with BGMEA to deliver the FP-MCRAH services with some selected Garments. DGFP has also developed a linkage of co-ordination with BGMEA. Central & Divisional Workshops with the NGOs and some selected Garments representatives of BGMEA will be organized.

Activities:

1. Maintain regular liaison with the partners NGOs through structured meetings
2. Monitor partners NGOs field level activities
3. Organize performance sharing Workshops at the Central and Divisional level.
4. Monitor FP-MCRAH performance achieved through partnership with BGMEA
5. Explore developing new partnership opportunities with the NGOs particularly in the urban areas

Component-4: Petty Repair & Maintenance of UH&FWC

Directorate General of Family Planning has systematic good network infrastructural facilities in the grass root level. Almost every Union of the country (around 4000) covered Union Health & Family Welfare Centre (UH&FWC) with residence facilities and provide central based FP-MCRAH services to the rural people. Regular maintenance is essential for smooth functioning of these centers. So, to

run the physical facilities smoothly, there will be some contribution of petty repair and maintenance in the emergency basis of UH&FWC. Fund will be delegated according to the Government Financial Rules from the central level to the Upazila level. All the Upazila Family Planning Officers will co-ordinate with their concern Deputy Director (Family Planning) for their emergency basis of petty repair & maintenance of UH&FWC. If possible, some resources will also be mobilized locally from UP and Upazila Parishad (MOLGRD). Assessment will be done on needs of repair/ renovation of different facilities.

Activities:

1. To meet urgent requirements of UH&FWC for smooth functioning.
2. In coordination with central and local FP managers (Upazila and District) undertake quick facility assessment which require petty repair and maintenance works
3. Based on the assessment findings allocate resources and monitor maintenance work through field visits

Component-5: Capacity Building

High performing staffs are very much required to plan and implement quality FP-MCRAH programs. Capacity building through different training programs (Local and Overseas) would be one of the priority activities of the PME OP. For strengthening the personnel of Planning Unit, both local & foreign training would be required.

Activities:

1. Local training for different training courses like on Planning and Development, Demography, PPP, Management, Computer Training etc for Planning personnel of DGFP.
2. Relevant overseas training for short-term courses like on Planning, Monitoring & evaluation, Planning and Development, Demography etc for Planning personnel of DGFP.
3. After completion the training, the leanings and knowledge of the training would be implemented.

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc

(i). Linkage to & sharing with other LDs the findings of Field Program Performance Monitoring and way out to materialize

OPs- All of DGFP, PMR- DGHS & SWPMM- MOH&FW

(ii). Alignment of sector wide program management & monitoring activities done by MOH&FW with DGFP.

OPs- All of DGFP & SWPMM- MOH&FW

(iii). Co-ordination and maintaining liaison with PFD-MOHFW for the construction, repair & maintenance of the infrastructural facilities of DGFP

7. Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl. No.	Indicators	Unit of Measurement	Base line (with Year and Data Source) (2015-2016)	Projected Target	
				Middle of Program (June 2020)	End of Program (June 2022)

1	2	3	4	5	6
1	Field Program Performance Monitoring Workshop (Central, Division & District Level).	Number of workshop	104 (Official/ Admin Reports)	444	734
2	Number of Annual Work Plan (AWP) with budgets of DGFP Operational Plans submitted to MOHFW by defined time period (by July)	Number (AWPs available).	07 OPs (Official Reports)	Total Number of OPs/Year	Total Number of OPs/Year
3	Monitoring of financial & physical progress of OPs for ADP Review Meetings.	Number of ADP Review Meeting	05 Meetings (Official Reports)	12 Meetings/ Year	12 Meetings/ Year
4	Co-ordination Workshop with NGOs/Garments/Private Organization on FP-MCRAH activities (Central & Divisional Level).	Number of W\workshop (Official/ Admin Reports)	N/A	07	11

10. Budget of the Operational Plan

10.1 Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
551.50	**1934.50**	0.00	**1934.50**	**2486.00**	

10.2 Component and activity wise physical and financial target of OP: PME

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1	Field Program Performance Monitoring												
1.1	Field Program Performance Monitoring Workshop at Central Level.	6	Nos	30.00		30.00		5.00	5.00	5.00	5.00	5.00	5.00
1.2	Divisional Workshop on Field Program Performance Monitoring	88	Nos	235.00		235.00		20.00	45.00	45.00	45.00	40.00	40.00
1.3	District Workshop on Field Program Performance Monitoring	640	Nos	1280.00		1280.00			260.00	260.00	260.00	250.00	250.00
1.4	Report writing & printing of Field Program Performance Monitoring	6	Nos	9.00		9.00		1.50	1.50	1.50	1.50	1.50	1.50
	Sub Total	740	Nos	**1554.00**	**0.00**	**1554.00**	**0.00**	**26.50**	**311.50**	**311.50**	**311.50**	**296.50**	**296.50**
2	Co-ordination & preparation of OP/ROPs (Workshops/ steering committee & OPIC meeting)	17	Nos	15.00		15.00		1.50	2.50	2.50	2.50	2.50	3.50
3	Workshop on OP's Monitoring (IMED Report) including APR, MTR & others.	5	Nos	7.50		7.50			1.50	1.50	1.50	1.50	1.50
4	Workshop on GO & NGO/Garments Collaboration at Central & Divisional level	11	Nos	33.00		33.00		3.00	6.00	6.00	6.00	6.00	6.00
5	Strenthening of Planning Unit												
5.1	Pay & allowances of Officers & Staff (MM)	330	MM	315.00	315.00			15.00	50.00	55.00	60.00	65.00	70.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5.2	Stationary and maintenance cost for op implementation			105.55	105.55			12.00	20.00	20.00	20.00	19.00	14.55
5.3	Local Training for Officers & staff (person)	64	Persons	16.00	16.00			2.50	3.50	2.50	2.50	2.50	2.50
5.4	Foreign Training for Officers (Person) (Two weeks)	60	Persons	325.00		325.00		30.00	60.00	65.00	65.00	70.00	35.00
	Sub Total	454		**817.05**	**436.55**	**380.50**	**0.00**	**64.00**	**143.50**	**152.50**	**157.50**	**166.50**	**133.05**
6	Procurement of goods												
6.1	Vehichle (Microbus)	1	Nos	50.00	50.00					50.00			
6.2	Machineries & Other Equipment	6	Nos	18.05	18.05			4.00	3.00	4.25	3.00	0.80	3.00
6.3	(Computer,Printer,UPS) set-25, Laptop-1, Scannar-6	32	Nos	27.90	27.90			2.40	5.00	5.50	5.00	6.00	4.00
6.4	Furniture	69	Nos	19.00	19.00			5.00	6.50	4.00	1.50	2.00	
	Sub Total	108	Nos	**114.95**	**114.95**	**0.00**	**0.00**	**11.40**	**14.50**	**63.75**	**9.50**	**8.80**	**7.00**
	Grand Total	1335		**2486.00**	**551.50**	**1934.50**	**0.00**	**101.90**	**469.50**	**527.75**	**478.50**	**471.80**	**436.55**

11. Budget support from other Operational Plan: Not applicable

4.4 Health Economics and Financing (HEF)

1. Name of the Operational Plan: Health Economics and Financing

2. Implementing Agency: Health Economic Unit (HEU)

3. Introduction

The Health Economics and Financing (HEF) Operational Plan comprises activities of Health Economics Unit (HEU), Gender, NGO & Stakeholder Participation (GNSP) Unit, Shastha Suraksha Karmasuchi (SSK) Cell, Bangladesh National Health Accounts (BNHA) Cell and that of the Quality Improvement Secretariat (QIS).The Health Economics Unit (HEU) was established in 1994 to develop overall capacity in the area of health economics and financing. 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 initially mandated activities of the HEU includes training (local & overseas), research and research findings dissemination, and networking with National, Regional and International Health Economics Institutions/Organizations with the aim of developing local capacity in the field of Health Economics. Based on this mandate, over the years, the HEU focused on conducting policy research on health economics and health financing, and giving policy support to the policy makers, but lately it has expanded its activities to other relevant health issues too. It has now been working as the focal point for Universal Health Coverage (UHC) and coordinating all activities geared to that SDG target being undertaken by government, non-government, academia and research organizations.

In 2014 HEU started working on Quality of Health Care. It has established Quality Improvement Secretariat (QIS) for the purpose. *Shastha Suraksha Karmasuchi* (SSK) Cell looks after activities of health protection scheme for the poor, an intervention mentioned in the Health Care Financing Strategy 2012. The BNHA Cell entrusted mainly with producing National Health Accounts that estimates health expenditures in Bangladesh based on OECD's System of Health Accounts Guidelines 2011. This report has significant impact on policy decision on health financing in Bangladesh. The BNHA Cell also prepares Public Expenditure Reviews on health.

During the HPNSDP period HEU developed Health Care Financing Strategy (2012-2032) to achieve Universal Health Coverage by expanding social protection for Health, also developed Resource Allocation Formula for allocating resources according to the need. One National Health Accounts (Round IV) and two Public Expenditure Review (PER) conducted during this period. HEU started piloting of social health protection scheme among below poverty line people named *Shastha Suraksha Karmasuchi (SSK)* in one Upazila of Tangail district. It also conducted several research studies in line with social health insurance. HEU designed social health protection schemes for the readymade garments (RMG) workers and for the civil servants. This will be achieved by starting pilot of these two schemes.

Gender, NGO and Stakeholders Participation Unit (GNSPU)

The Gender, NGO and Stakeholders Participation Unit (GNSPU) has been serving as one of the two functional components of the Health Economics and Financing OP. GNSPU has been entrusted with the implementing role along with the existing technical and policy support role and is assigned with the role of focal point/secretariat of EGV and NGO, Stakeholder Participation issue.

4. Objectives

i. To support the program for achieving the Universal Health Coverage Speciallyfocus to Quality health care.

ii. To provides health expenditure estimate by source, function and providers.

iii. To develop policy options and interventions for service and financial coverage

iv. To coordinate and steer the initiative of Quality improvement activities in HPN sector

v. To develop mechanism for improving efficiency in financing improvement in equity

vi. To provide policy and technical support on gender, equity, voice, accountability, public-private partnership (PPP), and stakeholder participation in HPN sector.

5. Components

The HEF OP will have five components in the next SWAP.

(i). Component 1: Health Economics &Financing including UHC and Capacity building

(ii). Component 2: Shasthyo Shuroksha Karmasuchi (SSK)

(iii). Component 3: Quality Improvement Secretariat

(iv). Component 4: Health Expenditure Tracking

(v). Component 5: Gender, NGO and Stakeholder Participation Unit (GNSPU)

Component-1: Health Economics &Financing including UHC and Capacity building

This component includes health economics and financing in health sector, Universal Health Coverage (UHC), capacity building on health economics and research.

Health Economics and Financing: Exploring health financing options and examining efficient and effective usage of existing available resources is one of the major mandated activities of HEU since its inception in 1994.The HEU plays a pivotal role in identifying effective and efficient health financing options, strategies for enhance accessibility of the poor to health services and to improve the quality of services as well as ensure equity.

The HEU of Ministry of Health and Family Welfare have developed Health Care Financing Strategy (HCFS) 2012-2032. The Strategy provides a framework for developing and advancing health financing in Bangladesh. The HCFS is aligned with major policy documents in Bangladesh that guide our health sector. HCFS address more resource generation, improving efficiency and addressing the equity in the health service delivery. HEU will work in these areas in next sector program.

The National Health Policy 2011, Vision 2021, the Health, population and nutrition Sector Development Program (HPNSDP) 2011-2016, all address the importance of bringing more funds to the health sector and pooling the resources more adequately. The HCFS has also been implanted in the National Social Security Strategy (NSSS) 2015 prepared by Planning Commission. The NSSS focuses on strengthening financial risk protection in receiving heath services especially for the poor to achieve universal health coverage. The HCFS also matched with the UN declared Sustainable Development Goals (SDGs) as its target 3.8 recognizes need of financial protection in achieving UHC.

Universal Health Coverage (UHC): Bangladesh has set target to achieve universal health coverage by 2032 under HCFS 2012. The target is entirely aligned with the UN SDG's target 3.8. The HEU has taken lead in promoting UHC in Bangladesh. During the last sector programme, the HEU has

undertaken different activities including stakeholder analysis, promotional meeting/advocacy meeting with major stakeholders, arranging national/international conferences and workshops. To achieve the UHC by 2032, HEU has designed and has started implementing a social health protection scheme for the below poverty line people. HEU also has designed separate schemes for the readymade garments (RMG) workers and for civil servant. It is planned that in next five years these 2 schemes will start their pilot phase. HEU also develops few instruments for implementing the different health financing tools, which can be piloted or can be implemented in the upcoming SWAP.

Research

To carry out the mandate of HEU in terms of providing policy options, HEU undertakes relevant research activities to develop the evidence base. The research includes in the area of health financing, resource allocation, equity, efficiency and others. HEU conducted these research partnering with academic and research organization for professional inputs. It regularly provides policy inputs through evidence based research and disseminate the research findings to different stakeholders, so that country can bring the best from the research.

Capacity building

Health Economics Unit constantly developing the capacity in different field of health economics and health system by providing training and acquiring knowledge by attending training, workshops, seminar, conferences, field visits etc. It develops the capacity primarily in the area of costing, benefit package development, Health Technology Assessment (HTA), Management of social health protection scheme, monitoring, management 4 health etc. Presently HEU identify a core team of young professional, who are building their career in the health economics field. HEU planned to conduct different capacity development activities to enhance the country capacity on health economics field.

Activities

1. Enactment of National Health Protection Act to create a legal and wider base for protecting all section of population of the country through forming a fund from prepaid mandatory contribution;
2. Testing different social health protection scheme through piloting - Below poverty line people, Readymade Garments Workers (RMG), Civil Servants.
3. Need based resource allocation – piloting and scale-up
4. Provide support on developing ESP, its costing and benefit packages
5. Evidence based research/study on health economics and financing and other health related issues
6. Capacity building on health economics and financing and other health issues;

Component-2: Shasthyo Shuroksha Karmasuchi (SSK)

The Health Economics Unit (HEU) of Bangladesh has implement a social health protection scheme termed as Shasthyo Shuroksha Karmasuchi (SSK: Health Protection Scheme).Under this scheme, the Government started piloting to promote free of charge hospital services (inpatient care) for the poor. The scheme started piloting in one upazila (Kalihati) and expands piloting to total three Upazilas in Tangail District, and will be scaled up based on lessons learnt. In this pilot scheme a benefit package is designed, transforming financing from input based allocation to output based financing, and testing the purchaser-provider split through 3rd party management.

SSK started pilot with the main objective to reduce out of payment expenditure of the below poverty line (BPL) households, thereby protecting them from impoverishment in case of catastrophic illnesses. This pilot will also ensure providing improved quality of health care. SSK will also improve efficiency and effectiveness of health care financing through risk pooling and innovative payment mechanism.

HEU has set up SSK cell for better management of the pilot scheme, contracted out the third party management scheme as scheme operator (SO), registered the BPL, make ready the facility and started functioning. Gradually SSK Cell would be transformed as a National Health Protection Authority. In doing so necessary initiatives would be undertaken.

Activities

1. SSK piloting in three sub-districts
2. Scale-up of SSK pilot (utilizing the learning)
3. Development of benefit package
4. Development of provider payment mechanism

Component-3: Quality Improvement Secretariat

Quality is one of the main dimensions of Universal Health Coverage (UHC). Government of Bangladesh has taken several steps to ensure quality health services at all level; therefore, quality has become the prime agenda in achieving UHC.

Quality is an integral part of health care service delivery and like many other health systems, health sector in Bangladesh is committed to provide quality healthcare to its citizens. The issue of quality has become more important since when Health Care Financing Strategy (2012-2032) has been adopted that which is necessarily a roadmap to achieve the Universal Health Coverage (UHC). Achieving Universal Health Coverage requires addressing the quality of care agenda. The government of Bangladesh hence planned different initiatives to improve the quality of health care service delivery.

Quality Improvement Secretariat is established in 2015 and is playing a crucial role in overseeing the nationwide activities of the quality improvement of health care service delivery areas. The unit is the formal management body of the National Quality Improvement Committee (NQIC) led by the DG (Director General) of the Health Economics Unit. QIS have strong linkages with the DGHS and DGFP who are the main service providers of the country. The major mandate of QIS is to guide & oversee the quality improvement activities nationwide through:

- M&E of Quality of Care for Heath Service Delivery
- Development of Quality of Care related protocols, guideline, SOP tools
- Ensuring attainment of National Health Care Standards
- Ensuring Coordination mechanism among GO,NGO,DP and autonomous body

Strategic Objectives

A strategic planning on Quality of Care has developed with the aim to achieve post MDG agenda "Universal Health Coverage". Through a collaborative and participatory process and taking the learning from executing quality focused implementation, a core committee comprising of the major

stakeholders of health and population sectors developed a strategic planning documents. An implementation plan has developed to achieve the following strategic objectives:

Strategic Objective 1: Introduce consumer and patient-centred services

Strategic objective 2: Improve patient safety

Strategic Objective 3: Improve clinical practice

Strategic Objective 4: Improve Leadership Management systems

Strategic Objective: 5: Improve public health & preventive services

Priority Interventions:

1. Lead the initiatives for development of National Quality Improvement Tools, protocols, Standard operating procedure, guideline and other necessary documents for QI;
2. Facilitate the process for implementation of National Health care standards for QI;
3. Establish the QI coordination mechanism among Government /Non Government Organization and other development organization;
4. Build, linkage and facilitate the OP related intervention with the Line Director Hospital Service Management (HSM) and Line Director Community Based Health Care (CBHC) for effective implementation of National Strategic planning on Quality of care;
5. Functioning the different organizational & facility level QI committee;
6. Capacity development of National & Regional Resource pool for Quality Improvement
7. Monitoring & Supervision of MPDSR implementation activities in selected districts
8. Periodical conduction of patient satisfaction survey;
9. Monitoring & Evaluation of QI framework, Key Performance Indicators(KPI) & Facility Level Indicators;

Component-4: Health Expenditure Tracking

Health Economics Unit (HEU) of the Ministry of Health and Family Welfare of the Government of Bangladesh have been instrumental in periodically producing the country's National Health Accounts (NHA) since 1997. NHA, following widely internationally accepted guidelines, provides a systematic description of financial flows related to health, producing national as well as internationally comparable estimates. It provides health expenditure estimates by financing schemes, type of services (functions), and by providers of these services for a given period. NHA estimate are policy relevant. It reflects the growth of the health system, providing insights on policy reform efforts that are linked to attaining the Sustainable Development Goals (SDG) as well as Universal Health Coverage (UHC). Fifth round of BNHA initiated in the last year of HPNSDP, depending on BNHA-V estimates a full Disease Specific Accounts (DSA) is planned. In addition to this, under NHA Institutionalization plan to produce BNHA every alternate year provision of another two rounds of BNHA is kept in the current HEF OP.

Strategic Objectives of BNHA

BNHA will examine the following:

- To track health expenditures and inform policy-makers on how funds flow within the health sector, such as how much is spent through which financing scheme and for what purpose, including the type of health services and goods are provided.
- The origin(s) of resources (e.g., general taxation, social security funds, out-of-pocket payments, and other private sources) and the agent(s)/agency through which the resources are managed (e.g. ministries, local government bodies, insurance companies, NGOs, households).
- The factors of provision (e.g., salaries, medicines and equipment) to spend the funds.

Public Expenditure Review is conducted by the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MOHFW) since 1995. HEU is mandated to produce Public Expenditure Review (PER) for the health sector and also National Health Accounts (NHA). Each round of the PERs has different focus, which is determined by the prevailing situation or challenges in the health sector or issues that require attention for future policy direction. Budget and expenditure are key to achieving sector policy goals. It is important to examine the policy framework as well as budgetary and expenditure framework, which in turn will help to understand whether budget allocation and expenditure patterns support the strategic priorities in health, population and nutrition (HPN) sector. The main objective of this PER is to examine the trends in public spending during a time period(s)/series in order to assess performance of health sector particularly the sector wide programs over the period. In addition to this, under NHA Institutionalization plan to produce PER every alternate year provision of another three rounds of PER is kept in the current HEF OP.

Strategic Objectives of PER

PER will examine inter alia the following:

- The total spending in health care by the public sector(Public sector includes MOHFW, other Ministries such as Ministry of Defence, Ministry of Home Affairs and so on).
- The health expenditure financing mechanism and comparison between GOB contributions vis-a-vis that of development partners.
- Area wise financing i.e. by function and inputs (e.g. salary, equipment, drugs, etc.)
- Efficiency and equity in using public resources.

Activities:

1. Conduct National Health Accounts to estimate total expenditure and
2. Conduct Public Expenditure review on health sector;
3. Conduct Disease Specific Accounts
4. Analysis and developing policy briefs on the NHA and PER

Component-5: Gender NGO and Stakeholder Participation Unit (GNSPU)

The increased attention of gender, equity, voice and accountability has placed on HPNSDP and this is one of the priorities. The component of GNSPU in HEF Operational Plan aimed to provide policy guidance for gender responsive health care service delivery and to identify the programs and activities where NGO, stakeholder participation and PPP can be utilized to improve efficiency, enhance accountability and transparency in the health sector.

GNSPU developed Gender Equity Strategy (GES) 2014 and finalized a comprehensive gender equity action plan for 10 years (2014-2024). The goal of the GES 2014 is to improve the health of the people of Bangladesh through better utilization of services especially for women, children, adolescents, and marginalized population and the poor.

A database on NGOs working in the HPN sector has been developed in collaboration with relevant agencies including NGO Affairs Bureau. The Unit conducts policy research to provide policy guidance; organizes trainings, workshops, and seminars to improve the capacity of the policy makers and service providers on equity, gender, voice, NGO, and participation (EGVNP) issues; and develops and maintains formal and informal networks with national and international stakeholders and experts on these issues.

Because for most activities GNSPU depends on other OPs for achieving goals, targets and inclusion of gender responsive indicators makes visible that mainstreaming gender needs a concerted effort. However, the Unit faces serious human resource capacity constraints, especially in light of the critical work ahead. Staff reposting and technical knowledge in gender, PPP, voice and accountability, NGO, and stakeholder participation are being described as the most pressing human resource issues.

Specific Objectives

- To facilitate generation of gender disaggregated information and strengthen gender data management;
- To implement pilot programs on gender, equity, voice, accountability, PPP, and stakeholder participation;
- To formulate PPP and stakeholder participation strategy to ensure involvement of key stakeholders on planning, implementing and reviewing health and family welfare services;
- To identify the programs and activities where PPP, voice and accountability can be utilized to improve efficiency and transparency in the HPN sector.

Priority activities of GNSPU

1. Capacity building of health service providers on gender auditing for promoting gender issues in health at different level.
2. Conducting hands on training of focal point of gender (in every Operation Plans) on Gender Responsive Budgeting (GRB)
3. Conducting training for health service providers to manage GBV
4. Analyzing health and family planning related sex-disaggregated data and identify gender gaps in existing data collection formats and finalizing set of sex-disaggregated indicators for periodic generation.
5. Reconstituting and activating the Gender Advisory Committee.
6. To formulate Stakeholder Participation Strategy and PPP in HPN sector and ensure involvement of key stakeholders on planning, implementing and reviewing health and family welfare services.
7. Functioning of the database on NGOs working in the HPN sector.

8. Facilitating a system for lodging client views, feedback and complaints and responding to these at local and national levels.
9. Developing and maintaining formal and informal networks with national and international stakeholders, and experts on EGVNP (Equity, gender, voice, NGO and participation) issues.
10. Designing and piloting health sector response to GBV.
11. To conduct research/studies having significant policy implications on EGVNP issues.

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc:

(i). Universal Health Coverage is not only the issue of financing, HEU will lead in the financing sector but contribution from all the other OPs of MOHFW is necessary. The service delivery will be provided from different OPs.

(ii). Health care quality is another area where all service delivery OPs are responsible for providing quality health care. QIS of MOHFW will monitor prepare guidelines and Standard Operating Procedures (SOPs) and service delivery OPs will provide quality health care service.

(iii). On gender, equity, voice, accountability, public-private partnership (PPP), and stakeholder participation issues, GNSPU will provide guideline and services will be implemented by different OPs.

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services: Annexed in Volume-II

9. Indicators:

Sl.	Indicators	Unit of Measurement	Base line (with Year and Data Source)	Projected Target	
				Middle of Programme (By June 2020)	End of Programme (By June 2022)
1	2	3	4	5	6
1.	Number of BNHA conducted	Number (Report/Doc available)	BNHA 4	1	2
2.	Number of PER conducted	Number (Report/Doc available)	PER 2014	1	2
3.	Number of upazila are in social health protection scheme	Number of facility (Admin record)	1 upazila	3 upazila	13 upazilas

Sl.	Indicators	Unit of Measurement	Base line (with Year and Data Source)	Projected Target	
				Middle of Programme (By June 2020)	End of Programme (By June 2022)
1	2	3	4	5	6
4.	Number of health facilities piloting health sector response to GBV	Number (Admin Records)	NA	1 upazila of1 district	3 upazilas of 2 districts

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
13518.45	7763.20	901.00	8664.20	22182.65	

10.2. Component and activity wise physical and financial target of OP: HEF

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component-1: Health Economics & financing including UHC													
1	Capacity building												
a.	Short local training	30	Batches	72.00	72.00	0.00	0.00	12.00	12.00	12.00	12.00	12.00	12.00
b.	Foreign training	2	Batch	50.00	50.00	0.00	0.00	0.00	25.00	0.00	25.00	0.00	0.00
2	Policy Advice: Conduct Research	10	Nos	200.00	120.00	80.00	0.00		40.00	40.00	40.00	40.00	40.00
3	Workshop/Seminar (National)	As per need		120.00	60.00	60.00	0.00	10.00	20.00	25.00	25.00	20.00	20.00
4	Printing & Publication	As per need		41.00	41.00	0.00	0.00	10.00	10.00	6.00	5.00	5.00	5.00
5	Different meetings	As per need		25.00	25.00	0.00	0.00	5.00	5.00	5.00	6.00	2.00	2.00
6	Consultancy: National (Short Term)	12	MM	35.00	0.00	35.00	0.00		0.00	35.00	0.00	0.00	0.00
7	Assets												
a	Purchase of Vehicle	1	Nos	75.00	75.00	0.00	0.00	0.00		75.00			
b.	Computers & Other Equipment	As per Need		68.00	68.00				12.00	20.00	12.00	12.00	12.00
8	Repair & Maintenance: All Office Equipment including Vehicles	As per Need		90.00	90.00	0.00	0.00	10.00	20.00	15.00	15.00	15.00	15.00
9	Office Running Cost: Fuel, Stationary, Telephone, Tax, Entertainment,Computer Tonar & Others Code	As per Need		105.00	105.00	0.00	0.00	20.00	25.00	25.00	25.00	5.00	5.00
	Sub TotaL			881.00	706.00	175.00	0.00	67.00	169.00	258.00	165.00	111.00	111.00
Component-2: Shasthyo Shuroksha Karmasuchi (SSK)													

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1	Pay & Allowance	10	Nos	385.00	385.00	0.00	0.00	0.00	77.00	77.00	77.00	77.00	77.00
2	Capacity building												
a.	Short local training	30	Batches	72.00	72.00	0.00	0.00	12.00	12.00	12.00	12.00	12.00	12.00
b.	Foreign training	2	Batches(Grade 1 to 10)	50.00	50.00	0.00	0.00	0.00	0.00	25.00	0.00	25.00	0.00
3	Policy Advice: Conduct Research & Policy briefs, strategies & options	2	Nos	90.00	0.00	90.00	0.00	0.00	0.00	0.00	90.00	0.00	0.00
4	Workshop/Seminar: National	As per need		79.00	79.00	0.00	0.00	10.00	12.00	12.00	15.00	15.00	15.00
5	Printing & Publication	As per need		50.00	0.00	50.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
6	Different meetings	As per need		30.00	30.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00	5.00
7	Consultancy: National (Short Term)	60	MM	135.00	0.00	135.00	0.00	0.00	30.00	30.00	30.00	30.00	15.00
8	Assets of SSK Piloting: Computers & Other Equipment	As per need		1226.40	470.80	755.60	0.00	40.00	200.00	246.60	246.60	246.60	246.60
9	Premium for UHC (SSK) piloting	As per Need		13500.00	8100.00	5400.00	0.00	1227.20	2454.56	2454.56	2454.56	2454.56	2454.56
10	Mgt. cost for Scheme Operator & Others	As per Need		1290.00	652.80	637.20	0.00	117.90	234.42	234.42	234.42	234.42	234.42
11	Repair & Maintenance (shifted to PFD)	As per Need		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
12	Others Office Running Cost (including maximum 1.00 crore for hiring vehicle)	As per Need		300.00	300.00	0.00	0.00	30.00	110.00	100.00	50.00	5.00	5.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	Sub Total			**17207.40**	**10139.60**	**7067.80**	**0.00**	**1442.10**	**3144.98**	**3206.58**	**3224.58**	**3114.58**	**3074.58**
Component-3: Quality Improvement Secretariat													
1	Pay & Allowance	18	Persons	726.75	726.75	0.00	0.00	0.00	145.35	145.35	145.35	145.35	145.35
2	Capacity building												
a.	Short local training	100	Batches	270.00	100.00	0.00	170.00	20.00	50.00	50.00	50.00	50.00	50.00
b.	Foreign training	1	Batches	25.00	25.00	0.00	0.00	0.00	25.00		0.00	0.00	
3	Policy Advice: Conduct Research & Policy briefs, strategies & options	3	Nos	90.00	90.00	0.00	0.00	0.00	30.00	30.00	0.00	30.00	0.00
4	Workshop/Seminar: National	As per need		294.00	90.00	0.00	204.00	38.00	38.00	38.00	60.00	60.00	60.00
5	Printing & Publication	As per need		95.00	25.00	0.00	70.00	10.00	20.00	20.00	15.00	15.00	15.00
6	Consultancy: National	48	MM	120.00	0.00	120.00	0.00	0.00	30.00	30.00	30.00	30.00	0.00
7	Computers & Other Equipment	As per need		30.00	30.00	0.00	0.00	0.00	6.00	6.00	6.00	6.00	6.00
8	Repair & Maintenance	As per need		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
9	Others Office Running Cost	As per need		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Sub Total			**1650.75**	**1086.75**	**120.00**	**444.00**	**68.00**	**344.35**	**319.35**	**306.35**	**336.35**	**276.35**
Component-4: Health Expenditure Tracking													
1	Pay & Allowance	3	Persons	132.42	132.42	0.00	0.00	18.92	18.92	18.92	37.82	18.92	18.92
2	Capacity building: Foreign training	1	Batches	25.00	25.00	0.00	0.00	0.00	0.00	25.00	0.00	0.00	0.00
3	Policy Advice: Conduct Research &Policy briefs, strategies & options	5	studies	200.00	40.00	42.00	118.00	118.00	42.00	0.00	40.00	0.00	0.00
4	Workshop/Seminar: National	As per Need		48.40	0.00	48.40	0.00	0.00	14.00	4.40	10.00	10.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Printing & Publication	As per need		25.00	25.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
6	Different meetings	As per need		3.90	3.90	0.00	0.00	0.00	0.40	0.50	1.00	1.00	1.00
7	Consultancy: National (Short Term)	24	MM	60.00	0.00	60.00	0.00	0.00	0.00	0.00	30.00	30.00	0.00
8	Computers & Other Equipment	As per Need		16.00	16.00	0.00	0.00	0.00	5.00	6.00	3.00	1.00	1.00
9	Office Running Cost	LS		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Sub Total			510.72	242.32	150.40	118.00	136.92	85.32	59.82	126.82	65.92	35.92
Component-5: Gender, NGO & Stakeholder Participation (GNSP)													
1	Pay & Allowance (All Staff draw their salary against the pay scale)	14	Nos	621.78	621.78	0.00	0.00	103.26	103.26	103.26	104.00	104.00	104.00
2	Capacity building												
a.	Short local training on Gender,NGO and Stakeholder Perticipation	60	Batches	280.00	225.00	0.00	55.00	32.00	47.00	47.00	54.00	46.00	54.00
b.	Foreign training	2	Batches (Grade 1 to10)	50.00	50.00	0.00	0.00	0.00	25.00	25.00	0.00	0.00	0.00
3	Policy Advice: Research and development of policy briefs,strategies framework on Gender,NGO and Stakeholder participation	13	Nos	220.00	120.00	100.00	0.00	0.00	60.00	60.00	40.00	40.00	20.00
4	Workshop/Seminar: National & international	As per need		138.00	72.00	0.00	66.00	20.00	20.00	22.00	32.00	22.00	22.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Printing & Publication	As per need		43.00	25.00	0.00	18.00	2.00	7.00	7.00	9.00	9.00	9.00
6	Health Sector Response to GBV	1nos		200.00	0.00	0.00	200.00	0.00	40.00	40.00	40.00	40.00	40.00
7	Different meetings	As per need		10.00	10.00	0.00	0.00	0.50	1.00	1.00	2.50	2.50	2.50
8	Consultancy :National	60	MM	150.00	0.00	150.00	0.00	0.00	30.00	30.00	30.00	30.00	30.00
9	Computer & Office Equipment	As per need		65.00	65.00	0.00	0.00	10.00	9.00	10.00	12.00	12.00	12.00
10	Repair & Maintenance: All Office Equipment including Vehicles	As per Need		60.00	60.00	0.00	0.00	5.00	10.00	15.00	10.00	10.00	10.00
11	Office Running Cost	As per Need		95.00	95.00	0.00	0.00	15.00	20.00	20.00	20.00	10.00	10.00
	Sub Total			1932.78	1343.78	250.00	339.00	187.76	372.26	380.26	353.50	325.50	313.50
	Grand Total			22182.65	13518.45	7763.20	901.00	1901.78	4115.91	4224.01	4176.25	3953.35	3811.35

11. Budget support from other Operational Plan: Not applicable

4.5 Strengthening of Drug Administration and Management (SDAM)

1. Name of the Operational Plan: Strengthening of Drug Administration and Management (SDAM)

2. Implementing Agency: Directorate General of Drug Administration (DGDA)

3. Introduction

Situation Assessment:

Drug is the main intervention for disease treatment. Drug is obvious for the treatment of diseases but at the same time we have to keep in mind that the medicinal products should be standard quality, efficacious and safe for the patients, otherwise these may be harmful for the patients and may create severe problems regarding public health. The Directorate of Drug Administration was established in 1974 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 (DGDA) in 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, Pharmacovigilance including post-marketing surveillance, import and export of drugs, vaccines, traditional medicines, medical devices in the country. In addition, the Director General of Drug Administration acts as the Licensing Authority and issues Licenses for the manufacture, distribution, export, import and sale of drugs, vaccines, traditional medicines and medical devices. 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 in the country.

Like the garments industry, the country's pharmaceutical sector has been one of the success stories of Bangladesh in the last three decades. After Bangladesh's liberation in 1971, the industry was largely dominated by multi-national companies (MNC) and the country was import-dependent. The defining moment came in 1982 when the government formulated the National Drug Policy and the Drug Control Ordinance. At the time, 75% of the market was dominated by MNCs, whereas the rest was shared by some local manufacturers. 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. Now the Bangladeshi pharmaceutical companies are producing vaccines and biological drugs. 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 has been done and it is in the final process of approval.

At present there are 853 pharmaceutical products manufacturing companies including allopathic, traditional medicine (unani, ayurvedic and herbal) and homeopathic medicine manufacturers. These companies are marketing more than 2833 generic products with 38473 brands in the country. Total size of the pharmaceutical market of Bangladesh is estimated to be approximate Tk. 157.5 billion, with an annual growth rate of about 11.37 %. 98% of the country’s need is fulfilled by domestic production and import amount is only 2% of total need. Bangladeshi medicines are exported to more than 123 countries worldwide. Some manufacturing facilities have achieved a ‘degree of excellence’

and obtained international recognition, such as US certification from the FDA, UK certification from the MHRA & TGA from Australia.

As we can provide the locally manufacturing drugs at an affordable price, directly helps the patients to reduce the healthcare cost individually and also several public health programs where medicines act as a major intervention.

Goals and targets achieved during HPNSDP:

During 3rd sector program (HPNSDP, 2011-2016) a number of positive lessons have been learned through implementation of the SDAM OP. Already an international standard drug testing laboratory (National Control Laboratory-NCL) comprising both drug and vaccine wing has been established at Mohakhali, Dhaka. Due to establishment of NCL the testing of drug samples has been increased dramatically (At 2010 the number of drug samples tested was 2,681 and during 2015-2016 the number was 10,800). It has created opportunities to provide the quality medicinal products throughout country. Now we can perform some tests of vaccines at the Vaccine Wing under National Control Laboratory (NCL). Due to lack of animal house at NCL we are not able to execute the toxicity test of vaccines. During the year 2010 our Number of inspections on Drug Manufacturing Units was 310 and from July 2015-June 2015 the number was 1552. Logistic support is pre-requisite for ensuring quality, efficacy and safety of drugs. All the inspectors, engaged for implementation of GMP (Good Manufacturing Practices), inspections at pharmaceutical manufacturing units, have received GMP training.

New challenges:

The Directorate General of Drug Administration will be substantially strengthened its capacity which will in turn improve 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 it will help to access to receive health care services for the poor people.

Counterfeit, spurious and sub-standard 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 drugs regarding 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 is absolutely essential. A strong Directorate General 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 Essential Drug List (EDL) followed by the guideline of World Health Organization.

An international standard drug testing laboratory (National Control Laboratory) has been established at Mohakhali, Dhaka. An animal house is urgently required for the testing of vaccines at National Control Laboratory, Dhaka. A new drug testing laboratory for traditional medicines has to be established. Furthermore, continuous up-gradation of both of the drug testing laboratories (National Control Laboratory, Dhaka and Drug Testing Laboratory, Chittagong) is required.

The Drug Policy-2016 has been finalized by MoHFW and now it is on the process to be placed on Cabinet for consideration. A consolidated Drugs Act 2016 has been prepared accommodating the Drugs Act, 1940 and the Drugs (Control) Ordinance, 1982 and its amendments. It is under process to be enacted.

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.

The priority areas of the OP will include:

(i) Strengthening Drug Testing Laboratories and Establishment of Animal House
(ii) Establishment of a New Drug Testing Laboratory for Traditional Medicine and Cosmetics
(iii) Strengthening Post Marketing Surveillances for ensuring the quality medicines in the market throughout the country and enhancing the Capacity of DGDA
(iv) Strengthening National Pharmacovigilance System for ensuring drug safety and promoting Rational Use of Drugs
(v) To support the local pharmaceutical industries to produce quality drugs as well as supporting the retail pharmacy

4. Objectives

General Objective: To ensure quality, efficacious and safe pharmaceutical products for improving the health of the people and contribute GDP growth of Bangladesh.

Specific Objectives:

(i) To support the pharmaceuticals industries to produce quality drugs as well as to support the pharmacists and store keepers of different public and private pharmacies on Good Pharmacy and Good Storage Practices as per international standard.
(ii) To strengthen the capacity of the National Regulatory Authority for Drugs, Vaccines, Medical Device and Traditional Medicines.
(iii) To enhance Post Marketing Surveillance Activities.
(iv) To improve the capacity and standard of government drug testing facilities for quality control of drugs, vaccines, medical devices and traditional medicines.
(v) To facilitate the Rational Use of Drugs and to strengthen Adverse Drug Reaction Monitoring (ADRM) Cell at every primary, secondary and tertiary level hospitals for performing Pharmacovigilance (PV) activities.
(vi) To update and implement the drug regulatory functions especially finalization of Drug Policy 2016 and a consolidated Drugs Act 2016 accommodating the Drugs Act, 1940 and the Drugs (Control) Ordinance, 1982 and its amendments.

5. Components

Component-1: Strengthening Drug Testing Laboratories and Establishment of Animal House

In order to ensure the standard quality of drugs and vaccines, the government needs to evaluate the quality standard of each drug / vaccine available in the market on a routine basis. The modernization work of National Control Laboratory (NCL) under DGDA has been completed. At present a few local companies are producing vaccines but for exporting vaccines pre-qualification of NCL by WHO is a pre-requisite. An animal house is urgently required for the testing purpose of vaccines at National Control Laboratory, Dhaka. Therefore establishment of an animal house nearby NCL has proposed in the 4th HNP Sector program.

Activities:

1. Renovation and validation works of existing Drug Testing Laboratories (National Control Laboratory, Mohakhali, Dhaka and Drug Testing Laboratory, Chittagong).
2. Supply of laboratory equipment for existing drug testing laboratories
3. Supply of laboratory equipment for Animal House under NCL.
4. Supply of machineries and other equipment for existing drug testing laboratories
5. TA support for WHO pre-qualification of both National Control Laboratory (NCL) and National Regulatory Authority (NRA)
6. Supply of furniture and fixture for existing drug testing laboratories
7. Supply of reagents and media for existing drug testing laboratories
8. Providing training for the officers of drug testing laboratories
9. Construction of Animal House for testing of vaccines under NCL.

Component-2: Establishment of a New Drug Testing Laboratories for Traditional Medicine and Cosmetics

In the 4th HNP Sector Development Program government has given emphasize to strengthen and expansion of Alternative Medical Care (AMC) services at various level of health care facilities and for ensuring effective and efficient AMC services we need to confirm the availability of standard quality of Unani, Ayurvedic, Homeopathic and herbal medicines in the market. At present we don't have any separate laboratory for traditional medicine and cosmetics. To address the above issue it is necessary to establish a new drug testing laboratory for traditional medicines. Honorable Prime Minister has given directive to establish the new drug testing laboratory for traditional medicine and cosmetics

It is therefore, proposed to establish a separate Drug Testing Laboratory for Traditional Medicine and Cosmetics in the 4th sector program. The site of the proposed laboratory will be selected in consultation with the experts, availability of land and according to the decision of higher authority.

Before establishment of Drug Testing Laboratories for Traditional Medicine and Cosmetics it is needed to recruit the qualified manpower as well as the supporting staffs (total number of manpower is 49) for smooth functioning of this laboratory. After recruitment of the manpower their salary has to be provided from this development budget before finalizing the revenue structure.

Activities:

1. Establishment of Drug Testing Laboratory for Traditional Medicines and Cosmetics
2. Supply of laboratory equipment for proposed drug testing laboratory of traditional medicines and cosmetics.
3. Supply of machineries and other equipment for proposed drug testing laboratory of traditional medicines and cosmetics.
4. Providing salary for the officers and staffs of Drug Testing Laboratory for Traditional Medicine and Cosmetics.
5. Supply of furniture and fixture for proposed drug testing laboratory for traditional medicines and cosmetics.
6. Supply of reagents and media for proposed drug testing laboratory for traditional medicines and cosmetics.

Component-3: Strengthening Post Marketing Surveillances and Enhancing the capacity of DGDA

A stringent 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 surveillances. The Directorate General of Drug Administration needs strengthening and building capacity to carry on its responsibilities effectively. A comprehensive logistic support is prerequisite for effective field monitoring to monitor the quality of drugs throughout the country.

Good Manufacturing Practices (GMP) at manufacturing sites as well as drug technology are updating on a regular basis. For monitoring the drug manufacturing and evaluating the system this is must to make conversant the DGDA personnel time to time by providing both theoretical and hands on training.

During the 3rd HNP Sector Program DGDA have got their own office building at Mohakhali, Dhaka. The DGDA Head Office Building up to three fourth of its 2nd floor has been completed. It is needed to expand the building vertically for arranging the office space for all the officers and staffs as well as for the other facilities for performing the official works properly. During the 3rd HNP Sector Program, Construction Works of Chittagong Divisional Office Building has been started and incomplete works should be completed and for divisional office some new physical facilities should be developed at divisional level.

Activities:

1. Providing logistic support like vehicles, furniture & fixture, computers & accessories, petrol & lubricant, stationary & stamps for head office, divisional offices as well as other peripheral offices.
2. Arranging local and foreign training on Good Manufacturing Practices (GMP), Quality Management System (QMS), Accreditation, Quality Assurance, Quality Control, Vaccine Technology, and Biologics for the officers of DGDA.
3. Computer training for the officers and staffs of DGDA
4. Construction of remaining of the 2nd Floor and 3rd to 7th Floor of the DGDA Head Office Building
5. Remaining construction works of Chittagong Divisional Office Building.

Component-4: Strengthening National Pharmacovigilance (PV) System and promoting Rational Use of Drugs

According to the WHO Guideline Pharmacovigilance (PV) is defined as the science and activities relating to the detection, assessment, understanding and prevention of adverse effects or any other possible drug-related problems. It is a very important medical discipline to prevent drug-related adverse effects in humans, ensure patient safety.

In 1999 Pharmacovigilance was introduced in Bangladesh but due to shortage of manpower and lack of financial support the program could not continue. It was revitalized in 2013 when the Directorate General of Drug Administration (DGDA) established the Adverse Drug Reaction Monitoring (ADRM) Cell and the Ministry of Health and Family Welfare (MOHFW) declared DGDA as the National PV Center for Bangladesh with ADRM cell overseeing the center's activities. The MOHFW also revised the independent committee known as the Adverse Drug Reaction Advisory Committee (ADRAC) to work in conjunction with the ADRM Cell to provide technical guidance for implementing PV activities; evaluate adverse drug event (ADE) reports and make recommendations for regulatory decisions to the Licensing Authority for Drugs. In December 2014, Bangladesh became the 120th member of the World Health Organization's International Drug Monitoring Center (WHO-UMC). Through this membership, Bangladesh has gained international recognition, access to early

worldwide information about potential safety risks. To this effect, DGDA planned to implement the pharmacovigilance activities across the country with cooperation from all stakeholders.

To run an effective pharmacovigilance system, a protocol is required for reporting adverse drug reactions associated with drug use. DGDA is now preparing the National Guideline on Pharmacovigilance Program of Bangladesh and a draft guideline has already been prepared.

National Pharmacovigilance Center have (1) to promote PV in the country, notably, to collect and manage adverse drug reaction (ADR) reports, reports of medication errors and suspected counterfeit/substandard drugs; (2) to identify signals of medicine safety i.e. unknown or poorly characterized adverse events in relation to a medicine or a combination of medicines and/or its use; (3) to undertake assessment of risk and options for risk management; (4) to identify if there are quality problems in medicines resulting in ADRs; and more generally, support the identification of medicine quality issues; (5) to provide effective communication on aspects related to medicine safety, including dispelling unfounded rumors of toxicity attributed to medicines and/or vaccines; (6) to apply resulting information from pharmacovigilance for the benefit of public health programs, individual patients and national medicines policies and treatment guidelines; (7) to develop and maintain drug utilization information; (8) to identify issues associated with unregulated prescribing and dispensing of medicines.

The Adverse Drug Reaction Monitoring (ADRM) Cell of DGDA is working as the National Pharmacovigilance Center for ensuring the drug safety. All the drug molecules have the characteristics of having some adverse effects. For ensuring drug safety it is necessary to find out the unwanted side effects through collecting the spontaneous ADR reports and evaluating these reports on regular basis. Awareness program would be helpful to create the spontaneous ADR Reporting culture throughout the country.

At present 32 hospitals and 30 pharmaceutical industries have focal persons and DGDA is collecting ADR reports continuously from these institutes and industries. The ADRM cell of DGDA is committed to collect ADR reports not only from each healthcare facility but also from each individual of our country to ensure safe drugs.

Presently, DGDA is preparing the online ADR reporting system under the fund of a2i of Honorable Prime Minister's Office. Through proper assessment of the submitted ADR reports the Licensing Authority will be able to take appropriate decision regarding individual drug products. ADRM Cell of DGDA is running from financial support of USAID. Sustainable funding is a criterion of a functional pharmacovigilance center according to the WHO guideline.

Extensive training program for the officers of DGDA is needed on Pharmacovigilance and the drug related problems. Effective communication among the ADRM Cell, healthcare professionals, pharmaceutical manufacturers and general people is a vital factor to minimize the adverse effect of drugs.

The rational use of medicines (RUM) contributes to high-quality health care while irrational use leads to health hazards and wastage of resources that are already insufficient in the majority of health care systems. Overuse, underuse or misuse of medicines that characterize irrational use has been called a problem beyond rationality that persists and is difficult to eliminate. To ensure rational use of drugs is one of the basic works of national regulatory authority. Continuous training is required, combined with monitoring, feedback and reinforcement. Educating all concerned in the appropriate and correct use of medicines becomes a critical issue to solve the problem of irrational use. Ensuring rational uses of drugs awareness programs are also required.

Activities:

1. Providing logistic support like vehicle and others for effective communication with the stakeholder and monitoring the program

2. Arranging seminar and workshops on Pharmacovigilance (PV), Rational Uses of Drugs and drug related problems for the healthcare professionals (Doctors, Pharmacists and Nurses).
3. Arranging awareness programs on PV, Rational Uses of Drugs, and Abolition of Counterfeit Drugs (such as awareness bulletin, awareness posters, advertisement through print and electronic media).
4. Providing training on Pharmacovigilance for the officers of DGDA

Component-5: To support the local pharmaceutical industries and retail pharmacy

DGDA is providing proper guidance and support to the local pharmaceutical manufacturers continually. DGDA prepared several guidelines on Good Manufacturing Practice (GMP), Good Clinical Practice (GCP) for trials on pharmaceutical products, Medical Device Registration, Dedicated and Campaign Facilities for pharmaceuticals production, Contract Manufacturing and many others. These guidance and directive documents help the manufacturers to prepare quality medicines. DGDA also arranged some training programs and consultation meetings for the qualified persons employed at different pharma industries.

Good dispensing practices ensure that an effective form of the correct medicine is delivered to the right patient, in the correct dosage and quantity, with clear instructions, and in a package that maintains the potency of the medicine. Dispensing includes all the activities that occur between the time the prescription is presented and the time the medicine or other prescribed items are issued to the patient. A safe, clean, and organized working environment provides a basis for good practice. Dispensing must be performed accurately and should be done in an orderly manner, with disciplined use of effective procedures. Staff members who dispense must be trained in the knowledge, skills, and practices necessary to dispense the range of medicines prescribed at the facility. Their performance should be regularly monitored. Ensuring patients' understanding of how to take their medicines is a primary responsibility of dispensers. Dispensers should check understanding by asking each patient to repeat instructions. Good records, though sometimes neglected, are an essential part of dispensing; they facilitate good management and monitoring of services provided.

Bangladeshi pharmaceutical manufacturers are producing good quality of drugs but at the user end it has found some problems that may not only affect the drugs' quality but also creates obstacles to ensure rational uses of drugs as well as promoting antibiotic resistance. People who use retail drug shops often self-diagnose and then request specific medicines or seek advice on treatment from the drug seller; therefore, retail drug sellers may be the only contact regarding health care for some individuals. Some shops also illegally sell prescription drugs and injections and shop personnel are often unqualified and untrained to offer medical advice. Addressing these issues offers a huge opportunity to improve the end point services.

Experiences in other parts of world have demonstrated that private-sector drug seller initiatives based on an accreditation and regulation model are feasible and sustainable, improve access to medicines, and can be scaled up. The Bangladesh Pharmacy Model Initiative (BPMI) was launched in November 2015 from the Joint Donor Technical Assistance Fund (JDTAF) for designing accredited drug seller model in Bangladesh.

This initiative is being implemented in three distinct phases. All phases should involve key public and private sector stakeholders so that the plans, processes, and materials reflect country program needs and buy-in, especially because some of the outputs require government or other stakeholder action (e.g., change in regulations). The three phases are as follows:

- Phase 1: Develop Bangladesh pharmacy model and implementation strategy, processes, and materials, including standards, laws and regulations, regulatory and inspection capacity, and program oversight
- Phase 2: Implement and evaluate the Bangladesh pharmacy model in target districts (pilot phase)

- Phase 3: Scale-up final model nationwide and ensure sustainability and maintenance without ongoing donor support

Continuous support is required for the pharmaceutical manufacturers and the retail pharmacy.

Activity:

1. Arranging training programs for the qualified persons employed at different pharmaceutical industries on Good Manufacturing Practices (GMP) at the pharmaceutical manufacturing sites to produce quality drugs.
2. Orientation training programs for the pharmacists employed at different pharmacies on Drug Storage, Dispensing and Patient Counselling.
3. Advertisement through print and electronic media regarding Model Pharmacy.

6. Cross-Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

Good coordination and harmonization with programs of different operational plans and other government agencies will enhance to implementing the objectives of SDAM OP.

Activities

1. Coordination with other relevant agencies like DGHS, DGFP, CMSD, HED and others.
2. HED will perform the relevant construction works and repair works for DGDA
3. DGHS has a major for strengthening the pharmacovigilance system of Bangladesh

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods and Services et.: Annexed in Volume –II

9. Indicators:

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1	Percentage of permitted drug tested annually	Percentage (Annual report)	28.07 % (2015-2016)	31.20 %	36.38 %
2	Number of inspections of Drug Manufacturing Units annually	Number (Admin report)	1552 (2015-2016)	1750	2000
3	Percentage of inspections of Depot of drugs, retail pharmacy shop annually	Percentage (Admin report)	54.44 % (2015-2016)	70 %	80 %
4.	Number of ADR reports collected from both healthcare facilities and pharmaceutical manufacturers	Number (Admin report)	640 (2015-2016)	1500	2500

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
3160.00	**3165.00**	0.00	**3165.00**	**6325.00**	

10.2. Component and activity wise physical and financial target of OP: SDAM

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component-1: Strengthening Drug Testing Laboratories and Establishment of Animal House													
1	Repair and Renovation of National Control Laboratory (NCL), Dhaka	1 unit		210.00	10.00	200.00	0.00	0.00	4.00	2.00	2.00	200.00	2.00
2	Repair and Maintenance of Equipment of Drug Testing Laboratories (including calibration and validation of the lab equipment)	As per requirement		175.00	175.00	0.00	0.00	0.00	35.00	35.00	35.00	35.00	35.00
3	Raw Materials for Drug Testing Laboratories (Chemicals, Reagents and Media) and Laboratory Apparatus	As per requirement		125.00	125.00	0.00	0.00	0.00	25.00	25.00	25.00	25.00	25.00
4	Consultancy for WHO Prequalification of both National Control Laboratory (NCL) and National Regulatory Authority (NRA)	2 (one person for NCL and one for NRA)		120.00	120.00	0.00	0.00	0.00	120.00	0.00	0.00	0.00	0.00
5	Books and Journals	As per requirement		30.00	30.00	0.00	0.00	0.00	0.00	10.00	10.00	0.00	10.00
6	Laboratory equipment for National Control Laboratory (NCL), Dhaka and Drug Testing Laboratory, Chittagong	219 nos		1416.00	0.00	1416.00	0.00	0.00	354.00	354.00	354.00	0.00	354.00
7	Laboratory equipment, Machineries and other equipment for Animal House under NCL	116 nos		308.00	0.00	308.00	0.00	0.00	0.00	0.00	154.00	154.00	0.00
8	Machineries and other equipment (AC, Digital Camera, Projector & Pointer)	55 nos		32.00	0.00	32.00	0.00	0.00	0.00	16.00	16.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
10	Furniture and Fixture for drug testing laboratories	As per requirement		90.00	0.00	90.00	0.00	0.00	0.00	0.00	90.00	0.00	0.00
11	Construction of Animal House for testing of vaccines under NCL.	1 unit		700.00	700.00	0.00	0.00	0.00	0.00	350.00	350.00	0.00	0.00
	Sub-total			3206.00	1160.00	2046.00	0.00	0.00	538.00	792.00	1036.00	414.00	426.00
Component-2: Establishment of a New Drug Testing Laboratories for Traditional Medicine and Cosmetics													
1	Construction of Drug Testing Laboratory for Traditional Medicine and Cosmetics	1 unit		900.00	900.00	0.00	0.00	0.00	0.00	450.00	450.00	0.00	0.00
2	Laboratory equipment for Drug Testing Laboratory for traditional medicines and cosmetics.	45 nos		678.00	0.00	678.00	0.00	0.00	0.00	0.00	339.00	0.00	339.00
3	Furniture and Fixture for Drug Testing Laboratory for traditional medicines and cosmetics.	As per requirement		40.00	0.00	40.00	0.00	0.00	0.00	0.00	20.00	0.00	20.00
4	Salary for the officers of Drug Testing Laboratory for Traditional Medicine and Cosmetics	21 persons		162.00	162.00	0.00	0.00	0.00	0.00	0.00	0.00	81.00	81.00
5	Salary for the staffs of Drug Testing Laboratory for Traditional Medicine and Cosmetics	28 persons		120.00	120.00	0.00	0.00	0.00	0.00	0.00	0.00	60.00	60.00
6	Raw Materials for Drug Testing Laboratory for traditional medicines and cosmetics.(Chemicals, Reagents and Media) and Laboratory Apparatus	As per requirement		45.00	45.00	0.00	0.00	0.00	0.00	0.00	0.00	20.00	25.00
	Sub-total			1945.00	1227.00	718.00	0.00	0.00	0.00	450.00	809.00	161.00	525.00
Component-3: Strengthening Post Marketing Surveillances and Enhancing the capacity of DGDA													

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1	Petrol and Lubricant	As per requirement		140.00	140.00	0.00	0.00	10.00	20.00	20.00	25.00	25.00	40.00
2	Computer accessories	As per requirement		25.00	25.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
3	Local training on Good Manufacturing Practices (GMP), Quality Management System (QMS), Accreditation, Quality Assurance, Quality Control, Vaccine Technology, Biologics and Good Manufacturing Practices (GMP) for Active Pharmaceutical Ingredients (API) Manufacturing and Pharmacovigilance for the officers of DGDA.	480 persons		40.00	40.00	0.00	0.00	0.00	5.00	5.00	10.00	10.00	10.00
4	Foreign training on Good Manufacturing Practices (GMP), Quality Management System (QMS), Accreditation, Quality Assurance, Quality Control, Vaccine Technology, Biologics and Good Manufacturing Practices (GMP) for Active Pharmaceutical Ingredients (API) Manufacturing and Pharmacovigilance for the officers of DGDA.	20 persons		50.00	50.00	0.00	0.00	0.00			25.00		25.00
5	Registration Fee for Vehicle	As per requirement		10.00	10.00	0.00	0.00	0.00	0.00		0.00	10.00	0.00
6	Repair and Maintenance of Motor Vehicles	As per requirement		15.00	15.00	0.00	0.00	0.00	3.00	3.00	3.00	3.00	3.00
7	Computer training for the officers and staffs of DGDA	100 persons		8.00	8.00	0.00	0.00	0.00	0.00	2.00	2.00	2.00	2.00
8	Vehicle	8 microbuses		280.00	0.00	280.00	0.00	0.00	0.00		0.00	280.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
		& 20 motorcycles										
9	Computer, Hardware & Accessories (Computer, Printer, UPS)	30 Desktop Computers, 30 UPS, 30 Printers	21.00	0.00	21.00	0.00	0.00	0.00	21.00		0.00	0.00
10	Furniture and Fixture	As per requirement	50.00	0.00	50.00	0.00	0.00	0.00	0.00	50.00	0.00	0.00
11	Remaining Construction Work of Chittagong Divisional Office Building	1 unit	250.00	250.00	0.00	0.00	50.00	200.00	0.00	0.00	0.00	0.00
	Sub-total		**889.00**	**538.00**	**351.00**	**0.00**	**60.00**	**233.00**	**56.00**	**120.00**	**335.00**	**85.00**
Component-4: Strengthening National Pharmacovigilance (PV) System and promoting Rational Use of Drugs												
1	Seminar and Workshops on Pharmacovigilance (PV), Rational Uses of Drugs and drug related problems for the healthcare professionals (Doctors, Pharmacists and Nurses).	10 nos	50.00	0.00	50.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
2	Printing and Publications of awareness bulletin, awareness posters, newsletters and research papers	As per requirement	25.00	25.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
3	Advertisement through print and electronic media	As per requirement	110.00	110.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	20.00
	Sub-total		**185.00**	**135.00**	**50.00**	**0.00**	**10.00**	**35.00**	**35.00**	**35.00**	**35.00**	**35.00**
Component-5: To support the local pharmaceutical industries and retail pharmacy												

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
1	Training programs for the qualified persons employed at different pharmaceutical industries on Good Manufacturing Practices (GMP) at the pharmaceutical manufacturing sites to produce quality drugs	600 persons	50.00	50.00	0.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
2	Orientation training programs for the pharmacists employed at different pharmacies on Drug Storage, Dispensing and Patient Counselling.	1250 persons	25.00	25.00				5.00	5.00	5.00	5.00	5.00
3	Advertisement through print and electronic media regarding Model Pharmacy	As per requirement	25.00	25.00				5.00	5.00	5.00	5.00	5.00
	Sub-total		**100.00**	**100.00**	**0.00**	**0.00**	**0.00**	**20.00**	**20.00**	**20.00**	**20.00**	**20.00**
	Total Cost		**6325.00**	**3160.00**	**3165.00**	**0.00**	**70.00**	**826.00**	**1353.00**	**2020.00**	**965.00**	**1091.00**

11. Budget support from other Operational Plan: Not applicable

HEALTH SYSTEMS STRENGTHENING

4.6 Health Information System and e-Health (HIS & e-H)

1. Name of the Operational Plan: Health Information System & e-Health

2. **Implementing Agency:** Directorate General of Health Services (DGHS)

3. Introduction

The 4th SWAp of the MOHFW will fall under the 7th five-year plan of the Government of Bangladesh and the first 5 year of the SDGs. So, major thrust of the 4th SWAp will be to create a condition for attainment of the health-related goals and targets of both 7th five-year plan and SDGs. It is obvious that the Government's 8th and 9th five-year plans will also evolve through the efforts of attainment of SDGs until 2030. The SDGs' annual global reporting requirement is an opportunity for countries to keep consistent watch on their national progress of SDGs inclusive of health-related SDGs. The conduction of national surveys annually would be too costly and too burdensome from financial and administrative points of view. In this case, the most cost-effective and intelligent solution is building robust national information system for routine data generation, analysis, interpretation, review and action. In Bangladesh, the MIS-DGHS has already made a prototype of national health information system that can exactly serve this purpose alongside generating other useful health data. But, scaling the effort in other agencies of MOHFW and of the government as a whole, where applicable, along with non-state sectors would be essential. More essential will be to ensure effective use of the health information system by all programs and stakeholders under a data-driven evidence generation and decision making policy framework.

The HIS has made the world's best and largest deployment of DHIS2, a globally well-recognized software system for public health data gathering and population-based electronic health records (EHRs), which has been recommended by the Health Data Collaborative for measurement of country's progress on health-related SDGs. It is possible that all health stakeholders, public, private or NGO, which provide citizen health service, can access the software system concurrently, without breaching the personal privacy or confidentiality of data, subject to strict boundary of business rules, accountability, ethical considerations, and access control. Currently, all Community Health Workers (HIs, AHIs, CHCPs, SIs) including many FWAs of DGFP and all hospitals under DGHS and a good number of private hospitals, NGOs and DPs in Bangladesh are running the same national DHIS2 platform in the national health data center of MIS-Health. The web portal of DGHS also presents an intelligent data dashboard (http://www.dghs.gov.bd/index.php/en/data) which pulls data from various databases real-time and summarizes the data in easy to understand visualization. This web portal also includes GIS maps and boundaries, for quick understanding and decision-making at each level of health delivery and decision making hierarchies down to the grassroots. It has demonstrated that real time estimation of different health-related SDGs and other indicators is possible, both for national and sub-national level, through this dashboard. Access to this dashboard is open from anywhere and requires just internet connectivity and an internet browser. Further to DHIS2, the MIS-DGHS introduced OpenMRS+ an open source customized software, for hospital automation to be distributed free of cost to all public and private health facilities. Until, full scale up of the OpenMRS+ in all hospitals, DHIS2 is capable of collecting core health data from hospitals, clinics, individual health records. Not only that, DHIS2 is even capable of collecting financial data on health facilities and organizations. The MIS-Health also initiated a process of Civil Registration and Vital Statistics (CRVS) Systems, in Bangladesh, through a whole of government approach, which is working under a

multi-ministerial CRVS Steering Committee headed by Cabinet Secretary of the Government with at least secretaries of 15 ministries to lead a unifying approach to electronically registering and tracking birth, death, cause of death and other vital-event-data of every citizen in the country. An integrated human resource information system (iHRIS) is also in use, quite satisfactorily by DGHS. It has recently been further customized to capture health workforce data for public and non-public sector, HR data inclusive of private practitioners, self-employed, and even informal healers. The iHRIS has been owned by HRM program of the HPNSDP 2011-16, however, will need to be fully enforced in other agencies and departments of the ministry.

The same ICT infrastructure created for HIS is being used for improving health service delivery, efficiency of health systems, transparency and accountability. The MIS-DGHS operates a 24/7 health call center namely 'Shaystho Batayan' which helps citizens to instantly get a doctor for health consultation free-of-charge, to call an ambulance from anywhere in the country, to seek any kind of health information, or to lodge complaints against any public or private healthcare provider just calling a phone number 16263. In addition to lodging complaints through Shaystho Batayan, patients and/or their relatives can also send grievances, through text messages, on each of about 800 specific hospitals and health managers' offices, where there are special display-boards guidance on how to send the grievances. Advanced telemedicine service is being provided from over 94 public hospitals through which patients get specialist doctors' advice without requiring travelling to the upper tiers of hospitals. Mobile phone-based health service is also being provided from all upazila and district hospitals as well as from 13,300+ community clinics. Video conference system has been put in place that can connect, at any time, the MOHFW, DGHS, DGFP, divisional health offices, district health offices and public hospitals having telemedicine systems, which is very effective for holding small to large meeting, conference, training, etc. saving time, cost and visit (TCV). The DGHS web portal is a sea of information-resource drawing a huge number of daily hits from across the world. The portal delivers contents through multiple social media channels, viz., Face book, Twitter, Google+, YouTube Channel, etc. For measuring the health staffs' punctuality in office attendance biometric finger-print touch sensitive machines have been installed in all upazila and district hospitals, which transmit to data to central server almost instantly and available for public viewing on the web portal. For efficient and quick communication of management information among health staffs, to all or to specific group(s), there is also bulk SMS system.

Under HPNSDP 2011-16, another program called Medical Biotechnology (MBT) has also been included under HIS-EH OP. MBT is a rapidly developing newer technology required for people's livelihood challenges, which is revealed in the National Guidelines on Medical Biotechnology. Many health professionals, from seniors to juniors, were given sensitization as well as dedicated hands-on training. New laboratory facilities created in different medical colleges. A center for medical biotechnology with state of the art laboratory with increasing improvement has been established at the Institute of Public Health at Mohakhali, Dhaka. A draft of Medical Biotechnology Commission Act has also been prepared. During the next Swap, implementation work of the National Guidelines on Medical Biotechnology will have to be continued.

The Strategic Investment Plan for the 4th SWAp laid due importance and crystal clear deliverables towards building the HIS in Bangladesh during period of 4th SWAp. The HIS will require sufficient use of ICT, which, with additional little resource, will also allow eHealth service improvement for efficiency gain and quality improvement of health service. Interestingly, although developed much earlier than global adoption of SDGs and 4th SWAp's SIP, the National Health Policy 2011, the HPN Sector Vision that aligns with Digital Bangladesh Vision 2021, and the National ICT Policy 2009 of

Bangladesh, all are comprehensive enough towards the long term vision of health-related SDGs, both in terms of policy and urge for financial support. A third element incorporated currently with HIS and eHealth Operational Plan namely "medical biotechnology" will require continuation in its own merit and utmost importance explained in National Guideline on Medical Biotechnology. The OP principally address the measurement, evaluation and response issues of different programs of the SWAp so that their progress of implementation can be kept on track with a broader objective of making health, population and nutrition-related targets achieved, and of assessing, acting on and reporting country-progress on health-related SDGs.

Progress made on HIS & e-Health during 3rd HNPSDP period (2011-16):

- **Infrastructure development:** ICT infrastructure has been created for national health information system, such as, the connectivity of the public health system beginning from community health workers, community clinics, union health facilities, upazila-, district-, tertiary-, and specialized-hospitals, and health managers' offices at all levels with tablets, laptops, desktops, networks and Internet populating health data in the shared national health data center is being used for improving health service delivery, efficiency of health systems, and transparency and accountability;
- **Population register for lifetime shared health records (SHR) of citizens:** SHR system has been developed and also completed the piloting in the one district hospital and also one upazila health complex with technical assistance from DFID;
- **Integrated Human resource information system (iHRIS):** Designed in way so that it can capture and maintain human resource information for entire health ministry including that for other ministries, private sector and even self-employed, however, would require appropriate policy and administrative interventions. iHRIS is in use , quite satisfactorily by DGHS.
- **Data Center (DC) in MIS-DGHS and Remote data disaster recovery (DR) center** at Khulna Divisional Director (Health)'s Office established;
- **Shaystho Batayan:** The MIS-DGHS operates a 24/7 health call center namely Shaystho Batayan which helps citizens to instantly get a doctor for health consultation free-of-charge, to call an ambulance from anywhere in the country, to seek any kind of health information, or to lodge complaints against any public or private healthcare provider just calling a phone number 16263;
- Beside the Shaystho Batayan **Mobile phone health service** is being also provided currently from all upazila and district hospitals with plan to role out to all nearly 13,000 community clinics. Citizens can take health suggestions 24/7 hours from doctors working in government health centers;
- **Modern telemedicine centers:** Advanced telemedicine service is being provided from over 80 public hospitals through which patients get specialist doctors' advice without requiring travelling to the upper tiers of hospitals;
- **Video conference system** has been put in place that can connect, at any time, the MOHFW, DGHS, DGFP, divisional health offices, district health offices and public hospitals having telemedicine systems, which is very effective for holding small to large meeting, conference, training, etc. saving time, cost and visit (TCV);

- **Citizens' feedback system - Complaint- suggestion box:** In 800 hospitals/health organizations there are display boards guiding clients on how to inform complaints or suggestions about respective hospital to authority by mobile text messaging; the authority then takes appropriate response actions;
- **Fingerprint office attendance machines:** For measuring the health staffs' punctuality in office attendance biometric finger-print touch sensitive machines have been installed in all upazila and district hospitals, which transmit to data to central server almost instantly and available for public viewing on the web portal;
- **Bulk SMS system** has been established to quickly send specific text messages to specific group(s) of health staffs;
- **Hospital automation:** Several hospitals have been undertaken for automation using OpenMRS open source software;
- **Strengthening local information culture:** Various measures have been undertaken to encourage building local information culture. These include using online database and doing regular multi-media meeting for review of health situation, progress, planning, decision making, intervention, publication of online local health bulletin, holding annual MIS conference, etc.
- **Data collection on shared software resource and use:** DHIS2 software is being used for collecting information online across country, across organizations and across stakeholders in a common national health information system platform;
- **DGHS web portal:** DGHS web portal is an information-rich and highly visited web portal. It is a combination of website and several social media platform, viz., FaceBook, Twitter, Google+, YouTube Channel, etc.
- **Dissemination of information and publications:** Dissemination of data and information is done through several ways, viz., web portal, workshops, conferences, journalists' meeting, and electronic and print publications, such as, Health Bulletin, Local Health Bulletin, EOC NewsLetter, IMCI Newsletter, and other publications;
- **Training, workshops, and seminars:** Both fresher's and refreshers' training is provided to staffs through a planned process. Workshops and seminars are held for innovation, skill transfer and stimulating discussions and debates; a critical mass of ICT and eHealth skilled staffs have already been developed;
- **COIA Initiative:** Under the United Nations Secretary General's COIA initiative for attainment of MDGs 4 & 5, an electronic registration and tracking system for every pregnant mother and every under-5 child has been started based on every community clinic but for the entire catchments of the community clinics. Representatives of all local health stakeholders, viz., DGHS, DGFP, RCHCIB, DP, NGO, and local community clinic management committee are sharing common responsibility in this initiative.
- **Civil Registration and Vital Statistics (CRVS) Systems:** A comprehensive assessment on national CRVS systems has been done by MIS-Health which has drawn global attention. The MIS-Health also initiated a process of Civil Registration and Vital Statistics (CRVS) Systems, in Bangladesh, through a whole of government approach, which is working under a multi-ministerial CRVS Steering Committee headed by Cabinet Secretary of the Government with

at least secretaries of 15 ministries to lead a unifying approach to electronically registering and tracking birth, death, cause of death and other vital event data of every citizen in the country.

- **Medical Biotechnology (MBT):** Under HPNSDP 2011-16, program called Medical Biotechnology (MBT) has also been included in HIS & eHealth OP. MBT is a rapidly developing newer technology required for people's livelihood challenges. Many senior to young health professionals given training. New laboratory facilities created in different medical colleges. A center for medical biotechnology established at the Institute of Public Health, Mohakhali, Dhaka. A draft of Medical Biotechnology Commission Act has been prepared.

Major Thrust of HIS & e-Health under the 4th Sector Programme Period (2017-2022):

In the 4th SWAP targets of MOHFW are to achieve sustainable development goal (SDG) by 2030 and also to achieve universal health coverage. Meeting this ambitious targets require registering, tracking and responding to each citizen's needs. HIS & eHealth will scale up, strengthen and sustain the Electronic Tracking System (ETS) of citizens' health through an integrated and comprehensive approach to achieve health-related SDGs. The health information system (HIS) and e-Health component of the 4th SWAp will principally address the measurement, evaluation and response issues of different programs of the SWAp so that their progress of implementation can be kept on track with a broader objective of making health, population and nutrition-related targets achieved, and of assessing, acting on and reporting country-progress on health-related SDGs. The main challenges of HIS & eHealth are to sustain the developments of different initiatives in 3rd sector.

Challenges& Issues

- Establishment of information culture among the managers
- Establishment of common national eHealth data standards and interoperability framework among the different agencies of MOHFW
- Avoiding duplication of ICT project or similar work related to HIS
- Establishment of Citizen's electronic health record to achieve SDG
- Quality data collection from both public and private health facilities
- Facilitating electronic data collection of self-employed health personnel like informal healer to establish effective HIS
- Use of HIS as a tool for real time performance measurement, evidence generation, and timely appropriate response for improving health situation at all level
- Ensure high speed internet connectivity for all level of health facilities
- Availability of knowledgeable and skilled staffs in all places related to HIS
- Update human resource information under Ministry of Health & Family Welfare through Integrated Human Resource Information System (HRIS) software
- Challenge to generate data for annual global reporting on progress of health-related SDGs
- Building robust national information system for routine data generation, analysis, interpretation, review and action

- Scaling the effort in other agencies of MOHFW and of the government as a whole, where applicable, along with in non-state sectors
- Ensuring effective use of the health information system by all programs and stakeholders under a data-driven evidence generation and decision making policy framework
- Strengthening collection and updating data on individual health of the citizens, through motivation, engagement and accountability of CHW
- Ensuring that all the health agencies including their LDs, directors, and managers made responsible for enforcing data collection; ensuring coverage, reliability, and timeliness of data; and responding with timely and appropriate actions.
- Digitizing the entire routine health information system by 2021
- Strengthen sector program monitoring and evaluation (M&E) processes through effective utilization of evidences
- Establish partnerships with relevant institutions for facilitating data demand, updating and utilization in MOHFW and its agencies and departments

4. Objectives

Health Information System

i. To improve existing health information system through population, program and institution based HIS

ii. To improve infrastructure and human resource capacity necessary for HIS

iii. To sustain the HIS initiatives and encourage public-private partnership

iv. To develop and strengthen logistic tracking, inventory, financial and procurement management in HIS

v. To scale up Shared Health Record (SHR)

vi. To scale up GIS in health service

e-Health

i. To improve e-Health through continuation and further development of mobile phone health service, health call center and other e-Health

ii. To strengthening and expand video conferencing

iii. To scale up telemedicine service

iv. To introduce other e-Health services and programs

v. To improve infrastructure and human resource capacity necessary for e-Health

vi. To sustain the e-Health initiatives and encourage public-private partnership

Medical Biotechnology

i. To improve medical biotechnology through achievement of the short and medium term deliverables mentioned in the National Guidelines on Medical Biotechnology

ii. To create of conditions for achieving the long term deliverables of the National Guidelines on Medical Biotechnology

5. Components:

Component-1: Health Information System (HIS)

MIS Health is working to build strong Health Information System throughout the country. Integrated HIS is consolidating data from a range of sources to strengthen the national capacity to plan, monitor and evaluate the progress of services.

Activities:

1. Equipping with computers, laptops, accessories, gadgets, etc.;
2. Continuation and expansion of Internet connectivity both in terms of bandwidth and coverage;
3. Placement, maintenance and upgrade of software (database, application, customized, etc.) and servers, where applicable and as appropriate looking into factors like cost, deployability, scalability, integration, inter-operability, security, user-friendliness, auto-reporting, dashboard, etc.;
4. Improvement of Data Center and disaster recovery center(s);
5. Use of mobile phones, handheld devices, and other technologies and tools based on suitability and effectiveness;
6. Strengthening of human resource capacity through training, and in case of shortage in-house, through outsourcing of services;
7. Liaison, feedback, monitoring and supportive supervision to ensure data quality in terms of reliability, timeliness and adequacy inclusive of non-state providers;
8. Repair and maintenance function and supply of logistics;
9. 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;
10. Strong monitoring, supervision, and response mechanism;

Component-2: e-Health

The term "eHealth", to describe health services to citizens delivered through the use of ICT. In Bangladesh our eHealth progress reached a level of global championship both with respect to theory and practical application. Presently we are using many eHealth initiatives successfully for better health services to the citizens.

Activities:

1. To continue and expand the scope and quality of Shaystho Batayan (including mobile phone health service, if required);
2. To continue/improve existing m-Health services, such as, bulk SMS, complaints-suggestions box, etc. and to explore other innovative and effective mHealth services;
3. To continue, strengthen and roll out telemedicine service;

4. 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.;
5. To work out for more innovations of eHealth services and programs for dissemination of information, listening to citizens, creation of health awareness, improving health systems efficiency and quality, etc.;
6. To improve infrastructure and human resource capacity necessary for eHealth;
7. To sustain the eHealth initiatives and encourage public-private partnership;
8. To supply of computers, accessories, gadgets, etc., if required, in addition to those provided for HIS;
9. To put in place appropriate database, application and customized software, where and when applicable looking into factors like cost, deployability, scalability, inter-operability, security, and user-friendliness, etc.;
10. To strengthen human resource capacity through training, and in case of shortage in-house, through outsourcing of services;
11. To produce and develop promotional materials to encourage people utilize the mobile phone health service, telemedicine and/or other e-Health services;
12. To strengthen liaison, feedback, monitoring and supportive supervision to ensure service quality and improve coverage;
13. To provide repair, maintenance and supply of logistics functions; and
14. To continue liaison and advocacy with the policy makers to sustain and further boost the eHealth initiatives and public-private-NGO collaboration.
15. To strengthen and scaling-up of digital Civil Registration and Vital Statistics (CRVS) system

Component-3: Medical biotechnology

MIS Health is implementing short and medium term deliverables of the National Guidelines on Medical Biotechnology.

Activities:

1. Improving functional capacity of the MBT laboratories already created;
2. Establishment of Center of Excellence on Medical Biotechnolgy;
3. Expansion of new MBT laboratories and further institutional capacity building adding clinical services and epidemiological surveillance for medical biotechnology;
4. Sensitization / orientation training and workshops;
5. Providing medical biotechnology resources in medical libraries;
6. Identifying MBT career group and facilitating the group members for further growth;
7. R&D environment through supporting related research projects;
8. Appropriate communication programs with potential entrepreneurs of medical biotechnology;
9. Appropriate public awareness programs;

10. Developing and enforcing standards, codes of practice and regulatory framework for medical biotechnology;
11. Implementing other activities of Medical Biotechnology.

6. Cross-Cutting Issues:

a) Governance and Prioritization

- Sustenance of the Health Minister's National Award introduced by MIS
- Enforcement of common national eHealth data standards and interoperability framework
- Avoid duplication of efforts by any MOHFW agency, department, organization, program, partner DP or NGO to develop and implement new software, or ICT project, or similar work related to HIS
- Creating mandatory binding for electronic health data reporting by the private health facilities
- Facilitating electronic data collection on where about of self-employed health personnel through effective link between BMDC, BNC, State Medical Faculty, Pharmacy Council, Homeopathic Board, Ayurvedic and Unani Board, etc.

b) Harmonization of HIS, eHealth and health programs:

- Use of HIS as a tool for real time performance measurement, evidence generation, and timely appropriate response for improving health situation at all level
- Harmonize health programs between different agencies, departments and partners to serve the common health goals
- Ensure flow of all health data of common interests to national health data center irrespective of source; public, private, DPs or NGOs.
- Mapping of health interventions (health services), delivered by different agencies at different levels for uniform distribution of essential and required services, not ignoring the special needs of special geographic locations

c) Electronic assessment of performance

- Use of electronic data for performance assessment and fund release
- Binding of fund release to designed criteria and results-based disbursement link indicators (DLIs)
- Strong monitoring and mentoring mechanism for identification and streamlining defaulters of performance based on electronic data

d) Coordination by the local health authorities

- Coordination by the local health authorities of data provision by the private, DP and NGO healthcare providers (hospitals, clinics, public health service providers, academic/training institutions)
- In negligence, conditions, such as, reminders, embargo, suspension of MoU, non-renewal or cancellation of license, etc. may be applied by appropriate parties authorized to do so

e) Procurement, establishment and maintenance of ICT devices and systems

For procurement, establishment and maintenance of ICT devices and systems for each organization and hierarchical level, one of the following two methods will be followed:

- Framework contract arrangement (FCA) will be established

(i). Specifications and type of devices and systems, and maintenance modalities will be determined by the national authorities

(ii). Selection of contractors through competitive bidding process

(iii). Bulk procurement and supply at a single go will not exist, rather annual, biennial or triennial contracts will be done

(iv). The end user organizations will issue indent as and when required

(v). Payment will be made on quarterly or annual basis subject to satisfactory completion of the work.

(vi). Determination by the national authority of specifications and type of devices and systems, maintenance modalities, maximum price of items

(vii). The required ICT items and service will be procured by respective local authority as and when required subject to approval of the justification by the LD.

(viii). Payment will be made and audit will be faced locally.

(ix). The above modalities may also be considered for procurement of goods, works and services of others Operational Plans, as well.

f) Collaboration

- All Ops of DGHS will have collaboration with OP HIS & eHealth

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl No.	OP Level Indicators	Unit of Measurement / Means of Verification	Baseline	Projected target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1	Percentage of government health facilities submitting timely report as specified by HIS	Percentage (Admin record)	100% of facilities from upazila level & above; 90% of community (APIR 2016)	100% of facilities from upazila level & above; 95% of community clinics	100% of facilities from upazila level & above: 98% of community clinics
2	Number of CCs reporting gender segregated data in	Number	0	4000	10000

Sl No.	OP Level Indicators	Unit of Measurement / Means of Verification	Baseline	Projected target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
	DHIS2				
3.	GRS is enhanced	Percentage of grievances	GRS in place	30%	60%
2	MIS reports on health service delivery published and disseminated	Number of report per year (Printed report available)	Health Bulletin 2015 (MIS-DGHS)	1	1
4	Data presented in online dashboard to be viewed publicly	Online Dashboard available with specific URL	DHIS2 data	DHIS2 and HRM data	DHIS2, HRM and Call Center data

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
52292.00	23466.00	2872.00	26338.00	78630.00	

10.2. Component and activity wise physical and financial target of OP: HIS & e-Health

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component-1: HIS & eHealth													
a)	**Local Training**												
1	Computer, HIS and eHealth Training	430	Batches	3300.00	0.00	3300.00	0.00	200.00	600.00	600.00	600.00	600.00	700.00
2	Training of CHCPs on HIS & eHealth	2420	Batches	1400.00	0.00	1400.00	0.00	0.00	250.00	250.00	300.00	300.00	300.00
3	Training of health workers on HIS & eHealth inclusive of use of mobile device (PDA)	2420	Batches	1800.00	0.00	1800.00	0.00	200.00	300.00	400.00	400.00	300.00	200.00
4	Training on EmOC, IMCI, ICD-10	350	Batches	1872.00		0.00	1872.00	122.00	350.00	350.00	350.00	350.00	350.00
5	Different Workshop and Orientation Training	998	Batches	1700.00	0.00	1700.00	0.00	50.00	400.00	400.00	400.00	300.00	150.00
b)	**Foreign Training**												
1	Various disciplines and areas related to HIS and eHealth to contributed to national system development	140	Persons	450.00	0.00	450.00	0.00	20.00	100.00	100.00	100.00	100.00	30.00
	Sub Total : HIS & eHealth Training	6748		10522.00	0.00	8650.00	1872.00	592.00	2000.00	2100.00	2150.00	1950.00	1730.00
2	Internet connections' bill (all hospitals, health facilities, USC, Health Workers and 13500 community clinics)	40,000	Nos	9000.00	9000.00	0.00	0.00	600.00	1700.00	1700.00	1700.00	1700.00	1600.00
3	TA for strengthening HIS & eHealth	LS		7379.00	7114.00	265.00	0.00	829.00	950.00	1400.00	1400.00	1400.00	1400.00
4	Printing, publication, research	5	Lots	915.00	765.00	150.00	0.00	15.00	150.00	150.00	200.00	200.00	200.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Advertisement (Health Call Center-16263, Citizen's Grievances and others)	5	Lots	2850.00	2600.00	250.00	0.00	650.00	800.00	600.00	300.00	300.00	200.00
6	Hardware Repaire and Maintenance	5	Lots	1000.00	940.00	60.00	0.00	10.00	200.00	200.00	200.00	200.00	190.00
7	Motor vehicles (2 Cross country vehicle and 400 Motor Cycle)	402		800.00	740.00	60.00	0.00	0.00	350.00	350.00	0.00	100.00	0.00
8	Video Conferencing System (500 Institutes)	500		4500.00	4500.00	0.00	0.00	0.00	900.00	900.00	900.00	900.00	900.00
9	Expansion of Telemedicine and Peripherals (50 hospitals)	50		1200.00	1200.00	0.00	0.00	0.00	0.00	600.00	0.00	600.00	0.00
10	Personal Computer/All in one (Replacemet/New for all hospitals, health facilities)	6000		3850.00	1800.00	1800.00	250.00	0.00	50.00	1850.00	50.00	1850.00	50.00
11	Laptop Computer (Replacement/New for all hospitals, health facilities, UH&FWC including 13500 community clinics)	12000		6850.00	3300.00	3300.00	250.00	0.00	50.00	3350.00	50.00	3350.00	50.00
12	Laser Printer (Replacement/New for all hospitals, health facilities and institutes)	4000		1200.00	1200.00	0.00	0.00	0.00	0.00	0.00	1200.00	0.00	0.00
13	Expansion of Shared Health Record (SHR) (300 Hospitals) & Strengthening of CRVS	300		6000.00	6000.00	0.00	0.00	0.00	0.00	2000.00	2000.00	2000.00	0.00
14	Datacenter (DC)/ Disaster Recovery (DR) Center Equipment	3	Lots	2100.00	2100.00	0.00	0.00	0.00	800.00	0.00	800.00	0.00	500.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
15	Telecommunication equipment (PDA, GPS, Wireless Modem, etc)	24000		5750.00	2800.00	2450.00	500.00	0.00	1200.00	1250.00	1100.00	1100.00	1100.00
16	Local Area Network (LAN), UPS, Multimedia, Photocopy, generator, Scanner, Air conditioner, fax, digital camera, Wi-Fi, other devices, etc	5	Lots	3000.00	2000.00	1000.00	0.00	0.00	600.00	600.00	600.00	600.00	600.00
17	Telephone, Petrol and Oil, Books and Periodicals, computer stationery, etc.	5	Lots	5000.00	5000.00	0.00	0.00	500.00	900.00	900.00	900.00	900.00	900.00
18	Electronic database of Women above 30 years for screening of Cerivcal & Breast cancer			2103.00	0.00	2103.00	0.00	0.00	423.00	420.00	420.00	420.00	420.00
	Total : (HIS & eHealth)	100986		74019.00	51059.00	20088.00	2872.00	3196.00	11073.00	18370.00	13970.00	17570.00	9840.00
Component-2: Medical Biotechnology (MBT)													
a)	**Local Training**			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Hands-on training for medical teachers & scientists	20	Batches	86.00	0.00	86.00	0.00	8.00	15.00	15.00	16.00	16.00	16.00
2	Training workshop for medical teachers	25	Batches	49.00	0.00	49.00	0.00	6.00	8.00	8.00	9.00	9.00	9.00
3	Sensitization workshop	50	Batches	68.00	0.00	68.00	0.00	0.00	13.00	13.00	14.00	14.00	14.00
4	Workshop for MBT Local Committee	240	Batches	50.00	0.00	50.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
5	Orientation on MBT for students at Medical College	60		65.00	0.00	65.00	0.00	0.00	12.00	12.00	12.00	12.00	17.00
6	Different Workshop and	84		110.00	0.00	110.00	0.00	12.00	23.40	17.90	18.90	18.90	18.90

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	Orientation Training												
b)	**Foreign Training**			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Various disciplines and areas related to to contributed to national Medical Biotecnology (MBT) system development	45	Persons	150.00	0.00	150.00	0.00	0.00	40.00	40.00	40.00	30.00	0.00
	Sub Total : MBT Training	524		578.00	0.00	578.00	0.00	26.00	121.40	115.90	119.90	109.90	84.90
2	Machinery and other equipment (14- Multimedia projector, 14- Projector screen, 2- photocopier, 20- AC , 2-Generator and others)	52		143.00	143.00	0.00	0.00	0.00	35.00	39.00	0.00	35.00	34.00
3	Medical Biotechnology Equipments (Spectrophotometer, DNA sequencer, Different types of Micropipettes, etc.)	5	Lots	3600.00	800.00	2800.00	0.00	0.00	400.00	800.00	800.00	800.00	800.00
4	Computers and accessories (5- Laptop, 25 - Desktop computer, 5- Laser printer, 5- Inkjet printer, 20- UPS)	60		20.00	20.00	0.00	0.00	0.00	5.00	5.00	0.00	5.00	5.00
5	Printing & Publication, Consultancy, Travel cost, Internet, Computer Stationery, Repair & Maintenance, etc	5	Lots	270.00	270.00	0.00	0.00	20.00	50.00	50.00	50.00	50.00	50.00
	Total : (MBT)	1170		4611.00	1233.00	3378.00	0.00	46.00	611.40	1009.90	969.90	999.90	973.90
	Grand Total :	102156		78630.00	52292.00	23466.00	2872.00	3242.00	11684.40	19379.90	14939.90	18569.90	10813.90

11. Budget support from other Operational Plan: Not applicable

4.7 Management Information System (MIS)

1. Name of Operational Plan: Management Information System (MIS)

2. Implementing Agency: Directorate General of Family Planning (DGFP)

3. Introduction

The Maternal Child Health & Family Planning Program of Bangladesh has evolved through a series of developmental phases and has undergone changes in strategy, structure, content and goals. Although Family Planning Program started during 1950s but it got momentum after independence in 1972 due to unanimous and high-level political support. Population growth was identified as number one national problem of Bangladesh during first fifth year plan (1973-1978). Since then commendable progress has been made in reducing population growth through implementation of an effective family planning program across the country. Total fertility rate (TFR) reduced from 6.3 births per woman in 1975 to 3.4 in 1994 and to 2.3 in 2014. Use of contraceptive increased from 8 % in 1975 to 62% in 2014. The Management Information System (MIS) was established during mid seventies as record keeping and reporting systems at the grass root level to generate information on FP-MCH services by the Management Information System (MIS) Unit. The MIS Unit has successfully introduced number of innovative approaches to strengthen and institutionalize data collection, collation, storage and dissemination at different level for effective decision making. To strengthen reliable data gathering, the key steps undertaken by MIS Unit included i) distribution of national FP-MCH projection to different upazilas; ii) introduction of a robust data collection mechanism through FWA registers, different clinic registers and reporting formats, periodic couple registration and survey by MIS personnel and iii) performance checking in high and low performing areas.

DGFP Service Statistics is a central repository for DGFP's service related information. During the last sector program (HPNSDP: 2011-2016) number of initiatives have undertaken to streamline information collection process like i) Online data collection process started from all District and Upazila Family Planning Offices; iii) At the upazila level , introduction of web-based online registration system for pregnant mothers , tracking of family planning permanent method users (using National ID); iii) inclusion of online Procurement Tracker (Online PT), web-based Logistics Management Information System (Web-LMIS) & DGFP Stock Status Report in the DGFP Supply Chain Information Portal; iv) making Warehouse Inventory Management System (WIMS) and Upazila Inventory Management System (UIMS) fully operational ; v) Personnel Management Information System (PMIS) is introduced for DGFP to utilize human resources appropriately including career planning system and vi) to harmonize the indicators for maternal health of DGHS and DGFP, and collect data through integrated approach for MIS as DGFP has been piloting DHIS-2 platform in 2 districts (online pregnant mother registration and e-FWA register at Habiganj & Tangail districts) which will be replicated in some other selective districts during 4th sector program in coordination with MIS, DGHS . Moreover, all divisions, districts, upazilas including selected UH&FWCs (upgraded) were provided with computers/laptops with internet facility.

Despite some positive lessons learned during last sector program number of challenges remained in terms of data collection, verification, reporting and dissemination for strengthening decision making process at different levels.

Key challenges:

(i). Manual registration process for FWAs and FWVs are time consuming and caused duplication of efforts.

(ii). Supervision and monitoring system is not adequate for accurate outcome evaluation.
(iii). Manual registration of the clients' particularly pregnant mothers and their follow-up is cumbersome and time consuming.
(iv). Lack of data in time, data accuracy and validity.
(v). Lack of updated information management system on human resources.
(vi). Inadequate information management system for almost five thousands service facilities at different levels.
(vii). Lack of coordination among MIS-DGHS, BBS, CRVS and NGOs & private sector.

This Operation Plan (OP) has been developed based on the unfinished tasks and to address the above mentioned challenges to develop an effective MIS. The MIS OP is in alignment with the strategic directions as mentioned in Health, Nutrition and Population (HNP) Strategic Investment Plan (SIP) 2016-2021, which aims to deliver quality and equitable HNP services to the people across the country in an efficient manner. The SIP Objective-6 has emphasized need for improving health measurement and accountability mechanisms and to build a robust evidence-base for effective decision making. For the 4th HNP sector program, the SIP has prioritized interventions like scaling-up of the electronic tracking system of citizen's health and integrating the health information and eHealth platforms that exist amongst different agencies and stakeholders. Mentionable the MTR and APIRs done during HPNSDP also highlighted issues like, need for digitization of the entire routine health information system, enforcing Data Quality Assurance (DQA) mechanism, strengthening CRVS by introducing population registration system and strengthen harmonization process of the MIS (DGHS &DGFP) through piloting DHIS-2 platform.

To ensure a reliable information management system through adaptation of new technologies and data quality for evidence based decision making process, priority focus of this MIS OP would be on i) digitalization of data collection, compilation and dissemination process; ii) data quality assurance (DQA) and performance monitoring & evaluation system including mentoring mechanism ; iii) greater accountability mechanism through electronic communications with the stakeholders; iv) digitalization of information management for logistics through LMIS; v) Personnel Management Information System (PMIS) for effective human resource & facility management; vi) Coordination with MIS -DGHS, BBS, CRVS & other OPs of DGFP as well as coordination with NGOs & private sectors and vii) capacity building through skill development training for different level of staff and vii) procurement of equipments (laptops/tabs)

4. Objectives:

(i). To introduce e-recording and reporting system (e-FWA register, e-Facility register and e-diary for field supervisors) all over the country for improve recording, reporting and monitoring of FP-MCH services.
(ii). To strengthen data quality assurance (DQA) and performance-monitoring & evaluation system using new technologies and intervention.
(iii). To implement Human Resource Information System (HRIS) for Human Resource (HR) planning and development linked with HRIS system of Ministry of Health & Family Welfare.
(iv). To initiate e-activities according to ICT policy 2015.
(v). To strengthen coordination with MIS- DGHS, BBS, CRVS and NGOs & private sectors.

5. Components:

Component-1: Digitalized data collection, compilation & dissemination

DGFP is responsible to provide MCH-FP services across the country and having a well-organized structure from community to national level. Manual data collection & compilation can't ensure the up to date, data flow & monitoring system. Digitalized data collection, compilation & sharing with MIS unit has already been expanded up to upazila & selected UH&FWC (upgraded) level from head quarter. In the next sector program this will be expanded to all service delivery level for quality, updated & timely information system.

Activities:

1. Generate Monthly and Annual Reports of MCH-FP activities, publishing and distributing to concerned agencies.
2. Procurement of Tab/Tablet PC for FWAs, FWVs and SACMOs.
3. Training of field staff on e-Register (e-FWA Register, e-Facility register and e-diary for field supervisors) and Refresher training of field staff on FWA register and reporting formats.
4. Set up an online network coverage system among related personnel of DGFP.
5. Procurement of FWA register & reporting formats. (Note: The manual FWA Register will be continued until e-Register has been established everywhere.)

Component-2: Data quality assurance with monitoring & evaluation

Only data collection, compilation & dissemination are not sufficient to establish a trustworthy data management system. So data quality observation & verification through monitoring & evaluation is very essential. To ensure data quality, there is a built-in system of MIS unit which include monitoring visit to upazila & below level to address problems related to anomaly or dissimilarity of the collected data. There is a process where monitoring teams undertake field visits to check meticulously the data and data collection process. The monitoring teams provide field finding report to director (MIS) & all Program Managers and brief them actual status with necessary recommendations.

Activities:

1. Set up an online network coverage system among all MIS related personnel of DGFP.
2. Design Software and develop gap mitigating plan to monitor Data Accuracy.
3. Develop data collection format for quality check / monitoring of the OP level activities of DGFP.

Component-3: Innovation & SPS (Service Process Simplification)

DGFP officials have taken many encouraging innovative activities to provide prompt service to the citizen. Many officials are already trained on innovation through Access to Information (a2i) program of Prime Minister (PM) Office & they are successfully implementing their innovation at the field level. Mentionable number of officials of DGFP have been awarded with PPA (Public Administration Award) and Innovation Award for their contribution. Training on SPS (Service Process Simplification) received by DGFP official has been found effective and will be scaled-up.

Activities:

1. Establishment of e-filing system in DGFP linked with Access to Information (A2i) program.
2. Training of DGFP officials on e-filing program.
3. To ensure more accountability establishing communication with local leaders, public representatives and other stakeholders through video conference and social media.
4. Procurement of Tab/Tablet for field supervisor.
5. Monitor individual performance & provide supportive supervision. E-diary will be introduced for field supervisors to monitor& supervise using IT.

6. Establish a help line for better & faster public services through mobile phone & internet access.
7. Foreign training for MIS personnel to learn information system management of other countries'.

Component-4: Digitalized information management for logistics through LMIS

DGFP supply chain information portal has already initiated online procurement tracker (PT) web based Logistics Management Information System (LMIS) & DGFP stock status report. This is a digitalized operational status of warehouse inventory management System (WMIS) & Upazila Inventory Management System (WMIS). This is a well established system and will be further strengthened. Mentionable, Supply Chain Information Portal of DGFP achieved National Digital Innovation Award as runner-up in e-health category & best e-governance award in Dhaka Divisional Innovation fair, 2011.

Activities:

1. Generate Logistics Management Information to streamline Supply Chain System, publish and distribute to concerned agencies.
2. Provide training to field staff on e-Register (e-FWA Register, e-Facility register and e-diary for field supervisors) and organize refresher training to selected field staff on FWA register and reporting formats.
3. Build capacity of the field level staff on LMIS.
4. Setting- up an online network coverage system among relevant personnel of DGFP.

Component-5: Outcome evaluation of ongoing activities & take follow-up actions

All activities done by different level of service providers of DGFP are captured in the form of "inputs" and "outputs" within regular data collection, compilation & dissemination system. In order to evaluate outcome level achievements against the targeted outcomes, a pilot initiative will be undertaken which will provide information on actual results (changes) in MCH-FP service delivery.

Activities:

1. Select the baseline indicator of the program.
2. Develop toolkits/formats to measure the gap between what was planned & what has been achieved.
3. Build a technical team to do the function & orient the team.
4. Piloting some areas for evaluation & expand it by turns.
5. Design a workshop for target providers on this process.
6. Review & analyze the reports generated by the evaluation team.

Component-6: Online Personnel Management Information System (PMIS) for human resource & facility management

DGFP personnel Management Information System (PMIS) has already developed a digital system for service record and career planning of BCS (FP) cadre officers in coordination with MOPA. Computers/Laptops provided to all divisions, districts & upazilas with selected upgraded UH&FWCs. Internet connection has been established using EDGE modem up to the mentioned level. It will be expanded among all service providers of facility level. So, personnel & facility data can be collected & compiled easily from every entity with collaboration of HRIS, MOH&FW.

Activities:

1. Training of DGFP personnel on newly developed HRIS system linked with MOH&FW.
2. Personnel and Facility Data collection and entry to HRIS system for Human Resource Management including capacity development.
3. Verify & update personnel & facility data and preserve for further use.
4. Using facility & personnel data for ongoing & upcoming personnel & facility management including training, promotion, pension etc.

Component-7: Software design, development & ICT activities

To build a progressive digital Bangladesh and to establish world level information system, it is very essential for service organization to adopt new information & communication technology. DGFP being a very large institution of Bangladesh has been delivering various important public services. To strengthen its service delivery system as well as provide better citizen services, designing and development of modern software and ICT activities would be given highest priority in the next HNP sector program. To achieve the goals of Vision2021, the MIS unit of DGFP will undertake various software designing and development, ICT activities and develop pools of high performing staff to provide quality services for the citizens of Bangladesh.

Activities:

1. Software design and development for Data Accuracy and Outcome evaluation.
2. Establishment of e-filing in DGFP linked with Access to Information (A2i) program.
3. Training of DGFP officials on e-filing program.
4. Establish communication with local leaders, public representative and other stakeholders through video conference and social media.
5. Develop a system to collect activity related data of all OPs in MIS system under DGFP.
6. Strengthen existing digital documentation centre.
7. Introduce digital attendance and security system: provide smart cards, install CC cameras, ensure entry and exit though metal detector security system.
8. Upgrading Data Centre of MIS, DGFP.

Component-8: Coordination and Collaboration (intra and inter-sectoral, NGOs and private sector)

All over the country DGHS & DGFP are working in a coordinated way in many areas of primary Health Care, Nutrition & MCH-FP services from door to door up to national level. So data duplication must be avoided and uniform national level data should be available for effective decision making. Coordination with MIS, DGHS will reduce service delivery duplication reporting. BBS is working with population data collection which is important for DGFP. The CRVS is a system to register all people for every service provided both in the public and private sector. The DGFP would be focusing more to build a coordinated system among the three systems. Moreover, information on MCH-FP services provided by other ministries/ departments of the government like LGD of MOLGRD (City Corporation/ Municipalities), Ministry of Railways (Railway hospitals) , local NGOs and private sector including Garments Factories, will be collected systematically for evidence-based planning.

Activities:

1. Coordination with DGHS, MIS especially on the service conducted jointly at different level.
2. Replicate piloting DHIS-2 platform from two districts to more districts in coordination with MIS-DGHS

3. Assist BBS to collect & compile population data through well organized field force.
4. MOE (Memorandum of Understanding) with CRVS to register population & to use the ID given by CRVS to serve the target people on MCH-FP activities.
5. Coordinate with City Corporation/ Municipalities, railway hospitals, NGOs and private sector including Garments Factories who are involved in providing MCH-FP services for a unified data management system to reflect the indicators at national web.

Component-9: Capacity building for family planning service providers at all levels

Developing a pool of high performing staff through skill development will be one of the priority interventions of the MIS OP. Different need-based training courses (Basic/refreshers) of different duration will be provided to service providers.

Activities:

1. ToT on FWA Register and reporting formats.
2. Training on e-Register and e-diary of field staff, field supervisors and other officials (e-FWA Register, e-Facility register).
3. Training of DGFP officials on e-filing program.
4. Foreign training for MIS personnel to learn information system management of other countries'.
5. Build capacity of the field level staff on LMIS.
6. Build a technical team to evaluate the outcome of ongoing activities and trained the team.
7. Training of DGFP personnel on newly developed HRIS system linked with MOH&FW.
8. Training on DHIS-2 of DGFP personnel to ensure input the family planning data DHIS-2 platform at upazila level all over the country coordination with MIS-DGHS

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

Coordination with Local Government Authorities to incorporate related RH-FP information in routine MIS reporting system. It will be effective to ensure desired accountability & extend program publicity & and network.

Gender segregated data will be collected and coordination will be made with MIS- DGHS, BBS, CRVS and other concerned units of DGFP to avoid duplication in the regular reporting system. Coordination with MIS, DGHS will reduce duplication of reporting on service delivery. The BBS is involved as the mainstream of population data management in the country. So coordination with BBS would be necessary for population data sharing avoiding duplication. The CRVS is working with a unique ID of every person to serve different services. It would be very useful to DGFP to avoid duplication of couple registration and providing MCH-FP services using this unique ID.

As other ministries/ departments of the government, NGOs and private sector are involved in providing MCH-FP services covering a large population area, effective coordination with these stakeholders would be very important to build a uniform information system on MCH-FP activities.

7. Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1.	Number of institutes scaling up automation for strengthening routine FP information system	Number of institutes (Admin record)	2	2	2
2.	Number of UHFWCs under e-MIS scale up	Number (Admin record)	30 (2016) E-MIS/DGFP)	800	1500
3.	Number of CCs reporting gender segregated data in DHIS2	Number (DHIS2)	0	4000	10000
4..	MIS reports on service delivery published and disseminated annually	Number (Printed report available)	01	3	5
5.	No. of districts submitting performance monitoring report through DHIS 2	Number of districts (MIS)	2	40	64

10. Budget of the Operational Plan

10.1 Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
6068.00	**7272.00**	0.00	**7272.00**	**13340.00**	

10.2 Component and activity wise physical and financial target of OP: MIS

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component-1: Digitalized Service Data Collection, Compilation, Analyzation and Dessemination													
1. Procurement of Computer & Accessories													
i)	Desktop Computer	800	Nos.	400.00	0.00	400.00	0.00	0.00	250.00	150.00	0.00	0.00	0.00
ii)	Printer												
	a) LaserJet	100	Nos	25.00	0.00	25.00	0.00	0.00	25.00	0.00	0.00	0.00	0.00
	b) Dot Matrix	700	Nos	105.00	0.00	105.00	0.00	0.00	60.00	45.00	0.00	0.00	0.00
iii)	Tab	12000	Nos	3000.00	0.00	3000.00	0.00	0.00	2000.00	1000.00	0.00	0.00	0.00
iv)	Scanner	150	Nos	24.00	0.00	24.00	0.00	0.00	12.00	12.00	0.00	0.00	0.00
v)	Color Printer	2	Nos	6.00	0.00	6.00	0.00	0.00	3.00	3.00	0.00	0.00	0.00
vi)	UPS	800	Nos	120.00	0.00	120.00	0.00	0.00	75.00	45.00	0.00	0.00	0.00
2	Pay & Allowance	500		380.00	380.00	0.00	0.00	30.00	70.00	70.00	70.00	70.00	70.00
3	Computer Consumable Item	0		280.00	280.00	0.00	0.00	30.00	50.00	50.00	50.00	50.00	50.00
4	Other Repair & Maintanance	0		25.00	25.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
5	**Printing & Publications**												
i)	FWA Register & MIS reporting Formats	40000	Nos	200.00	0.00	200.00	0.00	0.00	200.00	0.00	0.00	0.00	0.00
ii)	Manual of FWA Register	40000	Nos	60.00	0.00	60.00	0.00	0.00	60.00	0.00	0.00	0.00	0.00
iii)	Manual of e-register	12000	Nos	15.00	0.00	15.00	0.00	0.00	10.00	5.00	0.00	0.00	0.00
iv)	Monthly & Annual Report (SS)	18000	Nos	56.00	56.00	0.00	0.00	6.00	10.00	10.00	10.00	10.00	10.00
v)	Others			10.00	10.00	0.00	0.00	0.00	2.00	2.00	2.00	2.00	2.00
6	Stationary, Seals & Stamps			3.00	3.00	0.00	0.00	0.00	0.60	0.60	0.60	0.60	0.60

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	Sub Total	**125052**		**4709.00**	**754.00**	**3955.00**	0.00	**66.00**	**2832.60**	**1397.60**	**137.60**	**137.60**	**137.60**
Component-2 : Data quality assurance with monitoring and Evaluation													
1	Workshop of focus group on data monitoring & supervision.	64		160.00	160.00	0.00	0.00	10.00	30.00	30.00	30.00	30.00	30.00
2	Workshop on data accuracy through field visit	488		488.00	488.00	0.00	0.00	28.00	92.00	92.00	92.00	92.00	92.00
3	Maintenance of Motor Vehicle	4		27.50	27.50	0.00	0.00	2.50	5.00	5.00	5.00	5.00	5.00
4	Seminar /Conference on DQA	128		256.00	256.00	0.00	0.00	16.00	48.00	48.00	48.00	48.00	48.00
5	Travel Expenses			11.00	11.00	0.00	0.00	1.00	2.00	2.00	2.00	2.00	2.00
6	Over Time			3.00	3.00	0.00	0.00	0.00	0.60	0.60	0.60	0.60	0.60
7	Petrol & Oil			39.00	39.00	0.00	0.00	2.00	5.00	8.00	8.00	8.00	8.00
8	Honorium Allowance			10.00	10.00	0.00	0.00	0.00	2.00	2.00	2.00	2.00	2.00
9	Other Expenses			22.00	22.00	0.00	0.00	2.00	4.00	4.00	4.00	4.00	4.00
10	Cleanliness			2.00	2.00	0.00	0.00	0.00	0.40	0.40	0.40	0.40	0.40
11	Gas & Fuel			41.00	41.00	0.00	0.00	3.00	7.00	8.00	8.00	8.00	7.00
12	Telephone/Telex			15.00	15.00	0.00	0.00	1.00	2.00	3.00	3.00	3.00	3.00
	Sub Total	**684**		**1074.50**	**1074.50**	**0.00**	0.00	**65.50**	**198.00**	**203.00**	**203.00**	**203.00**	**202.00**
Component-3: Innovation & SPS (Service Process Simplification)													
1	Procurement of Video Conference equipment	80	Nos	400.00	0.00	400.00	0.00	0.00	300.00	100.00	0.00	0.00	0.00
2	Publice Helpline through mobile phone SMS & Voice call	0		22.00	0.00	22.00	0.00	2.00	4.00	4.00	4.00	4.00	4.00
3	Publication of Manual of e-diary	2000	piece	5.00	0.00	5.00	0.00	0.00	2.00	3.00	0.00	0.00	0.00
4	Books & Periodical			5.00	5.00	0.00	0.00	0.00	1.00	1.00	1.00	1.00	1.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Advertising & Publicity			25.00	25.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
	Sub Total	**2080**		**457.00**	**30.00**	**427.00**	0.00	**2.00**	**312.00**	**113.00**	**10.00**	**10.00**	**10.00**
Component-4 : Digitalized information management for logistics through LMIS													
1	Publication of Monthly Report (LMIS)	13000	piece	16.00	16.00		0.00	1.00	3.00	3.00	3.00	3.00	3.00
2	Workshop of field force & supervisors on LMIS	1200	batch	1200.00	1200.00		0.00	50.00	230.00	230.00	230.00	230.00	230.00
	Sub Total	**14200**		**1216.00**	**1216.00**	**0.00**	0.00	**51.00**	**233.00**	**233.00**	**233.00**	**233.00**	**233.00**
Component-5 : Outcome evaluation of ongoing activites & take follow-up actions													
1	Outcome Evaluation Workshop of reporting Personnel	80	batch	80.00	80.00	0.00	0.00	5.00	15.00	15.00	15.00	15.00	15.00
2	Seminar on Service Indicators & data validation	80		81.00	81.00	0.00	0.00	5.00	16.00	15.00	15.00	15.00	15.00
	Sub Total	**160**		**161.00**	**161.00**	**0.00**	0.00	**10.00**	**31.00**	**30.00**	**30.00**	**30.00**	**30.00**
Component-6 : Online Personnel Management Information System (PMIS) for human resource & facility management													
1	PDS Entry and quality varification			12.00	12.00	0.00	0.00	2.00	2.00	2.00	2.00	2.00	2.00
2	Publication of Annual Report (HRIS)	6000	piece	12.00	12.00	0.00	0.00	2.00	2.00	2.00	2.00	2.00	2.00
	Sub Total	**6000**		**24.00**	**24.00**	**0.00**	0.00	**4.00**	**4.00**	**4.00**	**4.00**	**4.00**	**4.00**
Component-7 : Software design, development & ICT activities													
1	Procurement of customize Software	8	Nos	40.00	40.00	0.00	0.00	5.00	10.00	10.00	5.00	5.00	5.00
2	Upgrading Documentation Center	1	Nos	11.00	11.00	0.00	0.00	1.00	2.00	2.00	2.00	2.00	2.00
3	Upgrading Data Center	1	Nos	350.00		350.00	0.00	0.00	150.00	75.00	75.00	25.00	25.00
4	Procurement of Furniture	0		23.00	23.00	0.00	0.00	1.00	5.00	4.00	5.00	4.00	4.00
5	Maintenance of Furniture & Fixture	0		5.50	5.50	0.00	0.00	0.50	1.00	1.00	1.00	1.00	1.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
6	Digital Attendance & Security System for DGFP	1	No	40.00	40.00	0.00	0.00	0.00	40.00	0.00	0.00	0.00	0.00
7	Internet Bill	0		2500.00	2500.00	0.00	0.00	50.00	250.00	400.00	600.00	600.00	600.00
8	Procurement of LED Monitor	6	Nos	6.00	6.00	0.00	0.00	0.00	1.00	2.00	1.00	1.00	1.00
9	Procurement of CC Camera & TV for DGFP	1	Set	30.00	30.00	0.00	0.00	0.00	30.00	0.00	0.00	0.00	0.00
10	Photocopy Machine	3	Nos	6.00	6.00	0.00	0.00	0.00	2.00	0.00	2.00	0.00	2.00
11	Upgrading Automation System of MCHTI & MFSTC	2	Nos	100.00		100.00	0.00	0.00	15.00	30.00	30.00	15.00	10.00
12	Procurement of AC, Fridge & Others	8	Nos	5.00	5.00		0.00	0.00	2.00	1.00	1.00	0.00	1.00
	Sub Total	**31**		**3116.50**	**2666.50**	**450.00**	0.00	**57.50**	**508.00**	**525.00**	**722.00**	**653.00**	**651.00**
Component-8 : Coordination and Collaboration (Infra and inter-sectoral, NGOs and private sector													
1	Seminar & Conference on coordination	10		55.00	55.00	0.00	0.00	5.00	10.00	10.00	10.00	10.00	10.00
	Sub Total	**10**		**55.00**	**55.00**	0.00	0.00	**5.00**	**10.00**	**10.00**	**10.00**	**10.00**	**10.00**
Component-9 : Capacity building for family planning service providers at all levels													
a	**Local Training :**												
1	TOT on FWA updated Register & Formats	2100	persons	80.00	0.00	80.00	0.00	0.00	0.00	80.00	0.00	0.00	0.00
2	Training on updated register & formates	22000	persons	1000.00	0.00	1000.00	0.00	0.00	0.00	1000.00	0.00	0.00	0.00
3	TOT on e-register & Formats	700	persons	75.00	0.00	75.00	0.00	0.00	25.00	25.00	25.00	0.00	0.00
4	Training on e-Register												
i.	Basic	10000	persons	500.00	0.00	500.00	0.00	0.00	150.00	175.00	175.00	0.00	0.00
ii.	Supervisory	2000	persons	100.00	0.00	100.00	0.00	0.00	30.00	35.00	35.00	0.00	0.00
5	Advanced Training on Computer	55	persons	55.00	0.00	55.00	0.00	5.00	10.00	10.00	10.00	10.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
6	Refresher Training on Computer	2500	persons	330.00	0.00	330.00	0.00	30.00	60.00	60.00	60.00	60.00	60.00
7	Training on SPS & Innovation	120	persons	12.00	12.00	0.00	0.00	0.00	3.00	3.00	3.00	0.00	3.00
8	Training on HRIS	1200	persons	65.00	65.00	0.00	0.00	5.00	12.00	12.00	12.00	12.00	12.00
9	Training on e-Filing for DGFP Personnel	100	persons	10.00	10.00	0.00	0.00	5.00	5.00	0.00	0.00	0.00	0.00
b.	**Foreign Training**	60	persons	300.00	0.00	300.00	0.00		60.00	60.00	60.00	60.00	60.00
	Sub Total=	**40835**		**2527.00**	**87.00**	**2440.00**	0.00	**45.00**	**355.00**	**1460.00**	**380.00**	**142.00**	**145.00**
	Grand Total=	**48156**		**13340.00**	**6068.00**	**7272.00**	0.00	**306.00**	**4483.60**	**3975.60**	**1729.60**	**1422.60**	**1422.60**

11. Budget support from other Operational Plan: Not applicable

4.8 Procurement, Storage and Supplies Management-HS (PSSM-HS)

1. Name of Operational Plan: Procurement, Storage and Supplies Management of Health Services (PSSM-HS)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

Situation Assessment

While several achievements are made over the past years in the PLSM-DGHS especially in terms of streamlining procurement processes and increasing availability of commodities at all levels, there still remain few challenges at various levels in the area of procurement planning, process, distribution and contract management. Further improvements to ensure quality and efficiency, appropriate service procurement, and capacity building will be essential in the coming program years. It is imperative to take these existing challenges into consideration in the next sector program; address them accordingly to sustain the achievements of the previous sector programs and continue to advance towards progress to safeguard public health services.

Procurement under HPNSDP encompasses procurement of goods and services and is done using Government (revenue and development) fund and funds of development partners (DP) (through Reimbursable Project Aid (RPA) and/or Direct Project Aid (DPA)). For the Government's own procurement, the national regulations (Public Procurement Rules and Public Procurement Act) apply and there are provisions for decentralized procurement by the users. For procurement financed by RPA (through GOB), the World Bank procurement guidelines are applicable. Procurement done using JICA fund that follows JICA guidelines.

The Central Medical Stores Depot (CMSD) of the Directorate General of Health Services (DGHS) is the entity for Goods procurement. The World Bank has identified CMSD as the agency for procurement of goods for procurement using RPA (through GOB) funds and all these are centrally managed. There is provision for decentralized procurement using GOB funds but this provision does not exist for RPA (through GOB).

There have been some gains in efficiency in the procurement process. A Medical Equipment Survey (MES) administered by the World Bank in 2012 revealed that the overall lead time for procurement of equipment by CMSD has been reduced from 46 months in 2008 to 26.5 months in 2012. The tender processing time by CMSD has also been reduced from 17 months in 2008 to 8.5 months in 2012. There, however, remain gaps in the process where efficiency gains can be achieved.

The risks associated with procurement identified during the preparation of HPNSDP have been mitigated to a large extent through capacity strengthening of the CMSD. Capacity strengthening has resulted in improvements in the quality of procurement documents prepared. The nature of risks has changed over the last few years and the procuring entities have to remain vigilant in dealing with such risks, particularly irregular practices of the bidders.

Challenges

1. ***Need-based Procurement:*** procurement is done based on budget available in the OP with less focus on the actual needs of the users. To address these issues, the MOHFW has issued a circular so that CMSD checks with the users to confirm that there is an actual need for the item at the facility. However, the process of basing procurement on actual needs, existing stocks, and

projected requirements need to be formalized. Moreover, there is limited coordination between the procurement planning of DGFP and DGHS and as a result similar items get procured from multiple sources creating duplication. Projects directly funded by some of the Development Partners (DPs) especially the UN agencies also procure goods that are processed in parallel without giving due consideration to the existing stock and/or actual need. Such procurement is not always communicated to the MOHFW at the design phase and is rather included during the implementation phase of the program as and when the projects get approved/ started.

2. ***Mis-match of resources:*** There is limited synchronization between the procurement of equipment and drugs, civil works and deployment of human resources (HR). There are instances where buildings are constructed but the facilities cannot be made operational due to lack of equipment, drugs and HR and/or equipment are lying unused as there are no technicians.

3. ***Enhance efficiency in the procurement process:*** In spite of the improvements noted earlier, there are significant issues relating to the procurement process. Some of these challenges include: delayed submission of procurement plans; same items being procured separately every year; technical specification of high-end medical equipment not generalized; bundling of procurement packages towards the end of the fiscal year; and goods are received all at once rather than staggered delivery throughout the year.

4. ***Improve distribution and supply chain management:*** Current warehousing system operates manually with no computers available at the facility stores and warehouses, particularly of DGHS. As a result, there is no formal mechanism for stock control and distribution.

5. ***Strengthen contract management:*** Contract administration is weak within adequate guidelines for contract management. Pre- and post-shipment inspections are not done to ensure quality of goods received.

6. ***Quality control:*** A mechanism to ensure quality of commodities needs to be in place. At present, a validated mechanism of routine surveillance for quality control is absent.

7. ***Adequate maintenance of equipment:*** The MOHFW has invested a lot of resources in procuring medical equipment. However, adequate maintenance budgets are not available. Therefore, there is a need to introduce a systematic mechanism for ensuring preventive and corrective maintenance of medical equipment.

8. ***Sufficient storage space:*** Adequate storage space is a precondition for improving storage condition and ensuring quality of the products. An assessment of the storage conditions across Bangladesh by MOHFW indicated the need to ensure additional storage space for all upgraded facilities and to renovate the existing stores to ensure optimum storage conditions as well as to control for environmental conditions.

9. ***Condemnation process:*** The MOHFW has issued new circulars to revive the process of decommission (condemnation) of old items/out-of-order equipment. Some of the DGHS facilities have also started the process of decommissioning. The process of condemnation needs to done regularly.

10. ***Role of CMSD to be strengthened (Upgrade/Restructure of CMSD):*** The Central Medical Stores Depot (CMSD) was established as storage and distribution organization in 1947. In 1998, with the start of 1st Health Sector Program (HPSP), CMSD was charged with Centralized Procurement for all the Line Directors of Directorate General of Health Services (DGHS).Since then CMSD started working as a warehouse cum main procurement agency for DGHS. CMSD procures

medical equipment, non medical equipment and pharmaceuticals products including vaccines for DGHS. In recent years the procurement volume increased significantly. But the capacity of CMSD has not increased at the same speed in terms of human and physical resources.

Therefore, there is an urgent need to upgrade/ restructure CMSD to serve effectively as a full-fledged procuring entity. International Consulting Firm 'HERA' submit their final report on 'Restructuring CMSD' on June -2016. In their report they proposed 03 (three) Options of new CMSD.

Option of new CMSD:

a) Upgrading CMSD to a Directorate General
b) Establishing a semi autonomous body under MOHFW
c) Creating a MOHFW level procurement agency in which the existing procurement function of DGHS and DGFP are merged.

In this respect, an assessment is being commissioned by the MOHFW to ascertain the needs for capacity enhancement of CMSD. The assessment proposed new organogram for CMSD, which is needed to be implemented following a Government endorsement (MOHFW, Ministry of Public Administration, and Ministry of Finance).

11. ***Strengthen capacity of bid evaluation committees****:* The existing bid evaluation committees need to strengthen their capacity to identify irregularities and red flags in procurement as well as to evaluate packages of medical equipment.

4. Objectives

(i) Improvement in procurement planning

(ii) Improvement in procurement process, distribution and contract management

(iii) Improvement in quality and efficiency

(iv) Enhancement of capacity

5. Components

Component-1: Procurement planning

Many times procurement is done as funds are available and not on the basis of actual requirements considering stock available and consumption pattern and thus projected requirements. Also lack of coordination between DGHS and DGFP procurement entities leads to procuring same items from multiple sources. Lack of planned procurement in coordination with civil works and deployment of human resources results in non-utilization of procured items.

Activities

1. Establish a formal mechanism for need-based procurement.
2. Expand the Supply Chain Management Portal (SCMP) to capture the total procurement plans of GOB (Development and Revenue) as a pilot initiative. Ensure sustainability of SCMP.
3. Introduce a mechanism for procurement coordination between DGFP and DGHS for commonly procured items.
4. All medical equipment procured should adhere to the relevant TOE.

Component-2: Procurement process, distribution and contract management

Issues regarding procurement process include delayed submission of procurement plans; same items being procured separately every year; technical specification of high-end medical equipment not generalized; bundling of procurement packages towards the end of the fiscal year; and goods are received all at once rather than staggered delivery throughout the year. Also since the warehousing system operate manually no formal mechanism for stock control and distribution exists.

Activities

1. Introduce e-GP
2. High-tech equipment should be procured only at the central level
3. Introduce multi-year contracts as well as framework agreements.
4. Introduce automated systems for stores and warehouses (provision to be made for IT equipment for all stores and warehouses)
5. Develop an asset management system.
6. Develop an effective on line tracking system.

Component-3: Quality and efficiency

Mechanism to ensure quality of commodities doesn't exist. Absence of proper maintenance system leads to non-optimum utilization of procured equipments. Stores suffer from inadequate space which in many instances are aggravated due to non-condemnation in due time and thus occupying space by unnecessary equipments, goods.

Activities

1. For high-tech/proprietary equipment, provision for comprehensive maintenance contracts may be introduced in the bidding document. This should be included as one of the evaluation criteria in the bidding documents so that the bids can be evaluated for this.
2. A "life-cycle cost" approach should be adopted for high-tech medical equipment and the required budget should be made available so that the required corrective and preventive maintenance can be performed. The log history also needs to be maintained so that proper maintenance can be ensured.
3. Introduce routine surveillance for ensuring quality of goods procured. Pre- and post-shipment inspection should be done.
4. Ensure adequate storage condition for distributed goods and equipment
5. Regularize the process of timely decommission of old/junk equipment/ items as per the existing GOB circulars.

Component-4: Capacity enhancements

CMSD was established as storage and distribution organization. With the start of sector-wide approach in 1998, CMSD was charged with centralized procurement for all the LDs under DGHS, which continue to be the main users of CMSD. Though over the years CMSD had been supported however its volume of procurements also increased. A report on Developing Strategy for Restructuring CMSD to Match Its Capacity in Performing Activities to Strengthen the Health System of Bangladesh is now available.

Activities

1. Upgrade capacity of CMSD based on the assessment findings
2. Strengthen the capacity of the existing GOB bid evaluation committees
3. Undertake regular capacity building initiatives for relevant procurement staff
4. Develop a database of staff trained in procurement so that these people can be called upon when required.
5. Restructuring of CMSD to match its capacity in performing activities to strengthen the health system of Bangladesh.
6. Ensure optimum storage condition by upgrading facilities.

6. Cross Cutting Issues

PLSM-DGHS OP will contribute in poverty reduction in many ways: timely availability of logistics like equipments and drugs will ensure effective treatment and thus restoring health to participate in economic development; timely availability of vaccines and other preventable items like vitamin A capsules, de-worming drugs, iron/folic acids etc. will ensure better health and thus not draining resources to safeguard economic development gain.

Procurement and supply of environment-friendly equipments and logistics and their proper maintenance will contribute in environment conservation and mitigate climate change effect. Also supplies will support the climate change victims to restore their health affected due to climate change effects.

Timely availability of required supplies will ensure effective comprehensive health care (promotive, preventive, curative, rehabilative) for the women and children and address the gender parity issues as well.

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc: Annexed in Volume-II

9. Indicators

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1	Procurement lead time reduced for the packages tracked through SCMP	Lead Time Admin records of SCMP	57.3 weeks SCMP (2014-15)	50 weeks	40 weeks
2.	Introduce e-GP	Percentage of Procurements Admin records	0	25%	100%

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
3.	Add comprehensive maintenance in the tender documents for high-tech equipments	Number of bid documents Admin records	0	50%	100%
4	Restructuring CMSD	Process	None	Proposal in MOPA	Proposal approved by MOPA and MOF

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
82972.00	8776.00	0.00	8776.00	91748.00	

10.2. Component and activity wise physical and financial target of OP: PSSM-HS

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Component-1 :Procurement Planning													
1	Computer Software (to be purchased through HIS ehalth OP)	LS		55.00	0.00	55.00	0.00	5.00	10.00	10.00	10.00	10.00	10.00
2	Computer & Accessories (to be purchased through HIS ehalth OP)	2938		495.00	0.00	495.00	0.00	0.00	99.00	100.00	120.00	150.00	26.00
3	Computer & Other Equipment (Repair & Maintenance) (Computer to be repaired through HIS ehalth OP)	LS		39.00	39.00	0.00	0.00	4.00	7.00	7.00	8.00	6.00	7.00
	Sub Total			589.00	39.00	550.00	0.00	9.00	116.00	117.00	138.00	166.00	43.00
Component-2 :Procurement process, distribution and contract management													
1	Publicity, Printing and Advertisement	LS		860.00	860.00	0.00	0.00	50.00	155.00	160.00	170.00	170.00	155.00
2	C& F Agent Commission & Vat	LS		4575.00	4575.00	0.00	0.00	330.00	805.00	860.00	870.00	930.00	780.00
3	Honorarium & Fees(Including Testing fees, Survey fees, Law expenses)	LS		284.00	284.00	0.00	0.00	29.00	45.00	50.00	55.00	62.00	43.00
4	Port Shipping Agent/ Ware House Charge	LS		2750.00	2750.00	0.00	0.00	350.00	400.00	500.00	600.00	600.00	300.00
5	CD VAT	LS		68000.00	68000.00	0.00	0.00	5000.00	12000.00	15000.00	12000.00	15000.00	9000.00
6	Stationery, Seal & Stamps	LS		250.00	250.00	0.00	0.00	15.00	40.00	45.00	60.00	60.00	30.00
7	Entertainment	LS		23.00	23.00	0.00	0.00	3.00	4.00	4.00	4.00	4.00	4.00
8	Transport & Freight Charge	LS		2280.00	2280.00	0.00	0.00	52.00	405.00	455.00	456.00	476.00	436.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
9	Contract & Other Management Expenditure	LS	165.00	165.00	0.00	0.00	10.00	30.00	30.00	35.00	30.00	30.00
	Sub Total		79187.00	79187.00	0.00	0.00	5839.00	13884.00	17104.00	14250.00	17332.00	10778.00
Component-3 :QUALITY AND EFFICIENCY												
1	Repair & Maintenance of Warehouse Equipments	LS	215.00	215.00	0.00	0.00	15.00	40.00	40.00	50.00	40.00	30.00
2	Vehicles (Repair & Maintenance)	LS	80.00	80.00	0.00	0.00	5.00	15.00	15.00	15.00	15.00	15.00
3	Furniture & Fixtures (Repair & Maintenance)	LS	33.00	33.00	0.00	0.00	3.00	6.00	6.00	6.00	7.00	5.00
4	Other Repair & Maintenance	LS	45.00	45.00	0.00	0.00	5.00	8.00	8.00	8.00	8.00	8.00
5	Equipment & Accessories (Repair & Maintenance)	LS	27.00	27.00	0.00	0.00	2.00	5.00	5.00	5.00	5.00	5.00
6	Telecommunication (Repair & Maintenance)	LS	20.00	20.00	0.00	0.00	1.00	3.00	4.00	4.00	4.00	4.00
7	Electric Goods (Repair & Maintenance)	LS	22.00	22.00	0.00	0.00	2.00	4.00	4.00	4.00	4.00	4.00
	Sub Total		442.00	442.00	0.00	0.00	33.00	81.00	82.00	92.00	83.00	71.00
Component-4 : Capacity Enhancement												
1	Pay & Allowances of Officer& Staff	53	775.00	775.00	0.00	0.00	75.00	140.00	140.00	140.00	140.00	140.00
2	Local Training	500	100.00	0.00	100.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
3	Foreign Training	20	100.00	0.00	100.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
4	Seminar/ Workshop	50	50.00	0.00	50.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
5	Service Procurement- Logistic Handling (out sourcing staff)	LS	100.00	100.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
6	Telex Fax/ E-Mail	LS	33.00	33.00	0.00	0.00	3.00	6.00	6.00	6.00	6.00	6.00
7	Fuel & Gas	LS	112.00	112.00	0.00	0.00	12.00	20.00	20.00	20.00	20.00	20.00
8	Fuel/Petrol & Lubricant	LS	100.00	100.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
9	Cleaning & Washing	LS	55.00	55.00	0.00	0.00	5.00	10.00	10.00	10.00	10.00	10.00
10	Computer & Photocopy Consumable	1810	220.00	220.00	0.00	0.00	20.00	40.00	40.00	50.00	40.00	30.00
11	Registration fee (Vehicle)	LS	9.00	9.00	0.00	0.00	1.00	8.00	0.00	0.00	0.00	0.00
12	Microbus	3	84.00	0.00	84.00	0.00	0.00	84.00	0.00	0.00	0.00	0.00
13	Jeep	1	30.00	0.00	30.00	0.00	0.00	30.00	0.00	0.00	0.00	0.00
14	Furniture & Fixtures	920	100.00	0.00	100.00	0.00	20.00	25.00	25.00	10.00	10.00	10.00
15	Telecommunication/ Video conference Equipments	2232	585.00	0.00	585.00	0.00	0.00	100.00	200.00	200.00	80.00	5.00
16	Warehouse Equipment	1027	5342.00	0.00	5342.00	0.00	0.00	2671.00	0.00	2000.00	600.00	71.00
17	Office Equipment &Medical Instrument	667	1835.00	0.00	1835.00	0.00	30.00	400.00	300.00	675.00	400.00	30.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
18	Additional Civil Works (Internal Sanitary and Water Supply, Internal Electrification, External Water Supply-Contraction underground water tank (10000 gal.), Septic Tank, Soak Well, Inspection Pit, Gas Connection, Construction of Compounded and Approach Ro	LS	500.00	500.00	0.00	0.00	0.00	500.00	0.00	0.00	0.00	0.00
19	Additional Cost (External Electrification, 630 KVA Sub station, 500 KVA Generator, Cold room, AC 140 Ton - 02 nos, Fire Detection, Protection and Alarm System, Telephone, CCTV, Cargo Lift-3000 Kg 4 stop, 7.5 HP centrifugal pump, Security & Compound Light	LS	1000.00	1000.00	0.00	0.00	0.00	1000.00	0.00	0.00	0.00	0.00
20	Extension of 4th Floor of Warehouse Cum Office Building	LS	400.00	400.00	0.00	0.00	0.00	400.00	0.00	0.00	0.00	0.00
	Sub Total		11530.00	3304.00	8226.00	0.00	186.00	5524.00	831.00	3201.00	1396.00	392.00
	Grand Total		91748.00	82972.00	8776.00	0.00	6067.00	19605.00	18134.00	17681.00	18977.00	11284.00

11. Budget support from other Operational Plan: Not applicable

4.9 Procurement, Storage & Supply Management-FP (PSSM-FP)

1. **Name of the Operational Plan: Procurement, Storage & Supply Management-FP (PSSM-FP)**

2. **Implementing Agency: Directorate General of Family Planning (DGFP)**

3. **Introduction**

Over the decades, Bangladesh has made remarkable progress in reducing population growth through implementation of an effective family planning program across the country. Total fertility rate (TFR) reduced from 6.3 births per woman in 1975 to 3.4 in 1994 and to 2.3 in 2014. Use of contraceptive increased from 8 % in 1975 to 62% in 2014. Factors like strong political commitment from the government, strong field service delivery with skilled providers, multi-sectoral behavior change communication, improved infrastructure and effective commodity supply chain, collaboration with government and no-government organizations and social development (education) have contributed in reducing the population growth.

Population growth in Bangladesh presents a "demographic dividend" with its increasing youth population. Considering present population growth pattern, the main labor force (age group of 15-59) will increase significantly from 87 million (2011) up to as many as 152 million by 2061. Sufficient investments are needed to be made in quality health and family planning services, education and employment for adolescents and youth to realize the "demographic dividend". In this changing scenario, to full-fill the health need for this growing potential workforce a responsive supply chain for quality reproductive services would be required.

Procurement, Storage and Supply Management program (PSSM-FP) of the Logistics and Supply Unit of Directorate General of Family Planning (DGFP) has been playing a vital role in supporting other operation plans to function effectively and achieve their program objectives. The unit is responsible to procure and supply quality contraceptives and reproductive health commodities to Service Delivery Points (SDPs) throughout the country at the right time and in right quantity in an efficient manner. During the SWAPs, Logistics and Supply Unit has procured various contraceptive items like Low dose Oral Pills, Condoms, I.U.Ds, Implants and Maternal, Child and Reproductive health drugs, Dietary supplement Kits, Delivery kit to facilitate 24/7 service, Medical and Surgical Requisites (MSR) for clinical contraception, instruments and equipment etc.

During the last SWAP commendable progress has been made in strengthening procurement and supply management of FP commodities. The automation of the Supply Management System through 2 (two) software namely Warehouse Inventory Management System (WIMS) and Upazila Inventory Management System (UIMS) have been very useful to make decisions on the basis of real time data. In order 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) found to be very useful tools for tackling any stock out/overstock situation. Effective supply system and on-time procurement reduced the stock-out of RH commodities to <1% at Upazila FP Stores – similar result has been achieved at service delivery points (SDP) of DGFP, as shown by the newly introduced SDP module (APIR, 2015). The launching of e-GP has been a great step towards digitalization of Procurement System of DGFP. Moreover the risks associated with procurement identified over the SWAPs have been mitigated through capacity strengthening. The capacity for bid preparation has also been developed

for the bidding community through several workshops. Different survey revealed that the lead time for procurement has been reduced to 8.5months from 17 months in 2008.

The Challenges

(i). Product quality assurance and material standardization including quality checks through reputable independent lab/ organization;

(ii). Forecasting and quantification including functioning of Forecasting Working Group;

(iii). Multi-year contract management (Framework Contract);

(iv). Developing infrastructure for better storage condition including a new central warehouse; and

(v). Transportation of the medical products

The PSSM-FP Operation Plan (OP) has been developed to proceed with the unfinished tasks on procurement and supply management as well as address the challenges as mentioned above. The OP is very much in alignment with the strategic objectives of the Health, Nutrition and Population (HNP) Strategic Investment Plan (SIP) 2016-2021 of the government that has emphasized developing quality and efficient procurement and supply management system. In future, keeping in mind the SDGs, FP2020 and Vision-2021, the PSSM-FP OP 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 PSSM-FP will work as a support service to other Line Directors of DGFP in executing their Operational Plans effectively.

4. Objectives:

(i). Ensure need based planning and timely procurement of commodities required for implementation of the national FP program for reaching the targets;

(ii). Ensure efficiency and transparency;in procurement and supply management system

(iii). Establish product quality assurance through testing and surveillance of goods to protect and fulfill clients' rights;

(iv). Strengthen storage and inventory management to reduce losses due to overstock, wastage and ;amaged

(v). Ensure timely distribution of contraceptives and RH commodities to the service delivery points all over the country;

(vi). Strengthen monitoring and feedback system of real time data to help address stock out and unmet need situations;

(vii). Implement e-procurement and on line procurement tracking system;

(viii). Ensure sustainability of software and assets.

5. Components

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 who are involved in supply management. For national and international procurements, there is a 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 outsourcing) or Ansar/Village Defense Party members.

It should be mentioned here clearly that under this Operational Plan, there is no scope for spending revenue fund against activities such as maintaining utilities (electricity, water, Internet, telephone etc.) ferry charges, toll payment, loading and unloading and any other activities belonging to the sector development program**.**

Activities:

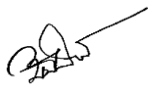
1. Retention of procurement and supply chain staff and creation of additional posts to handle increased volume of procurements;
2. Re-alignment of roles and responsibilities of desk officers and other staff in accordance with the procurement procedure manual;
3. Improve storage conditions in the Central Warehouse, Regional warehouses and Upazila stores through infrastructure development (constructions/ extensions of new floors, shelves etc.) and renovation;
4. Improve handling of goods through provision of new material handling equipment and other accessories;
5. Ensure security of Warehouse and Upazila Family Planning Stores through deployment of Ansar/VDP members;
6. Repair & maintenance of stores, vehicles, forklift, furniture equipment etc.
7. Supply of "personal protective equipment" for safe handling of warehousing equipment & working inside the Warehouse;
8. Stergthenexternal Security Measures for Warehouses.

Component-2: Procurement planning execution and contract management

PSSM-FP is the vital core operational 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 45-50 Packages each year. Planning for procurement begins with the estimation of annual requirements of contraceptives, medicines and MSRs 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. Over the years the lead time has decreased remarkably for procurement processing, however some new emergent issues need to addressed efficiently such as e-GP, multiyear contract/frame work agreement etc. Many challenges arise after signing of contracts as well. Hence we need to focus on contract management.

Activities:

1. Strengthen forecasting, quantification and supply planning system through FWG and other machineries;
2. Organize different review meetings such as the Logistic Coordination Forum, monthly meeting to review progress of implementation of procurement plans and the optimal functioning of the supply chain;
3. Continuous monitoring of all procurement related information for dealing with risks



4. ;and irregular parctice of bidders
5. Evaluation of Packages in an efficient manner following criteria;of guidelines and manuals
6. Ensuring that contracts are done in a transparent manner;
7. Evaluate and assess the adequacy of internal control;
8. Examine compliance with the procurement proceduresas per guidelines and manuals to attain ;value for money
9. Ensure that funds provided for procurement are spent efficiently;
10. Develop guideline for contract management;
11. Strengthening Functions of FWG (Forecasting Working Group): The FWG will consider demand for RH commodities from a national perspective and, to facilitate such an assessment, will consider private sector estimates and program plans from Social Marketing Company and other leading operators in the private sector;
12. Introduce Framework Contracts: DGFP may enter into a framework contract under section 36 of the PPA for the supply of a quantity of similar items at specified prices during a defined period to avoid repeated tendering for the same requirement and to obtain better prices through economies of scale.

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 achieved 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, and warehousing and distribution process. Implementation of PSI and laboratory testing from WHO standard organization will ensure that only quality assured products are shipped in the country.

Activities:

1. 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/organizations;
2. Implement a routine surveillance market verification/to ensure continued maintenance of the quality of products in the supply chain;
3. Ensure that storage and transportation condition guarantee the quality and integrity of products both in storage and in transit ;(.humidifier devices etc-procurement of airconditioners, De)
4. Development and regular update of a database of generic specifications for the goods or services as per WHO, local and international standards;
5. 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;
6. 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 contact 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 through outsourcing arrangement. Gradually area of private transportation of commodities will be increased at the rate of five percent each year in order to reduce government expenditure.

There is a risk of detoriation of product integrity during transportation and hence temperature controlled vehicals are essential. At the same time the stores at regional and Upazila level need some freezer for some temperature sensitive items.

Activities:

1. Improve communication to reduce delays in clearing goods and reducing storage fees;
2. Purchase new trucks, covered van and temparature controlled vehicals, freezers etc; according to requirement;
3. Continue GOB transport and hire private transportation for distribution of goods;
4. Build capacity for expediting contracts management;
5. .Introduce stagard delivery of goods for a better management of space and inventory

Component-5: Supply Chain Management (warehousing, distribution and monitoring)

The flow and distribution of commodities into and throughout the country should be optimized to create manximum supply chain effeciencies to improve the quality and availablility of services.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 three Software namely (i) Warehouse Inventory Management System (WIMS) (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 reporting and analysis. 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:

1. Develop additional reports from the various software to support different situation analysis and evidence based decision making;
2. Networking computer system with central file storage;
3. Carryout periodic physical inventory and commodity audits through independent firms;
4. Implementation of modern warehousing practice;

5. Effective implementation ofcondemnation and disposal process.

Component-6: Record Keeping and Feedback Mechanism

Record keeping and feedback mechanism have been automated**.** Up to Upazila level the supply situation has been recently quite reliable, while below this level there are sporadic unmet need issues. Proper reporting and feedback mechanism can avoid stock out and ensure continuity of services.The extension of eLMIS upto SDP has created an opportunity to respond quickly and effeciently to avoid stock-outs and overstock of FP commodities.

Activities:

1. Strngthen UP stores and SDPlevel stock management system s;
2. Establish modern central archives for all documents;
3. Ensure manual and electronic reporting system from all tiers;
4. Ensure accuracy of reporting;
5. Data validation and situation analysis;
6. Ensure use of information system by officers at all levels;
7. Purchase computers and installation of software at all Upazila Family Planning Offices;
8. ;connection Secure uninterupted power supply and internet
9. Conduct training and refreshers training on the software and store management.

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 Systems for Improved Access to Pharmaceuticals and Services Program (SIAP), 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 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. Some small courses in IDA guidelines in ASCI Hydrabad and ILO/Turin can be arranged from Pool fund.

Activities:

1. Improve capacity of procurement personel to be better prepared and empowered to identify and ;come procurement bottleneck and challengesover
2. ; Strenghthen the capacity of the TEC members to identify irregularities
3. Organize trainings, study tours workshops locally and abroadfor procurement and supply chain staff to perform their task as per standards;
4. Participate in international courses, conferences, seminars and related networking activities;

5. Capacity building on product quality issuesgood warehousing parctice/;
6. Organize workshops for bidders for reducing the numbers of ineligible bids;
7. l procurement performance reviewConduct annua

Component-8: e-Procurement and Web based information system

(i). **e-procurement:** 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.

(ii). **Supply Chain Information Portal:** The Web based Supply Chain Information Portal has been helping to monitor procurement progress through web and provides latest stock situation, archives of documents, latest procurement related news publications etc. The procurement dash board helps to monitor current packages status and intervene where necessary and LMIS helps to monitor stock of contraceptives from national to SDP level and take measures to stock out upazila. The portal is unique in terms of data management and presentation using dashboards in the Government sector. DGFP Supply Chain Information Portal helps to ensure contraceptives availability in upazila and field level, which eventually will assist to reduce unwanted pregnancy, population growth and help to reach relevant MDGs and SDGS of the government.

Activities:

1. Role out e-procurement system;
2. Capacity building on e-procurement process;
3. Build capacity for the establishment and management of multiyear framework and indefinite quantity contracts;
4. NecessarySoftware training purcahse of equipments fore-procurements;
5. Continue enhancement of the Supply Chain Information Portal (SCIP).

Component-9: Infrastructure Development & Maintenance

Central & Regional Warehouses: One of the main reasons for remarkable progress in Bangladesh Family Planning Program (BFPP) has made remarkable progress over the years is due to contraceptives security by smooth supply of commodities throughout the country. The supply chain in the BFPP starts from the Central Warehouse (CWH) situated at Mohakhali, Dhaka and 21 other Regional Warehouses up to the different service delivery points. The storage facility of the CWH is about 18,000 sqft with a total area of 30,000 sqft including functioning, repairing, spaces and others altogether. The CWH starts its functioning in the year 1979. Since long the building has not been repaired properly.

With the increasing demand of contraceptives, MSRs and other RH commodities rearrangements is essential for the Central Warehouse. Health Engineering Department (HED) under the Ministry of Health and Family Welfare has the plan to construct a modern Central Warehouse of Family Planning with total proposed area of 1,50,000 sq ft. The project was supposed to end within the 3rd SWAP (HPNSDP)

It should be mentioned that among the 21 Regional Warehouses, one of Bhola is functioning in a rented building. The HED had also plan to construct a new Warehouse at Bhola within this Sector Program period.

To construct the proposed new Central Warehouse a consultation firm will be required to hire for preparation of designing, planning estimating, supervision and monitoring etc. It may be mentioned that the Health Engineering Department will take the lead role in hiring the appropriate Consultant. And, it is expected that the USAID-SIAPS program implemented by MSH will provide necessary assistance to HED in the whole process of hiring a potential consulting firm. The cost will borne by PSSM OP.

Activities:

1. To construct a modern Central Warehouse (CWH) of Family Planning with total proposed area of 1, 50,000 sq ft. through PFD;
2. The CWH should have all capacity modern cold chain, modern parking area, modern fire fighting system, powerful generator, modern drainage system, security boundary wall, security lights etc.
3. To build a modern Regional Warehouse for family Planning at Bhola with respective facilities through PFD;
4. Hiring of Consulting Firm;
5. Renting of Store space for interim period
6. **Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc**

   i. Timely demand & fund placement by the LDs – for All OPs of DGFP and NIPORT,

   ii. Rollout e-Procurement

   iii. Infrastructure development & maintenance in an environment friendly manner - OP-PFD

7. **Manpower:** Annexed in Volume-II

8. **List of Works, Goods, Services etc.: Annexed in Volume-II**

9. **Indicators**

SL No.	Indicators	Unit of Measurement/Means of verification	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	**2**	**3**	**4**	**5**	**6**
1	Percentage of contracts awarded within initial Bid Validity period	Percentage (Admin record)	95% (APIR 2016; LD-L & S Unit, DGFP	100%	100%

SL No.	Indicators	Unit of Measurement/Means of verification	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	**2**	**3**	**4**	**5**	**6**
2	Percentage of SDPs without stock out of FP supply in all divisions (a), particularly in the lagging regions of Sylhet and Chittagong (b)	Percentage (Admin record; E-LMIS/DGFP)	>98% APIR 2016	>98%	>98%
3	Percentage of WIMS (a) and UIMS (b) functional	% (Admin record; SCIP/LMIS)	a) 100%; b) 100%; (APIR 2016	a) 100% b) 100%	a)100% b)100%
4	Percentage of Upazilas having no 'unusable'	% (Admin record/ Upazila survey & condemnation report)	78%(2016)	80%	95%
5	Rollout e-GP	%(e-GP)	5% (2016)	50%	100%

10. Budget of the Operational Plan

10.1Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
14935.00	710.00	0.00	710.00	15645.00	

10.2 Component and activity wise physical and financial target of OP: PSSM-FP

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
(i). Program Organization for procurement and supply management													
1	Maintain officer and staff: pay & Allowance	6270 (Month)		1003.00	1003.00	0.00	0.00	45.00	175.00	183.00	200.00	200.00	200.00
2	Maintain Utilities (Office, Elec., Water, E-mail Tele. Internet, Ferry charge ,toll, loading unloading & Others)	LS		785.00	785.00	0.00	0.00	60.00	125.00	150.00	150.00	150.00	150.00
3	Repair and Maintenance of Vehicles,CNG conversion of Vehicles, Forklift, Furniture & Equipment. etc.	LS		210.00	210.00	0.00	0.00	15.00	30.00	35.00	40.00	45.00	45.00
4	Procurement of Forklift(6), Hand Trolly(488), Steel Rack(260x8=2080), Pallets Plastic(260X14=3640), Ladder(488), Steel Almirah (488)	7189 (nos)		600.00	600.00	0.00	0.00	0.00	195.00	185.00	120.00	50.00	50.00
5	External Security apparates (CCTV(30x33000), Search Light(30x8000)	30 (nos) 30(nos)		13.00	13.00	0.00	0.00	0.00	13.00	0.00	0.00	0.00	0.00
6	Safety and Protective Equipment for Warehouse Support Staff (Helmet, Gumboat, Utility Gloves Safete Reflective Vest	50x4=200 (nos)		30.00	30.00	0.00	0.00	0.00	10.00	0.00	10.00	0.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
7	Security of the 22 Warehouses, Logistics Unit = 1 and 307 constructed Upazila FP stores(number of constructed stores may increase in the years to come) through contract out to private firms / Deployment of Ansar/VDP members (44+10+614=668)	44088 (Month)	5990.00	5990.00	0.00	0.00	575.00	1083.00	1083.00	1083.00	1083.00	1083.00
	Sub Total		8631.00	8631.00	0.00	0.00	695.00	1631.00	1636.00	1603.00	1528.00	1538.00
(ii) Procurement planning execution and contract management												
1	Honorium for tender, evaluation committees, tender opening committees, advertisement Refreshment cost etc.	LS	600.00	600.00	0.00	0.00	50.00	100.00	100.00	110.00	120.00	120.00
2	Expenditure for holding Meeting (LCF, FWG, TEC Monthly Meeting)	60(nos)	6.00	6.00	0.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00
	Sub Total		606.00	606.00	0.00	0.00	51.00	101.00	101.00	111.00	121.00	121.00
(iii). Product Quality Assurance and Material Standardization												
1	Shipment Inspection(Post-Shipment and Pre-Shipment)/Product testing (lab test) / physically verification.	LS	300.00	0.00	300.00	0.00	50.00	50.00	50.00	50.00	50.00	50.00
2	Dehumidifire device for Humidity controll of FP Stores 510X1X20000	510 (nos)	104.00	104.00	0.00	0.00	0.00	104.00	0.00	0.00	0.00	0.00
	Sub Total		404.00	104.00	300.00	0.00	50.00	154.00	50.00	50.00	50.00	50.00
(iv). Commodity Shipment, Clearing and Delivery												

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1	Continue GOB Transport (POL) In selected Warehouses & Upazila stores(50% Area)	LS		745.00	745.00	0.00	0.00	60.00	125.00	140.00	140.00	140.00	140.00
2	Continue Private Transport In selected Warehouses & Upazila stores (contract out).(50%Area)	LS		1280.00	1280.00	0.00	0.00	110.00	225.00	230.00	240.00	235.00	240.00
3	Clearance of commodities from Sea/Land and Airport, Transport, Jetty Charge &Jetty Wharf rent , Survey Fee Custom& DF Vat, C&F Commisson, Shipping charges & etc.	LS		590.00	590.00	0.00	0.00	60.00	80.00	100.00	110.00	120.00	120.00
4	Procurement of Vehicle (SUV, Covered Van, Temperature Controlled Van/Insulated Van, Pick-up Van, Micro-Bus etc.	17(nos)		875.00	875.00	0.00	0.00	0.00	250.00	250.00	250.00	125.00	0.00
5	Customs duty, supplymentary texes,Value Added Tax (CD.ST.VAT)	LS		850.00	850.00	0.00	0.00	100.00	150.00	150.00	150.00	150.00	150.00
	Sub Total			4340.00	4340.00	0.00	0.00	330.00	830.00	870.00	890.00	770.00	650.00
(v). Supply Chain Management (warehousing, distribution and monitoring)													

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
1	Fixed trem service contract wit IT/Software Firms to support development of new software, smooth running of existing IT activities, troubleshooting, systems upgradation etc.	IT/Software Firms	50.00	0.00	50.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
2	Conduct physical Inventories & Commodity Audit(GOB)	3Firms	150.00	100.00	50.00	0.00	0.00	50.00	0.00	50.00	0.00	50.00
3	Maintanace of hardware and software	Firms	30.00	30.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00	5.00
4	(a) Fire Fighting Equipment-Extinguisher (488x1500) (b) Fire Fighting Bucket with stand (488x3x1000)	488 (nos) 1464(nos)	15.00	15.00	0.00	0.00	0.00	15.00	0.00	0.00	0.00	0.00
5	Procurement of Computer & Accessories, equipment, furniture etc.for warehouse and L&S Unit	200 (nos)	150.00	150.00	0.00	0.00	0.00	30.00	30.00	30.00	30.00	30.00
	Sub Total		395.00	295.00	100.00	0.00	5.00	110.00	45.00	95.00	45.00	95.00
(vi). Record keeping and Feedback mechanism												
1	Broad Band Internet System for CWH(WIFI 10000x60 month), Router (5x2x5000)	60(month)	15.00	15.00	0.00	0.00	2.00	2.00	2.00	3.00	3.00	3.00
2	Logistics -MIS(Review, Revise and implemtent reporting system) Forms & Registers	3500 (nos)	59.00	59.00	0.00	0.00	0.00	20.00	0.00	20.00	0.00	19.00
	Sub Total		**74.00**	**74.00**	**0.00**	**0.00**	**2.00**	**22.00**	**2.00**	**23.00**	**3.00**	**22.00**

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
(vii). Capacity Building & Technical Assistance													
1	Training : Procurement, Logistics Management, Computer course, Supply Chain Management, Invantory, L/C, incterm etc.	40 (persons)		150.00	0.00	150.00	0.00	0.00	30.00	30.00	30.00	30.00	30.00
2	Training :Refresser Store/Warehouse Management (600 Persons x 5000-2 years)	1200 (nos)		120.00	120.00	0.00	0.00	0.00	60.00	0.00	0.00	60.00	0.00
3	Software Training Computerized Software Inventory Management e.g.WIMS&UMIS (600 persosn x 5000 x 2 years)	600 (nos)		60.00	60.00	0.00	0.00	0.00	0.00	30.00	30.00	0.00	0.00
4	Workshop: Supply Chain Management ,Logistics Management, and Procurement Management and Bidder Orientaion	11(nos)		55.00	0.00	55.00	0.00	5.00	10.00	10.00	10.00	10.00	10.00
5	Study Tour : Exposer visiting at foreign pharmaceuticals manufacturing plants and experience sharing.	30(persons)		75.00	0.00	75.00	0.00	5.00	14.00	14.00	14.00	14.00	14.00
	Sub Total			**460.00**	**180.00**	**280.00**	**0.00**	**10.00**	**114.00**	**84.00**	**84.00**	**114.00**	**54.00**
(viii). e-Procurement and Web based information system													
1	Capacity building on e-Procurment	12 (nos)		60.00	30.00	30.00	0.00	10.00	10.00	10.00	10.00	10.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
2	Supply Chain workshop to build capacity on SCMP, Web based Reporting systems and increase the utilization of data for decision making	5 (nos)	25.00	25.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
	Sub Total		**85.00**	**55.00**	**30.00**	**0.00**	**10.00**	**15.00**	**15.00**	**15.00**	**15.00**	**15.00**
(ix). Infrastructure Development & Maintenance												
1	Renting 40,000 sft of Storage Space for the interim construction period of CWH / build tin-shaded semmi-pakka building to use in the interim construction period of CWH	160000 (sqft)	650.00	650.00	0.00	0.00	0.00	0.00	220.00	220.00	210.00	0.00
	Sub Total		**650.00**	**650.00**	**0.00**	**0.00**	**0.00**	**0.00**	**220.00**	**220.00**	**210.00**	**0.00**
	Grant Total		15645.00	14935.00	710.00	0.00	1153.00	2977.00	3023.00	3091.00	2856.00	2545.00

11. Budget support from other Operational Plan: Not applicable

4.10 Human Resources Development (HRD)

1. **Name of the Operational Plan:** Human Resources Development (HRD)
2. **Implementing Agency: MOHFW**
3. **Introduction**

Bangladesh will strive to attain a number of targets in the road towards universal health coverage, consistent with the proposed major targets under the proposed UN Sustainable Development Goals (SDG) framework. Promoting and sustaining health and nutrition along with containing population growth are priorities in the human development strategy. Vision 2021 envisions a middle-income Bangladesh with drastic reduction in poverty and with conditions that allows individuals to reach and maintain the highest attainable level of health. To improve service delivery and utilize the vast health network, various innovative approaches will be explored. It will comprise of reviewing existing field-based service delivery, decentralization of the management of facilities including involvement of local government institutions like Upazila Parishad and providing autonomy to hospitals by protecting the interests of poor; updating of essential service package (ESP) at different tiers of health service delivery; diversification of service provision (inclusive of public-private partnership) particularly for hard-to-reach areas; development of a functional referral system involving all levels of facilities; ensuring quality of care targeting universal health coverage (UHC).

Health workforce is critical but vital component of the health system. Health system performance is heavily dependent on the workforce. In order to make the system responsive and functional, proper management of the workforce is important. However, management of the workforce in all sectors at all level is still remaining critical in terms of maintaining service quality and efficient management of resources.

The key Human Resource Management (HRM) functions include institutional education of Health Workforce (HWF), in-service training and development, as well as recruitment and retention. Entities like medical and dental colleges, nursing colleges and nursing institutes, homeopathy, ayurvedic and uniani colleges, medical assistants' and family welfare visitors' training institutes and institutes of health assistants provide institutional or pre-service education for the HWF in the country. These institutes, both from public and private sectors, play a vital role in producing the required number of HWF. However, there are issues regarding quality of education of some of these institutes posed by insufficient number of teaching faculty, inadequate laboratory/clinical facilities, teaching methods and inadequate supervision by the governing entities. Medical Education section of PIP further illustrates these issues.

The sanctioned posts of MOHFW and its agencies are close to 140,000 (Health Bulletin, 2015). Directorate General of Health Services (DGHS) and Directorate General Family Planning (DGFP) are the principal recruiters, employing 56% and 29% of the total HWF respectively. Directorate General of Nursing & Midwifery (DGNM) also manages around 13% of the HWF. Considerable recruitments were made (42,000 positions) during HPNSDP period, which include recruitment of 7,000 doctors and 4,100 nurses. However, some of the recruitment rules and policies were formulated in 1980s and 1990s and have not been updated in recent years. In spite of significant number of recruitment in recent times, there is still considerable shortage of human resources, especially in terms of nurses, medical technicians and ancillary workers. Shortage of manpower also impacts on maintenance of infrastructure and equipment, more so for regular preventive maintenances, including cleaning.

Retention of HWF, especially the physicians and nurses in remote and hard-to-reach (HTR) areas has been a challenge for MOHFW. Location of the facilities, lack of proper infrastructure and utilities,

insufficient logistics and social support system discourage the retention of the human resources in HTR areas. Staffing pattern of HWF traditionally depends on the category of the health facility rather than on service utilization status, disease pattern, demographic distribution or geographic location. As a result, position of HWF in urban areas is more skewed than in the rural areas. This creates imbalance in workload distribution in different geographic locations. Due to different nature of work in HNP sector in comparison with other sectors, the performance appraisal system followed for HWF is not always appropriate. The career progression path for HWF is not clear for different categories of human resources. The action plan of the approved HWF strategy – now under development will address these issues to improve service delivery to be able to achieve the goal of universal health coverage.

There was a specific OP in HPNSDP targeting in-service training (IST). Apart from that, there were significant resources allocated for all the OPs to arrange capacity building programs for the respective human resources. This modality was helpful as the periodic reviews of HPNSDP (APIRs and SmPRs) indicated significant progress in in-service training from almost all the OPs. **For instance in 2015/16 a total of 551,363 participants took part in training and workshop/seminars, of which over 217,224 attended in-country training programs.** While it is recognised that upgrading and refresher courses are important within the system the new Program would continuously review and assess the need for high proportion of short (1-3 days) workshop/orientation style trainings and the effectiveness. A training need assessment was conducted during the latter part of HPNSDP, with a view to developing comprehensive in-service training plan for the HWF in future.

Some of the entities under MOHFW execute specialized functions like evidence collection, procurement, supply chain management and human resources management. However, specialized resources are not recruited in these entities. Often, the sanctioned positions are filled with existing medical or admin officers through deputation. Since these resources do not have the specialized skills, the gap is met through short term technical assistances and consultancies. Key positions like statisticians, F.M or M&E personnel, procurement expert, supply chain managers, hospital administrators human resources managers, etc. need to be filled in with resources having appropriate skills and knowledge.

Monitoring of HWF is a challenge for MOHFW partly due to lack of information. DGHS, DGFP and DGNM use separate information platform to record HR information. The aforementioned three platforms have different protocols and are at different levels of implementation. The absence of a common and integrated Human Resources Information System (HRIS) challenges proper HR planning. HRM unit of MOHFW has developed Central-HRIS. Now it is in implementing and it is expected that MOHFW will have a clearer picture to improve HR interventions like career planning, capacity development and deployment using the Central HRIS.

During the 4th SWAp period the following key activities will be pursued for overcoming the challenges described above and for improving the situation of Human Resource Management in Bangladesh HNP sector:

(x). The approved HWF Strategy will be implemented through the 5-year comprehensive HWF Action Plan.

(xi). The organogram of all health and family planning facilities will be reviewed and updated.

(xii). Steps will be taken to address the shortage of human resources and the issues of skill mix, including that of ratio imbalance in the light of the HWF strategy and HWF action plan.

(xiii). Community participation and engagement of private sector will be explored in addressing shortage of human resources and provision of quality service through expanding the Chaugachha and Jhenaidah model.

(xiv). Public and private pre-service health workforce education system (including for Alternative Medical Care (AMC) providers) will be improved through the steps as mentioned in the "Medical Education" section.

(xv). In-Service Training (IST) will be based on an approved training master plan and IST will be linked with career development.

(xvi). Quality assurance of medical education at both private and public sector institutions will be strengthened through licensing and accreditation.

(xvii). Job descriptions of HWF at different level of services will be rationalized based on changing needs.

(xviii). Recruitment and retention planning, including incentives (non-financial) will be addressed to overcome distribution issues particularly for underserved/disadvantaged areas, appraisals and through career planning.

(xix). The Central-HRIS will be operationalized and all departments/ offices under MoHFW will be in same platforms.

4. Objectives

(i). Ensure availability of competent and adequate number of workforce as per health systems need;

(ii). Produce, develop and sustain quality health workforce at all level, by increasing the production capacity, improving the quality of education and training.

(iii). Recruit, deploy and retain health workforce equitably by rationalizing the recruitment rules, job description and career planning.

(iv). Promote and maintain high standards in health workforce performance through and performance management system and monitoring

(v). Use health resource information system (HRIS) to support decision making in improving health outcomes.

5. Components

Component-1: HWF strategy, HR Plan and Policy

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

The Health Policy 2011 acknowledges the contribution of the alternative medical practitioners such as the Homeopaths, Unani and Ayurvedic doctors. In addition, it is difficult to engage with the more than 300,000 informal providers, though associations of informal providers exist. Regulation of the for-profit and not-for-profit formal providers is constrained by the practicalities of the execution of the

regulations (e.g. lack of capacity of the regulatory bodies). Some providers fall within the jurisdiction of other ministries (e.g. Ministry of local Govt.). Nevertheless, the MOHFW, as the country's single biggest health workforce employer, can strive to lead developments, if not entirely manage them.

Activities:

1. Implementation of Health Workforce Strategy
2. Review and update the Health Workforce Strategy addressing private and informal sector.
3. Finalize and implement 5-Year comprehensive Health Workforce Action Plan Review the organogram of all health and family planning facilities and entities
4. Address shortage and skill mix, including ratio imbalance, task shifting addressing HWF strategy.
5. Develop and implement policy on outsourcing service delivery.
6. Developing an effective and fair HRM policies particularly policies on recruitment, deployment, transfer and promotion
7. Develop and implement policy related to HR in areas of financial and non-financial incentives, contracting in & contracting out of HR in hard-to-reach/rural areas.

Component-2: Production and Development of Health Workforce

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

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

Activities:

1. Improve quality of public and private pre-service health workforce education system (including for AMC providers)
2. Integrated in-service training, linked with career development.
3. Capacity development to ensure better management within district level and below
4. Introduce and/or strengthen quality assurance of medical education at both private and public

sector institutions through licensing and accreditation

5. Review professional licensing and accreditation of health professionals

Component-3: Recruitment, Deployment and Retention of Health Workforce.

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

Activities:

1. Rationalize job descriptions of HWF at different level of services based on changing needs
2. Recruitment and retention planning, including incentives to address distribution issues particularly for underserved/disadvantaged areas, appraisals and career planning.
3. Introduce innovative, unbiased and decentralized health workforce deployment and transfer system.
4. Gender sensitive HWF planning and implementation
5. Monitoring and coordination of the recruitment processes

Component-4: Performance Management System and Monitoring of Health Workforce

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

In the public sector, a traditional type of individual performance management system i.e. annual confidential report (ACR) is in practice for the public servants. Though the concerned authority is assessing how to introduce better management tools still no significant process has been made. Performance management function is still thought as an administrative task with no or little strategic impact on decision-making. There are many drawbacks of the present practice. Under the current framework of assessment, there is no scope of the supervisee to see the evaluation of his/her

supervisor that diminishes the level of confidence in the process, which ultimately affects performance. Maintaining fairness through proper transparent performance management processes at both public and private sectors are critical for health workforce management.

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

Activities:

1. Introduce and scaling up of performance management system with performance appraisal.
2. Capacity development of individual and facilities/ institutions for Individual & Institutional performance management.
3. Implementation of accreditation of training institutions
4. Monitoring, evaluation and coordination of training components of various OPs relating to HRH.

Component-5: Central Human Resource Information System (CHRIS)

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

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

Activities:

1. Establish one central HRIS that is linked to national HRIS.
2. Establish monitoring framework for implementation of HWF Action Plan.
3. Use of HRIS data for evidence-based planning and decision making.

6. Cross-Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc:

Gender balance

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

Motivation

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

Partnership

Health and family welfare services are collectively contributed by the both state and non-state actors. Adopting a partnership approach has been found to be useful for this strategy, which will create provisions to work collaboratively with stakeholders. A partnership approach is also conducive in order to create a high performance work culture at the work places.

Transparency and accountability

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

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services: Annexed in Volume-II

9. Indicators:

Sl	Indicators	Unit of Measurement (Means of verification)	Base line with Source	Projected Target	
				Mid of the Program (By June 2020)	End of the Program (By June 2022)
1	2	3	4	5	6
1.	Review and update TO&E for health facilities and organizations (2019) and implemented (by 2021).	Process (Admin report)	NA	Developed and implemented	Implemented

Sl	Indicators	Unit of Measurement (Means of verification)	Base line with Source	Projected Target	
				Mid of the Program (By June 2020)	End of the Program (By June 2022)
1	2	3	4	5	6
2.	Utlized Human Resources Information System (HRIS) for evidence based decision.	Process (Admin report)	NA	HRIS established and data entered	HRIS is utilized for HRM
3..	Percentage of public Health facilities offering normal delivery services with at least on staff trained on routine care for labor and delivery during past 24 months	Percentage	9.9%, BHFS 2014 11.5 %	30%	75%
4..	Percentage of service provider positions functionally vacant in public facilities, by category (physician, nurse/midwife, paramedics)	Percentage (BHFS 2014)	Physician: 30.5%, Nurse/MW: 7.8%, Paramedic: 7.1%, BHFS 2014	Physician: 22%, Nurse/midwife: 5.5%, Paramedic: 4%	Physician: 15%, Nurse/midwife: 04%, Paramedic: 4%

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
2737.97	3552.50	0.00	3552.50	6290.47	

10.2. Component and activity wise physical and financial target of OP: HRD

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1	Pay and Allowance												
a	Pay of Officer	15		394.42	394.42	0.00	0.00	12.05	24.10	83.12	87.28	91.64	96.23
b	Pay of Staff	31		273.08	273.08	0.00	0.00	8.53	17.06	57.42	60.29	63.31	66.47
c	Allowance	46		754.97	754.97	0.00	0.00	27.34	53.13	158.12	165.52	172.02	178.84
2	Supply and Service (except Research, Training, Workshp and consultancy)			1500.00	500.00	1000.00	0.00	150.00	300.00	300.00	300.00	300.00	150.00
3	Repair and Maintenance			57.00	57.00	0.00	0.00	3.00	6.00	12.00	12.00	12.00	12.00
4	Procurement												
a	Motor Vehicles	2		100.00	0.00	100.00	0.00	0.00	0.00	100.00	0.00	0.00	0.00
	Equipment & Others	As per list		59.00	15.00	44.00	0.00	3.00	6.00	9.00	9.00	13.00	19.00
b	Computer & Accessories	As per list		118.00	23.00	95.00	0.00	3.00	6.00	25.00	29.00	30.00	25.00
c	Office Equipment	As per list		27.00	7.50	19.50	0.00	1.50	2.50	7.00	12.00	2.00	2.00
d	Furniture & Fixtures	As per list		73.00	15.00	58.00	0.00	3.00	6.00	13.00	13.00	20.00	18.00
5	5. Component and Activities												
Component 1: HWF strategy, HR Plan and Policy													
1	Implementation of Health Workforce Strategy	Meeting-4 Workshop-4		10.00	2.00	8.00	0.00	0.00	0.00	5.00	0.00	0.00	5.00
2	Review and update the Health Workforce Strategy addressing private and informal sector.	TA-1, Meeting-4 Workshop-6		14.00	2.00	12.00	0.00	0.00	0.00	7.00	7.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
3	Finalize and implement 5-Year comprehensive Health Workforce Action Plan, costed and prioritized.	TA-1, Meeting-10 Workshop-10		25.00	5.00	20.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
4	Review the organogram of all health and family planning facilities and entities	TA-1, Meeting-10 Workshop-5		15.00	5.00	10.00	0.00	0.00	3.00	3.00	3.00	3.00	3.00
5	Address shortage and skill mix, including ratio imbalance, task shifting addressing HWF strategy.	*Study-1 Meeting-8 Workshop-12		28.00	4.00	24.00	0.00	0.00	0.00	9.00	9.50	9.50	0.00
6	Develop and implement policy on outsourcing service delivery.	*Study-1 Meeting-8 Workshop-8		20.00	4.00	16.00	0.00	0.00	0.00	10.00	10.00	0.00	0.00
7	Developing an effective and fair HRM policies particularly policies on recruitment, deployment, transfer and promotion	TA-1, Meeting-6 Workshop-10		23.00	3.00	20.00	0.00	4.50	4.50	7.00	7.00	0.00	0.00
8	Develop and implement policy related to HR in areas of financial and non-financial incentives, contracting in & contracting out of HR in hard-to-reach/rural areas.	*Study-1, Meeting-4 Workshop-6		14.00	2.00	12.00	0.00	0.00	0.00	7.00	7.00	0.00	0.00
9	Revisit and update recruitment, deployment and retention policy.	TA-1, Meeting-22Workshop-20		51.00	11.00	40.00	0.00	0.00	10.00	10.00	10.00	10.50	10.50
Component-2: Production and Development of Health Workforce													

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
1	Improve quality of public and private pre-service health workforce education system (including for AMC providers)	TA-1, Meeting-10 Workshop-20		45.00	5.00	40.00	0.00	0.00	9.00	9.00	9.00	9.00	9.00
2	Integrated in-service training, linked with career development.	TA-1, Meeting-10 Workshop-16		37.00	5.00	32.00	0.00	0.00	0.00	9.00	9.50	9.50	9.00
3	Capacity development to ensure better management within district level and below												
	LOCAL TRINING												
	a) Short Course	1550p		232.00	78.00	154.00	0.00	22.00	30.00	45.00	45.00	45.00	45.00
	b) Long Course	60p		268.00	134.00	134.00	0.00	28.00	40.00	50.00	50.00	50.00	50.00
	FOREIGN TRAINING												
	a) Short term training	40p		320.00	0.00	320.00	0.00	0.00	80.00	80.00	80.00	80.00	0.00
	b) Medium term training	4p		20.00	0.00	20.00	0.00	0.00	10.00	10.00	0.00	0.00	0.00
	c) Long term training	2p		60.00	0.00	60.00	0.00	0.00	0.00	30.00	30.00	0.00	0.00
4	Introduce and/or strengthen quality assurance of medical education at both private and public sector institutions through licensing and accreditation	TA-1, Meeting-12 Workshop-20		46.00	6.00	40.00	0.00	0.00	9.00	9.00	9.00	9.50	9.50
5	Review professional licensing and accreditation of health professionals	TA-1, Meeting-12 Workshop-20		46.00	6.00	40.00	0.00	0.00	9.00	9.00	9.00	9.50	9.50
6	Strengthen HRM Unit through restructure and linkage	Meeting-12 Workshop-10		26.00	6.00	20.00	0.00	0.00	5.50	5.50	7.50	7.50	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Component-3: Recruitment, Deployment and Retention of Health Workforce													
1	Rationalize job descriptions of HWF at different level of services based on changing needs	TA-1, Meeting-20 Workshop-30		70.00	10.00	60.00	0.00	5.00	14.00	14.00	14.00	14.00	9.00
2	Recruitment and retention planning, including incentives to address distribution issues particularly for underserved/disadvantaged areas, appraisals and career planning.	*Study-1 TA-1 Meeting-20 Workshop-15		40.00	10.00	30.00	0.00	5.00	6.00	8.00	8.00	8.00	5.00
3	Introduce innovative, unbiased and decentralized health workforce deployment and transfer system.	*Study-1 TA-1 Meeting-8 Workshop-10		24.00	4.00	20.00	0.00	0.00	5.00	7.00	7.00	5.00	0.00
4	Gender sensitive HWF planning and implementation	TA-1, Meeting-4 Workshop-5		12.00	2.00	10.00	0.00	0.00	2.50	2.50	2.50	2.50	2.00
5	Monitoring and coordination of the recruitment processes	Meeting-12Workshop-24		54.00	6.00	48.00	0.00	2.50	11.50	11.50	11.50	9.00	8.00
Component-4: Performance Management System and Monitoring of Health Workforce													
1	Introduce and scaling up of performance management system with performance appraisal	TA-1, Meeting-10 Workshop-20		45.00	5.00	40.00	0.00	4.50	9.00	9.00	9.00	9.00	4.50
2	Capacity development of individual and facilities/ institutions for Individual & Institutional performance management.	TA-1, Meeting-10 Workshop-20		45.00	5.00	40.00	0.00	4.50	9.00	9.00	9.00	9.00	4.50

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
3	Implementation of accreditation of training institutions	TA-1, Meeting-10 Workshop-18		41.00	5.00	36.00	0.00	2.50	9.00	9.00	9.00	9.00	2.50
4	Monitoring, evaluation and coordination of training components of various OPs relating to HRH.	TA-1, Meeting-10 Workshop-20		45.00	5.00	40.00	0.00	4.50	9.00	9.00	9.00	9.00	4.50
5	Accountability framework	TA-1, Meeting-8 Workshop-10		24.00	4.00	20.00	0.00	0.00	5.00	5.00	5.00	5.00	4.00
Component-5: Central Human Resource Information System (CHRIS)													
1	Establish one central HRIS that is linked to all agencies	Meeting-11 Workshop-20		62.00	22.00	40.00	0.00	6.00	8.00	12.00	12.00	12.00	12.00
2	Establish monitoring framework for implementation of HWF Action Plan.	Meeting-11 Workshop-20		61.00	21.00	40.00	0.00	5.00	8.00	12.00	12.00	12.00	12.00
3	Use of HRIS data for evidence-based planning and decision making.	Meeting-11 Workshop-20		61.00	21.00	40.00	0.00	5.00	8.00	12.00	12.00	12.00	12.00
4	Research/Survey/Study			800.00	200.00	600.00	0.00	0.00	200.00	200.00	200.00	200.00	0.00
5	Seminar/Conference/ Training required for Implementation of HWF			250.00	100.00	150.00	0.00	15.00	50.00	65.00	60.00	40.00	20.00
	Total			6290.47	2737.97	3552.50	0.00	325.42	989.79	1469.16	1375.59	1307.47	823.04

11. Budget support from other Operational Plan: Not applicable

4.11 Medical Education and Health Manpower Development (ME&HMD)

1. **Name of Operational Plan: Medical Education and Health Manpower Development (ME&HMD)**
2. **Implementing Agency: Directorate General of Health Services (DGHS)**
3. **Introduction**

Situation Assessment:

Health care is a labor-intensive service industry. Health workforce (HWF) are the personification of the system's core values – they heal and care for people, ease pain and suffering, prevent disease and mitigate risk – the human link that connects knowledge to health action. HWF spearheads and glues together the different components of health system. At the heart of each and every health system, the workforce is central to advancing health. There is ample evidence that worker numbers and quality are positively associated with health outputs. In health systems, workers function as gatekeepers and navigators for the effective, or wasteful, application of all other resources such as drugs, vaccines and supplies.

HWF covers very wide varieties–specialists of various disciplines, teachers of different HWF training institutes, researchers, managers, general duty physicians, nurses, midwives, paramedics (medical assistant, community paramedic), technologist of various disciplines etc. Medical education has expanded very rapidly in last few years both in public and private sectors covering post-graduate courses, graduate courses, medical assistants and technologists. The country currently has 33 postgraduate medical teaching institutes (23 government and 10 non-government), 100 medical colleges (36 government and 64 non-government), 33 dental colleges (9 government and 24 non-government), 176 medical assistant training schools (8 government and 168 non-government) and 112 institute of health technology (8 government and 104 non-government).

National Health Policy (NHP) 2011 recognized Bangladesh as one of 57 countries of the world with critical shortage in HWF. It also mentioned that though international standard of doctor, nurse ratio is 1:3, but the situation in Bangladesh was 1:0.48 and termed that as unacceptable. It also recorded that though the recognized ratio of doctor, nurse and other HWF was 1:3:5, the picture was completely different in Bangladesh. Thirteenth main objective of the NHP 2011 is modernization and updating as per need of the country of all medical, nursing, medical technologist and health paraprofessional education. Human resources development and management is mentioned as challenge in NHP 2011. Strategies of NHP 2011 include development of HWF strategy to tackle shortage, mal-distribution, skill-mix imbalance.

Total number of sanctioned posts under DGHS is 126,727. They are of varied categories and spread all over the country. As medical science is changing with the new knowledge replacing old, so also technologies are fast evolving – both demand these vast HWF need to be continuously trained and re-trained to provide qualitative care. However as most of government departments have their own training institutes, DGHS seems to be the odd! It doesn't have any training institute of its own creating enormous difficulty to equip its vast HWF with the knowledge and skill required to discharge their responsibilities.

Challenges

1. Post-graduate medical qualifications are awarded by two different authorities – Bangladesh College of Physicians and Surgeons (BCPS) awarding membership (MCPS) and fellowship

(FCPS); and Bangabandhu Sheikh Mujib Medical University (BSSMU) offering MS, MD, M.Phil, Diploma, MPH etc. The plurality of post-graduate medical qualifications leads to wastage and duplication and confusing general people.

2. Public health education is still limited considering the enormous need of the country.
3. A *Lancet* Commission highlights for major reform in the training of doctors for the 21st century. Changes are needed because of fragmented, outdated, and static curricula that produce ill-equipped graduates. The Commission argues for major reform across the entire medical education system, in order to produce competency-led curricula for the future. World Federation for Medical Education (WFME) also developed the WFME Trilogy: Global Standards for Quality Improvement of Medical Education, covering Basic (Undergraduate) Medical Education (BME).
4. Due to very fast expansion of medical colleges, government institutions are suffering from inadequate physical facilities, shortage/lack of teachers and other HWF, particularly of basic sciences and non-government institutes lack adequate patients, both affecting the quality of medical education. Since regulatory authorities (ME & HMD, DGHS; Bangladesh Medical and Dental Council – BMDC and respective public universities) capacities have not grown with pace of fast expansion of medical colleges, compliances of regulatory requirements are seriously compromised affecting effective medical education.
5. Centre for Medical Education (CME)'s efforts for improving quality of medical education is very limited within the public sector only.
6. To address NHP 2011 about skill-mix imbalances, the country needs more medical assistant schools and institutes of health technology. State Medical Faculty (SMF), the body that conducts examinations and issue certificates for medical assistants and different disciplines diploma health technologists has no legal basis. Moreover SMF don't cover all the disciplines like physiotherapy. On the other hand, Bangladesh Technical Education Board under Ministry of Education permitted non-government institutions to conduct certificates courses of one year duration along with diploma courses. This has created confusions and resulted with court case. Currently certificate, diploma, graduate and masters courses are offered in various disciplines of health technology. All are competing for the same job and no career progression is available.
7. Not having own training institutes and providing vast number of varied categories of HWF spreading all over Bangladesh need based training is a great challenge, however upon which proper service delivery is dependent.

4. Objectives

i. Streamlining post-graduate medical education in Bangladesh

ii. Expansion of public health education in Bangladesh to cater the need of the country

iii. Ensuring qualitative graduate medical education in Bangladesh

iv. Ensuring qualitative para-professionals education in Bangladesh

v. Ensuring proper health manpower development through need based in-service training.

5. Components

Component-1: Post-Graduate medical education

Post-graduate qualifications are awarded by two different authorities – Bangladesh College of Physicians and Surgeons (BCPS) awarding membership (MCPS) in 16 disciplines and fellowship (FCPS) in 47 disciplines (22 general and 25 specialized); and Bangabandhu Sheikh Mujib Medical University (BSSMU) offering MS (in 18 disciplines), MD (in 27 disciplines), M.Phil (7 disciplines), Diploma (13 disciplines), MPH (4 disciplines), MTM, MMED. In many disciplines 4 different types of post-graduate qualifications are offered, leading to wastage and duplication and confusing patients. On the other hands, many disciplines have only 1course. Physicians under DGHS get the opportunities of pursuing post-graduate qualification through deputation, the period in which they are fully paid with salaries and other benefits. However physicians choose the discipline to pursue higher education and DGHS doesn't control as per its need. Specialists are mostly not available in upazilas, medical colleges are facing acute shortage of teachers, particularly of basic sciences, comprehensive emergency obstetrical care are closing down at upazila health complexes due to scarcity of anesthesiologists.

Activities

1. A committee drawing people from BCPS, BSMMU, BMA and eminent health sector personalities will be formed for streamlining the post-graduate medical education of the country. LD, ME&HMD will provide secretarial assistance to get the work done.
2. A committee will be formed comprising representatives from the MOHFW, BCPS, BSMMU, BMA and eminent personalities of health sector to develop guidelines for deputation to pursue post-graduate medical education for the government physicians. LD, ME&HMD will provide secretarial support for the development of the guidelines and after development get the same approved by the competent authority and implement the same.
3. BCPS and BSMMU will act as cost centers under this OP and will receive grant allocation for the development of quality of post-graduate medical education.
4. Support research activities for post graduate students in different government medical colleges and post graduate institutions.

Component-2: Public health education

Public health education is still limited considering the enormous need of the country. Not only the education needs to be expanded covering different levels (certificates, graduate along with currently predominant post-graduation) and different disciplines (health services management, policy formulation, planning etc.). Effective public health professionals in adequate numbers can contribute significantly in achieving universal health coverage.

Activities

1. NIPSOM will be entrusted with the responsibilities of expanding public health education covering different levels and disciplines. As a cost center under this OP, NIPSOM will receive grant allocation to discharge its responsibilities assigned.

Component-3: Graduate medical education

Due to very fast expansion of medical colleges, government institutions are suffering from inadequate physical facilities, shortage/lack of teachers and other HWF, particularly of basic sciences and non-government institutes lack adequate patients, both affecting the quality of medical education. Since regulatory authorities (ME & HMD, DGHS; BMDC and respective public universities) capacities have not grown with pace of fast expansion of medical colleges, compliances of regulatory

requirements are seriously compromised affecting effective medical education. Medical teachers often face the conflict of teacher and practicing physician affecting quality medical education. Moreover they are not acquainted with the teaching methodologies. Centre for Medical Education conducting Master in Medical Education (MMED) courses and some short courses, which are very negligible and mostly limited to government sector. The current Residential Field Site Training required by the Community Medicine course is almost non-complied. However students need to engaged with the community for their proper education. Single entrance examination is conducted by the D, ME & HMPD of DGHS from which qualified get admitted into government and non-government medical colleges. However existing entrance examination is based on 100 mark MCQs together with SSC and HSC grades are weighted. Both can only judge academic performance, which may not be the sole criteria for medical student selection. Since the rapid growth of medical colleges resulted with capacity constrains in medical colleges, particularly those established in last few years, introduction of qualifying examination before awarding registration (temporary and/or permanent) to ensure quality of services may be considered. Currently this is in practice for those passing from non-approved (by BMDC) medical colleges (mostly from abroad). Absence of any accreditation body is also detrimental in ensuring quality medical education. A *Lancet* Commission highlights for major reform in the training of doctors for the 21st century. Changes are needed because of fragmented, outdated, and static curricula that produce ill-equipped graduates. The Commission argues for major reform across the entire medical education system, in order to produce competency-led curricula for the future. World Federation for Medical Education (WFME) also developed the WFME Trilogy: Global Standards for Quality Improvement of Medical Education, covering Basic (Undergraduate) Medical Education (BME). Though more than 100 medical colleges exist yet coordination and cooperation among those is very limited. Greater cooperation for academic, extra-curricular and social engagement will contribute to become more humanistic physician and society will also benefit from that.

Activities

1. Priority initiatives will be undertaken to expedite project implementation of the newly set-up government medical colleges together with post-creation and deployment of HWF for effective functioning of the medical colleges.
2. Provision of vehicle for the Principals of all government medical colleges.
3. A committee will be formed comprising representatives from the MOHFW, DGHS, BMDC, BMA and concerned public universities to agree minimum criteria for operating non-government medical colleges.
4. Task-forces will be formed to undertake regular visits to the non-government medical colleges for ensuring compliances as agreed by the above formed committee, otherwise disciplinary actions to be initiated.
5. D, ME & HMPD, DGHS current structure will be reviewed in the light of its mandates and workload and initiatives will be undertaken for implementation of revised structures for effective functioning.
6. CME will be a cost center under this OP. Initiatives will be undertaken through CME for setting up its outreach campuses in few government medical colleges for conducting MMED courses and short courses. Appropriate faculties will be developed. Non-government medical colleges will be encouraged to participate in these initiatives.

7. Support Community Oriented Medical Education (COME) for the 3rd year medical and 2nd year dental students under community medicine department of all government medical and dental colleges and dental units.
8. Each medical college will have a designated area in and around or the close vicinity of the medical college, where students will make periodical visits and engaged with the community, particularly slum/poor population. D, ME & HMPD, DGHS will facilitate area allocation among the medical colleges to avoid duplication and conflict. This provision will replace the currently non-compliance RFST required for community medicine course while revising the MBBS curriculum.
9. A committee will be formed for exploring the introduction of assessment for aptitude and attitude in the medical entrance examination.
10. Discussions and consultations will be initiated to explore introduction of qualifying examination before awarding registration (temporary and/or permanent) to ensure quality of services.
11. Initiatives will be undertaken to set up an autonomous accreditation body to ensure quality medical education in the country.
12. Initiatives will be undertaken to ensure improved cooperation and coordination among the medical and dental colleges from both government and non-government. Areas of cooperation will include academic, extra-curricular activities (both sports and cultural) and social responsibility engagement.
13. A committee will be formed for suggesting the possible revision of existing MBBS curricula taking into consideration of the Lancet Commission report and WFME Trilogy for producing medical graduates of international standards.

Component-4: Para-professional education

To address NHP 2011 about skill-mix imbalances, the country needs more medical assistant schools and institutes of health technology. State Medical Faculty (SMF), the body that conducts examinations and issue certificates for medical assistants and different disciplines diploma health technologists has no legal basis. Moreover SMF doesn't cover all the disciplines like physiotherapy. On the other hand, Bangladesh Technical Education Board under Ministry of Education permitted non-government institutions to conduct certificates courses of one year duration along with diploma courses. This has created confusions and resulted with court case for which recruitment of technologists by DGHS is halt creating enormous difficulties in service provision. Currently certificate, diploma, graduate and masters courses are offered in various disciplines of health technology. All are competing for the same job and no career progression is available. Like medical colleges, very fast expansion of medical assistant schools and institute of health technologies both in government and non-government created capacity constrains affecting quality of education.

Activities

1. Assessment of existing situation of medical assistant and health technologists (covering various disciplines) will be undertaken with requirement projections for 2030 and appropriate actions will be undertaken as per findings and recommendations of the assessment.
2. Efforts will be undertaken to pass a new law on priority basis for forming a legal body to conduct examinations and registering health technologists covering all the disciplines
3. Appropriate measures will be undertaken to resolve the issue with BTEB.

4. Assessment of existing situation of different courses of health technologists in various disciplines will be undertaken together with requirement projections for 2030 and appropriate initiatives will be undertaken following the findings and recommendations.
5. Priority initiatives will be undertaken to make all the government medical assistant training institutes and institutes of health technology to deploy adequate faculties and other HWF, supplies the other requisites including physical facilities so that quality education is ensured.
6. Tasks forces will be formed for regular periodic visits to the non-government medical assistant training schools and institutes of health technologies for ensuring proper compliances as laid down in the relevant guidelines resulting quality education

Component-5: Health Manpower Development

All most all the government departments have their own training institutes to train/re-train their workforce. National Academy for Planning, National Academy for Educational Management, BCS (Administrative) Academy, Bangladesh Institute of Administration and Management are some of the examples. Unfortunately DGHS has no such institute which deters the training capacity very much required to provide efficient and quality service. Efforts to construct Bangladesh Institute of Health Management (BIHM) didn't progress under HPNSDP. Technical Training Unit (TTU) established prior to 1998 is yet to transfer into the revenue. In absence of Training Management Information System (TMIS) there is no follow-up of trained personnel resulting acute shortage of anaesthesiologists, though many are trained for many years.

Physicians entering into the public service through the Bangladesh Civil Service examinations are often unaware of their roles and responsibilities, rights and obligations and this not only hampers proper service delivery by them but also give rise other problems. They are invited to undergo Foundation Training, a prerequisite for confirmation of job for all entrants into the civil service, often spending sometimes in the service.

Different promotes like Upazila Health and Family Planning Officer (UHFPO), Civil Surgeon (CS), Hospital Assistant/Deputy/Director, Director, Line Director, Principal (of IHT, MATS, Medical Colleges) are posted without any orientation to their newly assisssgned managerial roles. This puts the incumbent, in most cases, in difficult situation to perform optimally.

Health service plays an important role in the legal system by providing medico-legal opinion after the examination of victim of different types of injury/assault and rape, age determination, post-mortem etc. However these are carried out in the upazila and district by the medical officers who are neither fully equipped nor interested, in most cases and thus suffer from qualitative issues. Physician is taught forensic medicine in 3rd/4th year of MBBS course. During internship physician is not oriented in forensic medicine. Thus when they are asked to deal these cases at upazila or district level, they are not in touch with the subject for at least few years. Adding their disinterest to the issue in most of the cases, the important contribution from health service to the judiciary for the establishment of justice often suffers. Supreme Court has a verdict to post adequate female medical officers so that rape victims are only examined by them.

In the each sector program, new issues are emerged to deal with priorities. However the implementation managers (UHFPO, CS, Divisional Director etc.) are in many cases not aware of the same and thus unable to contribute optimally in the implementation of the sector program.

Activities

1. A Training Management Information System (TMIS) will be developed to cover all the training receive by the different HWF under DGHS from whatever sources by coordinating with all the Directors/Line Directors.
2. A crush program will be undertaken to incorporate past in-service training information of different categories of HWF under DGHS in the TMIS
3. To overcome the delay of Foundation Training of BCS (Health) cadre new recruits, an orientation for 15 (fifteen) days will be provided to all the new entrants before joining to their places of posting. This will be done through entering institutional arrangements with the existing institutes like NIPSOM, ICMH, and NIPORT etc.
4. All the new promotes will be provided with orientation for 5 (five) days to make them fully aware about their new roles and responsibilities. This training will also be provided through institutional arrangements with the existing institutes like NIPSOM, ICMH and NIPORT etc.
5. To strengthen the medico-legal service provided by the health service, selected medical officers covering females from the upazila and district hospitals will be provided with training in adequate numbers. The training curriculum and duration will be decided in consultation with the Forensic Medicine teachers and training will be provided by the Forensic Medicine Department of selected government medical colleges. Through TMIS these trained medical officers will be followed up to ensure sufficient numbers are present at upazila and district to provide quality service.
6. All the existing UHFPO, CS, Divisional Director will be oriented with the new priorities of the sector programme like issues of equity, efficiency, quality, stewardship, governance, functional integration etc. These orientations will be conducted through the contractual arrangements with the existing institutes like NIPSOM, ICMH, and NIPORT etc.
7. Construction works of the Bangladesh Institute of Health Management will be completed and equipped with all the required furniture, fixtures and other supplies. At the same time efforts for creation of posts will be undertaken to make the institute full functional.
8. IPH will be a cost center under this OP. Need-based training for the laboratory technologists will be provided through the IPH.
9. Efforts will be undertaken to transfer the TTU staff into revenue. Until the transfer to revenue TTU staff will be supported through the OP.

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

ME&HMD OP will contribute in poverty reduction in many ways. First it will produce different types of qualitative HWF which will contribute in the economic development. Second the produced HWF will support in expansion of healthcare services which will contribute in keeping the people healthy and thus contribute in economic development. Also qualified HWF will contribute in quick restoration of health in case of sickness thus blocking economic gain drainage.

This OPs contribution to environmental issues is through making people aware about ill-effects of environmental pollution through trained HWF and this will also contribute in environmental conservation.

HWF will be more aware about the climate change issues and better adoptability of health system through preparedness and response and support climate change affected population.

Women, children and gender issues will be taken care through trained HWF by improving access and utilization.

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program(by June 2022)
1	2	3	4	5	6
1.	Improvement of undergrad medical (MBBS, BDS) education according to national agreed minimum criteria of national guideline	Percentage of Medical institutes fulfilling the minimum criteria	NA	25%	50%
2.	Re-structured D, ME&HMD	Draft Revised organogram	Current organogram	Review completed with report	Revision proposal is at MOPA
3.	New law for technologists	New law enacted	SMF with no legal basis	Draft new law available	Law passed by parliament
4.	Development of TMIS	TMIS in place	No TMIS	TMIS capturing current training	TMIS captured some old training

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
142247.00	26410.00	0.00	26410.00	168657.00	

10.2. Component and activity wise physical and financial target of OP: ME&HMD

(Taka in Lakh)

Name of the components & activities	Phys. QTY/Unit		Total Physical & Financial Target (Jan 2017-June 2022) Total	GOB	PA RPA	PA DPA	Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
1	2		3	4	5	6	7	8	9	10	11	12
Component –1: Post Graduate Medical Education												
1 Enhance streamlining of post graduate medical education.	Workshop (167 batch)		30.00	30.00	0.00	0.00	0.00	6.00	6.00	6.00	6.00	6.00
2 Modifying deputation policy for higher medical education to address the urgent need of the country	Workshop (167 batch)		30.00	30.00	0.00	0.00	0.00	6.00	6.00	6.00	6.00	6.00
3 Support research activities for post graduate students in different medical colleges and post graduate institutes	1250 students		600.00	600.00	0.00	0.00	100.00	100.00	100.00	100.00	100.00	100.00
4 Need based support for the development of quality post graduate medical education in different govt. medical colleges and post graduate institutes..	BCPS , BSMMU & Govt. M.C		4500.00	4500.00	0.00	0.00	500.00	800.00	800.00	800.00	800.00	800.00
Sub Total			5160.00	5160.00	0.00	0.00	600.00	912.00	912.00	912.00	912.00	912.00
Component – 2: Public Health Education												
1 Expansion of public health education covering different levels and disciplines	NIPSOM		1500.00	1500.00	0.00	0.00	200.00	250.00	250.00	270.00	270.00	260.00
Sub Total			1500.00	1500.00	0.00	0.00	200.00	250.00	250.00	270.00	270.00	260.00
Component –3: Basic (Under Graduate) Medical Education												
1 Establishing Monitoring, Supervision & Evaluation in all Medical and Dental college/Units through task force.	30 M.C, 1 D.C & 8 D.units		410.00	230.00	180.00	0.00	70.00	70.00	70.00	70.00	70.00	60.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
2	Establishing autonomous accreditation body.	Workshop		1000.00	1000.00	0.00	0.00	300.00	200.00	200.00	100.00	100.00	100.00
3	Updating curriculum to meet the need for the 21st century's patients and communities	Workshop		700.00	700.00	0.00	0.00	150.00	150.00	150.00	100.00	100.00	50.00
4	Training of teaching professionals by different programme in home & abroad	Person		1400.00	0.00	1400.00	0.00	300.00	300.00	200.00	200.00	200.00	200.00
5	Setting up CME outreach campuses in few Govt. medical colleges for conducting MMED courses and short courses	8 Center		2100.00	2100.00	0.00	0.00	400.00	400.00	400.00	300.00	300.00	300.00
6	Increasing quality of students in the medical entrance examination.	35 Workshop		100.00	100.00	0.00	0.00	20.00	20.00	20.00	15.00	15.00	10.00
7	Strengthening cooperation & coordination among medical and dental colleges from both government and non government .	LS		180.00	180.00	0.00	0.00	30.00	30.00	30.00	30.00	30.00	30.00
8	Exploration of assessment examination to ensure quality of health services	35 Workshop		100.00	100.00	0.00	0.00	20.00	20.00	20.00	15.00	15.00	10.00
9	Provision of Vehicles for Principals of all Govt. medical colleges	17 M C		1700.00	1700.00	0.00	0.00	400.00	400.00	400.00	190.00	170.00	140.00
10	Supply & services for all exiting and new government medical colleges.	LS		30000.00	30000.00	0.00	0.00	4000.00	6000.00	6000.00	5000.00	5000.00	4000.00
11	Improvement of Dental colleges and Units though provision of supply and services	LS		7400.00	7400.00	0.00	0.00	1500.00	1500.00	1500.00	1000.00	950.00	950.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
12	Procurement of machineries & equipments, furniture & fixture for all government medical colleges	LS		60000.00	60000.00	0.00	0.00	12000.00	10000.00	10000.00	10000.00	10000.00	8000.00
13	Recruit driver, cook, security and cleaning services through outsourcing for all govt. medical colleges.	789 person		5400.00	5400.00	0.00	0.00	900.00	900.00	900.00	900.00	900.00	900.00
14	Capacity building of D, ME&HMD to be grown with pace of fast expansion of medical college.	LS		1200.00	1200.00	0.00	0.00	300.00	300.00	250.00	120.00	120.00	110.00
15	Strengthening libraries with home and aboard journal & books. And setting up an unique e-library.	17 M C		5000.00	5000.00	0.00	0.00	1000.00	1000.00	1000.00	700.00	700.00	600.00
16	Community Oriented Medical Education (COME)	18720 students		2000.00	0.00	2000.00	0.00	200.00	400.00	350.00	350.00	350.00	350.00
17	Strengthening the medical education unit and Medical Skill Centre in all Govt. Medical & Dental Colleges.	30 M.C, 1 D.C & 8 D.units		600.00	600.00	0.00	0.00	100.00	100.00	100.00	100.00	100.00	100.00
18	Ensure quality of teaching for all existing & newly setup Govt. medical colleges	30 M.C		500.00	500.00	0.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
19	National and Regional Scientific FAIR by medical colleges at one in year			3000.00	3000.00			500.00	500.00	500.00	500.00	500.00	500.00
	Sub Total			122790.00	119210.00	3580.00	0.00	22240.00	22390.00	22190.00	19790.00	19720.00	16460.00
Component –4: Paramedical Education													

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1	Establishing Monitoring, Supervision & Evaluation of all paramedical institutions	8 MATS & 8 IHT		90.00	90.00	0.00	0.00	15.00	15.00	15.00	15.00	15.00	15.00
2	Establish a paramedical education board.	167 Workshop		480.00	150.00	330.00	0.00	100.00	100.00	90.00	70.00	60.00	60.00
3	Training of teaching professionals of paramedicals institutions.	8 MATS & 8 IHT		400.00	400.00	0.00	0.00	70.00	70.00	70.00	70.00	60.00	60.00
4	Strengthening Educational Facilities for IHT & MATS	8 MATS & 8 IHT		9000.00	9000.00	0.00	0.00	1800.00	1800.00	1700.00	1400.00	1300.00	1000.00
5	To take initiatives with requirement projections for 2030 in MATS & IHTS.	8 MATS & 8 IHT		400.00	400.00	0.00	0.00	100.00	80.00	60.00	60.00	50.00	50.00
6	Establish utilization of updated IT in paramedical education (computer and IT accessories to be purchased thorugh His ehealth OP)	8 MATS & 8 IHT		400.00	400.00	0.00	0.00	50.00	100.00	100.00	60.00	50.00	40.00
	Sub Total			10770.00	10440.00	330.00	0.00	2135.00	2165.00	2035.00	1675.00	1535.00	1225.00
	Total of A			140220.00	136310.00	3910.00	0.00	25175.00	25717.00	25387.00	22647.00	22437.00	18857.00
B) HMPD													
Component-5: Administrative and Management													
1	Pay of Officers (4500) (For the personnel of Technical Training Unit(TTU))	2	Person	212.00	212.00	0.00	0.00	17.00	35.00	37.00	39.00	41.00	43.00
2	Pay of Establishment (4600) (For the personnel of Technical Training Unit(TTU))	5	Person	140.00	140.00	0.00	0.00	15.00	21.00	23.00	25.00	27.00	29.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)				PA		Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
3	Allowances (4700) (For the personnel of Technical Training Unit(TTU))	7	LS	198.00	198.00	0.00	0.00	25.00	30.00	32.00	35.00	37.00	39.00
4	Supply & Services (4800)	0	LS	1187.00	1187.00	0.00	0.00	187.00	200.00	200.00	200.00	200.00	200.00
5	Printing (4827)	0	LS	2100.00	2100.00	0.00	0.00	100.00	400.00	400.00	400.00	400.00	400.00
6	Repair & Maintenance (4900)	0	LS	300.00	300.00	0.00	0.00	50.00	50.00	50.00	50.00	50.00	50.00
7	Accusition of asset (capital-6800) Computer and accessories ,Machinery and equipment, Furniture & fixtures, Training room equipment and furniture for BIHM etc	192	LS	800.00	800.00	0.00	0.00	100.00	100.00	200.00	200.00	100.00	100.00
8	Develop and maintain Training management information system (TMIS)	0	LS	200.00	200.00	0.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
9	2 days user level hands onTtraining on operation for data entry in TMIS	250	Batch	200.00	0.00	200.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
10	Training Need Assessment (TNA) for different categories and tiers of health personnel	0	LS	30.00	0.00	30.00	0.00	5.00	5.00	5.00	5.00	5.00	5.00
11	Develop and Review of Curriculum	90	Curriculum	70.00	0.00	70.00	0.00	10.00	20.00	10.00	10.00	10.00	10.00
	Local Training :			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
13	15 days Basic Service Management Training for newly recruited Doctors	493	Batch	2500.00	0.00	2500.00	0.00	250.00	500.00	500.00	500.00	500.00	250.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
14	5 days orientation Training for awareness building about the roles and resposibility due to new promotes for feld service providers .	3870	Batch	6100.00	0.00	6100.00	0.00	710.00	1220.00	1220.00	1220.00	1220.00	510.00
15	5 days orientation Training for awareness building about the roles and resposibility due to new promotes for Doctors at Upazilla and District level.	1060	Batch	2690.00	0.00	2690.00	0.00	180.00	510.00	500.00	500.00	500.00	500.00
16	5 days orientation Training for awareness building about the roles and resposibility due to new promotes for SACMO/MTS etc and othrs.	510	Batch	1275.00	0.00	1275.00	0.00	25.00	250.00	250.00	250.00	250.00	250.00
17	5 days GLP Training for MTs(Lab)	85	Batch	170.00	0.00	170.00	0.00	20.00	30.00	30.00	30.00	30.00	30.00
18	2 days Orientation with the new priorities of the sector programme like issues of equity, efficiency, quality, stewardship, governance, functional integration etc. for all the existing UHFPO, CS, Divisional Director will be oriented	26	Batch	65.00	0.00	65.00	0.00	15.00	25.00	25.00	0.00	0.00	0.00
19	Training on medico-legal services for Doctors at Upazilla and District level	250	Batch	1500.00	0.00	1500.00	0.00	0.00	300.00	300.00	300.00	300.00	300.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
20	Monitoring and Supervision for following up through TMIS to ensure sufficient numbers of trained Health Personnel are present at upazila and district to provide quality service.	3000	UHC/ District	600.00	0.00	600.00	0.00	100.00	100.00	100.00	100.00	100.00	100.00
21	Non-Clinical management Training for Health Personnel in the area of : Office management, Financial management, Store management, Hospital Management, Patient management & Bio-medical equipment management	1920	Batch	2800.00	0.00	2800.00	0.00	300.00	500.00	500.00	500.00	500.00	500.00
22	Training for professional and personnel skill development of Health Personnel in the area of : Computer & Language	1600	Batch	500.00	500.00	0.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
23	Workshop and Seminar	120	Batch	300.00	300.00	0.00	0.00	50.00	50.00	50.00	50.00	50.00	50.00
	9. Overseas Training :												
24	Different Clinical Specialty	349	Person	3000.00	0.00	3000.00	0.00	300.00	600.00	600.00	600.00	600.00	300.00
25	Different Management & Public Health Specialty.	426	Person	1500.00	0.00	1500.00	0.00	100.00	300.00	300.00	300.00	300.00	200.00
	Total of B	14049		28437.00	5937.00	22500.00	0.00	2649.00	5426.00	5512.00	5494.00	5400.00	3956.00
	Grand Total	14255		168657.00	142247.00	26410.00	0.00	27824.00	31143.00	30899.00	28141.00	27837.00	22813.00

11. Budget support from other Operational Plan: Not applicable

4.12 Nursing and Midwifery Education Services (NMES)

1. Name of the Operational Plan: Nursing and Midwifery Education Services (NMES)

2. Implementing Agency: Directorate General of Nursing and Midwifery (DGNM)

3. Introduction

Nurses and midwives are the core members of health care delivery system. They comprise a large and diverse workforce in any health care institutions. The role of the nursing profession can be determined by a definition given by ICN "Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings. Nursing includes the promotion of health, the prevention of illness, and the care of ill, disable and dying people (International Council of Nurses, 1987)*".*

Registered Nurses (RNs) complete their Diploma in Nursing or Bachelor of Nursing course from any nursing institute/college affiliated by Bangladesh Nursing Council. Registered nurses are allowed to perform activities and provide care for the promotion of health, prevention of illness, and the care of individuals of all ages, sex, families, groups, communities, sick or well in all settings including public and private hospitals, schools, community and public health centers.

A Midwife has its own definition and unique function. According to the International Confederation of the Midwife (2011) "A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery". Registered Midwives (RMs) complete the International Confederation of the Midwife (ICM) recognized courses from an affiliated institute by the midwifery regulatory body or nursing regulatory body. Directorate General of Nursing and Midwifery involves in producing and recruiting registered nurse-midwives for the public sector. A total of 41,697 nurses have been registered with the Bangladesh Nursing Council (BNMC June 2016). There are 24,632 sanctioned posts (23,539 nurses, 1093 non-nurses) under the Directorate General of Nursing and Midwifery. Out of which 18,905 are working (17,974 nurses, 931 non-nurses). Among the sanctioned posts under DGNM 600 post are for the midwives (DGNM PMIS, June 2016). Government has taken initiative to produce more nurses with the expansion of nursing institutions including intake capacity both in public and private sector to address the increasing demand. At present yearly student intake for 3-years Diploma in Nursing Science and Midwifery is 8055 (2580 seats in 43 public and 5475 seats in 108 private Nursing Institutions). Since 2008 four years BSc nursing course has been introduced. Currently yearly student intake in BSc nursing is 2910 in 14 (1035 seats) public and 38 (1875 seats) private nursing colleges.

Midwives are recognized internationally as the best buy for addressing reproductive health issues. However, the concept of professional midwives defined by the global standards has been introduced in Bangladesh since 2012. On the other hand, registered nurses who have completed one year Diploma in midwifery with 3-year Diploma in Nursing course, have been playing a dual role in providing general and specialized nursing care including maternal and neonatal services.

The production and recruitment of competent and efficient nurses and midwives is essential for smooth functioning of the health care system. Scope of excellence for teaching-learning and practicing nursing and midwifery skills has strong influence in providing quality services. Competent and efficient nurse and midwives production, capacity building programme for enabling nursing and midwifery faculty with appropriate teaching-learning competencies; good accommodation for students, faculties, practice nurses and midwives; training in various disciplines of nursing and midwifery are essential to provide quality care. Producing adequate number of competent and efficient Nurse-midwives, midwives and enhancing the knowledge and skills of practicing nurses and midwives is crucial to pay due attention.

Government has introduced direct entry 3 years diploma in midwifery course since 2012. This course is offered in 53 institutions (975 seats in 38 public and 500 seats in 15 private institutions). Six month advance midwifery course is also offered for registered nurse-midwives as interim measures to address the required number of midwives in the country.

As part of human resource development, initiative has been taken to produce post basic graduate nurse since 1977. Two years post basic BSc in nursing and public health nursing is offered by 39 institutions with a yearly intake of 1875 students (400 seats in 4 public, 1395 seats in 35 private institutions). Master degree in nursing is recently introduced in six different fields (60 seats).

MOHFW created new post for nurses to address the increasing need for nurses and midwives. Four thousand one hundred (4100) senior staff nurses have been recruited and deployed in 2013. There have been ten thousand (10,000) nurses and three thousand (2996) midwives new post created and recruitment is in process. Twelve hundred (1200) certified midwives have been deployed as midwife in union sub centers and upazilla heath complexes. The senior staff nurses and supervisors positions have been upgraded to class-II in 2011. The DPHN and Deputy Nursing Superintendent position (128) has been upgraded to class-I in 2015.

Government has approved the structure of Directorate General of Nursing and Midwifery with 77 new posts and expected to be implemented soon.

Achievements:

82 nurse-midwives completed Masters Degree, 12 are studying PhD and 640 received specialized training on different fields from abroad. 4,980 nurse-midwives also received in country short term training on different fields. So far 497 midwives have been registered with BNC in 2016.
Construction of Nursing and Midwifery Bhaban in Mohakhali, Dhaka has been started in 2015. Construction of Manikganj and Kisoreganj Nursing College has been completed and seven (07) is ongoing in Gazipur, Lalmonirhat, Satkhira (Palashpur), Khulna (Khalishpur), Narail, Gaibanda and Bandarban. Construction of 200-seated students' hostel for College of Nursing, Mohakhali, Dhaka has been completed.

Personnel Management Information System (PMIS) for DGNM and registration database for Bangladesh Nursing and Midwifery Council has been developed and operationalized. Websites for DGNM and BNMC is fully functional.

During last HNP sector programme (HPNSDP, 2011-2016) a number of positive lessons have been learned through the implementation of NES and Quality Expansion Project. The total number of Nursing Institutes has been increased from 31 to 43 and number of seat has been increased from 1580 to 2580 for Diploma in Nursing Science and Midwifery during 2011-2016. *Moreover, the previous 07*

Nursing Institutes attached to the Medical College Hospitals were up-gradated to nursing colleges providing Basic B. Sc. Nursing course to 700 students per year. In addition, government has introduced direct entry 3 years diploma in midwifery course since 2012 in 38 institutions. Higher education, overseas and local training improved the capacity of nurse-midwives and are contributing to quality education and services.

Nurse's entry position has been upgraded to class-II and for the first time nurses has been recruited through Bangladesh Public Service Commission. This has a great impact on image building for the nursing profession. In addition up gradation of DNS to DGNM will contribute to ensure quality nurse midwife workforces for better health care services.
However In relation to the increase number of student capacity and introduction of midwifery courses, the facilities such as infrastructures, hostel, number of teachers and supporting staffs, classroom, lab, library facilities, provision of teaching learning materials are not increased proportionately which hinders the quality of education and services.

Challenges:

Various programmatic challenges remained in delivering the quality nursing and midwifery services at different level which need to be addressed such as:

- Equip the Nursing Institutes, Colleges in respect of infrastructure (new construction, repair & maintenance), Student and teacher accommodation, classroom, lab, library facilities, simulation lab etc.
- Ensure Quality of education (faculty development, improve examination/assessment system, supply of equipment and logistics, teaching learning materials) .
- Improve management/leadership capacity of nurse managers.
- Introduction of uniform central examination system for diploma nursing and midwifery education.
- Support to introduce preceptor ship for student's clinical practice.
- Strengthen monitoring and supervision system in nursing midwifery education and services.
- Promote image building activity to popularize nursing and midwifery profession.
- Support professional development, research, study and publication.
- Support to introduce/strengthen specialty courses such as pediatric, ICU, CCU, oncology, renal, cardiac, orthopedic, emergency and trauma, geriatric, mental health and psychiatric nursing.
- Support to enhance capacity of Bangladesh Nursing Council for regulatory activities including licensing, registration and accreditation of nursing institutes (Both public and private).
- Review, assess and expansion of midwifery led care.
- Strengthen and establish interoperability of MIS.

4. Objectives:

General Objective

To improve the quality of nursing & midwifery services in Bangladesh through increasing the number of qualified nurses & midwives production.

Specific Objectives

1. Strengthen Nursing Institutes & Colleges through expansion/renovation of infrastructure (institution/college/Hostels) through PFD operation plan. (Enhance faculty development of nursing institutes and colleges)
2. Introduce quality assurance system into nursing and midwifery education and services
3. Develop and strengthen capacity of nurses in specialized field including leadership and management.
4. Strengthen Management Information System (MIS) including PMIS.
5. Strengthen Nursing Research Cell through providing training, equipment and logistics.
6. Support Bangladesh Nursing Council
7. Support Nursing & Midwifery Professional Body
8. Strengthen nursing & midwifery networking within National and International bodies.
9. Support to restructuring Directorate of Nursing Services into Directorate General of Nursing and Midwifery (DGNM).

5. Components:

1. Policy guideline, Planning and Management;
2. Quality of Nursing and Midwifery Education and Services;
3. Evidence-based Nursing and Midwifery;
4. Management Information System
5. Supply of vehicles, equipment, furniture, logistics and maintenance
6. Technical Assistance;

Component 1: Policy guideline, Planning and Management:

Effective delivery of health services depends on the quality of nursing and midwifery education and services. Policy guidelines, SOPs, action plan, tools, checklists, and protocols related to nursing and midwifery education and services need to be developed, updated, approved and implemented.

Activities

1. Develop/review/update plans, SOPs, policy guidelines and tools for improving nursing and midwifery education, services and research;
2. Support to develop table of organgram and equipment for the Directorate of Nursing Services/Director General of Nursing and Midwifery Services;
3. Support BNMC to strengthen regulatory functions of nursing and midwifery education including accreditation of nursing institutes and colleges.
4. Support establishment of Nursing and Midwifery Education Centre to ensure uniform examination system for diploma nursing and midwifery education. Support for standard examination system for nursing and midwifery education and licensing.
5. Advocacy and orientation on midwifery-led care.

Component 2: Quality of Nursing and Midwifery Education and Services

Quality in Nursing and midwifery education for producing competent and efficient N-M ultimately influences the public health in terms of health promotion, prevention, restoration and rehabilitation.

For ensuring quality of education and services infrastructural development, physical facilities, faculty preparation, teaching- learning environment, scope of clinical practice, coordination between education and practice are essential. Construction, expansion, and renovation of Nursing Institutes, Colleges and hostel through PFD operation plan.

Activities

Establishment of teacher's training college and DCEC's are at Dhaka, rangpur, sylhet, and khulna and Construction, expansion and renovation of Nursing Institutes & Colleges through PFD operation Plan Enhance capacity of nurse teachers, managers, supervisors and bedside care providers through training and education.

1. Orientation and refreshment training for newly recruited nurses and midwives and short and long term education,training and study tour on different specialized areas for nurses, midwives and non nursing personnel (Foreighn and Local)
2. Enhance capacity of non nurse officials and support staff through skill development training
3. Production of increased number registered midwives.
4. Strengthen administrative functions relevant to Basic BSc in nursing (JICA TC)
5. Improvement of educational and clinical practice environment of targeted Nursing Colleges (JICA TC);
6. Development of digital library and strengthen the nursing and midwifery labs
7. Support establishing model nursing Institutes as centre of excellence
8. Support to introduce preceptorship for student's clinical practice
9. Initiate BSc program in Midwifery Education.
10. Strengthen and continuation of Masters-160 and PhD-5 programme in nursing and midwifery. Introduce 6-month internship programme for diploma in nursing, and midwifery graduates.
11. Revitalize and introduce 1-year diploma program on respiratory nursing; orthopedic nursing pediatric nursing; oncology and palliative nursing; mental health and psychiatric nursing cardiac nursing; geriatric nursing; nursing administration and management etc
12. Continuation of 6-months advanced midwifery course
13. Strengthen Monitoring & Evaluation System in education and services.(Checklist,TADA, videoconference equipments)

Component 3: Evidence-based Nursing and Midwifery care

Evidence based nursing is an approach to making quality decisions and providing nursing care based upon personal clinical expertise in combination with the most current, relevant research available on the topic. Implementation of evidence based practice helps to increase the client and providers satisfaction and achieve the health related goals.

Activities

1. Strengthen existing Nursing Research Cell at College of Nursing, Mohakhali, Dhaka
2. Strengthen the capacity of nursing and midwives to conduct action research and evidence based practice/study in the field of nursing and midwifery education and services. (2 weeks training)Exposure to evidence-based nursing and midwifery services by attending/participating at the national and international seminar/conference/workshop/study tour

3. Enhance the capacity of Nurses and Midwives to introduce EBP in Nursing & Midwifery Education and Services through training
4. Publish half yearly Nursing and Midwifery Newsletter to share the experience of doing research.

Component 4: Management and Information System (MIS)

Effective and quality service delivery requires authentic, accurate and updated data. DGNM- PMIS has been established to build HR planning and informed, transparent decision making for nursing and midwifery.

Activities

1. Capacity development for strengthening MIS at all level
2. Procurement of logistics (Computers/printers/photocopiers/scanners/internet modem/ broadband connection and computer programmes) for DGNM head quarter/NIs/NCs/AD of the division/DPHNs
3. Strengthen and updates DGNM website and DGNM-PMIS
4. Strengthen and establish interoperability with central HRIS
5. Develop Enterprise Resource Plan (Enterprise Solution) for DGNM and maintenance of existing DGNM-PMIS software. ERP is an integrated software covering HR, finance, procurement, inventory management.

Component 5: Supply of vehicles, equipment, furniture, logistics and maintenance

For smooth functioning of DGNM and institutions regular and adequate supply of logistics, equipments, furniture and vehicles and its maintenance is essential.

Activities

1. Support for postal, WASA, telephone, gas, electricity, internet connection, fuel, bedding, cookeries, stationeries, management of labour, cleaner, security guard, printing, honouriam, advertisement and others.
2. Procure furniture's, vehicles, equipments OMR machine with equipments and others.
3. Repair and maintenance of vehicle, furniture, equipments and others.

Component 6: Pay and Allowance.

Activities

1. Pay and Allowance.

Component 7: Technical Assistance.

TA may require for development of policy guidelines, preceptorship, review and develop curriculum, new course development, strengthen MIS, HRD, research, procurement, etc.

6. Cross-Cutting issues including Poverty, Environment, Climate Change, Women & Children and Gender etc:

Sl. No.	Area	Related Ops

1.	Constructions/ Renovations/ of Nursing Institutes, Colleges, Hostels and accommodation facilities	PFD
2.	Midwifery Education & Services	MNCAH, MCRAH
3.	Monitoring and Evaluation	SWPMM & HIS e-Health, MIS
4.	Human Resource	HRD, CBHC and HSM

7. Proposed Manpower: Annexed in Volume-II

8. List of Goods, Works, Services etc: Annexed in Volume-II

9. Indicators:

Sl. No	Indicators	Unit of Measurement (Means of verification)	Baseline (With year and Data source)	Projected target	
				Middle of the Program (By June 2020)	End of the Program (By June 2022)
1	2	3	4	5	6
1.	Number of nurses received specialized education and training.	Number of Nurses trained(Admin of Record)	1950 (APIR 2016) Admin Record	6000	9000
2.	Number of training manual developed and updated	Number (Availability of training manual	DGNM/BNMC	4	5
3.	Number of diploma Midwives produced.	admitted (Admin record)	975 Admin Record	1950	2925
4..	Number of UHCs have at least two midwives	Number of UHCs	(DLI baseline 0)	60	150

10. Budget of the Operational Plan:

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
9417.00	16570.00	14698.00	31268.00	40685.00	UNFPA/CIDA/JICA/WHO and Pool Fund.

10.2. Component and activity wise physical and financial targets: NMES

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Component 1: Policy guideline, Planning and Management													
1	Develop/review/update, plans, SOPs, policy guidelines and tools for improving nursing and midwifery education, services and research.	20		300.00	100.00	0.00	200.00	30.00	60.00	60.00	60.00	60.00	30.00
2	Support to develop table of organogram and equipment for the Directorate General of Nursing and Midwifery.	55		50.00	30.00	0.00	20.00	4.50	10.00	10.00	10.00	10.00	5.50
3	Support BNMC to Strengthen regulatory functions of nursing and midwifery education including accreditation of nursing institutes and colleges. (60 institutes)	60		250.00	50.00	0.00	200.00	25.00	50.00	50.00	50.00	50.00	25.00
4	Support for standard examination system for nursing and midwifery education and licencing.	6		300.00	0.00	0.00	300.00	30.00	60.00	60.00	60.00	60.00	30.00
5	Advocacy for Midwifery services and introduction and expansion of Midwifery-led care.	38		400.00	0.00	0.00	400.00	20.00	70.00	90.00	100.00	90.00	30.00
Component 2: Quality of Nursnig and Midwifery Education and Services.													
1	Enhance capacity of nurse teachers, managers, supervisors and beside care providers through training and education.	15000		1200.00	200.00	0.00	1000.00	120.00	240.00	240.00	240.00	240.00	120.00
2	Orientation and refreshment training for newly recruited nurses and midwives and short and long term education,training and study tour on different specialized areas for nurses,midwives and non nursing personnel (Foreighn and Local).	18000		10000.00	500.00	6500.00	3000.00	1070.00	1965.00	1965.00	1965.00	1965.00	1070.00
3	3. Enhance capacity of non-nurse officials and support staff through skill development	1100		400.00	150.00	130.00	120.00	40.00	80.00	80.00	80.00	80.00	40.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	training.												
4	Production of increased number registerd midwives. (800+975=1775) (975x5=4875)	6550		5000.00	1500.00	3500.00	0.00	500.00	1000.00	1000.00	1000.00	1000.00	500.00
5	Strenghthen adninistrative functions relavent to Basic BSc in nursing (JICA Technical Cooperation). (7 NCs)	7		860.00	0.00	0.00	860.00	240.00	240.00	240.00	140.00	0.00	0.00
6	Improve of educational and clinical practice enviroment of targeted Nursing Colleges (JICA T.C)(7 NCs)	7		1720.00	0.00	0.00	1720.00	490.00	490.00	490.00	250.00	0.00	0.00
7	Development of digital Library and strengthen the nursing and midwifery lab.	125		600.00	200.00	100.00	300.00	60.00	120.00	120.00	120.00	120.00	60.00
8	Support establishing model nursing Institutes as centre of excellence.(UNFPA,CIDA)	10		500.00	100.00	0.00	400.00	50.00	100.00	100.00	100.00	100.00	50.00
9	Support to introduce preceptorship for student's clinical practice (To all teaching Hospitals).	38		100.00	0.00	0.00	100.00	7.00	17.50	22.50	25.00	22.50	5.50
10	Initiate BSc program in Midwefery Education. (UNFPA)	160		100.00	40.00	0.00	60.00	10.00	20.00	20.00	20.00	20.00	10.00
11	Strengthen and continuation of Masters-160 and PhD-5 programme in nursing and midwifery.	165		3000.00	0.00	2000.00	1000.00	600.00	600.00	600.00	600.00	600.00	0.00
12	Introduce 6- month Internship programme for diploma in nursing and midwifery graduates.	2475		1500.00	500.00	500.00	500.00	120.00	300.00	300.00	300.00	300.00	180.00
13	Revitlize and introduce 1-year diploma program on respiratory nursing, orthopedic nursing, Pediatric nursing, oncology and Palliative nursing, mental health and psychiatric nursing, cardiac nursing, geriatric nursing, nursing administration and	180		200.00	60.00	140.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	management etc.												
14	Continuation of 6- months advanced midwifery course.	10		250.00	0.00	0.00	250.00	25.00	50.00	50.00	50.00	50.00	25.00
15	Strengthen Monitoring and evaluation System in education and services.(Check list,TADA, Vedeo conference equipments.	10		150.00	100.00	0.00	50.00	15.00	30.00	30.00	30.00	30.00	15.00
Component 3: Evidence Based-Nursing and Midwifery care													
1	Strengthen existing nursing research cell at college of nursing, Mohakhali, Dhaka.	5		120.00	20.00	0.00	100.00	24.00	24.00	24.00	24.00	24.00	0.00
2	Strengthen the capacity of nursing and midwives to conduct action research and evidence based practice/study in the field of nursing and midwifery education and services. (2 weeks training)	100		500.00	100.00	100.00	300.00	50.00	100.00	100.00	100.00	100.00	50.00
3	Exposure to evidence-based nursing and midwifery services by attending /participating at the national and international seminar/conference/ workshop/study tour.	125		1000.00	200.00	500.00	300.00	80.00	200.00	200.00	200.00	200.00	120.00
4	Enhance the capacity of Nurses and Midwives to introduce EBP in Nursing & Midwifery Education and Services through training .	500		200.00	100.00	100.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
5	Publish half yearly nursing and midwifery newsletter to share the experience of doing research.(1000)	10000		20.00	2.00	0.00	18.00	0.00	5.00	5.00	5.00	5.00	0.00
Component : 4 Management and Information System (MIS)													
1	Capacity devlopment for strengthening MIS	300		150.00	0.00	0.00	150.00	15.00	30.00	30.00	30.00	30.00	15.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	at all level.												
2	Procurement of logistics(computer/printer/photocopier/scanner/internet modem/broadband connection and computer programmes for DGNM head quarter/NIs/NCs/AD of the Division/DPHNs.	204		150.00	50.00	0.00	100.00	15.00	30.00	30.00	30.00	30.00	15.00
3	Strengthen and update DGNM Web site and DGNM-PMIS.	5		75.00	25.00	0.00	50.00	15.00	15.00	15.00	15.00	15.00	0.00
4	Strengthen and establish interoperability with central HRIS.	5		75.00	25.00	0.00	50.00	15.00	15.00	15.00	15.00	15.00	0.00
5	Develop enterprise resource plan (Enterprice Solution) for DGNM and maintenance of existing DGNM-PMIS software. ERP is an integrated software covering HR, finance, procurement, inventory management.	5		75.00	25.00	0.00	50.00	15.00	15.00	15.00	15.00	15.00	0.00
Component 5 : .Supply of vehicles, equipment, furniture, logistics and maintainance													
1	Support for postal,wasa, teliphone, gas, electricity, internet connection, fuel, bedding, crokeries,stationaries, management of labour,cleaner, security guard, printing ,honarium for tender,advertisement.(For 60 Ni and Colleges)	60		600.00	500.00	0.00	100.00	60.00	120.00	120.00	120.00	120.00	60.00
2	Procure frnitures, vehicles (1 Jeep, 20 Minibus, 1 Microbus), equipments, OMR Machine(omr machine for head qarter) and others.(For 60 Ni and Colleges)	44489	no.	8000.00	4000.00	3000.00	1000.00	1500.00	1500.00	1500.00	1500.00	1500.00	500.00
3	Repaire and maintenance of vehicle,furnitures,equipments and others.(For 60 Ni and Colleges)	60		800.00	300.00	0.00	500.00	80.00	160.00	160.00	160.00	160.00	80.00
4	CD & VAT	0		300.00	300.00	0.00	0.00	60.00	60.00	60.00	60.00	60.00	0.00
Component 6: Pay and Allowance													

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1	Pay and allowances.	17		240.00	240.00	0.00	0.00	40.00	40.00	40.00	40.00	40.00	40.00
Component 7: Technical assistant (TA)													
1	Provision for TA support and recruitment of consultants to identified ares (long and short term) 20x3(60) MM, 10x6(60) MM, 10x12 (120)MM	240		1500.00	0.00	0.00	1500.00	125.00	312.50	312.50	312.50	312.50	125.00
	Total			**40685.00**	**9417.00**	**16570.00**	**14698.00**	**5590.50**	**8209.00**	**8234.00**	**7906.50**	**7504.00**	**3241.00**

11. Budget support from other Operational Plan: Not applicable

4.13 Training, Research and Development (TRD)

1. Name of the Operational Plan: Training, Research and Development (TRD)

2. Implementing Agency: National Institute of Population Research & Training (NIPORT)

3. Introduction:

National Institute of Population Research and Training (NIPORT) was established in 1977 with a vision to develop an Ideal Regional Training and Research Institute in South Asia on health and population program management. One imperative activity of NIPORT is to undertake program focused evaluative and operations research and surveys to strengthen the reproductive health, child health, nutrition and family planning activities. Also competently disseminate research findings at different levels to develop and monitor program. NIPORT has been implementing Research activities directly from the headquarters. Most of the Training and Research activities of NIPORT has been implemented under Operational Plan "Training Research and Development". Moreover, 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 HPN service delivery and monitoring and evaluation under DGFP, DGHS, DNS and Ministry of Health and Family Welfare.

NIPORT has been providing regular updates of result frame work indicators of sector program for routine monitoring the program. During HPNSDP NIPORT conducted seven national surveys, the surveys were Bangladesh Demographic and Health Survey (BDHS)-2011, Utilization of Essential Service Delivery (UESD) Survey-2013, Bangladesh Urban Health Survey (BUHS)-2013, Bangladesh Health Facility Survey (BHFS)-2014 and BDHS-2014, UESD Survey-2016, Bangladesh Maternal Mortality and Health Care Survey (BMMS)-2016. Results of the five surveys were published and competently disseminated at the national to division level and two survey (UESD 2016 and BMMS 2016) results will be published very soon, we hope the results of this two survey will help us to set baseline and future target for the new sector program as well as sustainable development goals (SDGs). During the period NIPORT also conducted a number of program focused research (on demographic & behavioral aspects of population, family planning, health, reproductive health, child health,) and situation analysis & need assessment and disseminated the results through seminar, workshop, published annotated bibliography, etc. In the up-coming 4th Sector Development Program NIPORT has been targeted to conduct 9 national surveys, 3-4 operations research, a number of program focused and policy research/survey (on demographic & behavioral aspects of population, family planning, health, reproductive health, child health, nutrition, NCD) and situation analysis & need assessment to support in monitoring the result frame work indicators, SDG indicators as well as to strengthen the evidence base for health sector decision making

4. Objectives

i. To impart training as per needs in order to establish high quality health workforce available to all public health service providers

ii. To conduct research/survey and provide evidence base for health sector decision making

iii. To standardize training and research activities

iv. To explore the avenues and techniques for becoming a regional training and research institute

v. To enhance capacity of NIPORT and its institutes

5. Components

Component A: Training

As a National Training Institute, NIPORT has been playing a significant role in improving Health, Family Planning and Nutrition services to the people through increasing the knowledge & skills and changing the attitudes of the Service Providers (Program Managers, Physicians, Paramedics, Field Supervisors and Field Workers). NIPORT has been implementing multidimensional training program for Mid-level Program Managers, Physicians, Trainers, Paramedics, Field Supervisors and Field Workers of Directorate General of Family Planning and Directorate General of Health Services. NIPORT's achievement in last 10 years is remarkable and provided training to 109,415 Service Providers of Health, Population and Nutrition programs of Bangladesh working at District, Upazila and Field Level. Imparted Training Courses are Basic Training, Orientation Training, Refresher Training, Counseling, IUD & IP Training, Comprehensive New-born Care Training, Early Childhood Development Training, Midwifery Skill Practice Training, Management Training, Computer Training, Training of Trainers and other subject specific In-country Training. At the same period, a number of training curriculums were also developed and updated. In the 4th sector, NIPORT will provide Orientation Training for the newly recruited Medical Officers (MCH-FP) of DGFP. Strengthening NIPORT's facilities for effective In-service training of the FP personnel is the key intervention for the 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 of Component A:

1. Basic Training (for FWV, FWA, FPI & HA) and Orientation Training (for newly recruited Physicians, BCS (Health), BCS (FP), MOMCH & SACMO)
2. Refresher (In-Service) Training (for Program Managers, Paramedics and Field Workers)
3. Reproductive and Child Health Training (for Physicians, Paramedics and Field Workers)
4. Skill Development Training (for CSBA, CHCP, Paramedics and Field Workers)
5. Efficiency and capacity development Training (for Program Managers, Physicians and Field Supervisors)
6. e-Governance Training
7. Capacity Development (in country and abroad) for the Faculty
8. Revision of Curriculum & Instructional Materials
9. Training monitoring and follow-up
10. Collaboration with renowned international and regional Universities and organizations for enhancement of training quality to achieve global standard.

Component B: Research

Research is the prime source of information for policy makers, program managers and professionals to develop national policies, program strategies and design 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 and HPNSDP, NIPORT has undertaken a number of research studies / surveys including Bangladesh Demographic and Health Survey (BDHS) (in every three years), Utilization of Essential Service Delivery (UESD) Survey (in the year when BDHS will not be in place), Urban Health Survey, Health Facility Survey (in every two years), Bangladesh Maternal Mortality and Health Care Survey (BMMS) (first survey was done in 2010 and the second survey in 2016), 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

1. Conduct national surveys: BDHS, BMMS, UESD surveys, Health Facility survey, Urban Health Survey, etc.
2. Conduct program focused and policy research/survey for HPN sector;
3. Conduct HR research and training evaluation for improvement of quality of training;
4. Conduct operations research on HPN sector program improvements
5. Strengthen research capacity (in country and abroad), determine priority research areas and extend facilities for research;
6. Conduct research with international, government and non-government organizations involved in conducting health, nutrition and population related research;
7. Collaboration with renowned international Universities like Johns Hopkins Universities-USA, London School of Hygiene and Tropical, University of London-UK, renowned University – Canada etc. and international organization to enhancement capacity for ensuring global standard and quality.
8. Disseminate the research and survey findings to the policy makers, program managers and stakeholders at national to divisional level for future policy and planning;
9. Follow-up on use of research/survey findings.

Component C: Capacity Development

Activities

1. Facility development for training
2. Facility development for research
3. Improvement of physical facilities for NIPORT and field level institutes, (To be implemented through HED);
4. Procurement of logistics and equipment for training and research activities.

6. Cross-Cutting Issues including Poverty, Environment, Climate Change, Women and Children and Gender etc.

(To mention the linkage of this OP with other OPs, if any)

i. SWPMM

ii. PMR-DGHS,

iii. PME-DGFP,

iv. HIS&e-Health -DGHS,

v. MIS-DGFP,

vi. IEC-DGFP,

vii. MCRAH-DGFP

viii. MNCAH-DGHS

ix. HSM-DGHS,

x. FP-FSD,

xi. CBHC,

xii. HRD

xiii. NMES

xiv. PFD-HED

xv. CCSDP

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods and Services etc: Annexed in Volume –II

9. Indicators:

l. No.	Indicators	Unit of Measurement (Means of Verification)	Base line (with Year and Data Source)	Projected Target	
				Middle of Programme (by June 2020)	End of Programme (by June 2022)
(1)	(2)	(3)	(4)	(5)	(6)
1.	(a) Basic Training (for FWA, FPI & HA) and (b) Orientation Training (for newly recruited Physicians, BCS (Health), BCS (FP), MOMCH & SACMO)	Number of persons (Admin record)	5909 APIR 2016	6595	9395
2.	Efficiency & capacity development training including Reproductive and Child Health Training (IUD & IP, CNC, ECD) for Physicians, Paramedics and Field Workers	Number of persons (Admin record)	6060 APIR 2016	7050	9500

l. No.	Indicators	Unit of Measurement (Means of Verification)	Base line (with Year and Data Source)	Projected Target	
				Middle of Programme (by June 2020)	End of Programme (by June 2022)
(1)	(2)	(3)	(4)	(5)	(6)
3.	Conduct national surveys (including BDHS, BMMS, UESD surveys, Facility survey, Urban Health Survey, etc.)	Number (Disseminate Published report available)	7 (during 2011-2016)	4	9
4.	Number of program focused and policy research studies/ conducted	Number (Disseminated and published report available)	45 (during 2011-2016)	16	44

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in Lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
9607.51	15280.94	0.00	15280.94	24888.44	

10.2. Component and activity wise physical and financial target of OP: TRD

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component (i) Training													
1	Basic Training for FWV, FWA, FPI & HA	6245	Persons	2329.37	0.00	2329.37	0.00	527.91	1066.18	735.28	0.00	0.00	0.00
2	Orientation Training for MO, FPO. SACMO	3150	Persons	423.75	0.00	423.75	0.00	53.84	80.12	29.40	80.12	75.44	104.84
3	Refresher Training for FWV, SACMO, HA, FWA & FPI	28000	Persons	1400.00	1400.00	0.00	0.00	0.00	400.00	400.00	300.00	150.00	150.00
4	Reproductive & Child Health Training for Physicians, Nurses & FWV, SACMO	9500	Persons	536.97	536.97	0.00	0.00	0.00	147.20	142.52	125.97	51.95	69.34
5	Clinical Management for Nurses & FWV, SACMO, FWA, HA (F)	1368	Persons	594.78	0.00	594.78	0.00	0.00	148.70	148.70	148.70	136.95	11.74
6	Management Training for Program Managers (CS,DD-FP, DCS, AD-FP etc.), Staffs, FPI, HI, AHI, SI	10575	Persons	704.02	704.02	0.00	0.00	0.00	177.47	174.54	177.47	87.10	87.44
7	e-Governnance Training for NIPORT Faculty	461	Persons	43.63	43.63	0.00	0.00	0.00	5.77	11.64	11.64	5.87	8.71
8	Water, Sanitation & Hygiene Training for Physicians, Nurses & FWV, SACMO, FWA, HA (F)	5350	Persons	311.87	311.87	0.00	0.00	0.00	5.87	103.00	103.00	50.00	50.00
9	Gender and Leadership Training for Program Managers, Physicians	300	Persons	35.23	35.23	0.00	0.00	0.00	2.94	2.94	14.68	5.87	8.81

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
10	Instructional System Design Training for NIPORT Faculty	650	Persons	73.84	73.84	0.00	0.00	0.00	13.70	23.05	14.04	13.70	9.36
11	Capacity Development Training for NIPORT Faculty	108	Persons	650.00	0.00	650.00	0.00	90.00	140.00	140.00	140.00	70.00	70.00
12	In-country for NIPORT Faculty & Other Activities	20	Persons	36.00	27.00	9.00	0.00	0.00	9.00	9.00	9.00	5.30	3.70
13	Pre-service Training for Government/Non- Government Personnel	525	Persons	104.04	0.00	104.04	0.00	0.00	0.00	34.68	34.68	19.68	15.00
14	Preparation, Upgradation and Revision of Curriculum & Instructional Material	24	Persons	64.00	64.00	0.00	0.00	0.00	16.00	16.00	16.00	8.00	8.00
15	Training Aids	1652		412.00	412.00	0.00	0.00	2.00	150.00	100.00	100.00	30.00	30.00
	Sub-total	67928		7719.49	3608.56	4110.94	0.00	673.75	2362.93	2070.74	1275.29	709.86	626.93
Component (ii) Research & Development													
1	Program Focused and Policy related including DLI achievement related research /Studies (on Population & Development, Family Planning, MCRAH, Health; Training- HR, NCD related, Need Assessment; etc.)	44		3250.00	2350.00	900.00	0.00	0.00	600.00	600.00	700.00	750.00	600.00
2	Dissemination of Research/ Survey results, and follow-up on the use of research/survey findings, publications, workshop/ seminar	54		395.00	395.00	0.00	0.00	30.00	70.00	70.00	75.00	75.00	75.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
3	Research Capacity Building & Research methodology training (for faculty) & research/survey data analysis/ report writing workshop , and enhancement of research facilities	0		1150.00	400.00	750.00	0.00	0.00	230.00	230.00	230.00	230.00	230.00
4	National Surveys, Operations Research and Collaborative Research Activities including collaboration with renowned international universities/organizations	12		10200.00	1500.00	8700.00	0.00	400.00	1400.00	1400.00	1250.00	1250.00	4500.00
	Sub-total	110		14995.00	4645.00	10350.00	0.00	430.00	2300.00	2300.00	2255.00	2305.00	5405.00
Component (iii) Management & Strengthening													
1	**Salary & Allowances**												
a.	Salary & Allowances for Officers	10		4.00	4.00	0.00	0.00	0.00	1.00	1.00	0.70	0.70	0.60
b.	Salary & Allowances for Staffs	20		4.80	4.80	0.00	0.00	0.00	1.20	1.20	0.80	0.80	0.80
2	**Supply & Services**											0.00	0.00
a.	Sports Items	1265		12.65	12.65	0.00	0.00	2.00	5.00	2.00	1.65	1.00	1.00
b.	Bedding & Clothing (Bed Sheet, Quilt, Mattress, Mosquito Net, Pillow with Cover, Window Screen)	7825		78.25	58.25	20.00	0.00	0.00	25.00	23.25	20.00	10.00	0.00
3	**Repair & Maintenance**											0.00	0.00
a.	Furniture & Fixture	0		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
b.	Renovation Of Office Building	32		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
c.	Renovation of Residential Building	31		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
d.	Electrical Installation	1550		17.50	17.50	0.00	0.00	0.00	5.00	5.00	5.00	2.50	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
4	**Capital Expenditure**											0.00	0.00
a.	Construction of new Building (To be constructed through HED)	0		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
b.	Vehicle (1 new Jeeps and 22 15 seater Microbuses) for replacement	23		1350.00	550.00	800.00	0.00	0.00	525.00	550.00	275.00	0.00	0.00
c.	Office Equipment (31 Fax Machine & 31 Photocopier)	62		55.00	55.00	0.00	0.00	10.00	45.00	0.00	0.00	0.00	0.00
d.	Furniture & Fixture	3995		646.75	646.75	0.00	0.00	0.00	200.00	200.00	200.00	46.75	0.00
e.	Telecommunication	1		5.00	5.00	0.00	0.00	0.00	5.00	0.00	0.00	0.00	0.00
	Sub-total	14814		2173.95	1353.95	820.00	0.00	12.00	812.20	782.45	503.15	61.75	2.40
	Grand Total=	82852		24888.44	9607.51	15280.94	0.00	1115.75	5475.13	5153.19	4033.44	3076.61	6034.33

11. Budget support from other Operational Plan: Not applicable

4.14 Physical Facilities Development (PFD)

1. Name of the Operational Plan: Physical Facilities Development (PFD)

2. Implementing Agency: MOHFW

3. Introduction

Physical infrastructure has strong correlation with quality of health services, for which, this is one of the priority issues in health sector development in Bangladesh. Hence, the Govt. of Bangladesh has given emphasized on infrastructure development in terms of new construction, upgrading, repair and maintenance of physical structures. Accordingly, significant portion of the budget was allocated in Physical Facilities Development (PFD) OP, which is responsible for infrastructure development in HPNSDP. However, during implementation, priority was put on new construction and upgrading, while little emphasize was given on repair and maintenance in terms of developing a comprehensive maintenance plan. Also, the newly constructed or upgraded facilities were not systematically synchronized with provision of equipment and human resource, for which those could not be turned into effective service providing centers. From the importance in the health system and from the volume of financial investments, physical infrastructure development should be put especial emphasis in the 4th HNPSP.

PFD OP is responsible for physical infrastructure development in HPNSDP. Apart from developing infrastructure through HPNSDP, MOHFW has other discrete projects (29) in which physical facilities are being developed. However, while PFD only builds the infrastructure in HPNSDP (leaving equipment supply to CBHC and HSM), discrete projects included in the ADP have the construction and equipment supply incorporated into the same DPP. Yet in both methods of physical facility development, the arrangements for HR needed for providing services is not included.

There is a time lag between investment made on construction, and making those operational as service centers for the health-seeking public. Over the years, it has been seen that the completed infrastructure could not be operationalized due to supply side barriers like provision of equipment and HR. PFD's work is independent of other OPs of HPNSDP, but it has linkages with related OPs like HSM, ESD and HRM. Due to limited coordination, HRM, HSM and ESD often do not have adequate planning or resources to make supply of required equipment and HR. A comprehensive master plan for civil works might have helped the concerned OPs in this regard. However, no such master plan has been prepared by PFD-OP till date, even though it was an important component of that OP.

The uniform decision of upgrading 31 bed hospitals to 50 bed did not reflect or meet the need of all upazilas. Significant number of these hospitals remains underutilized, while some of the upgraded hospitals may still have excessive patient pressure and require further expansion. Moreover, the construction of 10/20 bed facilities in many cases has left MOHFW with the unresolved problem of how to make those functional. In contrast, the need for construction of UHC in the tribal areas or the urgency of meeting central/regional warehouses for family planning or having facilities for drug storage in the hospitals etc. have failed to receive the attention that these deserve. This calls for the need for adopting objective criteria for deciding on prioritization for construction/maintenance.

On the implementation side, questions have been raised about the quality and capacity of the implementing agencies, i.e. HED/PWD to complete construction within a Program-period. For example, HED completed 743 projects till June, 2016 out of 1559 projects it was handling under HPNSDP. Among these, 638 were handed over to the respective authorities. In the last financial year

of HPNSDP, 282 projects are still on-going and 120 projects are at the tendering phase. That leaves around 86 projects which are not yet ready for tendering. At this rate, HED may probably require eighteen months to complete the remaining projects.

Another portion of the health sector physical facilities development is carried out by Public Works Department (PWD) of the Ministry of Housing and Public Works. Backlog prevails in case of the PWD constructions also. PWD was assigned with the responsibility to complete 116 projects within HPNSDP period, against which, it could hand over 50 projects so far. In case of additional 20 projects, the progress is less than 90%. Progress of remaining 46 projects is at different stages. As per PWD, construction of the remaining projects will need to be rolled over to the 4th SWAp. As a result of such over programming for construction, the number of incomplete and non-functional physical facilities is expected to rise, unless there is a firm reconsideration to avoid such practices

Repair and maintenance is another concern of the structures. Some of the facilities like MCH, DH, UHC and union-level facilities were constructed long time before and need major overhauling and maintenance. A thorough assessment of maintenance needs is required followed by the development of a comprehensive maintenance plan for infrastructure and equipment, as was included in PFD OP. However no step has so far been taken by the PFD OP for developing a comprehensive maintenance plan.

Some initiatives were taken during the implementation of HPNSDP to improve the situation. A TA was processed for PFD OP from JDTAF fund for preparing a comprehensive master plan for civil works that could guide the future development and functional planning of health facilities over a long period. This activity could not be implemented due to timely start the recruitment process. But with the support from USAID MOHFW has already developed Tables of Equipment for 10-, 50- and 250-bed hospitals and is currently developing the same for 500-; 1000- and 1500-bed hospitals. HRM unit has taken a TA from JDTAF fund to develop table of organization for different types of health facilities. The outcome of these TA inputs can help the relevant program managers to synchronize physical construction with supply of equipment and human resource in a timely manner.

PFD OP face different challenges which are as follows

a) Absence of policy direction for maintaining balance between new construction, up gradation and repair;

b) Infrastructure development is not necessarily linked to systematic need assessment;

c) Lack of coordination among OPs related to infrastructure development and facility-based service provision (PFD, ESD, HSM and HRM);

d) Lack of emphasis on repair and maintenance;

e) Limited capacity of the infrastructure developing entities (HED and PWD) to maintain timeline;

f) Inadequate stewardship and supervision for operationalizing completed physical structures; and

g) Lack of emphasis on the needs of women and the physically challenged in accessing and using of public health facilities, etc.

During the 4thSector Program, the following key activities will be pursued for overcoming the challenges described above and development of the HNP sector of Bangladesh:

(i). A completion schedule will be prepared by MOHFW in coordination with HED and PWD to finish the incomplete civil works for priority structures. There will be improved supervision

and follow-up from MOHFW on HED and PWD to ensure completion of these structures within the agreed time period.

(ii). Emphasis will be put on the structures in hard-to-reach areas, underserved areas, structures related to medical/FP commodities storage and distribution and structures that are meant for serving specific interest groups (e.g. tribal people).

(iii). There will be increased coordination with HRD, PSSM-HS and PSSM-FP OPs to operationalize the already completed structures through supply of with required human resources and equipment thereby making those into active service centers.

(iv). A comprehensive maintenance plan will be prepared for the health and family welfare facilities for regular preventive and periodic curative maintenance of the structures.

(v). There will be a comprehensive construction plan developed upon execution of a construction need assessment and development of a detailed new construction action plan along with timeline. Priority for new construction will be focused on less attended areas, e.g. tribal areas, FP warehouses, community clinics remaining to be constructed, community clinics for the erstwhile enclaves, and stores for hospital drug and FP materials with appropriate temperature and humidity control.

(vi). Gender perspective will be incorporated into the construction and maintenance of physical facilities so that these can provide women-friendly services (e.g. separate functional toilet, privacy of examination room, breast-feeding corners, etc.). Attempt will be made to make the facilities user-friendly for older patients and the physically challenged.

(vii). Infrastructure for different service providers like Nursing Institutes, MATS, IHT, etc. are closely related to the evolving HR Strategy and HR Action Plan. Hence, decision of such construction will be synchronized with the HR Strategy and HR Action Plan.

(viii). The Table of Equipment and Table of Organization to be developed during HPNSDP will be synchronized so that these can be used while planning for new construction and upgrading of infrastructure in future.

4. Objectives

The main objectives of OP will be;

1. To develop new infrastructure facilities;
2. To upgrade existing facilities to meet increasing demand;
3. To develop comprehensive plan for repair and maintenance of health facilities, equipment and vehicles.
4. To complete the incomplete works of the carried-over activities
5. To strengthen coordination with relevant Ops for timely functioning of completed facilities and
6. To develop action plan for timely completion of construction works.

5. Components

Component –1: Re-Construction & up gradation of work

Activity

a) Re-construction of UHFWCs/UHCs

At present there are 3894 UHFWCs and 424 UHCs in the Country. As many as 600 UHFWCs (with semi pacca staff quarter) constructed in the early eighties. Many of them are in depilated condition and some of the facilities in costal areas are also in bad shape due to salinity. These facilities are unable to provided services to the people as per expectation. Huge cost is involved for regular maintenance of these facilities which is not cost effective. It would be better and cost effective to re-construct those facilities by demolishing them. It may be pointed out that some of the facilities have been eroded away by river. It is, therefore, proposed to re- construct of 250 UHFWCs in the 4th sector program.

b) Re-Construction of Community Clinics (CCs)

Community Clinic (CC) is a flagship initiative of the government which has been highly praised by the international community as a means to deliver services close to the people. Each community clinic has a defined catchment area with 7,000-10,000 population.

In rural Bangladesh, Community Clinics (CCs) are the closest health facilities to the Community People. The ideas of Community Clinic is to extend primary healthcare services to the doorsteps of the rural people.. A Community Clinic is the lowest and first level facility providing one stop services of health, family planning and nutrition to the community people.

It was planned to construct 13861 CC and upto June 2016 a total number of 13376 CCs were constructed.

In the meantime many of them are depilated and /or almost damaged. Further some of the Community Clinics (around 100) were eroded away by river. It is, proposed to re-construct 2000 Community Clinics in the next 4th Sector Programme.

c) Upgradation of UHFWCs

UHFWC constructed for providing coordinated health and family welfare services to the rural people at the union level. Due to lack of adequate space, some UHFWCs are not able to provide health and family welfare services as expected by the people.

In order to make the UHFWC a vital and effective facility for providing coordinated health and family welfare services including MCH services to the rural people, MOHFW decided to upgrade all UHFWCs in phases. Meanwhile 1748 UHFWCs (including 108. ongoing) have been upgraded; remaining 911 FWCs need to be upgraded. But due to resource constraint it is proposed to upgrade 300 of UHFWCs. in the 4th HNPSP program.

d. Upgrading Upazila Health Complex (UHC)

Initially a total number of 413 UHC 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. With the strength of 31 beds it is difficult to render desired services to the people around its catchment areas. Further, Honorable Prime Minister has declared to upgrade all the UHCs to 50 bed in phases. In view of the declaration, as of now 327 UHCs have already been upgraded and it is plan to upgrade another 45 in the 4th HNPSP.

e. Up-gradation of District Hospital (DHs)

The secondary health care is being provided at the district level through district hospitals where the be**d strength now varies from 50-250 beds.** Most of the district hospitals are old and not have

adequate facilities for providing expected services to the fast growing population in the districts. Considering the present health needs of the people, the Government has decided to upgrade the existing district hospitals from 50 beds to 150/200/ 250 beds in phases. Strengthening and modernization of District hospitals will ensure to provide quality health and family welfare services and will also reduce the load of tertiary care level facilities. 21 district hospitals have been taken up for up-gradation under HPNSDP. Out of which up- gradation of one district hospital has been completed and up- gradation works of 20 DHs are ongoing. It is, therefore, proposed to upgrade 15DHs under the 4th HNPSP.

Component-2: Construction of facilities

a) Construction of Union Health & Family Welfare Centers (UHFWCs)

As of now there are as many as 4550 Union Parishad across the country. So far 3894 UHFWCS have been Constructed/RD upgraded. But UHFWCs need to be constructed in 439 unions, where health and family welfare facilities such as, MCWC, and UHFWC do not exist. During 4th HNPSP it is proposed to construct 157 UHFWC out of 439 remaining unions where these facilities are not available.

b) Construction of 10 Bed MCWCs

To facilitate the delivery of health & family welfare services to mothers & children and enable them S an easy access to receive such essential services Govt. decided to construct MCWC in the country. A total of 117 MCWCs have since been established in the country. Considering the inadequacy of Mother & Child Care Health Facilities and their inequitable distribution, construction of 51 MCWCs have been proposed under the 4th HNPSP and initiative will be taken for functioning of the already completed 10 beded MCWC.

c) Construction/Establishment of IHT

Establishment of IHT will help to increase production of Laboratory Technicians. It will also help to reduce the existing shortage of laboratory technicians in the country. So far 8 IHTs have been established and 7 are under construction. Another 9 IHTs are proposed to be constructed during 4th HNPSP.

d) Construction of Medical Assistant Training School (MATS)

Govt. has so far established 9 of MATS across the country aiming at bringing out qualified Paramedics to assist the MBBS doctors and to dispense medical services independently to the patients. Govt. has, decided to establish 08 more MATS in the country under 4thHNPSP. During HPNSDP construction of 10 MATS has under taken and one MAT has been completed, construction of remaining 9 is ongoing.

e) Construction of 50 Bed Upazila Health Complex/Hospitals

In the past 31-bed hospitals were established in the upazila health complex in the country. Considering the population growth and increasing demand of health services Govt. has decided to construct 50-bed hospitals at the newly created Upazilas. Considering the above, it was planned to establish 10, 50 Bed UHCs at different newly created Upazilas. During HPNSDP it was planned to construct 10, 50 bed hospitals out of which 02 (two) have been completed and construction of 04 are ongoing.

f) Construction of Shishu Hospitals

The Govt. attaches very high priority for the improvement of child and maternal health. There is only one 25 bed govt. Shishu hospitals in the country which is totally inadequate to serve the increasing number of child patients. To address the health care needs of the children, govt. has decided to establish Shishu hospitals at every divisional headquarters of the country in phases. During HPNSDP construction of 04 shishu hospitals were under taken out of which 02 (Two) have been completed and 02 (Two) is under construction. It is therefore, proposed to construct shishu hospitals in the remaining divisional head quarter in phases under 4th HNPSP.

g) Construction/Establishment of Nursing Facilities

Government has taken initiative to produce more nurses with the expansion of nursing institutions including intake capacity both in public and private sector to address the increasing demand. At present yearly student intake for 3-years Diploma in Nursing Science and Midwifery is 8055 (2580 seats in 43 public and 5475 seats in 108 private Nursing Institutions). Since 2008 four years BSc nursing course has been introduced. Currently yearly student intake in BSc nursing is 2910 in 14 (1035 seats) public and 38 (1875 seats) private nursing colleges.

Government has introduced direct entry 3 years diploma in midwifery course since 2012. This course is offered in 53 institutions (975 seats in 38 public and 500 seats in 15 private institutions). Six month advance midwifery course is also offered for registered nurse-midwives as interim measures to address the required number of midwives in the country.

However, in relation to the increase number of student capacity and introduction of midwifery courses, the facilities such as infrastructures, hostel, number of teachers and supporting staffs, classroom, lab, library facilities, provision of teaching learning materials are not increased proportionately which hinders the quality of education and services. There are 8 Nursing Colleges (NCs) and 43 Nursing Training Institutes (NTIs) all over the country in public sector and 22 NTIs in private sector. But these existing facilities are not capable to produce required number of quality nurses and midwife. During 4th HNPSP more NTIs and NC will be established and the existing NTIs will also be upgraded on the basis of need assessment.

h) Construction of different office buildings

For proper functioning of official activities and to ensure better co-ordination with other agencies, private sector and NGOs. A total number of 44 offices {(HED circle offices (2), HED Divisional offices (3), HED Assistant Engineer's offices (2), Divisional offices for Directorate of Health Services (2), Civil Surgeon offices (10), Family Planning offices at District & Division Level (25)} will be established during 4th HNPSP. These offices at the Divisional/District levels will be established depending on the availability of land and other conditions. This will not only help to reduce cost by also ensure better co-ordination and management of services. **Construction of other Health and Family Welfare Facilities**

Besides the above mentioned facilities it is proposed to construct other facilities such as construction of Health Bhaban (3rd phase), construction of nurses training institute, 50 bed diabetic Hospital, construction of HED Bhaban (2nd phase), construction of 20 bed Trauma centre, Up gradation of BCPS (3rd phase), construction of remaining works of Bangladesh Institute of Health Management at Saver, construction of male and female hostel in the different medical colleges. Re-construction/ renovation of 5 (five) chest hospitals and 45 chest clinics, and remodeling and renovation of existing Upazila family planning stores will be included in the 4th sector program. Provision also proposes construct/ develop different other physical facilities based on demands from higher authorities and need assessment.

i) Periodical Maintenance of Infrastructures:

Till date approximately 17000 different types of infrastructures facilities have been constructed under DGHs and DGFP and more than 1000 are under process of completion. But due to lack of regular repair & maintenance, many of the completed facilities are failing to serve the people as per expectation. For regular maintenance and repair, some allocation is made through the revenue budget which is very inadequate and unable 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 functional. Therefore, it is proposed to allocate some maintenance fund under development budget.

A comprehensive maintenance plan would be prepared for the health and family welfare facilities for smooth maintenance, to avoid duplication and to ensure for providing quality services.

Component-3: Completion of incomplete works under taken during HPNSP:

Construction & up gradation works under Physical Facilities Development through HPNSDP have been implemented by HED, PWD. However, a total of 277 facilities out of which 227 under (HED) and 50 under (PWD) would not be completed by December, 2016 for various reasons. These incomplete activities have been proposed to be completed during 4th SDP.

Component-4: Procurement of Goods:

Activity-1: Procurement of Vehicles

Jeep: As per approved Organogram of HED there is a provision of 31 jeeps to support HED for rendering the services, out of 31 jeeps, 10 were purchased during the financial year 2011-2016 under PFD OP and 03 were replaced in the financial year 2014-2016. Remaining 18 jeep are around 20 years old and they are now in a dilapidated condition and calls for frequent repair & maintenance, incurring huge financial burden. In April 2016, 128 new posts have been created including Additional Chief Engineer, Deputy Chief Architect and number of Circle & Division offices are also increased in the approved Organogram of HED. So, a total of 10 Jeeps will be procured during 4th HNPSP. For site selection, supervision and monitoring of construction works of PWD 01 new Jeep will be procured for PWD during the next 4th sector program.

Motor Cycles: There are around 5000 UH&FWCs/Sub-Centers and 13358 Community Clinics throughout the country, most of which are established in remote places where movement with large vehicles is not convenient. Motor cycle is suitable for easy movement in the remote rural areas. At present there are 170 Motor cycles in the HED which were purchased between 1986-2000. Under PFD OP, 30 motor cycles were replaced during the financial year 2015-2016. Remaining 140 Motor cycles beyond repairable and need immediate replacement. Moreover, 40 posts of Sub Assistant Engineer have been created and approved for HED. Therefore, it is proposed to procure around 50 motor cycles during 4th HNPSP implementation period. Motor cycles will be used for field supervision during construction and repair and maintenance.

Microbus: Microbus is cost effective for survey, site selection, supervision, monitoring of construction, repair & maintenance works. In PFD OP, under HPNSDP 01(one) Microbus was procured in financial year 2014-2015. This vehicle is very effective fort OP execution, especially for coordination of HED head office officials with Ministry and other relevant agencies. It is proposed to procure another 1 microbus during 4th HNPSP implementation period.

Car: In approved organogram of HED, 01(one) car included in approved TO&E. The existing car was procured during project period of CMMU in the year 1989. The present condition of the car in a dilapidated and beyond repairable. So, it is proposed to procure 01 car for HED and 01 car for PWD.

After completion of the 4th Sector Development Program the vehicles will be included in the TO&E of the HED according to the government policy. POL and maintenance of the vehicles will be borne from the operational expenses of HED. Manpower will be attached from the department.

Component -5: Capacity Building

The overall purpose of the OP is to establish modern Physical Facilities all over the country. Training will enhance the capacity to identify priority needs, resource allocation and optimum resource utilization. It will enhance efficiency of the health care providers which will help to expand service coverage and ensure quality. It is proposed to allocate a small amount of fund for local and foreign training.

Component-6: Procurement of Service

To ensure proper design, supervision, timely completion, quality of works, etc. it is proposed to hire architect & engage architectural and engineering Consulting Firms. They will assist Health Engineering Department (HED) in the overall quality implementation of the works. This activity will be implemented in consultation and decision from higher authority.

Component-7: Co-ordination and monitoring;

Strong coordination mechanism will be established with other Ops (HSM, CBHC, NMES, and HRD etc.) and concerned agencies for timely functioning of constructed facilities. Considering the availability of resources and capacity of fund utilization a feasible procurement/ work plan will be developed for timely completion of construction works. Separate co-coordinator/ focal points will be engaged for important and large volume of works for continuous monitoring and feedback. Scheme summary will also be developed with detailed cost estimate, equipment and manpower requirement for important types of work to ensure governance and accountability. It is needed to strengthen field level monitoring and supervision to ensure quality and efficiency. Necessary steps will be taken for fully operationlized the asset management system. Procurement audit 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 4th HNPSP..

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

This OP is responsible for construction, re-construction, repair, renovation and maintenance of physical facilities under MOHFW.The proposed physical facilities will be developed following the strong adherence of environmental rules and regulation to avoid adverse effect of environment. Moreover, facilities for medical waste management will be developed under this OP which will reduce the health hazard. The physical established under this OP will render health services to men, women and children. Besides, separate facilities will also be established for providing health services to children. Therefore, men, women and children will be benefited from this OP.For proper functioning of the newly established facilities new post of doctors, nurses, technician and field workers will be created and this post will fill-up through recruitment of manpower. As a result a huage employment opportunity will be created through implementation of this OP. With the

establishment, expansion and upgradation of health facilities from villege to national level, health services will be accessable and affordable for all people, specially poor and marginalized. This will improve health status of people and thus increase productivity which will in turn reduce poverty.

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services: Annexed in Volume-II

9. Indicators:

Sl. No.	Indicators	Unit of Measurement (Means of verification)	Baseline June'2016	Project Target	
				Middle of the Program (By June 2020)	End of the Program (By June 2022)
1	2	3	4	5	6
1.	Introduce e-GP	Percentage (Admin record)	NA	75%	100%
2.	Percentage of Contracts awarded within initial Tender validity period.	% (Admin record)	97%% APIR 2016	100%	100%
3.	Preparation of a comprehensive plan for a) construction of facilities b) repair and maintenance	Availability of comprehensive plan	0	Draft approved	Implementation as per plan
4.	Percentage of non-development expenditure is for repair and maintenance at Upazila and below	Percentage	2.5%	4.0%	5.0%
5.	Number of Hospitals/ health facilities constructed/ renovated to make them gender and disability friendly (ramp, separate toilet for women and sitting arrangement).	% (Admin record)	NA	60%	95%
6..	Number of Facilities maintained/ repaired of different category.	% (Admin record)	NA	2200	5500
7.	Asset management	# of DH	AMS piloted	20	40

Sl. No.	Indicators	Unit of Measurement (Means of verification)	Baseline June'2016	Project Target	
				Middle of the Program (By June 2020)	End of the Program (By June 2022)
1	2	3	4	5	6
	system is implemented		in one district		

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
1145111.70	22514.31	0.00	22514.31	1167626.01	

10.2. Component and activity wise physical and financial target of OP: PFD

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Activity1:Reconstruction/Upgradation of facilities													
1	Upgradation of Upazila Health Complex (UzHC) from 10/31 to 50 Bed.	45		75600.00	75600.00	0.00	0.00	9828.00	16632.00	16632.00	15876.00	12096.00	4536.00
2	Upgradation of Upazila Health Complex (UzHC) from 10 to 50 Bed. (For Hill Tracks)	5		9000.00	9000.00	0.00	0.00	1170.00	1980.00	1980.00	1890.00	1440.00	540.00
3	Upgradation of Upazila Health Complex (UzHC) from 50 to 100 Bed.	4		12000.00	12000.00	0.00	0.00	1560.00	2640.00	2640.00	2520.00	1920.00	720.00
4	Upgradation of UH&FWC.	50		2000.00	2000.00	0.00	0.00	260.00	440.00	440.00	420.00	320.00	120.00
5	Upgradation of FWVTI	7		3600.00	3600.00	0.00	0.00	468.00	792.00	792.00	756.00	576.00	216.00
6	Re-construction of old existing Union Health & Family Welfare Centre. (UH&FWC).	100		16000.00	16000.00	0.00	0.00	2080.00	3520.00	3520.00	3360.00	2560.00	960.00
7	Re-construction of existing old Upazila Health Complex.	20		20000.00	20000.00	0.00	0.00	2600.00	4400.00	4400.00	4200.00	3200.00	1200.00
8	Vertical Extension of Health Bhaban.	1		8000.00	8000.00	0.00	0.00	1040.00	1760.00	1760.00	1680.00	1280.00	480.00
9	Extension of HED Circle Office and Divisional Office.	2		100.00	100.00	0.00	0.00	13.00	22.00	22.00	21.00	16.00	6.00
10	Re-Construction of existing old Community Clinic.	2000		40000.00	40000.00	0.00	0.00	5200.00	8800.00	8800.00	8400.00	6400.00	2400.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
11	Vertical Extension of DGDA Office from 2nd floor to 5th floor.	1	2000.00	2000.00	0.00	0.00	260.00	440.00	440.00	420.00	320.00	120.00
12	Remodeling, Renovation of existing Upazila Health Complex.	34	6800.00	6800.00	0.00	0.00	884.00	1496.00	1496.00	1428.00	1088.00	408.00
13	Remodeling & Renovation of existing Nurses Training Institute.	25	2500.00	2500.00	0.00	0.00	325.00	550.00	550.00	525.00	400.00	150.00
14	Remodeling, Renovation and Extension of existing RD/USC.	60	3000.00	3000.00	0.00	0.00	390.00	660.00	660.00	630.00	480.00	180.00
15	Remodeling & Renovation of existing community clinic.	500	2500.00	2500.00	0.00	0.00	325.00	550.00	550.00	525.00	400.00	150.00
16	Remodeling & Renovation of existing Regional Ware House.	21	4200.00	4200.00	0.00	0.00	546.00	924.00	924.00	882.00	672.00	252.00
17	Remodeling and Construction of Different Health and Family Planning Infrastructure.	146	36977.72	36977.72	0.00	0.00	4807.10	8135.10	8135.10	7765.32	5916.44	2218.66
18	Repair, Renovation of Health & Family Planning Infraustructure	8000	75000.00	75000.00	0.00	0.00	9750.00	16500.00	16500.00	15750.00	12000.00	4500.00
19	Repair and Maintainence Works of Different Health Infraustructure in Tangail District of SSK Pilot Project under Health	12	200.00	200.00	0.00	0.00	0.00	40.00	40.00	40.00	40.00	40.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Economics and Financing OP.											
20	Upgradation and Renovation of District Hospital from 100 to 250 Bed	14	63000.00	63000.00	0.00	0.00	8190.00	10710.00	13860.00	11340.00	10080.00	8820.00
21	Upgradation and Renovation of District Hospital	3	8000.00	8000.00	0.00	0.00	1600.00	1600.00	1600.00	1600.00	800.00	800.00
22	Vertical extention of Academic building at Dinajpur Medical College and other external services.	1	1900.00	1900.00	0.00	0.00	475.00	475.00	475.00	475.00	0.00	0.00
23	Vertical extention of Internee doctors hostel (Male and Female) ,doctors dormitory at Dinajpur Medical College.	1	500.00	500.00	0.00	0.00	125.00	375.00	0.00	0.00	0.00	0.00
24	Vertical extention of hospital Building at Dinajpur Medical College, Dinajpur	1	6000.00	6000.00	0.00	0.00	780.00	1020.00	1320.00	1080.00	960.00	840.00
25	Remaining work of Auditorium building at Dinajpur Medical College.	1	1400.00	1400.00	0.00	0.00	182.00	238.00	308.00	252.00	224.00	196.00
26	Vertical extention of hospital Building at Comilla Medical	1	2500.00	2500.00	0.00	0.00	325.00	425.00	550.00	450.00	400.00	350.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
	College,Comilla												
27	Vertical extention of Girls hostel at Mymensing Medical College	1		400.00	400.00	0.00	0.00	52.00	68.00	88.00	72.00	64.00	56.00
28	Retrofitting & Complete renovation,emergency repair,alteration and Maitenance work of Mymensingh Medical College Hospital	1		900.00	900.00	0.00	0.00	117.00	153.00	198.00	162.00	144.00	126.00
29	Vertical extention of Shaheed Ziaur Rahman Medical College Hospital at Bogra including Burn and Plastic Surgery unit	1		9000.00	9000.00	0.00	0.00	1170.00	1530.00	1980.00	1620.00	1440.00	1260.00
30	Vertical extention of Sylhet M.A.G Osmani Medical College, hospital Building from 3rd to 9th floor.	1		4500.00	4500.00	0.00	0.00	585.00	765.00	990.00	810.00	720.00	630.00
31	Vertical extention of Male and Female hostel at Sylhet M.A.G Osmani Medical College, Sylhet	1		2000.00	2000.00	0.00	0.00	260.00	340.00	440.00	360.00	320.00	280.00
32	Vertical extention of dental unit at Sylhet M.A.G Osmani Medical College,	1		1000.00	1000.00	0.00	0.00	130.00	170.00	220.00	180.00	160.00	140.00
33	Vertical extention of Academic building & Pharmacology building of	1		300.00	300.00	0.00	0.00	39.00	51.00	66.00	54.00	48.00	42.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
	Rajshahi Medical College												
34	Remaining work of Construction of Govt shishu hospital at Rajshahi	1		800.00	800.00	0.00	0.00	200.00	200.00	200.00	200.00		
35	Installation of 1000 KVA substation and 500 KVA generator at Rajshahi Medical College Hospital	1		200.00	200.00	0.00	0.00	60.00	140.00	0.00	0.00	0.00	0.00
36	Vertical extention of 4th to 9th floor over existing 3rd flloor of Academic building at Chitagong Medical College .Chittagong	1		3500.00	3500.00	0.00	0.00	455.00	595.00	770.00	630.00	560.00	490.00
37	Vertical extention of female hostel at Chitagong Medical College .Chittagong	1		750.00	750.00	0.00	0.00	225.00	262.50	262.50	0.00	0.00	0.00
38	Vertical extention of Dental Unit at Chitagong Medical College .Chittagong	1		325.00	325.00	0.00	0.00	65.00	260.00	0.00	0.00	0.00	0.00
39	Remaining work of Cardiac Surgery building at chittagong Medical College hospital	1		800.00	800.00	0.00	0.00	160.00	640.00	0.00	0.00	0.00	0.00
40	Vertical extention of ICU Building at Chittagong Medical College hospital	1		1000.00	1000.00	0.00	0.00	200.00	800.00	0.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
41	Vertical extention of Microbiology Lecture hall at Rangpur Medical College.	1		125.00	125.00	0.00	0.00	125.00	0.00	0.00	0.00	0.00	0.00
42	Vertical extention of Brother's hostel building at Rangpur Medical College Hospital.	1		75.00	75.00	0.00	0.00	75.00	0.00	0.00	0.00	0.00	0.00
43	Vertical extention of Dental Unit and outdoot at Rangpur Medical College ,Rangpur	1		500.00	500.00	0.00	0.00	125.00	375.00	0.00	0.00	0.00	0.00
44	Vertical Extension of Female hostel at Sher-e-Bangla Medical College at Barisal	1		1000.00	1000.00	0.00	0.00	300.00	350.00	350.00	0.00	0.00	0.00
45	Vertical extention of Library hall room at Sher-e- Bangla Medical College at Barisal	1		500.00	500.00	0.00	0.00	150.00	175.00	175.00	0.00	0.00	0.00
46	Remaining work of Construction of Govt shishu hospital at Barishal	1		800.00	800.00	0.00	0.00	240.00	280.00	280.00	0.00	0.00	0.00
47	Remaining work of Modernization & Extension of Barishal Medical College Hospital.	1		1690.00	1690.00	0.00	0.00	507.00	591.50	591.50	0.00	0.00	0.00
48	Vertical extention of 2nd and 3rd floor of Academic building at Khulna Medical	1		1150.00	1150.00	0.00	0.00	345.00	402.50	402.50	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
	College												
49	Vertical extention of of 4th floor of outdoor building at Khulna Medical College hospital.	1		300.00	300.00	0.00	0.00	60.00	240.00	0.00	0.00	0.00	0.00
50	Vertical extention of new building and Isolation ward at Noakhali 250 bed Sadar Hospital.	1		800.00	800.00	0.00	0.00	240.00	280.00	280.00	0.00	0.00	0.00
51	Renovation/Reconstruction of existing 5 nos Chest Disease Hospital	5		2000.00	2000.00	0.00	0.00	260.00	340.00	440.00	360.00	320.00	280.00
52	Renovation/Reconstruction of existing 45 nos Chest Disease Clinics	45		10000.00	10000.00	0.00	0.00	1300.00	1700.00	2200.00	1800.00	1600.00	1400.00
53	Vertical Extention of National Institute of Mental Hospital at sher-e- Bangla Nagar Dhaka	1		7200.00	7200.00	0.00	0.00	936.00	1224.00	1584.00	1296.00	1152.00	1008.00
54	Vertical extention of Shaheed Suhrawardi hospital at S.B. Nagar Dhaka	1		23428.00	23428.00	0.00	0.00	3045.64	3982.76	5154.16	4217.04	3748.48	3279.92

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
55	Vertical extention of of North and South block(4th floor to 6th floor) of National Institute of Cardiovascular Diseases and Hospital(NICVD) at sher-e- Bangla Nagar Dhaka.	1	8800.00	8800.00	0.00	0.00	1144.00	1496.00	1936.00	1584.00	1408.00	1232.00
56	Extention of National Institute of kidney Diseases and Urology Hospital at sher-e- Bangla Nagar, Dhaka	1	8100.00	8100.00	0.00	0.00	1053.00	1377.00	1782.00	1458.00	1296.00	1134.00
57	Vertical Extension of National Institute of Neurosciences Hospital (NINS) at S.B. Nagar, Dhaka.	1	2050.00	2050.00	0.00	0.00	266.50	348.50	451.00	369.00	328.00	287.00
58	Vertical extention of Ciivil Surgeon Office at Satkhira	1	400.00	400.00	0.00	0.00	120.00	140.00	140.00	0.00	0.00	0.00
59	Vertical Extention of Service Block of 500 bed hospital at Mugda	1	1600.00	1600.00	0.00	0.00	400.00	400.00	400.00	400.00	0.00	0.00
60	Remaining work of Nursing and Midwifery Bhaban at Mohakhali	1	4000.00	4000.00	0.00	0.00	520.00	680.00	880.00	720.00	640.00	560.00
61	Vertical extention of Asthma Center at Mohakhali,Dhaka	1	3000.00	3000.00	0.00	0.00	390.00	510.00	660.00	540.00	480.00	420.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
62	Approach road with relevant facilities to Infectious disease hospital at Mohakhali.	1		700.00	700.00	0.00	0.00	210.00	245.00	245.00	0.00	0.00	0.00
63	Vertical extention of BMRC bhaban at Mohakhali	1		4640.00	4640.00	0.00	0.00	603.20	788.80	1020.80	835.20	742.40	649.60
64	Extension of 200 Beded Hospital to 500 Beded Hospital at Narayangonj. (1st Phase)	1		7000.00	7000.00	0.00	0.00	910.00	1190.00	1540.00	1260.00	1120.00	980.00
65	Supply &Installation of Medical gas system at different district hospitals	20		2000.00	2000.00	0.00	0.00	260.00	340.00	440.00	360.00	320.00	280.00
66	Retrofitting & Complete renovation,emergency repair,alteration and Maitenance work of all Specialized Hospital & old Medical college and hospitals	50		75000.00	75000.00	0.00	0.00	9750.00	12750.00	16500.00	13500.00	12000.00	10500.00
67	Supply &Installation /replecement of Passanger lift / Bed lift at Different Medical Colleges & Hospitals, Specialized Hospital/ Hospitals	20		2000.00	2000.00	0.00	0.00	260.00	340.00	440.00	360.00	320.00	280.00
68	Remodeling/Reconstruction of Urban Health Dispensaries and School	4		800.00	800.00	0.00	0.00	104.00	136.00	176.00	144.00	128.00	112.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Health Clinics.											
69	Renovation/Remodeling of Existing NTIs	3	2500.00	2500.00	0.00	0.00	325.00	425.00	550.00	450.00	400.00	350.00
70	Vertical extension of Dierrhoea Ward from goroud floor to 1st floor at Kishorgonj 250 Bed general hospital, Kishorgonj	1	50.00	50.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00	0.00
71	Vertical extension of Faridpur Medical College Hospital building	1	4000.00	4000.00	0.00	0.00	520.00	680.00	880.00	720.00	640.00	560.00
72	Remaining workof Bangladesh Institute of Health Management at Savar	**1**	28000.00	28000.00	0.00	0.00	0.00	1000.00	10000.00	17000.00	0.00	0.00
	Sub Total	11241	632460.72	632460.72	0.00	0.00	81495.44	123885.66	143106.56	133746.56	93687.32	56539.18
Activity2: Construction of facilities												
1	Construction of Union Health & Family Welfare Centre (UH&FWC).	200	32000.00	32000.00	0.00	0.00	4160.00	7040.00	7040.00	7040.00	5120.00	1600.00
2	RD Converted to FWC	10	1600.00	1600.00	0.00	0.00	208.00	352.00	352.00	352.00	256.00	80.00
3	Construction of Boundary wall of existing Union Health & Family Welfare Centre (UH&FWC).	495	7425.00	7425.00	0.00	0.00	965.25	1633.50	1633.50	1633.50	1188.00	371.25
4	Construction of 50 Bed Hospital for new upazila.	10	30000.00	30000.00	0.00	0.00	3900.00	6600.00	6600.00	6600.00	4800.00	1500.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
5	Construction of 31 Bed Hospital for new upazila.	2	4000.00	4000.00	0.00	0.00	520.00	880.00	880.00	880.00	640.00	200.00
6	Construction of Upazila Family Planning office cum Store at UzHC.	100	9000.00	9000.00	0.00	0.00	1170.00	1980.00	1980.00	1980.00	1440.00	450.00
7	Construction of 10 Bed Mother and Child Welfare Centre.	50	27500.00	27500.00	0.00	0.00	3575.00	6050.00	6050.00	6050.00	4400.00	1375.00
8	Construction of 20 Bed Mother and Child Welfare Centre.	1	1000.00	1000.00	0.00	0.00	130.00	220.00	220.00	220.00	160.00	50.00
9	Construction of 100 Bed Child Hospital	2	7200.00	7200.00	0.00	0.00	936.00	1584.00	1584.00	1584.00	1152.00	360.00
10	Construction of FWVTI.	5	11000.00	11000.00	0.00	0.00	1430.00	2420.00	2420.00	2420.00	1760.00	550.00
11	Establishment of Institute of Health Technology.	10	40000.00	40000.00	0.00	0.00	5200.00	8800.00	8800.00	8800.00	6400.00	2000.00
12	Construction of Medical Assistant Training School.	8	28000.00	28000.00	0.00	0.00	3640.00	6160.00	6160.00	6160.00	4480.00	1400.00
13	Construction of Health Engineering Department (HED) Bhaban.	1	6500.00	6500.00	0.00	0.00	845.00	1430.00	1430.00	1430.00	1040.00	325.00
14	Construction of HED Circle and Divisional Office.	1	950.00	950.00	0.00	0.00	123.50	209.00	209.00	209.00	152.00	47.50
15	Constructin of HED Divisional Office.	3	600.00	600.00	0.00	0.00	78.00	132.00	132.00	132.00	96.00	30.00
16	Construction of Assitant Engineer Office.	2	200.00	200.00	0.00	0.00	26.00	44.00	44.00	44.00	32.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
17	Construction of Divisional Director Office. (Health)	2	1200.00	1200.00	0.00	0.00	156.00	264.00	264.00	264.00	192.00	60.00
18	Construction of Civil Surgeon Office	3	1650.00	1650.00	0.00	0.00	214.50	363.00	363.00	363.00	264.00	82.50
19	Construction of General Hospital and Trauma Center.	2	2400.00	2400.00	0.00	0.00	312.00	528.00	528.00	528.00	384.00	120.00
20	Construction of Deputy Director (FP) Office.	30	15750.00	15750.00	0.00	0.00	2047.50	3465.00	3465.00	3465.00	2520.00	787.50
21	Construction of Deputy Director and Divisional Director (FP) office at Barisal	1	650.00	650.00	0.00	0.00	84.50	143.00	143.00	143.00	104.00	32.50
22	Vertical Extension of BCPS Bhaban at Mohakhali, Dhaka	1	2000.00	2000.00	0.00	0.00	260.00	440.00	440.00	440.00	320.00	100.00
23	Construction of Office Building for IPHN at Mohakhali, Dhaka.	1	1500.00	1500.00	0.00	0.00	195.00	330.00	330.00	330.00	240.00	75.00
24	Construction of Regional Ware House for Family Planning services.	1	500.00	500.00	0.00	0.00	65.00	110.00	110.00	110.00	80.00	25.00
25	Construction of Community Clinic.	1029	20580.00	20580.00	0.00	0.00	2675.40	4527.60	4527.60	4527.60	3292.80	1029.00
26	Construction of Central Ware House for Family Planning at Mohakhali, Dhaka.	1	6000.00	6000.00	0.00	0.00	780.00	1320.00	1320.00	1320.00	960.00	300.00
27	Construction of NIPORT Bhaban.	1	3000.00	3000.00	0.00	0.00	390.00	660.00	660.00	660.00	480.00	150.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
28	Construction of Nursing College.	7	20000.00	20000.00	0.00	0.00	2600.00	4400.00	4400.00	4400.00	3200.00	1000.00
29	Construction of 20 Bed Hospital.	4	7400.00	7400.00	0.00	0.00	962.00	1628.00	1628.00	1628.00	1184.00	370.00
30	Construction of Central Warehouse to preserve EPI Vaccine at Mohakhali, Dhaka.	1	850.00	850.00	0.00	0.00	110.50	187.00	187.00	187.00	136.00	42.50
31	Construction of Nursing Institute.	2	5000.00	5000.00	0.00	0.00	650.00	1100.00	1100.00	1100.00	800.00	250.00
32	Construction of OPD and store building at 250 bed hospital at Dinajpur	1	500.00	500.00	0.00	0.00	65.00	85.00	110.00	90.00	80.00	70.00
33	Construction of dormitory building at Comilla Medical College and Hospital.	1	1000.00	1000.00	0.00	0.00	130.00	170.00	220.00	180.00	160.00	140.00
34	Construction of Isolation Unit and Other facilities at comilla Medical College.	1	1500.00	1500.00	0.00	0.00	195.00	255.00	330.00	270.00	240.00	210.00
35	Construction of Mosque at Comilla Medical College	1	200.00	200.00	0.00	0.00	40.00	160.00	0.00	0.00	0.00	0.00
36	Construction of Auditorium at Comilla Medical College	1	1500.00	1500.00	0.00	0.00	375.00	375.00	375.00	375.00	0.00	0.00
37	Establishment of Burn Unit at Mymensingh Medical College Hospital.	1	1000.00	1000.00	0.00	0.00	250.00	250.00	250.00	250.00	0.00	0.00
38	Construction of Staff quarter at Mymensingh Medical College Hospital.	1	900.00	900.00	0.00	0.00	225.00	225.00	225.00	225.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
39	Construction of Civil Surgeon office at Mymensing	1	500.00	500.00	0.00	0.00	150.00	175.00	175.00	0.00	0.00	0.00
40	Construction of Shishu Hospital at Mymensing	1	3000.00	3000.00	0.00	0.00	390.00	510.00	660.00	540.00	480.00	420.00
41	Construction of new 10 storied building at Sylhet M.A.G Osmani Medical College hospital ,Sylhet	1	954.00	954.00	0.00	0.00	286.20	333.90	333.90	0.00	0.00	0.00
42	Construction of landry building at Sylhet M.A.G Osmani Medical College hospital ,Sylhet	1	150.00	150.00	0.00	0.00	30.00	120.00	0.00	0.00	0.00	0.00
43	Construction of 250 Bed District Hospital at Sylhet.	1	8700.00	8700.00	0.00	0.00	1131.00	1479.00	1914.00	1566.00	1392.00	1218.00
44	Construction of Female hostel at Rajshahi Medical College	1	500.00	500.00	0.00	0.00	100.00	200.00	200.00	0.00	0.00	0.00
45	Construction of Administrative buildingat at Rajshahi Medical College.	1	1500.00	1500.00	0.00	0.00	375.00	375.00	375.00	375.00	0.00	0.00
46	Construction of Boy's Nurses hostel at Chittagong Medical College	1	1000.00	1000.00	0.00	0.00	250.00	250.00	250.00	250.00	0.00	0.00
47	Construction of Shishu Hospital at Chittagong	1	3000.00	3000.00	0.00	0.00	390.00	510.00	660.00	540.00	480.00	420.00
48	Construction of Civil Surgeon Office building at Rangpur	1	370.00	370.00	0.00	0.00	74.00	296.00	0.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
49	Construction of Ladies hostel at Rangpur Medical College	1	1350.00	1350.00	0.00	0.00	175.50	229.50	297.00	243.00	216.00	189.00
50	Construction of Isolation Unit and Other facilities at Rangpur Medical College Hospital	1	1500.00	1500.00	0.00	0.00	195.00	255.00	330.00	270.00	240.00	210.00
51	Construction of dormitory building for post graduate doctor's at Rangpur	1	1500.00	1500.00	0.00	0.00	195.00	255.00	330.00	270.00	240.00	210.00
52	Construction of office building and residence for Civil Surgeon office at Khulna.	1	700.00	700.00	0.00	0.00	210.00	245.00	245.00	0.00	0.00	0.00
53	Construction of Shishu hospital at khulna .	1	3000.00	3000.00	0.00	0.00	390.00	510.00	660.00	540.00	480.00	420.00
54	Construction of nurses dormitory and staff dormitory at khulna Medical College hospital	1	1367.00	1367.00	0.00	0.00	177.71	232.39	300.74	246.06	218.72	191.38
55	Construction of medical store building at khulna Medical College hospital.	1	300.00	300.00	0.00	0.00	39.00	51.00	66.00	54.00	48.00	42.00
56	Construction of boundary wall & Internal road at khulna Medical College	1	1000.00	1000.00	0.00	0.00	130.00	170.00	220.00	180.00	160.00	140.00
57	Construction of civil Surgeon office at Noakhali	1	500.00	500.00	0.00	0.00	125.00	375.00	0.00	0.00	0.00	0.00
58	Construction of walk way and palasiding work at	1	95.00	95.00	0.00	0.00	23.75	71.25	0.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Noakhali 250 beded sadar hospital at Noakhali											
59	Construction of Civil Surgeon Office building at Jessore	1	400.00	400.00	0.00	0.00	200.00	200.00	0.00	0.00	0.00	0.00
60	Construction of Waste Tretment plant at National Institute of Opthalmology at sher-e- Banglanagar Dhaka	1	65.00	65.00	0.00	0.00	65.00	0.00	0.00	0.00	0.00	0.00
61	Establishment of College of Physiotherapy at Dhaka (1st phase)	1	1000.00	1000.00	0.00	0.00	250.00	250.00	250.00	250.00	0.00	0.00
62	Establishment of National Blood Center.	1	1000.00	1000.00	0.00	0.00	300.00	350.00	350.00	0.00	0.00	0.00
63	Construction of Principal quarter,staff quarter,Boys hostel and ladies hostel at Institute of health technology at Mohakhali dhaka.	1	3000.00	3000.00	0.00	0.00	390.00	510.00	660.00	540.00	480.00	420.00
64	Construction of specialized hospital at kurigram district	1	2000.00	2000.00	0.00	0.00	260.00	340.00	440.00	360.00	320.00	280.00
65	Construction of civil surgeon office at kushtia	1	600.00	600.00	0.00	0.00	180.00	210.00	210.00	0.00	0.00	0.00
66	Construction of civil surgeon office at Tangail	1	400.00	400.00	0.00	0.00	120.00	140.00	140.00	0.00	0.00	0.00
	Sub Total-B	**2021**	341506.00	341506.00	0.00	0.00	46291.31	75163.14	75576.74	72614.16	52507.52	19353.13

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Activity3:Completion of Incomplete works under taken during HPNSDP													
1	Remaining Project from HPNSDP (HED)	556		85717.29	82832.98	2884.31	0.00	12017.29	22000.00	16000.00	17000.00	14000.00	4700.00
2	Remaining Project from HPNSDP (PWD)	**54**		73442.00	53812.00	19630.00	0.00	9547.46	12485.14	16157.24	13219.56	11750.72	10281.88
3	Sub Total	**610**		159159.29	136644.98	22514.31	0.00	21564.75	34485.14	32157.24	30219.56	25750.72	14981.88
Activity4:Procurement of goods													
1	Procurement of Goods and operational Expenses of HED.	(Jeep-5, Motor Cycle-20 and Furniture & others-LS)		1500.00	1500.00	0.00	0.00	195.00	330.00	330.00	315.00	240.00	90.00
2	Capacity Building (HED)	1		500.00	500.00	0.00	0.00	32.50	105.00	105.00	102.50	90.00	65.00
3	Procurement of Services.	6		500.00	500.00	0.00	0.00	65.00	110.00	110.00	105.00	80.00	30.00
4	Operational Expenses of PLMC	1		600.00	600.00	0.00	0.00	78.00	132.00	132.00	126.00	96.00	36.00
5	Procurement of Audit.	1		400.00	400.00	0.00	0.00	52.00	88.00	88.00	84.00	64.00	24.00
6	Land Purchess/ Acquision.	1		30000.00	30000.00	0.00	0.00	3900.00	6600.00	6600.00	6300.00	4800.00	1800.00
7	Procuremet of goods, operational expenses of PWD.	5		500.00	500.00	0.00	0.00	50.00	150.00	150.00	80.00	50.00	20.00
8	Capacity Building (PWD)	1		500.00	500.00	0.00	0.00	65.00	85.00	110.00	90.00	80.00	70.00
	Sub Total	**16**		34500.00	34500.00	0.00	0.00	4437.50	7600.00	7625.00	7202.50	5500.00	2135.00
	Grand Total	**13888**		1167626.01	1145111.70	22514.31	0.00	153789.00	241133.94	258465.54	243782.78	177445.56	93009.19

11. Budget support from other Operational Plan: Not applicable

4.15 Improved Financial Management (IFM)

1. Name of the Operational Plan: Improved Financial Management (IFM)

2. Implementing Agency: MOHFW

3. Introduction

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. Letter on with the guidance of PFC after several reform processes PFC shifted to FMAU and gradually started its journey from July 2003 in associated with the Improved Financial Management (IFM) Operational Plan. Presently FMAU (IFM) is administering with IDA credit no 4954-BD, TF 11556, TF 12281 & JICA P 68. 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 expenditure information of all pool fund sources to fulfill the needs of the Principal Accounting Officer, Secretary of MoHFW.

The Public Financial Management System in Bangladesh is required for gradual improvement of public fund management based on reimbursement effectively with economy, efficiency and accountability which is practiced at all levels of the system. It is evident that, GOB has made considerable progress in public financial reforms management MTBF & SPEMP initiatives with some limitations of understanding gap between reform areas and its implementation. As a thrust to improve the HPSP quality expenditure and ensure its financial accountability, three sector program of HPSP contributed to commendable results over the period of about past 22 years. These three programmes have been shaped financial governance and strengthened towards government's health systems and supported its implementation, technically and financially. There have been developments in budgeting procedures, planning of Operational Plan (OP) wise resource allocations, capacity building including the medium-term budget framework (MTBF), fund disbursements, financial monitoring and reporting systems. Further improvements in FM with a view to internal control during HPNSDP period. Others improvement also evident that, some interventions carried out through the engagement of FM personnel in transition who ensured support. FMAU's restructuring has been approved and revised recruitment rules is under process to expedite for its approval.

FAPAD of OCAG has been conducting consecutive 4 round external audit among 32 OPs of HPNSDP following the guidelines set out in the audit manual specifically meant for the auditors of the directorate. The 4 report has been contributed to more transparency and complement to guide financial management of 32 OP of MoHFW. Within 4 years of IFM interventions three audit firms were appointed for addressing systemic internal control, weaknesses identified and follow ups on the findings. Building on the experience of HPNSDP audit report ministry has developed a draft audit strategy (2011-16) with the consultation of respective stakeholder and WB for sector program. The strategy document highlighting the inherent weaknesses in audit has also identified the roles and responsibilities of FAPAD, MOHFW and DPs in an attempt to reach a common understanding on the importance of oversight arrangements for HPNSDP. Financial Management Task Group constitution was new reforms in the 3rd sector program Within the FMTG consultation process led fundamental reforms to influence to protect assets management and extended its future in addition to on-going Supply Chain Management. Beside this, inclusion of tools for assets tracking system may carry out the more value for money for multi-dimensional aspects of safeguards and resource utilization. FMAU played a coordination role to speed-up the intervention which has been piloted finally in the Moulovibazar District Hospital.

4. Objectives

The main objectives of OP will be;

(i) Strengthening financial Management through res-structuring and strengthening of FMAU

(ii) Ensure transparency and accountability in financial management of the program funds;

(iii) Minimize the fiduciary risk of fund utilization through strong adherence of financial rules and regulation and implementation of fiduciary risk reduction action plan;

(iv) Strengthen internal audit system in the Ministry and Directorates for achieving effective, efficient and quality of the Programme;

(v) Enhance capacities of the officials of OPs and Directorates on FM issues through provision of skilled human resources, imparting training and coordination with relevant agencies.

(vi) Ensure stewardship role of FMAU to monitor, supervise and guide the fund utilization, management and reporting of different LDs and entities.

5. Components

Component-1: Accounting and Reporting

The FMAU is responsible for two major tasks in the area of accounting and reporting. One relates to the preparation of program accounts at the year-end to meet the statutory requirements, and the other relates to generation of quarterly reports like IUFRs which is used to claim reimbursement from the health pool funds. The accounting of actual HPNSDP funds release and reporting procedures is still need to be strengthened through establishment of connectivity between Integrated Budget and Accounting System (iBAS) and FMAU, strengthening of the management of the accounting functions of FMAU of MOHFW, timely producing of accurate Financial Reports in future which may evolve in FM systems. That has to be rationalized and simplified which would it more flexible, aligned and predictable than in the past. So, an assessment of present accounting system to identify the existing gap of information systems in the MOHFW and has been completed to address them in the proposed Financial Management Information System (FMIS). In view of this, the MOHFW is considering the implementation of its own financial management information system (FMIS). The new FMIS, if implemented, will have an interface with iBAS ++, the successor system to iBAS, that is still initial stage at the MOF.

The restructuring of FMAU have to deal with HPNSDP expenditure monitoring, reporting and management of audits might be emancipate to another good step towards strengthening PFM. However, FMAU still continue to suffer from acute shortage of staff with the requisite skills to deliver its mandate. FMAU will intensify efforts according to need that ensure the use of new option to produce management accounting reports for monitoring the health sector program, expenditure monitoring by componentwise resource tracking, reviewing budget variances, analyzing financial information.

However, having with delay in restructuring process had to take long time for post creation and even the immediate the requirement is unmet. It is therefore critical that to mitigate fiduciary risks resulting from understaffing, limited authority and weak oversight over FM and internal audit functions at the LDs & field offices till to on board of required HR for FMAU. HNP Sector Program to ensure a clear

understanding about reporting within the Ministry of Health and family Welfare and LDs, but the use of dual reporting sources needs to be discontinued, requiring a phased approach to bring gradual improvements in the timeliness of the reporting and the reconciliation process.

Component-2: Internal Control and Audits:

To strengthen internal audit for ensuring effective periodic audit of financial and operational activities in the sector. During the implementation period of 3rd sector program, internal audit was carried out with acceptable TOR in a outsourced manner. Through hiring of private audit firms, MOHFW has made commendable efforts in improving internal audit assurance. However, more remain to be done to raise the profile of internal audit as an integral and strategic function within MOHFW. Over the year's internal audit also conducted by available on board auditor of FMAU in a cyclic order at the outset of other chartered duties. However, in a sustainable point of view both process were not adequate to meet total requirement of internal control. It is therefore, as an ad-interim arrangement FMAU is to be continued to outsource internal audit since required staff on board in align with restructured posts. Further step is also need for effectiveness of internal audit through adopting spot-heck as early warning to concern spending unit. The other requirement is important to enhance the more coordination with external audit aiming to minimize time, understanding of issues as well as flow-up process. For next sector program FMAU would intensify its efforts to address challenges of internal control.

The number of unresolved audit objections raised by the C&AG continues to be a matter of concern. This is due to lack of awareness about financial rules and regulation, lack of understanding in responding to audit objections by spending unit, field level cost centre and Upazila level and response of audit office between both ends appeared as time consuming which resulted in a number of unresolved audit objections. FMAU has been provided active effort for resolution of observations by holding bipartite and tripartite meeting with the auditor & audit team of MoHFW.

Component-3: Institutional Capacity Development:

In the previous of 3rd sector program the main Challenges of financial management relates to the weakness of establishing the basic institutional framework as much as required for sustainable systems management and development. At the initial stage of program, most of the directorate level PFM functions were carried out in a fragmented manner by different units with very little coordination amongst them. Ad-hoc and improvised arrangements were made to deal with FM functions. Similar arrangement also exists in some district and at Upazilla level. Under the 'Improved Financial Management' (IFM) several training program on FM has been implemented. Until June, 2016 under three sub components of IFM Operational Plan, 4708 officials including LDs, DDOs and Accounts Personnel have been given 2 days' training on Financial Management. The training program has certainly been useful. So, some re-arrangement with more time and resources to be need for regular training on FM, sustaining the capacity for more value addition in this area. Building positive efforts remain a key concern in the health financial sector. The implementation experience of such measures helps to mitigate fiduciary risks in agencies levels.

Therefore, FMAU of the MOHFW needs to be strengthened in order to enable it to provide better fiduciary oversight and discharge financial management activities more effectively. Restructuring of FMAU could be mitigated fiduciary risk, if it get rid of such present understaffing.

Component-4: 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, PFM reform program (SPEMP) and its Components 3, 5 and 6 which deal with strengthening the expenditure management systems and processes. The 3rd sector program moderately by linking and coordinating the activities with MOF and SPEMP project outputs. The new program objectives meant to focus on new option so, FM has to need prepare for discharging the new charters with country system through the concerted efforts of MOHFW and MOF.

Component-5: Strengthening the Monitoring, Oversight of Expenditure Management and Financial management:

In the analysis of the implementation experience of very beginning of 3rd sector program resulting from the weak monitoring of expenditure incurred by the spending units as well as a weak framework follow up. Despite of this limitation, some approaches in this area are remarkable, such as monitoring through the provision of monthly ADP review meeting contributed by suggestive measures led to recover the potentials time gap, risk of slow progress in earlier quarter and their evolved bottle-neck. IT based budget records has been used (website of MOF) in first quarter fund release, consecutive quarterly released process has been speed-up gradually. Over budgeting deviation in any line item of OP budget properly filtered in the 3rd sector program expenditure. But, in most cases within the purview of guiding principles drawings of advance and finalization somehow influenced by due compliance. Therefore, to address the advance drawn issues, material statements, relevant evidence for needed purpose with timely submission could be effective to mitigate risk which is also a future concern. It is noted that, some progress are commendable in some specific measures such as fund channeling through bank, coding compliance, case by case SOE trail and reconciliation between FMAU and CAO, though IUFR is produced manually.

Component-6: Capacity Building and Human Resource Development:

It was a clear understanding in two APR, FMAU restructuring only can prevent the weakness in financial management in health sector program. Upon provided the huge efforts from MOHFW and Ministry of Public Administration (MOPA) have been approved the 29 post of 8 categories in line with proposed restructuring even need it long time. Such commendable reforms might be combat the insignificant staff capacities to run the intended purposes of FMAU in next. It is expected that this new structure once implemented will fundamentally change the institutional arrangement to help adequate fiduciary oversight. Moreover, in terms of number and skill further need of some special measures such as professional training to enhance their required capacity. Beside this, LD and agencies level need account related some extra manpower instead of improvised personnel who will trained at the very beginning of next program. However, reasonable number of FM professionals will be needed to carry out the some operational interventions till to be required manpower on board in line with FMAU restructuring. FMAU has a plan to outsource them to minimize the capacity gap as exists.

Component-7: Funding Modalities:

a) Input based Pooled Fund:

The funding modality chosen during the third SWAp (HPNSDP) made the system more efficient and increase harmonization in line with the Paris Declaration. The modified version encompassed joint analytical work, joint financing arrangement (JFA) between DPs and GOB, open eligible expenditure

criteria, modified performance-based financing arrangement and procurement pre-review with increased threshold and streamlining the process.

The establishment of a large "pooled fund", financed by the development partners has certainly contributed to improve working relationships between the government and its development partners. Experience has been acquired with the funding modalities under the three SWAps that can now serve to improve any flaws that existed. Others will provide parallel financing within the remit of HPNSDP, to be reflected in the PIP and the relevant OPs.

In HPNSDP, out of the total DP funding, the World Bank and nine other DPs had put their money (US $ 699.34 million) in a pooled fund administered by the World Bank.. GOB maintained a designated foreign exchange account (Forex) at Bangladesh Bank and based on IFR, money was reimbursed to the Forex in the Bangladesh Bank. Any individual DP could maintain separate Forex as well (e.g. JICA). From this Forex, funds were deposited to the Government's Consolidated Fund or treasury. In GOB system, this DP resource was recognized as the Reimbursable Project Aid (RPA) allocation. Some DPs of HPNSDP provided fund through Direct Project Aid (DPA) mechanism.

b) Result based disbursement

In the fifth year of HPNSDP implementation, the World Bank provided additional funding of US $150 million through a new financing operation known as disbursement linked indictors (DLIs). It appears that the Bank intends to provide fund in the 4th Sector Program in the same modality.

During the preparation process of the 4th Sector Program, a new program financing operation had been discussed and agreed upon between the co-financing partners (World Bank and other Development Partners (DPs) and the Government of Bangladesh (GOB), through which pool funds in the form of reimbursable project aid funds would be disbursed based on results known as "Investment Project Financing (IPF) - DLI". The IPF-DLI is a lending instrument of the World Bank that ties funding directly to the delivery of results. The IPF-DLI instrument is designed to shift the GOB's focus from inputs based financing towards program results and to divert World Bank's attention to macro management of program financing instead of day-to-day management of transactions. But at the same time it is to be ensured that fiduciary and safeguards oversight is maintained through up-front assessment and agreement on system improvements during implementation.

Under the IPF-DLI modality, funds are disbursed upon achievement of some preset DLIs. DLIs are a set of tangible, transparent and verifiable performance indicators/results that provide the basis for fund disbursement. DLIs provide GOB to achieve key program milestones and improve performance of their own program. DLIs have been set on the basis of the 4th Sector Program's objective, systems' strengths and performance (through systems' assessment), results framework and program activities. Number and specification of DLIs, amount allocated per DLI, verification process and disbursement mode have also been determined jointly by co-financing partners (World Bank and other DPs) and GOB.

This new procedure is challenging as it needs to be harmonized with the timing of the preparation of ADP/RADP. Annual review of results for reimbursement in the DLI-based financing mode may call for annual revision of OP (at least some of those) in response to the review results. It, therefore, calls for a feasible and robust monitoring and verification protocol. The exact nature of the relationship between achievement or partial achievement of results and amount/proportion of fund disbursement would depend on prior agreement reached on this issue between MOHFW and the World Bank/DPs.

It is thus crucial to develop an effective and harmonized review mechanism for ascertainlity options and opted for a modified version of the previous funding modality system operated during HNPSP period.

With the opportunity to review and analyze past experiences and existing practices can decide what further changes could be made to realize even better results. This system has so far been working well and will help all stakeholders to make a better informed decision in future as well.

Issues to be addressed during implementation of 4th HPN sector program

There are five issues associated with Financial Management. FMAU would have to be strengthened. All five of these issues:

i. Adoption of a sustainable internal control system to reduce fiduciary risk. Monitoring dimension would be enhanced according to future need.
ii. Some possible administrative step to be taken for to maintaining integrity of FM system.
iii. Technology based accounting system for expenditure tracking.
iv. Assisting to introduce a system for assets management using updated technology so that relevant tracking could be done centrally and automatically.
v. Existing training modality of FMAU could be enhanced and extended in terms of duration and issues.

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc:

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services: Annexed in Volume-II

9. Indicators

	Indicators	Unit of Measurement	Base line (Source)	Projected Target	
				Mid By June 2020	End By June 2022
	1	2	3	4	5
1.	Financial management system is strengthen	Yes/ No (Admin record)	FMAU is restructuring is approved by MOPA	At least 50% of FMAU staffs are recruited	Second internal audit completed by FMAU itself for the previous FY
2.	Software to be developed and all LDs to use Computerized Accounting System	% Process	Not applicable LD, IFM	50%	100%
3.	Number of FM personnel trained at all levels	Number (Admin record)3000	4,708 FMAU	6,000	10,000

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
1738.00	1090.00	0.00	1090.00	2828.00	

10.2. Component and activity wise physical and financial target of OP: IFM

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
(1) Operating cost of the IFM													
1	Pay and Alowances	L/S		976.90	976.90	0.00	0.00	77.96	163.40	170.52	177.98	185.74	201.30
2	Supply and Services	L/S		414.00	414.00	0.00	0.00	42.00	62.00	70.00	72.00	80.00	88.00
3	Repair and Maintenance	L/S		93.80	93.80	0.00	0.00	8.00	13.50	15.00	16.40	19.45	21.45
4	Acquission of Assets (Furniture, Computer and 1(One) Jeep & others)	160		253.30	253.30	0.00	0.00	10.00	120.00	25.50	28.50	33.00	36.30
	Sub Total			1738.00	1738.00	0.00	0.00	137.96	358.90	281.02	294.88	318.19	347.05
(ii) Institutionalizing of the IFM (Capacity Building)													
1	All LD, PM, DPM & DDO's & others (Person)	1500		150.00	0.00	150.00	0.00	10.00	40.00	40.00	20.00	20.00	20.00
2	Training and other dessiminietion support to Asset management traking system(Person)	1530		150.00	0.00	150.00	0.00	16.00	18.00	28.00	28.00	30.00	30.00
3	Training matarials (Hand Book/Manual)printing (Pcs)	4000		20.00	0.00	20.00	0.00	0.00	20.00	0.00	0.00	0.00	0.00
4	Foreign Traning on Financial Management Monitoring internal contorol system (person)	36		120.00	0.00	120.00	0.00	19.00	20.00	23.50	23.50	23.50	10.50
	Sub total	3066		440.00	0.00	440.00	0.00	45.00	98.00	91.50	71.50	73.50	60.50
(iii) Workshop seminers & conference													
1	Cost center DGHS. All DDOs & Accounts Personel under Health (Person)etc.	2400		120.00	0.00	120.00	0.00	20.00	20.00	20.00	20.00	20.00	20.00
2	Cost center DGFP. All DDOs & Accounts Personel under FP (Person)etc.	2400		120.00	0.00	120.00	0.00	20.00	20.00	20.00	20.00	20.00	20.00
	Sub Total	4800		240.00	0.00	240.00	0.00	40.00	40.00	40.00	40.00	40.00	40.00
	(iv) Out Surcing of FM Personnel (For FMAU and LDs support (Person)	7		250.00	0.00	250.00	0.00	0.00	50.00	50.00	50.00	50.00	50.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	(v) Out Surcing of audit firm for internal Audit (Internal audit for 4th HNP sector Program Firm)	2		160.00	0.00	160.00	0.00	0.00	0.00	80.00	80.00	0.00	0.00
	(V) Tachnical Assistance (Other support)			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Grand Total			2828.00	1738.00	1090.00	0.00	222.96	546.90	542.52	536.38	481.69	497.55

11. Budget support from other Operational Plan: Not applicable

PROVISION OF QUALITY HEALTH SERVICES

4.16 Maternal, Neonatal, Child and Adolescent Health (MNCAH)

1. Name of Operational Plan: Maternal, Neonatal, Child and Adolescent Health (MNCAH)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

Situation Assessment:

Maternal and Neonatal Health:

The decline in MMR between 2001 and 2010 and further projected decline to 170/100,000 live births[1] indicates remarkable progress. This is linked to fertility reduction; access to qualified maternal health care; and overall care seeking during the antenatal period and during delivery. In the past decade, the coverage of facility delivery has rapidly increased from 12 percent (2004) to 37 percent (2014). It is evident that there is a clear shift in norm from home delivery to facility deliveries. However, the increase is accounted for more by the rise in facility delivery with private sector than that in the public sector facilities. There is progress in postnatal care with 36 percent of mothers and children receiving check-ups from a medically trained provider within 42 days of delivery. By the end of the third Sector Program, a revised maternal health strategy and standard operating procedures (SOPs) for maternal and newborn health have been finalized. Six hundred midwives have been deployed and their job description and model on midwives led maternal and newborn care developed and has been approved. Gap of anaesthesiologists has been reduced by engaging 173 newly recruited doctors (34th BCS). However, contracting model for engaging private sector providers is yet to be initiated.

In Bangladesh, the neonatal mortality rate declined in the past one decade, but continues to be high at 24 per 1000 live birth in 2014. Between 1990 and 2013, under-five mortality decreased by 72 percent, while neonatal mortality decreased by 55 percent[2]. Stronger efforts are required to bend the curve to achieve national NMR and still births target of 10 or less per 1,000 live births by 2035. Political commitment has also been evident in the area of MNCH and this is articulated in several policy and strategic documents and formed the basis of considerable progress. 'Promise Renewed: Bangladesh Call for Action to End Preventable Child Deaths by 2030', launched in July 2013 has prioritized 11 interventions focusing on maternal, newborn and child health. The Bangladesh Every Newborn Action Plan (BENAP) was developed based on the bottleneck analyses of priority maternal and newborn interventions. A wide consensus now exists for a newborn care package including several high impact interventions. Visible progress has been observed in addressing newborn complication and deaths due to birth asphyxia, prematurity and infection through establishing SCANU in six medical college and 20 district hospitals covering 26 districts and rolling out ETAT, sick newborn care and Helping Babies Breathe (HBB) initiative training and equipping over 28,000 SBAs. Application of 7.1% chlorhexidine (CHX) for newborn umbilical cord care has been rolled out across all 64 districts of the country, training over 85,000 health workers, supervisors and managers. Kangaroo Mother Care (KMC) has been established in several tertiary hospitals in Dhaka as well as at

[1] UN inter-agency estimate
[2] UN estimates 2014

selected district and upazila level facilities. The BENAP, however, requires further scale up through effective planning.

Child Health:

Bangladesh has been able to reduce the under-five mortality far below the MDG 4 target, from 144/1000 live birth in 1990 to 38/1000 live birth in 2015[3], reducing by 72 percent since 1990 with the annual rate of reduction of 5.4. There has been a significant shift in the epidemiological pattern of under-five mortality. Neonatal deaths still account for almost 61percent of under-five mortality (U5MR). Diarrheal deaths among under-five have decreased substantially over the last few years (2 percent). However, ARI/pneumonia continues to be the single most cause (21percent) of U5MR. The care seeking from trained providers for pneumonia and diarrhea has increased remarkably over the last few years. ORT use rate for diarrhea management has increased to more than 80 percent, vitamin A supplementation coverage among under-five children has increased from 85 percent in 2005 to 92 percent in 2011 while the exclusive breast feeding practices has stood at 54 percent (in 2014). Progress on EPI and introduction of new vaccines has progressed well and scaling up of C-IMCI and IMCI, and nutrition corners is taking place. About 81percent of children aged 12-23 months received all scheduled vaccines by 12 months of age. Under the Reach Every District Community Strategy routine EPI has further been strengthened in low performing 32 districts and 4 City Corporations. NGO/Private sector partnership exists for EPI program in a limited scale especially in urban areas.

Adolescent Health:

Adolescent health has been highlighted frequently during HPNSDP, as a priority area that needs further and focused attention. Bangladesh national ARSH strategy was formulated in 2006 and related action plan was developed in 2013. Two major operational plans included plans to carry out selected health activities of ARSH strategy. Training modules were developed by DGHS. Training was provided to service providers, school teachers and adolescent peers in 10 districts and, adolescent friendly health services (AFHS) have been established in nine districts and two city corporations. A guideline on AFHS (2015) and strategy and guideline on HIV/STI/ AIDS/ MR/ PAC are in place.

Challenges:

Maternal and Neonatal Health:

Despite the tremendous efforts in reduction of maternal deaths, the country still loses 14 mothers a day due to complication of pregnancy delivery and post-partum period and largely due to delivery by unskilled birth attendants at home and lack of appropriate care for obstetric complications from a skilled provider at facilities. Experiences show that if women-friendly services can be made available nearer to the communities, the utilization of services is high. Significant inequities exist across geographical regions and between different wealth quintiles. MMR is the highest in Sylhet division (425 per 100,000 live births) and the lowest at 64 per 100,000 live births in Khulna division (BMMS 2010). The increase in facility delivery is mostly in the private sector. Notably, 23 percent of all deliveries are conducted through caesarean section (CS). About four fifths of the deliveries in the private sector are by CS which is very expensive for the poorest and quality of care in these facilities is yet to be monitored. More than 80 percent of the neonatal deaths occur within 7 days, 50 percent within first 24 hours of life and most of these deaths are at home without the care by an SBA and are often unregistered. More than 80 percent of all newborn deaths stem from three largely preventable and treatable conditions – complications due to prematurity, intrapartum-related deaths (including

[3] IGME Report 2015

birth asphyxia) and neonatal infections. Estimated number of still births is similar to the number of early neonatal deaths.

Health facilities at upazila level and below are not ready to meet the increasing demand for quality MNH services. A large number of union level facilities exist (4,461), but a significant proportion of them (41 percent) are not ready or are not providing normal delivery care services. The union level facilities offer an actionable opportunity to strengthen the provision of life-saving care to mothers and newborns during and at the time of birth.

Child Health:

Despite the reduction in mortality over time, continued disparities are observed between the richest and the poorest quintiles, urban and rural areas and between divisions (e.g. Khulna, Sylhet). Mothers' education was found to be associated with U5MR, with the highest mortality rate (82/1,000) noted among mothers with no education compared to 39 among mothers with secondary education or higher. As for under-five deaths, pneumonia, neonatal causes and drowning are major causes. Diarrheal deaths among under-five has decreased substantially over the last few years (2 percent), however pneumonia remains the single most important cause (21 percent) of under-five mortality followed by neonatal causes. Although deaths due to preventable communicable diseases continued to decrease over times, the share of deaths due to drowning has resulted in a sharp rise from 26 percent in 2007 to 42 percent in 2011 among the age group of 1-4 years. Currently, a clear multi-sectoral strategy to address child drowning is absent. The current child health interventions mainly focus on mortality, with limited emphasis on child development. Sustaining the already achieved high coverage for EPI and reaching the unreached to further increase the coverage remain a challenge.

Adolescent Health:

Adolescent pregnancy and child bearing entail a high risk of maternal death among adolescents, and the children of the young mother have higher level of morbidity and mortality[4]. There are estimated 569,000 annual births among 15-19 year adolescent girls in Bangladesh[5]. They face a number of important health risks arising out of early pregnancies, violence and inadequate nutrition. Almost twice as many newborn deaths (45 per 1000 live birth) occur among very young pregnant women, less than 20 years old, compared to older age[6]. Teen pregnancy is also linked with stunting. The odds of children becoming stunted significantly increases by 22 percent if born to a mother who is a minor[7]. Adolescent birth rate is also not declining at a faster rate: it was 126 per thousand births in 2007 and reduced to 113 in 2014 (BDHS 2014). About 65 percent of girls are married before reaching the legal age of 18, and 31 percent of girls (15 to 19) has begun childbearing. Modern contraceptive method use among married teenage girls (15-19) is low at 47 percent with 42 percent of them spacing their second birth less than the recommended three years after the first. Legal age of marriage and planned childbearing is needed to protect girls and enable them to participate more fully in education and the workplace, and reduce the rate of population growth by extending the mean length of time to replace a generation. Bangladeshi teenage mothers are more likely to suffer from severe complications resulting in high neonatal mortality and both neonatal and maternal morbidities. Young women do not have

[4] UN World Population Monitoring 2002- Reproductive rights and reproductive health : selected aspects.

[5] United Nations, Department of Economic and Social Affairs, Population Division (2013). World Population Prospects: The 2012 Revision, DVD Edition

[6] BDHS 2011.

information on availability of MR, PAC services. Due to lack of such comprehensive information and knowledge they are more likely to seek these services at a later gestational age, which is more risky.

4. Objectives

i. To strengthen efforts of making home deliveries safe

ii. To strengthen 24/7 EmONC services at the upazila level in phases

iii. To establish a functional referral system from community to facility level

iv. At least 95 percent fully vaccination coverage among under one year children at national level and 90 percent fully vaccination coverage at each district level; and TT5 coverage among women of childbearing age reached at least 80 percent at national level and 75 percent at each district level

v. Maintain Polio Free Certification status, achieve Measles and Rubella Elimination status and control of Congenital Rubella Syndrome (CRS)

vi. Strengthen the Immunization supply chain and management system and reduce disease prevalence by introduction of new and underused vaccines

vii. Increase access and utilization of Newborn and IMCI services at facilities and communities including national scale-up of evidence based priority newborn health interventions

viii. Improved knowledge of Adolescents on Sexual and Reproductive Health issues

ix. Improved knowledge of primary school level student on personal hygiene issues

5. Components

Component-1: Maternal Health:

Bangladesh aims to achieve the SDG 3 targets by 2030, reduce the maternal mortality ratio to less than 70 per 100,000 live births (Target 3.1) and by 2030, end preventable deaths of newborns with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births (Target 3.2). Increasing access to SBA is one of the highest priority interventions that can contribute towards significant reduction of maternal mortality and morbidity. Concerted efforts will be made by the public sector, in the rural and under-served areas, to ensure increased access to facility delivery by the poor and marginalized groups. The program will emphasize on care during labor, around birth and the first week of life; and care for the small and sick newborn- have the greatest impact on ending preventable neonatal deaths and stillbirths. Further progress is needed to address newborn complications and deaths due to birth asphyxia, prematurity and infection. The program will also focus on fetal health, including stillbirths. High coverage of interventions before, during and after delivery could save the most newborn lives as well as prevent maternal deaths and stillbirths.

Activities:

1. Ensuring preconception care (including delivery) at home and facilities of all levels.
2. Phase wise implementation of 24/7 EmOC services including MR and Post abortion care (PAC) through improved HR placement with skill mix and appropriate training at District hospitals,

[7]Raj, A. et al (2010). The effect of maternal child marriage on morbidity and mortality of children under 5 in India: cross sectional study of a nationally representative sample.. BMJ 2010;340:b4258doi:10.1136/bmj.b4258

UHCs and first aid/Basic EmOC services at UHC and UH&FWCs in order to increase institutional child births.

3. Expanding the DSF program.
4. Develop and expand Midwifery services by deploying midwives at the Union Sub Centers.
5. Provide C-SBA training to ensure sustainable and round the clock C-SBA services at the Community Clinic and household level.
6. Strengthening Supervision, Monitoring and Mentoring of CSBA activities throughout the nation in phases.
7. To establish a functional referral system from community to different tiers of facility.
8. Country wide scaling up of MPDSR.
9. Increase skilled HR on EmOC including PAC, MR and Family planning.
10. Scaling up of different interventions to reduce PPH and eclampsia (e.g. active management of 3rd stage of labor, use of Misoprostol and Magnesium Sulfate).
11. Strengthening the maternal morbidity related treatment, prevention and rehabilitation services with referral mechanism.
12. Strengthening the pre-service curricula of doctors, nurses and paramedics in midwifery, essential newborn care and adolescent health.
13. Develop guideline on functional coordination of MNCH services between DGHS and DGFP.
14. Collect MNH data from DGFP MIS and add that to the DGHS MIS at the Upazila and below level.
15. Advocacy with NGOs and local government institutions to mobilize resources and collaborative MNCH activities at remote area especially in the urban slum.
16. Training of nurses and MO on surgical contraception, IUD and MR.
17. Training of Doctors and nurses on VIA and Colposcopy.

Component-2: Expanded Program on Immunization (EPI)

The government has developed comprehensive multiyear plan (cMYP) 2014-2018 for national immunization program, which is under revision for extension up to 2021. This Plan provides a framework to plan activities to achieve important objectives of the EPI, as outlined in the national health policy. During the last few years, based on the data on disease burden, new vaccines for selected emerging diseases such as PCV and IPVV (2015) have been introduced into the EPI programme. HPV Demonstration program in Gazipur District has been introduced in 2016 and it will be replicate nationwide by 2018. Measles follow-up campaign will be Conduction of in 2017. Hepatitis B vaccine birth dose (HepB0) will be introduced by 2019. In view of enhancing the injection safety auto-disable (AD) syringes were introduced into the Program from 2004 and it will be continued.

In coming years new vaccines may be introduced in the EPI Program.

Activities

1. Strengthening and expanding EPI service delivery with special focus on hard to reach and low performing areas

2. Maintaining Polio free certificate status by conducting SIAs (If needed)
3. Conduction of Sero Survey for all antigen specially OPV Vaccine in context of Global Polio Eradication Certification
4. Reaching Measles and Rubella Elimination Status by 2018 through introducing MR 2nd dose in routine EPI (from 2015) and follow up campaign in 2017
5. Maintaining Maternal and Neonatal Tetanus Elimination validation Status
6. Introducing New Vaccines: HepB0 and HPV vaccines
7. Ensure 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 by 2018
8. Ensure Effective Vaccine Management (EVM) at all level
9. Strengthening VPDs surveillance, AEFI surveillance and expansion environmental surveillance by ensuring specific surveillance manpower and operational cost
10. Exploration for cholera vaccine trial
11. Ensure injection safety and waste management
12. Timely procurement and distribution of vaccine and EPI Logistics
13. Monitoring and supportive supervision at all level
14. Annual conduction of coverage Evaluation survey
15. Human resource development by training in home and abroad
16. Ensure fill-up vacant post at all level
17. Advocacy, Social Mobilization and IEC activities

Component-3: National Newborn Health Program (NNHP) and IMCI

To improve newborn and child survival a National Newborn Health Program (NNHP) will be launched through this sector program and the Integrated Management of Childhood Illness (IMCI) program will be strengthened. The NNHP will focus on achieving equitable and effective coverage of high impact newborn services and practices at scale, through quality implementation of a comprehensive newborn health care package by the public health system. The activities under IMCI program will be implemented at all level of facilities as well as at community in line with the national policy and strategy for achieving high coverage and quality of IMCI services.

Program Management:

The existing IMCI unit under Line Director MNCAH will be strengthened and will be renamed as National Newborn Health Program and IMCI. The unit will have one Program Manager, NNHP & IMCI and five Deputy Program Managers (DPM): a) DPM-Admin & Finance b) DPM- Newborn Health c) DPM- Training and Child Injury d) DPM- Monitoring and Data Quality and e) DPM-Coordination and Logistics Management.

Along with strong leadership and ownership of MOHFW officials' at all level, functional coordination between different departments and facilitation role from development partners will be crucial to ensure successful implementation on NNHP and IMCI. A District MNCH Focal Person will work in district level to strengthen supervision and monitoring of all maternal newborn and child health related activities of the district level and below. With the support of development partners as

group of consultants will work from district and division level to facilitate the implementation NNHP throughout the country.

National Newborn Health Program:

Bangladesh has committed to ending preventable newborn deaths by 2030 as per the country's commitment to SDG. Though the country has achieved remarkable success in reduction of overall under-5 mortality during last decade, neonatal mortality is still high. The SIP of the 4th HNP has set a target to reduce NMR to 18 or below per 1000 live birth by 2021 from the baseline of 28/1000 live birth (BDHS-2014).

Newborn deaths in Bangladesh are largely preventable – complications due to prematurity, birth asphyxia and neonatal infections are the major contributor for neonatal deaths. The recently upgraded Essential Services Package (ESP) has identified the newborn health interventions by level of service provision and the 'roll out of an ESP with greater functional integration of services at district level and a functional referral system' is a key driving forces of the HNPSIP (2016-21). SIP stated that 'The Bangladesh Every Newborn Action Plan (BENAP) identifies a set of priority maternal and newborn interventions. A wide consensus now exists for a comprehensive newborn care package including several high impact interventions' (HNPSIP page-17).

The key interventions of the NNHP:

1. Promotion of birth preparedness, newborn care preparedness and proper care seeking through a comprehensive SBCC approach;
2. Care for all newborns:
    a. Immediate and essential newborn care (ENC) including application of 7.1% Chlorhexidine to the cord stump both in facilities and in the community;
    b. Postnatal care in facility and by home visit through community health workers;
3. For newborns in need of extra care due to intra-partum complications, illness and/or prematurity/Low Birth Weight (LBW)
    a. Newborn resuscitation using HBB protocol;
    b. Management of sick newborn starting at first level facilities;
    c. Kangaroo Mother Care (KMC) for management of preterm/LBW;
    d. Judicial use of antenatal corticosteroid in threatened premature deliveries.
4. Care of critically ill newborn through Special Care Newborn Unit (SCANU)

Approaches to achieve high effective coverage of these newborn health interventions are to:

A). Ensure availability of skilled service providers at service delivery points;

B). Capacity building and skill retention of service providers;

C). Ensure consistent supply of essential commodities, equipment and medical products;

D). Strengthen effective referral systems, including reliable and affordable transportation;

E). Establish functional supervision, monitoring including use of routine data;

F). Strengthen quality improvement initiatives for newborn health care;

G). Establish effective SBCC through comprehensive approaches.

Key Activities:

1. Capacity development of all staffs and manager on newborn health interventions

1.1. Development of NNHP management toolkit and training of national to upazila managers and MNCH focal person on Comprehensive Newborn Care Package (CNCP) Implementation
1.2. Training of health care providers and field workers of different levels on CNCP for healthy and sick newborn management
1.3. KMC training for doctors and nurses to manage preterm low birth weight babies at Upazila and higher level facilities
1.4. ETAT and sick newborn care training of doctors and nurses for management of sick newborn.

2. Facility readiness for providing quality and equitable services for newborn

2.1. Ensure logistics commodities and medicines at union, upazila and district level facilities under DGHS for management of sick newborn and management as per national guidelines
2.2. Establish standard KMC corner in all Upazila and district level facilities and ensure commodities and logistic supplies
2.3. Ensure functional newborn resuscitation device in all facilities with delivery services

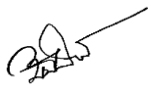
3. Ensure commodities medical products and job-aids and other supplies at different level of service provision

3.1. Procurement and supply of 7.1% Chlorhexidine in the facilities and in the community
3.2. Procurement and supply of equipment, commodities and drugs for sick newborn management
3.3. Procurement and replacement of necessary resuscitation device for newborn
3.4. Procurement of commodities to provide KMC services and resuscitation
3.5. Procurement of newborn training devices (simulator for resuscitation and preterm management)
3.6. Printing of training materials, job-aids, registers, report formats and reporting for tools and SBCC materials

4. Quality Improvement Initiatives Supervision and M&E:

4.1. Provision of a District MNCH Focal Person to coordinate, supervise and monitoring of all maternal newborn and child health related activities at the district level and below and reportable to Line Director MNCAH
4.2. Establishment of a functional supervision, monitoring and quality improvement facilitation team throughout the country through establishing a team of consultant under Program Manager NNHP and IMCI.
4.3. In coordination and collaboration of the QI Secretariat and HMIS directorate, strengthen field monitoring, improvement of data quality of newborn services and use of new newborn indicators from routine HMIS and monitoring data for program improvement
4.4. Strengthen data management and data use in local level to improve program implementation and organize periodic program review and appraisal of managers, supervisor and others.
4.5. Revision of National Neonatal Health Strategy and Standard Operating Procedure (SOP) for newborn health services.

5. Community and multi-sectorial engagement for promoting ENC and proper care seeking



5.1 Community engagement by using community group (CG) and community support groups (CSG) of community clinics in coordination with Community Based Health Care Service (CBHCS)

5.2 Strengthen societal engagement by orienting school teachers, local representatives, multi sartorial officials, NGOs through different existing platforms

6. Promotion of ENC practice and proper care seeking in coordination with BHE and other partners through:

6.1. National newborn campaign

6.2. Promotion of ENC practice and proper care seeking in coordination with BHE and other partners through social and mass-media communication specially television and radio commercial

6.3. IPC/counseling by health service providers and CHWs by using standard counseling materials and job aids

Integrated Management of Childhood Illness (IMCI)

The activities under IMCI program will be implemented at all level of facilities and community in line with national policy and strategy.

Activities

1. IMCI Clinical Management Training (CMT) for Doctors (8 days) Nurse and Paramedics (11 days)
2. Orientation on revised IMCI protocol to all facility and community level service providers
3. Community case management training for field level health service providers following IMCI protocol
4. Orientation of community level service providers on comprehensive package of ECD, autism, drowning and other child injuries.
5. Provision of well-equipped IMCI corner at District and Upazila Health Complexes with adequate skill manpower.
6. Development of Child Health Strategy
7. Development of comprehensive package on ECD, autism, drowning and other child injuries.
8. Ensure supply of logistics, commodities and medicines at UHC and union level facilities under DGHS for management of sick newborn and management of sick child as per IMCI protocol
9. Printing of IMCI related materials.

Component-5: Adolescent health

In Bangladesh, 36 million adolescents (age between 10 and 19) constitutes 24 percent of the population. Among them 14.8 million are female. Lack of knowledge and information of the adolescents about SRH leads them to unsafe sex, abortion etc. Services in conducive 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.

Activities

1. Upgrading of health facilities (all UHCs, and UH & FWCs/RDs) in phases and to provide adolescent friendly SRH services
2. **Providing training on adolescent friendly SRH services including counseling and communication**
3. Counseling and developing awareness for adolescents specially senior girls students on personnel hygienic practices including menstrual hygiene management
4. Establishment of referral linkages between school health clinics and other health facilities
5. Formation of coordination committee among the Adolescent Sexual and Reproductive Health (ASRH) implementing partners (GO, NGO, Private sector)
6. Incorporation of ASRH component into the existing MIS of DGHS
7. **Community mobilization around ASRH issues through court yard meetings, inter-personal communication, and workshops,**
8. Develop and printing training manuals, guidelines, booklets regarding adolescent health.
9. IEC activities: Short film show, poster, calendar, folder, wall-painting, bill-board, etc.
10. Develop and disseminate key messages and materials
11. Development of supervision and monitoring tools and establishment of supervision and monitoring system.

Component-6: School Health Program

Since 1951, 23 School Health Clinics in 20 districts are running under school health program. Each clinic has two graduate doctors, one pharmacist and one MLSS. The Medical Officers provide clinical service to the school going children and also visit school for health education and promotion of healthy environment.

Activities

1. 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.
2. Orientation of members of the school management committee on good health habits, making healthful school environment, sanitation etc.
3. Provision for supply of weighing machine with height measuring scale in school health clinic.
4. 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
5. To provide first-aid-box with essential drugs and MSR and establishment of referral system with near-by health facilities
6. Develop and printing training manuals, guidelines, booklets regarding school health

7. IEC activities: Short film show, poster, calendar, folder, wall-painting, bill-board, etc.
8. Vitalization of existing school health clinics (23) services
9. Advocacy, communication, social mobilization progrm for the guardian
10. Development of Supervision and Monitoring tools and establishment of Supervision and Monitoring system.

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc

MNCAH OP will contribute significantly in reducing the poverty. Improving maternal, neonatal, child and adolescent health it will make the future generation healthy and thus enable to effectively participate in the economic development of the country. Also access and utilization of promotive, preventive, curative and rehabilitative MNCAH services will reduce the morbidity and mortality burden and thereby protecting economic gain achieved.

This OP will contribute significantly in conservation of environment particularly through effective management of healthcare wastes generated through EPI and other initiatives and also through school health program promoting improved school environment and making school students, adolescents aware from environmental pollution.

Health vulnerability of climate change for mothers, neonates, children and adolescents will be taken care by this OP that includes preventive and curative measures.

This OP is dedicated for women and children and addresses the relevant gender issues as well.

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1	Utilization of Maternal health care service is increased in Sylhet and Chittagong division)	Percentage of normal delivery in public facilities	2016 (have to confirm)	12% of baseline	18% of baseline
2	Immunization coverage and equity both are enhanced in Sylhet and Chittagong children immunized for measles and rubella	Percentag of children immunized	70% in 4 districts in Sylhet 80% in 11 districts in Chittagong	73% in Sylhet 83% in Chittagong	75% in Sylhet 85% in Chittagong
3	School based adolescent health and nutrition services are developed	Percentage (public secondary		30%	50%

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
	in Sylhet and Chittagong	school a) 4 districts Sylhet and b) 5 districts chittagong (admin record)			
4	Percentage of new born received essential new born care)	Percentage	6.1 (BDHS, 2014)	15	25
5	ANC coverage (at least 4 visit(	Percentage	31.2 (BDHS, 2014)	40	50
6	Percentage of delivery by skilled birth attendant (SBA)	Percentage BDHS, every 3 years/UESD, every non-DHS years	42.1%, BDHS 2014	55%	65%
7	Percentage mothers with non-institutional delivery receiving post natal care from a medically trained provider within two days of delivery	Percentage BDHS, every 3 years/UESD, every non-DHS years	5.4	7	10

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
60086.96	185812.25	533234.25	719046.50	779133.46	

10.2. Component and activity wise physical and financial target of OP: MNCAH

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4		6		8		10	11	12
Component I: Maternal Health												
1	6 months training of doctors on Obs&Gyne and Anesthesia	896	1400.00	0.00	600.00	800.00	40.00	280.00	280.00	280.00	280.00	240.00
2	15 days training on MR, PAC, FP and Partograph for doctors and SSN	1400	600.00	0.00	0.00	600.00	0.00	120.00	120.00	120.00	120.00	120.00
3	MPDSR training for doctors, nurses and field staffs	24135	2600.00	0.00	1800.00	800.00	0.00	550.00	550.00	550.00	500.00	450.00
4	Training on Colposcopy (basic)	600	300.00	0.00	0.00	300.00	0.00	60.00	60.00	60.00	60.00	60.00
5	Basic training on VIA, Cencer cervix, CBE/SBE, Fistula AMTSL and Partograph	3375	748.50	0.00	0.00	748.50	0.00	148.50	150.00	150.00	150.00	150.00
6	VIA/CBE Camp/ health campaign to increase awareness of the health professionals and community on cervical and breast cancer screening and providing services - in collaboration with natioanl cancer research institute	240 camp	712.80	0.00	712.80	0.00	0.00	142.56	142.56	142.56	142.56	142.56
7	Srtrenthening of percancer treatment services (Colposcopy)- in collaboration with natioanl cancer research institute and fistula treatment services	LS	800.00	0.00	800.00	0.00	0.00	160.00	160.00	160.00	160.00	160.00
8	Procurement of consumable stores, MSR, Medicine and instuments	L S	5500.00	0.00	4500.00	1000.00	500.00	1000.00	1000.00	1000.00	1000.00	1000.00
9	Printing of MPDSR related items, differents registers, partograph	L S	650.00	250.00	0.00	400.00	0.00	130.00	130.00	130.00	130.00	130.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4		6		8		10	11	12
10	Support to LLP for strengthening of MNCH and MNHI activities for District level	11 dist including upazila	4400.00	0.00	400.00	4000.00	400.00	800.00	800.00	800.00	800.00	800.00
11	Operational cost	L S	1040.00	840.00	0.00	200.00	90.00	190.00	190.00	190.00	190.00	190.00
12	Demand side Financing (DSF)	103 UPZ	14000.00	400.00	13600.00	0.00	1500.00	2500.00	2500.00	2500.00	2500.00	2500.00
13	6 months training on CSBA of Gov't and Private Participants	1530	1400.00	0.00	400.00	1000.00	0.00	275.00	300.00	275.00	275.00	275.00
14	Performance apprisal workshop for CSBA	11500	140.00	0.00	140.00	0.00	0.00	40.00	40.00	20.00	20.00	20.00
	Sub Total -(i)		34291.30	1490.00	22952.80	9848.50	2530.00	6396.06	6422.56	6377.56	6327.56	6237.56
Component II: Expanded Programme on Immunization												
1	Increase and Sustain Routine EPI											
2	Develop and Printing of EPI Record Report Forms and Cards	475.08 lakh pcs	3915	3915	0	0	415	700	700	700	700	700
3	Procurement of Vaccine	8245.54 lakh dose	573997.62	0.00	142475.73	431521.89	29795.88	105092.46	112137.32	112922.10	114524.93	99524.93
4	Procurement of AD Syringe & Logistics Supplies	3869.78 lakh pcs	25639.93	20795.1	1000	3844.88	2795.05	5044.88	4450	4450	4450	4450
5	Procurement of Cold Chain & other equipments	6628 nos	2933.1	110	1023.1	1800	300	380.6	445	641.5	583	583
6	Support to the fields for ensuring quality vaccination session	L S	12000	12000	0	0	1200	2400	2400	2400	2400	1200
7	Operational cost	L S	8500	5000	0	3500	850	1700	1700	1700	1700	850

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4		6		8		10	11	12
8	Supplimentary Immunizastion Activities (SIA)											
9	Orientation of field workers	600000 persons	1415.65	0	0	1415.65	210	220.5	231.53	243.1	255.26	255.26
10	Operational cost	L S	792.5	792.5	0	0	0	158.5	158.5	158.5	158.5	158.5
11	Implementation and strengthening EVM at all level by UNICEF											
12	Establishment of cold room & cold chain equipment	37 cold rooms, 402 refirgerators, 74 freezers, 2000 F.tag, 19 generator etc.	6465.64	0	0	6465.64	2205.87	1383.08	2876.69	0	0	0
13	Procurement of vehicles for vaccine & logistic transportation and field supervision	4 trucks, 2 forklift, 600 motorcycles & 74 bicycles	1238.56	0	0	1238.56	210.94	606.68	420.94	0	0	0
14	Training & orientation	7500 persons	857.02	0	0	857.02	229.65	395.52	231.85	0	0	0
15	Operational cost	L S	5755.73	0	0	5755.73	1004.66	3232.64	1518.43	0	0	0
16	Maintaining certificate standard surveillance activity & disease control by WHO											
17	Procurement of vehicles for suveillance network	74 nos	1266.88	0	0	1266.88	684.8	582.08	0	0	0	0
18	Procurement of equipments for upgrading Polio Lab	L S	408.13	0	0	408.13	70.62	302.76	34.75	0	0	0
19	Training & orientation	1448 persons	461.34	0	0	461.34	122.32	263.74	75.28	0	0	0

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4		6		8		10	11	12
20	Operational cost for SMO, DMCHIO, DC, NC & networking etc.	L S	8401.52	0	0	8401.52	2714.24	3000.69	2686.59	0	0	0
21	Introduction of Pneumococcal ConjugateVaccine (PCV)											
22	Procurement and installing walk in cooler at District level	15 districts	81.31	0	0	81.31	81.31	0	0	0	0	0
23	MR Follow-up Campaign & Followup Activities utilizing MR Campaign fund											
24	MR Followup Campaign											
25	Procurement of Vaccine	235.50 lakh dose	12196.61	0	0	12196.61	0	12196.61	0	0	0	0
26	Procurement of AD Syringe & Logistics Supplies	628.2 lakh pcs	2227.63	0	0	2227.63	0	2227.63	0	0	0	0
27	Training & orientation	85718 persons	1997.44	0	0	1997.44	0	1997.44	0	0	0	0
28	Operational cost	L S	5264.02	659.72	0	4604.3	0	5264.02	0	0	0	0
29	Followup Activities utilizing MR Campaign fund											
30	Procurement of vehicles for supervision and transportation of vaccine & logistics	D. Pickup-110 & Micro-2	4294	0	0	4294	4294	0	0	0	0	0
31	Procurement of cold chain equipment	2635 nos	506.14	0	0	506.14	506.14	0	0	0	0	0
32	Operational cost	L S	9017.52	0	0	9017.52	2885.24	3132.84	2956.84	14.2	14.2	14.2

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4		6		8		10	11	12
33	Introduction of Human Papilloma Virus (HPV)											
34	Training & orientation	169723	2149.04	0	0	2149.04	89.42	89.42	1970.2	0	0	0
35	Procurement of cold chain equipment	87	52.06	0	0	52.06	52.06	0	0	0	0	0
36	Operational cost	L S	1270.83	112	0	1158.83	126.94	126.94	1016.95	0	0	0
37	Introduction of Inactivated Polio Vaccine											
38	Procurement of vehicles to ensure smooth supply of vaccine & logistic to the field	Truck-2 nos	84.91	0	0	84.91	84.91	0	0	0	0	0
39	Procurement of cold chain equipment	2410 nos	105.11	0	0	105.11	105.11	0	0	0	0	0
40	Introduction of Hepatitis -B Birth Dose											
41	Supervision & monitoring	L S	37.04	0	0	37.04	0	0	37.04	0	0	0
42	Training & Orientaion	129511 persons	237.54	0	0	237.54	0	0	237.54	0	0	0
43	Operational cost	L S	501.75	295.59	0	206.16	0	0	501.75	0	0	0
44	Introduction of Rota Virus Vaccine											
45	Supervision & monitoring	L S	79.94	0	0	79.94	0	0	79.94	0	0	0
46	Training & Orientaion	150863	2051.22	0	0	2051.22	0	0	2051.22	0	0	0
47	Operational cost	L S	439.21	0	0	439.21	0	0	439.21	0	0	0
	Sub-Total 2		696641.9	43679.9	144498.8	508463.3	51034.2	150499	139357.6	123229.4	124785.9	107735.9
Component III: National Newborn Health Program (NNHP) and Integrated Management of Childhood Illness (IMCI)												
	Sub-component (A) : NNHP		35000.00	13000.00	10000.00	12000.00	3000.00	6400.00	6400.00	6400.00	6400.00	6400.00
	Sub-component (B): IMCI		8225.40	225.40	5500.00	2500.00	160.40	1503.65	1750.00	1696.35	1645.00	1470.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4		6		8		10	11	12
	Sub-total 3		**43225.40**	**13225.40**	**15500.00**	**14500.00**	**3160.40**	**7903.65**	**8150.00**	**8096.35**	**8045.00**	**7870.00**
Component IV: Adolescent Health												
1	Training, Orientation and workshop of Teachers, Peer Groups, Service Providers, Basic Workers, Gate Keepers	79410	2429.80	0.00	2067.30	362.50	120.00	491.69	494.24	441.29	441.29	441.29
2	Printing of Training Module and IEC materials	177200	277.00	277.00	0.00	0.00	15.00	70.00	48.00	48.00	48.00	48.00
3	Procurement of Medicine and Senitary Nepkin for management of Menstrual Hygiene	L S	77.50	27.50	50.00	0.00	0.00	15.50	15.50	15.50	15.50	15.50
4	Operational Cost	L S	42.50	42.50	0.00	0.00	3.00	7.25	8.00	8.25	8.00	8.00
	Sub-Total 4		2826.80	347.00	2117.30	362.50	138.00	584.44	565.74	513.04	512.79	512.79
Component V: School Health												
1	Training, Orientation and workshop of Primary School Teachers, Students and Concern Manager	28270	643.32	0.00	643.32	0.00	44.00	112.83	131.65	118.28	118.28	118.28
2	Printing of Training Module and IEC materials	376500	145.00	145.00	0.00	0.00	5.00	28.00	28.00	28.00	28.00	28.00
3	Procurement of MSR and Medicine	L S	1110.00	1010.00	100.00	0.00	10.00	220.00	220.00	220.00	220.00	220.00
4	Procurement of vehicles	1	60.00	0.00		60.00	0.00	60.00	0.00	0.00	0.00	0.00
5	Operational Cost	L S	189.70	189.70	0.00	0.00	21.65	33.61	33.61	33.61	33.61	33.61

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4		6		8		10	11	12
	Sub-Total 5		2148.02	1344.70	743.32	60.00	80.65	454.44	413.26	399.89	399.89	399.89
	Grand Total		779133.46	60086.96	185812.25	533234.25	56943.21	165837.62	154909.13	138616.24	140071.13	122756.13

11. Budget support from other Operational Plan: Not applicable

4.17 Maternal, Child, Reproductive and Adolescent Health (MCRAH)

1. Name of the Operational Plan: Maternal, Child, Reproductive and Adolescent Health (MCRAH)

2. Implementing Agency: Directorate General of Family Planning (DGFP)

3. Introduction:

Bangladesh has made remarkable progress during last two decades in improving maternal and child health and reducing population growth. Maternal death has been reduced more than 60% from end of last century to till now. Maternal Mortality Ratio (MMR) has declined from 322 per 100,000 live births in 2000 to 176 in 2015 (SIP). Strong political commitment from the government during last three SWAPs (HPSP, HPNSP, HPNSDP) to improve MNCH services particularly strengthening ANC, PNC, deliveries by SBAs, CEmONC services and awareness building efforts have largely contributed in reducing maternal mortality.

It was found that antenatal care for pregnant women by medically trained providers nearly doubled from 33% in 1999-2000 to 64% in 2014 and delivery by medically trained providers increased from 12% to 42% during the same period. This increase in skilled delivery is predominantly due to a rise in facility deliveries, which increased from 8% to 38% during 1999-2014 (NIPORT 2015). However, geographical variations and inequity remained, like 55% of women in Khulna division are delivering babies at health facility compared to 41 % in Dhaka division and only 23% in women of Sylhet division. It was also found that overall 70% of women from the highest quintile deliver their babies at health facilities while only 15% of women from lowest wealth quintile deliver at health facilities (BDHS, 2014).

Bangladesh has successfully reduced the under-five mortality achieving the MDG 4 target (48 per 1000 live births by 2015). However, neonatal deaths still account for almost 60 % of under-five mortality (28 per 1000 live births) which is considered to be very high, although majority of this mortality can be prevented. Despite progress in reducing under-five mortality, continued disparity remains, like between the richest and the poorest quintiles, urban and rural areas and between the divisions (e.g. Khulna, Sylhet). Mother's education was also found to be associated with under-five mortality as the highest mortality rate (82 per 1000 live births) noted among mothers with no education compared to 39 per 1000 live births among mothers with secondary education or higher. There has been good progress in nutritional status of children in the last three years as stunting, underweight and wasting have been reduced. But the rates are still high and more attention should be given to decrease the rate faster. The IYCF practice among children 6-23 months has slightly increased but it is still very low among the children of highest wealth quintile (BDHS, 2014).

Child marriage and adolescent motherhood is very common in Bangladesh. Early teenage pregnancy can cause serious health problems for both the mother and the child. It was found that about 65 percent of girls are married before reaching the legal age of 18 and 31 percent of girls (age group 15 to 19) has begun childbearing which is more common in rural than urban areas (32 percent versus 27 percent respectively) (BDHS, 2014). Despite rapid improvement in female education, women's mean age at marriage has hardly changed. About 9% of the population is 15-19 years old and there are approximately three million married adolescents in Bangladesh. The data available about ARH knowledge and behavior is extremely limited. Adolescents seem to be very poorly informed regarding their own physical well-being, their health and their bodies. Lack of knowledge and information of the

adolescents about Sexual and Reproductive Health (SRH), in many occasions can lead to unwanted pregnancy, unsafe sex, abortion etc. There are also very limited adolescent-friendly health services available in the country.

Key Lessons Learned:

During 3rd HNP sector program (HPNSDP, 2011-2016) a number of positive lessons have been learned through implementation of the MCRAH OP. A total of 11,131 service providers (including FWAs - 5045) of DGFP and DGHS and 1501 private sector service providers were trained as Community Skilled Birth Attendant (CSBA) who are involved in providing quality ANCs, safe delivery, PNC services at different level (domiciliary, community clinics). A total of 1794 FWVs participated in training of midwifery skills. Referral system has been strengthened as more facility deliveries are taking place. Presently 1442 UH&FWCs are fully functional and providing 24/7 services on call basis for normal delivery. In order to prevent delivery complications including post-partum haemorrhage AMTSL (Acute Management of Third Stage of Labour) is in practice in all MCWCs. Magnesium Sulfate injections for management of eclampsia are also provided by the trained service providers. Tab. Misoprostol have been procured and distributed for prevention of post-partum hemorrhage (PPH) during home deliveries. To strengthen new born care, 4 priority interventions including SCANU's have been incorporated in the MNCAH and MCRAH OP during 3rd SWAP. Helping Babies Breathe (HBB) initiative has also been scaled up.

However various programmatic challenges remained in delivering MCARH services at different level which included i) inadequate skilled manpower ii) Weak "Facility Readiness" in terms of basic amenities, equipment, and standard precaution exercised while providing services, laboratory capacity, essential medicines and trained service providers; iii) inadequate Quality of Care iv) Low coverage of services delivery at Hard to Reach (HTR) and low performing districts and urban slums; v) Inadequate Social Behavioral Change Communication (SBCC) activities including motivation for ANC, safe delivery and PNC services and referral linkage for institutional deliveries; vi) inadequate inter-sectoral collaboration (MOLGRD, Education,) and less community engagement e.g.Union Parishad, community leaders and different community groups; vii) lack of effective referral system; viii) inadequate collaboration with NGO/private sector ix) insufficient functional co-ordination between DGFP & DGHS at different level and x) lack of effective monitoring and performance review processes.

To address the challenges and carry forward the unfinished tasks, this MCRAH OP has been developed in light of the strategic objectives of the 4th Health, Nutrition and Population Strategic Investment Plan (SIP), 2017-2022 of the government. The aim is to ensure that quality HNP services are provided for both public and private sector more efficiently and in an equitable manner. The Maternal, Newborn, Child, Reproductive and Adolescent Health (MNCRAH) services are mainly provided through two OPs, one OP by DGHS (MNCAH) and another one by DGFP (MCRAH) under Ministry of Health and Family Welfare. In light of strategic objectives of the SIP, this MCRAH OP of DGFP will deliver effective, responsive and quality maternal, new-born, child, adolescent and reproductive health services through an integrated approach involving different stakeholders including DGHS.

4. Objectives

(i) To strengthen comprehensive and basic EmONC services

(ii) To improve quality ANC, PNC services and strengthening 24/7 delivery at the facility level

(iii) To improve new-born care practice and services including implementation of Comprehensive New-born Care Packages (CNCP)

(iv) To strengthen nutritional practice and services for under five children, adolescents, Pregnant and Lactating Women (PLW)

(v) To improve adolescent health practices and services

(vi) To improve reproductive health care services including RTI/STI, MR, MRM, PAC

(vii) To improve Quality of Care including "Facility Readiness" through availability of the skilled service providers, development of adequate physical infrastructures, adequate supply of drugs, equipment, logistics and other commodities

(viii) To strengthen partnership with NGOs and private sector and replicate best practices

(ix) To strengthen functional co-ordination with DGHS as well as NGOs, private and community engagement

5. Components:

Component -1: Strengthening Health Care Services

a) Maternal Health Care Services:

To address the challenges in terms of increasing availability and utilization of quality maternal health services at different level, different strategies will be taken in alignment with the standard Essential Services Packages (ESP) of 4th HPN SWAP like i) ensuring ANC, PNC services through domiciliary visits, counselling at satellite and Community Clinic level through field level service providers (FWAs, Female HAs, CHCPs, CSBA and FWVs); ii) ensuring 24/7 delivery services from functional UH&FWCs (including RDs of DGHS), UHCs and MCWCs; iii) develop a comprehensive referral system from community to different facilities; iv) ensure 24/7 BEmONC and CEmONC services for every women who needs the services; v) ensure all deliveries to be conducted by the CSBAs including women who delivers at home.

Activities:

1. Registration and mapping of all pregnant women with contact mobile number by field level workers (FWAs) and updating the lists at facilities (by FWVs at UH&FWCs).
2. Providing 4 (Four) quality ANC (Ante-natal Care) with counseling among pregnant women and their families on Birth Preparedness and Complication Readiness (BPCR).
3. Conducting essential laboratory tests (blood test for haemoglobin & sugar estimation, urine test for sugar and albumin and pregnancy detection) at facilities.
4. Sustainable distribution of tab. Misoprostol among pregnant women by field level workers to render proper use of it immediate after delivery to prevent Post-partum Haemorrhage (PPH).
5. Routine iron-folic acid (IFA) and other micronutrients supplementation to pregnant women during ANC and to lactating women upto 3 (three) months after delivery.
6. Routine Calcium supplementation among pregnant women for prevention of pre-eclampsia, particularly among those who are at higher risk with hypertension from 20 weeks' gestation till the end of pregnancy.
7. Conduct safe delivery at facilities (MCWCs and UH&FWCs) with Active Management of Third Stage of Labor (AMTSL) and applying partograph by trained service providers.

8. Prevention of Pre-eclampsia and Eclampsia by giving loading dose of magnesium sulphate (MgSo4) and referring to higher centres.
9. Mapping exercise to be established for 24/7 BEmONC services with seven signal functions in selected UH&FWCs.
10. Strengthening 24/7 CEmONC services with nine signal functions in MCWCs at district level.
11. Providing 4 (Four) quality Postnatal care (PNC) services for mothers and newborns with follow up by CSBAs and other community workers after discharge from facilities.
12. Target setup for facility delivery considering capacity, location and availability of skilled service providers.
13. Ensure CEmONC facilities' standards by keeping minimum two pairs (2 pairs for MCWC) of obstetrician and anesthesiologist (or appropriately trained Medical Officer), a trained pediatrician and 24/7 blood transfusion facilities.
14. Initiation of Mother's Bank Deposit Program to meet the financial demand during and after delivery.

b) National New-born Health Programme (DGFP part):

The Bangladesh Every Newborn Action Plan (BENAP) identifies a set of priority maternal and newborn interventions to ensure equitable and effective coverage of high impact newborn service defined in the Essential Service Package (ESP) for different service delivery points. The MCRAH OP would give special focus to reduce preventable newborn deaths by providing Comprehensive Newborn Care Package (CNCP). The implementation of CNCP will focus on (i) Capacity building and retention, (ii) Ensuring availability of commodities and drugs, (iii) Strengthening monitoring, supervision and mentoring; (iv) Ensuring quality of care and (v) promoting healthy MNH behavior and care seeking through SBCC.

Activities:

1. Promote healthy Maternal Newborn Health (MNH) behavior and proper care seeking including essential newborn care messages (immediate drying and skin to skin care, application of CHX and proper cord care, skin-to-skin contact, early initiation and exclusive breastfeeding (EBF), delayed bathing and immunization by trained service providers) to families through SBCC by inter-personal communication (IPC), community mobilization, community and social engagement and mass media promotion.
2. Antenatal corticosteroid therapy as per national guideline for women with threatened preterm deliveries from 24 weeks to 34 weeks of gestation to improve newborn outcome at MCWC and institutes having KMC services with capacity development of service providers.
3. Provide essential newborn care service immediately after birth including newborn resuscitation at all level of service delivery points.
4. Provide Essential newborn care (ENC) services including use of 7.1% chlorhexidine for umbilical cord care to reduce newborn mortality.
5. Strengthen postnatal care (4 visits) both at home and facility including identification of newborn danger signs of severe illness and referred as needed.
6. Provide Sick newborn management services at UH&FWC with capacity development of service providers , ensuring the supply of commodities and drugs and giving emphasis on referral linkage as per national guideline with simplified antibiotic regimen

7. Provide Kangaroo Mother Care (KMC) services for preterm and low birth weight babies at district level MCWCs (as per national KMC guideline) including capacity building of providers, facility preparedness and with enforcing monitoring mechanism and scaling up to UH&FWC.
8. Strengthening recording and reporting of services at all level and use of service data for program review and to take initiatives for program improvement.

c) Child Health Care Services:

To reduce child mortality and morbidity, targets will be achieved by ensuring quality and continuum of care services. Along with the services provided by DGHS, special attention would be provided to the growth, nutrition, preventable communicable diseases, child illness and health education to the mothers.

Activities:

1. Provide counseling on appropriate feeding practices including exclusive breast feeding, Infant & Young Child Feeding (IYCF)
2. Strengthen limited curative care services to under-five children at all facilities.
3. Strengthen Integrated Management of Childhood Illnesses (IMCI) both at community and facility levels in collaboration with DGHS (including Community based management of childhood priority illness, i.e. pneumonia, diarrhea, neonatal sepsis and first aid of common injuries; Management of pneumonia at 1st level facilities like CC/ UHFWC).
4. Provide Growth Monitoring & Promotion (GMP) services for under-five children.
5. Assist EPI Program to provide immunization services to children and De-worming of under five children by DGHS through routine program and national campaign
6. Build awareness among mothers on IYCF Practices, danger signs of both mother and newborn as well as on cleanliness, hygiene and hand washing through SBCC activities.

d) Reproductive Health Care Services

Every woman has rights to have access to information and services on Reproductive Health. Special emphasis would be given to reduce unwanted pregnancy and unsafe abortion, RTI/STI case Management and early detection of female cervical and breast cancers.

Activities:

1. Strengthen safe Menstrual Regulation (MR), MR with Medication (MRM) by skilled service providers at facilities (UH&FWCs, UHCs, MCWCs) and ensuring supply of equipment and commodities (MR kits, MVA kits, Mifepristone & misoprostol and antibiotics).
2. Provide Post Abortion Care (PAC) services following standard guideline at MCWCs and phase wise scale-up to UH&FWCs with facility readiness for proper management of complications.
3. Improve integration of Family Planning counseling and services during postpartum, post-MR, post abortion care.
4. Counseling and distribution of Emergency Contraceptive Pill (ECP) to prevent unwanted pregnancy.
5. Strengthen community level awareness program for post-partum, post-MR, PAC services and Emergency Contraceptive Pill (ECP) through need-based SBCC activities.

6. Counseling on RTI/STI, HIV/AIDS and condom promotion at all facilities and management of RTI/STI cases in MCWCS by trained service providers.
7. Strengthen early detection of Cervical cancer through Visual Inspection of Cervix with Acetic acid (VIA) and of Breast cancer by clinical breast examination (CBE) at MCWCs and scale up to UH&FWCs by capacity building of service providers in coordination with BSMMU.
8. Strengthening facilities for the management of infertility cases including counseling, motivation, and referral linkage.
9. Counseling, motivation and referral linkage for fistula and utero-vaginal prolapse prevention program with DGHS and integrated into management of normal labor and delivery setup.

e) Adolescent Health Care Services

Adolescent constitutes about one-fourth of our population. A comprehensive adolescent health interventions will be delivered through MCRAH operation plan to make this huge portion of population more productive citizen of Bangladesh.

Activities:

1. Promotion of adolescents friendly health services at the facility and community level; curative care, counseling, health education.
2. Phase wise scale-up of Adolescent Friendly Health Services (AFHS) in all MCWCs and at least2 UH&FWCs in each upazila including SBCC activities.
3. Strengthen school health services by conducting satellite clinics (by Sub-Assistant Community Medical Officers) linking referral mechanism from schools to Adolescent Friendly Health Services at the facilities (MCWCs & UH&FWCs).
4. Awareness building for the gatekeepers (parents, guardians, community leaders, teachers, political leaders, religious leaders and marriage registers) to prevent child marriage, adolescent pregnancy, substance abuse, violence, non-communicable diseases and also to ensure proper nutrition and mental health.
5. Finalize and implement the National Plan of Action for Adolescent Health through greater collaboration with other sectors.
6. Develop and printing training manuals, guidelines, booklets regarding adolescent health.
7. Develop strong network on Adolescent and Reproductive health involving different stakeholders/ partners (launch website, publish newsletter etc.)
8. Capacity building of supervisors, managers, service providers and field staffs considering national gender equity strategy and National Plan of Action for Adolescent Health.

f) Nutrition Services

To mainstream nutrition services with collaboration of NNS OP of DGHS, every health and family planning service delivery points will provide nutrition services including special emphasis on under five children, adolescents, pregnant and lactating women. At the domiciliary level nutrition education and services will be provided by the trained field workers through house-hold visits, satellite clinics, community clinics and at the facility level (UH&FWCs, UHCs, MCHWCs), the nurses, paramedics (FWVs, SACMOs) will be responsible for counseling and services.

Activities:

1. Continuation of nutrition services in 91 upazilas of 11 districts and scaling up of services;

2. Counseling on Early initiation and exclusive breast feeding with establishing breastfeeding corner at facility level.
3. Micronutrient supplementation of children, adolescents and PLW (Pregnant and Lactating Women) ;
4. Strengthen counseling of PLW during ANC, PNC on maternal & child nutrition and monitoring of pregnancy weight gain with micronutrient supplementation;
5. De-worming in children and adolescents collaboration with DGHS.
6. Vit-A supplementation of children with EPI sessions;
7. Zinc supplementation with ORS to under five children after episode of dairrhoea;
8. Screening for and community based management of acute malnutrition with referral;
9. Capacity development of service providers, managers and supervisors
10. Strengthening of nutrition inclusive information system and data management

Component-2: Strengthening Health System including Improving Facility Readiness

The BHFS 2014, revealed that overall the facility readiness to provide quality MNCAH services at different facilities are inadequate. In order to provide quality MNCAH services including facility delivery, high emphasis will be given on Facility Readiness in the 4th HNP sector program. Phase-wise all functional UH&FWCs would be equipped to provide 27/4 delivery and basic EmONC services. Based on lessons learned, a greater collaboration with different stakeholders (NGOs/ private sector) and multi-sectoral approach would be followed.

Activities:

1. Strengthen MNCARH services through skilled service providers with standard guidelines, equipment and commodities at all facilities.
2. Strengthen UH&FWCs with skilled service providers, adequate physical facilities, equipment and ensuring availability of supply of drugs and commodities for 24/7 safe delivery with referral linkage to comprehensive EmONC facilities (UHC, MCWC, DH).
3. Functioning MCWCs for Comprehensive EmONC and other MCWCs and some selected UH&FWCs for basic EmONC services.
4. Timely procurement of the all essential Drugs, MSR, equipment as per the standard ESP service packages and other logistics including furniture and fixtures and print materials (registers, training manuals, guidelines etc.).
5. Improve minimum Laboratory Diagnostic services (Haemoglobin test, Blood glucose, Urine protein, Urine glucose, Urine pregnancy test).
6. Need based deployment of human resources.
7. Capacity development of the service providers (MOs, FWVs, SACMOs).
8. Repair/ Renovate physical facilities of the service centres including residence through PFD OP under HED.
9. Ensuring water and electricity supply and improving security system of the facilities.

Component-3: Capacity Building of the Service Providers

Developing a pool of high performing staff through skill development will be one of the priority interventions of the MCRAH OP. Different need-based training courses (basics/ refreshers) of different

duration (short-term and long-term) will be provided to service providers like doctors, paramedics, field workers, supervisors and managers. Training need assessment will be done before designing any training program and selection of participants will be done based on their actual needs and opportunity to implement the learning at workplace. Mentorship for clinical training will be introduced. Like on completion, the trainees will be attached to experts for hands-on practice for a short period. A comprehensive Training Follow-up plan will be developed.

The key training/ workshops/ orientations would include:

a) Long term Courses

(i). Training of service providers (one year for Doctors on Emergency Obstetric Care (EOC) and six months for FWVs on OT Management).
(ii). Six month training for FWVs on midwifery skill.
(iii). Training of FWVs to transform ICM (International Confederation on Midwives) standard midwives.

b) Short term Courses

(i) MNCRAH services related TOT for Managers and supervisors ;
(ii) Training and refreshers course on MR, MRM and PAC for facility level service providers of MCWCs and UH&FWCs
(iii) Training and refreshers course on CNCP including KMC for service providers (MCWCs, UH&FWCs) and field level staffs and supervisors (FWAs and FPIs);
(iv) Training on ICT, RTI/STI, infection prevention and other RH services and new interventions on newborn health care for Doctors and other service providers, managers and supervisor level officers.
(v) Training on adolescent health activities for service providers, managers, supervisors and peer educator, school teachers and marriage registers;
(vi) Training on first line management of pre-eclampsia /eclampsia for service providers.
(vii) Training on UH&FWC Manual for service providers, supervisors and managers and Orientation on UH&FWC manual for union MCH and FP committee members
(viii) Training on TQM (Total Quality Management) for MCWC and UH&FWC based service providers
(ix) Training on web based pregnant women, child, adolescent register and on ANC and PNC monitoring tools and orientation of service providers and supervisor level officers.
(x) District and Upazilla level orientation program and Community mobilization activities for promoting healthy MCH behavior and proper care seeking for community groups and community support groups including 24/7 normal delivery.

Moreover, participation of the program related personnel including field level service providers and supervisors in different international / overseas conferences / workshops/ seminars for learning and sharing of best practices and lessons learned of MNCRAH services would be encouraged through this MCRAH OP.

Component-4: Functional Co-ordination

To provide quality MNCARH services more efficiently functional co-ordination between DGHS and DGFP is essential for the 4th HNP sector program. Key strategies will include i) sharing of facilities and

coordination like at Community Clinics, UHFWCs, UHC, MCWCs, DHs; ii) joint performance review and sharing data (registration of pregnant mothers/ ANC/ PNC/ referral) ; iii) joint tracking of the service recipients (ANC, PNC, FP users) by field workers and supervisors of DGHS and DGFP; iv) develop common platform for MIS iv) capacity building of different service providers by DGHS and vi) task sharing of human resources

Activities:

1. At the community level, work closely in registering pregnant mothers, provide ANC (Satellite Clinic/ Community Clinic), make link with CSBAs, refer for facility delivery, follow-up with PNC visits.
2. Review performance jointly at CC and UH&FWC level.
3. Facilitate active involvement of FWAs in CC Management Committee meetings and of CHCPs/HAs in UH&FWC Management Committee meetings.
4. Capacity development by sharing for service providers on MNCRAH between DGFP and DGHS.
5. Coordination in deploying/ attaching DGHS staff (doctors/ nurses) at the facility level during special program (Regional Service Packages in HTR and low performing areas).
6. Mechanism for task sharing of human resources to ensure CEmONC services at district and upazila level under DGFP (MCRAH) and DGHS (MNCAH).
7. Incorporating technical expertise and facility sharing and work jointly with DGHS staff in planning and organizing different awareness raising campaigns on MNCRAH activities.
8. Joint effort for maintenance of the functional UH&FWC's, USC/RDs and supply of logistics and commodities.
9. At the national level activate Functional co-ordination through greater collaboration between MNCAH and MCRAH OPs and develop a Plan of Action with follow-up mechanism
10. Develop effective referral system through greater coordination with DGHS including CEmONC activities.
11. Establish coordination mechanism from Upazila to national level for implementation of CNCP

Component-5: Quality of Care including Supervision and Monitoring and Referral Linkage

Though emphasis was given in the last sector program on Quality of care, referral linkage, supervision and monitoring but the satisfactory outcome could not be achieved. So an effective referral system from community to facility level would be developed involving different community groups and institutions (like Union and Upazila Parishad). A structured referral system from Community and Satellite Clinics to the higher facilities at union and Upazila levels would be made available involving community members and the service providers. Service providers at facilities would negotiate with family decision makers for ANC and PNC and helping them for birth planning and for setting up fund to support in case of emergency including transportation system. To ensure Quality of Care expansion of Total Quality Management (TQM) including clinical supervision will be emphasized.

Activities:

1. Revisiting and updating SOP guideline and Protocol for MNCRAH services at all level service delivery points
2. Efficient management of HR including capacity development and ensure proper logistics management as per standards
3. Assist managers and supervisors to develop a comprehensive monitoring plan including clinical supervisory checklists
4. Intervention for prevention and treatment of maternal peripartum infections.
5. Expansion of Total Quality Management (TQM) at all MCWCs and Strengthening of medical waste management and infection prevention practices
6. Strengthening of MPDSR activity in institution and community level
7. Institutionalization of Partograph at all SDPs
8. Introduce quality indicators at national and process level to measure on a routine basis, set targets and monitor
9. Strengthen involvement of community groups, peoples representatives in management of different health facilities (UH&FWC Management Committees) and giving support in referral mechanism and transport system for client / patients.
10. Strengthen regulatory framework including private sector on MCRAH activities and Enforce performance-based renewable accreditation system.

Component-6: Partnership with NGOs/private sector

Existing partnership with different NGOs and technical assistances provided by UNs will be thoroughly reviewed, like the i) pilot initiative with Save The Children on Health System Strengthening (MaMoni Project) in five districts ; ii) operation research undertaken by Population Council on providing 24-hours normal delivery services at UH&FWCs in two districts; iii) CSBA supervision and reporting project initiated by Plan International, iv) Technical assistance by the UNs like UNFPA, UNICEF ; v) capacity development of different level of service providers on MR and PAC by Ipas Bangladesh; vi) SBCC experience through BKMI; vii) implementation of Adolescent Friendly Health Services (AFHS) in MCWCs and UH&FWCs; viii) scaling up nutrition activities after successful completion of MYCNSIA (Mother & Young Child Nutrition Initiative in Asia), December 2011- December 2015).

Emphasis will be given on effective MNCRAH services delivery strategies like facility readiness, quality of care, community engagement, awareness raising, capacity building, monitoring and supervision. Moreover, lessons learned from other successful models like Joint GOB-UN MNHI, SMPP, HRH Project will also be scaled-up in collaboration with DGHS.

Activities:

1. Develop plan of action to prepare the facilities (UH&FWCs) to provide 24/7 delivery care through renovation, staffing, adequate supplies as required
2. Scaling - up of CNCP (Comprehensive Newborn Care Package) throughout the country
3. Scaling-up KMC and Sepsis Management services to selected MCWCs and UH&FWCs with adequate logistics and equipment
4. Organize campaigns to promote and popularize institutional delivery with special reference to 24/7 normal delivery

5. Organize mothers events at MCWCs to promote institutional delivery and safe motherhood including ANC, PNC, birth planning, PPFP and identify ideal family who will be 'role model' in the community and speak in support of MNCH issues;
6. Continue MYCNSIA and IYCF initiatives in selected 17 and 91 upazilas respectively through either RPA or DPA funding mechanism
7. Strengthen collaboration with NGOs/ private sector particularly in the HTR and low performing and urban areas
8. Develop partnership with local NGO for community mobilization, hiring volunteers
9. Undertake operation researches and surveys.

Component-7: Community/ Stakeholders' Engagement at different level: Community, Union Parishad (UP), UpazilaParishad.

To strengthen community engagement in delivering comprehensive MNCARH services the key strategies would be i) developing an effective referral system from community to facility level involving different community groups and institutions (like Union and Upazila Parishad) ; ii) improving accountability mechanism with active participation of community groups and representatives in different committees (CC management committee, UH&FW management committee) and iii) community mobilization to promote 24/7 normal delivery.

Activities:

1. Organize community dialogue at district, upazila and union levels involving community support groups and key stakeholders like elected representatives, media personality, educationists, celebrities, representatives of the NGOs/CSOs, development partners, youth representatives for vigorous promotion of 24/7 normal delivery
2. Form community support groups involving youths, elected representatives preferably female UP members, school teachers and mobilize them to identify, motivate and support pregnant mothers in receiving ANC services from CCs, UH&FWCs and MCWCs;
3. Facilitate timely referral of women with obstetric complications to an appropriate EmOC facility (arrange local transport by involving community volunteers/ representatives and service providers)
4. Review performance regularly in Education and Health Standing Committee Meeting of Union and Upazila Parishad
5. Monitor and review performance of the CCs, UHFWCs on regular basis involving the UP Chairman and other community support group members and the service providers and supervisors (CC Management Committee/ UH&FWC Management Committee meetings).
6. Organize orientation/training for different government representatives (MOLGRD, MOE, MOSOW) member of the civil society organizations including journalists, teachers, students, religious leaders, women groups, social welfare officers & staffs.
7. Gradual scaling-up of the evidence based service delivery modalities (like lessons learned through partnership with NGOs in improving Union Level Facilities for Institutional Deliveries).
8. Hiring human resources from private sector particularly for HTR, low performing areas and Urban slums

Component 8: Urban Health

Due to rapid urbanization, providing primary health care including MCH-FP services for the urban population particularly for the poor is one of the biggest challenges in Bangladesh. Bangladesh Urban Health Survey, 2013 (NIPORT 2013) revealed huge disparity between slums and non-slum population in terms of availability and accessibility of MCH services. It was found that only half of the women living in slums receive ANC from medically trained providers. Facility delivery found highest among women living in non-slums (65%) and lowest in slums (37%). Although UPHCP under Local Government Institution (LGI) of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRD&C) is being implemented in different city corporations and municipalities but it covers limited areas leaving large disadvantaged groups out of service reach. An Urban Health Strategy (2014) has been developed with the objective to provide equitable and quality health services for the urban population particularly for the poor. Emphasis would be given for greater coordination and collaboration between MOHFW and LGI of MOLGRD&C and with other stakeholders (NGOs/ private sector) to ensure urban MNCRAH services.

Activities:

1. At the policy level facilitate effective coordination between MOHFW and LGI through steering committee meetings
2. At the local level develop a joint plan of action (on awareness raising, capacity building of different service providers, hiring volunteers, supply of drugs and logistics etc.) by involving DGHS , LGI (MOLGRD&C) and NGOs/ private sector
3. Strengthen MCH-FP services provided by Government Dispensaries (GODs)
4. Contract out services including hiring trained HR
5. Strengthen partnership with local NGOs and build capacity of the NGO service providers
6. Strengthen monitoring and reporting system
7. Develop an effective referral mechanism from different service outlets to static centres (like UHCs, MCWCs, DHs, MCs and NGO & private clinics)

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

During implementation of MCRAH OP of the 4th SWAP several cross cutting issues would be addressed for effective coordination and harmonization of priority activities with other related operational plans thus enhancing improvement in delivering quality, equitable and gender sensitive services for vulnerable population.

Activities

1. P**overty**: Improved maternal, newborn, child and adolescent reproductive health saves money in many ways and benefits individuals, families, communities and society. Because households with healthier and nourished mothers and children spend less on healthcare. Improved health would reduce out-of-pocket expenses which is catastrophic (more than 64%) and will have positive economic impact on individual, societal and national poverty level.

2. **Equity:** Increasing equity to access different MNCH-FP services is extremely important to reduce the existing discrepancy between rich and poor. Priority would be given to reach the unreached. Major focus of the program would be for the vulnerable and hard-to reach population.
3. **Gender**: Gender disparities in terms of service provision and access (like between girls child and boys) will be carefully monitored. Gender sensitive and need-based SBCC materials will be developed and disseminated to targeted groups. Service centres will be made women friendly.
4. **Voice and accountability**: Community engagement in planning and monitoring services will be given highest priority. Different committees and local support groups, members of the civil society etc. will be involved in different local level planning and performance review meetings. Higher number of women representation in different support groups and their participation in different meetings, would be ensured.

7. Proposed Manpower: Annexed in Volume-II.

8. List of Works, Goods, and Services etc: Annexed in Volume-II.

9. Indicators

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1	Utilization of Maternal health care service is increased in Sylhet and Chittagong division)	Percentage of normal delivery in public facilities	2016 (have to confirm)	12% of baseline	18% of baseline
2	Percentage of new born received essential new born care)	Percentage	6.1 (BDHS, 2014)	15	25
3	ANC coverage (at least 4 visit)	Percentage	31.2 (BDHS, 2014)	40	50
4	Percentage of delivery by skilled birth attendant (SBA)	Percentage BDHS, every 3 years/UESD, every non-DHS years	42.1%, BDHS 2014	55%	65%
5	Percentage mothers with non-institutional delivery receiving post natal care from a medically trained provider within two	Percentage BDHS, every 3 years/UESD, every non-DHS years	5.4	7	10

	days of delivery				
6.	Number of health facilities (MCWC/UH &FWC) made functional adolescent friendly health services	Number	93 (MCH-S unit report, DGFP)	600	979

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
38650.80	**80738.00**	**17362.00**	98100.00	**136750.80**	

10.2.Component and activity wise physical and financial target of OP: MCRAH

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
(i) Component 1: Strengthening Health Care Services													
	(a) Maternal Health Care												
1	BP machine	26000	pcs	390.00	0.00	390.00	0.00	60.00	60.00	60.00	60.00	60.00	90.00
2	Stethoscope	26000	pcs	130.00	0.00	130.00	0.00	20.00	20.00	20.00	20.00	20.00	30.00
3	Height and Weight Machine	5500	pcs	550.00	0.00	550.00	0.00	0.00	100.00	100.00	100.00	100.00	150.00
4	Glucometer with Strip and needle	5500	pcs	220.00	0.00	220.00	0.00	0.00	40.00	40.00	40.00	40.00	60.00
5	Uristix	5000000	pcs	250.00	0.00	250.00	0.00	0.00	50.00	50.00	50.00	50.00	50.00
6	Talquest book with Lancet	24000	pcs	60.00	0.00	60.00	0.00	0.00	12.00	12.00	12.00	12.00	12.00
7	Tab. Misoprostol	14	Million pcs	2267.85	0.00	2267.85	0.00	481.71	481.71	326.28	326.28	326.28	325.59
8	Pregnancy test kit	300000	pcs	300.00	0.00	300.00	0.00	0.00	60.00	60.00	60.00	60.00	60.00
9	Delivery Kit with packaging	95000	pcs	5375.00	0.00	5375.00	0.00	750.00	875.00	875.00	875.00	875.00	1125.00
10	Delivery table	5000	pcs	625.00	625.00	0.00	0.00	0.00	125.00	125.00	125.00	125.00	125.00
11	Spot light	8000	pcs	240.00	0.00	240.00	0.00	0.00	90.00	30.00	30.00	30.00	60.00
12	Inj. Oxytocin and other costs per Delivery Case Managenent	820000	case	920.00	920.00	0.00	0.00	0.00	180.00	180.00	180.00	180.00	200.00
13	Mother's Bank for Money Deposit	200000	pcs	200.00	0.00	200.00	0.00	0.00	40.00	40.00	40.00	40.00	40.00
14	One year Doctor's Training on Obstetric/Gynae and Anaesthesia.	150	person	330.00	0.00	0.00	330.00	30.00	60.00	60.00	60.00	60.00	60.00
15	6 months Training on OT management & nursing care for FWVs	300	person	360.00	0.00	360.00	0.00	36.00	72.00	72.00	72.00	72.00	36.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
16	6 months Training on Midwifery skill for FWVs	900	person	1080.00	0.00	1080.00	0.00	108.00	216.00	216.00	216.00	216.00	108.00
17	Refresher training on EOC (7 days) for Doctors	700	person	175.00	0.00	0.00	175.00	0.00	35.00	35.00	35.00	35.00	35.00
18	Refresher Training (7 days) on Midwifery skill & OT management & nursing care for FWVs	720	person	144.00	0.00	0.00	144.00	24.00	24.00	24.00	24.00	24.00	24.00
	Sub-Total (Maternal Health Care)			**13616.85**	**1545.00**	**11422.85**	**649.00**	**1509.71**	**2540.71**	**2325.28**	**2325.28**	**2325.28**	**2590.59**
	(b) Newborn Care Services												
1	Baby Weighing Scale	8000	pcs	640.00	0.00	640.00	0.00	0.00	240.00	80.00	80.00	80.00	160.00
2	Baby Bag and Musk	8000	pcs	40.00	0.00	40.00	0.00	0.00	15.00	5.00	5.00	5.00	10.00
3	Baby Nasal Aspirator	8000	pcs	32.00	0.00	32.00	0.00	0.00	12.00	4.00	4.00	4.00	8.00
4	Inj. Corticosteroid 100mg and Disposable Syringe	200000	pcs	100.00	0.00	100.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
5	Inj. Gentamycin and Disposable Syringe	600000	pcs	60.00	0.00	60.00	0.00	3.60	10.00	10.00	15.00	10.00	11.40
6	7.1% Chlorhexidone Solution (10 ml)	6900000	bottle	1733.00	0.00	1733.00	0.00	258.00	275.00	300.00	300.00	300.00	300.00
7	Amoxicillin Paediatric Dry Powder (15ml)	1881600	pcs	489.22	0.00	489.22	0.00	15.60	43.68	76.75	113.57	119.81	119.81
8	KMC binder and Diapers	42900	2 per case	6.47	0.00	6.47	0.00	0.00	1.03	1.03	1.03	1.03	2.35
9	KMC Training for Doctors and FWVs/ Nurse	28	Batch	112.50	0.00	100.00	12.50	0.00	22.50	22.50	22.50	22.50	22.50
10	CNCP Training for Doctors, SACMOs, FWVs, FWAs and FPIs	1463	Batch	2200.00	0.00	2000.00	200.00	200.00	400.00	400.00	400.00	400.00	400.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
11	Refrsher Training on CNCP for FWVs, FWAs, FPI and SACMOs	375	Batch	885.50	0.00	500.00	385.50	0.00	177.00	177.00	177.00	177.50	177.00
12	Printing & Training Material Development and Printing for KMC and CNCP	64850	pcs	923.45	350.00	150.00	423.45	98.20	175.00	150.25	75.00	75.00	350.00
	Sub-Total			**7222.13**	**350.00**	**5850.68**	**1021.45**	**575.40**	**1391.21**	**1246.53**	**1213.10**	**1214.84**	**1581.06**
	(c) Child Helalth Care Services												
1	MUAC Tape	8000	pcs	24.00	0.00	24.00	0.00	0.00	9.00	3.00	3.00	3.00	6.00
2	Weight Machine (Bathroom Type)	8000	pcs	200.00	0.00	200.00	0.00	0.00	75.00	50.00	25.00	25.00	25.00
3	GMP Card	600000	pcs	1200.00	0.00	900.00	300.00	0.00	240.00	240.00	240.00	240.00	240.00
	Sub-Total			**1424.00**	**0.00**	**1124.00**	**300.00**	**0.00**	**324.00**	**293.00**	**268.00**	**268.00**	**271.00**
	(d) Adolescent Health Care Services												
1	Adolescent Friendly Health Service (AFHS)	1000	Facility	2500.00	250.00	750.00	1500.00	0.00	500.00	500.00	500.00	500.00	500.00
2	ARH Drugs (7 items)	214.5	Million pcs	2131.40	0.00	2131.40	0.00	0.00	443.20	446.20	445.80	446.20	350.00
3	Sanitary Pads	320000	pcs	320.00	0.00	320.00	0.00	0.00	100.00	100.00	40.00	40.00	40.00
4	Develop Mobile Apps on FP-MCH issues and Maintainence	1	number	100.00	0.00	0.00	100.00	0.00	100.00	0.00	0.00	0.00	0.00
5	Adolescent website maintenece and Publish News letter	0	0	145.00	25.00	0.00	120.00	20.00	25.00	25.00	25.00	25.00	25.00
6	TOT and Training on AFHS for service providers	2520	person	386.30	0.00	0.00	386.30	0.00	71.40	71.40	71.40	72.10	100.00
7	Orientation/Meeting/Workshop on ARH and & Life Skill Training	0	0	549.40	50.00	150.00	349.40	39.40	80.00	80.00	80.00	80.00	190.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	Sub-Total			**6132.10**	**325.00**	**3351.40**	**2455.70**	**59.40**	**1319.60**	**1222.60**	**1162.20**	**1163.30**	**1205.00**
	(e) Nutrition Services												
1	Micronutrient Powder (MNP) sachet	12	Million pack	550.00	0.00	300.00	250.00	130.00	70.00	70.00	70.00	70.00	140.00
2	TOT on Basic Nutrition	480	person	96.00	0.00	0.00	96.00	16.00	16.00	16.00	16.00	16.00	16.00
3	Training on Basic Nurition for field staff	19656	person	591.40	0.00	0.00	591.40	98.28	98.28	98.28	98.28	98.28	100.00
	Sub-Total			**1237.40**	**0.00**	**300.00**	**937.40**	**244.28**	**184.28**	**184.28**	**184.28**	**184.28**	**256.00**
	(f) Reproductive Health Care Services												
1	MR kit	48000	kit	720.00	0.00	720.00	0.00	120.00	120.00	120.00	120.00	120.00	120.00
2	MVA kit	10000	kit	400.00	0.00	400.00	0.00	0.00	100.00	0.00	100.00	100.00	100.00
3	MRM (Mifepristone-200mg +Tab. Misoprostal-200mcg)	60000	pack	180.00	0.00	180.00	0.00	30.00	30.00	30.00	30.00	30.00	30.00
4	Training on MR & PAC for Doctors and FWVs	139	person	772.07	0.00	375.07	397.00	125.27	124.80	125.40	124.80	124.80	147.00
5	Tab. Levonorgestrel (1.5mg) (ECP)	600000	pcs	390.00	0.00	390.00	0.00	65.00	65.00	65.00	65.00	65.00	65.00
6	Training on MRM	6000	person	600.00	0.00	600.00	0.00	100.00	100.00	100.00	100.00	100.00	100.00
	Sub-Total			**3062.07**	**0.00**	**2665.07**	**397.00**	**440.27**	**539.80**	**440.40**	**539.80**	**539.80**	**562.00**
(ii) Component 2: Health System Strengthening/ Health Care Facility Readiness													
1	Drugs for Maternal & Child Health with packaging	4528.44	Million pcs	59118.00	7188.00	51930.00	0.00	9200.00	9780.00	9780.00	9780.00	9768.00	10810.00
2	FWC kit	3000	kit	660.00	0.00	660.00	0.00	110.00	110.00	110.00	110.00	110.00	110.00
3	MCH kit	3000	kit	750.00	0.00	750.00	0.00	125.00	125.00	125.00	125.00	125.00	125.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
4	Machineries and Hospital Equipments for MCWC,MCHTI, MFS&TC	1770	pcs	2828.00	1478.00	0.00	1350.00	125.00	500.00	425.00	428.00	800.00	550.00
5	Procurment of Office equipments	222	pcs	205.00	195.00	0.00	10.00	15.00	40.00	40.00	40.00	40.00	30.00
6	Procurement of Furnitures and fixures	1212	pcs	540.00	525.00	0.00	15.00	75.00	100.00	100.00	100.00	100.00	65.00
7	Procurement of other Related Materials	577024.8	pcs	960.00	960.00	0.00	0.00	160.00	160.00	160.00	160.00	160.00	160.00
8	Procurement of other necessary medicine, MSR & Beds and linen for service centers (MCWC, UH&FWC, MCHTI, MFSTC)	0	Lump sum	7580.00	3430.00	0.00	4150.00	1100.00	920.00	1320.00	1370.00	1370.00	1500.00
9	Procurement other Equipments	0	Lump sum	1652.00	882.00	0.00	770.00	165.00	335.00	380.00	335.00	202.00	235.00
10	Repairs of Machinery and other Equipments	0		937.00	610.00	0.00	327.00	115.00	165.00	162.00	165.00	165.00	165.00
11	Iron Cot-, Bed Side Locker, Saline Stand	6000	set	1500.00	1500.00	0.00	0.00	250.00	250.00	250.00	250.00	250.00	250.00
12	Procurement of Disposable Syringe, Cotton, Gloves etc	0	0	180.00	180.00	0.00	0.00	30.00	30.00	30.00	30.00	30.00	30.00
13	Logistics and Equipments for newly constructed 10 beded MCWCs	89	Facility	1394.00	360.00	434.00	600.00	160.00	160.00	268.00	268.00	268.00	270.00
	Sub-Total			**78304.00**	**17308.00**	**53774.00**	**7222.00**	**11630.00**	**12675.00**	**13150.00**	**13161.00**	**13388.00**	**14300.00**
(iii) Component 3 : Capacity Building of Service Providers													
1	Overseas conferences/workshops/ Best Practices sharing	240	person	791.26	0.00	400.00	391.26	44.60	46.66	175.00	175.00	175.00	175.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
2	Workshop on Capacity Building and Performance Appraisal for Managers and Report Related Personnel	70	Batch	100.88	0.00	0.00	100.88	50.48	50.40	0.00	0.00	0.00	0.00
	Sub-Total			**892.14**	**0.00**	**400.00**	**492.14**	**95.08**	**97.06**	**175.00**	**175.00**	**175.00**	**175.00**
(iv) Component 4: Functional Integration													
1	Performance Sharing / Review meetings on cross-cutting issues	0		700.00	220.00	0.00	480.00	100.00	120.00	120.00	120.00	120.00	120.00
	Sub-Total			**700.00**	**220.00**	**0.00**	**480.00**	**100.00**	**120.00**	**120.00**	**120.00**	**120.00**	**120.00**
(v) Component 5: Quality of Care including Supervision and Monitoring													
1	Training on Quality Management (TQM)	9600	person	210.00	0.00	0.00	210.00	35.00	35.00	35.00	35.00	35.00	35.00
2	Training on Data Monitoring & supervision	1800	person	236.00	18.00	170.00	48.00	11.00	45.00	45.00	45.00	45.00	45.00
3	Divisional Quaterly Performance and Data Review Workshop	192	number	250.84	12.00	0.00	238.84	40.40	40.50	39.50	40.40	38.04	52.00
4	National Level Annual Performance and Data Review Workshop	24	number	107.47	48.00	0.00	59.47	17.60	18.00	18.67	17.60	17.60	18.00
5	Health care waste management	3600	number	288.00	288.00	0.00	0.00	8.00	40.00	40.00	40.00	80.00	80.00
6	Supportive Supervision and Monitoring	0		499.00	209.00	0.00	290.00	85.00	85.00	85.00	85.00	85.00	74.00
	Sub-Total			**1591.31**	**575.00**	**170.00**	**846.31**	**197.00**	**263.50**	**263.17**	**263.00**	**300.64**	**304.00**
(vi) Component 6: Partnerships with NGOs/ Private Sectors													
1	Orientation of Awareness bulding on 24/7 delivery at UH&FWC (Upazilla level)	3000	number	2740.00	540.00	1200.00	1000.00	490.00	490.00	490.00	490.00	390.00	390.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
2	National Technical Committee (NTC) and Others (TEC) meeting at National Level (HQ)	24	number	78.00	18.00	0.00	60.00	13.00	13.00	13.00	13.00	13.00	13.00
	Sub-Total			**2818.00**	**558.00**	**1200.00**	**1060.00**	**503.00**	**503.00**	**503.00**	**503.00**	**403.00**	**403.00**
(vii) Component 7: Community/Stakeholder Engagements at different level													
1	Strengthening of referral system and incentive for HTR areas.	0	0	420.00	0.00	360.00	60.00	70.00	70.00	70.00	70.00	70.00	70.00
	Sub-Total			**420.00**	**0.00**	**360.00**	**60.00**	**70.00**	**70.00**	**70.00**	**70.00**	**70.00**	**70.00**
(viii) Component 8: Urban Health													
1	Strenthening of Urban Health at City Corporation and Municipility Areas	0	0	480.00	0.00	120.00	360.00	80.00	80.00	80.00	80.00	80.00	80.00
	Sub-Total			**480.00**	**0.00**	**120.00**	**360.00**	**80.00**	**80.00**	**80.00**	**80.00**	**80.00**	**80.00**
(ix) Component 9: Miscellenious and Support Services													
1	Pay and allowances	27522	mm	5410.00	5410.00	0.00	0.00	60.00	950.00	1100.00	1100.00	1100.00	1100.00
2	Advertising and publicity	0	0	250.00	250.00	0.00	0.00	15.00	40.00	45.00	50.00	50.00	50.00
3	Security, Cleaning and facility management	0	0	1500.00	1500.00	0.00	0.00	250.00	250.00	250.00	250.00	250.00	250.00
4	Stationery, Seals and Stamps	0	0	60.00	60.00	0.00	0.00	20.00	0.00	0.00	0.00	40.00	0.00
5	Petrol, Oil and Lubricant	0	0	1950.00	1950.00	0.00	0.00	200.00	350.00	350.00	350.00	350.00	350.00
6	Municipal Rates & Taxes	0	0	372.00	372.00	0.00	0.00	62.00	62.00	62.00	62.00	62.00	62.00
7	Printing and Publication (Forms, Cards, Registers, Log Book, Training Materials & manual, brochur etc)	27.555	million pcs	3025.00	2750.00	0.00	275.00	250.00	550.00	550.00	550.00	550.00	575.00
8	Maintenance cost (Recurrent	0	0	2631.20	2631.20	0.00	0.00	385.40	435.20	435.20	435.20	435.20	505.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	expenditure)												
9	Repairs and maintenance of Motor vehicles, computers, sanitation & office equipment	0	0	1305.00	550.00	0.00	755.00	50.00	225.00	225.00	225.00	230.00	350.00
10	Motor vehicle (Ambulance-31, Four wheel Jeep-4, Microbus-1)	36	pcs	1512.00	1512.00	0.00	0.00	220.00	290.30	260.00	290.30	241.10	210.30
11	Procurement of Tyre tube, Battery for motor vehicle	0	0	240.00	240.00	0.00	0.00	40.00	40.00	40.00	40.00	40.00	40.00
12	Computer,Laptop, Multimedia,Photocopier etc.	80	pcs	110.00	110.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	20.00
13	Tubewell and Equipment	0	0	60.00	60.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00	10.00
14	Telecommunication equipment	0	0	35.00	35.00	0.00	0.00	5.00	6.00	6.00	6.00	6.00	6.00
15	Electrical equipment	0	0	120.00	120.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00	20.00
16	Survey/ Research Expenses	0	0	51.00	0.00	0.00	51.00	0.00	10.00	10.00	10.00	11.00	10.00
17	Others expense (Captital exp)	0	0	219.60	219.60	0.00	0.00	24.60	33.80	53.80	35.80	35.80	35.80
	Sub-Total			**18850.80**	**17769.80**	**0.00**	**1081.00**	**1622.00**	**3292.30**	**3437.00**	**3454.30**	**3451.10**	**3594.10**
	Grand Total			**136750.80**	**38650.80**	**80738.00**	**17362.00**	**17126.14**	**23400.46**	**23510.26**	**23518.96**	**23683.24**	**25511.75**
				*Other RPA (JICA)-2330.00 lakh									

11. Budget support from other Operational Plan: Not applicable

4.18 National Nutrition Services (NNS)

1. **Name of the Operational Plan:** National Nutrition Services (NNS)

2. **Implementing Agency:** Directorate General of Health Services (DGHS)

3. Introduction

Adequate nutrition is a basic human right and an important determinant of physical and mental development. Along with under nutrition, obesity and nutrition-related non-communicable diseases are major public health problems in Bangladesh. Government of the People's Republic of Bangladesh is committed to improve the nutritional status of the people. Over the last decades, different nutrition interventions/programs contribute to significant improvement in the country nutrition situation, though it has not reached at an expected level. Childhood malnutrition has been decreasing slowly in Bangladesh, 36% under five years aged are stunted while 14% are wasted. Only 55% of children below 6 months of age are exclusive breastfed and 23% of children 6-23 months aged are fed with appropriate feeding practices (BDHS 2014). Around 10% adolescent girls (10-18 years) are undernourished (FSNSP 2014). Overweight or obesity is more prevalent (24%) among women 15-49 years (BDHS 2014). Though nutrition parameters are mostly better off in urban areas compared to rural but the situation is worst in urban slum areas. Half of the under 5 children in slums are stunted, which is one-third for non-slums areas. Only 26% of children aged 6-23 months in slums are fed with proper IYCF practices, compared with 40% for non-slum children (UHS 2013). Micronutrient deficiencies among the children and women of reproductive age are still a challenge. Sub-clinical vitamin A deficiency is 20% and zinc deficiency is 44% in preschool aged children. About 40% of school-aged children and 42% women are suffering from iodine deficiency. Prevalence of iron deficiency is 11% in the pre-school age children, 10% in the school age children (12-14 years) and 7% in the NPNL women (NMS 2011-12). About 33% of pre-school aged children (NMS 2011-12) and 50% of pregnant women are anemic (BDHS 2014). Unsafe food has been long standing challenge in the country and poses a serious public health risk leading to increase prevalence of food borne diseases. Hygiene and sanitation standards still remain poor, only 3 percent of caregivers wash their hand before feeding a child (FSNSP 2014). Bangladesh has achieved Millennium Development Goal (MDG) targets for nutrition and is committed to achieve the targets of Sustainable Development Goals (SDGs) through Universal Health Coverage. The government has taken the initiative to mainstream nutrition through health and family planning services. National Nutrition Policy 2015 reflects the commitment of the Government to improve the nutritional status of the population through multi-sectoral approach. Bangladesh National Nutrition Council (BNCC) established in 1975 to address multi-sectoral approach. Nutrition OP will facilitate to establish effective coordination mechanism at national and sub-national level in coordination with BNNC (revitalized). This National Nutrition Services (NNS) Operational Plan has developed based on Strategic Implementation Plan (SIP) for the fourth HNP Sector Development Program. All the activities have planned considering National Nutrition Policy 2015, National Plan of Action for Nutrition (NPAN), National Strategy on prevention and control of Micronutrient deficiencies (2015-2024), Seventh Five Year Plan, Vision 2021, SDG targets and other relevant programs and strategies. NNS OP 2011-16 focused mainstreaming of nutrition services through DGHS and DGFP during the implementing period 2011-16. This new OP will focus more on system strengthening and multi-sectoral coordination to ensure universal and equitable coverage of both specific and sensitive nutrition interventions.

4. Objectives:

General Objective:

To improve nutritional status of the people of Bangladesh with special emphasis to the children, adolescents, pregnant & lactating women, elderly and underserved population of both rural and urban area in line with National Nutrition Policy 2015.

Specific Objectives:

i. To strengthen the mainstreaming of nutrition issues into relevant sectoral policies, plans and programs.

ii. To scale up a comprehensive package of nutrition services through DGHS, DGFP and relevant ministries/ departments/ organizations to prevent and reduce double burden of malnutrition among the people of Bangladesh with special focus on children, adolescents, pregnant & lactating women, elderly, poor and underserved population.

iii. To ensure universal and equitable access to and utilization of quality services of nutrition for all in rural, urban and hard-to-reach areas.

iv. To develop and strengthen coordination mechanisms for nutrition with key relevant sectors/ stakeholders to ensure a multi-sectoral approach at national and sub-national levels.

v. To improve food safety activities related to MOHFW.

vi. To improve capacity of human resources to manage, supervise and deliver quality nutrition services (both specific and sensitive) at the different levels of health, family planning and other services.

vii. To strengthen institutional capacity of IPHN as a Centre of Excellence for nutrition.

viii. To strengthen Nutrition Information System (NIS), monitoring & evaluation, surveillance, survey and research.

5. Component

Component-1: Nutrition Specific Activities:

a) Promote, Protect and Support Infant and Young Child Feeding (IYCF) Practices

NNS OP will strengthen program implementation to improve the current IYCF situation through different strategies.

Activities:

1. Social and Behavior Change Communication (SBCC) for IYCF promotion
2. Update of National Strategy for Infant and Young Child Feeding 2007
3. Revitalization of Baby Friendly Hospital Initiatives (BFHI)
4. Implementation of BMS Act 2013
5. Promote work place support protection for breastfeeding and creation of breastfeeding corner at health facilities
6. Capacity development counseling on lactation management

7. Orientation for mother support group
8. Advocacy to include IYCF issue in the emergency response plan
9. Program coordination among IYCF stakeholders through IYCF Alliance
10. Publish IYCF bulletin

b) Promote Maternal Nutrition

Pregnant and lactating women will be counseled during ANC/PNC services and also during domiciliary visits of the health and family planning workers as part of essential service package (ESP).

Activities:

1. Conduct SBCC activities to improve awareness on maternal diet and nutrition care
2. Micronutrients supplementation i.e. Iron Folic Acid (IFA), Calcium
3. Update IEC materials, reminder tool, monitoring tools etc.

c) Promotion of Adolescent Nutrition

To promote adolescent nutrition increase knowledge about importance of adolescent nutrition, advocacy and awareness raising program will be conducted to increase knowledge about importance of adolescent nutrition.

Activities:

1. Awareness raising program to promote adolescent nutrition
2. Development of guideline, IEC materials, training module, academic curriculum related to adolescent nutrition on adolescent nutrition and IFA
3. Micronutrients supplementation i.e. IFA
4. Orientation program for teachers and students
5. Establish link with relevant authorities to include/ strengthen the nutrition component in academic curriculum

d) Control of Micronutrient Deficiencies

(i) Vitamin A Supplementation:

Government is implementing bi-annual vitamin A supplementation program (NVAC) for children aged 6-59 months since long with high program coverage. NNS OP will further strengthen activities to address challenges (e.g. improve coverage in hard-to-reach areas, target setting) which will contribute to sustain the high program coverage.

Activities:

1. Awareness creation about food based approach
2. Vitamin A supplementation through campaign
3. Organizing national and sub-national level advocacy/orientation programs

(ii) Iron Folic Acid (IFA) Supplementation:

IFA supplement to pregnant & lactating women and adolescent girls will be provided based on "National Strategy on Prevention and Control of Micronutrient Deficiencies, Bangladesh (2015-2024)".

Activities:

1. Awareness creation about food based approach
2. Update National Strategy for Anemia Prevention and Control (2007)
3. IFA supplementation for pregnant, lactating women and adolescents girls

(iii) Zinc Supplementation:

Zinc supplementation as part of the management of diarrhea for under-five children will be promoted and strengthened.

Activities:

1. Awareness creation
2. Zinc supplementation for as part of the management of diarrhea for under five children
3. Establishing collaboration with Integrated Management of Childhood Illness (IMCI)

(iv) Calcium and Vitamin D Supplementation

Calcium supplementation for pregnant women will be provided as per "National Strategy on Prevention and Control of Micronutrient Deficiencies, Bangladesh (2015-2024)".

Activities:

1. Awareness creation about food based approach
2. Calcium supplementation for pregnant women
3. Vitamin-D and calcium supplementation geriatric population

(v) Multiple Micronutrient Powder (MNP) Supplementation for targeted children

Targeted children aged 6-23 months will be supplemented with MNP as per "National Strategy on Prevention and Control of Micronutrient Deficiencies, Bangladesh (2015-2024)".

Activities:

1. Awareness creation about food based approach
2. Micronutrient supplementation for targeted children

(vi) Management of Moderate and Severe Acute Malnutrition

Facility-based inpatient care is essential for SAM children with medical complications. SAM units have been established in the selected secondary and tertiary level health facilities to manage SAM children with complications as per national guidelines. Uncomplicated SAM/MAM cases will be managed at community level. Malnourished PLW (<21 cm MUAC) will be identified and managed as per guidelines.

Activities:

1. Expansion of SAM units in primary, secondary and tertiary level health facilities

2. Revision/update of SAM/CMAM guideline and training modules
3. Develop guideline for childrenunder-6 months of age with SAM
4. Develop and adopt simplified Bengali version of national SAM guidelines and training modules for nurses and SACMOs
5. Capacity development of service providers on management and counseling
6. Strengthen screening and referral and reporting system
7. Established linkage with TBL&ASP OP to ensure screening of malnourished children, detection of respective cases and ensure nutrition supplementations

(vii) Strengthen Nutrition Services for Elderly Persons

Changes associated with normal aging process increases nutritional risks for elderly population. As part of life cycle approach, preventive and curative nutrition services for the elderly population will be strengthened at all tiers of health services.

Activities:

1. Awareness raising program
2. Promotion of dietary guideline
3. Vitamin-D and calcium supplementation
4. Geriatric nutrition strategy development and orientation

(viii) Strengthen Nutrition Interventions in Emergencies

Bangladesh is considered as a disaster-prone country. IPHN will coordinate with relevant stakeholders to ensure appropriate preparedness and response and will continue co-leading the Nutrition Cluster.

Activities:

1. Awareness development campaign to address nutrition issue during emergency
2. Update of Rapid Nutrition Assessment Guideline
3. Facilitating implementation of full set of nutrition response package as per cluster contingency plan
4. Coordinate with relevant ministries to incorporate nutrition in emergency response plans

(ix) Growth Monitoring and Promotion (GMP)

GMP is a tool that facilitates communication and interaction with mother/care givers and generates adequate action to promote child growth. Children under 5 years of age (priority focus on under 2 years aged children) will be measured as per guideline and mother/caregivers will receive counseling and services as appropriate.

Activities:

1. GMP at all service centers
2. Printing GMP cards and supply logistics (e.g. weighing scale, length/height board etc.)

(x) Strengthen Deworming Program for Children 24 to 59 Months

The aim of deworming is to prevent and control morbidity of soil-transmitted helminthes infections through the periodic treatment of at-risk population. Children aged 24 to 59months will receive de-worming tablet.

Activities:

1. Implement Deworming program for Children 24 to 59 months twice in a year
2. Conduct national and sub-national level advocacy/orientation programs

(xi) Prevention of Overweight and Obesity

Bangladesh is experiencing rapid increase of overweight and obesity which causes substantial burden of non-communicable diseases. Overweight/obesity is not only prevalent in higher income classes but also found among people living across poverty level.

Activities:

1. Implement awareness development campaign on obesity prevention
2. Finalization of Dietary Guideline
3. Development of Nutrient Profile Model
4. Establish linkage with Bangladesh Food Safety Authority (BFSA) and relevant OPs

(xii) Social Behavior Change Communication (SBCC)

Comprehensive, coordinated and multichannel SBCC activities will be implemented at health facilities, academic institutes and community to promote appropriate nutrition practices.

Activities:

1. Develop and update SBCC materials including IEC materials for handicapped and disabled people, CHT area and other tribal population
2. Update of National Communication Plan for IYCF
3. Comprehensive, coordinated and multichannel mass media campaign
4. Awareness raising through alternative medias e.g. street show, folk song, road show etc.
5. Design and conduct special SBCC program for hard-to-reach areas
6. Organize nutrition fair at national and sub-national level
7. Publication of IYCF bulletin
8. Establish coordination with Ministry of Information (MOI), other relevant ministries and stakeholders for successful implementation of the program

Component-2: Nutrition Sensitive Activities:

(i) Food Safety Program

A National Food Safety Laboratory (NFSL) has established in the Institute of Public Health (IPH).Support will be provided to run the laboratory effectively. Risk-based inspection planning and implementation across the country will be strengthened.

Activities:

1. Awareness raising program for food safety
2. Strengthen Food borne Illness Surveillance
3. Strengthen food safety laboratory services
4. Capacity development

(ii) Good Hygiene Practices (GHP) Including WASH at All Level

The goal of hygiene promotion is to help people to understand and develop good hygiene practices to prevent food/water borne diseases.

Activities:

1. Conduct SBCC activities to promote GHP at household level and also in the preparation and sale of street food

(iii)Food Fortification

In collaboration with Bangladesh Small and Cottage Industries Corporation (BSCIC), Ministry of Industries (MOI) and relevant partners, consumption of iodized salt will be promoted.

Activities:

1. Conduct SBCC activities
2. Provide technical support to BSCIC, Ministry of Industries (MOI)

(iv)Nutrition Challenges Due to Climate Changes

Climate change is one of the major causes of disaster and has long term impact on health and nutrition. Nutrition services and SBCC activities will be strengthened in the areas that are vulnerable to climate change.

Activities:

1. Conduct SBCC activities to address nutrition issues related to climate change
2. Advocate for preparing climate change adaptation strategies considering food security and disease management issues and its' impact on nutrition

Component-3: System Strengthening:

(i) Revitalization of Bangladesh National Nutrition Council (BNNC)

NNS OP will facilitate to establish effective coordination mechanism involving all relevant stakeholders in coordination with BNNC.

Activities:

1. Facilitate establishment of effective coordination mechanism with BNNC.
2. Implement relevant activities of NPAN

(ii) Multi-sectoral Coordination, Collaboration of Nutrition Activities Across Different Sectors at National and Sub-national Level

Strengthened partnership and coordination among sectors/ministries/ government institutions/ non-government organizations and development partners are essential to implement and scale up multi-sectoral, multi-stakeholder nutrition program throughout the country.

Activities:

1. Formation of following committees with appropriate ToR:
2. Steering Committee for Nutrition Implementation (SCNI)
3. Nutrition Implementation Coordination Committee (NICC)
4. GO-NGO-DPs, Nutrition partners' forum/ IYCF Alliance etc.
5. Nutrition Coordination committees at all the divisions, districts and upazilas

(iii) Human Resource Development (HRD)

Developing a trained, qualified workforce (health and family planning service providers) for nutrition will be a major priority for Nutrition OP. A comprehensive competency nutrition training package will be developed for service providers and supervisors. Training modules will cover IYCF, basic nutrition, maternal nutrition, adolescent nutrition, geriatric nutrition, micronutrients, nutrition in emergencies, GMP, food safety, GHP etc.

Activities:

1. Develop comprehensive nutrition training package
2. Capacity development of health and family planning service providers through Comprehensive Competency Nutrition Training (CCNT)
3. Capacity development of supervisors on supportive supervision
4. Capacity development of Districts Nutrition Officers (approved)
5. Prepare training database and updated regularly both at national and sub-national levels

(iv) Institutional Capacity Development

Institutional capacity development of IPHN will be an important and integral part of system strengthening for nutrition. IPHN will be developed and capacitated as an academic and research institution and center of excellence. For implementation of nutrition services, program managers and deputy program managers will be deployed from DGHS and DGFP. Existing development manpower of NNS will continue their job in next nutrition OP and the process of absorption in revenue set up will be continued.

Activities:

1. Establish Nutrition and Food Safety Cell at MOHFW
2. Mainstream nutrition service delivery at all service delivery point of DGHS and DGFP
3. Consider and implement Public Private Partnership (PPP) model in hard-to-reach areas and where CC is not available
4. Develop and implement nutrition related academic courses (long/short)

5. Develop/ strengthen infrastructure and facilities

(v) Monitoring and Enforcement of Nutrition Related Legislations

Monitoring and enforcement of nutrition related legislations will be strengthened to support successful implementation of different nutrition interventions.

Activities:

1. Establish linkage with relevant ministries/ agencies to implement all nutrition related laws/acts, specifically to monitor and enforce BMS Act 2013
2. Orientation program on BMS Act 2013 at national and sub-national level

(vi) Strengthen Nutrition Supply Chain Management

Ensuring adequate, timely and uninterrupted supply of nutrition logistics and commodities is essential to deliver quality nutrition services.

Activities:

1. Establish an online Supply Chain Management Portal (SCMP)/ Logistics Management Information System (LMIS) to ensure timely supply of products from central to service delivery points
2. Establish linkage with DGHS,DGFP, and CMSD supply chain management information system

(vii) Monitoring, Surveillance, Survey, Research and Evaluation

An effective monitoring and evaluation (M&E) system will be established to monitor coverage, progress, program performance and also for evidence based planning/decision making. System will be strengthened to ensure/improve monitoring data quality and reporting.

Activities:

1. Strengthen/develop nutrition reporting system with special emphasis on urban, CHT etc.
2. Capacity development of statisticians and relevant persons on nutrition data management system
3. Strengthen monitoring and supervision system
4. Conduct survey, surveillance, research as relevant
5. Publish monitoring report, newsletter etc.

(viii)Nutrition Information System

Nutrition Information System will be strengthened in linkage with HMIS, DGFPMIS and National Information Platform for Nutrition (NiPN).

Activities:

1. Establish a separate unit as part of Nutrition Information System
2. Capacity development of relevant personnel
3. Regular compilation and analysis of nutrition specific/ sensitive data/information

(ix) Strengthen nutrition services in hard to reach areas and urban slum

Special service delivery modalities will be designed for hard-to-reach areas including Chittagong Hill Tracts (CHT). Equitable and universal coverage for nutrition will be ensured by expanding/ strengthening and harmonizing nutrition services for urban with special focus to slums.

Activities:

1. Develop urban nutrition strategy
2. Design and implement special SBCC program for hard-to-reach areas
3. Conduct situation analysis
4. Provide technical support to develop capacity of the human resources for nutrition
5. Supply relevant logistics and nutrition commodities to NGOs/projects working in urban and hard-to-reach areas
6. Develop coordination with MOLGRD, NGOs and other projects

(x) Strengthening and expansion of IMCI-Nutrition Corner

Nutrition services e.g. counseling of mothers/caregivers, screening for SAM/MAM children, referral of SAM cases to the SAM corner etc. will be strengthened at IMCI-N corner.

Activities:

1. Supply relevant logistics
2. Update and harmonize register and reporting format
3. Develop linkage with National Tuberculosis Program (NTP) to ensure screening of malnourished children for childhood TB

6. Cross-Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

Sl. #	Activity	Name of cross-cutting OPs	Co-ordination mechanism
1.	Effective Integration of priority nutrition Interventions in the field level at all service delivery points of DGHS and DGFP	MNCAH, CBHC, NCDC, HSM, MCRAH	Inter-OP meeting
2.	Strengthening human resource	HRM, ME&HMD	Steering Committee for Nutrition Implementation
3.	Providing nutrition education (SBCC)	LHEP,IEC, CBHC	Coordination meeting
4.	Deworming to prevent and control morbidity	CDC	Coordination committee
5.	Strengthen nutrition supply chain management	DGFP-OP,CMSD	Linkage with Supply Chain Management Portal

6.	Develop linkage with NTP to ensure screening of malnourished children and nutrition services for detected TB cases	TBL&ASP	Linkage with TBL&ASP

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods and Services et.: Annexed in Volume –II

9. Indicators:

Sl.	Indicators	Unit of Measurement	Baseline (Year and Data Source)	Projected Target	
				Mid (By June 2020)	End (By June 2022)
1	2	3	4	5	6
1.	Number of field level workers trained in Comprehensive Competency Nutrition Training (CCNT)	Number of service providers (NNS Training/ Admin Record, 2016)	NA	5000	15000
2.	Number of SAM unit functional (UHC, District hospital & govt. medical college)	Number of SAM unit (Admin record)	202 (August 2016, Monitoring data)	300	488
3.	CCs and UH& FWCs delivering maternal nutrition services during ANCs in Sylhet and Chittagong division	Percentage DHIS2	(2016)	30%	50%
4.	CCs and UH& FWCs delivering infant and child specified nutrition services in Sylhet and Chittagong division	Percentage DHIS2	(2016)	30%	50%
5.	Infants 6-23 months are fed with minimum acceptable diet	Percentage	BDHS, UESD 22.8	35%	45%

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		

7089.45	53717.65	12107.08	65824.73	72914.18	

10.2. Component and activity wise physical and financial target of OP: NNS

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
A. Nutrition specific activities												
A1	**Promote, protect & support Infant Young Child Feeding (IYCF) practices**											
1	Update National IYCF Strategy	8	53.50	5.00	0.00	48.50	20.50	21.00	9.50	1.00	1.00	0.50
2	Baby Friendly Hospital Initiative (BFHI)	1200	6153.13	222.00	933.00	4998.13	153.13	1200.00	1200.00	1200.00	1200.00	1200.00
3	Orientation Program on IYCF including Home fortification	6611	809.50	0.00	709.50	100.00	90.00	170.00	170.00	170.00	169.50	40.00
4	Orientation on BMS Act-2013	2000	1000.00	100.00	750.00	150.00	155.00	205.00	205.00	178.33	178.34	78.33
5	Oketani Lactation Management	101	527.75	13.00	514.75	0.00	52.00	102.00	103.00	103.00	103.00	64.75
	Sub-total	9920	8543.88	340.00	2907.25	5296.63	470.63	1698.00	1687.50	1652.33	1651.84	1383.58
A.2	**Promote Maternal Nutrition**											
1	Develop and updating of handout/job aid, reminder tools, monitoring tools etc.	3000006	1618.00	0.00	1518.00	100.00	110.00	420.00	320.00	320.00	320.00	128.00
2	Procurement of printed food plate	50000	75.00	0.00	75.00	0.00	10.00	15.00	15.00	15.00	15.00	5.00
	Sub-total	3050006	1693.00	0.00	1593.00	100.00	120.00	435.00	335.00	335.00	335.00	133.00
A.3	**Promote of adolescent nutrition**											
1	Workshop on Development of Adolescent Nutrition Guideline	5	15.00	5.00	0.00	10.00	7.50	7.50	0.00	0.00	0.00	0.00
2	Updating of existing training module and academic curriculum etc.	8	13.50	8.50	0.00	5.00	7.00	2.00	2.00	1.50	0.50	0.50

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
3	Training for teachers and student representatives on adolescent nutrition	130	65.00	20.00	0.00	45.00	15.00	15.00	15.00	15.00	5.00	0.00
4	Orientation (1 day) on adolescent Nutrition	300	316.00	36.00	80.00	200.00	35.00	65.00	65.00	55.00	55.00	41.00
5	Procurement of IFA for adolescent	500000000	2000.00	0.00	2000.00	0.00	0.00	1000.00	1000.00	0.00	0.00	0.00
	Sub-total:	500000443	2409.50	69.50	2080.00	260.00	64.50	1089.50	1082.00	71.50	60.50	41.50
A.4	**Control of micronutrient deficiencies**											
1	Vitamin A supplementation:	208833733	15230.00	120.00	14850.00	260.00	2470.00	2570.00	2580.00	2553.34	2553.33	2503.33
2	Iron folic acid supplementation	500000005	1515.00	0.00	1507.00	8.00	3.00	758.00	754.00	0.00	0.00	0.00
3	Procurement of Zinc for under 5 children	250000000	375.00	0.00	301.90	73.10	20.00	120.00	120.00	65.90	24.00	25.10
4	District orientation workshop on food fortification	64	102.50	0.50	2.00	100.00	2.50	30.00	30.00	20.00	20.00	0.00
5	Procurement of Calcium tablet for pregnant women:	80000000	1600.00	0.00	1600.00	0.00	0.00	600.00	600.00	400.00	0.00	0.00
	Sub-total	1038833802	18822.50	120.50	18260.90	441.10	2495.50	4078.00	4084.00	3039.24	2597.33	2528.43
A.5	**Management of moderate and severe acute malnutrition**											
1	SAM/CMAM Guideline/training module development/update	13	17.50	7.50	0.00	10.00	6.00	6.50	2.00	1.00	1.00	1.00
2	Training	66000	2000.00	400.00	1400.00	200.00	200.00	400.00	400.00	400.00	400.00	200.00
3	Procurement	10261000	401.45	0.00	185.95	215.50	40.00	80.00	80.00	80.00	80.00	41.45
	Sub-total	10327013	2418.95	407.50	1585.95	425.50	246.00	486.50	482.00	481.00	481.00	242.45

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
A.6	**Nutrition services for elderly population**											
1	Geriatric nutrition strategy development	200006	112.75	0.00	112.75	0.00	50.00	62.75	0.00	0.00	0.00	0.00
2	Orientation	548	700.00	0.00	700.00	0.00	35.00	150.00	150.00	150.00	150.00	65.00
3	Procurement of Calcium with vitamin D for geriatric people	500000000	1250.00	0.00	1250.00	0.00	0.00	625.00	625.00	0.00	0.00	0.00
	Sub-total	500200554	2062.75	0.00	2062.75	0.00	85.00	837.75	775.00	150.00	150.00	65.00
A.7	**Nutrition services in emergencies**											
1	Revisiting of existing Rapid Nutrition Assessment Guideline	2	4.00	0.00	0.00	4.00	0.00	4.00	0.00	0.00	0.00	0.00
2	Emergency supplies (Need base)	0	541.00	0.00	91.00	450.00	100.00	100.00	100.00	84.00	84.00	73.00
3	Cluster coordination/ emergency nutrition	0	46.00	0.00	0.00	46.00	10.00	10.00	10.00	6.00	6.00	4.00
	Sub-total	2	591.00	0.00	91.00	500.00	110.00	114.00	110.00	90.00	90.00	77.00
A.8	**Growth Monitoring & Promotion (GMP)**											
1	Printing of GMP card	12000000	2400.00	0.00	2400.00	0.00	300.00	500.00	500.00	400.00	400.00	300.00
2	Procurement of anthropometric equipment (weighing scale, height-length board/scale, MUAC tape etc.) for all facility	0	300.00	0.00	300.00	0.00	100.00	100.00	100.00	0.00	0.00	0.00
	Sub-total	12000000	2700.00	0.00	2700.00	0.00	400.00	600.00	600.00	400.00	400.00	300.00
A.9	**Deworming programme for children 24 to 59 months**											

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
1	Procurement of Albendazole Tablet (400 mg)	50000000	1000.00	0.00	1000.00	0.00	0.00	500.00	500.00	0.00	0.00	0.00
2	Workshop for development of Deworming printing materials (Brochure, Folder, poster, report form , tally form, supervision checklist etc..)	3	6.75	3.00	3.75	0.00	3.00	3.75	0.00	0.00	0.00	0.00
3	Printing materials (Brochure, Folder, poster, report form , tally form, supervision checklist etc.)	10	200.00	0.00	200.00	0.00	0.00	200.00	0.00	0.00	0.00	0.00
4	Orientation	650	500.00	100.00	400.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
5	Supervision from national level	500	75.00	75.00	0.00	0.00	10.00	10.00	15.00	20.00	10.00	10.00
	Sub-total	50001163	1781.75	178.00	1603.75	0.00	63.00	813.75	615.00	120.00	110.00	60.00
A.10	**Prevention of overweight, obesity**											
1	Nutrient profile model	9	22.50	0.00	22.50	0.00	12.00	10.50	0.00	0.00	0.00	0.00
2	Dietary guideline	25001	30.25	30.25	0.00	0.00	5.00	20.00	5.25	0.00	0.00	0.00
	Sub-total	25010	52.75	30.25	22.50	0.00	17.00	30.50	5.25	0.00	0.00	0.00
A. 11	**Social Behavior Change Communication (SBCC) on nutrition**											
1	Develop & Update SBCC materials	37	86.50	0.00	86.50	0.00	15.00	20.00	15.00	15.00	15.00	6.50
2	SBCC Coordination, E-toolkit & Website (maintenance & update)	28	125.50	6.70	18.80	100.00	16.00	26.20	27.00	23.80	21.50	11.00
3	SBCC related Campaign	1225	3500.00	0.00	3000.00	500.00	400.00	700.00	700.00	700.00	600.00	400.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
4	Printing of IEC materials, bulletin, training modules & guidelines, poster/festoon, recording & reporting tools etc.	1	1000.00	90.00	760.00	150.00	195.00	245.00	245.00	105.00	105.00	105.00
	Sub-total	1291	4712.00	96.70	3865.30	750.00	626.00	991.20	987.00	843.80	741.50	522.50
	Total (A)	2114449204	45788.08	1242.45	36772.40	7773.23	4697.63	11174.20	10762.75	7182.87	6617.17	5353.46
B. Nutrition sensitive activities:												
B.1	Food Safety Program											
1	Laboratory Analysis of Food:	284	1246.30	115.00	280.00	851.30	360.00	320.00	170.00	155.00	155.00	86.30
2	Risk Based Food Inspection	5989	1387.85	100.00	260.00	1027.85	290.00	320.00	350.00	150.00	150.00	127.85
3	Food-borne illness surveillance (in coordination with MIS)	80	377.50	15.00	40.00	322.50	62.50	60.00	50.00	70.00	70.00	65.00
4	IEC/BCC on Food Safety	240515	915.20	95.00	200.00	620.20	190.00	180.00	230.00	130.00	130.00	55.20
	Sub-total	246869	3926.85	325.00	780.00	2821.85	902.50	880.00	800.00	505.00	505.00	334.35
B2	**Good Hygienic Practices (GHP) including Wash at all level**											
1	Workshop on development of GHP and GMP communication materials	2	4.50	4.50	0.00	0.00	4.50	0.00	0.00	0.00	0.00	0.00
2	Training of targeted street food vendors on GHP	45	9.00	9.00	0.00	0.00	4.00	5.00	0.00	0.00	0.00	0.00
3	Observation of National/International/ World-Handwashing, Food Safety day/week, sanitation week etc. at national and sub-national level	20	50.00	30.00	20.00	0.00	10.00	10.00	10.00	7.00	7.00	6.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
4	Assessment of GHP among street food vendors	1	50.00	0.00	50.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00
	Sub-total	68	113.50	43.50	70.00	0.00	18.50	65.00	10.00	7.00	7.00	6.00
		246937	4040.35	368.50	850.00	2821.85	921.00	945.00	810.00	512.00	512.00	340.35
C. System strengthening:												
C.1	**Revitalization of Bangladesh National Nutrition Council (BNNC)**											
1	Revitalization & operation (Inter-ministerial & multisectoral coordination) of BNNC (a. Revitalize BNNC and institutionalize at all level, b. Revise National Monitoring and Surveillance tools, c. Establish Coordination Committee at district and upazilla level, d. Research Activities, Policy analysis, knowledge management, Nutrition seminar and National Nutrition Week & e. Build Capacity, develop network with Global forums and mobilize resources for BNNC)	0	500.00	30.00	270.00	200.00	110.00	100.00	90.00	66.66	66.67	66.67
	Sub-total	0	500.00	30.00	270.00	200.00	110.00	100.00	90.00	66.66	66.67	66.67

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
C.2	Multisectoral Coordination, Collaboration of Nutrition Activities Across Different Sectors at National and Sub-national Level		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Supporting multisectoral Divisional, District and Upazila Nutrition Coordination Meetings.	17780	300.00	0.00	300.00	0.00	20.00	60.00	60.00	60.00	60.00	40.00
2	NPAN printing and dissemination	0	100.00	0.00	40.00	60.00	40.00	40.00	20.00	0.00	0.00	0.00
3	District orientation workshop on food fortification for Supervision & monitoring among district/upazila level respective personnel	0	100.00	0.00	100.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
	Sub-total	17780	500.00	0.00	440.00	60.00	70.00	120.00	100.00	80.00	80.00	50.00
C3	**Human resource development (HRD) in nutrition**											
1	Comprehensive Competency Nutrition Training (CCNT) Module	136012	423.25	130.00	293.25	0.00	70.00	80.00	70.00	70.00	63.25	70.00
2	Comprehensive Competency Nutrition Training (CCNT)	2756	10377.00	185.00	9792.00	400.00	1600.00	1805.00	1800.00	1800.00	1800.00	1572.00
3	Supportive supervision	336500	3000.00	200.00	2700.00	100.00	200.00	600.00	600.00	600.00	600.00	400.00
4	Development of e-learning modules, software and Dissemination of guidelines nutrition	1	80.00	30.00	0.00	50.00	15.00	25.00	25.00	5.00	5.00	5.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
5	Training of District Nutrition Officers (Approved) on CCNT and others nutrition related activities	2	10.50	5.50	0.00	5.00	1.00	2.00	2.00	2.00	2.00	1.50
6	Pay & allowance including TA (51 person)	0	1500.00	1500.00	0.00	0.00	250.00	250.00	250.00	250.00	250.00	250.00
7	Office Maintenance Cost	0	2500.00	1800.00	700.00	0.00	250.00	500.00	500.00	500.00	500.00	250.00
	Sub-total	475271	17890.75	3850.50	13485.25	555.00	2386.00	3262.00	3247.00	3227.00	3220.25	2548.50
C.4	**Institutional Capacity Development**											
1	Strengthen institutional capacity of IPHN as a centre of Excellence for nutrition	25	2101.00	556.00	1425.00	120.00	300.00	480.00	445.00	373.33	273.34	229.33
	Sub-total	25	2101.00	1556.00	425.00	120.00	300.00	480.00	445.00	373.33	273.34	229.33
C.5	**Strengthen legal protection of nutrition related legislations**											
1	Monitoring and enforcement of BMS Act-2013	0	100.00	0.00	0.00	100.00	20.00	20.00	20.00	13.33	13.34	13.33
	Sub-total	0	100.00	0.00	0.00	100.00	20.00	20.00	20.00	13.33	13.34	13.33
C.6	**Strengthen nutrition supply chain management**											
1	Establishment of supply chain management portal (SCMP) software	2105	288.00	1.00	237.00	50.00	51.00	50.00	50.00	46.66	46.67	43.67
	Sub-total	2105	288.00	1.00	237.00	50.00	51.00	50.00	50.00	46.66	46.67	43.67
C.7	**Monitoring, Surveillance, Survey, Research & Evaluation**											
1	Monitoring	0	400.00	12.00	288.00	100.00	20.00	80.00	80.00	80.00	80.00	60.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
2	Survey, Surveillance & Research (in coordination with PMR & MIS)	0	700.00	0.00	700.00	0.00	50.00	150.00	150.00	150.00	150.00	50.00
3	Quarterly Newsletter publication on Nutrition (4/ year x 5)	0	16.00	0.00	0.00	16.00	3.20	3.20	3.20	2.13	2.14	2.13
	Sub-total	0	1116.00	12.00	988.00	116.00	73.20	233.20	233.20	232.13	232.14	112.13
C.8	**Nutrition Information System**											
1	Strengthening of NIS unit	0	312.00	12.00	0.00	300.00	32.00	62.00	62.00	62.00	62.00	32.00
	Sub-total	0	312.00	12.00	0.00	300.00	32.00	62.00	62.00	62.00	62.00	32.00
C.9	**Strengthen nutrition services in hard to reach areas and urban slum**											
1	Situation analysis	2	250.00	0.00	250.00	0.00	50.00	100.00	100.00	0.00	0.00	0.00
2	Development of urban nutrition strategy	1005	13.00	2.00	0.00	11.00	3.00	3.00	2.00	1.50	1.50	2.00
	Sub-total	1007	263.00	2.00	250.00	11.00	53.00	103.00	102.00	1.50	1.50	2.00
C.10	**Strengthening and expansion of IMCI-Nutrition Corner**											
1	Printing of register for Nutrition Corner including distribution etc.	3000	15.00	15.00	0.00	0.00	2.00	3.00	3.00	3.00	2.00	2.00
	Sub-total	3000	15.00	15.00	0.00	0.00	2.00	3.00	3.00	3.00	2.00	2.00
	Total (C)	499188	23085.75	5478.50	16095.25	1512.00	3097.20	4433.20	4352.20	4105.61	3997.91	3099.63
	GRAND TOTAL	2115195329	72914.18	7089.45	53717.65	12107.08	8715.83	16552.40	15924.95	11800.48	11127.08	8793.44

11. Budget support from other Operational Plan: Not applicable

4.19 Communicable Disease Control (CDC)

1. Name of the Operational Plan: Communicable Disease Control (CDC)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction:

Bangladesh has achieved significant success in preventing, controlling and elimination of a number of communicable diseases through immunization, accessibility of safe water and sanitation, early diagnosis and treatment and vector control. Elimination of Filariasis and over 90% elimination of Kala-azar have been achieved; Malaria, STH and rabies are also controlled expectedly. Though, the country and the world shows a paradigm shift to non-communicable disease but still control of communicable diseases continues to be one of the highest public health priorities both in the SDG and the SIP for the 4th HPN sector program. The target 3.3 of SDG states that by 2030, the world aims to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. The goal of the CDC OP in the 4th sector program would be to sustain the efforts to achieve elimination of Kala-azar and rabies within 2021 and control significantly other communicable so that elimination of them can be achieved subsequently.

4. Objective:

1. To bring malaria death to 5 within 2019 and to zero within 2022 and achieve elimination in phases within 2025
2. To prevent and control Aedes transmitted viral diseases including dengue, chikungunya and zika
3. To achieve filaria free status by 2022
4. To reduce the prevalence of STH among <15 children to 5%within 2022
5. To eliminate Kala-azar by 2017 and achieve Kala-azar frees Bangladesh by 2022
6. To eliminate rabies within 2022
7. To strengthen capacity for detection, management, prevention and control of various communicable diseases. To strengthen disease surveillance

5. Components:

Component-1: Program for Malaria, Dengue, Chikungunya, Zika

a) **Malaria Elimination Program**

The National Malaria Control Program (NMCP) has achieved recommendable success in controlling malaria through reduction of cases and death. Though, presently the disease is hyper endemic in 3 hilly districts and moderate endemic in one district (Cox's Bazar), but it is in pre-elimination state in remaining 9 districts. The country is in a situation to achieve 75% reduction of morbidity and mortality by 2025 and zero transmission within 2030 through strengthening early diagnosis, prompt treatment and integrated vector management and with GO-NGO collaboration. The following activities will be implemented during the 4th HPNSP:

1. Updating national strategy and budgeted national action plan;
2. Sustenance of the early diagnosis and prompt treatment with universal coverage;
3. Supply of drugs ,insecticides, spray machine and other logistics;

4. Implement two rounds of integrated vector management in all the endemic focuses of the 13 malaria districts of the country;
5. Strengthening of cross-border collaboration with neighboring countries; and
6. Promotion of Operational research for insecticide resistance monitoring.
7. Community participation through multipurpose health volunteers for the purpose of detection and management.

b) Dengue, Chikungunya and Zika Control Program

The incidence of dengue has grown dramatically around the world in recent decades infecting around 50–100 million annually d with risking over 2.5 billion people. The re-emergence of dengue in Bangladesh since 2000 has emerged as a public health problem especially for the growing urban population. Though the country has been able to contain the mortality but not been able to contain the transmission of dengue. Most of activities for prevention and control of dengue are limited to the capital but the transmission tends to occur throughout the country. Recent outbreaks of chikungunya in the country and emergence and spread of zika in different parts of the world have warranted importance to institute programs for control and prevention of these two diseases. The following activities will be implemented during the 4th HPNSP:

1. Scaling up the integrated vector management;
2. Drafting and or updating national strategy and costed action plan;
3. Annual survey for Aedes vector and projection on disease outbreaks;
4. Promotion of clinical management, prevention and control measures against dengue, chikungunia and zika virus infection; and
5. Active engagement of the community.

Component-2: Programs for Lymphatic Filariasis (LF), Soil Transmitted Helminthiasis (STH) and Little Doctors (LD)

a) Lymphatic Filariasis Elimination Program

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. Bangladesh has been able to achieve preliminary elimination of the disease during the 3rd sector program in all the 19 endemic districts. According to WHO protocol at least five years surveillance with no sign of transmission is required to declare elimination. The program has started to concentrate its attention on morbidity control for about 3.5 lakh persons who have already developed deformity and disfiguration. Eliminating of filariasis according to the WHO protocol, the following activities will be implemented during the 4th HPNSP:

1. Ensure universal accessibility of morbidity management;
2. Strengthening of cross-border collaboration with neighboring countries;
3. Sustain and scaling up morbidity management in all the 19 endemic districts;
4. Establish management of complications in the endemic upazila and districts; and
5. Strengthen surveillance for disease and vector of lymphatic filariasis.
6. Community participation through multipurpose health volunteers for the purpose of detection and management.

b) Soil Transmitted Helminthiasis (STH) Control Program

Soil Transmitted Helminthes is one of the major health problems, particularly affecting pre-school and school aged children. All the targeted children 2-15 years 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. Bangladesh is one of the few countries of the world deworming a huge number of children of about 50 million and attaining WHO target of 75% coverage up to 12 years age since 2008 reducing the prevalence of STH from around 80% to around 12%. Along with regular deworming, safe water, sanitation and hand hygiene are important components for achieving elimination of STH. STH Control program under CDC Operation Plan has been deworming 6-12 years children through school based program; the program has to cover the 13-15 years aged children to have better impact. The following activities will be implemented during the 4th HPNSP:

1. Sustenance of high coverage of all 6-12 years children
2. Scaling of deworming program among 13-15 years aged children

c) Little Doctors Program for Improvement of Health of School Children

Little Doctors Program, introduced in 2012 play an important role in child to child education on hygiene, healthy life style, and prevention of diseases and promotion of health. There are more than hundred thousand educational institutes of primary level having more than 25 million students in Bangladesh. Selected relatively senior students (Class III-V level) identified as "Little Doctors" are engaged to provide child to child education on important health related issues on limited scale without hampering their study. The issues include personal hygiene, control and prevention of intestinal worm (Soil Transmitted helminthes- STH), Rabies, Malaria, Dengue and improvement of nutrition including vitamin-A supplementation. The 'Little Doctors' have been playing key role in health check- up of the students, administration of anti-helminthic drug and observance of health related days pertinent to children. Under 4th HPNSP this program will be expanded and strengthened through implementation of the following activities:

1. Scaling up of Little Doctors Program in Junior Schools
2. Active engagement of the Primary School Teachers in the interventions
3. Updating national strategy and budgeted national action plan
4. Coordination with National Nutrition Services on deworming and Vit. A distribution to 2-5 years children through Little Doctors

d) Kala-azar (KA) Elimination Program

Bangladesh is on the verge of achieving elimination of Kala-azar (KA) during the 3rd HPNSDP, reducing the number of cases and endemic upazila by over 90%. The country is said to have a burden of as high as 25,000 annual cases and over hundred upazila being endemic reducing to less than one thousand cases in 2015 and less than 5 upazilas being above the elimination target. Through a MOU with 4 other countries of the South East Asia, Bangladesh has set the target for public health elimination by 2017 bringing down the cases to less than 1 per 10,000 population at the upazila level. Early diagnosis and prompt treatment with vector control are the main stay of elimination of the disease. A number of conventional and innovative interventions including 'Active Case Search' through 'Case Based Camp Approach', 'Blanket House to House Search' and Zero KA transmission applied during the 3rd HPNSD also contributed in the achievement. The following activities will be implemented during the 4th HPNSP:

1. Sustain and expansion of the early diagnosis and prompt treatment;
2. Cross-border issues will be addressed in collaboration with neighboring countries;

3. Six monthly active search in next 5 years for PKDLwill be continued and strengthen;
4. Advocacy, communication and social mobilization; and
5. Community participation through multipurpose health volunteers for the purpose of detection and management.

Component-3: Program for Zoonotic Diseases: Rabies, Nipah, Japanese Encephalitis, Leptospirosis, Brucellosis

a) Rabies Elimination Program

Domestic dog (87%) was found to be the single most important animal reservoir followed by cat (11%) and jackal (2%) in a recent study. There is an estimated 1.6 million dog population with around 3-4 hundred thousand human exposures and around 50 thousand animal exposures annually. Bangladesh has started the program from 2010 aiming elimination of rabies from the country by 2020. The main strategies are multisectoral collaboration, advocacy, communication and social mobilization, post-exposure prophylaxis and mass dog vaccination (MDV). A total of 67 of centers have been established with at least one in all the 64 districts of the country providing PEP with free ID-RV and RIG. Piloting at Cox's Bazar municipality in 2011, MDV has been scaled up in all the district municipalities and 8 whole districts. National rabies survey was conducted in 2010 and 2012 with decrease in rabies cases over time. The country is now in unique position of achieving elimination of rabies if three rounds MDV can be completed within 2019 and need quality vaccine and financial support. The following activities will be undertaken during the 4th HPNSP:

1. Updating the National Strategy and budgeted National Action Plan for Rabies elimination;
2. Three round campaign of mass dog vaccination will be implemented in all the districts of the country;
3. Scaling up post exposure prophylaxis to ensure universal access to all victims of animal exposure;
4. Establishment of rabies diagnosis centers for human in Infectious Disease Hospital and National Institute of Neurosciences and for animal in the Livestock department with procurement of diagnostics and equipments; and
5. Capacity building for proper diagnosis and management of animal bite and rabies cases.

b) Nipah, Japanese Encephalitis, Leptospirosis, Brucellosis Control and Prevention Program

Among the emerging infections, Nipah is unique zoonotic disease for Bangladesh, as the only country having endemicity of the disease. From 2001 to 2015 there have been 215 suspects with 164 deaths due to nipah. There are little information and intervention for zoonotic diseases like Japanese encephalitis, leptospirosis and brucellosis. To address this issue following activities will be implemented:

1. Collaboration with Local Govt. Division, Department of Livestock Services (DLS), Department of Forest and Environment and Non-Government Organizations;
2. Cross-border issues in will be addressed in collaboration with neighboring countries;
3. Updating National Strategy and budgeted National Action Plan for Prevention and control of Nipah, Japanese Encephalitis, Leptospirosis, Brucellosis;
4. Advocacy Communication and Social Mobilization (ACSM) on prevention and control of Nipah, Japanese Encephalitis, Leptospirosis, Brucellosis; and

5. Community participation through multipurpose health volunteers for the purpose of detection and management.

Component-4: Program for Antimicrobial Resistance Containment, Viral Hepatitis and Diarrhoea

a) Antimicrobial Resistance Containment and Prevention

Antimicrobial resistance (AMR) has become a great public health concern and is a mounting threat to the control of infectious diseases globally including in Bangladesh. Linkage of development of AMR with inappropriate use of AMs was also acknowledged in the World Health Assembly Resolution WHA51.17 (1998), Regional Taskforce on Antimicrobial Resistance (2000), WHO Global Strategy for containment of AMR (2001). Resistance has emerged even to newer, more potent anti microbial agents (AMs). Indiscriminate and irrational use, unregulated dispensing and manufacture of AMs, easy availability, truncated antimicrobial therapy, lack of knowledge about sensitivity pattern, absence of standard treatment guide lines, and drugs of questionable quality in some instances are the major driving forces for development of AMR in human as well as in animal & fisheries sectors that are also spreading in the environment. A National strategy has been approved and preparation of National Action Plan based on the National Strategy is ongoing. The following activities will be taken into consideration during the 4th HPNSP:

1. Establish of multi-sectoral approach for planning, coordination and implementation of antimicrobial resistance containment (ARC) activities;
2. Updating National Strategy and budgeted National Action Plan for ARC;
3. Establish of national reference laboratory for ARC;
4. Establish and strengthening of microbiology laboratory capacity at tertiary/district/upzila level hospitals;
5. To establish surveillance system;
6. Establishment of reporting, data analysis, system evaluation, networking and data sharing system of antimicrobial resistance;
7. Development of institutional antimicrobial policy/ guideline;
8. Promotion and ensuring rational use of antimicrobial agents in human health, livestock and fisheries sectors;
9. Promotion of optimal prescribing and dispensing of AMs; and
10. Promotion of infection prevention and control measures and establish proper waste management Promotion of adherence to GPP and proper use of AMs.

b) Viral Hepatitis, Diarrhoea and Typhoid Prevention and Control:

Viral hepatitis is the seventh leading cause of death globally, in Bangladesh, more than 10 million are living with viral hepatitis and 20,000 die per year. The World Health Organization expects member states' support to ensure 90% diagnosis of viral hepatitis B and C by 2030. Bangladesh has been pioneer in development and use of ORS in management of diarrhoea and also been champion in decreasing the deaths due to diarrhoea, still diarrhoea has been an important cause of morbidity and mortality. Typhoid fever also remains an important public health problem in developing countries; with approximately 22 million new cases and 200,000 deaths annually. Bangladesh is in the region of typhoid high endemic area. Multiple factors including improper hygiene practice, exposure to unsafe water quality and sanitation, and improper food handling have a huge impact on transmission of the enteric pathogens of S. typhi. In addition, emergence of single or multi-drug resistance strain of

S. typhi is also potentiating clinical severity and outcome of the disease. Early and reliable diagnosing; effective treatment and increasing community awareness & participation regarding targeted preventive measures including improved water quality and sanitation, ensuring food safety as well as vaccination of high-risk group are potential prevention and control strategy of the disease. The following interventions/activities will be undertaken for prevention and control of above diseases.

1. Drafting and approval of national strategy and costed action plan for Viral Hepatitis, Diarrhoea and Typhoid;
2. Establishing a multi-sectoral approach for planning and coordination of activities related to prevention and control;
3. Promoting and strengthening viral hepatitis prevention and control measures; and
4. Introduction of vaccine to high risk group for prevention and control of Hepatitis B and Diarrhoe Establishment of surveillance system for Hepatitis virus infected cases.

Component-5: Programs for IHR, Migration Health and Emerging Remerging Diseases

a) International Health Regulation (IHR) Program

The world Health Organization has revised International Health Regulation (2005) for preventing spread of disease across the world through development of national capacity for detection and response to disease outbreak and health events. Bangladesh is a signatory of IHR, 2005 and adopted it in 2007. The country has been implementing different activities under IHR, 2005 through multisectoral and One Health approach.

Development a strong national public health system for maintaining active surveillance of diseases and public health events, ensure rapidly investigate reports, assess public health risk, share information, and implement public health control measures. The following activities proposed to be implemented in the 4th HPNSP:

1. To formulate and revise/updates legislation for implementation of IHR;
2. To develop the capacity of surveillance units at different levels;
3. To develop core capacity at designated points of entry in compliance with IHR (2005); and
4. To develop capacity for prevention, early detection, proper management and effective control of impending threats, PHEIC etc. in compliance with IHR 2005.

b) Migration Health:

Two typical flows of international migration occur in Bangladesh. One flow relates to migration to high income countries of usually long term or permanent emigrants. The other is labor migration of short –term contractual workers, usually for low-income jobs in Middle Eastern and other South East Asian countries. Bangladesh classifies the latter category of temporary migrant populations into four categories. These are professional, skilled, semi –skilled and unskilled. A substantial majority of labor migrants belong to semi skilled or unskilled workforce. The contracts of such laborers often do not provide health insurance and other social protection measures. Bangladeshi semi-skilled and unskilled migrant's labors working abroad are also likely to experience health problems due to their vulnerability in destination countries. So the migration health issue is increasingly being recognized as a priority. To address the migration health following activities will be implemented:

1. To develop a robust monitoring and reporting system to ensure evidence based decision making and policy formation;

2. To establish a legal mechanism to address migration health malpractice and violation of regulations;
3. To develop guideline and training for capacity building of health care workers, as well as non health sector authorities to address the specific healthcare needs of migrants under the existing health system in Bangladesh; and
4. To enhance public Private Partnership (PPP) through sharing of relevant information, capacity building of staff to provide migrant sensitive healthcare and social services.

c) Emerging & Re-Emerging Diseases(ERD)

Despite of remarkable advances in medical science, continuous evolvement of new and previously unrecognized infectious disease as "emerging" threat as well as "re-emergence" of old and previously well-controlled diseases are alarming public health concern all around the globe. A variety of factors including changes in human demographics, behaviors, increasing human-animal inter-phase, are contributing to emergence of new human pathogens especially those are zoonotic in origin by changing their transmission dynamics. Emerging and re-emerging infectious diseases have a devastating impact nationally and globally. However, significant technological advancement in the field of medicine especially improvement of diagnostic and detection methods within the last few decades has strengthened the capacity to identify previously unknown human pathogens and those diseases also need to address with utmost priority to prevent a wide range of mortality and morbidity, and to control, eliminate and eradicate the diseases. Therefore, development and implementation of strategic objectives and action plan can alleviate suffering due to these diseases. Activities under this OP will be as follows:

1. Establishing a multi sectoral approach for planning and coordination of activities related to prevention and control of emerging diseases;
2. Establishing advocacy, communication and social mobilization (ACSM) activities;
3. Strengthening the surveillance system for prediction, early detection, preparedness and early response for upcoming emerging diseases and to develop National Guidelines, SOPs and procedures regarding ERDs; and
4. To enhance infection prevention and Control (IPC) Measures.

d) Influenza Control and Prevention Program

Programs for influenza include intervention for preventing and managing seasonal influenza and also prevention and control of novel influenza virus including response to impending pandemic. Also, the country needs to vaccinate the pilgrims, expatriate workers and member of peace contingents against influenza. Under influenza control and prevention program following activities will be implemented:

1. Updating national guideline for diagnosis and management of influenza due to seasonal, avian and novel influenza viruses;
2. Campaign and management of seasonal influenza vaccine for population at risk; and
3. Establishment of functional influenza diagnostic laboratory in Medical University, public health institutes like NIPSOM and IPH, infectious diseases hospitals like BITID, IDH and medical colleges.

Component-6: Disease Burden Due to Climate Change

a) **Emergency preparedness and Response (EPR), Post Disaster Health Management**

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 a part of the readiness program for flood, cyclone, tornado and earthquake. 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. The activities of this program will be:

1. Strengthening capacity of hospital services (UHC, DH, MCH) on emergency preparedness and response;
2. Establishing System for early warning sign for early preparation for health service delivery in disaster prone area (coordination with non-health sector);
3. Training of community volunteers on disaster preparedness and response and establish network of volunteers;
4. Development and publication of posters, pamphlets, booklets and books to spread the message of Emergency Preparedness and Response;
5. Increase capacity in health services on Post Disaster Health Management skills and techniques;
6. Provide Support to different associations, professional bodies and civil society organizations for comprehensive disaster health management;
7. Countrywide Awareness building campaign through IEC using different methods & media; and
8. Awareness workshop & Coordination/Sensitization meetings for health service providers, community leaders, Teachers, Social workers & other stake holders on Emergency Preparedness and Response (EPR) throughout the country.

b) Disease Surveillance

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 will act as lead Institution in integrated disease surveillance along with other relevant institutes like NIPSOM, ICMH etc. Field epidemiology training program (FETP) program will be supported for development of future public health leader. To address the above issues following activities will be implemented:

1. To support the strengthening of surveillance data management and utilization of information
2. To strengthen the capacity and involvement of laboratories at upazila, district and national levels
3. To establish epidemiological unit at district level
4. To support Field Epidemiology Training Program (FETP)

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women and Children and Gender etc:

The communicable diseases like Malaria, Kalazar, Dirrahoea, Typhoid etc; are the leading causes of mortality and morbidity. Women, children and poor are most vulnerable of these diseases. Under this OP, various activities will be implemented for prevention and control of these diseases through increasing accessibility, efficiency and quality of services. It will help to improve overall health status of people specially the women, children and poor, which will in turn contribute to increase productivity, reduce poverty and gender disparity and would create employment opportunities. To implement the propose activities of this OP, inter-OPs, inter- agencies and multi-sectoral collaboration/ coordination will be strengthen. Besides emphasize will be given for, engagement of local government institutions and community to support implementation and monitoring of the program.

7. Proposed Manpower: Annexed in Volume- II

8. List of Works, Goods and Services etc.: Annexed in Volume- II

9. Indicator:

Sl	Indicators	Unit	Baseline (Year, Source)	Projected Target	
				Middle (By June 2018)	End (By June 2022)
1	**2**	3	4	5	6
1.	Malaria incidence per 1000 population in endemic area	Number (Rate - per 1,000 people)	1.6 per 1000 (2016) MIS	1.5	1.5
2.	Hepatisis B incidence	Per 100000 people	546 (BBS, 2014)	450	400
3.	Prevalence of STH among children < 16 years	Percentage (survey by CDC unit	15 (2014,)	8	4
4.	Human rabies death	Annual Number (CDC report)	1400 (Survey, 2012)	280	70

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
41292.00	44283.00	13260.00	57543.00	98835.00	

10.2. Component and activity wise physical and financial target of OP: CDC

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
i) Component: Malaria													
1	Office Rent	66		197.00	0.00	0.00	197.00	30.00	33.00	36.00	40.00	40.00	18.00
2	Telephone/Telegram/Telepr inter	66		9.00	9.00	0.00	0.00	5.00	0.80	0.80	0.80	0.80	0.80
3	Registration Fee	3		33.00	33.00	0.00	0.00	6.00	6.00	6.00	6.00	6.00	3.00
4	Petrol & Oil	66		130.00	110.00	0.00	20.00	15.00	30.00	30.00	25.00	15.00	15.00
5	Printing & publication	17		790.00	325.00	437.50	27.50	142.50	130.00	130.00	130.00	130.00	127.50
6	**Stationaries, Seals & Stamps**	6		88.50	77.50	0.00	11.00	17.00	17.00	17.00	12.00	17.00	8.50
7	Research & Survey- Drug Resistance Monitoring-1, Vector Bionomics-6, Bio-assay on LLIN-4, Molecular Molecular Epidemiological study with sequencing-2, Vector incremination study-2, G6PD deficiency survey-1 (In coordination with MIS)	21		1300.00	350.00	600.00	350.00	50.00	300.00	300.00	300.00	300.00	50.00
8	Pay & Allowance	66		1490.00	0.00	40.00	1450.00	245.00	252.00	252.00	247.00	247.00	247.00
9	Medicine, MSR,Insecticide	18		11972.50	200.00	5901.50	5871.00	1032.00	2032.00	2032.00	2032.00	2032.00	2812.50
10	Training & Workshop	143		3000.00	1000.00	1000.00	1000.00	300.00	600.00	600.00	600.00	600.00	300.00
11	**Advertising & Publicity, Audio Video & Flim**	12		600.00	220.00	380.00	0.00	125.00	105.00	120.00	120.00	70.00	60.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
12	Other's Expenses (Integrated Vector Management)	11		1500.00	500.00	950.00	50.00	100.00	300.00	300.00	300.00	300.00	200.00
13	Repair & Maintenance	70		93.50	93.50	0.00	0.00	17.00	17.00	17.00	17.00	17.00	8.50
14	Capacity building for Program Personnel	6		100.00	60.00	0.00	40.00	15.00	17.00	17.00	17.00	17.00	17.00
15	Acquisition of Assets (Motor Vehicle - 1 jeep, 1 double cabin pickup, Computer & Others)	3		200.00	75.00	75.00	50.00	20.00	40.00	40.00	40.00	40.00	20.00
	Sub Total			21503.50	3053.00	9384.00	9066.50	2119.50	3879.80	3897.80	3886.80	3831.80	3887.80
ii) Component: Filaria													
1	**Focal MDA for Filariasis for antigen positive cases**	24		415.00	295.00	120.00	0.00	70.00	80.00	70.00	90.00	70.00	35.00
2	Community Based Morbidity Management & Disability Prevention (MMDP) services	19		1038.00	540.00	498.00	0.00	115.00	150.00	250.00	158.00	165.00	200.00
3	MDA for De-Worming 2 rounds/year	12		3625.00	1950.00	1675.00	0.00	400.00	650.00	650.00	750.00	800.00	375.00
4	STH Prevalance Estimation	6		471.00	245.00	226.00	0.00	35.00	61.00	80.00	80.00	175.00	40.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Training, advocacy, health chevck-up, supervision for Little Doctor initiatives - 2 rounds/year	12		1300.00	1000.00	300.00	0.00	100.00	250.00	250.00	250.00	250.00	200.00
6	**Serveillance activities for Lymphatic Filariasis (in coordination with MIS)**	19		350.00	100.00	150.00	100.00	30.00	85.00	85.00	50.00	50.00	50.00
7	Microfilaria (Mf) Survey for LF dectection in non-endemic areas	30		55.00	27.50	27.50	0.00	10.00	10.00	10.00	10.00	10.00	5.00
8	Pay of establishments	72		120.00	120.00	0.00	0.00	10.00	22.00	22.00	22.00	22.00	22.00
9	Allownaces	0		30.00	30.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00	5.00
10	Operational Research (in coordination through PMR) & Survey for LF & STH (in coordination with MIS)	12		300.00	100.00	100.00	100.00	30.00	60.00	60.00	60.00	60.00	30.00
11	Fuel for vehicles	72		150.00	150.00	0.00	0.00	20.00	30.00	30.00	30.00	30.00	10.00
12	Medicine, MSR,Insecticides	12		3603.00	145.00	437.00	3021.00	487.00	728.00	723.00	706.00	706.00	253.00
13	Development/Printing & publication of educational materials (IEC) for LF, STH & Little doctor initiatives	12		2074.00	687.00	1387.00	0.00	150.00	430.00	422.00	420.00	430.00	222.00
13	Rent for office	66		463.00	173.00	290.00	0.00	30.00	30.00	320.00	32.00	33.00	18.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
14	Consultancy	72		359.00	92.50	192.00	74.50	52.00	66.00	66.00	71.00	71.00	33.00
15	Acquisition of Assets (equipment)	20		800.00	400.00	400.00	0.00	80.00	160.00	160.00	160.00	160.00	80.00
16	Others (Maitenence/repairs of vehicle, asset etc)	72		370.00	160.00	210.00	0.00	20.00	75.00	75.00	100.00	80.00	20.00
	Sub-Total			15523.00	6215.00	6012.50	3295.50	1644.00	2892.00	3278.00	2994.00	3117.00	1598.00
iii) Component: Kala-azar													
1	HR recruitment and maintenance	16 staff		950.00	0.00	950.00	0.00	170.00	170.00	170.00	170.00	170.00	100.00
2	Workshop/Training for Doctor, Nurses, HI, AHI and CHCP	400 batch (12000 paticipants)		500.00	400.00	100.00	0.00	100.00	100.00	100.00	100.00	50.00	50.00
3	Active case detection(training and camp)	600 training and camp		300.00	300.00	0.00	0.00	50.00	50.00	50.00	50.00	50.00	50.00
4	No Kala-azar Transmission Activity (NKTA)	250		125.00	75.00	50.00	0.00	25.00	20.00	20.00	20.00	20.00	20.00
5	Procurement of diagnostics	63000 pcs rk39 strips		220.00	160.00	60.00	0.00	40.00	40.00	40.00	40.00	40.00	20.00
6	Procurement of anti-leishmanial drugs	AmBisome=25,000 vial, Miltefosine= 4,65,000 pcs,		350.00	200.00	150.00	0.00	50.00	50.00	120.00	80.00	50.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
		Paramomycin= 20,000 pcs											
7	Procurement of insecticides	425 ton		5000.00	0.00	5000.00	0.00	0.00	2000.00	0.00	3000.00	0.00	0.00
8	Workshop/Training & Activities on IRS	840 batch (39,000 Participants and indoor spraying on 100 upazilas)		1900.00	950.00	950.00	0.00	200.00	350.00	350.00	350.00	350.00	300.00
9	Disease surveillance and research (in coordination with MIS & PMR)	6 events		100.00	50.00	50.00	0.00	15.00	20.00	20.00	20.00	15.00	10.00
10	Vector surveillance and research (in coordination with MIS & PMR)	40 events		130.00	60.00	70.00	0.00	25.00	25.00	20.00	20.00	20.00	20.00
11	Monitoring & Evaluation	9500 visit by different level staff		200.00	100.00	100.00	0.00	40.00	40.00	40.00	40.00	20.00	20.00
12	Pharmacovigilence of anti-leishmanial drugs	AmBisome=10 ,000 vial, Miltefosine= 1,50,000 pcs, Paramomycin= 8,000 pcs		100.00	50.00	50.00	0.00	20.00	20.00	20.00	20.00	20.00	0.00
13	Monitoring of insecticide resistance	30 times and 30 visits		100.00	50.00	50.00	0.00	20.00	20.00	20.00	20.00	10.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
14	Cross border issues	5 internationa l workshops		100.00	0.00	0.00	100.00	20.00	20.00	20.00	20.00	20.00	0.00
15	Sustaining functional SKKRC hospital in Mymensingh	6 staff and necessary drugs		100.00	50.00	50.00	0.00	20.00	20.00	20.00	20.00	20.00	0.00
16	ACSM	Folksong=600 events, Television commercial=1 2 events, Street drama=600 events, Docudrama=1 2 events		200.00	100.00	100.00	0.00	40.00	40.00	40.00	40.00	40.00	0.00
17	Acquisition of asset and others(office rent & furniture)	Different types of asset for office		100.00	75.00	25.00	0.00	75.00	25.00	0.00	0.00	0.00	0.00
	Sub-total			10475.0 0	2620.00	7755.00	100.00	910.00	3010.00	1050.00	4010.00	895.00	600.00
iv) Component: IHR & Migration Health													

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1	Case Detection,development of minimum core capacities under IHR at PoEs, instruments & maintenance, equipment & personnel for transfer of ill travellers, vector control, safe environment at PoEs, examination room, isolation room, safe water, food, sanitation and waste disposal facilities	202		1030.00	580.00	450.00	0.00	200.00	190.00	140.00	160.00	200.00	140.00
2	Improve access to health information for migrant populations through effective and tailored communication strategiers and capacity development of health workers	15		50.50	33.00	17.50	0.00	11.00	11.00	11.00	6.00	6.00	5.50
3	Pay & Allowance	72		104.50	104.50	0.00	0.00	15.00	17.00	19.00	21.00	23.00	9.50
4	Influenza Antivirsal drugs	300000		500.00	280.00	220.00	0.00	100.00	100.00	100.00	100.00	50.00	50.00
5	Influenza Vaccines	66000		550.00	385.00	165.00	0.00	100.00	100.00	100.00	100.00	100.00	50.00
6	MSR	LS		165.00	110.00	55.00	0.00	30.00	30.00	30.00	30.00	30.00	15.00
7	Petrol & Fuel (litre)	150000		60.00	60.00	0.00	0.00	10.00	15.00	15.00	10.00	5.00	5.00
8	Printing & publication	LS		475.00	235.00	240.00	0.00	90.00	80.00	100.00	65.00	100.00	40.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
9	Capacity Building & IHR related hazard workforce development, seminar, simulation exercise, table top discussions ,training of personeel for inspection of conveyances, sensitize stake holders, relevant authorities to the roles & responsibilities, obligations about IHR, etc	218		590.00	325.00	265.00	0.00	200.00	130.00	65.00	65.00	65.00	65.00
10	Sensitization of Doctors and paramedics,updates of seasonal and pandemic influenza and preparedness, workshop, seminarand advocacy meeting on updates and preparedness of Influenza.	103		315.00	175.00	140.00	0.00	100.00	70.00	55.00	50.00	20.00	20.00
11	Research & Survay, Surveillance, needs assessment to identyfy gaps, dev risk communication plan, SOPs. Guidelines (In coordination with MIS & PMR)	0		200.00	120.00	80.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
12	Consultancy	2		110.00	60.00	50.00	0.00	10.00	20.00	20.00	20.00	20.00	20.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
13	Acquisition of asset with 1 double cabin pickup, 2 microbus	LS		200.00	200.00	0.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
14	Repair, Maintenance and Construction Activities, examination room, thermal scanner, infrared hand held thermometer and digital web cum maintenance for surveillance of suspected cases at PoEs, at airports, sea ports and ground crossings	LS		338.00	190.00	145.00	3.00	113.00	60.00	30.00	60.00	60.00	15.00
15	Containment emerging health problems, stockpiles of medicine and reagents for critical stock level to respond priority biological, chemical and radiological events, laboratory, biosafety and biosecurity equipments, laboratory equipments, satelite-based global cholera warning center for one health activities at IEDCR	LS		800.00	400.00	400.00	0.00	65.00	160.00	160.00	160.00	155.00	100.00
16	One Health Secretariate			265.00	150.00	115.00	0.00	60.00	50.00	50.00	40.00	35.00	30.00
	Sub-Total	0		5753.00	3407.50	2342.50	3.00	1144.00	1113.00	975.00	967.00	949.00	605.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
v) Component: Zonotic													
1	Hands on training on Animal Bite Management,	65		310.00	144.00	166.00	0.00	50.00	120.00	20.00	40.00	20.00	60.00
2	Workshop (updating national strategy, MDV action Plan, Animal bite management guideline); training on prevention, control & management of nipah and other zoonotic diseases	25		84.00	37.00	47.00	0.00	15.00	15.00	15.00	15.00	9.00	15.00
3	Mass Dog Vaccination (orientation, microplanning, hands on training on animal vacination and dog catching, vaccination campaign (3 rounds in all districts)	195		10730.00	5336.00	5394.00	0.00	580.00	3480.00	3480.00	2900.00	290.00	0.00
4	Establishment and functioning of rabies Diagnosis laboratory (including procurement of lab. Equipments, reagent, SOP development, training, sample collection, transportation etc.)	1		100.00	45.00	55.00	0.00	50.00	10.00	10.00	10.00	10.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Survillance (Animal bite, rabies, other zoonotic diseases) (in coordination with MIS)	10		50.00	22.50	27.50	0.00	5.00	10.00	10.00	10.00	10.00	5.00
6	National Rabies Survay and Research (In coordination with MIS & PMR)	14		120.00	108.00	12.00	0.00	0.00	105.00	4.00	4.00	5.00	2.00
7	Petrol and Oil	185000		100.00	100.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
8	Medicine	0		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
i	Inj. Human Anti Rabies Vaccine	2200000		9900.00	4950.00	4950.00	0.00	900.00	1800.00	1800.00	1800.00	1800.00	1800.00
ii	Inj. Animal Anti Rabies Vaccine	430000		2640.00	780.00	1860.00	0.00	120.00	840.00	840.00	840.00	0.00	0.00
ii	Inj. Rabies Immunoglobulin	80000		800.00	0.00	800.00	0.00	50.00	150.00	150.00	150.00	150.00	150.00
9	MSR (Insulin D/S; MSR for MDV)	LS		370.00	170.00	200.00	0.00	30.00	100.00	100.00	100.00	20.00	20.00
10	Printing, publication & others for awareness building	LS		87.50	55.00	32.50	0.00	5.00	25.00	15.00	25.00	10.00	7.50
11	Pay and Allowance (consultancy & Manpower	8		500.00	137.00	363.00	0.00	45.00	91.00	91.00	91.00	91.00	91.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
12	Acquisition of Asset (Computer & accessories, Motor vehicle-1 microbus, etc) (computer and accessories to be purchased through HIS ehealth OP)	LS		50.00	44.00	6.00	0.00	0.00	40.00	5.00	5.00	0.00	0.00
13	Repair & Maintenance	5		12.00	6.00	6.00	0.00	1.00	2.00	3.00	2.00	2.00	2.00
14	Registration Fee	0		7.00	6.00	1.00	0.00	1.00	1.00	1.00	1.00	1.00	2.00
15	Others (observation of WRD, rabies prevention and control centre monitoring & evaluation etc.)	LS		145.00	70.00	75.00	0.00	10.00	20.00	25.00	30.00	30.00	30.00
	Sub-Total			26005.50	12010.50	13995.00	0.00	1872.00	6829.00	6589.00	6043.00	2468.00	2204.50
vi) Antimicrobial Resistance Containment (ARC), Viral Hepatitis, Diarrhoea													
1	Development of Instititional antimicrobial (AMs) guideline (for different medical colleges/ national institutes), training of doctors on rational use of AMs based on guideline, monitoring & evaluation for ensuring adherence to AMs guideline; Development of national AM policy, updating of national strategy and NAP	24		236.00	108.00	113.00	15.00	16.00	100.00	60.00	20.00	10.00	30.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
2	Hands on trainingfor doctors (microbiologist), technologist on Antimicrobial Susceptibility Testing, AMR surveillance, networking; Training, seminar, workshop on ARC, IPC, VH, diarrrhoea etc.	1920	320.00	160.00	160.00	0.00	20.00	60.00	60.00	60.00	60.00	60.00
3	Establishment/strengthening and functioning of national reference microbiology lab and regional microbiology labs at medical colleges/district hospitals for AST	LS	430.00	215.00	215.00	0.00	10.00	200.00	40.00	60.00	60.00	60.00
4	Survillance (AMR, usage of antimicrobials by physicians at HCFs, Hepatitis, Diarrhoea)	52	200.00	100.00	100.00	0.00	10.00	40.00	40.00	40.00	40.00	30.00
5	Research & Survay	45	200.00	120.00	80.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
6	Petrol and Oil	71000	45.00	45.00	0.00	0.00	8.00	10.00	8.00	8.00	6.00	5.00
7	Medicine (HBV vaccine for high risk group eg. HCPs; drugs for HCV infcted individuals , reagents for AST, cholera vaccine etc.)	995000	5080.00	2510.00	2110.00	460.00	30.00	1150.00	1200.00	1100.00	800.00	800.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
8	MSR (Equipments and reagrents for functioning of microbiology lab for AST), Disposable syringe with needls	LS	254.00	102.00	102.00	50.00	4.00	50.00	50.00	50.00	50.00	50.00
9	Printing, publication	LS	235.00	95.00	85.00	55.00	25.00	50.00	40.00	45.00	40.00	35.00
10	Advertisement and activities for awareness building	LS	235.00	95.00	85.00	55.00	25.00	50.00	40.00	45.00	40.00	35.00
11	Pay and Allowance (consultancy & Manpower	2	110.00	110.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00	10.00
12	Acquisition of Asset (Computer & accessories, Microbus-1, etc) (computer and accessories to be purchased through HIS ehealth OP)	LS	50.00	44.00	6.00	0.00	0.00	40.00	5.00	5.00	0.00	0.00
13	Repair & Maintenance	5	16.00	6.00	10.00	0.00	1.00	3.00	3.00	3.00	3.00	3.00
14	Registration Fee	5	7.00	6.00	1.00	0.00	1.00	1.00	1.00	1.00	1.00	2.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
15	Infection Prevention & control at healthcare facilities (SOP development, training of HCP, ensure adherence) and at community level, observation of WHD, prevention and control centre monitoring & evaluation; promotion of rational use of antimicrobials, Awareness building	3240	540.00	270.00	270.00	0.00	40.00	100.00	100.00	100.00	100.00	100.00
	Sub-Total		7958.00	3986.00	3337.00	635.00	230.00	1914.00	1707.00	1597.00	1270.00	1240.00
vii) Surveillance												
1	Seminar/ hands on training on Disease Surveillance	1590	270.00	105.00	110.00	55.00	20.00	60.00	50.00	50.00	50.00	40.00
2	Emergency Preparedness and Response	155	2315.00	1150.00	1120.00	45.00	315.00	400.00	400.00	400.00	400.00	400.00
3	Computer, C. accessories, machinary	LS	97.00	50.00	47.00	0.00	7.00	20.00	20.00	20.00	20.00	10.00
4	Survillance (in coordination with MIS)	34	170.00	85.00	85.00	0.00	20.00	30.00	30.00	30.00	30.00	30.00
5	Research & Survay (In coordination with PMR & MIS)	12	20.00	10.00	10.00	0.00	2.00	4.00	4.00	4.00	4.00	2.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
6	Petrol and Oil	24000		15.00	15.00	0.00	0.00	3.00	3.00	3.00	3.00	2.00	1.00
7	Medicine, MSR	LS		175.00	55.00	60.00	60.00	25.00	30.00	30.00	30.00	30.00	30.00
8	Printing, publication & others for awareness building	LS		55.00	30.00	25.00	0.00	5.00	10.00	10.00	10.00	10.00	10.00
9	Building construction	1		8500.00	8500.00	0.00	0.00	1000.00	2600.00	2500.00	2000.00	200.00	200.00
	Sub-Total			11617.00	10000.00	1457.00	160.00	1397.00	3157.00	3047.00	2547.00	746.00	723.00
	Total of A			98835.00	41292.00	44283.00	13260.00	9316.50	22794.80	20543.80	22044.80	13276.80	10858.30

11. Budget support from other Operational Plan: Not applicable

4.20 Tuberculosis-Leprosy and AIDS/STD Programme (TB-L & ASP)

1. Name of the Operational Plan: Tuberculosis-Leprosy and AIDS/STD Programme (TB-L&ASP)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

Integration of two OPs into one OP (Tuberculosis-Leprosy and AIDS/STD Programme) is taking place in this 4th Sector programme. In Bangladesh, Tuberculosis, Leprosy and AIDS/STDs are leading public health problems.

Though significant progress in the fight against TB achieved globally, yet recent TB prevalence surveys in a number of countries reveal upward change. In Bangladesh, in spite of significant achievement, TB is still the most important communicable disease in terms of incidence, prevalence and mortality. More than three hundred sixty thousand people are getting ill by the disease and the disease has been claiming about 72 thousand lives annually. About 150 thousands cases are either undetected, untreated or remain unreported annually. With this burden, Bangladesh is in the list of high TB and MDR-TB burden countries. Inequity in accessibility and delay in diagnosis, slow introduction of new diagnostic technology, insufficient capable human resource, sustainability of diagnostic facilities in field level and in hospitals and inadequate financial resources areimportant issues and challenges. There are also issues of high urban transmission, co-morbidity with Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Diseases (COPD), HIV/AIDS etc.

Though Bangladesh achieved elimination of leprosy at national level at the end of December 1998, still after 18 years leprosy remains endemic in some districts posing threat of reemergence of the disease. Yearly reported case detection is around four thousand leaving behind another four thousand undetected. Therefore, incidence and prevalence of leprosy per 10,000 populations would be double the reported figure and more districts would have low or medium leprosy endemicity in the country. Grade-2 deformity also remains high in 2014 and 2015with 11.0% and 8.20% respectively. Planning for Leprosy in the 4th sector program should emphasize on universal access and equity in early diagnosis and prompt management of leprosy. The country has also burden of deformity and disability requiring attention for universal access to morbidity management also. The goal of NLEP for the 4th sector programme is to achieve elimination of leprosy at upazila level and universal access to morbidity management through community clinics of the country.

Although Bangladesh is a low-prevalence country for HIV but it is one of the four countries with consistent increase in new cases. In 2015, 469 new cases were reported and in the last decade on an average 500 new cases were added every year. Majority of the cases remain undetected with more than five thousand cases being undetected and more than seven thousand could not be included for antiretroviral therapy. Though most of the interventions were for the key populations of HIV, case reporting was high among migrant workers. Migrants constituted between 33.3%-46.3% of annual cases on average; in 2015, 140cases (30%) were reported from migrant population. As per reported cases in 2014, the most heavily affected districts were Dhaka (21.2% of cases), Sylhet (8.8%) and Chittagong (8.5%). In Dhaka, 64% of cases were among PWID while 14% were migrant related. In contrast, Sylhet and Chittagong had 95% and 32% migrant related cases respectively, but none among PWID. And also, about one third cases are women and an increase of infection was seen among spouses of migrants, who constituted around 10% of detected cases since 2011. As estimated using

the AIDS Epidemic Model, the main routes of transmission are through heterosexual unprotected sex and husband to wife transmission.

The early response to HIV/AIDS helped to maintain a low prevalence in the country. AIDS Epidemic Model (AEM) analysis demonstrated that ongoing interventionshave averted an estimated total of 141,225 HIV infections and saved 3,841,000 DALYs and 19,545 lives till 2014. Without specific interventions since 2000, HIV prevalence would have exceeded 20% in most KPs within the next 20 years and a generalized epidemic would have taken off. The goal of the NASP for the 4th sector program is to minimize the spread of HIV and the impact of AIDS on the individual, family, community, and society, so that HIV is ended in Bangladesh by 2030.

4. Objectives:

1. To attain annual case detection of all forms of TB over 85% by 2022
2. To sustain and attain treatment success rate of at least 90% in non-MDR and 75% in MDR TB
3. To detect over 80% of the estimated MDR-TB and 100% enrollment for treatment
4. To achieve and sustain elimination of leprosy in all upazilas of the country by 2022
5. To achieve zero-disability among children by the year 2022
6. To bring people with deformity and disability due to leprosy to community morbidity management
7. For AIDs STD
8. By 2020, 90% of the estimated PLHIV under coverage HTC and percentage of detected increased to 2022
9. By 2020, 90% detected PLHIV are on ART and sustained to 2022
10. By 2020, 90% viral suppression gain who are on ART of PLHIV and sustained to 2022
11. To established and to strengthen coordination with different ministry and stakeholders for effective use of resources (mobilization)

5. Activities

Component-1: Tuberculosis Program

The tuberculosis program achieved significant progress during the last decade but still TB faces huge challenges that need priority attention in the 4th sector program.

- **Increase detection and rate of notification**

To attain annual case detection of TB to over 85% of the estimated cases by 2022 through improvement of detection and notification following activities will be implemented in the 4th sector programme:

1. Strengthening and scaling-up lab diagnostic facilities
2. Increase detection of TB in children
3. Strengthen the engagement of private providers in the diagnosis of TB
4. Community participation through multipurpose health volunteers for the purpose of detection.

- **Sustain a treatment success rate of at least 90% in all forms of detected non-MDR TB cases**

Activities:

1. Ensure patient friendly DOT services to attain patient centered care

2. Ensure regular supervision of all DOT providers
3. Expand TB care for special populations such as prisons, garment industry , slums , migratory populations
4. Ensure uninterrupted supply of quality controlled drugs at all facilities
5. Implement a comprehensive infection control policy at all implementation sites
6. Improve the management of TB cases with co-morbidities

a) Ensure universal access to DST by 2020;

To detect over 80% of the estimated MDR-TB and to treat 100% of detected MDR-TB cases and to achieve a treatment success rate of at least 75% in detected MDR-TB cases, following activities will be implemented:

1. Ensure history taking of all TB cases for adequate identification of presumptive MDR TB
2. Ensure testing of all smear positive PTB cases with Gene Xpert at the sites where machines are available and cover whole country by 2020
3. Ensure adequate second line anti-TB drug supply both for shorter regimen as well as longer regimen
4. Introduction/ expansion of use of new drugs (Bedaquiline and Delanamide) for the treatment of DR TB/ Pre XDR and XDR TB

b) Monitoring, supervision and operational research:

Ensure that 100% of TB service facilities receive regular supervision and monitoring, and produce timely and accurate reports, by 2017

1. Revise the existing M&E plan to provide more detail on the organization of supervision and staff responsibilities at various program levels
2. Strengthening electronic reporting system at peripheral sites
3. Continue quarterly monitoring meeting at district level
4. Strengthen and expand operational research activities

Component-2: Leprosy Program

- Active Case Search for early leprosy case detection
- Community - Based Morbidity Management
- Strengthen health management information system for Leprosy case diagnosis and reporting
- Community awareness & social mobilization to reduce stigma & discrimination
- Diagnosis & management of leprosy cases
- Program monitoring and supervision
- Collaboration and Partnership at international level for improvement of leprosy services
- Strengthening Hospital service & facilities for management of G2 disabilty -linked with HSM
- Research & Survey

Component-3: ASP

a) Detection of left Over Cases

One of the most important issues in ASP is to detect over five thousand undetected cases and over seven thousand cases to be included on ART. If we consider about 40% reported cases to be migranted, then a major portion of the undetected five thousand cases may be migrant returnees living in the rural community. Stratification of the population into the smallest possible unit and engagement

of the community in detection of HIV cases among migrant returnee may be one of the possible cost effective methods. Six to nine thousand people in the catchment area of the community clinic with 1200-1800 households may be the target population for the intervention. Multipurpose health volunteers (MHV) along with field health workers may play significant role in detection of left over cases.

Activities:

1. Drafting, updating and approval of the strategy, guideline, SOP and IEC material
2. Training of district and upazila level managers, field health workers, CHCP and MHV
3. Awareness in the community on HIV in terms of alleviating the stigma, promotion of health seeking behaviour for diagnosis and management of HIV
4. Listing of migrant returnee in the community with stratification into at risk groups
5. Detection of suspected HIV cases through self-declaration or analysis of population at risk
6. Referral to District HIV Testing and Counseling centers (DHTC) through Community Clinics (CC)
7. Referral back to CC for management and follow up of the cases

b) Detection of new cases among Migrants

About 40% of recently detected cases are migrants and in Chittagong district, 95% cases are migrants. In the coming years, about half of the new cases may belong to the migrants. We need some mechanism to prevent and detect this half of the national annual HIV cases among the migrants. The interventions should include both practice of preventive measures and health seeking behaviour of the migrants.

Activities:

1. Awareness raising of migrant workers during their preparatory training under BMET and in the port of exit
2. Counseling service through hot line and website of the One Stop HIV Management Center in the capital and in the division level
3. Establishment of HIV counseling center in ports
4. Counseling of the migrant returnees in the community for detection and management of HIV cases ;
5. Community participation through multipurpose health volunteers for the purpose of detection.

c) Strengthen Detection of Cases among key Population

The national prevalence among the key population groups remains low with PWID 1.1%, FSW 0.3%, MSW 0.4%, MSM 0.4% and Hijra 1.0%. But in certain geographical areas, key populations have high HIV prevalence with 7.1% among the hijras and 1.6% among casual sex workers of Hili, Dinajpur. HIV prevalence among MWID in Dhaka city has increased steadily over the years from 1.4% in 2000 to 7.0% in 2007 and it was 5.3% in 2011. Coverage is still low among certain KPs and PLHIV; 13.1% of MSM and 27.3% of MSW are covered by prevention.

Activities:

1. Establishing drop in centers (DICs) for preventive services including condom promotion, BCC, needle syringe exchange, counseling and also care and support programs for HIV among key populations
2. Training for the implementing partners
3. Counseling service through hotline and website of the One Stop HIV Management Center in the capital and in divisional level

d) Functional HIV Testing and Counseling (HTC) Center

For strengthening accessibility and equity, we need to strengthen and scale up HIV Testing and Counseling (HTC) centers in all the 23 priority districts and scaling up in other districts up to 50 centers. The steps may be as follows:

1. Procurement of necessary equipment, logistics, consumablesetc
2. Purchase of necessary consultancy
3. Counseling service
4. Lab diagnosis of HIV
5. Management of HIV cases and related issues
6. Community participation through multipurpose health volunteers for the purpose of management.

e) One Stop HIV Management Centre

HIV patients need management in such a way that all the services are available in one center to increase the detection rate, treatment rate and to interrupt transmission. There should be one national center and one in each of the divisional towns of the country with diagnostic, treatment, counseling services 24/7 having IT facilities and hotlines.

Activities:

As per priority, the following programs/ interventions are required in the 4th health sector program to attain the OP goal and objectives:

1. Intervention for Migrants and cross-border Populations;
2. Establish and functioning HTC center (in at least 23 districts in Bangladesh at Government Hospitals or NGO set up and the number of HTC centerswill have to increase up to 50);
3. Establish Care, Support and Treatment facility for the PLHIV in the GO and NGO set up;
4. Establish and operate Drop In Centers (DIC) for KPs (FSWs, PWIDs and MSM/TG) and provide preventive service packages including Condom promotion and lubricants distribution; BCC; STI/ HIV Counseling, STI and abscess management, Needle syringe exchange, SRH referral services for adolescent and young KPs;
5. Update and continuation of school and higher secondary curriculum;
6. Mass awareness among general population though mass media, electronic media, BCC/ IEC material development, etc;
7. Conduct training for different level staff/ service providers;
8. Strengthen coordination with different ministry, stakeholders for effective use of resources;
9. Develop different protocol/ SOP/ strategy to maintain the standard of the services Survey/ study for generating evidence.

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women and Children and Gender etc.:

Tuberculosis, leprosy and HIV/AIDS are still most important communicable diseases causing mortality and morbidity. Women, children and thepoor are most vulnerable to these diseases. Under this OP, various activities will be implemented for prevention and control of these diseases through increasing accessibility, efficiency and quality of services. It will help to improve overall health status of vulnerable population, which will in turn contribute to increase productivity, reduce poverty, gender disparity and create employment opportunities. To implement proposed activities of this OP, multi-sectoral collaboration/ coordination will be strengthened.Emphasis will be given for involvement of local government institutions and community to support implementation and monitoring of the program.

7. Proposed Manpower: Annexed in Volume- II

8. List of Works, Goods and Services etc.: Annexed in Volume- II

9. Indicator:

Sl	Indicators	Unit	Baseline (Year, Source)	Projected Target	
				Middle (By June 2020)	End (By June 2022)
1	**2**	3	4	5	6
TPL:					
1.	Notification of New TB case	Number (NTP MIS Report)	209438 (NTP MIS Report)	245000	255000
2.	Enrolment of MDR patients for treatment	Number (Cumulative) Number (NTP Annual Report)	880 (2015, NTP MIS Report)	2,600	4000
3.	Registered Prevalence of Leprosy	Rate per 10,000 population	0.23 (Source: MIS Leprosy 2015)	0.18	0.10
ASP:					
4.	Notification of new HIV infections (by age, sex, and key population)	Per thousand population (MIS, NASP)	0.004 (2016)	0.003	0.002

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
28426.39	48973.50	88252.83	137226.33	165652.72	

10.2. Component and activity wise physical and financial target of OP: TB-L&ASP

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component (i)TB													
1	TB Case (Drug Sensitive) Management	0		35417.10	1172.09	28965.00	5280.00	2770.00	5552.55	5872.55	6670.00	7075.00	7477.00
2	MDR TB/ DR TB Case Management	0		13176.03	0.00	0.00	13176.03	480.00	2207.70	2007.36	2354.87	3063.05	3063.05
3	Strengthening of Diagnostic services by installing new technologies (Gene Xpert, LPA) & equipment for TB diagnosis	975		18032.53	33.00	1500.00	16499.53	2461.02	6065.05	6089.05	2618.02	493.39	306.00
4	Ensure Gene Xpert Cartidges, reagents, x-ray film and other supportive kits	36660375		39274.16	262.50	1338.51	37673.16	1710.50	3623.48	7316.44	8195.82	9092.60	9335.32
5	Program Monitoring & Supervision	6633		4500.00	400.00	700.00	3400.00	500.00	800.00	800.00	800.00	800.00	800.00
6	(a). Human Resources	0		7564.34	3302.84	0.00	4261.50	528.50	1115.62	1380.45	1462.99	1512.84	1563.94
	(b). Human Resources Development	5625		7058.53	60.00	1006.86	5991.67	513.40	1147.73	1375.30	1366.20	1339.75	1316.15
7	Printing guidelines, SOP, reports and distribution	0		312.00	207.00	0.00	105.00	25.00	55.00	54.00	60.00	60.00	58.00
8	Storage of TB Drugs (refreezerator)	500		550.00	0.00	550.00	0.00	55.00	110.00	110.00	110.00	110.00	55.00
9	Active case finding from hard to reach areas/more afftected districts	0		370.00	0.00	0.00	370.00	30.00	60.00	70.00	70.00	70.00	70.00
10	Supportive instrument (computer, printer, laptop, etc) for office management (to be purchased by HIS-ehealth OP)	187		50.80	42.30	2.50	6.00	5.80	8.00	8.00	9.00	10.00	10.00
11	Research (in coordination with PMR)	0		565.00	300.00	0.00	265.00	30.00	163.00	114.00	86.00	86.00	86.00
12	Others (honorium for MSV health volunteers, others)	0		250.00	250.00	0.00	0.00	25.00	50.00	50.00	50.00	50.00	25.00
	Sub total	**36674295**		**127120.49**	**6029.73**	**34062.87**	**87027.89**	**9134.22**	**20958.13**	**25247.15**	**23852.90**	**23762.63**	**24165.46**
Component (ii) Leprosy													

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
1	Active Case Search for early leprosy case detection	686	182.18	28.11	21.20	132.87	15.31	48.16	50.11	29.63	20.84	18.13
2	Community - Based Morbidity Management	174	73.96	15.00	16.13	42.83	0.00	21.88	14.88	14.83	12.83	9.54
3	Strengthen health management information system for Leprosy case dignosis and reporting	34	68.91	6.22	25.00	37.69	31.18	35.73	0.50	0.50	0.50	0.50
4	Community awareness & social mobilization to reduce stigma & discremination	84	43.20	14.65	10.00	18.55	0.00	8.57	15.57	6.42	6.42	6.22
5	Diagnosis & management of leporsy cases		22.38	10.00	12.38	0.00	0.00	5.00	0.00	9.64	4.64	3.10
6	Programme Monitoring & Supervision		253.00	20.00	0.00	233.00	0.00	105.00	37.00	37.00	37.00	37.00
7	Collaboration and Partnership at the international level for improvement of leprosy services		20.00	0.00	0.00	20.00	0.00	4.00	4.00	4.00	4.00	4.00
8	Strengthening Hospital service & facilities for management of G2 disabilty -linked with HSM		30.00	10.00	20.00	0.00	0.00	0.00	20.00	0.00	10.00	0.00
9	Research & Survey (in coordination with PMR)	18	90.00	50.00	0.00	40.00	0.00	20.00	20.00	20.00	20.00	10.00
Subtotal (Component (ii))		996	783.63	153.98	104.71	524.94	46.49	248.34	162.06	122.02	116.23	88.49
Grand Total A		36675291	**127904.12**	**6183.71**	**34167.58**	**87552.83**	**9180.71**	**21206.47**	**25409.21**	**23974.92**	**23878.86**	**24253.95**
B) ASP												
i) Component: Prevention of STI and HIV among KPs												
1	STI and HIV prevention program for brothel based sex workers	3600	1500.00	1500.00	0.00	0.00	100.00	300.00	300.00	300.00	300.00	200.00
2	STI and HIV prevention Package for Street Based Female Sex Workers and their clients;	5000	1500.00	0.00	1500.00	0.00	100.00	300.00	300.00	300.00	300.00	200.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
3	STI and HIV prevention Package for Hotel and Residence Based Female Sex Workers and their clients	5000	1500.00	0.00	1500.00	0.00	100.00	300.00	300.00	300.00	300.00	200.00
4	STI and HIV prevention Package for MSM/MSW/TG and their clients	5000	1500.00	0.00	1500.00	0.00	100.00	300.00	300.00	300.00	300.00	200.00
5	Harm reduction package for male and female PWID (in geographically prioritized districts)	10000	3500.00	0.00	3500.00	0.00	350.00	700.00	700.00	700.00	700.00	350.00
6	Opioid substitution therapy (OST) Package for male and female PWID	1500	1500.00	0.00	1500.00	0.00	100.00	300.00	300.00	300.00	300.00	200.00
7	HIV Prevention Program for external Migrant Workers and their partners	100000	2500.00	2500.00	0.00	0.00	250.00	500.00	500.00	500.00	500.00	250.00
8	Migration and Development: Cross border intervention	20000	1000.00	1000.00	0.00	0.00	100.00	200.00	200.00	200.00	200.00	100.00
9	Continuation of HIV text teaching through the formal and non-formal educational institutions (secondary and Higher Secondary)	2	801.90	801.90	0.00	0.00	63.64	133.61	140.29	147.30	154.66	162.40
10	Mass campaign through electronic media Drama, talk show, TVC and debate competition	4	311.69	311.69	0.00	0.00	24.73	51.93	54.53	57.26	60.12	63.12
11	Mass campaign through FM and community radio and social media	3	113.28	113.28	0.00	0.00	0.00	20.50	21.53	22.60	23.73	24.92
12	Mass awareness through development and printing IEC/ BCC media and folk media	8	234.94	234.94	0.00	0.00	18.64	39.14	41.10	43.16	45.32	47.58

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Sub Total		15961.81	6461.81	9500.00	0.00	1307.01	3145.18	3157.45	3170.32	3183.83	1998.02
ii) Component: Universal access to treatment, care support for the PLHIV												
1	HTC center established and continuation as per geographical priorities areas (among the 23 center 5 center will provide care support and treatment service along with HIV testing)	50	1500.00	1500.00	0.00	0.00	100.00	300.00	300.00	300.00	300.00	200.00
2	CST (Care support and Treatment) Service with drug adherence, monitoring and community sencitization	5	1000.00	1000.00	0.00	0.00	100.00	200.00	200.00	200.00	200.00	100.00
	Sub Total		2500.00	2500.00	0.00	0.00	200.00	500.00	500.00	500.00	500.00	300.00
Component 3- Strengthening coordination mechanisms and management capacity at different levels												
1	Training to the service providers including doctor/ nurses/ program managers and other NGOs partners	6000	1076.10	1076.10	0.00	0.00	192.00	160.00	168.00	176.40	185.22	194.48
2	Continuation coordination liaison through workshop, meeting with different OP/ department/ stakeholders	250	103.21	103.21	0.00	0.00	7.60	19.95	20.95	21.99	15.96	16.76
3	Higher level advocacy for creating enabling environment and monitoring supervision	1	700.00	0.00	0.00	700.00	100.00	200.00	200.00	200.00	0.00	0.00
4	Developing module/ guideline	20	168.05	168.05	0.00	0.00	13.33	28.00	29.40	30.87	32.41	34.04
5	Consultant services to strengthen collaboration	7	602.69	0.00	602.69	0.00	47.82	100.42	105.44	110.71	116.25	122.05
	Sub Total		2650.05	1347.36	602.69	700.00	360.75	508.37	523.79	539.97	349.84	367.33
iv) Component: Strengthening strategic information systems and research for an evidence based response												
1	Conduct Serological Surveillance in every other year	1	500.00	0.00	500.00	0.00	0.00	0.00	0.00	500.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
2	Behavioral Surveillance Survey in every other year	1	550.00	0.00	550.00	0.00	0.00	0.00	0.00	550.00	0.00	0.00
3	Conduct STI Surveillance once in every 5 year	1	600.00	0.00	600.00	0.00	0.00	0.00	600.00	0.00	0.00	0.00
4	Conduct Size Estimation for Key Populations once in every 4 years	1	300.00	0.00	300.00	0.00	0.00	0.00	0.00	300.00	0.00	0.00
5	Maintain a uniform national HMIS and PLHIV database	5	1.00	1.00	0.00	0.00	0.09	0.19	0.18	0.18	0.18	0.18
6	Conduct operational research (in coordination with PMR)	3	75.00	0.00	75.00	0.00	0.00	15.00	15.00	15.00	15.00	15.00
	Sub Total		2026.00	1.00	2025.00	0.00	0.09	15.19	615.18	1365.18	15.18	15.18
	Total of 4 component		23137.86	10310.17	12127.69	700.00	1867.85	4168.74	4796.42	5575.47	4048.85	2680.53
Procurement of Goods												
1	ARV (Anti rectoviral Drugs)	19300	6948.00	6948.00	0.00	0.00	468.00	1440.00	1440.00	1440.00	1440.00	720.00
2	Air cooler	10	9.00	9.00	0.00	0.00	4.50	0.00	4.50	0.00	0.00	0.00
3	Furniture/ fixture (NASP HQ and HTC/ CSTC)	51	57.00	57.00	0.00	0.00	27.94	7.82	11.18	10.06	0.00	0.00
4	Office communication equipment (PA System)	1	20.00	20.00	0.00	0.00	20.00	0.00	0.00	0.00	0.00	0.00
5	Office equipment (computer/ printer, HTC lab equipment) (computer and IT accessories to be purchased by HIS e health OP)	50	30.00	30.00	0.00	0.00	6.00	8.00	8.00	6.00	2.00	0.00
6	Viral load machine	3	150.00	150.00	0.00	0.00	150.00	0.00	0.00	0.00	0.00	0.00
7	Viral load reagents	20000	607.40	607.40	0.00	0.00	60.74	121.48	121.48	121.48	182.22	0.00
8	CD 4 Machine	5	75.00	75.00	0.00	0.00	45.00	0.00	30.00	0.00	0.00	0.00
9	CD 4 reagents	10000	227.60	227.60	0.00	0.00	68.28	45.52	34.14	45.52	34.14	0.00
10	Photocopier	3	6.00	6.00	0.00	0.00	4.00	0.00	2.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
11	HIV testing kit	150000		714.70	714.70	0.00	0.00	95.29	142.94	142.94	142.94	190.59	0.00
12	Male condom	60000000		1500.00	0.00	1500.00	0.00	0.00	1000.00	500.00	0.00	0.00	0.00
13	Lubricant	1000000		150.94	0.00	150.94	0.00	75.47	30.19	45.28	0.00	0.00	0.00
14	Vehicle	2		100.00	100.00	0.00	0.00	50.00	50.00	0.00	0.00	0.00	0.00
15	Syringe/ neddle for PWID intervention	20000000		800.00	0.00	800.00	0.00	200.00	0.00	400.00	200.00	0.00	0.00
	Sub Total			11395.64	8944.70	2450.94	0.00	1275.22	2845.95	2739.52	1966.00	1848.95	720.00
1	Human resource salary and benefits for HTC/ CSTC and HQ/ divisional staff	98		1512.46	1512.46	0.00	0.00	120.00	252.00	264.60	277.83	291.72	306.31
	Sub Total			1512.46	1512.46	0.00	0.00	120.00	252.00	264.60	277.83	291.72	306.31
Office maintainance cost													
1	Vehicle fuel	4		150.00	150.00	0.00	0.00	20.00	35.00	35.00	35.00	15.00	10.00
2	Office stationery (NASP HQ +50 HTC)	51		292.18	292.18	0.00	0.00	23.18	48.68	51.12	53.67	56.36	59.17
3	Support for CD/ Vat	5		55.00	55.00	0.00	0.00	5.00	10.00	10.00	10.00	10.00	10.00
4	Meeting cost	50		33.80	33.80	0.00	0.00	2.68	5.63	5.91	6.21	6.52	6.85
5	Printing cost	30		144.37	144.37	0.00	0.00	11.45	24.06	25.26	26.51	27.85	29.24
6	Advocacy / seminer cost	520		400.00	400.00	0.00	0.00	20.00	80.00	80.00	80.00	80.00	60.00
7	World AIDS day celebration across the country	5		400.00	400.00	0.00	0.00	20.00	80.00	80.00	80.00	80.00	60.00
8	Hiring contract management agency for selecting the implementation organization	1		170.00	0.00	170.00	0.00	120.00	50.00	0.00	0.00	0.00	0.00
9	Monitoring and supervision	250		57.29	0.00	57.29	0.00	4.55	9.55	10.02	10.52	11.05	11.60
	Sub Total			1702.64	1475.35	227.29	0.00	226.86	342.92	297.31	301.91	286.78	246.86
	Total of B			37748.60	22242.68	14805.92	700.00	3489.93	7609.61	8097.85	8121.21	6476.30	3953.70
	Grand Total (A+B)	0	0	165652.72	28426.39	48973.50	88252.83	12670.64	28816.08	33507.06	32096.13	30355.16	28207.65

11. Budget support from other Operational Plan: Not applicable

4.21 Non-communicable Diseases Control (NCDC)

1. Name of the Operational Plan: Non-communicable Diseases Control (NCDC)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

Due to epidemiological transition, there is a need for a policy and legislative shift to meet the challenges of increasing non-communicable diseases (NCDs). WHO defines, NCDs which include primarily cardiovascular diseases (heart disease and stroke), cancers, chronic obstructive pulmonary disease (COPD) and diabetes mellitus. They are linked to four shared risk factors: tobacco use, unhealthy diet, low physical activity and harmful use of alcohol. These risk factors contribute to maturation of the NCDs through a few intermediary risk factors: obesity, high blood pressure, abnormal glucose tolerance, and abnormal blood lipids. WHO published NCD Country Profile 2014: that NCDs account for 59% of total death in Bangladesh (17% cardiovascular diseases, 11% chronic respiratory diseases, 10% cancers, 9% injuries, 3% diabetes and 10% other NCDs).

Population level studies on NCDs are inadequate. Zaman et al reported a population prevalence of ischemic heart diseases 3.4% in adults. Prevalence of stroke was 9.4 per 1000 aged 30 years or older. The national Sample Vital Registration System (SVRS) of the Bangladesh Bureau of Statistics (BBS), estimates that cardio- and cerebrovascular diseases combined are the major causes of death, followed by asthma and respiratory diseases. CVD has an age standardized mortality rate of 411 per 100,000. CVDs and hypertension has been showing an increasing trend. National level prevalence of diabetes hardly available. Approximately 5.5% adults were found to have diabetes in STEPS 2006 survey. IDF Atlas 2014 provides a prevalence of 6.3% in Bangladesh. COPD data are rare. Among 30 years or older, the prevalence of COPD was 29.7 per 1000 (WHO survey).

According to GLOBOCAN 2012 the number of new cancer cases per year is 122,700. Age standardized incidence rate is 104.5 per 100,000 population. Five most frequent cancers in male and female are the cancers ofbreast (12.1%)**,** oesophagus (11.3%), cervix uteri (9.7%)**,** lung (8.8%), andlip and oral cavity (8.7%).

Survey on mental health in Bangladesh revealed that 16.1% of adult and 18.4% of child and adolescent population suffered from any form of mental disorders. Common mental illnesses in adults were anxiety disorders, depression, schizophrenia and substance abuse. In children and adolescent mental retardation was found to be 3.4% and autism was 0.8%.

People from all strata suffer from NCDs, however its impact on poor segment is devastating, they are more exposed to risk factors such as more tobacco and dietary salt compared to the richer segment. Many of the underlying factors for NCDs are beyond the health sector interventions such as poorly planned urbanization, air pollution, availability of affordable unhealthy food, weak tobacco tax and various international treatises such as GATT and TRIPS etc. Therefore, a multisectoral collaboration using “Whole of the Government” approach needs to be ensured.

Some other chronic diseases that have limited or no link to the shared risk factors mentioned above but they do not fall under communicable disease category. Oral diseases (especially oral cancer) and kidney diseases have a few shared risk factors like NCDs. Mental and neurological diseases, autism and other neurodevelopmental disorders, impairment of vision and hearing, chronic arsenic poisoning are common problems. Occupations expose people to unfavourable health outcomes. Poor become poorer because of occupational hardship and cost of treatment. Other forms of physical disability,

injuries with special attention to road traffic injuries, drowning, violence related injuries, poisoning and snakebite, burns deserve special attention.

There is strong political commitment of the Government of Bangladesh (GoB) for the control of NCDs. The Government's response to NCD control: was demonstrated by enacting the tobacco control act 2005 updated in 2013 to comply with the FCTC, adopted the Strategic Plan for Surveillance and Prevention of Non-Communicable Diseases in Bangladesh 2011-2015. Unfortunately, these strategies were mostly for the health sector. Although some progress has been made, public awareness, screening and engagement of primary health care (PHC) are far from optimum. Non-state actors are working with poor coordination with public sector. HPNSDP 2011-2016 planned integrated programmes for prevention of NCDs in alignment with the 6th FYP. However, the implementation of activities for NCD control could not be achieved as expected. It is praiseworthy that GoB has given priority for prevention and control of NCDs in upcoming 4th sector program as proposed in 7th FYP and SIP document.

In the group 'NCDC' at least five targets from health related Sustainable Development Goal (Goal 3. Ensure healthy lives and promote well-being for all at all ages) are included: 3.4, 3.5, 3.6, 3.9, 3a.

NCDs are largely preventable by lifestyle modification and importantly treatable.

For operational purpose the program under 'NCDC' was divided into Conventional NCDs and Non-conventional NCDs.

- **Conventional NCDs (CVD, cancer, diabetes, kidney diseases, injuries, COPD, etc.)**

In the 3rdSector Program (HPNSDP 2011-2016), control of NCDs was given priority but with inadequate resource allocation. The operational plan was categorized as conventional and nonconventional NCDs. Most of the resources were used in purchasing equipment, training of manpower and arsenicosis and emergency related activities. Major activities conducted were: Steps Survey, piloting PEN interventions in 2013 at Satkhira in Debhata Upazilla HC, establishment of Health Promotion Model villages for NCD control in few areas, model school initiatives in 91 schools.Creation of health literacy by courtyard meetings, facility based education, use of mass media, and establishment of NCD corner are few examples.

The Mid Term Review (MTR 2014) recommended that the health system will need to re-consider its response by realigning efforts to tackle NCDs in a comprehensive manner. The role of the private sector service providers for NCDs has also been emphasized but with a provision of more effective regulatory mechanism. Lifestyle changes deserves due importance. Use of media has been warranted for creation of awareness. Strengthening of MIS has also been recommended urging attention to major cancers. Accidents and suicide amongst specific sections of the population is presenting as a major proportion of mortality and morbidity. Little emphasis has been placed on these in the past and deserves a revisit. Little engagement of the MOHFW has been observed in environmental health or climate change issues although there is growing concern about environmental pollution (air, water, and land). The MTR has given due importance to urban health also especially related to pollution and sanitation.

- **Non-conventional NCDs (eye care, dental health, birth defects, etc.)**

Disabling hearing loss is prevalent in 9.6 per cent of Bangladeshi people. Hearing loss is more prevalent in socio-economically deprived and in those older than 60 years. Impacted ear wax and chronic suppurative otitis media are the most common preventable causes of hearing loss.

Prevalence of blindness is 1.5% among those aged 30 years or older. Cataract is the commonest cause of blindness followed by childhood blindness, refractive error and diabetic retinopathy. Twenty-seven percent of diabetic patients have diabetic retinopathy.

- **Challenges:**
    - **Challenges to address: No organized body/authority for NCD control to lead and coordinate stakeholders such as non-health sectors and non-state actors:** A central body or authority is essential to lead and coordinate the NCD control in Bangladesh. An existing national centre, NCCRFHD, can be designated as the National NCD Prevention Centre. At the beginning, little additional human resource or fund will be needed to make this shift. It can serve the purpose of the NCD Directorate and can be the hub to formulate policies and legislations required for NCD prevention involving non-health and health sector.
    - **Weak surveillance system for NCDs and their risk factors having poor link to HMIS:** Routine hospital based surveillance is incomplete and inaccurate. Inclusion of major NCDs is relatively new. The capacity of the Systems is still weak. Sentinel surveillance sites are yet to be established. Periodic STEPS survey is done but it should be taken up by the routine surveys done by BBS and NIPORT. HMIS needs to assimilate data from all sources.
    - **Tier specific health system essential package for NCD is lacking:**Community based screening programme is not yet introduced for NCD control: Defined packages are needed to define the roles and responsibilities of the tiers from tertiary to primary care down to community clinics. Essential packages should have been developed, hypertension and diabetes should be brought under a screening system.
    - **Inadequate supply of affordable essential drugs, diagnostic and other logistics:** Detection of NCDs will be sustainable only when supply of drugs and logistics are made available at all levels. A big hindrance to engage PHC in early detection and effective management is absence of essential affordable drugs. The essential drug list for NCDs require updating, the supply has to be ensured

4. Objectives:

- **General Objective:**

To reduce mortality and morbidity from NCDs in Bangladesh through strengthening of evidence-based measures for control of risk factors, and health service delivery options for early detection and management.

- **Specific Objectives:**

a) To promote development and implementation of effective, integrated, sustainable, and evidence-based public policies for chronic non communicable diseases, their risk factors, and determinants.

b) To development and strengthening of capacity for surveillance of chronic non communicable diseases, their consequences, their risk factors, and the impact of public health interventions.

c) To foster, support, and promote social and economic conditions that address the determinants of chronic non communicable diseases and empower people to increase control over their health and to adopt healthy behaviors.

d) To strengthening the capacity and competencies of the health system for the integrated early detection, management of chronic non communicable diseases and their risk factors.

5. Components:

Component A: Conventional NCDs (Cardiovascular Diseases, Diabetes, COPD, Cancer):

Control of NCD risk factors through lifestyle intervention: A recent global report highlights the modifiable risk factors (90%) and air pollution (29%) as risk factors for stroke.

STEPS surveys were done in 2006, 2010 and 2013; GATS was done in 2009. Almost nine in ten adults have at least one risk factor. Three-quarters of the population have two or more risk factors with a high proportion of clustering. Low intake of fruit and vegetables is the commonest- more than 93% population consumes less then minimum recommended of 5 servings of fruits and/or vegetables per day. Lack of physical activity is 38%. Tobacco use is still very high in Bangladesh- 38% male smokes, 27% men and women consume smokeless tobacco. Salt intake is very high, 11gms per day with 5 gm daily recommendation of WHO. Results of three STEPS surveys indicate that use of tobacco has been declining but all other risk factors are increasing in Bangladeshi adults. These risk factors are amenable to lifestyle and other interventions. Interventions will work better only if legislative or policy support is provided.

In this component the area to be addressed are: capacity of primary health care (PHC) will be strengthened for screening/early detection, management and referral; for health communication and counseling; for control of shared risk factors like tobacco use, unhealthy diet, lack of physical activity and harmful use of alcohol (also linked to STG component- 8 To promote healthy life choices and environment); control of intermediate metabolic risk factors (Overweight/obesity, high blood pressure, raised blood sugar and raised blood lipids. Also, improvement of air quality will be promoted (also linked to STG-8.

Activities A:

Action Area 1: Screening

Primary Health Care (PHC) system (community, community clinic, union health facility and Upazila Health Complex) will be used for prevention of NCDs through public awareness, screening and early detection, treatment and referral. Activities for screening of the risk factors of NCDs, and NCDs will be conducted at population level- for detection of NCDs - hypertension, diabetes mellitus, high cholesterol, COPD. Health Workers (Health assistant (HA), FWAs, Community Health Care Provider (CHCP), AHI and HI will be trained. The cases of NCDs identified in the community and community clinic will be referred to Upazila Health Complex for further advice. At individual level- NCD care will established at Upazila Health Complex for diagnosis, management and advice for hypertension, diabetes mellitus, high cholesterol, COPD, breast and cervix cancer.

For early diagnosis and management of NCDs (Conventional) and their risk factors the major activities will include the following:

1. Development/update the Guidelines and SOPs for diagnosis and management of NCDs.
2. Provision of training of doctors and non-doctors (pilot to understand best practices were completed at Debhata, Shatkhira District). Train 50000-60000 HA, FWA, CHCP on healthy lifestyle education using Healthy Lifestyle Module.
3. Provision of Quality care of NCDs at the level of primary health care (community clinic, Union Health and Family Welfare Center (UH & FWC)/Union Sub Centre (USC), Upazila Health Complex (UHC); Secondary level (District Hospital); Tertiary level (Medical College Hospital & Specialized Institutes). A strong referral linkage with feedback will be established from CC to UHC and further referral to DH/MCH/Specialized institutes.

4. Infrastructure- An 'NCD corner' based on Package of Essential Non-communicable (PEN) Disease Interventions for Primary Health Care in Low-Resource Settings was piloted at UZHC and below in the 3rd sector program, lesson learnt from it will be used to scale out the activities at different health care facilities. The intervention package developed under three strategic headings of (a) Capacity building- NCD care strengthening, referral system, training/orientation, within health sector collaboration: communicable and Non-communicable diseases. (b) Health information system- ICT equipment, baseline survey, reporting, stock taking, record books, (c) Public awareness- Settings -School health -Union council, observance of days, community radio programme, IEC materials, volunteer networks will be implemented for NCD control. There will be a strong collaboration with CBHC, HSM MIS, LHEP.
5. Essential medicines for treatment and prevention of diabetes, hypertension and heart diseases and essential technologies will be provided- at UZHC: X-ray, ECG, Nebulizer, Glucometer, BP machine, Measurement tape, weighing scale; at HFWC, UHC, CC: BP machine, glucometer, urine sugar strip.
6. Arrangement will be made to ensure supply of the diagnostics and drugs available as per ESD package (antihypertensive, insulin and other diabetes medicine, affordable asthma inhalers, nebulization equipment and solutions).
7. Free/subsidized treatment for NCDS at least for the poor (identified) will be provided.
8. Initial expansion of PEN in seven districts and gradual expansion to all over the country (20% community clinic).
9. Special NCD program targeting marginalized population, migrant workers will be arranged.
10. Review the essential drug list to include NCD drugs as per Essential Health Service Package (ESP) will be made.
11. Arrangement to revisit the medical curriculum for NCD prevention and care in collaboration with the Line Director Pre-service education.
12. Refine Essential Package of Essential NCD services.
13. Make an addendum on healthy lifestyle promotion for MCH and FP Health workers.
14. Development of service protocol for diagnosis and treatment of NCDs, and screening of cancer of breast, cervix and oral cavity.
15. Advocate medical colleges/institutions to focus on integration of NCD in primary health care.
16. Collaboration with other directors (example- CHCB, CBHC, HSM) will be made.
17. Health education and skills development of the NCD patients will be arranged by a 'NCD Resource Centre'/cell for providing training about risk factors, life style, inhalers technique, insulin injection etc.
18. Referral- There is no structured referral system in Bangladesh, from 'where' the patients will go to 'where' and the system is yet to develop a formal inter - facility referral system. The patients are at liberty to seek care to any health care professional and in any facility of his/her choice. Most of the time 'social referral' happens. Development of a referral system and back referral with advice for the care of NCDs will be made (cross cutting with CBHC and HSM) this is more applicable for the subjects referred from the community clinic or union facilities when diagnosis

will be confirmed and treatment will be initiated at UHC and refill of drugs will be made from the CC (policy issue). Intra-institutional referral mechanism will be established as well.

19. Activity for surveillance of NCDs: Development and maintenance of effective surveillance (population and facility based) in alignment with Management information system of DGHS for monitoring and evaluation of NCDs and risk factors and morbidity/mortality statistics by cause. Data will be collected from different sources- community and service delivery sites on morbidity, mortality and risk factors.
20. Multi-sectoral coordination

Action Area 2: Advocacy, partnerships, and leadership

Actions:

- Raise public and political awareness/understanding about NCDs and their risk factors through social marketing, mass media and responsible media reporting;
- Set up an effective national multisectoral coordination mechanisms for NCDs at various levels of governance and eventually reporting the progress to the Head of the State;

Multisectoral NCD Coordination Committee (MNCC) at the national level, Divisional/District/Upazilla Level Committees.The NCD Control Programme of the DGHS will be the Secretariat of the multisectoral NCD Coordination Committee (MNCC).

- Catalyze a systematic society-wide national response in NCD control by addressing the underlying social, environment and economic determinants of health by engaging broad range of actors; and
- Advocate for innovative financing mechanisms in NCDs prevention particularly ear marking funds from tobacco tax revenues;
- Strengthen the NCDC Program as a national unit on NCDs in the MoHFW to be a fulltime Secretariat and carry out needs assessment, strategic planning, policy development, multisector coordination, and programme implementation and evaluation.

Major Activities:

(i) Conduct yearly high level advocacy meetings including but not limited to the Ministry of Health and Family Welfare, Ministry of Food, Ministry of Education, Ministry of Local Government, City Corporations, Youth and Sports, Urban Planning, Police, academia and other institutions. (ii) Conduct meetings with other UN agencies and development partners for funding support to draw linkages to the multisectoral NCD Action Plan. (iii) Conduct orientation of media agencies on responsible media reporting on NCDs. (iv) Sign MoU between MoHFW and Ministry of Education and MoHFW and Ministry of Local Government to initiate Healthy Settings programs in cities and schools. (v) Reconstitute multisectoral NCD Coordination Committee and conduct six monthly NCD Meetings.

Action area 3:

- **Health promotion and risk reduction (Healthy Lifestyle and practices):**

Actions:

Healthy lifestyle and practices will be promoted at community level and at facility levels.

Major Activities:

(i) At community level- massive and rapid public health campaign will be made on diet, reduce salt intake, harmful effects of tobacco use, reduce exposure to indoor air pollution, exercise promotion; Awareness will be created using purposefully developed flip chart on NCD risk factors and NCDs (prepared for HA and CHCP, and other health and FP workers), school health programmes, opinion leader's orientation, observance of NCD related days, community radio programmes and other relevant methods of BCC. A network of NGOs, local clubs and other organizations will be promoted. (LHEP, DGHS). (ii)At all health facilities- regular communication program will be arranged (by Upazilla Health education unit proposed in National Health Policy)- related to diet, tobacco cessation, exercise promotion, reduce salt intake, reduce exposure to indoor air pollution.

- **Reduce tobacco use:**

Actions:

Accelerate full implementation of the Tobacco Control Act 2013 of Bangladesh;
Raise taxes on tobacco products including smokeless tobacco through effective policy dialogue with the policy makers and legislators;
Advocate for 100% tobacco-free environment in all indoor workplaces, public transport, indoor public places and strengthen enforcement programs through mobile court checks;
Implement pictorial health warning on tobacco use including smokeless tobacco through strategic mass media and behavioral change campaigns;
Enforce measures to eliminate the illicit tobacco trade, including smuggling, illicit manufacturing and counterfeiting (in line with WHO FCTC Article 6);
Develop trading substitutes and relocation policies for tobacco farmers; and
Set up a national quit line for tobacco users.

Major Activities:

Multisectoral co-ordination (non-health interventions, stewardship and regulatory).
(i) Conduct mobile court enforcement visits in smoke free public places in cities of Dhaka, Chittagong, Khulna, Sylhet, and Barisal and other prioritized 20 districts. (ii) Orient enforcement teams on control of illicit tobacco trade. (iii) Propose for tax revisions for all types of tobacco and ear marking 1% tax revenue for tobacco control program. (iv) Initiate trade relocation program for tobacco farmers.

- **Healthy diet: High fruits and vegetables and low intake of saturated fats/trans fats, free sugars and salt**

Actions:

(i) Disseminate Bangladesh National Dietary Recommendation in mass media and through channels; (ii) Conduct public campaigns through mass media and social media to inform consumers about a healthy diet high in fruits and vegetables and low saturated fat, sugar and salt; (iii) Implement national salt reduction campaigns in mass media, schools and institutions; (iv) Support consumer protection groups in Bangladesh to advocate and discourage marketing of foods and non-alcoholic beverages to children; (v) Increase collaboration between salt/sodium reduction programmes and salt iodization programmes for increased public health gains and higher programme efficiency; (vi) Promote nutritional labeling, according to but not limited to international standards, in particular the Codex Alimentarius, for all pre-packaged foods including those for which nutrition or health claims are made; (vii) High tax impose in energy drinks/beverage; (viii) Conduct counter advertisement; and ban advertising, promotion and sponsorship of unhealthy diet.

Major Activities:

Multisectoral co-ordination (non-health interventions, stewardship and regulatory).

(i) Network with Codex committees on inclusion of trans fat, saturated fat, salt and sugar, (ii) Educate mobile courts on food labeling and contents on salt, trans fat, saturated fat, and sugar, (iii) Regulate private industries to voluntarily reduce salt, trans fat, saturated fat, etc in packaged food products. (iv) Conduct review of fast food, sugary drinks, beverages, soft drinks marketing and promotion and make strategic recommendations to take counter measures, (v) Mass media promotion of consumption of fruits and vegetables, (vi) Salt reduction mass media campaigns.

- **Promote Physical Activity:**

Actions:

(i) Adopt and advocate the national guideline on physical activity for health; (ii) Develop multisectoral policy measures to promote physical activity through active transport, recreation, leisure and sports; (iii) Advocate town and urban planners and increase number of public spaces supporting physical activity, urban housing complexes that include safe walking and cycling spaces; (iv) Advocate for construction of built and natural environments supporting physical activity in schools, universities, work places, and health facilities. (v) Carry out mass media campaigns and social marketing to raise awareness on the benefits of physical activity throughout the life cycle, (vi) Make the existing footpaths free from vendors. (vii) Make provision of separate bicycle ways, free space like parks, lakes, ponds inspiring people to walk more to avoid motor vehicle

Major Activities:

Multisectoral co-ordination (non-health interventions and stewardship).

(i) Develop national physical activity recommendation. (ii) Disseminate 1000 PSA per year on TV, radio and social media on physical activity recommendations. (iii) Establish addendum on information on physical activity and healthy lifestyle promotion in school curricula. (iv) Develop a healthy lifestyle advocacy toolkit for community health educators.

- **Promote healthy behaviors in key settings**

Actions:

(i) Enable healthy settings programs in schools and work places for health promotion activities; (ii) Establish Health Promoting Schools with guidelines for implementation and mechanisms for monitoring and evaluation; (iii) Establish Healthy City Projects with guidelines for implementation and mechanisms for monitoring and evaluation; (iv) Conduct advocacy and training workshops among teachers to promote healthy behaviors in schools and work places; (v) Lobby for discouraging processed food high in saturated fat, sugar and salt from schools premises and work place catering facilities.

Major Activities:

Multisectoral co-ordination (non-health interventions, stewardship and regulatory).

(i) Conduct needs assessments for urban healthy lifestyle promotion; (ii) Define Healthy City Program Intervention Packages; (iii) Institute an Inter-sectoral Committee to Promote Healthy City; (iv) Implement Healthy City Program in Two Dhaka City Corporations, Chittagong and one another major city; (v) Conduct an annual inter-city meeting on Healthy Cities; (vi) National workshop of mayors,

urban planners, and urban chief health officers; (vii) Review and Develop Health Promoting Package interventions; (viii) Implement Health Promoting Schools Programs in 100 schools.

- **Reduce household air pollution**

Actions:

(i) Strengthen advocacy in support of transitional to cleaner technologies and fuels (LPG, bio-gas, solar cookers, electricity, and other low fume fuels); (ii) Promote private producers to manufacture improved stoves through providing bank loans and stove designs; (iii) Create mass awareness through popular print and electronic media about the health impact of indoor air pollution; (iv) Develop programmes aimed at encouraging the use of improved stoves, good cooking practices, reducing exposure to fumes, and improving ventilation in households; (v) Create awareness and develop appropriate strategies to reduced exposure to second-hand tobacco smoke in households.

Major Activities:

Multisectoral co-ordination (non-health interventions and stewardship).

(i)Promote use of clear technologies and reduction of biomass fuels for cooking and heating through projects supporting improved cook stoves, and good cooking practices. (ii) Create awareness and develop appropriate strategies to reduce exposure to second-hand tobacco smoke in households. (iii) Promote private producers to manufacture improved stoves through providing bank loans and stove designs. (iv) Create mass awareness through popular print and electronic media about the health impact of indoor air pollution. (xxi) Activities to improve the quality of health services related to prevention and treatment of NCDs in some targeted districts through strengthened district health administration, service delivery capacities and referral system including key activities above and practicing 5S-CQ1-TQM at facilities through JICA TCA project.

Component B: Mental health and substance abuse

Mental health strategy is yet to be developed. Widespread social stigma, limited human resource capacity and lack of formal initiative to address mental health problems are hindrance. Identification of the signs of the most common priority mental health conditions (autism and neurodevelopmental disorders, epilepsy, and common mental health disorders including depression, psychosis, anxiety and substance abuse) and their referral to UHC and DH is essential for management. Community and union-level facilities will also participate in the support to the rehabilitation of mental health patients, including the fight against stigma. The DH is the main facility for organizing these services, and will host the Community Mental Health Team, in charge of providing specialized support to UHC and others in the territory.

Activities:

1. Training of primary health care providers (CBHCP, HA), nurses, SACMO, Medical Officers on screening, identification and counseling of priority mental health conditions also includes providing ‘psychosocial first aid’. (NCDC will arrange it through NIMH, MCH psychiatry department).

2. Screening & counseling: identification and support to mental health cases, including fighting stigma and others at different levels of primary health care at rural and urban areas, UHC and District Hospital. (modalities to be developed)
3. Identification of signs of mental health conditions and referral from community clinic and UH&FWC/UHC and urban PHC to UHC and District Hospital.
4. Diagnosis and management of priority mental health conditions: (Autism &Neuro Developmental disorders, epilepsy, common mental disorders: psychosis (schizophrenia), depression, bipolar mood disorder, anxiety, substance abuse) at UHC and District Hospital.
5. Inpatient care for acute, severe cases at District Hospital and Medical College Hospital/NIMH/Pabna Mental Hospital (strengthening PMH).
6. Formation of Mental Health Team (MHT) (Consisting of trained physician/psychiatrist, psychologist, trained nurse, counsellor): one for each District Hospital and (one mobile team to visit UHC periodically to be agreed).
7. To establish and strengthening of 'Shishu Bikash Kendra' (SBK) and services for autism and neuro developmental disorders at all medical college hospitals and DH (Cross cutting- HSM) (post creation as well DGHS). Provision of services at UHC and a referral linkage with SBK DH will be established with a mechanism of prior appointment. Provision of life time support for the disabled at different stages of life will be a stewardship role of MOHFW- with health and non-health sectors.
8. Public awareness program on priority mental health conditions: preparation, distribution and use of IEC materials (print and electronic version, flip chart, bill board, leaflet).
9. Support to rehabilitation of mental health patients.
10. Development of Mental Health Strategy and implementation of the policy on Integration of Mental Health into Primary Health Care.
11. Supplying psychotropic drugs (haloperidol, risperidone, amitriptyline, fluoxetine, procyclidine) and antiepileptic drug (carbamazepine, barbiturate) in the primary health care and district hospital.
12. Providing mental health care and psychosocial support for disaster-affected population.
13. Prevention of substance abuse and suicide in the community, to develop helpline for suicide prevention (cross cutting issue).
14. Conducting national mental health survey.

Component C: Injury including poisoning and snakebite

WHO estimates, approximately 70,000 yearly deaths in Bangladesh due to injury (burn, drowning, acid and accidents at work), estimated 18,000 yearly death due to road traffic injury. Injury is also the leading cause of disability. Poisoning is a leading cause of morbidity and mortality across the country with an approximate annual admission of 64,000 cases, (2% of all admission) injury and poisoning responsible for 9% of all hospitalized death. Snakebite is a rural health problem among the poor farming community causing more than 700,000 episodes and more than 6000 deaths in a year.

Prevention and emergency management of various injuries will be addressed in this component. These include: road traffic injury, drowning, prevention and treatment of poisoning, burns, prevention

and treatment of snakebite, occupational injury, intentional injuries, and violence against women (GBV).

Activities on Road Traffic Injury:

1. Education and publicity-Improved knowledge and behaviour of road users, and raise awareness about traffic rules and safety. Multisectoral co-ordination (non-health interventions and stewardship)
2. Education of pedestrian regarding use of road, foot path and over bridge and signals through school, community safety program and media. Multisectoral co-ordination (non-health interventions, and stewardship).
3. Driver recruitment, training and testing – Ensuring minimum standards for drivers such as ensuring eligibility according to age, physical fitness and provide adequate training on safe driving practices. Multisectoral co-ordination (non-health interventions, stewardship and regulatory).
4. Training on pre-hospital care by the first responder and comprehensive training on trauma case management to the health care providers. Cross cutting issue: Linked to Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM).
5. Engineering and environmental approach multisectoral co-ordination (non-health interventions, stewardship and regulatory).
6. Legislation and standards multisectoral co-ordination (non-health interventions, stewardship and regulatory).
7. Vehicle design and safety equipment multisectoral co-ordination (non-health interventions, stewardship and regulatory).
8. Emergency medical care Cross cutting issue**:** Linked to Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM). (i) Ensure emergency assistance for rescue and transportation of the crash victims within golden hour. (ii) Establish emergency medical service system – Pre-hospital care and hospital care. (iii) Ensure treatment of the road crash victims in public and private hospitals.
9. Collaboration and coordination multisectoral co-ordination (non-health interventions and stewardship). (i) Effective co-ordination and collaboration of road safety council which is responsible for planning, implementation and monitoring of road safety activities, formulating road safety policy, facilitating funding, dissemination of information, organizing road safety education and publicity and training. (ii) Collaboration between relevant sectors/departments. /agencies for injury information and reporting and also in providing emergency medical services. (iii)Effective collaboration with vehicle owner's association and worker's association.

Activities for prevention of drowning:

i. Education and skill development:

1. Awareness building and education in School/Madrasha, families and communities and river transport drivers on primary prevention, rescue and resuscitation. Multisectoral co-ordination (health and non-health interventions, and stewardship).

2. Supervision of children at home and community through developing a community based supervision system. Multisectoral co-ordination (health and non-health interventions, and stewardship).
3. Swimming learning including creating facilities for swimming. Multisectoral co-ordination (health and non-health interventions, and stewardship).
4. Strengthening hospital facilities by providing training of health care providers. Cross cutting issue: Linked to Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM).
5. Strengthening mass awareness through different media. Cross cutting issue: Linked to BCC.

ii. **Legislation and standards multisectoral co-ordination** (non-health interventions, stewardship and regulatory).

iii. **Environmental and engineering multisectoral co-ordination** (non-health interventions and stewardship).

Activities for prevention of burns:

a) **Education and skill development** multisectoral co-ordination (health and non-health interventions and stewardship).

   i. Home safety specially during cooking and work place safety for fire thorough awareness creation.

   ii. Social movement and steps to stop acid burn.

   iii. Educate and train parents, care givers, students and community on primary prevention and first aid for burns.

b) **Environmental and engineering** multisectoral co-ordination (non-health interventions and stewardship).

c) **Legislation and standards** multisectoral co-ordination (non-health interventions, stewardship and regulatory).

d) **Emergency Medical Care** Cross cutting issue: Linked to Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM).

   a. Establishment of "One Stop Crisis Centre" (HSM).

   b. Strengthen health system for burn case management including human resources (ESD, HSM).

   c. Establishment of burn unit in each Medical College and facilities for burn patients at District Hospital and a provision for scale up (HSM).

Activities for prevention and treatment of poisoning:

Education and skill development multisectoral co-ordination (health and non-health interventions and stewardship)

1. Prevention of poisoning related to agrochemicals (e.g., pesticides: herbicides, insecticides, rodenticides):

   a. Legal issues of import, distribution, use;

b. Community engagement including training farmers and sparymen on the appropriate use of such products (multisectoral coordination with agrochemical sector). Educate family members and school students on risk of poisonous substances. Careful storage and proper labeling of poisonous substances at home.

2. Preventing suicides by appropriate counseling of victims of self-harm (most cases of intentional self-harm involve pesticides or drugs) (cross-cutting issue with Mental Health).
3. Preventing poisoning of commuters (i.e., drug-facilitated crimes mostly involving sedatives) (cross-cutting issue with multisectoral cooperation: law enforcement agencies and health sector).
4. Environmental modificationmultisectoral co-ordination (health and non-health interventions and stewardship). (1) Keep out of reach of children and vulnerable groups through building protective shelves.
5. Legislation and standardsmultisectoral co-ordination (non-health interventions, stewardship and regulatory). (i)Safe packaging of insecticide, pesticide and poisonous substances. (ii)Decrease access to poisonous substances through restriction on selling and storage of deadly chemicals.
6. Treatment and emergency Medical Care:
   a) Creation of community awareness for prevention, first aid and quick referral of cases of poisoning to UHC.
   b) Setting up (I) four interlinked poison information centres (PIC), one each at Dhaka, Chittagong, Rajshahi, Sylhet medical college hospitals, to improve case management, surveillance and prevention; (II) one central analytical toxicology laboratory at PIC Dhaka to provide services in clinical toxicology.
   c) Improving the management of poisoning by establishing emergency medical care: training human resources with provision of drugs and logistics (cross-cutting issue with ESD, HSM) Quality Care. Cross cutting issue: Linked to Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM).
   d) Establish referral system. Cross cutting issue: Linked to Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM).

Activities for prevention and treatment of snakebite including animal injury:

1. Education and skill development (Cross cutting issue): Linked to Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM) and communicable diseases control (CDC) and non-health sector (Example PKSF). (i) Awareness creation regarding the consequences of animal and snakebite and mal practices of traditional healers. (ii)Training on appropriate first aid following animal and snakebite.
2. Environmental modification multisectoral co-ordination (non-health interventions and stewardship). (1) Remove bushes near habitation.
3. Legislation and standards Cross cutting issue: Linked to non-health sector and Communicable Diseases Control (CDC).
4. Emergency Medical CareCross cutting issue: Linked to Community based health care (CBHC), Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM) and Communicable Diseases Control (CDC). (i) Development of Bangladesh snakebite policy/strategy based on WHO SEARO Guidelines 2016 and updating the National Guideline for Management of Snake bites. (ii) Provision of quality treatment snakebite:

5. Reduction of deaths by 25% by 2021 through improved management of snake bite: (a) (1) Provision of adequate polyvalent antivenom (purchased from Indian source) at UHC, DH, medical college hospital and BITID. (2) Provision of improved antivenom (AV): collection, processing and preservation of snake venom from the major venomous snake species that are medically relevant in Bangladesh, for the production of appropriate antivenom (multisectoral coordination with Ministry of Forestry, Department of Zoology of Chittagong University, Toxicology Society of Bangladesh, DGHS, and manufacturers of AV abroad). (b) (1) Improving community engagement: BCC for prevention, appropriate first aid, quick referral to UHC linked with (2) provision of appropriate treatment of snake bite at UHC, DH and MCH (including AV and supportive treatment) (cross-cutting issue with ESD, HSM). (c) Training human resources for improving the management of snake bite at UHC, DH and MCH (cross-cutting issue with ESD, HSM). (d) Development of alternative occupation opportunities for snake handlers and traditional healers ('ohzhas') (cross-cutting issue, multisectoral coordination with non-health, MOLG&RD).

Activities for prevention of occupational injury:

1. Education and skill development multisectoral co-ordination (non-health interventions and stewardship).
2. Environmental and engineering multisectoral co-ordination (non-health interventions, stewardship and regulatory).
3. Legislation and standardsmultisectoral co-ordination (non-health interventions, stewardship and regulatory).

Activities for prevention of intentional injuries:

a) **Education and skill development** Multisectoral co-ordination (health and non-health interventions and stewardship)
   i. Mass awareness for behavioral and social change through developing communication strategy and life skill based education.
   ii. Promote psychological well- being, Resilience and family connectivity.
   iii. Increase public awareness about social problem related to dowry and violence against women through family education, counseling and school education, adolescence education and peer support.
   iv. Enhance social support network for high risk group.

b) **Environmental modification** multisectoral co-ordination (non-health interventions and stewardship).

c) **Legislation and standards** multisectoral co-ordination (non-health interventions, stewardship and regulatory).

Activities for prevention and treatment- violence against women (GBV)

Multi-sectoral Response Services of Gender-Based Violence (SGBV) through the establishing of one-stop centers (OCC), which provide integrated, multi-disciplinary services in a single physical location primarily by MoWCA. Key areas covered are Clinical, Legal and Psychosocial Support.

Component D: Climate Change

Effects of climate change on health: "Climate change is harming human health, and the magnitude of the harm is increasing". Bangladesh is a hot humid country in the tropics. In the cities, there is industrial and vehicle transmission resulting in poor air quality due to smog and expected to increase morbidity and mortality from COPD and other respiratory illness. Storms and flooding are frequent

occurrence. There will be acute effects of storms and flooding- injury and death; indirect effects of compromised sanitation lead to increased incidence of diarrhoeal diseases. Warmer humid conditions will accelerate vector breeding contributing to increased vector borne diseases.

Activities:

1. Multisectoral National Policies and strategy in Bangladesh about greenhouse gas emissions, energy, transport, agriculture, and land use to address the driving forces and pressures contributing to climate change to be developed/updated. "Climate change adaptation (preparedness) and mitigation (prevention) can occur through policies and interventions adapted from treaty under the United Nations Framework Convention on Climate Change".
2. Increase community awareness of health consequences of climate change.
3. Mass awareness is to be developed for increased plantation, avoiding carbon emitting vehicles, adopting carbon free transportation like bicycle, walking & to go for climate friendly housing & renewable energy.
4. Capacity assessment- Descriptions of the status of infrastructure and clinical capacity to respond to health impacts of climate sensitive conditions are needed.
5. Resilience of existing health systems is required to be increased against climate change. In view of that hospitals & health centers should be reinforced to withstand powerful storms, heat waves and other extreme weather events. It also must be ensured that water and sanitation services must be continued to function under flood and drought conditions. Specific sites will require to address region specific climate issue- example, North Bengal draught, salinity- in southern coastal area
6. Climate-sensitive injury and disease surveillance. To identify direct impacts of extreme weather events on public health systematic reporting of acute morbidity and mortality (e.g., blunt force trauma and drowning), sub-acute infectious disease impacts, influenza-like illness, vector-borne illness, and diarrhea may be made. By using geographic information system (GIS) one can map population proximity to flooding risk and health system capacity, linking disparate sources such as census estimates, hospital bed data, and evaluation data from healthcare site visits.
    a. Increase capacity in health services on Climate Change and related disease surveillance skills and techniques.
    b. Training of health service providers at field level, on feasible screening/diagnostic methods of the targeted Diseases.
    c. Sensitization and orientation of health facility staff on targeted climate attributed vector borne, water borne and emerging diseases etc.
7. Systematic documentation of climate-sensitive health outcome (mentioned above) in certain cyclone and flood prone upazilla.

Component E: Occupational health

Major occupations in Bangladesh are farming (two thirds of the population are farmers- rice, tea, mango, potato, and onion crops), fishing community, garments workers, migrant workers, cleaners, livestock and poultry workers, forest workers, health care professionals. Workers in ship breaking industry are at increased risk of injury and death. These occupations have their own unique health related problems. Industrial workers have different health problems as well. Occupational safety board of Bangladesh (BUET) identified safety issues in different industries. In order to address the

health of the major occupations in relation to equity, poverty, and marginalized population the health hazards of major occupations need to be addressed. Few observations suggest important health hazards of common occupations are- injury, pesticide related harms (self-poisoning and environmental hazards), animal injury (dog bite and snakebite), NCD at early age, drowning at sea and river, back pain and sciatica, various infections (hepatitis, B, C; anthrax, typhoid, leptospirosis, malaria, melliodosis, typhus, TB, HIV infection). National health policy provided guidance for improvement of health of the farming, industry, livestock and poultry workers

Activities:

1. Situational analysis of health hazards of major occupations- farming, fishing, garments, migrant workers overseas and internal (slum dwellers migrating from rural areas), industry and ship breaking industry.
2. Based on activity one regulations for safety measures to be prepared and approved. (multisectoral health and non-health, stewardship and regulatory).
3. Strategy and preventive measures (occupational safety) and management of health hazards of major occupations will be prepared and further activities will be under taken. (multisectoral health and non-health, stewardship and regulatory).
4. Operation research and survey- health issues of farming community, rural migrants at slums, garments workers, migrant workers, and industry workers.
5. Industry- workers will require support for different occupational health problems.
6. General public and others may require advice related to proper application of principle of ergonomics- posture, back health, neck health, weight lifting, bed etc. A cross cutting issue with carpenters and industry (standards to be developed as basic as chair, bench, table, school desk, computer desk etc)

Component F: Oral health

Poor oral health is related to diseases like oral cancer, NCDs (linked with periodontal infections), infections. Diabetic patients are prone to develop oral infections. Basic education on proper oral health may prevent or delay such conditions.

Activities:

1. Promotion of oral hygiene by incorporating the topic in school education, school health, community education. BCC for avoiding unhealthy habits of tobacco consumption/chewing of different forms.
2. Managing common dental diseases including tooth extraction.
3. Development of National Oral health policy incorporating oral health education, preventive programs, and curative service programms.

Component G: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

a) **Substance abuse, including narcotic drug abuse:**

Abuse of narcotic drugs and substance abuse is an emerging social problem particularly among the youth. Detail about the situation is yet to be determined.

Activities:

1. Development of booklet manual on substance abuse to be used by field workers.
2. Development of IEC material, posters, leaflets for public awareness against illicit use of drugs and also for 'Yaba' and 'Phensedyl' abuse.
3. Mass media campaign against 'Yaba' abuse in young people.
4. Organizing awareness seminars/meetings against substance abuse for 'Yaba', Phensydil etc. (in coordination with other stakeholders Department of Narcotics).
5. Establishing health education program at urban/rural level College/ schools against 'Yaba', 'Phensedyl' and for other addictive substance abuse. Already incorporated in the school curriculum.
6. NGO collaboration activities like workshop/ seminars/ symposium on Substance abuse subject.
7. Capacity for diagnosis, treatment and rehabilitationof 'Yaba', 'Phensedyl' and other substance abuse increased. (In co-ordination with Department of Narcotics).

b) **Alcohol and related problems:**

According to WHO alcohol consumption is one of the four modifiable risk factors for non-communicable diseases. Estimated prevalence of alcohol consumers in general population of Bangladesh is low (1.9%) but binge drinking is on the rise. In some rural areas, as high as 93.9% consumers reported positive drinking habit among their senior family members (for example, in tribal population) Cases of alcohol intoxication were reported from all over the country. In Bangladesh, the majority of methanol poisonings occur after consumption of methanol-contaminated alcoholic drinks. Higher prevalence of alcohol use among the university students, truck drivers, sex workers, substance abusers, homeless children, indigenous people, and in families with positive history for alcohol drinking implies the need to formulate cost effective prevention programs for specific society groups and clusters.

Activities:

Situation analysis related to prevalence with special note to tribal areas, and adulteration of alcohol (methanol poisoning).

1. Updating the legislation related to alcohol production (including local produce), sale, consumption and related health hazards. (multisectoral coordination, health and non - health, stewardship and regulatory).
2. Health education/BCC: Targeted intervention among high-risk population to encourage consumption of alcohol within a safe limit or to quit drinking.
3. Provision of emergency and supportive care required to treat acute alcohol related toxicological crisis (Acute alcohol, methanol and ethylene glycol poisoning) at all health facilities. (Cross cutting with ESD and HSM).
4. Diagnostic tools to determine blood alcohol level will be made available. The logistics for diagnosis and treatment of acute alcohol related problems will be made available in health care setting. (Cross cutting ESD and HSM).
5. Training of the health care professionals and communities to manage alcohol related problems.

c) Energy Drinks

Activities:

Awareness about potential harm of energy drinks and restriction of energy drinks (cross cutting issue non-health sector, Dept. of Narcotics, food authority)

Component H: Environmental Health hazards (Water, Arsenosis, Air, Soil)

a) Arsenicosis:

Groundwater contamination with arsenic resulted in chronic arsenicosis in population in a large area in Bangladesh. Health problems are- skin manifestations, palmoplanter keratosis, peripheral nerve disease, vascular involvement and skin and internal malignancies. Collaboration between DGHS and DHPE was ongoing to address the problem under a National Policy for Arsenic mitigation (2004), with key interventions for providing safe water and providing care to the identified patients.

Activities:

1. Updating of National Arsenic Mitigation policy and strategy (co-ordination with DOPHE).
2. Strengthening of mass awareness programs on Arsenic free safe drinking water (Health Education Bureau, CHCP/HA, ESD).
3. Testing tubewell water at Health facilities for prevention of arsenicosis.
4. Improve patient screening (house to house searching) programs.
5. Identification, diagnosis and management of arsenicosis patient at UHC, DH, MCH. Selection of suitable new treatment regimen for arsenicosis. (Recommended by experts and from evidence). Present treatment: some commonly used anti-oxidants include beta carotene, vitamin E and vitamin C. Presently, 5-10% of salicylic acid and 10-20% of urea-based ointment for the treatment of keratotic lesions is the most common prevailing practice.
6. Refresher's training- capacity building of human resources from different level and facilities for effective case management and referral.
7. Capacity building for scientific diagnosis of arsenicosis at Govt. Institute (NIPSOM, Dhaka/Toxicology Analytical Lab, HSM).
8. Strategic partnership with local bodies and community based organization regarding the mitigation of arsenicosis.
9. Further collaboration between DGHS and DPHE at field level to strengthen water screening at the community level.
10. Develop a national computerized database of arsenicosis patients. Long term follow up of patients.
11. Review of Bangladesh standard for safe arsenic level in drinking water (Dept. of Environment-BUET, BSTI, Public health engineers, chemists and arsenic experts).
12. Conducting surveys, research on arsenicosis.

b) Lead Contamination:

Lead is known to cause neurocognitive impairment.

Prevention of lead contamination of food (turmeric, rice), soil is essential.

Activities:

1. Prevention of lead contamination of food and cosmetic by strict adherence of food regulations and reduce the use of lead containing pesticide. (Stewardship with Food authority, and Pesticide authority).
2. Identification of lead in food by testing rice, turmeric; in cosmetic 'kajal, and lipstick (capacity to be developed or by collaborative research).

c) Air pollution:

Air quality in major cities and in rural areas in Bangladesh is poor. Poor air quality is contributor to the development of NCD (COPD for example) and childhood acute reparatory infection. Considering the importance of air pollution in the economy and health DoE, Bangladesh has developed 'Air Pollution Reduction Strategy for Bangladesh (2012)'.

Activities:

1. Diagnosis and management of COPD and ARI (NCD collaboration with ESD, HSM, IMCI).
2. Implementation of the strategy by DoE (stewardship role of MOH, NCD DGHS).

d) Noise pollution:

Activities:

1. Creation of community awareness about health hazards of noise pollution.
2. Identification of noise level at strategically important sites in big cities (DoE).
3. Enforcement of law for prevention of noise pollution (DoE).

e) Soil contamination:

Soil is an important source of bacteria, bukhdorhelia causing melliodoiosis, a serious bacterial disease affecting rural farmers having diabetes.

Activities:

Situation analysis of soil born disease by studies and Capacity to diagnose B. psudomelli (linked with CDC and HMS).

f) Water, sanitation and other environmental health issues:

Ensuring safe water, sanitation and hygiene (Goal 6, SDG) is a prerequisite for sustainable prevention of water borne diseases. In addition, increase salinity in water also contributes in high incidence of hypertension in the community (a climate change related issue as well). MOHFW may perform stewardship role in implementation of the relevant policies by other relevant ministries.

Component J: Ear care

a) **Hearing impairment:** Disabling hearing loss is prevalent in 9.6 per cent of Bangladeshi people. Hearing loss is more prevalent in socio-economically deprived and in those older than 60 years. Impacted ear wax and chronic supportive otitis media are the most common preventable causes of hearing loss.

Activities: Services at community clinic, union health centre, upazilla health complex

a) Early identification, diagnosis, and treatment of common ear problems. Diagnosis and primary management of common ear diseases: i. Impacted wax, ii. Foreign bodies of ear, iii. Otitis externa, iv. Acute Otitis Media (AOM), v. Chronic Otitis Media (COM) and its complications, vi. Injuries to ears (CC, UHFWC, UHC, DH).

b) Behavior change communication:Provision of Health Education and Promotion of ear care. (CC, UHFWC, UHC, DH).

   1. Development of IEC/educational materials for prevention of deafness and hearing impairment.
   2. Providing support with ear health education within the community by mobilizing trained volunteers, school teachers and Imams.
   3. Development of primary ear care awareness using appropriate media;
   4. Special campaign for the development of awareness in the community on prevention of deafness and hearing impairment.
   5. Special campaign in the educational institution for the development of awareness among the student and teacher on the prevention of deafness and hearing impairment.
   6. Developing a primary ear care booklet & other educational material to mobilize community resources to improve ear health;

c) Diagnosis and causes of sensorineural hearing loss. (DH)

d) Assessment of hearing levels (whispered & conversational voice tests, tuning fork tests and the use of screening audiometer. (DH)

e) Awareness about ototoxic drugs and sources of noise-induced hearing loss.

Component K: Disability

Support for disabled (differently abled): (Cross cutting ESD, HSM)

Activities of:

1. Disabled friendly health facility- priority in reception and service, ease for movement, toilet (ESD, HSM).
2. Human approach to disabled patient by health care professionals (skill development of HC professionals).

Component L: Elderly people/ senior citizens: (Cross cutting ESD, HSM)

Activities:

1. Priority
2. Support and assistance- stick, wheel chair
3. Approach with respect & dignity.

Component M: Physical therapy/Physiotherapy: (Cross cutting CBHC, HSM, ME&HMD)

Activities:

May or may not be associated with disability.

Various exercise (neck, back pain, Osteoarthritis, paralysis, following stroke), devices, Human resources- PSE.

Component N: Prevention of Thalassaemia: Cross cutting issue with HSM

B- Thalassaemia (Hb E disease) is the most common genetic disorder in Bangladesh with a gene prevalence rate of around 6%. This translates that 6 out of every 100 Bangladesh carry this mutant gene. With a population of about 160 million, around 10 million people are healthy carriers of this gene. Thalassaemia is an autosomal recessive disease, which means that if two carriers get married to each other then they will have a 1 in 4 (25%) chance of having an offspring with B-Thalassaemia Major in every pregnancy. Over 5000 affected children are born. These children require regular monthly blood transfusions and chelation therapy to remove the excess iron from their bodies in order to just stay alive. A large amount of money is required for each child per annum. Currently, majority of the patients in Bangladesh do not get adequate treatment, especially the transfusion of safe blood has been a big problem and the majority of the Thalassaemics are positive for infections such as Hepatitis B, C and HIV.

Since there is no easily available cure for this disorder, the only hope lies in adopting a preventive program on the line pursued by countries like Italy, Cyprus and Iran, which has resulted in either complete control or significant reduction in the births of new Thalassaemia Major children in these countries. Considering the gravity of the issue, the Government of Bangladesh should take the lead and initiative Bangladesh Thalassaemia Prevention Programme (BTPP), which will be unique and can be compared with any other preventive program of the world.

Activities:

The BTPP will be working on the following: (i) Awareness about Thalassaemia. (ii) Screening of carriers (extended family screening). (iii) Pre-marital screening for the general public. (iv) Genetic Counseling (v) Pre-natal Diagnosis

Component O: Emergency preparedness and Response (EPR), Post Disaster Health Management

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.

Activities:

1. Strengthening capacity of hospital services (UHC, DH, MCH) on emergency preparedness and response.

2. Establishing System for early warning sign for early preparation for health service delivery in disaster prone area (coordination with non-health sector)
3. Training of community volunteers on disaster preparedness and response and establish network of volunteers.
4. Establishment of buffer stock of drugs and logistics for emergency preparedness
5. Electronic database, Website and its maintenance at the DGHS (Logistics, human resource & IT and Network).
6. Initiate program on 'Hospital Preparedness in Emergencies' HOPE for hospital personnel
7. Development/update of promotion material on Health Impact of Community Disaster Preparedness and Response.
8. Development and publication of posters, pamphlets, booklets and books to spread the message of Emergency Preparedness and Response.
9. Training of community based Workers on Mass Casualty Management.
10. Increase capacity in health services on Post Disaster Health Management skills and techniques
11. Coordination of Emergency Medical Service (EMS) and School Health Promotion to reduce health hazards during disasters and emergencies.
12. Development of documentary films/TV spots/Radio spots on different Disaster health consequences etc.
13. Strengthening collaboration between Directorate General of Health Services and different stakeholders to increase coverage of Emergency Preparedness and Response at the community level.
14. Capacity building of human resources and facilities for effective Post Disaster Health management and referral.
15. Strategic partnership with local bodies and community based organizations regarding the activities of Response and Recovery during Disaster.
16. Dissemination of surveillance data through Periodic publication of newsletters, reports.
17. Provide Support to different associations, professional bodies and civil society organizations for comprehensive disaster health management.
18. Countrywide Awareness building campaign through IEC using different methods & media
19. Awareness workshop & Coordination/Sensitization meetings for health service providers, community leaders, Teachers, Social workers & other stake holders on Emergency Preparedness and Response (EPR) throughout the country.
20. Gender related issues (including gender based violence): To tackle (1) injury, (2) downing and (3) snake bite, (4) MNCAH issues, (5) CDCs, (6) non-communicable diseases (including mental health) of women NCA during disaster.
21. Emergency Medical Services (EMS) cross cutting issue (with CBHC and HSM**):** Training of Health Service Providers (doctors, nurses and field workers) on Emergency Medical Services. Review and Updating of Training/Workshop Modules.Strengthening emergency services at the district and upazila level to bring quality health care closer to the door steps of the people.

Component P: Palliative Care

The WHO in 2002 stated that 'Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. The WHO recommends palliative care should be provided from the time a disease is diagnosed and continued even after the death of the patient, in the form of bereavement care for family members

In 2014, the World Health Assembly (WHA) passed a resolution calling on all member states to "integrate palliative care services in the continuum of care, across all levels, with emphasis on primary care, community and home-based care, and universal coverage schemes." Palliative care is also recognized as an essential health service within the World Health Organization (WHO) definition of Universal Health Coverage (UHC).

In Bangladesh, palliative care services are very limited. There are only 6 comprehensive palliative care programs are available in the country and all are in Dhaka. There is very little awareness about the field of palliative care among physicians and other health care providers. Under the 4th HPNSP initiative will be taken to improve the quality of life of patients with limited diseases in Bangladesh through the development of a palliative care awareness and capacity building program, targeting medical professionals.

Monitoring, Research and Evaluation: Evidence generation for control and prevention of NCDs:

1. Development of monitoring and evaluation framework, and monitoring checklist.
2. Effect of community interventions (to be made in next sector program) on risk factors and NCD-prospective cohort- rural and urban areas
3. Feasibility of using IT in improving management of acute coronary syndrome and stroke.
4. Prevalence of diabetes mellitus in Bangladesh
5. KAP of the migrants about occupational health/NCDs before and after residing abroad (interventions may be made before going for job first time)
6. Situation of NCDs among migrants
7. Situation analysis: common occupational health problems among the major occupational groups of Bangladesh; alcohol related health problems; other substance abuse issues; travel-related poisoning ('commuters poisoning')
8. Demonstration of links between community engagement and strengthened UHC, and improved outcomes and reduced cost of snake bite treatment at DH/MCH.
9. Evaluation of the Operational Plan.
10. Setting up hospital cancer registries in 19 medical colleges.
11. Pilot population based cancer registry covering both urban and rural area.
12. Conduct national school health survey.
13. Conduct tobacco law compliance assessment.

6. Cross-Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

Creating a health literate society is a core necessity for NCD control in the long run. Infection related NCDs such as of cancer of cervix uterus, liver, stomach. Diabetes predisposes to or aggravates certain communicable diseases such as tuberculosis, HIV/AIDS, etc. A large pool of mothers suffers from hypertension and diabetes at their pre-natal and post-natal stage. The pathogenesis of heart disease and stroke starts at early childhood. Therefore, a life course approach to NCD prevention with a continuum of care is warranted. WHO published NCD Country Profile 2014: that NCDs account for 59% of total death in Bangladesh (17% cardiovascular diseases, 11% chronic respiratory diseases, 10% cancers, 9% injuries, 3% diabetes and 10% other NCDs). NCDs are largely preventable by lifestyle modification and importantly treatable.The communicable diseases like Malaria, Kalazar, Dirrahoea, Typhoid etc; are the leading causes of mortality and morbidity. Women, children and poor are most vulnerable of these diseases. Under this OP, various activities will be implemented for prevention and control of these diseases through increasing accessibility, efficiency and quality of services. It will help to improve overall health status of people specially the women, children and

poor, which will in turn contribute to increase productivity, reduce poverty and gender disparity and would create employment opportunities. To implement the propose activities of this OP, inter-OPs, inter- agencies and multi-sectoral collaboration/ coordination will be strengthen. Besides emphasize will be given for, engagement of local government institutions and community to support implementation and monitoring of the program.

i. Linked with Strategic Thematic Group -3, MNCA&H. (i.i) NCD management linked with MNACH- diagnosis and treatment of hypertension and diabetes in pregnancy. (i.ii) Screening of cancer cervix and breast- linked with MNACH. (i.iii) CD and NCD link- (a) TB/HIV linked with diabetes mellitus. (b) Diabetes linked with melliodosis. (c) Cancer linked with acquiring infections.

ii. Other cross cutting issues: Stroke, CAD, cancer, COPD treatment available at tertiary hospitals-medical college hospitals (MCH) MCH and specialized institutes: With CBHC, HSM, urban health, DGDA, Medical education on NCDs:

General activities required to coordinate all NCD activities:

1. Establishment of NCD directorate /designation of NCD Prevention Centre. Coordination mechanism facilitation. Possible site National Rheumatic Fever Prevention centre may be renamed as NCD Directorate with space and HRs absorbed (considering the drastically reduced number of cases of RF and increasing attention requires for addressing NCDs)

Policy and legislation formulation Engagement of "Whole of Government" and non-state actors

7. Proposed Manpower: Annexed in Volume II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators:

Sl.	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1.	Proportion of adults with high blood pressure Note: (Systolic blood pressure ≥140 and/or diastolic blood pressure ≥90 among persons aged 25 years.) GI 6. Prevalence of hypertension among adult population SDG* CORE	% NCD STEPS NCD-RF	17.9% (NCD STEPS 2010) BDHS, every 3 years/NCD-RF, every 2 years	17%	17%
2.	Autism diagnosis and management at DHs	Number of DHs (Admin record)	0	25	64
3	Number of Upazilas covered by awareness campaigns on road traffic injuries and childhood, drowning)	Number of Upazilas (NCD InfoBase/ Admin		200	490

Sl.	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
		record)			
4.	Development and implementation of NCD management model (diabetes and hypertension) at community clinics with referrals to Upazila Health Complexes	Number of CCs and UHcs (NCD InfoBase/ Admin record)	None	20 UHC 200 CC	200 UHC 2000 CC
5.	Setting up hospital cancer registries in Medical Colleges	Number (Admin record)	0	10	19

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
72765.20	32462.07	6600.00	39062.07	111827.27	

10.2. Component and activity wise physical and financial target of OP: NCDC

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component (i): Cardiovascular Diseases, Diabetes, COPD, Cancer													
1	Screening of Major NCDs			24325.60	17973.60	5952.00	400.00	260.00	5350.00	5550.00	5000.00	4450.00	3715.60
2	Management of Major NCDS			27000.00	22200.00	4800.00	0.00	550.00	4950.00	6250.00	5950.00	4700.00	4600.00
3	Referral			380.00	250.00	130.00	0.00	30.00	70.00	70.00	70.00	70.00	70.00
4	NCD Surveillance (in coordination with MIS)			200.00	150.00	50.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
5	Multisectoral Coordination			15.00	15.00	0.00	0.00	1.00	3.00	3.00	3.00	3.00	2.00
6	Health Promotion & Risk Reduction			3076.67	1486.00	1390.67	200.00	60.00	400.00	700.00	766.67	650.00	500.00
7	Observance of different NCDs Day			505.00	303.00	202.00	0.00	65.00	95.00	115.00	70.00	70.00	90.00
8	Monitoring & Evalution			700.00	500.00	200.00	0.00	100.00	125.00	125.00	125.00	125.00	100.00
9	Technical assistance (JICA)			3360.00	0.00	0.00	3360.00	300.00	700.00	700.00	800.00	500.00	360.00
10	Awareness raising and Campaign			6000.00	4000.00	2000.00		500.00	1500.00	1000.00	1000.00	1000.00	1000.00
11	Multipurpose Volunteer			7897.00		7897.00	0.00	0.00	897.00	2000.00	2000.00	2000.00	1000.00
	Sub total			73459.27	46877.60	22621.67	3960.00	1886.00	14130.00	16553.00	15824.67	13608.00	11457.60

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Component (ii): Mental & Neurological Health, Autism & Neurodevelopmental Disorder and Alcohol													
1	Identification and referral system			785.00	471.00	314.00	0.00	30.00	185.00	235.00	185.00	50.00	100.00
2	Diagnosis and management of priority mental health conditions			2000.00	1200.00	800.00	0.00	100.00	400.00	400.00	400.00	400.00	300.00
3	Formation of Mental Health Team			460.00	276.00	184.00	0.00	20.00	100.00	125.00	105.00	105.00	5.00
5	Public Awareness Program			600.00	500.00	100.00	0.00	50.00	150.00	100.00	100.00	100.00	100.00
7	Supply of psychotropic and antiepileptic drugs			390.00	234.00	156.00	0.00	20.00	75.00	100.00	75.00	70.00	50.00
8	Post Disaster Mental Health and Psychosocial Support			600.00	500.00	100.00	0.00	50.00	150.00	100.00	100.00	100.00	100.00
9	Training of primary health care providers			185.00	111.00	74.00	0.00	15.00	20.00	50.00	25.00	25.00	50.00
10	Screening and counseling			215.00	129.00	86.00	0.00	20.00	40.00	40.00	40.00	45.00	30.00
11	Inpatient care for acute , severe cases			255.00	153.00	102.00	0.00	10.00	25.00	55.00	55.00	55.00	55.00
12	Formation of Mental Health Team			140.00	84.00	56.00	0.00	10.00	20.00	35.00	35.00	35.00	5.00
13	Support to rehabilitation of Mental Health Patients.			310.00	186.00	124.00	0.00	25.00	50.00	75.00	75.00	75.00	10.00
14	Development of Mental Health Strategy			100.00	60.00	40.00	0.00	15.00	20.00	35.00	15.00	15.00	0.00
16	Conducting National Mental Health			170.00	102.00	68.00	0.00	15.00	15.00	45.00	45.00	45.00	5.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	Survey												
17	Conducting Research on Autism and NDD			145.00	87.00	58.00	0.00	10.00	35.00	30.00	30.00	30.00	10.00
18	Generate awareness of NDDs among expecting mothers			210.00	126.00	84.00	0.00	25.00	50.00	40.00	40.00	40.00	15.00
19	Generate awareness about healthcare services for PwNDDs			265.00	159.00	106.00	0.00	15.00	50.00	60.00	60.00	60.00	20.00
20	Sensitize healthcare providers in order to promote social integration			300.00	200.00	100.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00
21	Prevent NDDs through proper healthcare of expecting mothers			300.00	200.00	100.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00
22	Create access to obstetric care			300.00	200.00	100.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00
23	Provide treatment of mental health of parents and siblings of PwNDDs			300.00	200.00	100.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00
24	Conduct nationwide screening of all children 0-5 years for NDDs			300.00	200.00	100.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00
25	Ensure proper diagnosis of PwNDDs			300.00	200.00	100.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
26	Ensure proper assessment of the degree of the disorder in each diagnosed PwNDD			350.00	200.00	150.00	0.00	35.00	70.00	70.00	70.00	70.00	35.00
27	Ensure ongoing health assessment of PwNDDs throughout their lives			350.00	200.00	150.00	0.00	35.00	70.00	70.00	70.00	70.00	35.00
28	Deliver evidence-based interventions to PwNDDs			350.00	200.00	150.00	0.00	35.00	70.00	70.00	70.00	70.00	35.00
29	Explore and promote the use biomedical interventions to mitigate the effects of NDDs and their associated health conditions			436.00	261.60	174.40	0.00	35.00	75.00	102.00	102.00	102.00	20.00
30	Provide support for the management of adolescent and young adult behavior			380.00	228.00	152.00	0.00	35.00	65.00	85.00	85.00	85.00	25.00
31	Provide training to parents of PwNDDs on early identification of NDDs in their children			400.00	280.00	120.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
32	Train parents and siblings of PwNDDs on first aid and other medical emergencies			400.00	280.00	120.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
33	Ensure the availability of emergency health services who are capable of caring for PwNDDs during medical emergencies			400.00	280.00	120.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
34	Ensure access to affordable healthcare for PwNDDs		360.00	216.00	144.00	0.00	15.00	75.00	85.00	85.00	85.00	15.00
35	Provide assistive technology to PwNDDs to enhance their lives and independence		285.00	171.00	114.00	0.00	10.00	55.00	65.00	65.00	65.00	25.00
36	Prevention of Substance abuse and suicide		345.00	207.00	138.00	0.00	30.00	180.00	90.00	20.00	20.00	5.00
Awareness building on common people on Alcohol												
1	Alcohol and related Problems		400.00	200.00	200.00	0.00	25.00	80.00	80.00	80.00	80.00	55.00
2	Situation Analysis on prevalence of Alcohol Drinking in tribal areas		600.00	400.00	200.00	0.00	50.00	120.00	120.00	120.00	120.00	70.00
3	Health education / BCC to targeted high –risk populations		600.00	400.00	200.00	0.00	50.00	120.00	120.00	120.00	120.00	70.00
4	Training for Health Care Professionals to manage alcohol related problems		400.00	200.00	200.00	0.00	25.00	80.00	80.00	80.00	80.00	55.00
	Sub total		14686.00	9301.60	5384.40	0.00	1110.00	3045.00	3162.00	2952.00	2817.00	1600.00
Component (iii): Injury Prevention including Road safety, Drowning, Violence against Women, Poisoning & Snakebite, Burn and EPR												
a.	Road Traffic Injury:											

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
1	Education and publicity-Improved knowledge and behavior of road users, and raise awareness about traffic rules and safety including on Education of pedestrian regarding use of road, foot path and over bridge and traffic signals		1000.00	800.00	200.00	0.00	100.00	200.00	200.00	200.00	200.00	100.00
2	Training on pre hospital care by the first responder and comprehensive training on trauma case management to the health care providers. Cross cutting issue: Linked to Essential Services Delivery (ESD), Secondary and Tertiary-level Hospital Management System (HSM).		700.00	500.00	200.00	0.00	100.00	120.00	120.00	120.00	120.00	120.00
b.	Emergency Medical care											
1	Collaboration between relevant sectors/departments./agencies for injury information and reporting and also in providing emergency medical services		100.00	100.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
c.	Prevention of Drowning:		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
1	Awareness building and education in School/Madrasha, families and communities and river transport drivers on primary prevention,knowledge & skill development of community peopleon rescue and resuscitation.Multisectoral co-ordination (health and non-health interventions, and stewardship).			700.00	600.00	100.00	0.00	40.00	140.00	140.00	140.00	140.00	100.00
2	Supervision of children at home and community through developing a community based supervision system(e.g. Anchol).Multisectoral co-ordination (health and non-health interventions, and stewardshipSwimming learning including creating facilities for swimming.Multisectoral co-ordination (health and non-health interventions, and stewardship))			100.00	60.00	40.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
3	Community mobilization to reduce environmental hazards and risks as per local context.			200.00	150.00	50.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
d.	Prevention of Burns			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Home safety specially during cooking and work place safety for fire thorough awareness creation			100.00	60.00	40.00	0.00	5.00	19.00	19.00	19.00	19.00	19.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
2	Educate and train parents, care givers, students and community on primary prevention and first aid for burns.		150.00	90.00	60.00	0.00	25.00	25.00	25.00	25.00	25.00	25.00
e.	Prevention and treatment of Poisoning		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Preventing suicides by appropriate counseling of victims of self-harm (most cases of intentional self-harm involve pesticides or drugs) (cross-cutting issue with Mental Health).		145.00	87.00	58.00	0.00	15.00	20.00	35.00	30.00	25.00	20.00
2	Creation of community awareness for prevention, first aid and quick referral of cases of poisoning to UHC.		150.00	90.00	60.00	0.00	10.00	25.00	30.00	35.00	30.00	20.00
f	Prevention and treatment of Snakebite includingAnimal Injury:		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Awareness creation regarding the consequences of animal and snakebite and mal practices of traditional healers		100.00	100.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
2	Training on appropriate first aid following animal and snakebite.		800.00	600.00	200.00	0.00	40.00	160.00	160.00	160.00	160.00	120.00
3	Provision of quality treatment snakebite		800.00	600.00	200.00	0.00	40.00	160.00	160.00	160.00	160.00	120.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
4	Improving community engagement: BCC for prevention, appropriate first aid, quick referral to UHC linked with (2) provision of appropriate treatment of snake bite at UHC, DH and MCH (including AV and supportive treatment) (cross-cutting issue with ESD, HSM			500.00	300.00	200.00	0.00	40.00	100.00	100.00	100.00	100.00	60.00
5	Provision of adequate polyvalent antivenom (purchased from Indian source) at UHC, DH, medical college hospital and BITID.(2) Provision of improved antivenom (AV): collection, processing and preservation of snake venom from the major venomous snake species that are medically relevant in Bangladesh, for the production of appropriate antivenom (multisectoral coordination with Ministry of Forestry, Department of Zoology of Chittagong University, Toxicology Society of Bangladesh, DGHS, and manufacturers of AV abroad).			800.00	600.00	200.00	0.00	40.00	160.00	160.00	160.00	160.00	120.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
6	Training human resources for improving the management of snake bite at UHC, DH and MCH (cross-cutting issue with ESD, HSM)		100.00	60.00	40.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
g	**Prevention of intentional injuries**		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
1	Mass awareness for behavioral and social change through developing communication strategy and life skill based education.		100.00	60.00	40.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
2	Increase public awareness about social problem related to dowry and violence against women through family education, counseling and school education, adolescence education and peer support.		100.00	60.00	40.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
h	Violence against women (GBV)		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Community awareness-raising		525.00	315.00	210.00	0.00	25.00	50.00	100.00	120.00	115.00	115.00
i	Emergency Preparedness and Response (EPR), Post Disaster Health Management		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Strengthening capacity of hospital services on EPR		200.00	150.00	50.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
2	Training of community volunteer on disaster preparedness , volunteer network establish		200.00	100.00	100.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
3	Establishment of Buffer stock of Drugs and Logistics for EPR		2000.00	2000.00	0.00	0.00	50.00	400.00	400.00	400.00	400.00	350.00
4	Electronic database, website network setup with proper human resource and logistics (in coordination with MIS)		150.00	100.00	50.00	0.00	10.00	40.00	40.00	30.00	20.00	10.00
5	Develop/ update of Promotion material on Health Impact of Community Disaster Preparedness and Response		175.00	105.00	70.00	0.00	10.00	20.00	50.00	35.00	30.00	30.00
6	Development and Publication of Posters, pamphlets, booklet etc on EPR.		130.00	80.00	50.00	0.00	10.00	30.00	30.00	30.00	20.00	10.00
7	Training of Community based workers on Mass Casualty Management		125.00	75.00	50.00	0.00	10.00	30.00	25.00	30.00	20.00	10.00
8	Development of documentary film / TV spot on different disaster health consequences		120.00	72.00	48.00	0.00	30.00	10.00	35.00	15.00	15.00	15.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
9	Countrywide Awareness building campaign through IEC using different methods and media		300.00	200.00	100.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00
	Sub total (iii):		10570.00	8114.00	2456.00	0.00	730.00	2009.00	2129.00	2109.00	2059.00	1534.00
Component (iv): Oral Health, Renal Disease, Arsenicosis, Climate Change and other NCDs												
	Oral Health											
1	Development of National Oral Health Policy		7.00	5.00	2.00	0.00	1.00	2.00	1.00	1.00	1.00	1.00
2	Promotion of Oral Hygiene by incorporating it in School education, community education , school health program		290.00	240.00	50.00	0.00	15.00	60.00	60.00	60.00	60.00	35.00
3	Capacity Building of Health Service Providers		5.00	5.00	0.00	0.00	0.00	1.00	1.00	1.00	1.00	1.00
4	Preparation of Training Module		50.00	50.00	0.00	0.00	5.00	10.00	10.00	10.00	10.00	5.00
5	Mass awareness raising activities		500.00	300.00	200.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
6	Piloting, model demonstration and scale up of ODDC counseling centers		500.00	300.00	200.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
7	Strengthening Surveillance System and Management Information System		500.00	300.00	200.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
8	Supporting institutional development		200.00	200.00	0.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
9	Operational Research and Survey (in coordination with PMR)		200.00	200.00	0.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
10	Coordination and Partnership		200.00	200.00	0.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
	Sub-total (Oral Health)		2452.00	1800.00	652.00	0.00	231.00	493.00	492.00	492.00	492.00	252.00
	Renal Disease		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Development of National SOP for the treatment and management of CKD patients		60.00	36.00	24.00	0.00	5.00	10.00	10.00	15.00	10.00	10.00
2	Traininig for prevention and control of renal disease		250.00	150.00	100.00	0.00	0.00	50.00	50.00	50.00	50.00	50.00
3	Mass awareness creation on prevention of renal diseases		50.00	30.00	20.00	0.00	50.00	0.00	0.00	0.00	0.00	0.00
4	Observance of World Kidney Diseases Day		160.00	96.00	64.00	0.00	20.00	20.00	40.00	30.00	25.00	25.00
	Arsenicosis		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
1	Improve patient screening (house to house searching) and management program		285.00	171.00	114.00		40.00	50.00	50.00	50.00	50.00	45.00
১	Arsenicosis treatment by Ars-Detox and Arsenicure		4140.00	1500.00		2640.00	400.00	800.00	800.00	800.00	800.00	540.00
2	Updating of National Arsenic Mitigation policy and strategy (co-ordination with DOPHE).		80.00	48.00	32.00	0.00	10.00	20.00	15.00	15.00	10.00	10.00
3	Strengthening of mass awareness programs on Arsenic free safe drinking water (Health Education Bureau, CHCP/HA, ESD).		200.00	200.00	0.00	0.00	20.00	50.00	50.00	50.00	20.00	10.00
4	Refresher's training- capacity building of human resources from diffenernt level and facilities for effective case management and referral.		300.00	300.00	0.00	0.00	20.00	60.00	60.00	60.00	60.00	40.00
	Climate Change		0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Community awareness of health consequences of climate change and on climate sensitivity injuries diseases		400.00	300.00	100.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
2	Development of Strategy & Action Plan of Climate Change on Health		100.00	80.00	20.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
3	Assessment of health status due to climate change in coastal area of Bangladesh			250.00	200.00	50.00	0.00	25.00	50.00	50.00	50.00	50.00	25.00
4	Impact of extreme heat on health status in Bangladesh			250.00	200.00	50.00	0.00	25.00	50.00	50.00	50.00	50.00	25.00
	Energy Drink – potential harm on health												
1	Awareness among common people on potential harm of Energy Drink on health			100.00	60.00	40.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
	Noise Pollution												
1	Creation of community awareness about health hazards of noise pollution			100.00	60.00	40.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
	Air Pollution												
1	Implementation of the Air Pollution Strategy			100.00	60.00	40.00	0.00	15.00	17.00	17.00	17.00	17.00	17.00
	Tobacco												
1	Awareness among common people on potential harm of Tobacco			400.00	300.00	100.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
2	Observance of World No Tobacco Day			1300.00	1300.00	0.00	0.00	130.00	260.00	260.00	260.00	260.00	130.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
3	Anti tobacco campaign among high school children			400.00	300.00	100.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
4	Mass media campaign against smoking in public			400.00	300.00	100.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
	Sub total			9325.00	5691.00	994.00	2640.00	930.00	1817.00	1832.00	1827.00	1782.00	1137.00
Component (v): Disability, hearing impairment, physical disability and Occupational Health Safety													
	Disability												
1	Support for disabled			400.00	240.00	160.00	0.00	50.00	50.00	75.00	80.00	75.00	70.00
	Ear Care			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Early identification, diagnosis, and treatment of common ear problem			135.00	81.00	54.00	0.00	25.00	20.00	30.00	25.00	20.00	15.00
	Occupational Health Injury			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
1	Awareness creation on safe work practice			400.00	300.00	100.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
2	Training of workers particularly on protective devices			200.00	180.00	20.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year -6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
3	Prevention & management of occupational health hazards			200.00	180.00	20.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00
	Sub total			1335.00	981.00	354.00	0.00	155.00	230.00	265.00	265.00	255.00	165.00
	Total			111827.27	72765.20	32462.07	6600.00	5042.00	21724.00	24433.00	23469.67	21013.00	16145.60

11. Budget support from other Operational Plan: Not applicable

4.22 National Eye Care (NEC)

1. Name of the Operational Plan: National Eye Care (NEC)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction:

Vision 2020 – the Right to Sight, aims to eliminate avoidable blindness by the year 2020.The World Health Assembly2013 approved a Global Action Plan 2014-2019-Towards Universal Eye Health with key elements, to strengthen national efforts to prevent avoidable visual impairment including blindness, through inter alia, better integration of eye health into national health plans and health service delivery, as appropriate; to implement the proposed actions in the global action plan 2014-2019 on universal eye health in accordance with national priorities, including universal and equitable access to service.

Blindness is one of the major public health problems in Bangladesh. There are many reasons of blindness, majority of them are preventable or easily curable. Bangladesh national blindness prevalence rate is 1.53% and thus there are 7, 50,000 blind adult above the age of 30 years in the country. Eighty percent of bilateral adult blindness is due to cataract which is avoidable & curable by simple surgery. In additional, about 40,000 children are blind and this also a major public health problem in the country About 5 million people including children are suffering from refractive error, about 2.8% of population aged 35 years above are suffering from guaucoma,25% diabetic patients are suffering from diabetic retinopathy (Bangladesh National Blindness and low vision survey-2000).The other predominant diseases which have to be addressed are retinal diseases, uncorrected aphakia, corneal diseases, Ocular trauma (due to agricultural and occupational hazards), ocular growth and malformation About 25% diabetic patient (1.85 Million) is at risk of having DR in Bangladesh. In HPNSDP the National blindness program is implemented in co-operation with local & INGO's & utilizing available facilities. Over the years NEC has achieved remarkable success in eye care. The number of eye health care professionals has been increased corresponding to the number of eye care facilities in the country. Cataract surgery rate has increased from 1172 in 2010 per million population per year to over 1,900 per million in 2015, a coronation mechanism is established to work in the partnership with NGOs, INGO and the private sector and initiated a number of pilot activities to reach the marginalized population, women, children living in hard to reach areas.

National Eye Care under HPNSDP has provided leadership to achieve Vision 2020 target through district Vision 2020 committees in all districts; improve infrastructure at secondary level hospitals; training for eye care providers, paramedics, nurse and PHC workers. The INGOs have been playing very important role in supporting the government and NGOs eye care initiatives, improving human resources, infrastructure whereas the local NGOs having their own eye care facilities rendering services to the people. The NEC has been coordinating of all the non- government eye health care providers and the private sectors.

Challenges: Removal 100% cataract surgery backlog by 2020; addressing emerging eye care problems such as Diabetic Retinopathy, Glaucoma, Ocular Trauma and Retinopathy of prematurity; National blindness survey to know incidence and prevalence rate of blindness; activating district, national vision 2020 committee and BNCB committee; redistribution /deployment of eye care professional based on actual need; need based uninterrupted supply of equipment and MSR; improve MIS capturing data from both public &private sectors; Creation and posting of mid-level ophthalmic personnel (Optometrists and orthoptists) at upazila health complexes; improving coordination among

the eye health service providers (Public, Private, NGO, INGO);transferring trained personnel (Ophthalmologists, Nurses, paramedics) without prior consent of local authority.

Way forward / Projection (2017-2022): To achieve CSR rate from 1950/million population (2016) to 3000/million population by the year 2022; training of one primary school teacher from 20% of Govt. primary schools who can identify students with refractive error, cataract and refer them; creation and posting of mid-level ophthalmic personnel (optometrists and orthoptists) at upazila health complexes in phases; identified physicians (Eye) at pilot upazila health complexes to diagnose and refer low vision, glaucoma, and diabetic retinopathy and cataract cases to district hospitals; all district hospitals manage cataract (including in children above 10 years of age)&follow up of all of cataract surgery cases & also diagnose low vision, glaucoma, diabetic retinopathy; creation of National eye care data base for planning, decision making and reporting to HMIS, DGHS and MOH&FW; Screening& treatment of Diabetic retinopathy (5% of total DR) at all level.

4. Objective

To improve eye care service delivery at primary and secondary centers in Bangladesh

Specific Objective:

- To develop and improve eye care facilities at secondary and primary care level through improving skill of ophthalmologists, Nurses, paramedics and supplying appropriate equipment and MSR.
- To increase awareness of mass population on blindness prevention.
- To strengthen coordination among GO-NGO & private eye care providers.
- To control childhood blindness.
- To expand & sustain Demand Side Financing (DSF) / Vouchering scheme to increase accessibility to the poor, marginalized and disadvantaged population.
- To build capacity of eye care service providers.
- To increase Cataract Surgical Rate (CSR).

5. Components

Component-1: Service Delivery (Quantity and Quality)

Cataract:

Cataract is the main cause of blindness in Bangladesh. The country is having 1.53% people (over 750,000) with visual impairment of that 80% (over 650,000) due to cataract which is easily preventable. A combined effort of the government, INGOs, NGOs and the private sector is necessary to combat the situation to achieve vision 2020 goal.

Activities: All the eye care activities will be carried out as per national eye care plan; Geographic coverage of NGO activities will be coordinated and consolidated; Resource allocation will be done as per need of the district.; Mega eye camp will be organized in the remote and hard to reach areas; Effective reporting mechanism will be established; Expansion of DSF at hard to reach & hilly areas; Development of infrastructure at district and Upazilla Hospitals for Eye Health Care Services.

Refractive Error:

Activities: Childhood Refractive Error, Adult Refractive error and Post-operative Refractive error:

Sight Testing for School Students will be done by eye care team, trained eye care teachers and field workers; Identified refractive error students referred to District/ Upazilla hospitals; Distribution of Spectacles for the identified refractive error students; Most of the Adults above the age of 40 years are suffering from refractive error for the near vision which is called Presbyopia and these people will need spectacle for near vision. During Out Reach Mega Eye Camp (OMEC) and other Eye Camps, Eye care team can detect the refractive error patients and advise them for spectacles and refer them to the district and other centers where it is available; Establishment of effective referral system to the higher level if not treated in district hospitals; After cataract surgery spectacles are required for near vision and these spectacles will be provided by National Eye Care (NEC) at the district hospitals; Establishment of effective referral system to the higher level if required.

Ocular Trauma:

Activities: During the harvesting season, Ocular Trauma is a very common incident among the children and the adults, especially the farmers working in the fields; To prevent ocular trauma, National Eye Care (NEC) will be providing black glasses (Sun glasses) to the farmers and will be spreading awareness about the Ocular Trauma among the farmers and community people by the field workers; Awareness raising programs about the Ocular Trauma among the farmers and community people by the field workers; Corneal ulcer is one of the main causes of Ocular Trauma. So, people affected with Ocular Trauma will be referred to the nearby district hospitals and then to the other tertiary eye care facilities /centers depending on their severity. Special training will be given to the consultants of the district hospitals to manage the corneal ulcer and so on.

Diabetic Retinopathy:

Activities: Awareness raising program regarding diabetes/ diabetes retinopathy at all levels for both service receivers and service providers; screening of Diabetic Patient at Upazilla Health Complex by the glucometer and if diabetics is diagnosed then refer it to the district hospital; mass screening programs at the community level, treatment and referral. Coordination and Collaborative work with diabetic hospitals; in district hospitals, the consultants will be examined the fundus through non-dilating fundus camera and further decision will be taken according to the result. If the result shows that the patient is only diabetic then refers it to the nearby diabetic center. Patients diagnosed with diabetic retinopathy will be provided with laser therapy and other treatments in district hospital; Follow up the treated patients at the district hospitals as per instructions; effective referral (if required) to tertiary center apex Institute;

Glaucoma:

Activities: Glaucoma screening will be done among the patients above 40 years of age at Upazilla Health Complex, coming from Outreach Mega Eye Camp (OMEC) and also in the district hospital. Special trained consultants at the district level hospitals will be examining the patients by using hand hold tonometer and portable fundus cameras and these instruments will be supplied by the National Eye Care (NEC).In established case, start the treatment at once; suspected cases will be referred to Medical College and National Institute of Ophthalmology and Hospital; Follow up treatment receiving cases by the consultants at district hospitals.

Retinopathy of Pre maturity (ROP):

Activities: ROP screening will be done in medical college-hospitals and National Institute of Ophthalmology and Hospital. The Consultants, assistant professors, associate Professors or Professor from the medical colleges will be given special training for ROP; Standard Operating Procedures

(SOP) will be introduced for ROP screening at the tertiary hospitals in the special new born unit care and neo-natal care unit.; Proper training need to the nurses and the auxiliary staff regarding ROP screening, referral and follow up and then will be assigned to the new born care units. Indirect ophthalmoscope and condensing lens of 20 & 30 Diopter will be supplied to the respective medical college for smooth running of the program by National Eye Care (NEC).

Age Related Macular Degeneration (ARMD):

Activities: In the district hospital, tertiary hospital during funduscopic ARMD patient can be screened out and give treatment and if required refer to the apex Institute.

Component-2: Human Resource Development

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

Activities: Vision 2020 workshop at different level; Training of the eye care providers at all tiers; Orientation of community leaders; Undertake baseline survey to gradually map out eye health workforce who did not receive any formal training; Gap analysis on existing institutional capacity to produce eye health workforce (degree, diploma certificate, refreshers training according to present and future requirements; Review the existing system of performance management for identifying laps and gaps and develop a guideline for improvement; Review the current situation of eye health workforce information system in the public, NGOs, and private sectors and update the design and implement eye health information system plan; Determine service level wise(primary, secondary and tertiary)eye health work force needs and project demand up to 2030 considering national and international context, standards and organizational skill mix; Strengthening of routine supportive supervision and monitoring; Provide adequate incentive package to the health staff for remote areas (hard to reach and hilly) and high risk population.

Component-3: Monitoring and supervision

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

Activities: Quarterly OPIC Meeting; Yearly meeting by Bangladesh National Council for Blind (BNCB); Strengthening of supportive supervision, monitoring and mentoring by the national level supervisor; Quarterly district vision 2020 committee meeting; Half yearly national 2020 advisory committee meeting; Quarterly public-private partnership meeting; Half yearly Public-Private Partnership Meeting with MOHFW; Half yearly performance review meeting among GOB, NGOs and private hospitals; Quarterly monitoring visit from NEC/NIO&H to the NGO and private hospitals for eye health service providers & Provide technical assistance as per monitoring findings.

Component-4: Behavior Change Communication (BCC) Programs

BCC is one of the important components of the program which relates to awareness creation for change in the health – seeking be behavior of the population for increasing voluntary of cases at outpatient department of secondary and primary eye care centers. Coordination & cooperation between public, private, NGOs are required in respect of service delivery (Geographical areas & quality) to avoid duplication & maintain uniformity.

Activities: Celebration of World Sight Day all over the country; Development of BCC material in collaboration with HEP of DGHS,NGOS and Private sectors; Orientation of community leaders on prevention of avoidable blindness; Awareness raising program for agricultural and industrial workers

to prevent ocular trauma; Use of mass media for awareness raising ;Development of need based awareness for local elites, religious leaders & others; Sight testing program for school students (Primary and Secondary Level)

Component-5: Procurement

To provide quality eye care at district and upazila level equipment and other logistic will be procured.

Activities: Providing MSR & equipment support for eye care at designated service centers; IOL support for cataract surgical camps; Provide protecting glass to farmers to prevent ocular trauma; Provide low vision devices to the Low Vision Patients.

Component-6: 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: Conducting research to identify service delivery gaps at all levels; End line evaluation of all the pilot DSF activities; phase wise expansion of DSF activities at district hospital; Development of National Eye Care strategy; Survey on prevalence of eye diseases among garment workers; Prospective study of clinical assessment for Glaucoma patients at tertiary hospital; Study of outcome of pediatric cataract surgery in tertiary hospital ; Conducting clinical research; Population based research on magnitude, risk factors, accessibility and utilization of health services; Dissemination after ending of survey/research; Revision of training manuals for doctor, nurse & field worker (Workshop).

Component-7: Management information system

Activities: In collaboration with MIS, DGHS, establishment of key eye indicators and data management formats for the National eye health programs; Trained personal bestowed with the responsibilities of HMIS at different levels on the formats; Facilitates data recording and reporting on eye care from all levels to HMIS. Provide logistic supports when necessary; Use of NEC information system data for evidence based planning and decision making.

Component-8: Introducing Primary Eye Care with primary health care:

Activities: Establish vision centers at UHCs; Formation and functioning of upazila vision 2020 committee; Assign eye care service to one of the existing Medical Officers Nurses at upazila& District levels for Indoor and Operation theater; Ensure efficient of available resources; Develop district and Local eye health care plans; Establish effective referral system from CC & onwards

6. Cross Cutting Issues

Including poverty, environment, and climate change, women, children and gender etc; Blindness is one of the major public health problems in Bangladesh. Women, children, poor and elderly people are more vurnerable of eye diseases. Under this OP, various activities will be implemented to reduce Eye such as increase contract surgery, diagnoses, low vision, glaucoma and diabetic retinopathy etc; which will reduce incidence and prevalence of blindness of the country. It would help to reduce morbidity and thus contribute to increase productivity. Therefore, through implementation of various activities under this OP, will create employment opportunities which will instance contribute to increase income, reduce poverty. Liaise with lifestyle, health education & promotion, I/NGO & Private Organizations in respect of preparation of IEC materials (Print, Electronic media and observation of

World Sight Day);Liaise with other non-communicable disease control activities and neglected tropical disease Prevention and control (OP-NCD); Promote partnership between the public, private and voluntary organization and national & international level (OP); Prevention Vitamin A deficiency blindness through NNS, immunization against measles through EPI (child health) and control of childhood diarrhea through, CDD (OP-CBHC, NNS)

7. Proposed Manpower: Annexed in Volume II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators:

Sl.	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1.	Number of adult cataract patients undergone surgery	Number per million population (Admin record)	1950	2000	3000
2.	Number of cataract patients received DSF/ cash voucher	Number (Admin record)	850/1000	6,000	10,000
3.	Number of hospitals following standard protocols.	Number (Admin record)	220	240	330

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
2187.00	6098.00	0.00	6098.00	8285.00	

10.2. Component and activity wise physical and financial target of OP: NEC

Lac in Taka

Name of the components & activities		Total physical and financial target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Physical QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
1. Manpower												
1.1	Pay of Establishment	4	44.00	44.00	0.00	0.00	2.50	8.00	8.00	8.00	8.00	9.50
1.2	Allowances	4	35.00	35.00	0.00	0.00	2.50	6.00	6.00	6.00	6.00	8.50
1.3	Pay of Casual labor	6	65.00	65.00	0.00	0.00	3.00	12.00	12.00	12.00	12.00	14.00
	Sub-Total 1		144.00	144.00	0.00	0.00	8.00	26.00	26.00	26.00	26.00	32.00
2. BCC activities												
2.1	Obser. of World Sight Day (Rally & advocacy meeting, Seminar)	5	20.00	0.00	20.00	0.00	0.00	4.00	4.00	4.00	4.00	4.00
2.2	Installation of bill board at service centers	32	32.00	0.00	32.00	0.00	0.00	6.00	6.00	8.00	6.00	6.00
2.3	Publicity & Advertisment	Lumpsum	15.00	0.00	15.00	0.00	1.00	4.00	3.00	3.00	2.00	2.00
2.4	Development TV spot and on air	10	50.00	0.00	50.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
2.5	Develop Radio Spool and on air	5	10.00	0.00	10.00	0.00	0.00	4.00	4.00	2.00	0.00	0.00
	Printing & Publication											
2.5	IEC materials (Poster, leaflet, Stikers, cards, forms, files, documents of NEC Strategy etc.)	Lumpsum	25.00	0.00	25.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00
2.6	Book & Booklets for primary health workers, vision center & others	10000	15.00	0.00	15.00	0.00	0.00	5.00	0.00	5.00	5.00	0.00
	Sub-Total 2		167.00	0.00	167.00	0.00	1.00	38.00	32.00	37.00	32.00	27.00

Lac in Taka

Name of the components & activities		Total physical and financial target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Physical QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
3. Planning & Research												
3.1	Finalization National Eye care Strategic Plan	1	5.00	0.00	5.00	0.00	5.00	0.00	0.00	0.00	0.00	0.00
3.2	Revision and update of training manuals for doctors,nurse & field workers (Workshop) - 4 division / 60 person	240 person	20.00	0.00	20.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00
3.3	End line evaluation of all the pilot DSF activities	1	5.00	0.00	5.00	0.00	0.00	5.00	0.00	0.00	0.00	0.00
3.4	Nation wide blindness Survey	1	450.00	0.00	450.00	0.00	0.00	150.00	300.00	0.00	0.00	0.00
3.5	Development of training module for MO/ MLOP/ Nurses for Vision center (2 phases 5+5 days)	1	1.00	0.00	1.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00
3.6	Dissemination after ending of Module development & survey	3	6.00	0.00	6.00	0.00	0.00	2.00	2.00	2.00	0.00	0.00
	Sub-total 3		487.00	0.00	487.00	0.00	5.00	158.00	307.00	7.00	5.00	5.00
4. Repair & Maintenance												
4.1	Repair & Maintenance of the eye care equipments	Lumpsum	64.00	64.00	0.00	0.00	2.00	12.00	14.00	12.00	12.00	12.00
4.2	Repair & Maintenance of the office equipments	Lumpsum	12.00	12.00	0.00	0.00	1.00	3.00	2.00	3.00	2.00	1.00
4.3	Repair & Maintenance of transport	6	31.00	31.00	0.00	0.00	1.00	6.00	6.00	6.00	6.00	6.00

Lac in Taka

Name of the components & activities		Total physical and financial target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Physical QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Sub-Total 4		107.00	107.00	0.00	0.00	4.00	21.00	22.00	21.00	20.00	19.00
5. Monitoring & Spervision												
5.1	Review of eye care existing facilities (HR,equipment & Service) for identifying laps and gaps at limited DH and Medical colleges Hospital & reporting for improvement	8 Medical college hop.& 8 DH	10.00	0.00	10.00	0.00	0.00	6.00	4.00	0.00	0.00	0.00
5.2	Half yearly OPIC meeting	11	5.50	5.50	0.00	0.00	0.50	1.00	1.00	1.00	1.00	1.00
5.3	Yearly BNCB Discussion Workshop	5	5.00	0.00	5.00	0.00	0.00	1.00	1.00	1.00	1.00	1.00
5.4	Half yearly public private partnership activity Review with MOH&FW (Workshop)	10	8.00	0.00	8.00	0.00	0.00	1.60	1.60	1.60	1.60	1.60
5.5	National V-2020 Advisory committee review meeting /workshop	10	10.00	0.00	10.00	0.00	0.00	2.00	2.00	2.00	2.00	2.00
5.6	Distict hospital visit by the national level supervisor for monitoring	60	25.00	25.00	0.00	0.00	1.00	4.80	6.00	6.00	4.80	2.40
5.7	Distict Vision 2020 committee activity review workshop	30	24.00	0.00	24.00	0.00	0.00	4.80	6.40	6.40	4.80	1.60
	Sub-Total		87.50	30.50	57.00	0.00	1.50	21.20	22.00	18.00	15.20	9.60
6. Human Resource Development												

Lac in Taka

Name of the components & activities		Total physical and financial target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Physical QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
6.1	Hands on Microsurgery training for Ophthalmologist 4 person per batch duration 4 weeks	82	328.00	0.00	328.00	0.00	8.00	64.00	64.00	64.00	64.00	64.00
6.2	Training Medical officer / Medical Assistant /Nurse for Vision Center at UHC- 3 person from each UHC total 600 person = 64 district for 5yrs ,duration 5 days	600 person	80.00	0.00	80.00	0.00	0.00	27.00	27.00	26.00	0.00	0.00
6.3	OT, ward management & Counseling Training for Nurses/ MLOP 10 person per Batch duration 1 months - 3 batch per year Total = 50 batch	50	200.00	0.00	200.00	0.00	8.00	48.00	48.00	48.00	40.00	8.00
6.4	Orientation/short term fellowship training on retina/ paediatric Ophthalmology/glaucoma 6 person per batch duration 2 weeks -1batch * 5 Yr = 50 batch	50	125.00	0.00	125.00	0.00	5.00	30.00	30.00	30.00	25.00	5.00
6.5	1 days training of PEC workers on PEC Batch of 30-15 Batch for 5 yrs.	60	30.00	0.00	30.00	0.00	0.00	6.00	7.00	7.00	6.00	4.00
	Sub-Total 6		763.00	0.00	763.00	0.00	21.00	175.00	176.00	175.00	135.00	81.00
7. Service Delivery (Strengthening of eye care service in distict hospi, Med.C.hospi& UHC)												

Lac in Taka

Name of the components & activities		Total physical and financial target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Physical QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
7.1	Conduction of Cataract Screening and surgical camp	42	252.00	252.00	0.00	0.00	30.00	48.00	48.00	48.00	48.00	30.00
7.2	Distribution of spectacles at vision center and school students	40000	80.00	0.00	80.00	0.00	0.00	16.00	16.00	16.00	22.00	10.00
7.3	Screening of glaucoma patients at out reach mega camp	30	30.00	0.00	30.00	0.00	0.00	6.00	6.00	6.00	6.00	6.00
7.4	Piloting of DR screening at DH - 10 DH / 5 yrs	10	50.00	0.00	50.00	0.00	0.00	10.00	10.00	15.00	15.00	0.00
7.5	Sight Testing for Primary/High School Students (Age between 9-15 years) - 60/ 5year	58	60.00	0.00	60.00	0.00	2.00	12.00	12.00	12.00	12.00	10.00
7.6	Demand Side Financing/ vouchering scheme for poor patient - 3000 per year Total Patient= 15000	15000	300.00	0.00	300.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00
7.7	Vision center - 200 UHC	200	500.00	0.00	500.00	0.00	0.00	125.00	125.00	125.00	125.00	0.00
7.8	3 Cost Center at tertiary level including Sheikh Fazilatunnessa Mujib Eye Hospital & Training Institute, Gopalgonj (Service Deliv, MLOP course.)	2	600.00	0.00	600.00	0.00	0.00	300.00	200.00	100.00	0.00	0.00

Lac in Taka

Name of the components & activities		Total physical and financial target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Physical QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
7.9	Establishment & Functioning of retina,Glaucoma and paeditac Oph at medical college hospital - 5/ 5 year	5	150.00	0.00	150.00	0.00	0.00	30.00	60.00	60.00	0.00	0.00
	Sub-Total 7		2022.00	252.00	1770.00	0.00	62.00	607.00	537.00	442.00	288.00	86.00
8. Utility Management Cost												
8.1	Utility management Cost (POL, Gas,Internet, Transportation, Currier, etc.)	Lumpsum	189.50	189.50	0.00	0.00	11.50	37.00	37.00	37.00	37.00	30.00
	Sub-Total 8		189.50	189.50	0.00	0.00	11.50	37.00	37.00	37.00	37.00	30.00
9. Procurement												
9.1	Salary of National Co-ordinator - 1 person 66month	6	66.00	0.00	66.00	0.00	6.00	12.00	12.00	12.00	12.00	12.00
9.2	Medicine & Vaccine	0	614.00	614.00	0.00	0.00	50.00	114.00	100.00	100.00	150.00	100.00
9.3	Logistics & IOL support for eye care & Cataract surgery patients - 400000 patient	0	750.00	750.00	0.00	0.00	50.00	150.00	150.00	150.00	150.00	100.00
9.4	Bus for Patients during screening eye camp - Coster Bus 30-35 seat / 02	2	80.00	0.00	80.00	0.00	0.00	80.00	0.00	0.00	0.00	0.00
9.5	Procurement of Eye Care equipment for districts, upazila & vision , Cost centers	0	2200.00	0.00	2200.00	0.00	0.00	500.00	600.00	500.00	500.00	100.00

Lac in Taka

Name of the components & activities		Total physical and financial target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Physical QTY/ Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
9.6	Procurement of dextop computer with accessories for NEC office & DH,Cost cnter & Vision center (computer and accessories to be purchased by HIS ehealth OP)	20	8.00	0.00	8.00	0.00	0.00	6.00	2.00	0.00	0.00	0.00
9.7	Furniture for Vision center & Cost center	200 vision center & 2 cost center	100.00	100.00	0.00	0.00	0.00	50.00	50.00	0.00	0.00	0.00
9.8	Procurement of Laptop Computer (to be purchased by HIS ehealth OP)	18	2.00	0.00	2.00	0.00	0.00	2.00	0.00	0.00	0.00	0.00
9.9	Procurement of office equipment (photocopier, Fax	2	3.00	0.00	3.00	0.00	0.00	0.00	3.00	0.00	0.00	0.00
9.10	Protecting glass for agro/ industrial workers	50000	45.00	0.00	45.00	0.00	0.00	10.00	10.00	10.00	10.00	5.00
	Sub-Total 9		3868.00	1464.00	2404.00	0.00	106.00	924.00	927.00	772.00	822.00	317.00
	Grand Total		8285.00	2187.00	6098.00	0.00	220.00	2157.20	2386.00	1535.00	1380.20	606.60

11. Budget support from other Operational Plan: Not applicable

4.23 Community Based Health Care (CBHC)

1. Name of Operational Plan: Community Based Health Care (CBHC)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

Situation Assessment

Community Clinic

Community Clinic (CC) is a flagship initiative of the current government which has been highly praised by the international community as a means to deliver services very close to the people. CC is the lowest tier health facility from the government in the rural areas all over the Bangladesh including the remote and very hard to reach areas. Each CC has a defined catchment area with 7,000-10,000 population. Currently 13,136 CC are functioning. Each CC has a Community Health Care Provider (CHCP). Also Health Assistant (HA) and Family Welfare Assistant (FWA) attend the CC, each for three days in a week. Each CC has a Community Group (CG) and three Community Support Groups (CSGs). CC promotes health and provides preventive and basic curative care. 1008 CC conduct normal delivery. During 2009-2015 period, 23,837 normal deliveries were conducted in CCs without any mortality of mother or newborn. All the CCs are provided with laptop and internet connection and are reporting online. CCs are unique public facilities in many ways. Lands are donated by the community and government constructed the facilities, provided supplies and human resources. Community people participate in the operation of CCs through CG and CSGs. Many NGOs are supporting for the proper functioning of the CCs. When CCs were planned in 1998 as each for 6,000 population, 18,000 were required calculating the then rural population. However considering union and upazila facilities to provide CC services to their immediate surrounding population, 13,500 CCs were planned to construct. Considering remoteness of some community, currently 13,861 CCs are aimed to construct of which 13,376 are already constructed.

Upazila Health System

National Health Policy (NHP) 2011 mentioned that infrastructure in government health system throughout the country is remarkable. However full benefits from these health infrastructures are obstructed by shortage of medicines, lack of health workforce, weakness in the maintenance of equipment and physical facilities, administrative complexity and absence of structured referral system. NHP 2011 mentioned that importance would be given for strengthening the upazila health system to ensure health, population and nutrition services up to village level.

Upazila health system comprises of domiciliary services, services through outreach and satellite clinics and services through fixed facilities at different levels. Both health and family planning departments have parallel domiciliary workers – under the DGHS, there are 26,481 sanctioned posts of domiciliary workers, of which 20,877 are for health assistants (HA – the basic domiciliary worker), 4,205 for assistant health inspectors (AHI, the immediate supervisor of HA) and 1,399 for health inspectors (HI, the supervisor of AHI) and in the DGFP, there are 23,500 units, each covers by one family welfare assistant (FWA), supervised by family planning inspector (FPI), each for an union (4,500). EPI outreach is conducted by HA and satellite clinic by family welfare visitor (FWV) from DGFP. Among the fixed facilities lowest one is the community clinic at ward level and 13,136 are functioning. In the union level from DGHS 302 UH&FWC and 884 USC/RD and from DGFP 3,131 UH&FWC operate. Out of total 4,550 unions in the country, 529 unions do not have a union level health facility, but 185 of those unions have an upazila health complex located in the union and thus

358 unions do not have any health facilities. In the upazila, 414 upazila health complex exist (51 bed – 1, 50 bed – 211, 31 bed – 191 and 10 bed – 11) from DGHS. Also 424 MCH units operate from Upazila Health Complex by the DGFP.

Besides upazila health complexes, four 31bed, one 30 bed and five 20 bed trauma centre hospitals exist at upazila level. At union level, thirty 20 bed and twenty 10 bed hospital exist. Similarly MCWCs exist at union (23 in numbers) and at upazila (12 in number) from DGFP.

Urban Health

Currently MOHFW's facilities from DGHS and DGFP are providing services in the urban areas which includes 414 upazila health complexes, 64 district/general hospitals, 13 chest hospitals, 3 leprosy hospitals, 5 infectious diseases hospitals, 14 medical college hospitals, 3 specialized hospitals, 11 specialty care hospitals, urban dispensaries, school health clinics, chest clinics and MCWCs. DGHS and DGFP also provide vaccines and contraceptive supplies respectively in the urban areas. LGD of the MOLGRD&C is implementing third phase of urban primary health care project, which covers 10 city corporations and 4 municipalities currently and deliver services through contracted NGOs. Some city corporations have their own health facilities of various categories. NGOs also provide services in urban areas, of which Smiling Sun networks (supported by USAID-DFID), Marie Stopes (supported by DFID), brac Manoshi (supported by DFID) have wide coverage.

Some confusion exits about the responsible ministry for urban health. According to the Allocation of Business among the Different Ministries and Divisions (Schedule I of the Rules of Business, 1996) Revised up to December 2014 published by the Cabinet Division MOHFW is entrusted with Medical and Health Services including promotive, preventive, curative and rehabilitative aspects (# 7). However LGD of MOLGRD&C is not assigned with any health activities. But according to Local Government (City Corporation) Act 2009 City Corporation is responsible for the health system of the city and according to Local Government (Municipality) Act 2009 Municipalities responsibility include public health. Article 59 of Bangladesh Constitution vested local government institutions (city corporations and municipalities) with the authority to prepare and implementation plans relating to public services and economic development. Thus their relationship with the LGD is not like subordinate departments, whose responsibilities may be shouldered by the superior authority like division/ministry. Bangladesh Urban Health Survey 2013 found that 95 percent of communities in slums and non-slums and about 90 percent in other urban areas had a health facility available within two kilometers.

Tribal Health

Bangladesh is largely ethnically homogeneous and Bangali ethno-linguistic group comprises 98 percent of the population. However Chittagong Hill Tracts (CHT), Sylhet, Mymensingh and North Bengal divisions are home to diverse ethnic peoples. The total population of ethnic people in Bangladesh was estimated to be over 2 million in 2010, of which almost half are in the CHT and rest are in the plains. The 2011 Census reports 27 ethnic population groups, each having varied number of population. CHT houses 11 ethnic groups. CHT is also different from rest of Bangladesh in many other ways like different terrain comprising hills, jungles and springs/canals/rivers, scattered population, jum cultivation practice. Health services are limited in CHT as facilities are few with difficult communication and retention of health workforce is also another challenge. The different cultures and languages of the ethnic groups also pose as obstacles in health service delivery.

Moreover according to the Rangamati, Khagrachari and Bandarban Hill District Council (HDC) Acts 1998 health and family planning departments are transferred to the respective HDCs.

Challenges

Community Clinic

1. With the SDG for health (SDG3) and aim to achieve Universal Health Coverage (UHC), CC has become a unique instrument for both, however needs some fine tuning.
2. The just adopted Essential Service Package (ESP) has identified nine essential services (with some sub-services) and two extra services to be delivered at CC level. This requires reviewing of existing staffing of CCs.
3. CCs earned confidence from the community as evidenced by ever increasing utilization, which now need to reposition to deliver comprehensive promotive, preventive, basic curative and to some extent rehabilitative and palliative care.
4. Effectively participating in establishing an effective referral system is another challenge.
5. Facilitating a health movement through the active participation of the catchment population in close cooperation with the CG and CSGs for improved health outcome and its measurement by collecting, collating and updating population based data is another challenge.

Upazila Health System

1. When health and family planning started domiciliary activities, both assissgned field workers (HA/FWA) for each of 6,000 population, the exact catchment area for which now community clinics (CC) are established. Given the universality of knowledge about family planning, very high uptake of immunization, improved connectivity (transportation, mobile phones, television, radio etc.) in rural areas and functioning of CC, justification of blanket domiciliary visit demands review. Moreover HA/FWA are assissgned with other roles (3 days in CC, CSBA for some, attendance of EPI outreach/satellite clinics) also and thus domiciliary visits are seriously compromised.
2. Currently FWV (from UH&FWC of family planning) conduct 1-2 (depending upon the availability of SACMO) satellite clinics per week. The satellite clinics were provisioned to cover the population at distance locations within the union other than the immediate vicinity of U&HFWC. With the functioning of the CCs, those populations are already covered. Thus justification of still conducting satellite clinics need to revisit. Moreover CSBAs and CHCPs remain technically unsupervised, as their assissgned supervisors (AHI, FPI) are not technically competent of supervising and thus affecting quality of service delivery.
3. In absence of structured referral system, the upper level facilities are crowded, whereas facilities at lower tiers remain under-utilized.
4. Many unions have more than one facilities resulting duplication, wastage and inefficient use of resources.
5. 10-20 bed hospitals were built in the union on ad-hoc basis. Most of them are yet to be functioning as desired.
6. Skill-mix imbalance in the staffing of upazila health complexes (lack of dedicated workforce to operate emergency, outdoor, cleaning, counseling etc.) seriously affecting the quality of the services delivered.
7. The ESP identified range of services (essential and extra) to be delivered at different components of upazila health system (CC, union-level facility and upazila health complex) and thus demands streamlining of the system avoiding multiple facilities at each level.

8. Upazila health complexes are now resourced from both revenue and development budgets creating confusion in supply of diets, drugs and thus affecting services.
9. Health care waste management is absent or seriously constrained in the upazila health complexes and all other facilities (union level and CC) under upazila health system.
10. Facilities under upazila health system (upazila health complex, union facility and CC) suffer from lack of medicines and other supplies, functionality of equipments and improvised physical facilities.
11. Many of the problems faced by the facilities of upazila health system may be overcome through local level resource mobilization from local government institutes (municipality, upazila and union parisads), business communities, philanthropists, schools, colleges etc.
12. Demands over the post of Upazila Health and Family Planning Officer (UH&FPO) is increasing. Besides managing the field functionaries and different public health interventions, s/he now needs to manage an increasing number of facilities (CC and union levels) and the hospital is also increasing in size (50 beds).

    Urban Health
13. With close proximity of health facilities fail to ensure utilization of the same by the poor and working class in urban areas as challenges remain to overcome other barriers like economic, information, non-discrimination and opening timing of the facilities etc.

Tribal Health

1. Ensuring access and utilization of services by the tribal population both at CHT and in plain land through adopting appropriate strategies followed by proper activities with effective monitoring and supervision.

4. Objectives

i. CC to assume full responsibility of health (population and nutrition) of the entire population of the catchment area.
ii. Adequately staffing CC with proper supervision mechanism to effectively deliver the services entrusted by the ESP.
iii. Facilitating CG and CSG for active participation in creating a health movement in the catchment area for improved health outcomes of the population.
iv. Sustaining institutionalization of the community based health care efforts
v. Streamlining and strengthening upazila health system
vi. Establishing functional referral within and beyond upazila health system
vii. Ensuring supplies for proper functioning of upazila health system
viii. Institutional development at different levels of upazila health system for improved performance
ix. Improve urban health through enhance utilization of facilities
x. Improving access and utilization of services by the tribal population

5. Components

Community Clinic

Measuring health outcomes:

Since the CC aims to assume full responsibility of the health (population and nutrition) of the entire population of the catchment area, it needs to collect data from its catchment population, collate the

same to infer base-line and repeat the same yearly to measure the results. Having population based data will also help to ensure equity of access and utilization of services.

Activities:

1. With support from MIS, DGHS a format to collect household information will be developed
2. CC staff will be oriented on the format for collection of data, compilation and interpretation of the same
3. CG and CSG members will be oriented and the households will be distributed among them for the collecting household information following the format. Existing NGOs support will also be utilized through local planning for effective collection of data.
4. Collected data will be inserted in the laptop, collated the same and pass to CBHC office
5. Data collection and compilation will be repeated in each year in a pre-fixed time.
6. Service delivery by CC data will be checked against population data to ascertain equity of access and utilization and measures to take to overcome, if exist.

Staffing and Supervision of CC:

Currently CC is staffed with CHCP (full-time), HA and FWA (both part-time). However ESP has identified following essential and extra services to be delivered at CC level:

Essential Services	*Extra Services*
Maternal care: ANC, PNC	Normal deliveries
Newborn care: ENC, IYCF	DOTS and other program strategies
Child care: IMCI, EPI	
Adolescent health: counseling, nutrition	
FP: Condoms, Pills, Injectables	
Nutrition: assessment, prevention, moderate acute malnutrition	
NCD: screening for risks factors	
Limited curative care	
Social Behavioral Change Communication (SBCC)	

CC is assuming full responsibility of the health (population and nutrition) of its catchment population and the same population is also assisssgned for domiciliary services by the HA and FWA. Moreover with universal knowledge of family planning and very high uptake of immunization together with improved communication (physical and technological, particularly mobile phone), relevance of blanket domiciliary services by HA and FWA will be reviewed in the light of efficiency gain by avoiding duplication and wastage. Thus they will be posted as additional staff of CC to cater the additional need of staff and their roles and tasks will also be reviewed.

Currently CHCP and HA are supervised by AHI and FWA by FPI. When the ESP services will be delivered tasks will also be redistributed among the CHCP, HA and FWA. For the sake of supportive supervision more technically qualified people will be required to supervise at least some of the staff of CC.

Activities

1. Initiatives will be undertaken for proper staffing of the CC to deliver services assigned by the ESP. Relevance of existing blanket domiciliary visits of HA and FWA will be reviewed and after details discussions of all concerned MOHFW will take the final decision about the staffing of CC.

2. If HA and FWA are assigned as full-time staff in CC, then designated service delivery tasks will be distributed among them considering their knowledge, skills, attitude and other issues like social acceptability.
3. Their designation and job description will be changed accordingly.
4. They will be properly trained to equip them for delivering the newly assigned service delivery responsibilities.
5. Supervisory lines will also be reviewed so that supervisors can provide supportive supervision for effective and quality service delivery
6. Supervisors' designation, job descriptions will be revised and they too will be trained accordingly.

Community engagement

Currently each CC has one CG and three CSGs. Their engagement varies. Some limitations exist in the formation of these committees (may not have females as should be, may not have representatives from other segments of society etc.), in the operation (may not meet as frequently as should be, may not have adequate quorum for the meeting, all may not participate in the meeting, decisions may not be taken, minutes may not be prepared, decisions may not be followed up etc.) and in broad engagement with the community for bringing improved health outcomes of the population. CG and CSGs will be revitalized by orienting them thoroughly about their roles and responsibilities not only for proper functioning of the CC but also creating a health movement within their respective community by promoting healthy lifestyles, making the environment for conducive for health and making sure utilization of all required service from the CC and higher facilities.

Activities

1. A community engagement manual will be prepared detailing roles of different stakeholders like CC staff and their supervisors, CG and CSG members, Union Parisad, other local institutions like NGOs, schools, religious institutions etc. with the aim of creating a health movement in the community for bringing improved health outcomes.
2. Different BCC/IEC materials will be developed and produced in adequate quantities to supply at CC to support the social movement.
3. CC staff and their supervisors will be oriented thoroughly to steer the process,
4. CC staff and their supervisors will orient CG and CSG members and other stakeholders, as mentioned above to ignite the social movement. They will also be supported by need based BCC/IEC materials and others, if needed
5. CC staff to follow up the process of social movement.
6. There will be provision for multi-purpose health volunteer for incentive based activities.

Referral system

Since CC is assuming full responsibilities of health (population and nutrition) of the population of its catchment area, it should provide services whatever it can and ensure other services required through appropriate referral and adequate follow-up. Initially CC will refer the clients/patients to the respective UzHC and when union facilities will be strengthened then to the union facilities.

Activities

1. CC staffs will be properly oriented about the referral system with their respective roles and responsibilities.
2. Existing medicine and equipment list will be reviewed to response to the need to referral (e.g medicine supply to the diabetes and hypertension patients sent back as referral after confirmation of diagnosis)

3. Engaged periodically with the referred facilities to discuss issues to make the referral effective and functioning.

Sustaining institutionalization

Though CC initiated in the HPSP (first SWAp), only the construction were done and during the half-way in 2001 was abandoned due to change of the government. Revitalization of CC was initiated as a separate project outside the SWAp. After the closure of the project it was merged within the third SWAp as a separate OP. Therefore its need to be institutionalized with the government system, so that the progress made so far not only sustain, but also further flourish contributing to achieve UHC aim.

Activities

1. Initiative will be undertaken to gradually transfer the head office based staff and CHCP in the revenue budget phase-wise. However till the transfer of revenue these human resources will be financed from the OP.
2. Drugs and other supplies will be provided to keep these CC functioning.
3. Efforts will be taken for establishing one CC in each upazila health complex to cater the need of immediate population of its vicinity. This is more required when structured referral system is planned and upazila health complexes will only be entertaining referred and emergency clients. These will be located within the physical structure of upazila health complex. However posts of CHCPs required be creating and deploying. Required HA and FWA also need to deploy. Necessary supplies also need to ensure. Gradually this will cover the union level facilities also.
4. Newly recruited CHCPs will require training. Also gradually female CHCP will be trained as CSBAs.
5. As per need repair/renovation of CC, approach road, utilities like electricity and water supplies will be taken care. However if possible, these will be undertaken through the support of Union/Upazila Parisads and/or local level resource mobilization.
6. To meet initial target of 13, 861 CC, 485 needs construction as 13,376 have been constructed. Out of 485, JICA has committed to construct 300. Thus 185 are left. Moreover many earlier constructed CCs need re-building due to demolition or beyond repair. Moreover wards are continuously re-organized, thus there are requirements of constructing new CCs in new wards. It is found that in 1029 wards there are no health facilities. Thus 1214 new CCs are required to construct.

Upazila Health System

Streamlining upazila health system

For the same catchment population domiciliary services are provided by the health and family planning departments in parallel. Moreover CC is now functioning serving the same population. Since domiciliary workers (HA, FWA) are also assigned with other multiple tasks (EPI outreach, satellite clinic, CC), they hardly undertake domiciliary visits. With universal knowledge of family planning, high uptake of immunization and improvement in communication, continuity of blanket domiciliary visits remain a question. Similarly satellite clinics conducted by FWV is most cases now covered by CC, so their continuity may be reconsidered. In many unions there are multiple facilities from health and family planning and most of those are not functioning optimum. Similarly in most of the upazila, within the health complex a separate MCH is functioning in parallel from DGFP. Multiple facilities also exist in many upazilas and none functioning properly. To gain efficiency by avoiding duplication and wastage continuity of domiciliary visit and satellite clinic need to be reviewed. Similarly proper functioning of a single facility at union and upazila pulling resources from multiple improper functioning facilities may also be considered.

Activities

1. Initiatives will be taken for the formation of a committee comprising MOHFW, DGHS, DGFP, BMA etc. for reviewing domiciliary visits and satellite clinic conduction in light of changed context. This OP will provide secretarial assistance to the committee for proper functioning and prepare recommendations for the MOHFW to decide finally.
2. Follow-up actions for the implementation of the decisions made by the MOHFW for domiciliary visit and satellite clinic.
3. Initiatives will be taken for the formation of a committee comprising MOHFW, DGHS, DGFP, BMA etc. for reviewing current existence of multiple facilities at union and upazila level and recommend policy direction about those in light of fully functional facility at each level for the upazila health system to the MOHFW for final decision. This OP will provide secretarial assistance to the committee for proper functioning and prepare recommendations.
4. Follow-up actions for the implementation of the decisions made by the MOHFW for fully functioning facility at union and upazila.

Functional Referral

Currently no referral system exists. Therefore the higher facility like upazila health complex in most cases caters the needs of immediate surrounding population. People who need those services and coming from far distance place may not avail due to absence of referral system and thus priority attention. Lack of referral also crowds the upper facility leaving under-utilized lower facility. Crowd in facility deter to provide quality services. Since equity, efficiency and quality are the guiding principles of the current sector program, these will be addressed by establishing and functioning referral system within the upazila health system and beyond.

Activities

1. In discussions with all the relevant stakeholders' referral system within the upazila health system will be decided. Currently due to improper functioning of facilities at union level, CC refers directly to upazila.
2. Referral manual needs will be developed narrating roles of responsibilities at each tier of facilities (CC, union and upazila) for referral in both ways
3. Thorough orientation of staffs of all levels for the establishment and functional of referral system
4. Quarterly monitoring of the functionality of referral system and decide for remedial measures
5. Establishment functional referral with the district/general/medical college hospital, as the case may be.
6. Establishment of a CC within the premise of upazila health complex (other facilities like trauma center etc.) to serve the immediate surrounding catchment as after establishment of the functional referral system upazila health complex to entertain only referred and emergency cases.

Functioning of Upazila Health System

Upazila health system comprises CC, union facilities and upazila health complex. Some of these facilities may not function properly due to shortage of human resources, medicines and other supplies; improvised physical facilities with limitation in utilities like water and electricity supply; physical up-gradation facilities (31 to 50 bed upazila health complex, upgraded UH&FWC etc.) not backed by other requirements like human resources, supplies (MSR), diets, some of which may be supported from development budget but confusion continues. Wastes generated by different facilities of upazila health system are not properly managed creating threats for HWF as well as general population.

Activities

1. Initiatives will be taken for transformation of hospitals operation fully by revenue by creating adequate posts, sanctioning bed strengths for supplying diet and MSR etc.
2. Till the transformation to the revenue support continues from this OP for proper functioning of upazila health complexes
3. Need based supplies including medicines, reagents, equipments will be supplied to the facilities of upazila health system
4. Medical waste management will be initiated in all the facilities under the upazila health system by developing appropriate manual, orienting all staff, supplying required logistics and monitoring of the same.
5. Efforts will be undertaken for local level resources mobilization (cash, kind, human resource etc. from upazila/union parisads, municipalities, philanthropists, business community, college etc.) for making the upazila health system functioning better

Institutional development

Required adequate skill-mix is not properly reflected in the staffing pattern of upazila health complex (UzHC)– 10 consultants in 50 bed, 4 consultants in 31 bed with 2 medical officers (1 now assissgned for nutrition and another for community clinic), 5 sweepers etc. There are no separate HWF for operating emergency though UzHC is the first facility in rural areas to provide such essential services. Posts are created at union levels for assistant surgeons and medical assistants from DGHS without the existence of any facilities. Work-load of Upazila Health and Family Planning Officer has increased many folds but not supported by any appropriate human resource or required transport.

Activities

1. Staffing pattern at different upazila health complexes (31 and 50 beds) will be reviewed to reflect adequate skill-mix required to deliver the services assigned in the ESP and emergency services.
2. Initiatives will be undertaken to revise the existing organogram in light of the review recommendations and government decision
3. Staffing pattern at the Union Sub Centre/Rural Dispensaries will be reviewed to reflect adequate human resources required with skill-mix to deliver services assigned in the ESP and initiatives will be undertaken for the compliance of the decision made by the government in light of the review recommendations.
4. Initiative will be taken for deciding about the posts of assistant surgeons and medical assistants at union level from DGHS having no facilities
5. Initiative will be taken to review the work-load of UH&FPO and recommend appropriate level and number of supporting HWF and other support like transport requirement for proper discharging the responsibilities tasked with.

Urban Health

Multiple barriers deter urban dwellers, particularly poor to access and utilize health services. Due to confusion that LGD of MOLGRD&C is responsible for urban primary health care, MOHFW didn't paid enough attention to urban health. However with universal health care agenda, the sector program is committed to ensure the same in urban areas too by supporting the responsible institutions like city corporations and municipalities.

Activities

1. Upazila Health and Family Planning Officer, Civil Surgeon, Divisional Director for Health with their corresponding colleagues from the Family Planning Directorate will support the Mayor (of City Corporations and Municipalities) and his/her health team to map the health facilities available from MOHFW and other government departments, NGOs and private sectors in their respective catchment area

2. Then each facility is assigned with a catchment area to serve its population for ESP ideally free of cost.
3. Guidelines for establishment and operation of non-government medical college 2011 (revised) require non-government medical college hospitals to reserve 10 percent of its beds to serve free of cost. This provision may be revised to serve assigned population in lieu.
4. Municipality/City Corporation may also impose this as condition to provide registration to those organizations by themselves and/or provide incentives in reducing holding tax for those facilities.
5. Monitoring of functioning of the system may be vested to Ward Commissioners as routine and through periodical meetings by the Mayor.

Tribal Health

As the CHT is distinct from rest of the Bangladesh in respect of topography, culture, language, residence and cropping patters but all the three districts are also not homogenous and existing cultural and linguistic barrier in the plain lands deter ethic population's access and utilization of public sector health services, new initiatives need to be undertaken to address the tribal health issues.

Activities

1. District-specific tribal health strategies to be developed for each of the three districts in the CHT and another for the ethic population of the plain land
2. Supporting the respective HDCs to implement their respective health strategies
3. Supporting the concerned plain land upazila and district health and family planning department personnel for proper implementation of plan land tribal health strategies

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

CBHC OP will contribute in many ways in the reduction of poverty. Through improving access and utilization of services both in rural and urban areas including marginalized ethic population it will contribute in improving the health status and thus enabling improved economic productivity and also through protecting resources from draining incase of injury or sickness through providing prompt services.

Its health movement through CC groups and respective tribal health strategies will make people aware for environmental conservation and protecting from environmental pollution problems.

This OP will contribute substantially in adopting to minimize adverse effect of climate change through improved awareness and also support the climate change affected people both in rural and urban areas by strengthening health services for better access and utilization.

Women, children and gender issues will be addressed by bringing health services at door step both at urban and rural areas but also for the ethnic population through more culturally and linguistic sensitive health services.

7. Proposed Manpower : Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1.	2.	3.	4.	5.	6.

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1.	2.	3.	4.	5.	6.
1.	Number of CC functioning at Upazila Health Complex	Number of CCs at Upazila Health Complex	0 (CBHC 2016)	200	400
2.	Number of CC having population based data	Number of CCs (HIS/ CC Monitoring report)	0 (CBHC 2016)	1000	5000
3.	Functional referral system	Referral system functioning in UHC (facilities records)	No functional referral system exist	Initiatives undertaken for establishment of referral	Referral system functioning in 200 UHCs
4.	Medical waste management operating at all levels of Upazila health system	Different levels of facilities practicing medical waste management (Observance)	Very limited medical waste management at UzHC only	Medical waste management process initiated at all levels of facilities	Medical waste management operating at 100 UHCs
5.	Institutional mechanisms developed in 3 CHT districts and respective plain land upazilas for delivering tribal health services	Number of CHT districts and plain land upazilas (monitoring report / Admin report)	0	3 CHT and 10 plan land upazilas	All 3 CHT districts and all required plain land upazilas

10. Budget of the Operational Plan:

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
358054.45	146533.50	2010.00	148543.50	506597.95	

10.2. Component and activity wise physical and financial targets: CBHC

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
A. Community Clinic													
(i) Component: Measuring health outcomes													
1	Development of a format to collect household information with MIS, DGHS support	8 Workshop		11.50	11.50	0.00	0.00	0.00	11.50	0.00	0.00	0.00	0.00
2	Training/Orientetion of Community Clinic Staff			1135.00	15.00	1120.00	0.00	0.00	1135.00	0.00	0.00	0.00	0.00
3	Training/Orientetion of CG and CSG members			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	Process collected data in collaboration with MIS			12.00	12.00	0.00	0.00	0.00	3.00	3.00	3.00	3.00	0.00
5	Data collection and compilation (repeated in each year in a pre-fixed time)			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6	Comparison of CC service delivery data with population data to ascertain access and utiliation			1308.00	3.00	1305.00	0.00	0.00	23.00	135.00	1150.00	0.00	0.00
	Sub total			2466.50	41.50	2425.00	0.00	0.00	1172.50	138.00	1153.00	3.00	0.00
(ii) Component: Staffing and Supervision of CC													
1	Contunuation of CC functionality with required staffing			220800.00	210800.00	10000.00	0.00	15410.00	34347.00	39337.00	41098.00	43934.00	46674.00
2	Designating HA and FWAs as full-time CC staff, and develop capacity development			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	Updating designation and job description of HA and FWAs assigned in CCs			3.00	3.00	0.00	0.00	0.00	3.00	0.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
4	Training of FA and FWAs on updated job description			800.00	6.00	794.00	0.00	0.00	400.00	400.00	0.00	0.00	0.00
5	Review supervisory lines to enable the supervisors to provide supportive supervision for effective and quality service delivery			3000.00	1000.00	2000.00	0.00	300.00	1000.00	1000.00	300.00	200.00	200.00
6	Updating supervisory roles, job descriptions and capacity building of the Supervisors			3.00	3.00	0.00	0.00	0.00	3.00	0.00	0.00	0.00	0.00
Subtotal (Component-ii):				224606.00	211812.00	12794.00	0.00	15710.00	35753.00	40737.00	41398.00	44134.00	46874.00
(iii) Component: Community engagement													
1	Preparation of a community engagement manual detailing roles of different stakeholders like CC staff and their supervisors, CG and CSG members, Union Parisad, other local institutions like NGOs, schools, religious institutions etc. with the aim of creating a health movement in the community for bringing improved health outcomes.			11000.00	50.00	10950.00	0.00	1100.00	2200.00	2200.00	2200.00	2200.00	1100.00
2	Multipurpose Health Volunteer for incentive based activities			10020.00	20.00	10000.00	0.00	0.00	2020.00	2000.00	2000.00	2000.00	2000.00
3	Development of different BCC/IEC materials to be supplied at CC to support the social movement.			425.00	425.00	0.00	0.00	75.00	75.00	100.00	100.00	75.00	0.00
4	Orientation of CC staff and their supervisors to steer the process,			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Orientation of CG and CSG members and other stakeholders by CC staff and their supervisors to ignite the social movement.			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
6	Strengthening the social movement.			2000.00	1500.00	500.00	0.00	200.00	500.00	500.00	400.00	300.00	100.00
	Sub total			23445.00	1995.00	21450.00	0.00	1375.00	4795.00	4800.00	4700.00	4575.00	3200.00
(iv) Component: Referral system													
1	Orientation of CC staffs on the referral system with their roles and responsibilities.			253.00	53.00	200.00	0.00	0.00	153.00	100.00	0.00	0.00	0.00
2	Review and update the existing medicine and equipment list to response to the need to referral			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
3	Medicine & equipment list will be reviewed periodically by the existing committees			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Sub total			253.00	53.00	200.00	0.00	0.00	153.00	100.00	0.00	0.00	0.00
(v) Component: Sustaining institutionalization													
a.	Initiative to be undertaken to gradually transfer the head office based staff and CHCP in the revenue budget phase-wise. However till the transfer of revenue these human resources need to be financed.												
1	Drugs and other supplies to be provided to keep these CC functioning.			114039.50	70699.50	42330.00	1010.00	5384.50	19987.00	20823.00	22021.00	22886.00	22938.00
2	Overtime	LS		40.00	40.00	0.00	0.00	3.00	7.00	5.00	6.00	8.00	11.00
3	Travel Allowance			15.00	15.00	0.00	0.00	0.00	3.00	3.00	3.00	3.00	3.00
4	Land Tax			250.00	250.00	0.00	0.00	0.00	50.00	50.00	50.00	50.00	50.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	CD/VAT			1000.00	1000.00	0.00	0.00	100.00	500.00	100.00	100.00	100.00	100.00
6	Income Tax			15.00	15.00	0.00	0.00	0.00	5.00	5.00	5.00	0.00	0.00
7	Postage			10.50	10.50	0.00	0.00	0.50	2.00	2.00	2.00	2.00	2.00
8	Telephone/Telegram/Teleprinter			15.00	15.00	0.00	0.00	1.00	2.00	3.00	3.00	3.00	3.00
9	Telex/Fax			11.00	11.00	0.00	0.00	1.00	2.00	2.00	2.00	2.00	2.00
10	Registration Fee			51.00	51.00	0.00	0.00	0.00	10.00	15.00	10.00	8.00	8.00
11	Water			27.00	27.00	0.00	0.00	2.00	5.00	5.00	5.00	5.00	5.00
12	Electricity			51.00	51.00	0.00	0.00	3.00	8.00	10.00	10.00	10.00	10.00
13	Audio Video/ Film Production			100.00	100.00	0.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
14	Books and Periodicals			100.00	100.00	0.00	0.00	0.00	20.00	20.00	20.00	20.00	20.00
15	Best CC Award			220.00	160.00	0.00	60.00	0.00	40.00	40.00	40.00	40.00	60.00
16	Meeting with others OPs having crosscuting isuse			10.00	10.00	0.00	0.00	0.00	2.00	2.00	2.00	2.00	2.00
17	Casual Labour/Job Work			80.00	80.00	0.00	0.00	5.00	15.00	15.00	15.00	15.00	15.00
18	Consultancy/TA			500.00	0.00	0.00	500.00	0.00	100.00	100.00	100.00	100.00	100.00
19	Security Staff	5 Person		53.00	53.00	0.00	0.00	3.00	10.00	10.00	10.00	10.00	10.00
20	Honorarium/Fees/Remuneration			16.00	16.00	0.00	0.00	1.00	3.00	3.00	3.00	3.00	3.00
21	Copying Charges			11.00	11.00	0.00	0.00	1.00	2.00	2.00	2.00	2.00	2.00
22	Research/Survey/study			80.00	80.00	0.00	0.00	0.00	0.00	30.00	0.00	0.00	50.00
23	Computer Consumables			31.00	31.00	0.00	0.00	0.00	8.00	8.00	5.00	5.00	5.00
24	Day/Ceremony observation			1000.00	1000.00	0.00	0.00	0.00	200.00	200.00	200.00	200.00	200.00
25	Courier Service			15.00	15.00	0.00	0.00	1.00	3.00	3.00	3.00	3.00	2.00
26	Other Expenses			550.00	350.00	0.00	200.00	100.00	250.00	50.00	50.00	50.00	50.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
27	**Repair**				**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
28	Motor Vehicles			160.00	160.00	0.00	0.00	5.00	25.00	25.00	35.00	35.00	35.00
29	Computers & Office Equipments (to be purchased in collaboration with HIS ehealth OP)			16.00	16.00	0.00	0.00	1.00	3.00	3.00	3.00	3.00	3.00
30	Sanitary & Water Supply			10.00	10.00	0.00	0.00	0.00	2.00	2.00	2.00	2.00	2.00
31	Other Repair and Maintenance			27.00	27.00	0.00	0.00	2.00	5.00	5.00	5.00	5.00	5.00
32	**Capital:**				**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
33	Machinery and other Equipments			40.00	40.00	0.00	0.00	0.00	10.00	10.00	10.00	10.00	0.00
34	Furniture and Fixtures			50.00	50.00	0.00	0.00	0.00	10.00	10.00	10.00	10.00	10.00
35	Computers and Accessories (to be purchased in collaboration with HIS ehealth OP)			30.00	30.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00	5.00
36	Office Equipments			20.00	20.00	0.00	0.00	0.00	5.00	5.00	5.00	5.00	0.00
37	Efforts will be taken for establishing one CC in each upazila health complex to cater the need of immediate population of its vicinity.			0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
38	Newly recruited CHCPs will require training.			2000.00	20.00	1940.00	40.00		400.00	400.00	400.00	400.00	400.00
39	As per need repair/renovation of CC, approach road, utilities like electricity and water supplies will be taken care.			1500.00	1000.00	500.00	0.00	0.00	400.00	400.00	400.00	300.00	0.00
40	In country Exchange tour for service providers, community leaders & manegers			500.00	500.00	0.00	0.00	0.00	250.00	0.00	250.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	Sub total			122644.00	76064.00	44770.00	1810.00	5619.00	22369.00	22391.00	23812.00	24322.00	24131.00
	TOTAL OF A			373414.50	289965.50	81639.00	1810.00	22704.00	64242.50	68166.00	71063.00	73034.00	74205.00
B. Primary Health Care Services Upazila & Below													
(i) Upazila Health System & Referrel System													
1	Procurement and supply Medical Equipment	158	set	22000.00	0.00	22000.00	0.00	2200.00	4400.00	4400.00	4400.00	4400.00	2200.00
2	Procurement and supply Furniture	158	set	4740.00	4740.00	0.00	0.00	346.50	900.00	1050.00	900.00	900.00	643.50
3	Pay and allowances to the manpower under development budget	37440	Men month	8383.85	8383.85	0.00	0.00	586.87	1676.77	1676.77	1676.77	1676.77	1089.90
4	Operating Cost to the newly constructed & upgraded hospital at primary level	25055	bed	50000.00	50000.00	0.00	0.00	5000.00	10000.00	10000.00	10000.00	10000.00	5000.00
5	Procurement and supply of lab Equipment	250	set	1250.00	0.00	1250.00	0.00	87.50	250.00	250.00	250.00	250.00	162.50
6	Ensure regular gender auditing process		LS	50.00	0.00	50.00	0.00	3.50	10.00	10.00	10.00	10.00	6.50
7	Assess gender auditing		LS	50.00	0.00	50.00	0.00	3.50	10.00	10.00	10.00	10.00	6.50
8	Comprehensive services to all geriatric patients	150	UHC	750.00	0.00	750.00	0.00	52.50	150.00	150.00	150.00	150.00	97.50
9	Suituation analysis	60	UHC	120.00	0.00	120.00	0.00	8.40	24.00	24.00	24.00	24.00	15.60
10	Upgrade health facilities to provide adolescent friendly services	100	UHC	33.00	0.00	33.00	0.00	2.45	7.00	7.00	7.00	5.00	4.55
11	Development of Safe blood transfusion centre	100	UHC	750.00	0.00	750.00	0.00	52.50	150.00	150.00	150.00	150.00	97.50
12	Development of monitoring software (to be done in collaboration with	0	LS	35.00	0.00	35.00	0.00	0.00	25.00	10.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	MIS)												
13	Distribution of SONO Filter (Water Purifier to all UHCs, 10 for each UHC)	5000	apprx. No.	500.00	300.00	0.00	200.00	0.00	100.00	100.00	100.00	100.00	100.00
14	Printing and publication of Training guideline	30000	Guide book	180.00	0.00	180.00	0.00	21.00	60.00	60.00	0.00	0.00	39.00
15	Supervision, Monitoring & report keeping systems	0	LS	50.00	0.00	50.00	0.00	3.50	10.00	10.00	10.00	10.00	6.50
16	Operational cost for HQ	0	LS	400.00	400.00	0.00	0.00	40.00	80.00	80.00	80.00	80.00	40.00
17	Strengthening of emergency unit of all UHC (Procurement & supply of Medicine & MSR)	150	Set	174.60	174.60	0.00	0.00	12.18	35.10	35.10	34.80	34.80	22.62
18	TOT (SOP) & other training & Workshop	566	batchs	1000.00	0.00	1000.00	0.00	100.00	200.00	200.00	200.00	200.00	100.00
19	Capacity bulding	45	batchs	2250.00	0.00	2250.00	0.00	157.50	450.00	450.00	450.00	450.00	292.50
20	Orientation on SOP	120	#	168.00	0.00	168.00	0.00	10.50	34.00	34.00	36.00	34.00	19.50
21	Strengthening of referral linkage		batchs	2300.00	0.00	2300.00	0.00	91.00	510.00	510.00	510.00	510.00	169.00
22	Orientation and awarness meetings amongs NGO workers and different stake holders on referrence linkage (as per SOP guideline)	430	batchs	500.00	0.00	500.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
23	Leadership Training for Upazila level Manager and service provider	430	batchs	500.00	0.00	500.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
24	Allocation of Impress Fund for each facility (UHC, Union facility and CC)	490	UHC	2800.00	2800.00	0.00	0.00	140.00	600.00	600.00	600.00	600.00	260.00
25	Vehicle for UHFPO	440	#	22000.00	0.00	22000.00	0.00	0.00	5500.00	5500.00	5500.00	5500.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
26	Ambulance	250	#	7500.00	0.00	7500.00	0.00	0.00	1500.00	1500.00	1500.00	3000.00	0.00
	Sub Total			128484.45	66798.45	61486.00	200.00	9019.40	26881.87	27016.87	26798.57	28294.57	10473.17
(ii)	**Urban Health**												
1	Strengthen urban dispensaries by providing logistics	35	Set	250.00	50.00	200.00	0.00	10.00	140.00	25.00	25.00	25.00	25.00
2	Strengthening Chest Clinic for providing urban health services	45	Nos	500.00	0.00	500.00	0.00	0.00	250.00	100.00	50.00	50.00	50.00
3	Satellite clinic	250	#	200.00	0.00	200.00	0.00	14.00	40.00	40.00	40.00	40.00	26.00
4	Development of IEC & BCC materials	0	LS	100.00	0.00	100.00	0.00	7.00	20.00	20.00	20.00	20.00	13.00
5	Advocacy meeting, workshop, seminar	75	batchs	75.00	0.00	75.00	0.00	5.25	15.00	15.00	15.00	15.00	9.75
6	Training	1	Batch	50.00	0.00	50.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00
	Sub Total			1175.00	50.00	1125.00	0.00	36.25	515.00	200.00	150.00	150.00	123.75
(iii)	**Medical Waste Management**												
1	Procurement & supply of logistic	430	set	1176.00	1176.00	0.00	0.00	86.10	246.00	246.00	246.00	192.00	159.90
2	Creating facilities for Medical waste disposal	100	Nos	600.00	0.00	600.00	0.00	0.00	100.00	150.00	150.00	100.00	100.00
3	Development of (Enviromental Management Plan (EMP)	0	LS	5.00	0.00	5.00	0.00	0.35	1.00	1.00	1.00	1.00	0.65
4	Disposal of general waste by Municipality/Union Parishad from UHC	430	UHC	164.50	64.50	100.00	0.00	4.73	33.50	33.50	33.50	30.50	28.77
5	Activation of different committee formed for facilitating MWM	4300	# meetings	16.00	0.00	16.00	0.00	1.16	3.30	3.30	3.30	2.80	2.14

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
6	Capacity development/Training on MWM (Foreign)	1	batch	50.00	0.00	50.00	0.00	0.00	50.00	0.00	0.00	0.00	0.00
7	Capacity development/Training on MWM	240	batchs	175.00	0.00	175.00	0.00	12.25	35.00	35.00	35.00	35.00	22.75
8	TV show, audio visual materials, radio program etc.	0	LS	50.00	0.00	50.00	0.00	3.50	10.00	10.00	10.00	10.00	6.50
9	Development of IEC & BCC materials	0	LS	50.00	0.00	50.00	0.00	3.50	10.00	10.00	10.00	10.00	6.50
10	Printing & distribution of Manuals	0	LS	50.00	0.00	50.00	0.00	3.50	10.00	10.00	10.00	10.00	6.50
11	TA requirment	15	Men month	20.00	0.00	20.00	0.00	1.75	15.00	0.00	0.00	0.00	3.25
	Sub Total			2356.50	1240.50	1116.00	0.00	116.84	513.80	498.80	498.80	391.30	336.96
(iv)	**Tribal Health Programme**												
1	Meeting	35	batchs	52.50	0.00	52.50	0.00	3.68	10.50	10.50	10.50	10.50	6.82
2	Development of IEC & BCC materials	0	LS	10.00	0.00	10.00	0.00	0.00	2.00	2.00	2.00	4.00	0.00
3	Raise awareness	0	LS	5.00	0.00	5.00	0.00	0.35	1.00	1.00	1.00	1.00	0.65
4	MSR & Other Logistic	50	Sets	350.00	0.00	350.00	0.00	20.00	70.00	70.00	70.00	60.00	60.00
5	Satellite clinics/ Mobile Medical Team	6000	Nos	700.00	0.00	700.00	0.00	30.00	160.00	160.00	160.00	110.00	80.00
6	Exchange visits for experience sharing in home and abroad	1	Batch	50.00	0.00	50.00	0.00	0.00	0.00	50.00	0.00	0.00	0.00
	Sub Total			1167.50	0.00	1167.50	0.00	54.03	243.50	293.50	243.50	185.50	147.47
	Total of B			133183.45	68088.95	64894.50	200.00	9226.52	28154.17	28009.17	27690.87	29021.37	11081.35
	Total A+B			506597.95	358054.45	146533.50	2010.00	31930.52	92396.67	96175.17	98753.87	102055.37	85286.35

11. Budget support from other Operational Plan: Not applicable

4.24 Hospital Services Management (HSM)

1. Name of the Operational Plan: Hospital Services Management (HSM)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

Hospital Services Management is a key operational plan in the health sector development program. The operational plan aims to provide all necessary support for ensuring basic and advanced healthcare needs of the people. Traditionally routine government expenditure on health is meager in comparison to other countries. HSM OP gives an opportunity to bridge the gap between demand and supply. As medical science is developing very rapidly, a modern diagnostic or therapeutic facility becomes obsolete in the blink of eye and needs to be replaced by a newer one. As hospitals are the face of the healthcare system, common people perceive the quality of care provided at hospitals as the overall quality of the healthcare system.

Bangladesh has a large population and a wide healthcare delivery network to cater them. But the infrastructure is inefficient and sometime inadequate. The design and inherent integration of the different tiers of healthcare facilities are also inefficient. Moreover, doctors and healthcare facilities are not fairly distributed throughout the country. Modern and sophisticated services are limited to capital city or mostly 3 or 4 big cities. Ensuring equitable access to all healthcare services is a big challenge. The use of modern knowledge and technologies, research and development sector lags behind. Bangladesh has an acute dearth of qualified professionals such as Intensivists, Dialysis physician, trained nurses, and medical technologists. Resources and efforts should be ensured to develop trained manpower and their capacity development. Hospitals face the challenges to provide services to chronically ill patients, geriatric and mental health patients, provide modern state of the art facilities equitably as well as handling overcrowding issues at District and Medical College Hospitals.

Article 15.1 of the constitution of the People's Republic of Bangladesh asserts that the State will ensure basic healthcare services to all citizens of the country. National Health Policy 2011 has 3 specific objectives includes ensuring primary and emergency healthcare for all, enhancing equitable quality healthcare and accessibility, and promoting preventive healthcare services. So, the ultimate goal of Hospital Services Management OP is ensuring universal health coverage (UHC) by providing quality healthcare services to all citizens of Bangladesh. This OP is concerned with secondary and tertiary level healthcare services provided at public and private sectors.

4. Objectives:

General Objective: To provide equitable and accessible healthcare services at secondary and tertiary hospitals of Bangladesh.

Specific Objectives:

i) To strengthen, upgrade and support secondary and tertiary level hospital services to ensure equitable access to quality healthcare for the population

ii) To reduce the maternal mortality by ensuring and further strengthening of existing 24/7 CEmOC activities at district and Medical college hospital

iii) To strengthen the regulatory framework for private healthcare services.

iv) To ensure laboratory and imaging services specialized services (ICU, NICU, SCANU, CCU, Dialysis unit) at district hospitals and Medical College Hospitals, specialized institutes.

v) To ensure services for autism and neuro developmental disorders through 'Shishu Bikash Kendro'.

vi) To ensure effective and efficient delivery of services of essential service package (ESP) at secondary and tertiary hospitals until referral system is fully functional.

vii) To improve the clinical service delivery of hospital services by ensuring Emergency management services.

viii) Introducing Geriatric care, palliative care, mental health, evidence-based practices (EBP), Clinical Management Protocol, patient safety program, club foot, cleft palate and reconstructive surgery services, improved care of poisoning and snakebite

ix) To improve the Quality of Care in the health care services by introducing 5S-CQI-TQM approach for public hospitals, Standard Hospital operating manual and SOPs, clinical audit and risk management program, accreditation system for private sectors, and a comprehensive monitoring and supervision framework

x) To introduce Structured Referral system in the hospital services for the proper utilization of resources in the health care system

xi) To introduce standard medical waste management in both public and private sector

xii) To strengthen the regulatory framework for private sectors and improving collaboration with public sectors

xiii) To ensure equitable healthcare services irrespective of age, sex, race and social and economic condition.

xiv) To establish safe blood transfusion program countrywide

xv) To improve the coverage and meet the gaps of urban health services

xvi) To strengthen the capacity of district hospitals to provide appropriate services to tribal people and upgrading services for the hill tract districts, coastal area, haor areas hospitals

xvii) To establish and strengthen an effective procurement, inventory management and financial system at different levels of hospitals

xviii) To engage and enhance community participation in healthcare management system

5. Components:

Component A: Continuation of support to secondary and tertiary care hospitals

Hospitals are the face of the healthcare system of any country. The HSM operational plan will continue to support the 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 till its transfer. Salaries and allowances for the staffs, diet, equipment, drugs and other logistics will be supported through this OP. At the same time, any completed new construction or expansion of secondary, tertiary and specialized facilities under the 4th sector program will be supported. Proper procurement, store and asset management and stringent financial management will be ensured through effective and comprehensive monitoring system.

a) **District Hospitals:** The OP aims to provide support for upgrading all existing district hospitals to 250 bed facility. The district hospitals where new medical colleges are established will be

continued to be used as Medical College Hospitals until new medical college hospitals are being functioning. The district hospitals will be the referral hospitals for the corresponding upazila health complexes (UHC) of the district as well as will provide primary healthcare services (ESP) to nearby catchment urban population.

Activities:

1. Salaries, allowances, logistic support services/ or operational cost for existing expanded/ constructed facilities to be continued till their transfer to non-development budget
2. Supply of equipment and logistics to the completed new construction or expansion facilities under the 4th sector program
3. Ensuring services of Essential Service Package (ESP) at all district hospitals, a separate arrangement of it will be made by setting a Primary Healthcare Centre/facility for the urban catchment area at all district hospitals. An initiative to engage the Community Medicine Department of the Medical College in the activity of Primary Healthcare centres will be instituted. Placement of Intern doctors in the centres will be encouraged.
4. Improvement of waiting area for the patients at OPD and for patient's attendants in the hospital premises, outside the ICU, CCU and other specialized services centres.
5. Supply of equipment, furniture and logistics for Kuwait Bangladesh Friendship Government Hospital, Uttara, Dhaka
6. Capacity development of service providers and managerial staffs.
7. Standardization of different level hospitals in respect of manpower, instrument/equipment and bed distribution according to different discipline.
8. Ensuring community participation in the management process.
9. Diet related issues: Diet categories will be reorganized to make it inclusive for all types of patients in the hospital (Diabetic patient, CKD patient, ICU patient, Obese patients etc.)

b) Medical College Hospitals: The capacity and efficiency of Medical College Hospitals will be enhanced. The Old Medical College Hospitals will be upgraded to 1000 bed facility with all specialized services available. Medical College Hospitals will be used as the tertiary level referral hospitals with all facilities and services.

Activities:

1. Salaries, allowances, logistic support services/ or operational cost for existing expanded/ constructed facilities to be continued till their transfer to non-development budget
2. Supply of equipment and logistics for the completed new construction or expansion facility under the 4th sector program
3. Arrangement for setting up a Primary Healthcare Centre/corner for delivery of ESP for urban population for the nearby catchment area at all Medical College hospitals.
4. Improvement of waiting area for the patients at OPD and for patient's attendants in the hospital premises, outside the ICU, CCU and other specialized services centres.
5. Capacity development of service providers and managerial staffs.
6. Ensuring community participation in the management process.

7. Setting up Thalassaemia prevention facility
8. Diet related issues: Diet categories will be reorganized to make it inclusive for all types of patients in the hospital (Diabetic patient, CKD patient, ICU patient, Obese patients etc.)

c) **Specialized Institutes and Hospitals:** HSM OP will continue to support the existing Specialized National Institutes and hospitals. The National Institutes will be regarded as a truly national centre of excellence providing state of the art specialized services as well as acting as a national resource centre for providing technical support and guidance in the field of their respective subjects throughout the country. Terms of references will be introduced for the National Institutes and specialized hospitals.

Activities:

1. Salaries, allowances, logistic support services and/ or operational cost for existing expanded/ constructed facilities to be continued till their transfer to non-development budget
2. Supply of equipment and logistics for the completed new construction or expansion under the 4th sector program
3. Improvement of waiting area for the patients at OPD and for patient's attendants in the hospital premises, outside the ICU, CCU and other specialized services centres.
4. Strengthening of National Institutes for acting as National resource centre and providing technical and stewardship role in their respective services relevant to the operational plan.
5. Development of Terms of Reference (TOR) for the National Institutes for supporting the health Sector programme to ensure providing technical support to the National programm- for standard setting and quality assurance, development of Protocol and SOP, training, assist monitoring, conducting research and providing necessary support for developing a referral system in the relevant field through UHC, District hospitals, MCH and Specialized Institutes
6. Capacity development of service providers and managerial staffs.
7. Strengthening of 'Bangladesh Institute of Tropical and Infectious Diseases (BITID)' the national institute for Tropical Medicine & ID, Fauzdarhat, and Chittagong.
8. Establishment of National Institute for Geriatric Care at a suitable place in Dhaka.
9. Establishment of Bone Marrow Transplant Unit in BSMMU.
10. A standard for providing diet suitable for the patients for the institutes by reorganizing the existing structures.

Component B: Strengthening of Clinical Service delivery in secondary (DH) and tertiary hospitals (MCH, Specialized institute)

Hospitals are most utilized part of the entire healthcare system in Bangladesh. The clinical service delivery system in the hospitals is expected to be significantly improved thorough the following activities.

Activities

1. Ensuring all essential service package (ESP) services at all district hospitals and develop a referral linkage with lower level hospitals and ensure preferential treatment of referred patients.

2. Introducing training for basic life support (BLS) to all health care professionals and advanced life support (ALS) training to all internee doctors, newly recruited assistant surgeons. Strengthening the program through PSE among medical colleges.
3. Emergency Obstetrics and Neonatal Care (EmONC) and gender issue: A model of providing EmONC at the district hospital will be developed with Technical Assistance and will be replicated in all district hospitals in a phase wise manner. Gender issues including establishment of VAW corner in DH, Gender responsive budgeting and Gender auditing will addressed.
4. Strengthening of Hospital emergency system including management of casualty: The emergency department of Medical College Hospitals and Specialized institutes will be strengthened by provision of Emergency care and resuscitation linked with inpatient & ICU, Observation beds, short stay bay, diagnostic and Imaging facilities with Emergency OT.
5. Ensuring 24/7 Comprehensive Emergency management system in all district hospitals and possible linkage with EmOC services and Inpatient departments
6. Strengthening of quality management of Snakebite and other poisoning at district and Medical College Hospitals will be ensured. A model Snake bite and Poisoning Management clinic will be established in Chittagong Medical College Hospital (already in existence through local initiative) and will be replicated to other 7 Divisional headquarters medical colleges.
7. Strengthening of Trauma management by establishing casualty departments and provision of casualty OT in the emergency.
8. Ensuring proper management of NCD emergencies such as Stroke, Acute Coronary Syndrome, Diabetic Ketoacidosis, Acute exacerbation of COPD in the Emergency/in patient with manpower and resources.
9. Expansion of specialized services such as ICU, CCU, NICU, SCANU, Dialysis units, stroke units in all Medical College Hospitals with development of Manuals and SOPs.
10. Expansion of specialized services such as ICU, CCU, NICU, SCANU, Dialysis units, in all district hospitals with development of Manuals and SOPs.
11. 10% of beds in different major clinical departments of hospitals will be renovated as High Dependency Unit (HDU) to provide upgrade emergency care in Medicine, Surgery, Obstetrics & Gynaecology and Paediatrics with SOPs developed for management and optimal use
12. Strengthening of Mental health services at Medical College Hospitals including inpatient care and development of district mental health team.
13. Scale up of 'Shishu Bikash Kendra' focusing comprehensive care of autism and neurodevelopmental disorders including facility for diagnosis and management of epilepsy (considering the life span need of the National Strategic plan for neurodevelopmental disorders 2016-2021 (health care components by MOHFW, and for other components stewardship).
14. Establishment of geriatric and palliative care services at all Medical College Hospitals & geriatric care in district hospital, DH.
15. Development and introduction of 'Clinical Management Protocol', Infection control Program, Evidence based Practice, introduction of communication skill development program, and Clinical audit and risk management programs.
16. Establishment and scale up of baby, adolescent and women friendly hospital initiative

17. Ensuring effective management of genital fistula, cervical cancer screening and care
18. Addressing gender issue including Gender Responsive Budgeting (GRB), gender violence, appraisal of health care professionals on sexual assault.
19. Club foot management in NITOR, all medical college and district hospitals
20. Cleft palate and reconstructive surgery services at medical college hospitals
21. Establish an outreach Paediatric Surgery Program in Chittagong Medical College Hospital (already in place) and replicate them in Dhaka, Khulna and Rajshahi.
22. Establish Thalassemia prevention Centre in Dhaka Medical College Hospitals and replicate them in divisional headquarters.
23. Strengthening of quality laboratory services at all DH and MC hospitals with provision of ward side selected emergency tests
24. Strengthening of quality radiology and imaging services at all DH and MC hospitals
25. Establishment of a central Procedural Room for all Intervention facilities at old Medical College Hospitals
26. Introducing IT for reporting and sending the laboratory and radiology reports
27. Strengthening of Medicolegal services at district hospitals
28. Ensuring services and supply for providing treatment of Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) with close partnership with National Nutrition Services (NNS)

Component C: Private Healthcare Facilities

The close partnership and collaboration between public and private hospitals is vital for ensuring comprehensive coverage of all healthcare needs of people. But it is imperative that private healthcare facilities should be under close supervision. The regulatory framework will be updated. A comprehensive private healthcare act should replace the age old 1982 ordinance. Establishment of an autonomous National Accreditation body for accreditation of hospitals and laboratories will contribute to the delivery of quality care in private sectors.

Activities

1. Strengthening of HSM for monitoring and supervision of expanding private health sector (hospitals, diagnostics, private practice)- for profit and non-profit (HR, space, logistics, transport, IT support). A policy decision is needed to strengthen this department in respect of Manpower and Logistics.
2. Development of Private Clinic Rules and regulations, standards for specialized services
3. Development of a Comprehensive Monitoring strategy and policy with Technical assistance.
4. Provision of Providing Emergency management to all patients.
5. Provision of Standard Medical Waste Management, ensuring quality care and a referral system in Private facilities. Regular advocacy workshops with private healthcare facilities will be organized.
6. Approval of National accreditation bill. Establishment of National accreditation body and functional accreditation program.

7. Development of a comprehensive database of private healthcare facilities, facilitate quick disposal of licensing and renewal process
8. Ensuring that the poor and disadvantaged people get services (at least 10%) from the private sectors through regulations and social safety net programs.
9. Regular reporting of services provided to appropriate authority and link up to health MIS system.
10. Promotion of Public Private Partnerships (PPP) and outsourcing of expensive services.

Component D: Quality care

Ensuring quality of care at all service points is the key issue in the management of HSM operational plan. The development of National healthcare standards is vital in maintaining a consistent service delivery throughout the country. The OP will introduce the 5S-CQI-TQM approach in the management of all secondary and tertiary care hospitals. Improvement of hospital environment, ensuring proper service delivery, maintaining the quality of care and a cordial management-community relationship are the main focus of the TQM approach. . Active participation of lower and mid-level managers will play the key role for proper implementation of the Program.

Activities

1. Developments/updating and Implementation of National Health Care Standards at secondary and tertiary hospitals.
2. Introduction of different SOPs and quality improvement tool kits in healthcare facilities
3. Capacity development of the service providers regarding TQM approach.
4. Orientation and motivation of community to help management for smooth functioning of healthcare facilities
5. Introduction and maintenance of TQM approach of management at hospitals at district level and above.
6. Operational research on quality issues
7. Coordination with Quality Secretariat (HEU) and hospitals under DGHS & private sector
8. Introduction of standard patient care forms (all type of patient request & report) for hospitals
9. Development and establishment of Hospital Manual and SOPs

Component E: Safe Blood Transfusion

Universal access to safe blood for the patient is the cornerstone of the Safe Blood Transfusion Program. Blood should be collected from eligible non remunerated voluntary blood donor after proper grouping, screening, cross-matching, rational use of blood or its component with standard transfusion procedure, post transfusion follow up with improved transfusion services in a quality ensured procedure.

Activities:

1. Voluntary Blood donor Pool

2. Hemovigilance

3. Improved Transfusion Service

4. Transfusion Transmissible Infection & Quality Control

Component F: Introduction/implementation of Medical Waste Management at Public & Private Hospitals

Effective implementation of Medical waste management in the public and private hospitals is a key determinant of improvement of Hospital environment and providing quality service. Capacity development and awareness of the service providers will be the most important aspect of MWM. Supply of logistics and technical support to the hospitals together with smooth coordination with local government agencies and department of environment will ensure the proper implementation of the program. Enforcement of Medical Waste law may be of great help for achieving the goals. For outhouse management of medical wastes PPP and outsourcing will be encouraged.

Activities

1. Awareness building for service providers and recipients.
2. Supply of necessary logistics for MWM.
3. Establishment of in-house waste management system including temporary waste disposal room.
4. Establishment of Outhouse management in collaboration with local civic bodies.
5. Dissemination and Implementation of National guideline for Medical waste management.
6. Capacity development of the service providers.
7. Coordination with local government agencies and Department of Environment.
8. To monitor that Standard MWM is in place in private healthcare facilities.

Component G: Introduction and scale up of the Structured Referral system

The aim of structured referral system is to maximize the utilization of UHC and load minimization of the secondary and tertiary level hospitals by introduction of effective upward and downward referral system. Structured referral system is to be rolled out countrywide from Primary, Secondary and Tertiary level hospitals by defining the specific catchments area in collaboration with other related departments and OPs. By ensuring the ownership and accountability of the hospital service provider, referral system will be implemented effectively. Patient will be made 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

1. Preparation and implementation of referral procedures and rules across the health tiers, within the institutes, and between institutes.
2. Capacity building of the service providers, Orientation of hospital management and opinion leaders.
3. Development, finalization, dissemination and printings and distribution of different forms, guideline and registers to different hospitals.
4. Development of Referral data base and automated referral system.

Component H: Patient Safety

Patient safety is a new healthcare discipline that emphasizes the reporting, analysis, and prevention of medical error that often lead to adverse healthcare events. According to the World Health Organization (WHO) patient safety issue is an endemic health concern. Patient safety involves applying lessons learned from business and industry, adopting innovative technologies, educating providers and consumers, enhancing error reporting systems, and developing new economic incentives. Patient safety has emerged as a powerful force in the current movement to improve quality and lower cost in health care. Patient safety involves minimizing the risk of error to patients.

Activities

1. Development, finalization, dissemination and printings and distribution of Patient Safety guidelines.
2. Orientation of healthcare service providers based on guidelines about patient safety issues: incident reporting, medication safety, adverse drug reaction monitoring, surgical safety, infection control including hand wash, crisis management tools, death audit etc.
3. Provision of logistics for DH, MCH, Specialized Institutes for addressing patient safety issues
4. Ensure Patient safety issues are properly addressed at Private Medical College Hospitals and other private facilities. Introduction of patient safety in private sector hospitals.
5. Incorporation of Patient safety issues in Undergraduate curriculum and internship training.

Component I: Urban Health

The primary healthcare delivery system for urban area is one of the weak crosslink of the health system.

Activities

1. Provision of Primary Healthcare Centres for providing ESP for catchment population in urban secondary (DH) and tertiary hospitals (MCHs- public and private)- dual role- service of ESP, segregating referred cases plus teaching the healthcare professional students and trainees.
2. Capacity building of healthcare providers in Secondary and tertiary hospitals in providing primary healthcare, through developed manual.

Component J: Strengthening of Procurement, Store Management, Asset management and financial management of Hospitals

The effective administration of hospitals at different levels need to procure a wide range of equipment, medical and surgical instruments, state of the art laboratory and imaging machineries, need assessment and their proper maintenance. The system requires an efficient Store management, Asset management and above all maintaining a high standard of financial propriety.

Activities

1. Capacity development of concerned managers, officials and staffs
2. Development of Manuals, SOPs and guidelines
3. A comprehensive framework of monitoring and supportive supervision

Component K: Repair, Maintenance and Disposal of Vehicles, Biomedical equipment and others

Hospital Services Management OP aims to all necessary support for maintenance and servicing of all vehicles, electrical and electronics equipment, biomedical instruments to keep them functional. TEMO is responsible for providing maintenance, repair and replacement of parts to all vehicles under DGHS. NEMEW is responsible for providing installation, maintenance and functioning support to hospital instruments and medical equipment. This is vital to ensure continuous functioning of the health systems. The maintenance and replacement services beyond the capacity of those two organizations should be outsourced to ensure proper functioning.

Activities

1. Setting up of Division based NEMEW & TEMO centers
2. Provision of common minor Repair- Tyre, Battery, Dent Paint, Mirror, Light, Horn, Shock absorber, Belts, Servicing at TEMO
3. Installing, maintenance, repair and functioning of AC, refrigerators, generators, Suction machines, OT table, OT lights by NEMEW
4. Provision of outsourcing the maintenance work beyond the capacity of NEMEW and TEMO
5. Regular holding of condemnation board for smooth disposal of non-repairable nonfunctioning vehicles, furniture, equipment
6. Development of a SOP & procedure for proper disposal of electro medical equipment.

Monitoring, Research and Evaluation:

Evidence generation for improved healthcare services at secondary and tertiary hospitals:

1. Development of monitoring and evaluation framework, and monitoring checklist.
2. Effect of key hospital innovations (e.g. patient safety, waste disposal) (to be made in next sector program) on patient satisfaction and outcome.
3. Evaluation of the Operational Plan.
4. Pattern and number of patients requiring primary health care (CBHC) in DHs, MCHs.
5. Feasibility of using IT in referral and in improving management of acute coronary syndrome and stroke.
6. Feasibility of using IT in patient management (OPD, in patient and emergency).
7. Feasibility of using IT in laboratory reporting, including histology reporting of FNAC samples.
8. Feasibility of using IT in radiology & imaging reporting.
9. Prevalence of TB in diabetic patients in Bangladesh.
10. Prevalence of hospital acquired infection in Bangladesh.
11. Prevalence of infection in diabetic patients in Bangladesh.
12. Prevalence of infection in cancer patients in Bangladesh.
13. Setting up hospital cancer registries in 19 Medical Colleges.
14. Situation analysis: dietary need have admitted patients and other diet related issues.
15. 'Demonstration project':

i) Teaching primary health care to medical professional students (MBBS, Nursing and Medical Assistants) in the ESP area of Medical College Hospital.

ii) Can improved communication skill lead to better patient satisfaction?

A comprehensive monitoring and supervision framework for secondary and tertiary hospitals will be developed with technical assistance. The framework will include regular monthly reporting and yearly statement of activities Capacity development of concerned officials at DGHS, divisional and district level will be done. A quarterly meeting with hospital administration regarding management and quality of care issues is planned

6. Cross-Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

In this OP provision of care for women & children, addressing gender **issues** and poor segment of population was kept, example, 24/7 MNCAH services at DH, 10% beds in private hospitals will be used for poor people. Also, primary health care provision and OCC will be kept in a structured manner in DH and MCH.

Sl. No.	Area	Primary responsibility	Collaboration with	
			Health	Non-health
1	2	3	4	5
1.	Essential service Package (ESP) services at DH	HSM	CBHC	
2.	Essential service Package (ESP) services at MCH	HSM	CBHC, Medical Education for teaching	
3.	Strengthening of National Institutes	HSM	CDC, NCDC	
4.	Quality management of Snakebite and poisoning at DH & MCH	HSM	CBHC, NCDC	
5.	Establishment of poisoning information centre & Toxicological Analytical Lab	NCDC	HSM	
6.	Addressing Malnutrition Treatment	NNS	HSM	
7.	Teaching basic life support (BLS) to all health care professionals	HSM, Nursing services, CBHC	CBHC, ME&HMD	Ambulance services
8.	Teaching advanced life support (ALS) to all doctors	HSM	BSMMU, Private Medical Colleges	Ambulance services
9.	Quality Care	HSM, CBHC	HEU quality secretariat	
10.	Medical waste management	HSM, CBHC	Private Hospitals, Diagnostic Lab, Local Govt.	Dept. of Environment

Sl. No.	Area	Primary responsibility	Collaboration with	
			Health	Non-health
			Institutions	
11.	Patient Safety	HSM, CBHC	Private Hospitals, Diagnostic Lab, PSE	
12.	Adverse drug reaction monitoring & surveillance	HSM, CBHC	DGDA, Private Hospitals, PSE,	
13.	Antibiotic resistance monitoring	CDC	HSM, CBHC, DGDA, Private Hospitals, PSE	
14.	Life span need of neurodevelopment disorder	NCDC, HSM	CBHC, other non-health sectors	
15.	Gender based violence, One stop crisis centre(OCC)	MoWCA	MNCAH, HSM, CBHC, ?NCDC	
16.	Support for disabled	NCDC	CBHC, HSM	
17.	Elderly people/ senior citizens	NCDC	CBHC, HSM	
18.	Physical therapy/Physiotherapy SAM and MAM management	NCDC NNS	CBHC, HSM, PSE	
19.	Thalassemia prevention centre	HSM	NCDC	

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators:

Sl.	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1.	Number of Hospitals (DH & above) introduced standard in-house medical waste management	Number of hospitals (Admin report)Number of hospitals (Admin report)	MCH-6 Spec. H – 10 DH – 04 (APIR, 2016)	MCH-18 Spec. H – 14 DH – 28	MCH- 28 Spec. H – 22 DH – 48
2.	Number of public and non-public facilities accredited	Number of hospitals (Admin / Status report)	0	Accreditation mechanism established	MCH-12, DH – 19 Non public hospitals-30

Sl.	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
3.	Number of district hospitals connected to structured Referral System	Number of hospitals (Admin / Status report) Number of hospitals (Admin/ Status report)	MH-1 DH-24 UHC-17	30	50
4.	Number of district with a public hospital having five essential specialist (medicine, surgery, paediatrics, obs and gynae, anesthologist)	Number of districts	NA	25	45
5.	District Hospitals provide CEmONC services in Sylhet and Chittagong divisions	Number of district Hospitals	0	9	13

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
150019.00	251153.00	2939.00	254092.00	404111.00	

10.2. Component and activity wise physical and financial target of OP: HSM

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component 1: Continuation of Support to Secondary and Tertiary care hospital													
1	Pay and allowance of Officers and Staffs	606		4396.00	4396.00	0.00	0.00	261.00	827.00	827.00	827.00	827.00	827.00
2	Diet	12000 beds		24071.00	24071.00	0.00	0.00	1712.00	3422.00	3880.00	4563.00	5019.00	5475.00
3	Other Medicine	12000 beds		10369.00	5223.00	5146.00	0.00	576.00	1490.00	1656.00	2038.00	2233.00	2376.00
4	MSR Supplies	12000 beds		82316.00	53282.00	29034.00	0.00	5366.00	11625.00	13175.00	16145.00	17350.00	18655.00
5	Instruments, equipment, vehicles & other assets	12000 beds		150000.00	3000.00	147000.00	0.00	15000.00	30000.00	30000.00	30000.00	30000.00	15000.00
6	Cleaning and washing	12000 beds		11863.00	11286.00	577.00	0.00	778.00	1680.00	2015.00	2250.00	2450.00	2690.00
7	Security	12000 beds		5290.00	5100.00	190.00	0.00	350.00	756.00	861.00	1013.00	1100.00	1210.00
8	Special expenditure (Laundry)	12000 beds		5462.00	5370.00	92.00	0.00	380.00	810.00	912.00	1015.00	1120.00	1225.00
9	Petrol and Oil	66 vehicles		1009.00	1009.00	0.00	0.00	21.00	89.00	154.00	219.00	263.00	263.00
10	Water and Electricity	99 hospitals		336.00	281.00	55.00	0.00	31.00	61.00	61.00	61.00	61.00	61.00
11	Stationeries, other consumables	99 hospitals		5000.00	4000.00	1000.00	0.00	500.00	1000.00	1000.00	1000.00	1000.00	500.00
12	Spare Parts	99 hospitals		640.00	110.00	530.00	0.00	40.00	60.00	90.00	120.00	150.00	180.00
13	Repair and Maintenance	99 hospitals		2775.00	1374.00	1401.00	0.00	211.00	466.00	515.00	537.00	520.00	526.00
14	Support fof strengthening of National Institutes	11 inst.		171.00	32.00	139.00	0.00	16.00	30.00	35.00	40.00	35.00	15.00
15	Monitoring and Supervision	99 hospitals		195.00	45.00	100.00	50.00	10.00	70.00	28.00	32.00	30.00	25.00
16	Establishment of Bone Marrow Transplant Unit in the National Cancer	**1 unit**		4000.00	2500.00	1500.00	0.00	0.00	1500.00	2000.00	500.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Research Institute & Hospital and in BSMMU											
17	Others	**100 units**	2500.00	1500.00	1000.00	0.00	250.00	500.00	500.00	500.00	500.00	250.00
	Sub Total		310393.00	122579.00	187764.00	50.00	25502.00	54386.00	57709.00	60860.00	62658.00	49278.00
Component 2: Strengthening of Clinical Service delivery in secondary (DH) and tertiary hospitals (MCH, Specialized institute)												
1	Strengthening of hospital emergency system	99 hospitals	2620.00	495.00	2125.00	0.00	44.00	268.00	673.00	642.00	504.00	489.00
2	Expansion of specialized services such as ICU, CCU, NICU, Dialysis unit	64 districts	16650.00	1250.00	14050.00	1350.00	625.00	2865.00	3545.00	3605.00	3260.00	2750.00
3	Providing mental health services at secondary and tertiary hospitals	64 districts	2095.00	1910.00	185.00	0.00	30.00	290.00	470.00	435.00	435.00	435.00
4	Geriatric and Palliative care	8 MCHS	340.00	110.00	230.00	0.00	17.00	102.00	106.00	50.00	45.00	20.00
5	Comprehensive Thalassemia management care	4 MCH	438.00	38.00	400.00	0.00	3.00	75.00	140.00	85.00	80.00	55.00
6	Clinical Management protocol, EBP, Risk management and Accreditation	99 hospitals	200.00	45.00	155.00	0.00	15.00	35.00	55.00	40.00	35.00	20.00
7	Baby, Women and Adolscent friendly hospital initiative	60 hosp	500.00	150.00	350.00	0.00	0.00	125.00	130.00	120.00	90.00	35.00
8	Shishu Bikash Kendra	40 Hosp	4980.00	3500.00	1480.00	0.00	160.00	600.00	740.00	1150.00	1190.00	1140.00
9	CEmNOC and gender issue	50 Hosp	765.00	52.00	513.00	200.00	20.00	234.00	248.00	106.00	100.00	57.00
10	Club foot, cleft palate and reconstructive surgery	36 PTC	1486.00	214.00	1272.00	0.00	52.00	282.00	320.00	296.00	280.00	256.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)			PA		Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
11	Specialized Outreach surgery	4 MCH	340.00	45.00	295.00	0.00	15.00	50.00	65.00	70.00	70.00	70.00
12	Strengthening of Laboratory and Imaging services	20 Hosp	27246.00	252.00	26994.00	0.00	0.00	4666.00	6086.00	7344.00	5764.00	3386.00
13	Strengtheing of medicolegal services at district hospitals	36 DH	244.00	69.00	175.00	0.00	0.00	67.00	75.00	40.00	35.00	27.00
14	Establishment of HDU facilities at major departments of medical college hospitals	8 Div HQ MCH	3285.00	50.00	3235.00	0.00	0.00	415.00	1105.00	1015.00	365.00	385.00
15	Introduction of ALS and BLS training for all service providers	Fresh doctors	187.00	46.00	141.00	0.00	15.00	30.00	37.00	42.00	38.00	25.00
	Sub Total		61376.00	8226.00	51600.00	1550.00	996.00	10104.00	13795.00	15040.00	12291.00	9150.00
Component 3: Private healthcare facilities												
1	Development and implementation of regulatory framework for private sector hospitals	All private Hosp,Diag	44.00	14.00	30.00	0.00	7.00	14.00	7.00	0.00	9.00	7.00
2	Capacity development of concerned Officials and workers	Health managers	167.00	19.00	148.00	0.00	5.00	60.00	16.00	30.00	28.00	28.00
3	Accreditation of private hospitals, clinics, diganostic centres	All private Hosp,Diag	93.00	45.00	48.00	0.00	12.00	25.00	20.00	12.00	12.00	12.00
4	Development of a comprehensive monitoring strategy with Technical	**1**	20.00	0.00	20.00	0.00	0.00	20.00	0.00	0.00	0.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)			PA		Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Assistance											
5	Advocacy workshop at Private hospitals, clinics for emergency management, serving poor etc.	**80 Workshop**	94.00	17.00	77.00	0.00	10.00	18.00	18.00	18.00	18.00	12.00
6	Monitoring and Supervision	All private Hosp,Diag	86.00	27.00	59.00	0.00	7.00	17.00	17.00	15.00	15.00	15.00
	Sub Total		504.00	122.00	382.00	0.00	41.00	154.00	78.00	75.00	82.00	74.00
Component 4: Quality of Care												
1	Pay of Officers and Staffs	8 persons	190.00	190.00	0.00	0.00	0.00	38.00	38.00	38.00	38.00	38.00
2	Introduction and maintenance of TQM approach of management at secondry and tertiry hospitals	45 hospitals	644.00	0.00	234.00	410.00	67.00	95.00	125.00	125.00	125.00	107.00
3	Capacity development of service providers	Service providers	757.00	70.00	308.00	379.00	60.00	146.00	155.00	150.00	132.00	114.00
4	Development and implementation of Standard forms, registers and reporting format for hospitals	99 hospitals	94.00	20.00	74.00	0.00	3.00	36.00	30.00	15.00	5.00	5.00
5	Development and implementation of hospital manuals and SOPs	3 Manuals 8 SOPs	174.00	37.00	137.00	0.00	7.00	65.00	45.00	20.00	22.00	15.00
6	Honorarium for Consultants	2 consult.	150.00	0.00	150.00	0.00	0.00	30.00	30.00	30.00	30.00	30.00
7	Others	99 hospitals	117.00	40.00	72.00	5.00	7.00	17.00	24.00	25.00	25.00	19.00
	Sub Total		2126.00	357.00	975.00	794.00	144.00	427.00	447.00	403.00	377.00	328.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Component 5: Safe Blood Transfusion													
1	Pay and allowance of Officers and Staffs	18 persons		399.00	399.00	0.00	0.00	0.00	71.00	86.00	86.00	86.00	70.00
2	Voluntary blood donor pool	7 lac donors		1200.00	680.00	400.00	120.00	120.00	240.00	240.00	240.00	240.00	120.00
3	Hemovigilence	99 blood bank		375.00	35.00	340.00	0.00	0.00	215.00	115.00	15.00	15.00	15.00
4	Improved Transfusion Services	1 blood bank		166.00	16.00	150.00	0.00	0.00	155.00	5.00	2.00	2.00	2.00
5	Transfusion transmissible infection & Quality Control	8 blood bank		1000.00	620.00	200.00	180.00	100.00	200.00	200.00	200.00	200.00	100.00
6	Supply of logistics and consumables	99 blood bank		20000.00	14000.00	6000.00	0.00	2000.00	4000.00	4000.00	4000.00	4000.00	2000.00
	Sub Total			23140.00	15750.00	7090.00	300.00	2220.00	4881.00	4646.00	4543.00	4543.00	2307.00
Component 6: Introduction of Medical Waste Management at Public & Private Hospitals													
1	Capacity development of Health Managers and Service providers for inhouse MWM	82 hospitals		410.00	35.00	375.00	0.00	15.00	85.00	95.00	90.00	75.00	50.00
2	Support for outhouse MWM	99 hospitals		440.00	440.00	0.00	0.00	40.00	80.00	80.00	80.00	80.00	80.00
3	Establishment of Temporary waste storage house	20 hospitals		100.00	0.00	100.00	0.00	10.00	30.00	20.00	40.00	0.00	0.00
4	Supply of logistics and consumables	99 hospitals		250.00	0.00	250.00	0.00	30.00	40.00	45.00	45.00	45.00	45.00
5	Research (in coordination with PMR OP)	4 projects		20.00	0.00	20.00	0.00	0.00	10.00	10.00	0.00	0.00	0.00
6	Honorarium for Consultants	2 consultants		150.00	0.00	150.00	0.00	0.00	30.00	30.00	30.00	30.00	30.00
7	Advertisement and Publicity	Print electronic media		95.00	25.00	70.00	0.00	0.00	35.00	15.00	15.00	15.00	15.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
8	Printing, Stationeries and others	Guideline, leaflet, stationeries	125.00	55.00	70.00	0.00	10.00	15.00	20.00	35.00	25.00	20.00
	Sub Total		1590.00	555.00	1035.00	0.00	105.00	325.00	315.00	335.00	270.00	240.00
Component 7: Introduction and scale up of the Structured Referral system												
1	Development and implementation of referral guideline	Workshop,dissemination, printing	75.00	40.00	35.00	0.00	15.00	15.00	0.00	30.00	5.00	10.00
2	Development and introduction of referral forms and electronic databases	Workshop, printing, distribution	310.00	45.00	265.00	0.00	25.00	115.00	50.00	50.00	35.00	35.00
3	Orientation and capacity development of all stakeholders	64 DH, 14 MCH, 11 Spl. Inst	500.00	100.00	400.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
	Sub Total		885.00	185.00	700.00	0.00	90.00	230.00	150.00	180.00	140.00	95.00
Component 8: Patient Safety												
1	Development, dissemination and distribution of Patient Safety Guidelines	1 guideline	114.00	30.00	84.00	0.00	15.00	50.00	15.00	11.00	13.00	10.00
2	Workhops and Orientation of Service Providers regarding Patient Safety issues	175 Workshops	300.00	20.00	35.00	245.00	30.00	60.00	60.00	60.00	60.00	30.00
3	Supply of logistics and consumables	30 hospitals	83.00	28.00	55.00	0.00	8.00	15.00	15.00	15.00	15.00	15.00
	Sub Total		497.00	78.00	174.00	245.00	53.00	125.00	90.00	86.00	88.00	55.00
Component 9: Urban health												

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)			PA		Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
1	Establishment of PHC Centres in Secondary and tertiary hospitals and related activities	86 hospitals	136.00	65.00	71.00	0.00	8.00	18.00	20.00	35.00	35.00	20.00
2	Capacity development of service providers	86 hospitals	79.00	33.00	46.00	0.00	8.00	12.00	14.00	20.00	15.00	10.00
	Sub Total		215.00	98.00	117.00	0.00	16.00	30.00	34.00	55.00	50.00	30.00
Component 10: Strengthening of Procurement, Store Management, Asset management and financial management of Hospitals												
1	Capacity development of health managers	830 persons	215.00	35.00	180.00	0.00	10.00	55.00	55.00	35.00	30.00	30.00
2	Development of Manauals, SOPs and Monitoring framework	1 Manual, 4 SOPs, 1 Monitoring framework	30.00	12.00	18.00	0.00	5.00	15.00	0.00	10.00	0.00	0.00
	Sub Total		245.00	47.00	198.00	0.00	15.00	70.00	55.00	45.00	30.00	30.00
Component 11: Repair, Maintenance and Disposal of Vehicles, Biomedical equipment and others												
1	Strengtheing of NEMEW	99 hospitals	200.00	200.00	0.00	0.00	10.00	30.00	40.00	40.00	40.00	40.00
2	Strengthening of TEMO	99 hospitals	200.00	200.00	0.00	0.00	10.00	30.00	40.00	40.00	40.00	40.00
3	Support of Outsourcing of repair and maintenance services	99 hospitals	370.00	200.00	170.00	0.00	30.00	50.00	55.00	65.00	75.00	95.00
4	Development of SOPs for safe disposal of electo medical equipments	1 SOP	25.00	12.00	13.00	0.00	5.00	10.00	0.00	10.00	0.00	0.00
	Sub Total		795.00	612.00	183.00	0.00	55.00	120.00	135.00	155.00	155.00	175.00
Capacity development of Line Director's Office												
1	Pay of Officers and Staffs	59 person	620.00	620.00	0.00	0.00	20.00	120.00	120.00	120.00	120.00	120.00
2	Supplies and others	LS	700.00	700.00	0.00	0.00	70.00	140.00	140.00	140.00	140.00	70.00
3	Training expenses	930 persons	495.00	45.00	450.00	0.00	15.00	75.00	125.00	105.00	105.00	70.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
4	Acquisition of assets (Vehicles, Computer, furniture, telcom equipments)			530.00	45.00	485.00	0.00	10.00	230.00	230.00	60.00	0.00	0.00
	Sub Total			2345.00	1410.00	935.00	0.00	115.00	565.00	615.00	425.00	365.00	260.00
	Grand Total			404111.00	150019.00	251153.00	2939.00	29352.00	71417.00	78069.00	82202.00	81049.00	62022.00

11. Budget support from other Operational Plan: Not applicable

4.25 Clinical Contraception Services Delivery Programme (CCSDP)

1. Name of the Operational Plan: Clinical Contraception Services Delivery Programme (CCSDP)

2. Implementing Agency: Directorate General of Family Planning (DGFP)

3. Introduction:

During last four decades the Contraceptive Prevalence Rate (CPR) has increased eightfold from 8% in 1975 to 62% in 2014 which is very encouraging. However during 2004–2014, all-method contraceptive use increased from 58% to 62%, a 4 percent increase only in the last 10 years and regional variations persists as Sylhet being the lowest (48%), Chittagong is the 2nd lowest (55%) and Dhaka being the largest division having CPR of 63% (BDHS 2014).The use of Long Acting Reversible Contraceptive and Permanent Method (LARC&PM) became stagnant at 8 % since last four years (2011 and 2014).

The clinical FP services particularly the LARC &PM are being provided mainly through Clinical Contraception Services Delivery Program (CCSDP) Operation Plan (OP) of Directorate General of Family Planning (DGFP) across the country. Services are provided through service outlets at different levels (Tertiary centers like Medical Colleges, Hospitals, DHs, MCWCs, UHCs, UH&FWCs). The LARC & PM services contain the following elements:

A. Long Acting Reversible Contraceptive (LARC):

(i). Intra-Uterine Contraceptive Device-IUD (Cu-T-380A)-effective for 10 years

(ii). Implants – Single rod (Implanon)-effective for 03 years

- Two rod (Jadelle)-effective for 05 years

B. Permanent Methods (PM):

(i). Bi-Lateral Tubal Ligation (BLTL)/permanent method of contraception for the female.

(ii). No-Scalpel Vasectomy (NSV)/ permanent method of contraception for the male.

C. Contraceptive related back-up and humanitarian services, like-

(i). Management and treatment of side-effects/complications arise due to use of any clinical contraceptive method, and

(ii). Arrangement for reversal operation of BLTL and NSV (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.

During the last health sector program (HPNSDP: 2011-2016) considerable progresses have been made in terms of service coverage and skill development of the service providers in clinical FP service delivery. Special attention was given to strengthen LARC&PM services in HTR and low performing areas. As recommended during the MTR (2014), a Regional Service Package (RSP) was undertaken through CCSDP OP in selected Districts of Chittagong and Sylhet Divisions.
However various programmatic **challenges** remained in FP service delivery which included:

- Lack of "facility readiness" as many of the service facilities (UHFWCs, UHCs) are missing trained staff, equipment, and/or supplies to provide the LARC&PM services;
- Inadequate FP services delivery in the HTR and low performing districts and urban slums;
- Over reliance on temporary short acting methods;

- Inadequate Social Behavioral Change Communication activities including motivating clients for LARC&PM and referral by FWAs and volunteers;
- Limited availability of LARC&PM services in District Hospitals, Medical Colleges and Private Hospitals;
- Inadequate inter-sectoral collaboration (MOLGRD, MOPME) and less community engagement (like Union Parishad, community leaders, different community volunteer groups) in planning and monitoring of FP services;
- Inadequate collaboration with NGO/private sector;
- Inadequate functional coordination between DGFP & DGHS at different level;
- Shortage of Doctors and paramedics to provide LARC & PM services and
- Lack of Quality of Care (clinical Supervision) and performance monitoring by the managers and supervisors.

The CCSD Operation Plan (OP) has been developed to address the unfinished tasks and challenges as mentioned above and it is very much in alignment with the strategic objectives of the Health, Nutrition and Population (HNP) Strategic Investment Plan (SIP) 2016-2021 of the government.

4. Objectives:

i. To contribute in reducing Total Fertility Rate (TFR) from 2.3 to 2.0 by 2022
ii. To increase CPR with 20% share of LARC and PM in method–mix.
iii. To provide quality clinical (LARC & PM) contraceptive services including Post-Partum Family Planning (PPFP) and Post MR/MRM PAC FP services with special focus in the hard-to-reach and low performing areas including urban slums.
iv. To improve functional coordination with DGHS and other ministries (intra and intersectoral)
v. To build service providers' skill on LARC & PM services
vi. To ensure procurement and supply of LARC & PM commodities all over the country.
vii. To strengthen Quality of Care including clinical supervision and monitoring in delivering LARC & PM services
viii. To strengthen partnership with GO-NGOs & private sector for expansion of LARC & PM services coverage.

5. Components

Component-1: Strengthening LARC & PM Services:

The use of Long Acting Reversible Contraceptive and Permanent Method (LARC&PM) became stagnant at 8 % since last three years (2011 and 2014). Although female sterilization was 5% but male sterilization and implant usage are found to be very low at 1% and 2% respectively. To increase the access and availability of the LARC& PM services for the target population key strategies will include i) strengthening readiness of the facilities with skilled service providers, equipment, standard guidelines and supply of commodities and logistics; ii) shifting contraceptive use patterns towards more effective longer-acting and permanent methods from short-term hormonal and traditional methods through extensive SBCC activities; iii) Implement a comprehensive regional service package for HTR and low performing districts and urban slums; iv) improve quality of Care (including Clinical supervision & monitoring) and v) increase service coverage through stronger functional

coordination with DGHS and greater involvement of the NGOs/ private sector and local institutions likes Union Parishad and community groups and leaders.

Activities:

1. Provide Financial Support for Permanent and Longer-acting Contraceptive Services through Imprest Mechanism throughout the country.
2. Strengthening satellite clinics, CCs, UH&FWCs, UHCs, MCWCs, DH, Medical College hospital & specialized hospital providing necessary equipments, drugs, FP commodities, MSR & other medical supplies.
3. Effective implementation of PPFP action plan. Ensure availability of post-partum family planning services particularly post-partum bilateral tubal ligation (PPBTL), post-partum IUD (PPIUD) services and post partum Implant services as well as post MR/MRM/PAC FP services in the DGHS hospitals, DGFP facilities, private hospitals and NGO facilities. Provision for placement of Imprest fund at DGHS hospital (District, Medical College and specialized hospital) and other hospital under different ministry for better PPFP services.
4. Increase IUD service through trained FWVs, staff nurses, female SACMOs, and MOs.
5. Reinvigorating domiciliary visit especially in hard-to-reach, far-flung, low-performing areas slums of urban areas by well-informed field staff i.e. FWAs and Paid volunteer/community volunteer.
6. Targeting the Young Married Couple (YMC) aged up to 24 years to reduce unmet need: Introduce peer activities like counseling, motivation and group discussion to increase referral for LARC & PM services.
7. Promoting increased male participation specially for No-scalpel Vasectomy (NSV) through extensive SBCC activities & sensitization workshops involving satisfied NSV clients.
8. Involve satisfied BLTL, NSV, IUD & Implant clients for motivation, counseling and referral of the LARC & PM clients. Community mobilization against adolescent marriage and delaying first pregnancy among adolescents
9. Use religious leaders as advocates for increasing the uptake of LARC & PM with greater collaboration of IEM Unit.
10. Develop model MCWCs with increased LARC&PM services
11. Emergency Contraception by introducing new hormone and IUD.
12. Strengthening Model Family Planning Clinic at Medical College Hospitals & gradually establish LARC & PM services in all Medical College Hospitals
13. Follow-up of LARC & PM clients as well as service providers using updated mobile phone technology for better and continued use of LARC & PM.
14. Award/Reward for field worker/clinical service providers/ officers/ Managers as best performer.
15. Introduce newer technology in LARC & PM services. Special address to minimize pain for LARC & PM Methods. Introduce Laparoscopic BLTL.
16. Strengthen monitoring and supervision (Clinical Supervision) through increased field visit (by QIT members/ Field officers and managers)
17. Regular performance review involving key stakeholders including DGHS at different level.
18. Improve management capacity of the managers in terms of planning, monitoring and reporting.

19. Increase coordination with other OPs of DGFP for necessary support (MIS, IEM, Logistics and Supply, Field Service Delivery and MCRAH).
20. Share progress at the policy level (Six monthly)
21. Introduce Floating/ Mobile clinics for ensuring LARC & PM services in Haor, HTR, Reverine/ Hilly remote areas with collaboration of DPs, NGOs
22. Introduce E-toolkit & e-learning course for frontline service providers on LARC & PM services specially PPFP & Post MR/MRM/PAC FP services.
23. Organizing special LARC & PM service camp in remote/fur flung areas in each & every month regularly.

Component-2: Ensuring availability of LARC and PM contraceptives & MSR

To implement a successful FP program, an efficient supply management system plays a vital role. During last sector program good progress has been made in strengthening procurement and supply management of FP commodities by the procurement and logistics supply unit of DGFP. Warehouse Inventory Management System (WIMS) and Upazila Inventory Management System (UIMS) are fully functional. Supply of LARC & PM commodities and MSR would be made available on continuous basis without stock out at any point. To ensure timely procurement and supply for both public and private sector advance projection will be made based on OP targets and specific needs assessment. Procurement plan will be prepared accordingly and in coordination with Logistic and Supply unit, timely supply of commodities and logistic will be ensured.

Activities:

1. Develop Procurement Plan: contraceptives projection, specific needs assessment including Regional Service Packages
2. Procurement of contraceptives (implants and IUD) and other essential commodities like Drugs, MSR, Instrument, Equipment, Surgical apparels and printing materials
3. Provide Imprest fund Delivery of LARC & PM 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.
4. Regular coordination with partners

Component-3: Strengthening LARC&PM services in hard-to-reach, low performing and urban areas through Regional Service Package (RSP)

To address the low coverage of the FP services including LARC&PM in the HTR and low performing areas particularly in Sylhet, Chittagong, Barisal and Dhaka Divisions a comprehensive Regional Service Package will be developed and implemented involving different stakeholders (local volunteers, NGOs). Mentionable positive lessons have been learned during last sector program while implementing the RSP in low performing and HTR districts as LARC&PM service coverage showed increasing trend. The key focus of the RSP would be i) involvement of local community volunteers of different NGO partners recruitment of community volunteers including filling the vacant positions of FWAs; ii) capacity building of the service providers; iii) involvement of Roving Teams; iv) strengthening BCC activities organizing workshops, discussions, rally and campaigns; v) Mobile clinic/floating clinic for providing LARC & PM services in collaboration with DPs and NGOs.
In the private sector, FP services are provided (at cost) mainly by the initiative of Social Marketing Company (SMC), particularly temporary methods: pill, condoms and injectables through different private sector outlets. However SMC has started its support in providing LARC & PM services in a

limited scale. In the urban areas , there are many local NGOs and donor funded NGOs/ projects are involved in FP services delivery program like in partnership with 25 local NGOs, a large Urban Primary Health Care Services Delivery Project is being implemented in all city corporations. Under USAID funding the MOLGRD in partnership with local NGOs, a large scale urban MCH-FP service delivery program (NHSDP) has been delivering MCH-FP services in different districts. Moreover, Local NGOs, UN Organization and development partners have been providing FP services in cities/ rural areas throughout the country. The areas which need strengthening , for FP services , particularly for the urban slums are i) registration of couples ; ii) domiciliary visits, counseling and contraceptive distribution ; ii) LARC&PM services at the referral centers and iii) arranging Regional Service Package programs in selected urban areas

Activities:

1. Situation analysis and mapping of LARC & PM service provisions
2. Develop a comprehensive costed Regional Service Package (RSP)
3. Recruit volunteers and provide training on motivation and counseling
4. Develop partnership with NGOs and outsource services
5. Deploy LARC & PM Roving Team (NGOs)
6. Capacity building through basic and refresher training to service providers (Doctors, FWVs) on LARC&PM
7. Undertake awareness building through SBCC activities like workshops, discussions, rally and campaigns.
8. Register all slum and non-slum couple in urban area through GO-NGO collaboration with assistance of volunteers (MOHFW & MOLGRD).
9. Joint planning and performance sharing with City corporation/ Pauroshava authority
10. Provide necessary Technical and logistics support to the NGOs.
11. Indentify/strengthen service facility with adequate service providers, equipments, commodities and logistics particularly in urban area. Hire experienced surgeons where service provider are not available by service procurement procedure (contracting out)
12. To boost service delivery arrange LARC&PM special day
13. Strengthening Clinical Supervision through expansion of Quality Improvement Team (QIT)
14. Strengthen Peer activities like counseling, motivation and group discussions targeting the Young Married Couple (YMC) aged up to 24 years
15. Strengthen Coordination with FPFSD, IEM, MCRAH, MIS, PSSM OPs
16. Strengthen monitoring and performance review system

Component-4: Quality of Care on Family Planning- LARC & PM services

For quality service delivery particularly in the field of reproductive health and family planning it is important to focus on clients' satisfaction and basic rights including their rights to information, access , choice , safety, privacy and confidentiality, dignity, opinion, comfort and continuity. During last sector program through DGFP number of initiatives have been taken to improve quality of care (including Clinical Supervision) for delivering LARC&PM services like i) development of a Strategy on LARC and PM for 2011 – 2016 which includes ensuring constant and sustained attention to the Fundamentals of Care (FoC): ensuring informed and voluntary decision making process in FP

program, assuring safety for clinical techniques and procedures and providing a mechanism for ongoing quality assurance and management; ii) establish clients' rights and address provider's needs at the core of FP service delivery. In connection with ensuring clients' rights, DGFP has developed a Program Manager's Manual on Informed Choice and Voluntarism (ICV) to strengthen and monitor ICV in FP program. Moreover, to ensure quality of care 10 Family Planning Clinical Supervision Teams named Quality Assurance Teams (FPCST-QAT) have been providing technical supervision at the facility level and building capacity of the service providers across the country. Mentionable high emphasis has been given by MOHFW on implementation of Total Quality Management (TQM) modality at all levels. At the national level a Quality Improvement Secretariat (QIS) has been formed to observe the quality issues in MNCHFP and Reproductive Health. An operation manual on TQM has been drafted to train different levels of service providers, supervisors and managers on quality monitoring and supervision. Regional and district level quality improvement team will be deployed to ensure quality of services.

Activities:

1. Activate Quality Improvement Teams (QITs regional and districts) to strengthen monitoring and clinical supervision covering all service centres both for public and private sector (District Hospital, UHCs, MCWC at District/Upazilla/Union level, UH&FWC, Community Clinics and approved Private Hospitals/ clinics).
2. Develop and implement a Plan of Action for QIT.
3. Develop capacity of the QIT through different technical training as well on TQM approaches.
4. Provide orientation/ training to field workers and managers about supervision and monitoring.
5. Develop and implement a Plan of Action to strengthen FP information and services for post-partum, PAC and post-MR clients
6. Provide orientation/ training on Informed Choice and Voluntarism (ICV) to strengthen and monitor ICV in FP program
7. Training on management and follow-up of side effects/ complications of LARC & PM
8. Expansion of Quality Improvement Team (QIT) to strengthen robust monitoring in Region/Division (City Corporation) & District level with special emphasis in HTR and Low performing districts and urban areas
9. Capacity development on counseling and management of Reproductive Health issues (STI/RTIs, HIV/AIDS) in relation to LARC & PM.
10. Regular reporting and performance review of the QIT.

Component-5: Build capacity of the service providers

To provide quality LARC&PM services, developing a pool of high performing staff (service providers) would be one of the priority interventions of CCSDP OP. Service providers like doctors, paramedics, field workers, supervisors and managers would be provided with adequate skills through different trainings (basics/ refreshers) with a follow-up mechanism. To create an enabling environment for the service providers to achieve higher performance, emphasis would be given on effective supervision that includes mentoring, jointly problem solving and a both-way communication between supervisors, service providers and the staffs. To address the programmatic challenges and needs of LARC&PM services different types of trainings/ orientations/ workshops (clinical/ non-clinical) will be organized for Managers and Supervisors like Doctors, UFPO, FWV/SACMO/Staff nurse/Paramedics & AFWO,

FWAs, FPIs, CHCPs, HIs, AHIs, HAs Volunteers from both DGFP & DGHS and Community leaders. Mentionable majority of the training/ workshops will be organized in-country.

a) **Training Needs Assessment and Follow-up**: Needs assessment will be done before design and implement any training program. Selection of training participants will be done based on actual needs and their opportunity to implement the learning. Each trainee will develop a brief action plan upon completion of the training, about how she/he would implement the learning and what supports are required. Introducing mentorship for clinical training: on completion trainees will be attached with experts for hands-on practice for a short period. Develop and implement Training Follow-up Plan (with regular visits by QIT). Organize refresher courses. Training MIS (Database).

b) Study /Research related to LARC & PM:

(i) Study/Research to introduce newer contraceptive technology.

(ii) Operation research.

(iii) Periodical evaluation of different program

c) The key training/ workshop/ orientation would include:

(i) Technical training on LARC& PM, PPFP and post MR/MRM/PAC FP for Doctor & Paramedics;

(ii) Training on Motivation, Counseling, referral, Client segmentation for Volunteers, FWAs, FPIs, SACMOs, FWVs;

(iii) Training on Side effects/Complication Management of LARC & PM procedure;

(iv) Training on Infection prevention procedure, RTI/STI & HIV/AIDS related to LARC & PM;

(v) Training on Quality of Care; Quality improvement

(vi) Training on Post MR/MRM/PAC FP method focused on LARC & PM;

(vii) Training on Gender responsive family planning training for service providers (Officer & Field Staff)

(viii) Workshops and Orientations like i) bottom up projection by utilizing client segmentation ; ii)satisfied NSV/IUD client orientation; iii) orientation workshop on LARC & PM for the members of union, upazila & District FP committee, religious leaders, Mosque Committees, members of community support groups, community groups, journalists, media person and other stakeholders

(ix) Orientation workshop on FP in the light of Islam with religious leaders

(x) Improve management capacity of the managers in terms of planning, monitoring, supervision & reporting.

(xi) Highly technical trainings like training on Laparoscopic Tubal ligation, recanalization: (NSV & Tubectomy) & PPBLTL, PPIUD, training on Primary Infertility management will be organized overseas through technical assistance from Pas (Project aids) & GOB development.

Training, Workshop and Orientation Sessions (Local & Foreign) on LARC & PM service under CCSD OP: Jan'2017-June'2022.

No.	Name	Total	Jan'17 to June'17	2017-18	2018-19	2019-20	2020-21	July'21 to June'22

		Person	Person	Person	Person	Person	Person	Person
1	2	3	4	5	6	7	8	9
	A. Training Local							
1	LARC & PM (Doctor & Paramedics)	5800	520	1056	1056	1056	1056	1056
2	PPFP (Doctor & Paramedics)	6900	500	1280	1280	1280	1280	1280
3	Training on Motivation, Counseling, referral, Client segmentation related to LARC & PM (Participants-Volunteer, CHCP, FWA, FPI, SACMO, FWV, HA, AHI, HI, SSN, Nurse & others). Duration 1-2 days at district level.	68000	5500	12500	12500	12500	12500	12500
4	Web based online software data entry training: Bottom-up projection, LARC & PM acceptors tracking and service provider performance monitoring, e-filling for office management & others related to LARC & PM.	1980	180	360	360	360	360	360
5	Training on Side effects/ Complication Management of LARC & PM procedure	550	50	100	100	100	100	100
6	Training on Infection prevention procedure, RTI/STI & HIV/AIDS related to LARC & PM.	550	50	100	100	100	100	100
7	Training on quality improvement 3-5 days.	1100	100	200	200	200	200	200
8	Training on Post MR/MRM/PAC FP method focused on LARC & PM	550	50	100	100	100	100	100
9	Gender responsive family planning training for service providers (Officer & Field Staff).	550	50	100	100	100	100	100
10	Orientation workshop & training (Basic & Refresher) for Paid peer volunteer at upazila level (Basic-5-6 days, Refresher-1-2 days).	10100	0	2730	1910	1820	1820	1820
11	Training on Laparoscopy for Tubal Ligation & Infertility. Participant : MO 02 & Paramedics 02 from each center, Per batch participant Doctors 10 and Paramedics 10 Person, Duration : 1 Month (by Out sourcing)	260	0	40	60	60	60	40
	B. Training Foreign:							
1	Training on Post-Partum IUD & Tubectomy	96	0	24	24	24	12	12
2	Training on Laparoscopic Tubal ligation	60	0	12	12	12	12	12
3	Training on recanalization:	48	0	12	12	12	12	0

No.	Name	Total	Jan'17 to June'17	2017-18	2018-19	2019-20	2020-21	July'21 to June'22
		Person	Person	Person	Person	Person	Person	Person
1	2	3	4	5	6	7	8	9
	(NSV & Tubectomy) & Primary Infertility management							
4	Training on any latest technology related to LARC & PM (e.g. Tubectomy with Tubal hook, etc.)	60	0	12	12	12	12	12
5	Experience sharing study tour in high IUD/ Implant/ NSV/ BLTL performing country.	36	0	12	12	12	0	0
	Workshop							
1	Workshop on Bottom up projection by utilizing client segmentation(upazila and District)	16500	1500	3000	3000	3000	3000	3000
2	Satisfied NSV client orientation workshop (union, upazila & District)	11550	1050	2100	2100	2100	2100	2100
3	Satisfied IUD client orientation workshop (union, upazila & District)	14850	1350	2700	2700	2700	2700	2700
4	Orientation workshop on LARC & PM for service Provider of DGFP & DGHS, NGO, Private Sector (Doctor, Paramadics).	21450	1950	3900	3900	3900	3900	3900
5	PPFP orientation workshop Upazila, District & Divisional level. DGFP, DGHS, NGO, Private Sector (Doctor, Paramadics).	21450	1950	3900	3900	3900	3900	3900
6	Regional workshop for QIT	4950	450	900	900	900	900	900
7	By annual workshop with QIT at head quarter level	770	70	140	140	140	140	140
8	Orientation workshop on LARC & PM with member of union, upazila & District FP committee	9900	900	1800	1800	1800	1800	1800
9	Orientation workshop on LARC & PM for Teachers, Religious Leaders, Mosque Committee & Journalists.	4400	400	800	800	800	800	800
10	Orientation workshop on Family Planning in the light of Islam with religious leader	5500	500	1000	1000	1000	1000	1000
11	LARC & PM orientation workshop for Medical Officer, Gynae & Obs professionals from DGFP, DGHS, NGOs (District level) and private sectors (District level). Participants: 70-80 person (Gynae & Obs proffesionals, MO-Clinic, UH&FPO, MO-MCH-FP, UFPO and others),	8000	0	2000	2000	1500	1500	1000

No.	Name	Total	Jan'17 to June'17	2017-18	2018-19	2019-20	2020-21	July'21 to June'22
		Person	Person	Person	Person	Person	Person	Person
1	2	3	4	5	6	7	8	9
	Duration 01 day.							
12	Orientation workshop on PPFP Upazilla, District, Division level. Participants: 70-80 person (MO-MCH-FP, MO-Clinic, UH&FPO, RMO, Consultant Gynae and Obs, Medical Officer of private sector and others), 01 day. DGFP, DGHS, NGO, Private sector.	8000	0	2500	2500	1500	1000	500
13	Orientation workshop for LARC & PM with member of union, upazila & District FP committee. Participants:40-50 person. District and Upazlla & union level. (Member of FP comittee District and Upazilla union, MO-MCH-FP, MOCC, MO-Clinic, UFPO, Community group, CSG, Community Leader), 01 day	7000	0	2000	2000	1500	800	700

Component-6: Intra and inter-sectoral Coordination and Collaboration

To increase access to and utilization of LARC&PM services by the target population, a coordinated strategy would be adopted through effective functional coordination involving DGHS service providers and representatives of the MOLGRD including Union and Upazila Parishad.

A coordinated Plan with roadmap will be developed jointly with DGHS and MOLGRD. Main focus would be on i) building capacity of the different service providers of DGHS on LARC &PM so that they can complement services with the DGFP service providers at the UHC, UH&FWC, CCs, and SCs and also during domiciliary services for motivation, counseling and referral and ii) resource sharing in terms of human resources and physical facilities with DGHS and iii) strengthening community engagement by involving local elected representatives of Union, Upazila , Pauroshava and City Corporation in planning and monitoring of FP services including LARC&PM. Trained doctors and nurses from DGHS would be involved in delivering LARC&PM services and all physical facilities including Operation Theaters (OTs) of the UHCs would be made available for surgical interventions.

Activities:

1. Develop a coordinated Plan involving mangers, supervisors, medical doctors of DGHS and elected representatives of Union, Upazila, Pauroshava and City Corporation
2. Provide training on LARC&PM including PPFP for the Doctors and Nurses from DGHS,
3. Provide training on LARC&PM to DGHS field workers and supervisors like CHCPs, HAs & AHIs and HIs
4. Strengthen LARC&PM referral through greater collaboration

5. Facilitate involvement of DGHS service providers (CHCP/HA) in Union level FP meetings including UH&FWC management meetings
6. Increase FWAs' participation in CC management committee and community support group meetings
7. Work jointly with DGHS staff and MOLGRD representatives in planning and organizing different awareness raising campaigns, assist jointly activities of the Roving teams
8. Increase collaboration in hiring volunteers
9. Explore funding source for LARC & PM and PPFP, Post MR/MRM/PAC FP service (Imprest Fund) through DGHS.
10. Joint effort for maintenance of the upgraded UH&FWC's, USC/RDs and supply of logistics
11. Provide training on FP services including LARC&PM to Union, Upazila Pauroshava and City Corporation Chairmen and members
12. Revitalize Union and Upazila Family Planning Committees by organizing bi-monthly/monthly performance sharing meetings on regular basis
13. Organize orientation/ training for, member of the civil society organizations including journalists, teachers, religious leaders, women groups, Social welfare officers & staffs.

Component-7: Coordination and Collaboration with NGOs and Private sector

It is estimated that more than 4000 national NGOs, including international organizations and local NGOs are involved in providing primary health care services including FP throughout the country. The CCSD OP having partnership with several local NGOs, UN organization and development partners throughout the country. During last sector program number of positive lessons have been learned in terms of raising skills of the service providers, community mobilization, deploying Roving Teams, improving quality of care and overall improving service coverage of LARC&PM. Based on the lessons learned collaboration and partnership will be strengthened with the existing partners and new partnership opportunities will be explored. Mentionable the "private sector initiative program" which was initiated during last sector program will be further strengthened. The main focus areas of the partnership would be: skill development of service providers, development of standard guidelines, community mobilization, Quality of Care, monitoring and performance review, improve service coverage in HTR and low performing areas and Urban slums.

Activities:

1. Deploy LARC & PM Roving Team especially in Hard to reach and low performing areas.
2. Deploy IUD Roving Team all districts to increase quality service of IUD.
3. Engagement of NGO volunteers at community level and urban areas for Family Planning demand creation and referral for LARC & PM client.
4. Strengthening LARC & PM activities by involving private sectors with the help of local NGOs, UN organization and development partners.
5. Strengthening Post MR/MRM/PAC FP services in collaboration with local NGOs, UN organization and development partners.
6. Review the partnership outcomes (like BAVS to receive GOB funding to provide LARC & PM services).
7. Capacity building of service providers through Technical Assistance from development partners and other experienced and competent NGOs.

8. Quality improvement through Technical Assistance from development partners and other experienced and competent NGOs.
9. Develop strategies, standard clinical guideline through Technical Assistance from development partners & other experienced and competent NGOs.
10. Organize different sensitization orientations, workshops, campaigns on LARC & PM at district/ upazila/union level in collaboration with development partners and other experienced and competent NGOs.
11. Involvement of private sector hospitals, clinics, chamber practitioners etc. for LARC & PM service delivery.
12. Provide logistic support/ incentives (through Imprest fund) to private sector
13. Ensuring regular reporting and periodic performance review with the partners
14. Explore new partnership with NGOs/ private sector for expanding LARC & PM services delivery, capacity building and other support.

6. Cross-Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

a) **"Family Planning -a Pathway to Poverty Reduction**": It is being well documented throughout the world including Bangladesh, that effective family planning programs have made remarkable contribution in reducing maternal, infant and under five mortalities and reduced health care costs at individual and national budgets. Family planning not only help couples to achieve their desired family size and spacing but it also directly contributes to improved economic security for families and communities which impacts positively the national economy. It is estimated that total costs of US$18,832.41 million to individual households and national budgets will be saved as a result of the abortions and infant and maternal deaths averted by the comprehensive family planning program (source: Costed Implementation Plan (CIP): 2016-2021, DGFP, UNFPA, 2015).

b) **Gender Equity and male Participation**: In order to ensure gender equity at the implementation level and increase overall male participation in FP program gender sensitive communication plan will be developed jointly with IEC, FP-FSD OPs in light of national "Gender Equity Strategy 2014".

c) **Patients' Charter of Rights**: For quality service delivery focus on clients' satisfaction and basic rights including their rights to information, access , choice , safety, privacy and confidentiality, dignity, opinion, comfort and continuity would be given high priority. Program Manager's Manual on Informed Choice and Voluntarism (ICV), developed by DGFP will be used as key tool to ensure clients' rights and monitor IVC.

7. Manpower: Annexed in Volume -II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl #	Indicators	Unit of Measurement (Means of verification)	Base line (with Year and Data Source) by June 2016	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1.	Percentage of targeted public health facilities meeting	Percentage (BHFS, admin	0	20%	60%

Sl #	Indicators	Unit of Measurement (Means of verification)	Base line (with Year and Data Source) by June 2016	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
	readiness criteria for delivery of PPFP services in Sylhet and Chittagong divisions	record,)			
2.	Number of BLTL & NSV performed	Number of operations per year (DGFP-MIS)	1,63,031 (APIR 2016)	7,00,000 (Cumulative)	11,00,000 (Cumulative)
3.	Number of IUDs insertion	Number of insertion per year (MIS-DGFP) Number of operations per year (DGFP-MIS)	2,33,557(APIR 2016)	8,75,000 (Cumulative)	14,50,000 (Cumulative)
4.	Number of Implants insertion	Number of insertion per year (MIS-DGFP) Number of operations per year (DGFP-MIS)	3,53,239(APIR 2016)	14,00,000 (Cumulative)	24,00,000 (Cumulative)
5	Percentage of health facilities visited quarterly by Quality Improvement Team (QIT) for Quality LARC & PM Service	Percentage of health facilities (Monitoring Report)	5%	15%	30%

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
107073.97	40264.85	2502.98	42767.83	149841.80	

10.2. Component and activity wise physical and financial target of OP: CCSDP

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
1. Strengthening LAPM Services													
a.	Providing financial compensation (wages lose, food charge and transportation cost) for permanent and long term FP services	4950000	Cases	39740.07	39740.07	0.00	0.00	3298.19	7397.38	7224.38	7211.38	7311.38	7297.38
	Sub-total			**39740.07**	**39740.07**	**0.00**	**0.00**	**3298.19**	**7397.38**	**7224.38**	**7211.38**	**7311.38**	**7297.38**
2. Ensuring availabilities of LARC & PM contraceptives & MSR													
	Procurement of commodities												
i.	Contraceptives (02 item)	4800000	Set	21975.00	13207.50	8767.50	0.00	1460.00	4582.50	4125.00	4125.00	3785.00	3897.50
ii.	Procurement of MSR (33 item)	36705064	Pcs.	17799.64	6161.84	11637.80	0.00	60.00	3981.82	3694.72	3216.60	3137.70	3708.80
iii.	Procurement of drugs (13 item)	226625000	Pcs.	3484.80	1069.80	2415.00	0.00	30.00	770.50	531.50	551.10	431.10	1170.60
iv.	Surgical/Clinical Linen and bedding (15 item)	143000	Pcs.	693.00	498.00	195.00	0.00	5.00	146.60	131.60	156.60	126.60	126.60
v.	Printings of manual, registers, forms, cards etc. (19 item)	11656900	Pcs.	709.95	582.09	0.00	127.86	0.00	186.43	148.28	129.31	94.73	151.20
	Sub-total			**44662.39**	**21519.23**	**23015.30**	**127.86**	**1555.00**	**9667.85**	**8631.10**	**8178.61**	**7575.13**	**9054.70**
3: Strengthening LARC&PM services in hard-to-reach, low performing and urban areas through Regional Service Package (RSP)													
i.	Peer activities paid volunteer/ Domiciliary	10100	Person	15312.00	15312.00	0.00	0.00	633.60	1670.40	2707.20	3600.00	3600.00	3100.80

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	services												
ii.	Yard meeting (Uthan Baithok)	121200	Nos	2000.00	2000.00	0.00	0.00	132.00	348.00	564.00	780.00	176.00	0.00
iii.	Financial support to NGO grant for LAPM services (BAVS and other NGOs)		Lot	7505.00	7505.00	0.00	0.00	1120.00	1256.00	1321.00	1371.00	1437.00	1000.00
iv.	Roving Team (HTR and low performing area)	0	Lot	1000.00	0.00	0.00	1000.00	500.00	500.00	0.00	0.00	0.00	0.00
	Sub-total			**25817.00**	**24817.00**	**0.00**	**1000.00**	**2385.60**	**3774.40**	**4592.20**	**5751.00**	**5213.00**	**4100.80**
4. To provide quality of care of Family Planning LARC & PM Services													
i.	Vehicle-76 (Jeep 64, Micro 12)	76	Nos	6240.00	6240.00	0.00	0.00	0.00	3000.00	3000.00	120.00	120.00	0.00
ii.	Hospital/Medical equipment (18 item)	29752	Pcs.	14503.79	1173.79	13330.00	0.00	4.11	3961.13	4489.13	3309.53	2431.90	307.99
iii.	Office equipment and others	4235	Pcs.	329.55	50.00	279.55	0.00	47.50	60.00	65.00	70.50	10.00	76.55
iv.	Hospital/Medical furniture and others (12 item)	1242	Pcs.	186.91	186.91	0.00	0.00	2.00	45.28	51.53	59.73	25.28	3.09
v.	Computer with accessories & software 8 item	771	Pcs.	250.54	250.54	0.00	0.00	14.75	63.65	56.83	72.88	24.20	18.23
vi.	Electrical equipment (IPS , Fan, Air Conditioner etc.)	3711	Pcs.	2663.22	103.22	2560.00	0.00	0.83	824.00	824.88	848.45	2.93	162.13
vii.	POL, Gas & maintenance of vehicle	0	Lot	2152.00	2152.00	0.00	0.00	24.00	275.00	450.00	463.00	463.00	477.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
	and LP gas cylinder												
viii.	Infection Prevention Materials	0	Lot	658.42	658.42	0.00	0.00	55.00	70.26	79.74	98.62	254.80	100.00
	Sub-total			**26984.43**	**10814.88**	**16169.55**	**0.00**	**148.19**	**8299.32**	**9017.11**	**5042.71**	**3332.11**	**1144.99**
5. To provide build capacity development and research													
	Training												
i.	Foreign Training for 300 person in batches	25	Batch	1080.00	0.00	1080.00	0.00	0.00	259.20	259.20	259.20	172.80	129.60
ii.	Training for LAPM-Local in batch	704	Batch	1726.56	863.28	0.00	863.28	156.96	313.92	313.92	313.92	313.92	313.92
iii.	PPFP training-Local in batch	692	Batch	1299.42	974.58	0.00	324.84	95.97	240.69	240.69	240.69	240.69	240.69
iv.	Orientation training for motivation, councelling, client segmentation for grass route level workers (Batch)	1750	Batch	1753.00	1753.00	0.00	0.00	128.00	325.00	325.00	325.00	325.00	325.00
v.	Seminar/ orientation workshop: Satisfied LAPM acceptors, NSV, Tubectomy, IUD, Implant, Peer (paid volunteer) (Batch)	968	Batch	1221.33	1034.33	0.00	187.00	111.03	222.06	222.06	222.06	222.06	222.06
	Sub-total			**7080.31**	**4625.19**	**1080.00**	**1375.12**	**491.96**	**1360.87**	**1360.87**	**1360.87**	**1274.47**	**1231.27**
	Other expenditures												

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
i.	Salaries and allowance (MM)	12456	MM	3596.00	3596.00	0.00	0.00	34.50	653.94	678.51	708.08	743.08	777.88
ii.	Survey/Study of LARC & PM services		Lot	800.00	800.00	0.00	0.00	0.00	200.00	200.00	200.00	100.00	100.00
iii.	OPIC meeting and Others		Lot	6.00	6.00	0.00	0.00	1.00	1.00	1.00	1.00	1.00	1.00
iv.	Repair and maintenance (Office equipment etc.)		Lot	89.50	89.50	0.00	0.00	10.00	17.00	17.00	17.00	17.00	11.50
v.	Office operational costs (Office rent, Electricity, Water, Telephone etc)		Lot	1066.10	1066.10	0.00	0.00	398.35	144.75	144.75	144.75	119.75	113.75
	Sub-total			**5557.60**	**5557.60**	**0.00**	**0.00**	**443.85**	**1016.69**	**1041.26**	**1070.83**	**980.83**	**1004.13**
	Grand total			149841.80	107073.97	40264.85	2502.98	8322.79	31516.51	31866.91	28615.40	25686.92	23833.27

11. Budget support from other Operational Plan: Not applicable

4.26 Family Planning Field Services Delivery (FP-FSD)

1. Name of the OP: Family Planning Field Services Delivery (FP-FSD)

2. Implementing Agency: Directorate General of Family Planning (DGFP)

3. Introduction

During last two decades Bangladesh has been very successful in reducing Total Fertility Rate (TFR) from 6.3 births per women in 1975 to 2.3 in 2011. However, the TFR has been stagnant at 2.3 births per women (BDHS2014) since 2011. Regional variation also exists - Sylhet and Chittagong Divisions are lag behind with the highest TFRs of 2.9 and 2.5, respectively. Moreover, Dhaka division is very crucial, as it accounts for 1/3 of the population of the country and has a TFR of 2.3 (BDHS 2014).

Regarding contraceptive use, the Contraceptive Prevalence Rate (CPR) has increased only by 4 percent from the level of 58 percent to 62 percent, during 2004–2014 and regional variation persists, as Sylhet being the lowest. For use of temporary FP methods like use of oral pills remained at 27 percent in 2011 and 2014. However use of injectable rose by 1 percent during last three years and reached at 12 percent in 2014. Annual rate of CPR increment found to be less than one percentage point. To achieve the target of 75 percent by 2021, CPR rate of increase needs to be doubled. It has been found that despite high desire to use contraceptives, many of the married women didn't have any contacts with field workers and they had to rely (41%) on pharmacies for contraception (BDHS, 2014).

During HPNSDP, based on MTR and APIRs recommendations, high attention has been given on the interventions such as, strengthening field service delivery through domiciliary visits and satellite clinics, filling-up vacant positions, skill development of the service providers, development and implementation of technical protocols (SOPs), improve supply of commodities and up-gradation of service facilities (UH&FWCs). In addition, stronger collaboration has been established with NGOs to increase demand for and use of LARC&PM and to improve skills of the service providers.
This Operation Plan (OP) has been developed based on the strategic directions mentioned in the Health, Nutrition and Population (HNP) Strategic Investment Plan (SIP) 2016-2021 to address challenges related to population growth and to attain replacement levels of fertility through an integrated family planning program. The outcome level FP targets have been set in alignment with government's commitment for SDGs and FP2020.

4. Objectives

i. To contribute in increasing Contraceptive Prevalence Rate (CPR) to 75% by 2021
ii. To provide family planning services for the target population with special focus in the hard-to-reach and low performing areas including urban slums and adolescent
iii. To improve quality of care
iv. To strengthen GO-NGO/ private sector collaboration
v. To contribute in reducing unmet need of contraceptives to 9% by 2021
vi. To contribute in reducing discontinuation rate to 20% by 2021

5. Components

Component-1: Ensuring availability of contraceptives and other supplies

Supply of contraceptives to the millions of clients across the country is one of the major activities of the Directorate General of Family Planning. Family Planning - Field Services Delivery (FP-FSD) operational plan will take necessary steps to ensure nationwide availability of temporary methods: condom, oral pill and injectables. Need assessment and procurement of those contraceptives are mainly processed through the FP-FSD operational plan and procurement is done by the Logistic & Supply Unit of DGFP. The OP targets, present stock balance, quantity in the pipe-line, stock-security etc. will be taken into consideration while preparing the procurement plan during the program period. To increase contraceptives basket, initiatives will be explored to introduce new contraceptive like third/fourth generation oral contraceptive pill and Sayana Press.

Activities:

1. Need assessment for required contraceptives and MSR;
2. Procurement of contraceptives (Oral pill, PoP,Condom & Injectables);
3. Procurement of MSR (Calcium, Povidon, cotton, stethoscope, thermometre, BP machine etc)
4. Procurement of safety box

Component-2: Strengthening Field Services Delivery:

a) **Domiciliary services:** DGFP has been providing both domiciliary and center- based services through field workers named Family Welfare Assistants (FWAs) and Family Welfare Visitors (FWVs). At present approximately 23,000 FWAs are involved in distributing condom, oral pill and injectables to the acceptors at domiciliary and Community Clinic level. Through house-to-house visit the FWAs register the Eligible Couples (ELCOs) for FP services. FWAs conduct courtyard meetings with the eligible couples in the respective areas. They counsel, motivate and refer eligible couples for other FP methods (long acting methods) and also for other MCH services to CCs or to other static service centers. FWAs those who are trained as CSBA have been providing antenatal care, safe delivery and essential newborn care in the community. While domiciliary visits by the FWAs have been reduced as they need to spend three days at the CC level, to maintain the domiciliary visits at optimal level initiative will be undertaken to involve volunteers along with other field level workers from DGHS like HAs, AHIs and. Necessary orientation/ training will be provided to HAs, AHIs, His and CHCPs, on family planning service delivery and domiciliary visit plan will be shared among all the field workers. Moreover, to address the reduced domiciliary visit problem “depot corner” initiative will be introduced in the hard to reach and low performing areas. Mentionable this initiative introduced selectively (in Narail Sadar upazila) by the local initiative earlier during last sector program found effective. To increase contacts with the eligible couples by the FWAs use of volunteers from the existing community group members (CGs, C-STGs of Community Clinics) will be explored.

Activities:

1. Procurement and distribution of bag, apron, umbrella, diary, steel trunk, BP machine, thermometer etc.
2. Printing of registers, client cards, training manuals, consent forms, counseling forms, notebook and folders.
3. Capacity development of FWAs, FPIs and SACMOs, HAs, HIs, CHCPs.

4. Orientation of the community representatives (CG, C-STGs members) on family planning field service delivery.
5. Monitoring by field supervisors (FPIs) and review in monthly meetings.
6. Orientation program for traditional healers (village doctors, medicine shop keepers etc).

b) **Satellite Clinics (SCs):** While providing services to the population of hard to reach areas and vulnerable population is a major challenge, conducting satellite clinics is one of the major activities of FP-FSD operational plan aiming to take services to the doorstep of the clients. A total of approximately 30000 satellite clinics are held every month (8 SCs per union per month at the union level) at the community level. Main objective of SC is to provide family planning, maternal and child health services and FWVs are mainly responsible to conduct the SCs and are assisted by the FWAs. Necessary logistics and financial support are provided to conduct quality SCs. Mentionable SACMOs will also conduct SCs at the schools where health education sessions will be conducted along with limited primary health care services to the adolescents.

Activities:

1. Supply of commodities, logistics and organize quality satellite clinics weekly at the word level.
2. Budgetary support to strengthen satellite clinics.
3. Organizing satellite clinics in the schools by the SACMOs.
4. Orientation program for the service providers on strengthening of SC.

c) **Addressing unmet need and dropouts:** To achieve replacement level of fertility, use of contraceptives has to be increased and the discontinuation rate needs to be reduced. Even though BDHS (2014) reflects high level of awareness about oral pill, IUD, condom, injectables and sterilization, dropout rate (30 percent) of contraceptives and unmet need (12 percent) are very high. Discontinuation rates for condom and pill are 40 percent and 34 percent respectively. The reasons of high dropout rate and unmet need included i) concern for side effects; ii) lack of side effect management; iii) inadequate counseling; iv) shortage of manpower; v) lack of follow up and vii) absenteeism etc. To address these issues quality service delivery will be ensured with the help of different interventions like i) orientation of the service providers and other stakeholders (community volunteers); ii) effective counseling on family planning methods by the service providers; iii) use of client selection checklist; iv) follow up of the clients (at the household level, SC/ CC) or through mobile phones and v) ensuring required logistics support.

Activities:

1. Orientation program for the FWAs, FPIs, FWVs, HAs, CHCPs and SACMOs.
2. Refresher courses on counseling for the field workers.
3. Ensuring counseling services while providing domically services as well as at the services centers (Satellite clinics/ Community Clinics).

d) **Services to newlywed couple:** In addition to the existing orientation program for the newlywed couples, FP-FSD operational plan will introduce new intervention under which all marriage registrars in the rural areas will be oriented on Family planning issues and will receive fancy gift boxes containing pills, condoms, decorated wall clock and communication materials on MCH-FP (booklet, leaflet etc.).They will be instructed properly to distribute gift boxes to every newlywed

couple during the time of marriage registration on the day of marriage ceremony. Mentionable this initiative will be introduced phase-wise like initially this will be tried out in two districts in the year one and based on the experience and lessons learned the initiative will be gradually scaled up nationally.

Activities:

1. Orientation program for the marriage registers.
2. Procurement of gift box, certificate for the newlywed couples.
3. Orientation program for the newlywed couples on FP-MCH.

e) **GO-NGO (including private sector) coordination:** While DGFP is the main FP-MCH services providers in rural areas, NGOs are the major service providers in urban areas. Evidence suggests that NGO services are equally important for achieving demographic goals as there are about 400 national and local-level NGOs are working on FP service delivery. More collaboration will be made with the NGOs/private sector, like SMC, Ma-Moni, Shurjer Hashi, and other USAID supported projects. Besides existing registered local NGOs with DGFP for FP service delivery, large scale national NGOs like BRAC, Grameen Bank etc. will be on board to increase the service coverage. Effective GO-NGO coordination and cooperation will be strengthened for field level family planning services through performance sharing meetings on regular basis. Along with existing interventions to address the family planning needs of the married adolescents working in the garments factories , FP-FSD operational plan will introduce right-based initiative which will not only improve the reproductive rights of around 3.5 million female garment workers across the country, it will also improve the working environment in the garments' sector.

Activities:

1. Formulation of GO-NGO Coordination Forum.
2. Systematic information dissemination on reproductive health and MCH-FP services to female garment workers.
3. Special satellite clinic for garments workers to address their immediate FP-MCH needs and provide them with take-away BCC materials.
4. Orientation program for the supervisors of garments factories on contraception and reproductive rights.
5. Advocacy meetings with the garment owners, buyers including general managers, production managers on FP-MCH services, personal hygiene and reproductive right based working environment.

f) **Functionally coordinated services**: While functional integration of services under the sector program is the key strategy, FP-FSD interventions will create scope of providing services by both the DGFP and DGHS service providers. CHCPs, HAs & AHIs will be oriented on family planning services so that they can complement services with the DGFP service providers at the UH&FWC, CCs, and SCs and during domiciliary services. To ensure smooth functioning of the UH&FWC's there will be some contribution of petty repair and maintenance for emergency/urgent demand of the Upazilla managers.

Activities:

1. Development of joint field visit plan with the DGHS service providers involving local level supervisors.
2. Involving DGHS service providers in Union level FP meetings including UH&FWC management meetings.
3. Ensuring FWAs' participation in CC management committee and community support group meetings.
4. Ensuring increased involvement of the HAs (Female) and who received CSBA training in the SCs to provide FP services.
5. Increase supervision and monitoring.
6. Outsourcing of security guards (Ansar VDP) for the upgraded UH&FWCs (outsourcing of security guard could not be continued due to fund constraints.).Explore funding source through DGHS.
7. Regular maintenance of UH&FWCs.
8. Supply of logistics.

Component-3: Strengthening Family Planning services in Hard-to-Reach Areas

a) **Recruitment of volunteers:** Using different service delivery approaches for different geographical regions is one of the approaches for family planning program under the fourth sector program. Based on the positive lessons learned in terms of increased contraceptive coverage in 10 hard to reach Upazillas where volunteers were hired (150) against vacant positions of the FWAs during last sector program, FP-FSD OP has planned to recruit volunteers in selected 50 more hard-to-reach and low performed upazillas during the implementation period of the fourth sector program in coordination with CCSDP OP.

Activities:

1. Recruitment of volunteers.
2. Training of volunteers (basic & refresher).
3. Logistics support to the volunteers.
4. Monitoring and performance review.
5. Quarterly monitoring meeting with the district and Upazilla level managers of the ten lowest performing districts.

b) **Regional service package:** While regional variations in terms of program performance and need for services are highly emphasized in the strategic documents of the fourth sector program, FP-FSD operational plan has designed regional service package considering the demand for services particularly in the hard-to-reach areas. Focus will be on: i) involvement of local community volunteers of different NGO partners and train them on counseling motivation and referral of clients; ii) hiring volunteers against vacant field workers positions (FWA) to streamline domiciliary services organizing satellite clinics; iii) capacity building through basic and refreshers' training of service providers and v) strengthening IEC activities organizing workshops, discussions, rally and campaigns.

Activities:

1. Recruitment of volunteers and provide training.
2. Hiring of specially designed engine boat.
3. Additional logistics support to strengthen satellite clinics in the HTR and low performing areas.
4. Coordination with CCSDP and IEC OPs.
5. Monitoring and periodic performance review.

c) **Multi-sectoral approach:** As part of innovative approach, the FP-FSD operational plan will engage Sub Assistant Agriculture Officer of Agricultural Department and microcredit groups to increase male involvement which has been a great challenge for the FP program. In this regard selected BSs and microcredit groups of Sylhet and Chittagong divisions will be oriented on FP-MCH issues in collaboration with the ministry of Agriculture so that they can help to increase awareness among the farmers group on the benefits of small family, use of contraceptives, availability of services, importance of mothers health in the family and other reproductive health issues.

Activities:

1. Advocacy meetings with the ministry and directorate level officials of concern ministries.
2. Orientation program for the field level service providers of agriculture department, Ansar & VDP and microcredit group members of BRDB and NGOs.
3. Monitoring and reviewing the results.

Component-4: Family Planning Services in Urban Slums

During last decades, availability of the temporary methods of contraception has increased substantially through private sector in Bangladesh. In the private sector, FP services are provided mainly by Social Marketing Company (SMC), which has been selling its own brand of pills, condoms and injectables through different private sector outlets. There are many local NGOs who are also involved in delivering FP services as part of maternal and child health (MCH) interventions, while they (registered ones) receive supply of FP commodities free of cost from DGFP.

Due to rapid urbanization, providing quality primary health care services including family planning for the urban poor remained as one of biggest challenges since last two decades. Bangladesh Urban Health Survey, 2013 (NIPORT 2013) has revealed that fertility is below the replacement level in all three surveyed urban areas including the slums. The MOHFW is involved in providing primary health care services including FP in the urban areas since last two decades. Specifically, for FP services , the areas which need strengthening particularly for urban slums included i) registration of couples and counseling ; ii) domiciliary visits and contraception distribution ; iii) establishing referral linkages between urban slum and FP service centers ; iv) arranging FP package programs in selected urban areas and v) orientations/ training. Considering above issues FP- FSD initiated urban family planning pilot project in August 2014 in Sylhet City Corporation areas involving one local NGO. Based on the findings of the end-line survey of the piloting in the Sylhet City Corporation, FP-FSD operational plan will scale up the intervention in other city corporation slum areas.

Activities:

1. Outsourcing of NGOs for FP program in the urban areas.

2. Registration of eligible couples in urban slums.
3. Counseling and motivational activities for FP services in the city corporation areas.
4. Establishment of referral linkage between urban slum and FP service centers within the City Corporation and Pourashava.
5. Technical and logistics support to the NGOs.
6. Coordination with the MoLGRD at different level.
7. Assessment to know the effectiveness of the program.
8. Undertake feasibility study for scaling-up.

Component-5: Community Participation

While community engagement is one of the strategic objectives of the 4th Sector Program, FP-FSD operational plan will implement various activities to strengthen community engagement in delivering quality family planning services like capacity development of the community groups, awareness raising on FP-MCH issues and involving community in greater social mobilization and in planning and monitoring of FP service delivery at different level.

Activities:

1. FP Dialogue at divisional HQs involving key stakeholders to solicit their support to FP-MCH and population issues.
2. Community sensitization workshops in seven divisions with different community groups to promote and to facilitate community engagement from planning to implementation of FP-MCH interventions.
3. Orientation programs for the local government representatives, local elites and journalists, religious leaders, cultural activists, women groups (female school/college teachers, women chamber of commerce, local singers/artists etc).
4. Sharing meetings with the members of Upazilla family planning committee with special focus on the prevention of child marriage, teenage pregnancy and benefits of small family, ANC & PNC, spacing and limiting births, girls' education etc.
5. Revitalization of Union FP committees and engage them in the movement against child marriage, teenage pregnancy, malnutrition.
6. Orientation for the different existing community groups like CC management and CC support groups (youth & adolescents, Ansar-VDP, BRDB women groups) in support of FP-MCH programs.
7. Sensitization of satellite clinic management committee.

Component-6: Quality of Care

To provide quality services particularly in the field of reproductive health it is important to focus on clients' basic rights such as their rights to information, access , choice , safety, privacy and confidentiality, dignity, opinion, comfort and continuity. Women rights in terms of informed choice will be given highest priority, and care will be taken to avoid coercion, extortion and provocation. On the other hand, almost seventy percent family planning service providers are female for whom gender

sensitive working environment will be the key factor for quality service delivery. While addressing the needs of the clients, it should be acknowledged that service providers have also needs like good supplies and infrastructure, good management and supervision and information and training.

MoHFW has given high emphasis on implementation of Total Quality Management (TQM) modality at all levels and accordingly a Quality Improvement Secretariat (QIS) has been formed to oversee the quality issues in MNCHFP and Reproductive Health. Mentionable, quality monitoring committees have been formed at the divisional, district and Upazila level and an operation manual on TQM has been drafted. Managers and supervisors at different levels will be trained and oriented to enhance supervision capacity and different monitoring tools and checklists will be introduced in this regard. Moreover, innovative initiatives like use of social media (Face book), video conferencing, client and service providers tracking will be introduced at the field level. To ensure quality the key activities will include:

Activities:

1. Orientation program for the field level managers on TQM approach.
2. Refresher training for the field level service providers on quality of care.
3. Foreign training /exchange program on community based FP-MCH program.
4. Training for the district and Upazilla level managers on demographic analysis and monitoring and supervision of FP-MCH program.
5. Strengthening of monitoring and supportive supervision (use client satisfaction checklist).
6. Procurement of training materials.
7. Procurement of jeeps and motorcycles for districts and Upazilla family planning offices and one microbus and one jeep for the headquarter.
8. Study/assessment of SC, volunteer-based intervention.
9. Feasibility study for family planning interventions in the slums of Chittagong and Dhaka division.
10. Training on counseling for all service providers.

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

Under population sub-sector of 4th HNP Sector Program, the three OPs under DGFP named FP Field Services Delivery; Clinical Contraceptive Service Delivery Program; and MC&RH Services Delivery Programs work in a complementary manner. These three OPs will be supported by other four OPs of DGFP named MIS, IEC, Procurement and Supplies and Planning, Monitoring & Evaluation:

(i). IEC-OP: IEC OP would be closely working in creating demand for family planning services through comprehensive Social Behavioral Change Communication (SBCC) initiatives using multiple and innovative BCC channels/ approaches (print, electronic media) also ICT/social media to reach targeted population. IEC will play a pivotal role in community mobilization to address child marriage, teenage pregnancy, delaying first pregnancy among adolescents, unmet need and FP dropout rate as well as promoting PPFP and LARC/PM particularly in the low performing areas.

(ii). In developing high performing staff, the Training –OP, TRD will provide necessary training support to newly recruit filed workers (FWAs, FWVs) and refresher training from different level of service providers.

(iii). MIS data generated through digitalize system will be used for decision making. The reports generated through MIS will be reviewed on regular basis for programmatic decision making.

(iv). The PME OP will be involved in performance monitoring of the operational plans on regular basis. It will help to assist in conducting Annual Program Review (APR), Mid Term Review (MTR) by providing information, co-ordination with LDs and MOH&FW, making suggestions for further improvement of program/project etc.

7. Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl. No.	Indicators	Unit of Measurement	Base line (with Year and Data Source)	Projected Target	
				Middle of Program (By June 2020)	End of Program (By June 2022)
1	2	3	4	5	6
1	Proportion of women of reproductive age (age 15-49 years) who have their need for FP satisfied with modern methods	Percentage	12% (2014)	8	6
2	Adolescent birth rate (age 10-14 years: aged 15-19 years) per 1,000 women in that age group		83 per 1000 (2015)	60	55
3	CPR (modern methods) in lagging regions	Percentage BDHS, UESD	Syl 40.9%. Ctg 47.2% BDHS 2014	55	60
4.	Number of Upazillas covered for orientation of DGHS service providers on FP-MCH issues	Number of Upazila with trained HA/AHI/ CHCP (Admin record)	-	250	488

10. Budget of the Operational Plan

10.1Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
35346.00	109242.00	350.00	109592.00	144938.00	

10.2Component and activity wise physical and financial target of OP: FP-FSD

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component-1:													
1	Ensuring availability Contraceptives and other supplies (Injectables 75500, AD Syring 83200, Oral pill (COP) 548000, Oral pill (POP) 1500, Safety box 750, MSR 1650)	710600		111352.00	3000.00	108352.00	0.00	100.00	19329.00	22832.50	23120.50	24770.00	21200.00
	Sub Total =	710600		111352.00	3000.00	108352.00	0.00	100.00	19329.00	22832.50	23120.50	24770.00	21200.00
Component-2:													
1	Strengthening Field Services Delivary (Bag, Umbrella & Apron 247, Printing 7800, Satellite 2400)	10447		20421.00	20421.00	0.00	0.00	1215.20	4018.68	3885.05	3761.98	3749.22	3790.87
	Sub Total =	10447		20421.00	20421.00	0.00	0.00	1215.20	4018.68	3885.05	3761.98	3749.22	3790.87
Component-3:													
1	Strengthening Family Planning Serviecs in Hard to reach areas (Volunteer 3750)	3750		5530.00	5340.00	0.00	190.00	105.00	470.00	815.00	1420.00	1360.00	1360.00
	Sub Total =	3750		5530.00	5340.00	0.00	190.00	105.00	470.00	815.00	1420.00	1360.00	1360.00
Component-4 :													
1	Family Planning Serviecs in Urban	11		225.00	100.00	0.00	125.00	125.00	20.00	20.00	20.00	20.00	20.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit	Total	GOB	PA							
					RPA	DPA						
1		2	3	4	5	6	7	8	9	10	11	12
	Slums (NGO)											
	Sub Total =	11	225.00	100.00	0.00	125.00	125.00	20.00	20.00	20.00	20.00	20.00
Component-5 :												
1	Community Participation (Committee Meeting)	425	650.00	650.00	0.00	0.00	50.00	120.00	120.00	120.00	120.00	120.00
	Sub Total =	425	650.00	650.00	0.00	0.00	50.00	120.00	120.00	120.00	120.00	120.00
Component-6 :												
1	Quality of care	4939	6760.00	5835.00	890.00	35.00	205.00	1835.00	1630.00	1520.00	785.00	785.00
	Sub Total =	4939	6760.00	5835.00	890.00	35.00	205.00	1835.00	1630.00	1520.00	785.00	785.00
	Grand Total=	730172	144938.00	35346.00	109242.00	350.00	1800.20	25792.68	29302.55	29962.48	30804.22	27275.87

11. Budget support from other Operational Plan: Not applicable

4.27 Lifestyle, and Health Education & Promotion (L&HEP)

1. Name of the OP: Lifestyle, and Health Education & Promotion (L& HEP)

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

Bangladesh has unfinished agenda related to maternal, neonatal, child-adolescent health (MNCAH), and the dual burden of communicable and non-communicable diseases. Besides there are climate, and environment related health problems, various injuries, poisoning and snakebite, alcohol and substance abuse, occupation health risks, early marriage, and gender based violence. In the new Essential Health Service Package (ESP) emphasis has been given to counseling and communication across the core services provided in PHC and by different service providers1. Lowest tier of PHC, the community and community clinic will provide different health promotion and disease prevention advice/message by CHCP, HA, FWA.

Solution of many present day health problems require involvement of Ministry of Health and Family Welfare, and many other ministries, and the community as a whole if we consider prevention of many of the risk factors causing illness and death. There is increasing realization of importance of involvement of individual and the community for prevention of illness, promotion of health and improved management outcome of illness. Community engagement can be attained through effective individual, inter-personal and public communication using different media. Individual and community healthy behavior is a part of social change achieved through communication, social behavior change communication (SBCC). SBCC is the use of communication to influence individual and collective behavior to have impact on diseases/health conditions. Methods of communication may be interpersonal, community mobilization by using mass media, ICT and others. Bangladesh has an approved Comprehensive Social and Behavior Change Communication Strategy2. It is expected that a health literate society will be an asset and gradually such a society will be developed by implementing the SBCC strategy. Creation of a massive and rapid awareness among the public on risk factors of NCDs, on the health effects of climate change, benefit of keeping the environment clean will be possible by implementing the strategy involving the health care professionals, and the public.

4. Objectives:

General:

To influence the healthy behavior of individuals and community, and living conditions that influence health by improving their knowledge, attitude and skills by creating a ‘health literate society’.

Specific Objective:

i. To establish legislative framework, communication strategy, implementation strategy, and intersectoral collaboration for healthy lifestyle and healthy environment.

ii. To improve the activities for implementation of lifestyle, and health education & promotion at individual and community level.

iii. To identify different target audience and address communicable, non-communicable diseases, MNCAH issues, and emerging & re-emerging health problems.

iv. To establish linkage with other OPs/units of DGHS for implementation of respective SBCC.

v. To use and establish linkage with print, electronic, and social media and effective community engagement for SBCC

5. Components:

Component A: Legislation, inter-sectoral collaboration and stewardship for SBCC

There are rules for prevention of illness, to keep the environment clean; some of them are age old and some need updating-revision. Coordination between different implementing agencies within and outside the MOHFW will be necessary. Implementation of preventive strategies requires the involvement of ministries and departments other than health where the stewardship role of MOHFW will play important role[3].

Component A-i: Legislative framework

Activities:

1. Evidence based advocacy for enforcement of legislation
2. Develop/consider to have a 'parliamentary caucus group' for LE&HEP.
3. Conduct advocacy workshop with the Parliamentarian Caucus group
4. Awareness building for legislation on air standards/pollution and controls in Industrial areas

Component A.ii: Implementation of comprehensive social and behavior change communication strategy (SBCC)

Activities:

1. District level workshop on promotion around healthy diet, the effects of dietary salt intake, hazards of excessive sugar and oil intake, and need for high fruit and vegetable intake (cross cutting with NCDC)
2. Activities to stop tobacco consumption and substance abuse (cross cutting with NCDC)
3. Public education campaigns about the benefits of exercise (cross cutting with NCDC)

Component A.iii: Integrated communication strategy based on new media platforms, including BCC

Activities:

1. Develop lifestyle and environmental strategy in collaboration with other Ministries and stakeholders.
2. Develop and implement social media strategy
3. Roll out of targeted knowledge products via media platforms

Component A.iv: Establish inter-sectoral collaboration on lifestyle, including private sector engagement

Activities:

1. Workshop to promote safe and healthy environments within health facilities, household, workplaces and schools, including overall cleanliness, ordinary and medical waste management, sanitation facilities.

2. Workshop to promote importance of air quality especially involving cooking fuels and urban air controls especially linked to vehicle emissions for concerned users
3. Workshop to promote value of urban Green spaces including in new urban developments. Promote the important of biodiversity and health.
4. Awareness building on road accident, drowning and waterway safety.
5. Collaboration for NCD prevention: Important stakeholders & key output areas[3]

Stakeholders	Key strategic areas
Prime Minister's Office	Provide overall policy directions, financial commitment, support to the Ministries and stakeholders, and review and monitor Bangladesh's national and global commitments in NCD control
Ministry of Health and Family Welfare	Provide national coordination and manage the Multisectoral NCD Coordination Committee, advocate "health in all policies" with other sectors to include NCD control, regulate standards of health services, provide NCD prevention, early detection, treatment services, conduct NCD surveillance , and conduct healthy literacy and mass media campaigns
Ministry of Local Government, Rural Development and Co-operatives	Lead initiatives to promote Healthy Settings programs through Healthy City Projects which holistically address establishing pedestrian friendly environment, creating more public grounds and gardens, enforce tobacco, food safety, and alcohol rules; support Healthy Schools and Healthy work place initiatives; and integrate healthy lifestyle education and NCD screening in urban primary health care facilities
Ministry of Education	Support for curricular inclusion on healthy lifestyle, participate in scaling up of Healthy Schools programs
Ministry of Youths and Sports	Support healthy lifestyle promotion through sports development programmes in schools and academic institutions
Ministry of Food	Ensure implementation of food safety standards, advocate for consumer protection through development of regulations reduction of salt, trans fat, saturated fat and sugar control in food products
Ministry of Housing and Public Works	Integrate friendly built environments that promote health and healthy lifestyles
Ministry of Agriculture	Institute policies and programs to increase production of fruits and vegetables and making them accessible and affordable to general public
Ministry of Commerce and Ministry of Industry	Review trade and import policies pertaining to unhealthy processed food products, tobacco and alcohol beverages
Academia	Participate in capacity building in skilled health workforce, provision of tertiary NCD services, and engage in research and surveillance for informing policies and programmes.

Stakeholders	Key strategic areas
NGOs	Participate in policy lobby, provide NCD services, and engage in prevention specific risk factor prevention programs such as projects related to improve cooking stoves, tobacco control and physical activity promotion.

Collaboration with other programms of DGHS- CBHC, IEC, NCDC, HSM; Medical Colleges, Specialized institutes; Private sector, NGOs.

Component B: Communication Campaign through different Medias for behavior change.

There are different communication methods to change individual and community behavior. Entertainment education has been found to be one of the important method where emotions are used to inform the audience and change their attitude, behavior and social norms. ICT based SBCC will be initiated conforming to the government commitment of establishing digital Bangladesh.

Activities

1. Specific local level campaigns for vulnerable and hard to reach groups using community approaches such as community meetings, local entertainment-education activities, fairs, folk songs, street dramas, video shows, etc.
2. Develop and broadcast issue based TV and radio spots, TV serial, video shows and production of display boards, billboards, posters, etc.
3. Introduce mobile phone messages (e.g. voicemails on maternal healthcare and nutrition for the pregnant women, call centre).
4. Design issue based health education and promotion events, including folk dramas, songs etc
5. Use Bioscope, an entertaining medium, to disseminate health messages to illiterate and low literate populations, poorest of the poor or marginalized people.
6. Campaign for specific Life style, and Health Education & Promotion campaigns in the community coinciding with World Health Day, World Autism Day, World No Tobacco Day, Safe Motherhood Day, and other Special Days and Weeks.
7. Provide community messages on preventive measures against various injuries/accidents, drowning, snakebite, poisoning.
8. Campaign for awareness building to promote healthy lifestyle for prevention and control of non-communicable diseases control and mental health including module development
9. Communication Campaign on arsenic free water.
10. Campaign on prevention of Hepatitis, Diabetic, Cancer and other non-curable disease.
11. Awareness on prevention, control and elimination of Malaria, Kala-Azar, Filaria and Dengue.

Component C: Community Engagement and Mobilization

Community engagement (CE) refers to the process of engaging a broad range of stakeholders, communities, and audience representatives to participate and build ownership of SBCC programs by identifying and working towards a collective vision'[2]. Different methods may be used for CE including community dialogue, round table, workshop etc.

Activities

1. Provide practical health education on hygiene and hand washing to pre-school children and follow-up at home to ensure healthy practices.
2. Conduct Child Health and School Health programs.
3. Conduct community based workshop/Seminar to promote compassion for elderly health care through procurement of Service Package
4. Counseling on safe sexual behavior, mental health, HIV/AIDS, Tobacco and Drug abuse among the Adolescents
5. Counseling on prevention of early marriage and delaying pregnancy among the adolescents and their parents
6. IPC/counseling by health service providers by using counseling job aids on different health promotion issues
7. Promote personal hygiene practices among the school children at community level
8. Provide need based SBCC support in order to increase awareness and community participation
9. Promotion of oral hygiene at Primary school in rural level.
10. Introduce campaign on de-worming at primary schools with the support of community stakeholders
11. Ensure newborn care and infection control by promoting safe delivery, prevention of newborn asphyxia, thermal control, hygiene, chord care and eye care
12. Communication Campaign for promoting recognition of newborn danger sign and care seeking for newborn illness
13. Health education for mothers on cleanliness and care for the newborn

Component D: Advocacy and Coordination

Advocacy and coordination is essential to have SBCC activities aligning with different public health policies and guidelines, preventing duplications, promoting linkage with different health care services.

Activities:

1. Collaborate with relevant sectors and organizations for comprehensive planning and implementation of Lifestyle and Health Education and Promotion programs (BCC WG)
2. Conduct workshops with stakeholders (HPN) at National, Divisional, District and Upazila levels to facilitate smooth implementation of activities.
3. Coordinate interventions with other National and Sectoral Interventions conducted by other departments and organizations.
4. Advocate to reduce NCD high risk behaviors
5. Procurement of Service Package to conduct advocacy meeting, seminars and other awareness raising activities on Non Communicable and Communicable Diseases including Road Accident, Snake bite and other non-conventional issues
6. Intersectoral & Multisectoral advocacy and coordination meeting with other OP's

7. Promotion of quality essential health-care services at public hospitals to achieve the Universal Health Coverage

Component E: Capacity Development and Logistic support for SBCC

Capacity development for SBCC will include 'high performing workforce' at different levels- policy, planning & design, programme management and programme delivery including different service providers, community based health workers (public and private, NGOs). Through a strengthened system of SBCC the behavior of individuals and community will change which in return will close the gap between knowledge and practice, and improve health outcome.

Activities:

1. Capacity building of Bureau of Health Education personnel, and other field staffs on health promotion, evaluation, SBCC, environmental and occupational health, MNC&AH, media development etc (local + foreign)
2. Capacity development, including pre and in-service curricula, on lifestyle choices, public health and school health
3. Software development to Maintain consistency of information and maximum utilization of resources.
4. Develop Health resource center and other IEC support to HEP
5. Provide adequate logistic supports for smooth implementation of the Programme.

Component F: ICT and Innovation

In line with the governments' policy of supporting Digital Bangladesh innovations with ICT based communication will be considered using mobile technology, social media, voice and text messages, web sites etc.

Activities:

1. Regular maintenance of the BHE Website in collaboration with the MIS Unit of DGHS
2. Collect newly developed materials, conduct vetting and incorporate in the eToolkit every year
3. Regular update the Digital Archive of BHE and promote the archive through different media
4. Advocate regularly among the officers and staffs to enroll on the eLearning courses.
5. Active engagement in social media groups (i.e. Facebook, Twiter, FlickR, Photo Share, Health Communication Spring Board}

Component G: Occupational and Environmental Health

Bangladesh is transforming from poor economy to middle income country with change in pattern of occupations. Existing and new occupations have their occupation related hazards which require adoption of standard preventive methods for which SBCC should be adopted.

Activities:

1. Orientations and seminars with workplace owners and supervisors to develop appropriate workplace policies and norms
2. Develop linkages between concerned ministries, BSCIC, Trade/workers unions and concerned organizations

3. Design communication program to reduce health hazards in factories, tanneries, mills, welding shops and ship breaking.
4. Advocate for risk allowance for healthcare providers and Health Insurance for all.
5. Design and conduct orientation for the relevant groups to increase their health hazards knowledge while working at factory, tannery, mill and welding workshop.
6. Procurement of Service Package focused on Occupational and Environmental Health
7. Awareness on climate change, food safety, injuries and healthy aging.

Component H: Production, Distribution and Dissemination of SBCC materials

High quality SBCC materials will be produced, distributed and disseminated for use.

Activities:

1. Design issue-based gender sensitive Health Education and Promotion materials i.e. Poster, Sticker, Leaflet, Flipchart etc. on different health promotion issues with a view to supporting the programs in line with other components
2. Regular maintenance of press to print quality SBCC materials
3. Distribution of regionally focused SBCC materials

Component I: Monitoring, Research and Knowledge Management

According to the comprehensive SBCC strategy[2]: 'Monitoring and evaluation (M&E) is a necessary component of a successful SBCC program, as it allows for an in-depth understanding of the impact of a specific program on people's attitudes, other ideational factors, and behaviors, which ultimately affect behavioral and health outcomes". 'A basic M&E framework for SBCC has three major elements; inputs, outputs and outcomes. Inputs are the resources that are put into SBCC programs. Outputs are things like audience coverage, household coverage, activities completed, knowledge, couple/household communication, and attitudes. The outcomes to be achieved as a result of SBCC programs are positive changes in people's health behaviors and social norms'.

Activities:

1. Baseline Survey on Health Seeking behavior
2. Behavioral research on Health Promotion
3. Midterm evaluation to assess the change of target audience on desired behavior
4. End line evaluation
5. Conduct impact study through third party (Procurement of Service Package)

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc.

i. Linkage of other OPs of DGHS and DFP for SBCC activities.

ii. Identify local champions, local mass media initiatives, community radio, journalist association, representatives of local elected bodies.

iii. Nutrition: As per SIP 2016-2021, and APIR 2015 the government recommended for mainstreaming nutrition and interventions to address nutrition & have been incorporated in services provided by DGHS and DGFP along with NGOs and partners with objective to

reduce maternal and child health, adolescent mal-nutrition and ensure universal access with a multi-sectoral approach. Through L & HEP Operation Plan, mass media campaign, social mobilization and advocacy initiatives will carried out to promote good health and nutrition practices. (Cross cutting with NNS).

iv. Gender Equity: "Gender Equity Strategy 2014" has been formulated 'Gender Equity Action Plan' that recommends to incorporate development of gender responsive SBCC materials. Existing IEC/SBCC materials will be reviewed to identify gender gaps and develop a framework for development of Gender sensitive IEC/SBCC materials.

v. Management Information System (MIS): MIS helps to ensure better monitoring and supervision through institutionalizing data collection, storage and transmission. Initiatives have been taken to incorporate distribution of IEC/SBCC materials through DGHS/DGFP formal distribution channels and incorporation in LMIS software. This will allow us to identify the need/demand of IEC/SBCC materials at all level of service providers and make a plan for distribution.

vi. Male participation: Despite many interventions male participation is still very low in FP, MNCAH. The service providing units of DGFP (FSD, CCSDP and MCH) are trying to increase male participation and IEC activities are aligned with demand generation of the services provided by the units through IEC/SMCC interventions. (Cross cutting with IEC DGFP).

vii. Collaboration with GFATM initiated SBCC activities on TB, AIDS & malaria.

viii. HIV/AIDS: Bangladesh is highly vulnerable to HIV and AIDS due to number of reasons, such as high prevalence of HIV in neighboring countries, low-risk perception among young population (15-24 years of age), low condom use rate, high prevalence of STI among the vulnerable groups and high client turnover in Bangladesh brothels. Considering the situation, information dissemination on HIV and AIDS will be incorporated in the L & HEP OP. (cross cutting with HIV/AIDS OP).

ix. Involvement/participation of other ministries: Multi sectoral action plan for control of NCDs and the Population Policy 2012 has recommended Action Plan that requires participation of different ministries for the betterment of the people for development of Bangladesh. L & HEP will maintain strong collaboration with the activities performed by the different ministries as well as ensure their participation in health, FP & nutrition activities.

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators:

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1.	Implementation of comprehensive SBCC strategy	percentage of activity implemented	Approved strategy available	50%	80%
2.	Number of SBCC material produced and distributed/	Number (Admin record)	1134500	765330	1175690

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline (with Year and Data Source)	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1.	Implementation of comprehensive SBCC strategy	percentage of activity implemented	Approved strategy available	50%	80%
3	Number of survey/research on L& HEP conducted	Number	07	02	07

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
14067.07	6226.00	867.00	7093.00	21160.07	

10.2. Component and activity wise physical and financial target of OP: L& HEP

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component A .i: Legislative framework													
1	Evidence based advocacy for enforcement of legislation	80	Work shop	300.00	190.00	110.00	0.00	55.00	60.00	55.00	65.00	35.00	30.00
2	Develop/consider to form a 'parliamentary caucas group' for L&HEP.	10	Meeting	10.80	10.80	0.00	0.00	10.00	0.40	0.40	0.00	0.00	0.00
3	Conduct Advocacy workshop with the Parliamentary Caucas Group	8	Workshop	4.00	4.00	0.00	0.00	0.00	0.00	1.00	1.00	1.00	1.00
4	Awareness building for legislation on air standards/ polution and controls in Industrial areas	60	Awareness session	30.00	22.50	7.50	0.00	0.00	6.00	6.00	6.00	6.00	6.00
Component A.ii: Implementation of comprehensive social and behavior change communication strategy (SBCC)													
1	District level Work shop on Promotion around healthy diet, the hazards of salt, oil and sugar, and need for high fruit and vegetable intake (cross cutting with NCDC)	55	Workshop	110.00	110.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	20.00
2	Workshop for awareness building to stop tobacco consumption and substance abuse (cross cutting with NCDC)	16	Workshop	16.00	16.00	0.00	0.00	1.00	3.00	3.00	3.00	3.00	3.00
3	Recruit consultant on SBCC and Knowledge Management to provide adequate support in implementing the Comprehensive Social and Behavior Change Communication Strategy	1	Number	95.40	95.40	0.00	0.00	9.00	21.60	21.60	21.60	21.60	0.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
4	Public education campaigns about the benefits of physical exercise (cross cutting withn NCDC)	384	Campaign	76.80	76.80	0.00	0.00	12.80	12.80	12.80	12.80	12.80	12.80
5	Awareness Creation on Cervical & Breast cancer screening and prevention		Campaign	684.00	0.00	684.00	0.00	0.00	136.80	136.80	136.80	136.80	136.80
Component A.iii: Integrated communication strategy based on new media platforms, including BCC													
1	Develop lifestyle and environment strategy in collaboration with other Ministries and stakeholders.	9	Workshop	13.50	13.50	0.00	0.00	1.50	6.00	6.00	0.00	0.00	0.00
2	Develop and implement social media strategy	LS	Guide line /Strategy	95.00	95.00	0.00	0.00	5.00	20.00	20.00	20.00	20.00	10.00
3	Roll out of targeted knowledge products/SBCC materials via media platforms	5	Material (TVC + Airing)	125.00	125.00	0.00	0.00	0.00	25.00	25.00	25.00	25.00	25.00
Component A.iv: Establish inter-sectoral collaboration on lifestyle, healthy environments, including private sector engagement													
1	Work shop to Promote safe and healthy environments within health facilities, household, workplaces and schools, including overall cleanliness, ordinary and medical waste management, sanitation facilities.	300	Workshop	150.00	100.00	50.00	0.00	10.00	30.00	30.00	30.00	30.00	20.00
2	Work shop to Promote importance of air quality especially involving cooking fuels and urban air controls especially linked to vehicle emissions for concerned users	64	Workshop	64.00	44.00	20.00	0.00	4.00	12.00	12.00	12.00	12.00	12.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
3	Workshop to Promote value of urban Green spaces including in new urban developments. Promote the important of biodiversity and health.	64	Workshop	64.00	44.00	20.00	0.00	4.00	12.00	12.00	12.00	12.00	12.00
4	Awareness building for road, drawning and waterway safety.	704	Workshop	150.00	100.00	50.00	0.00	10.00	30.00	30.00	30.00	30.00	20.00
5	Collaboration for NCD prevention: Important stakeholders & key output areas	22	Meeting	11.00	9.00	2.00	0.00	1.00	2.00	2.00	2.00	2.00	2.00
Communication Campaign through different medias for behavior change													
1	Specific local level campaigns for vulnerable and hard to reach groups using community approaches such as community meetings, local enter-educate activities, fairs, folk songs, street dramas, video shows, etc.	22	Campaign	1500.00	1000.00	450.00	50.00	150.00	300.00	300.00	300.00	300.00	150.00
2	Develop and broadcast issue based TV and radio spots, TV serial, video shows and production of displays boards, billboards, posters, etc.	31	Production	626.00	420.00	200.00	6.00	60.00	122.00	122.00	122.00	120.00	80.00
3	Introduce mobile phone messages (voicemails on maternal healthcare and nutrition for the pregnant women).	3000 000	Voice Message	147.00	120.00	0.00	27.00	26.00	24.00	24.00	24.00	24.00	25.00
4	Design issue-based Health Education and Promotion events, including folk dramas, songs, etc.	275	Events	139.00	93.75	31.25	14.00	62.50	14.50	14.50	15.50	14.50	17.50

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Use Bioscope, an entertaining medium, to disseminate health messages to illiterate and low literate populations. Poorest to the poor or marginalized people.	275	Events	139.00	93.75	31.25	14.00	62.50	14.50	14.50	15.50	14.50	17.50
6	Campaign for specific Health Education and Promotion in the community coinciding with World Health Day, World Autism Day, World No Tobacco Day, Safe Motherhood Day and other Special Days and Weeks.	27	Day Observance	1500.00	1000.00	500.00	0.00	100.00	300.00	300.00	300.00	300.00	200.00
7	Provide community messages on preventive measures against accidents, drowning and injuries.	120	Billboard/ Outdoor Advertisement	280.00	140.00	140.00	0.00	30.00	50.00	50.00	50.00	50.00	50.00
8	Campaign for awreness building to promote healthy lifestyle for non communicable disease control including mental health and design/develop of module	13	Workshop /Seminer/ Module//Poster/Leaflate	768.00	400.00	350.00	18.00	204.00	204.00	105.00	105.00	100.00	50.00
9	Needbase installation of LED screen, Mega sign, Billboard and island decoration with lights and cut-outs etc on different occasion and day observation	LS	Events	1030.00	640.00	280.00	110.00	80.00	190.00	190.00	190.00	190.00	190.00
10	Communication campaign on arsenic free water.	9	Workshop /Seminer	200.00	200.00	0.00	0.00	20.00	40.00	40.00	40.00	40.00	20.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
11	Campaign on prevention of Hepatitis, Diabetic, Cancer and other non curable diseases	16	Workshop /Seminer	400.00	350.00	50.00	0.00	50.00	80.00	80.00	80.00	80.00	30.00
12	Awareness on prevention, control and elimination of Malaria, Kala-Azar, Filaria and Dengue	10	Workshop /Seminer	400.00	350.00	50.00	0.00	50.00	80.00	80.00	80.00	80.00	30.00
Community Engagement and Mobilization													
1	Provide practical health education on hygiene and hand washing to pre-school children and follow-up at home to ensure healthy practices.	3200	Student Orientatio n	173.00	160.00	0.00	13.00	0.00	34.00	34.00	34.00	35.00	36.00
2	Conduct Child Health and School Health programs.	3520	Session	181.00	175.00	0.00	6.00	15.00	32.00	32.00	34.00	34.00	34.00
3	Conduct community based workshop/Seminer to promote compassion for elderly health care through procurement of Service Package	3520	Workshop /Seminer	180.00	175.00	0.00	5.00	15.00	32.00	32.00	34.00	33.00	34.00
4	Counseling on safe sexual behavior, mental health, HIV/AIDS, Tobacco and Drug abuse among the Adolescents	960	Workshop /Seminer/ Poster/Le af late	61.00	50.00	0.00	11.00	0.00	11.00	11.00	13.00	13.00	13.00
5	Recruit Consultant specialized on Community Engagement issues to provide necessary support on social mobilization and engagement mostly at the rural areas	1	Number	67.20	67.20	0.00	0.00	0.00	16.80	16.80	16.80	16.80	0.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
6	Counseling on prevention of early marriage and delaying pregnancy among the adolescents and their parents	3200	Session	180.00	175.00	0.00	5.00	15.00	32.00	32.00	34.00	33.00	34.00
7	IPC/counseling by health service providers by using counseling job aids on different health promotion issues	960	Session	58.00	50.00	0.00	8.00	0.00	11.00	11.00	11.00	13.00	12.00
8	Promote personal hygiene practices among the school children at community level	3520	Workshop /Seminer	185.00	175.00	0.00	10.00	16.00	33.00	33.00	34.00	34.00	35.00
9	Provide need based SBCC support in order to increase awareness and community participation	330	Field Visit	18.00	18.00	0.00	0.00	3.00	3.00	3.00	3.00	3.00	3.00
10	Promotion of oral hygiene at Primary school in rural level.	960	Workshop /Seminer	58.00	50.00	0.00	8.00	0.00	11.00	11.00	11.00	13.00	12.00
11	Introduce campaign on de-worming at primary schools with the support of community stakeholders	960	Workshop /Seminer/ Poster/Le af late	55.00	50.00	0.00	5.00	0.00	10.00	11.00	11.00	11.00	12.00
12	Ensure newborn care and infection control by promoting safe delivery, prevention of newborn asphyxia, thermal control, hygiene, chord care and eye care	3520	Workshop /Seminer/ Poster/Le af late	184.00	175.00	0.00	9.00	16.00	33.00	33.00	33.00	34.00	35.00
13	Communication Campaign for promoting recognition of newborn danger sign and care seeking for newborn illness	10	Package	500.00	500.00	0.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
14	Health education for mothers on cleanliness and care for the newborn	0	Workshop /Seminer/ Poster/Le af late	143.00	90.00	30.00	23.00	24.00	22.00	24.00	23.00	24.00	26.00
Advocacy and Coordination													
1	Collaborate with relevant sectors and organizations for comprehensive planning and implementation of Lifestyle and Health Education and Promotion programs (BCC WG)	100	Advocacy /Co-ordination meeting	58.00	50.00	0.00	8.00	6.00	11.00	11.00	11.00	12.00	7.00
2	Conduct workshops with stakeholders (HPN) at National, Divisional, District and Upazila levels to facilitate smooth implementation of activities.	210	Workshop	200.00	200.00	0.00	0.00	10.00	40.00	40.00	40.00	40.00	30.00
3	Coordinate interventions with other National and Sectoral Interventions conducted by other departments and organizations.	80	Advocacy /Co-ordination meeting	50.00	38.00	0.00	12.00	4.00	9.00	9.00	12.00	10.00	6.00
4	Advocate to reduce NCD high risk behaviors	10	Package/ Advocacy Workshop	500.00	500.00	0.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
5	Procurement of Service Package to conduct advocacy meeting, seminars and other awareness raising activities on Non Communicable and Communicable Diseases including Road Accident, Snake bite and other non conventional issues	13	Package	600.00	500.00	100.00	0.00	70.00	120.00	120.00	120.00	120.00	50.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
6	Intersectoral & Multisectoral advocacy and coordination meeting with other OP's	320	Advocacy /Co-ordination meeting	492.00	320.00	160.00	12.00	49.00	98.00	97.00	99.00	99.00	50.00
7	Promotion of quality essential health-care services at public hospitals to achieve the Universal Health Coverage	11	Package	600.00	500.00	100.00	0.00	50.00	120.00	120.00	120.00	120.00	70.00
Capacity Development and Logistic support for SBCC													
1	Capacity building of Bureau of Health Education personnel, and other field staffs on health promotion, evaluation, SBCC, environmental and occupetional health, MNC&AH, media development etc i.e local + **foreign** (Please see the detail training plan)	228	Training batch	645.00	633.00	0.00	12.00	40.00	170.00	170.00	165.00	100.00	0.00
2	Capacity development, including pre and in-service curricula, on lifestyle choices, public health and school health	36	Training Batch	104.00	36.00	60.00	8.00	18.00	17.00	17.00	17.00	17.00	18.00
3	Development of logistic database to Maintain consistency of information and maximum utilization of (to be done though MIS)	0	Software	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
4	Develop Health resource center and other IEC support to HEP (Please also see the list of furniture and Fixture)	384	Resource Centre	301.00	215.00	80.00	6.00	25.00	71.00	71.00	71.00	31.00	32.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
5	Provide adequate logistic supports for smooth implementation of the Programme. With Motorcycle procurement and repair. (Please see the atachment "Logistic Support-Machinaries and Equipments)	LS	Logistics	250.00	250.00	0.00	0.00	20.00	75.00	75.00	30.00	30.00	20.00
ICT and Innovation													
1	Regular maintenance of the BHE Website in collaboration with the MIS Unit of DGHS	LS	LS	36.37	26.37	0.00	10.00	7.37	6.00	6.00	7.00	5.00	5.00
2	Collect newly developed materials, conduct vetting and incorporate in the eToolkit every year	6	Job	34.00	24.00	0.00	10.00	7.00	6.00	6.00	7.00	4.00	4.00
3	Regular update the Digital Archive of BHE and promote the archive through different media	6	LS	67.00	26.00	30.00	11.00	12.00	11.00	12.00	12.00	10.00	10.00
4	Recruit a Consultant-ICT and Digital Strategist for regular maintenance of BHE Website and Digital Archive, promote and update the eLearning courses and the eToolkits for field workers and Program Managers	1	Number	60.00	60.00	0.00	0.00	0.00	15.00	15.00	15.00	15.00	0.00
5	Advocate regularly among the officers and staffs to enroll on the eLearning courses.	384	Training Batch	135.00	90.00	30.00	15.00	22.00	22.00	22.00	23.00	23.00	23.00
Occupetional and Environmental Health													
1	Orientations and seminars with workplace owners and supervisors to develop appropriate workplace policies and norms	96	Workshop /Seminer	574.00	270.00	270.00	34.00	104.00	105.00	104.00	105.00	106.00	50.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
2	Develop linkages between concerned ministries, BSCIC, Trade/workers unions and concerned organizations	96	Workshop /Seminer	434.00	260.00	110.00	64.00	26.00	78.00	78.00	80.00	82.00	90.00
3	Design communication program to reduce health hazards in factories, tanneries, mills, welding shops and ship breaking.	12	Poster/Leaf late	675.00	300.00	300.00	75.00	110.00	105.00	110.00	115.00	110.00	125.00
4	Advocate for risk allowance for healthcare providers and Health Insurance for all.	96	Advocacy/ Co-ordination meeting	195.00	60.00	60.00	75.00	30.00	25.00	30.00	35.00	30.00	45.00
5	Design and conduct orientation for the relevant groups to increase their health hazards knowledge while working at factory, tannery, mill and welding workshop.	96	Advocacy/ Co-ordination meeting	436.00	230.00	170.00	36.00	55.00	74.00	75.00	75.00	75.00	82.00
6	Procurement of Service Package focused on Occupational and Environmental Health	12	Package	1170.00	600.00	570.00	0.00	190.00	190.00	190.00	200.00	200.00	200.00
7	Awareness on climate change, food safety, injuries and healthy aging.	12	Workshop /Seminer	868.00	360.00	400.00	108.00	170.00	175.00	115.00	118.00	130.00	160.00
Production, Distribution and Dissemination of SBCC materials													
1	Design issue-based gender sensitive Health Education and Promotion materials i.e. Poster, Sticker, Leaflet, Flipchart etc. on different health promotion issues with a view to supporting the programs in line with other components	5200 000	Print Materials	598.00	290.00	290.00	18.00	82.00	102.00	102.00	102.00	105.00	105.00

(Tk. In Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
2	Regular maintenance and upgradation of press to print quality SBCC materials	2	Printing Machine	155.00	80.00	75.00	0.00	20.00	35.00	30.00	30.00	30.00	10.00
3	Distribution of regionally focused SBCC materials	440000	SBCC materials/set	85.00	85.00	0.00	0.00	10.00	15.00	15.00	15.00	15.00	15.00
Research and Knowledge Management													
1	Baseline Survey on Health Seeking behavior	1	Survey	100.00	100.00	0.00	0.00	100.00	0.00	0.00	0.00	0.00	0.00
2	Behavioral research on Health Promotion	2	Research	200.00	0.00	195.00	5.00	0.00	100.00	0.00	100.00	0.00	0.00
3	Mid term evaluation to assess the change of target audience on desired behavior	1	Evaluation	93.00	0.00	90.00	3.00	0.00	0.00	93.00	0.00	0.00	0.00
4	End line evaluation	1	Evaluation	100.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00
5	Conduct impact study through third party (Procurement of Service Package)	2	Package	173.00	90.00	80.00	3.00	0.00	0.00	90.00	0.00	83.00	0.00
	Total			**21160.07**	**14067.07**	**6226.00**	**867.00**	**2469.67**	**4092.40**	**4020.40**	**3935.00**	**3779.00**	**2863.60**

11. Budget support from other Operational Plan: Not applicable

4.28 Information, Education & Communication (IEC)

1. Name of Operational Plan (OP): Information, Education & Communication (IEC)

2. Implementing Agency: Directorate General of Family Planning (DGFP)

3. Introduction

Bangladesh has made commendable success in health, population and nutrition sector during last two decades reducing maternal and child mortality. Substantial progress has been made in reducing population growth through implementation of an effective family planning program across the country. Total fertility rate (TFR) reduced from 6.3 births per woman in 1975 to 3.4 in 1994 and to 2.3 in 2014. Use of contraceptive increased from 8 % in 1975 to 62% in 2014. Factors like strong political commitment from the government, strong field service delivery, multi-sectoral social and behavior change communication (SBCC), effective commodity supply chain, collaboration with government and no-government organizations and social development including increased literacy rate have contributed in reducing the population growth.

The Information Education and Motivation (IEM) Unit of DGFP has been playing a very crucial role in creating demand for MCH-FP services by implementing different SBCC activities across the country . Different awareness raising initiatives undertaken by IEM Unit over the years have positively contributed in reducing population growth of Bangladesh. During last HNP sector program (HPNSDP: 2011-2016) number positive lessons have been learned while implementing different innovative SBCC activities. Key lessons learned were:

i. **Regional Service Packages:** To enhance FP-MCH services in HTR and low performing areas including Sylhet, Chittagong and Dhaka, audience based specific regional SBCC activities were found effective with increased service coverage.

ii. **Greater engagement with Media:** For mass media campaign, using radio and TV (Bangladesh Betar and Bangladesh Television) has been proved to be an effective approach to disseminate messages to the target audiences. Moreover the impact survey conducted on IEC/SBCC activities in 2015 found that about 74 percent respondents listened to radio program and 73.2 percent watched TV programs including National Broadcasting channels i.e. BTV and Bangladesh Betar

iii. **ICT and Capacity building through innovation:** Creating SBCC Digital Archive to disseminate SBCC messages using online and offline platform was an innovative approach and first of its kind in Bangladesh. Developing different learning and counselling materials for the frontline workers like eToolkit and eLerarning courses were found very effective.

iv. **Coordination:** To strengthen the SBCC activities a strong platform has been formed through closer interactions with different professional groups and committees like BCC Working Group, the HPN Coordination Committee which helped integrating and harmonizing different SBCC initiatives across the health and population sector. Establishing linkages with all relevant actors including NGOs, and the private sectors to increase service coverage was found effective.

v. **Advocacy:** Intensive communication campaigns can break religious conservatism and negative barriers on FP-MCH issues. Repeated dissemination of messages through Workshops and Campaigns to targeted stakeholders has increased the service demand. As part of policy advocacy IEM unit has taken initiatives to update current communication strategy in line with the Comprehensive Social and Behavior Change Communication Strategy (CSBCCS) prepared by MOHFW.

However, number of demand side **challenges** still remaining, like

(i). Overall awareness on FP and MNCH issues are high but specific knowledge of each FP method is lacking;

(ii). Heavy reliance on short-term methods due to inadequate and complete understanding about the usefulness of long term or permanent methods;

(iii). Overall quality of FP counseling appears to be weak in existing system;

(iv). Low focus on client segmentation and audience specific IEC/SBCC program;

(v). Lack of counseling on PPFP and most of the deliveries are taking place at home ;

(vi). Inadequate focus on geographic differences in FP acceptance and use, social norms, community support system, language etc;

(vii). Inadequate Post-abortion and post-MR FP counseling;

(viii). Lack of comprehensive information and knowledge for young women about dangers of teenage pregnancy and birth complications and

(ix). Need of ASRH information and services are not address adequately and no national model on ASRH service delivery is in existence.

The IEC OP for the 4th sector program has been developed based on the current context, lessons learned & best practices and it is very much in alignment with the Health, Nutrition and Population Strategic investment Plan-SIP (2016-2021) which aims to ensure that quality HNP services are provided for both public and private sector more efficiently and in an equitable manner. Accordingly, in light of the recently developed and approved Comprehensive Social and Behavioral Change Communication Strategy 2016 by MOHFW, bringing positive changes in people's lifestyle to improve maternal, child health and family planning would be the key strategic focus of the IEC OP.

4. Objectives

(i). Create demand for FP-MNCH information and services through massive SBCC activities using different innovative channels with special focus in low performing regions and pockets.

(ii). Design and implementation of short and long-term SBCC campaigns to address child marriage, teenage pregnancy, unmet need and FP dropout rate as well as massive promotion of PPFP and LARC/PM.

(iii). Engage and mobilize community leaders, gatekeepers, religious leaders, youth representatives, media (print, electronic and folk media) from planning to implementation of SBCC initiatives.

(iv). Undertake high level advocacy initiative through organizing policy dialogue/roundtable discussion to draw policy attention towards pressing FP-MNCH and population issues (such as child marriage, teenage pregnancy, PPFP).

(v). Engage and collaborate with print and electronic media including folk media for increased coverage and reporting on FP-MNCH and population issues.

(vi). Promote and encourage PPP/Partnership with NGOs, INGOs and Private sectors for greater coverage throughout the country including RTR and urban areas.

5. Components

Component-1: Community Mobilization, Sensitization & Advocacy

Advocacy and community mobilization play substantial role in mobilizing policy makers at national and local levels in support of resource mobilization, policy formulation, influencing policy and program decisions as well as program's sustainability. It also enables environment for social and behaviour change. IEM Unit has undertaken a number of community mobilization, sensitization and advocacy activities which included roundtable discussions, community dialogues, media fellowships, short & long-term SBCC campaigns, sensitization workshops, identifying and engaging best performers, involve satisfied clients who can play as a "champion" or role model to revitalize family planning program.

Activities:

1. Country wide awareness building through Campaigns on child marriage, teenage pregnancy, delaying first pregnancy among adolescents, facility delivery, unmet need and FP dropout rate as well as promoting PPFP and LARC/PM.
2. Orientation workshops on prevention of early marriage, promoting small family norms, nutrition, ANC, PNC & FP in Islam, spacing and limiting births, ARH, facility delivery, safe motherhood.
3. Segment clients and develop BCC messages and materials appropriate for the targeted population group like observing safe motherhood day, poribar sommelon, and workshop with the students of Class VII to Class X and school teachers.
4. Organizing Road show, street drama and Folk Song program in local dialect on FP-MCH, and early marriage issues in selected HTR and low performing districts engaging local IPT groups and folksong team.
5. Community based programs with the participation of adolescents, young couples, opinion leaders, community influential, elected female representatives, female teachers, religious leaders to raise massive awareness on FP-MNCH issues with special focus in low-performing regions/pockets through connecting Bangladesh.

Component-2: Media campaign, ICT & Social Media

Entertainment education (EE) has been a powerful tool for changing health behaviour. EE uses drama, music, or other communication formats that engage the emotions to inform audiences and change attitudes, behaviour, and social norms. IEM-DGFP uses media mix (television, radio, short film, newspaper, billboards, etc) including traditional media (street drama, folk-song shows, etc), to generate demand for FP-MNCH services. To align with government's commitment towards a digital Bangladesh, IEM Unit of

DGFP brings innovation by adopting state-of-the-art information and communication technology (ICT) and social media in its SBCC initiatives which include SBCC digital archive, eToolkit, eLearning course, website and Facebook.

Activities:

1. Message dissemination through call center and Mobile voice call
2. Develop and maintenance of IEM website along with Digital Archive and Facebook.
3. Functional integration with DGHS, through capacity development on eToolkit and eLearning course for the frontline service providers (FWAs, FWVs, Projectionists, HI, AHI & HA) to equip them with ICT knowledge and skills.
4. Broadcasting programs through Population cell of Bangladesh Betar and Bangladesh TV.
5. Media campaign on ARH, FP-MCH specially LAPM, newborn danger signs and care seeking through different channels (Print, electronic, outdoor, Cable TV Network & Cinema Hall etc).
6. Develop mobile apps on FP-MCH, ASRH issues. The target audience of the activity is adolescents and young people.

Component-3: Regional Service Package for HTR, low performing and urban slums

To address the regional variation, IEC OP will take different need based and audience specific SBCC activities to increase the demand for family planning and MCH services including adolescent health. This will be done through a collaborative approach with the service delivery units of DGFP as well as DGHS and local NGOs and Donor agencies.

Activities:

1. Develop a counseling Handbook on FP-MNCH and adolescent health and conduct training for the frontline workers and volunteers recruited by CCSD and FSD units.
2. Motivational program on early marriage, FP, MNCH, ARH & Gender Issues through street drama, folk song, jarigan & pot singing in local dialect.
3. Audio-visual shows to be organized at schools, local clubs during day time to reach-out adolescents and youth population would be provided with specific and reinforcing messages on ARH through film show program.
4. Marketing of service providers (FWA, FWV, SACMO, FPI, Volunteers) and service centers of DGFP to popularize them to community people.
5. Introduction of special kits like FP Kit, adolescent Kit, Newly-wed couple Kit, Pre-marital counseling Kit to disseminate information in an innovative way.

Component-4: Capacity Building for different service providers, supervisors and managers

Capacity development at all levels (from grassroots to policy, from individual to organization and system levels) is crucial. It includes the capacity to plan, design, implement, monitor and evaluate SBCC, as well as the willingness to allocate resources for SBCC. Under the next sector program, IEM will develop an extensive capacity building plan to deliver high-quality SBCC programs at all level.

Activities:

1. Skill development training on IPC for service providers (FWA, FPI, FWV, SACMO etc.).
2. Develop a Training Curriculum on pre-marital counseling to be used by front-line FP workers of DGFP & DGHS.
3. Organize workshop on Effective planning and distribution of IEC/BCC materials, annual work plan, effective audio-Visual show, eToolkit & eLearning Course as part of functional integration.
4. Organize Strategic SBCC training (Local & Foreign) for DGFP, Betar and BTV Pop Cell officials as well as Upazila & District managers.

Component-5: Production, distribution & Display of SBCC materials

The IEM Unit of DGFP has a rich history in creating awareness throughout Bangladesh on family planning, maternal, newborn and child health; and population and development issues. Series of high quality BCC materials like posters, booklets, training materials including entertainment-education materials like TV and radio spots, short films, , drama serials, music videos, etc. have been developed and tested.

Activities:

1. Production of TVC, RDC, Short film, TV Magazine, Documentary and other TV and Radio programs to disseminate messages on FP-MCH, ASRH, facility delivery, prevention of child marriage for mass media communication.
2. Printing of different IEC materials for distributing throughout the service centers and field workers including Parikroma.
3. Message dissemination on FP-MCH through daily Newspaper, hoardings/ bill boards at upazila/ Union level in Sylhet and Chittagong Divisions for addressing regional variation in FP.
4. Country wide Film show program by audio-visual van specially at schools, local clubs emphasizing on hard-to-reach area/low performing area.

Component-6: Monitoring, Research and documentation of best practices

Different kinds of research initiatives will be undertaken to measure the impact of IEC/SBCC activities on target audiences and identify and document best practices. Operational research will be undertaken on pilot basis to identify the causes behind the low performance of FP-MNC indicators in Low performing Divisions as well as other hard-to-reach areas. Systematic program monitoring will be done through regular field visits and using monitoring tools

Activities:

1. Identify and document best practices and success stories to showcase them in different national and international forums.
2. Conduct operational research, formative research in collaboration with national/ private institutions.
3. Mid-term and End evaluation to see the effectiveness of SBCC interventions.
4. Monitoring of the implementation of communication initiatives.
5. Integrate SBCC monitoring checklist in DGFP MIS to reflect the progress & achievements of SBCC initiatives.

Component-7: Coordination, Collaboration & Partnerships

Functional coordination is crucial for successful implementation of SBCC initiatives. Various activities have been incorporated to coordinate both within and beyond the health sector and these initiatives ultimately support the goals as outlined in 4th sector program. All IEC interventions are linked with demand generation for the services provided by the service units of DGFP (MCH, CCSDP and FSDP). A collaborated approach will be undertaken to harmonize the SBCC activities with other units in DGHS (HEB and NNS) through HPN Coordination Committee (IEM, HEB, and NNS BCC Working Group where all Govt. and partner NGOs and Agencies work together to share the knowledge and resources on IEC activities)

Activities:

1. Capacity building of DGHS field workers (HAs, CHCPs) and supervisors and managers of different level (Community, Union, Upazila and District) including Health Education Officers.
2. Organizing different BCC activities jointly with DGHS staff: rally, discussion/ round tables, campaigns, school health programs, adolescent groups activities etc.
3. Involvement in Regional Service Package delivery.
4. Performance review and monitoring jointly DGHS through regular HPN Coordination meeting (HEB, NNS).
5. Organize coordination workshop with various line departments and development partners for convergent planning and implementation of IEC activities.
6. Coordination through HPN Coordination Committee and Continue supporting BCC Working Group to facilitate and incorporation and harmonization of new SBCC initiatives.

6. Cross Cutting Issues including Poverty, Environment, Climate Change, Women & Children and Gender etc

(i). **Nutrition:** As per SIP 2016-2021, Govt. has positioned nutrition as central to development and the process of mainstreaming nutrition has started. The APIR 2015 also recommended for mainstreaming nutrition and interventions to address nutrition have been incorporated in services provided by DGHS and DGFP along with NGOs and partners. The objective is to reduce maternal and child health, Adolescent mal-nutrition and ensure universal access with a multi-

sectoral approach. Through IEC Operation Plan, mass media campaign, social mobilization and advocacy initiatives have been carried out to promote good health and nutrition practices.

(ii). **Gender Equity:** "Gender Equity Strategy 2014" has been formulated 'Gender Equity Action Plan' that recommends to incorporate development of gender responsive IEC materials. As per recommendations, existing IEC /SBCC materials will be reviewed to identify gender gaps and develop a framework for development Gender sensitive IEC/SBCC materials.

(iii). **Management Information System (MIS):** MIS helps to ensure better monitoring and supervision through institutionalizing data collection, storage and transmission. Initiatives have been taken to incorporate distribution of IEC/SBCC materials through DGFP formal distribution channels and incorporation in LMIS software. This will allow us to identify the need/demand of IEC/SBCC materials at all level of service providers and make a plan for distribution.

(iv). **Male participation:** Though many interventions have been taken to increase male participation in family planning and maternal-child health, but male participation is still very low. The service providing units of DGFP (FSD, CCSDP and MCH) are trying to increase male participation and IEC activities are aligned with demand generation of the services provided by the units through IEC/SMCC interventions.

(v). **HIV/AIDS:** Bangladesh is highly vulnerable to HIV and AIDS due to number of reasons, such as high prevalence of HIV in neighboring countries, low-risk perception among young population (15-24 years of age), low condom use rate, high prevalence of STI among the vulnerable groups and high client turnover in Bangladesh brothels. Considering the situation, information dissemination on HIV and AIDS will be incorporated in the IEC OP.

(vi). **Participation of other ministries:** The Population Policy 2012 has recommended Action Plan that requires participation of different ministries for the betterment of the people for development of Bangladesh. IEC will maintain strong collaboration with the activities performed by the different ministries as well as ensure their participation in FP-MCH activities.

7. Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline 2015-2016 Admin Record	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
1	Number of FP, MCH and Nutrition campaign organized	Number (Admin record)	127	500	650

Sl. #	Indicators	Unit of Measurement (Means of Verification)	Baseline 2015-2016 Admin Record	Projected Target	
				Middle of the Program (by June 2020)	End of the Program (by June 2022)
1	2	3	4	5	6
2	Number of workshop organized for awareness building of community leaders, professional and religious leaders on FP, MCH and Nutrition at upazila level	Number (Admin record)	280	1500	2200
3	Number of IEC materials (audio and video) produced and broadcasted in mass media	Number (Admin record)	Video produced : 15 Video telecasted: 1784 Audio broadcasted : 15830	Video produced : 40 Video telecasted: 10000 Audio broadcasted : 20000	Video produced : 60 Video telecasted: 15000 Audio broadcasted : 30000
4.	Number of survey/research conducted and best practices documented	Number	1 (impact survey)	3	5

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
15007.00	13469.00	870.00	14339.00	29346.00	

10.2. Component and activity wise physical and financial target of OP: IEC

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Component-I: Community Mobilization, Sensitization & Advocacy													
1	Country wide awareness building Campaign and workshop on fp-mch issues (No of campaign & workshop)	842		500.00	0.00	500.00	0.00	150.00	250.00	100.00	0.00	0.00	0.00
2	Organize advocacy meeting and dialoghue with different stakeholders (No of meeting)	692		1354.00	754.00	600.00	0.00	30.00	480.00	120.00	484.00	100.00	140.00
3	Observation of World population day, service and campaign week along with othe national events (No of Program)	62		1615.00	1105.00	60.00	450.00	280.00	285.00	285.00	285.00	285.00	195.00
	Total	1596		3469.00	1859.00	1160.00	450.00	460.00	1015.00	505.00	769.00	385.00	335.00
Component-II: ICT and Social Media													
1	Mobile Voice Call , developments of mobile apps, IEM website (No of orientation and Voice call)	1114		570.00	260.00	300.00	10.00	25.00	149.00	49.00	149.00	49.00	149.00
	Total	1114		570.00	260.00	300.00	10.00	25.00	149.00	49.00	149.00	49.00	149.00
Component-III: Outdoor Media													
1	Campaign through Road-show, Boat show under regional service package, street drama, folksong show, film show (No of show)	49740		1762.00	348.00	1414.00	0.00	85.00	307.00	316.00	330.00	359.00	365.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
2	Message dissemination on FP-MCH through bill boards at upazila/ Union level in Sylhet and Chittagong Divisions for addressing regional variation in FP and school health program (No of Billboard & school health program)	12100		855.00	855.00	0.00	0.00	80.00	155.00	155.00	155.00	155.00	155.00
	Total	61840		2617.00	1203.00	1414.00	0.00	165.00	462.00	471.00	485.00	514.00	520.00
Component-IV: Capacity Building for different service providers, supervisors and managers													
1	Organize training for DGFP and DGHS oficials and staffs on sbcc activities including SBCC strategy (No of Batch)	606		1606.00	668.00	938.00	0.00	61.00	345.00	345.00	340.00	255.00	260.00
2	Organize training on e-toolkit and eresources and pre-marital counselling (No of Batch)	591		484.00	134.00	350.00	0.00	50.00	121.00	110.00	50.00	53.00	100.00
	Sub total	1197		2090.00	802.00	1288.00	0.00	111.00	466.00	455.00	390.00	308.00	360.00
	Capital												
3	Procurement of AV van (Micro) (No of Vehicle)	30		1155.00	1155.00	0.00	0.00	192.50	192.50	192.50	192.50	192.50	192.50
4	Establishment of Call center, Modernization of IEM Press and procurement of other assets (No of goods)	454		435.00	435.00	0.00	0.00	20.50	292.50	30.50	30.50	30.50	30.50
	Sub total	484		1590.00	1590.00	0.00	0.00	213.00	485.00	223.00	223.00	223.00	223.00
	Total	1681		3680.00	2392.00	1288.00	0.00	324.00	951.00	678.00	613.00	531.00	583.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component-V: Production, distribution & Display of SBCC materials													
1	Production of different Iaudio video materials on FP-MCH isuues (No of video)	77		1705.00	0.00	1705.00	0.00	125.00	340.00	280.00	340.00	280.00	340.00
2	Advertise through News paper to disseminate message on FP, MCH & RH / messages dissemination through News Paper (No of publication)	6028		2198.00	588.00	1460.00	150.00	169.00	356.00	367.00	426.00	440.00	440.00
	Total	6105		3903.00	588.00	3165.00	150.00	294.00	696.00	647.00	766.00	720.00	780.00
Component-VI: Media campaign through BTV & Bangladesh Betar													
1	Radio programme through Population cell of Bangladesh Betar (No of transmission)	22236		1650.00	1650.00	0.00	0.00	150.00	300.00	300.00	300.00	300.00	300.00
2	TV programme through Population Cell of Bangladesh Television (No of production)	231		835.00	835.00	0.00	0.00	80.00	145.00	150.00	150.00	150.00	160.00
	Total	22467		2485.00	2485.00	0.00	0.00	230.00	445.00	450.00	450.00	450.00	460.00
Component-VII: Support service and Logistic													
1	Salary support of officers and staffs of IEM Unit (Man-Month)	6444		2000.00	2000.00	0.00	0.00	90.00	370.00	370.00	370.00	400.00	400.00
2	Supply and services and maintenance & other recurrent cost	0		3970.00	3970.00	0.00	0.00	170.00	500.00	700.00	800.00	900.00	900.00
	Total	6444		5970.00	5970.00	0.00	0.00	260.00	870.00	1070.00	1170.00	1300.00	1300.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
Component-VIII: Media campaign through Private TV & Radio Channels													
1	Media campaign through private TV channels on FP-MCH issues (TV spots, drama, magazine, TV scrolls etc. (No of transmission)	24972		4780.00	0.00	4680.00	100.00	510.00	920.00	820.00	820.00	920.00	790.00
2	Campaign through Private FM & Community Radio, cable network, and other mass media (No of broadcasting)	24666		1622.00	0.00	1462.00	160.00	132.00	320.00	320.00	320.00	320.00	210.00
	Total	49638		6402.00	0.00	6142.00	260.00	642.00	1240.00	1140.00	1140.00	1240.00	1000.00
Component-IX: Monitoring, Research and documentation of best practices													
1	Conduct operational research, formative research, mid term and end evaluation to identify impact of SBCC activities (No of research)	6		220.00	220.00	0.00	0.00	30.00	30.00	60.00	50.00	0.00	50.00
2	Monitoring the implementation of communication initiatives (No of activities)	6		30.00	30.00	0.00	0.00	5.00	5.00	5.00	5.00	5.00	5.00
	Total	12		250.00	250.00	0.00	0.00	35.00	35.00	65.00	55.00	5.00	55.00
	Grand Total	150897		29346.00	15007.00	13469.00	870.00	2435.00	5863.00	5075.00	5597.00	5194.00	5182.00

11. Budget support from other Operational Plan: Not applicable

4.29 Alternative Medical Care (AMC)

1. Name of the Operational Plan: Alternative Medical Care (AMC), DGHS

2. Implementing Agency: Directorate General of Health Services (DGHS)

3. Introduction

In Bangladesh AMC means Homoeopathy and Traditional Medicine (Unani, Ayurvedic). Traditional Medicine is as ancient as human civilization, dating back to 5000 B.C. in China. 4500 B.C. in India, 1600 B.C in Egypt & Babylon. Traditional Medicine includes mainly Unani and Ayurvedic medicine in this region. Homoeopathy is low-priced, less side-effected available treatment system which is popular in rural areas in case of PHC sector as well as in case of chronic metastatic conditions. These medicine may be herbal, animal & mineral origin, those Systems of medicine can be called as Alternative Medicine, which are used in this country for years together & is handed down generation to generation. Our country is very rich in medicinal flora & these Systems are closed at our culture, diet & regimen. Introducing Homoeopathy and Traditional Medicine as an Alternative Medicine will help the nation in five dimensions;-

- Saving foreign exchange.
- Use general labor for intensive cottage industries.
- Make self reliant medicine.
- It will save the environmental balance by plantation of more medicinal plants.
- It also makes vital roles in GDP by producing Alternative Medicine (Unani, Ayurvedic and Homoeopathy) in traditional method to use different medicinal plants or herbs which are available in our country.

The rural people of Bangladesh accept the Alternative medicine over allopathic medicine for following reasons

- It is cheap, simple & generally without serious side effects,
- It involves indigenous technology & labor.
- It is locally available & culturally acceptable.

It is an effective extension of home remedies quit prevalent in rural areas. Alternative Medicine (AM) playing a significant role in health care delivery not only in developing countries but also in the developed countries including USA, UK, Canada and others. The Alternative medicine in Sri Lanka meets the basic health needs of 70% of population. About up to 80% of the people in Africa are reported to seek traditional medicine for their medical care, and 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 also has taken different steps such as manpower recruitment and strengthen of educational institutes; Government Unani and Ayurvedic Medical College & Hospital along with Production & Research Unit was established in 1990 and Government Homoeopathic Medical College & Hospital along with Production & Research Unit established separately

in the same year. Bachelor of Unani Medicine & Surgery (BUMS), Bachelor of Ayurvedic Medicine & Surgery (BAMS), Bachelor of Homoeopathic 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 beded college hospital. Under private sector there are a 01 Homoeopathic Medical College, 17 Unani diploma institutes, 9 Ayurvedic diploma institutes and 53 Homoeopathic diploma institutes in Bangladesh. Diplomas (Unani/Ayurved/Homoeopathy) are given after completion of four years of study and 6 months of internship. The Board of Unani & Ayurvedic Systems of Medicine and Homoeopathic board controls control and offer the diploma certificates & Practice Registration. Bachelor degrees (Unani/ Ayurvedic/ Homoeopathy) in any of these three disciplines are given by the University of Dhaka and registrations for graduate doctors are given by the Homoeo & Traditional Medicine wings of DGHS. Near about 3,50,000 different categories Unani, Ayurvedic & Homoeopathic doctors are practicing in our country and about 700 industries are producing Unani, Ayurvedic & Homoeopathic medicines. At present 326 Unani, 296 Ayurvedic & 1384 Homoeopathic registered graduate doctors are practicing in the country. Upgrading the modernizing the alternative medical care (AMC) systems and educations is one of the objectives under the National Health Policy, 2011.

In the 40th World Health Assembly held in May 1987, a resolution urging the member states to utilize the traditional practitioners of their country optimally was adopted unanimously.

The WHO Traditional Medicine Strategy 2002-2005 was the first formal statement from the Organization and was developed through extensive consultations among the various stakeholders. The strategy document defined a collective term - Traditional Medicine / Complementary and Alternative Medicine (TM/CAM) - to represent all systems of medicine other than the modern (allopathic) system. The strategy document acknowledged the potential of TM/CAM and outlined a framework for action which aimed at the following 4 objectives:

- Developing policy to integrate TM/CAM with national health care systems in its health system.
- Promoting safety, efficacy and quality of TM/CAM medicines.
- Improving availability and affordability of TM/CAM, with emphasis on access for poor populations.
- Promoting rational use of TM/CAM.

Following a request from World Health Assembly 2009, WHO has updated the strategy and released WHO Traditional Medicine Strategy 2014-2023 in the year 2013. The updated strategy incorporates updates on progress made by member states and presents a set of strategic objectives, strategic directions and strategic actions to be pursued in the next decade.

The WHO Regional Committee for South East Asia Region adopted a resolution in its 67th meeting held at Dhaka in September, 2014 urging the member states to (a) take necessary steps to implement the Delhi Declaration, (b) adopt and implement WHO TM Strategy 2014- 23, (c) integrate traditional medicine into its mainstream health system and (d) strengthen systems, particularly pharmacovigilance systems, to ensure that TM products meet safety, efficacy and quality standards.

A Memorandum of Understanding (MoU) was executed on 9th September, 2014 between the Governments of Bangladesh and India. The objective of the MoU is to strengthen, promote and develop co-operation in the field of Traditional Systems of Medicine and Homoeopathy.

AMC will play a vital roles in achieving SDG's 'better health for prosperous society' to provide equitable access to high quality Unani, Ayurvedic and Homoeopathic medical services for all citizen of Bangladesh. To achieve the SDGs following steps should be taken:

- Strengthening AMC council to regulate practitioners through a registration system.
- Raise awareness about AMC and treatments especially for NCDs.
- Promote effective treatments based on Unani, Ayurvedic and Homoeopathic Medical services within communities and wider health systems.
- To build up capacity of AMC service providers by conducting orientation, workshop & training.

A detailed situational analysis of the AMC was undertaken during September, 2014 to January, 2015 and prepared the Strategy on AMC which has some identified actions on service delivery; education and training; regulation of education and practice; regulation of manufacture and quality of drugs; cultivation and conservation of medicinal plants and research. (annex- A). The challenges in terms of access of AMC services:

- Though Unani, Ayurvedic and Homoeopathic systems of medicine are low cost, less side effect and popular in mass people but not available in Primary to tertiary level of health services along with Allopathic system.
- There is no permanent council like BMDC, to regulate AMC doctors.
- There is no drug regulatory body to standardization for Unani, Ayurvedic and Homoeopathic drugs.
- Lack of awareness about Unani, Ayurvedic and Homoeopathic systems of medicine.
- There is no Post Graduation institute for Unani, Ayurvedic and Homoeopathic systems of medicine.
- There is no research center/institute for upgrading and evaluation of Unani, Ayurvedic and Homoeopathic systems of medicine.
- Huge amounts of malpractice occurred by the quack throughout the country in the name of Unani, Ayurvedic and Homoeopathic systems of medicine.
- There is no proper infrastructure of medical colleges of Unani, Ayurvedic and Homoeopathic systems of medicine.
- Lack of standard scientific method to use of medicinal plants.

4. Objectives

- To explore people's perceptions about Unani, Ayurvedic & Homoeopathic medicines by providing quality services and thus reduce the unsound practices by the name of AMC.
- To develop and expand Unani, Ayurvedic & Homoeopathic Medical services as an effective treatment and give those institutional shape.
- To monitor & Control AMC practitioners by strengthening and functioning the regulatory body of `Unani, Ayurvedic & Homeopatic registration council".
- To establish AMC unit for Unani/Ayurvedic/Homeopathy in BSMMU for PG Course.
- Improve standards of AMC education, practices and training systems.
- To establish a Central Research Council and a National Herbal garden for academic and research purpose.

- To save foreign currency by using local medicinal plants in AMC Medicinal industries.
- To upgrade the existing Unani, Ayurvedic & Homoeopathic Medical College & Hospital.
- To develop capacity of AMC service providers by conducting workshop, Orientation & Training.
- To develop a National Policy of AMC services and practice.
- To develop a strict regulation to control the quality of AMC drugs in the country.
- To create export market by exporting Medicinal plants and herbal Product.
- To developed a carrier path (a national strategic plan) for the development of Unani/Ayurvedic/Homoeopathic system.

5. Components wise Activities

Components-1: Strengthen AMC services in public hospitals in a phased manner

The National strategy and action plan of AMC proposed that 3 AMC doctors (1 from each stream-Unani, Ayurvedic and Homoeopathic) may be provided to Medical College Hospitals whereas only 2 AMC Doctors (One from Unani or Ayurvedic and the other form Homeopathy) may be provided to district hospitals and upazilla hospitals. This was strongly opposed in the dissemination workshops, on the ground that Unani and Ayurvedic are very different from each other. It was suggested that, as such, at least 1 Medical Officer from each of the three streams should be made available from each to these three levels.

Activities:

1. Continuation of AMC services by providing adequate Human resources, Medicine and equipments through the LD-AMC, DGHS to the MCHs, DHs & UHCs.
2. To provide preventive and curative services to the service recipients at Govt. Health facilities.
3. To integrate AMC services with the national health care delivery systems.
4. Service facilities increase from primary to tertiary level.

To implement the above activities procurement of necessary Unani/Ayurvedic/Homoeopathic medicines, equipments of MSR & furniture will be needed. Fund also be allocated for pay & allowance, orientation, workshop & training purposes.

Component-2: Upgradation of Unani/Ayurvedic/Homoeopathic education system.

GUAMCH, GHMCH and Govt. Tibbia College, Sylhet do have attached hospital but these could be better utilized particularly in term of providing maternal and child health care services. There is no institution available in the country to impart Post graduate education and research. BSMMU mandate includes establishment of a faculty for AMC (Unani, Ayurvedic and Homoeopathy). However, this has not yet been implemented. For this the "**National Strategy and Action Plan of AMC**" proposed that established Bangladesh National Institute for AMC (**B-NIAMC**) as an autonomous institution under BSMMU. It also proposed that Unani, Ayurvedic and Homoeopathic hospital may start 24X7 MCH care and should also start handling minor pregnancy complications overtime. This should be a pre requisite for considering PG education in these two institutions.

Activities:

1. Prepared Unani, Ayurvedic and Homoeopathic Pharmacopoeia and formularies.
2. Review & upgrade of Curriculum of BUMS/BAMS/BHMS.
3. Introduce Scholarship/Fellowship for PG courses; MD, PhD.

Compnent-3: Functioning of production & research unit of GUAMCH, GHMCH & Govt. Tibbia(Unani) College.

Currently there is no academic research in AMC (Unani, Ayurvedic and Homoeopathy) in the country as there is no academic institution providing PG education and research. To encourage collaborative research for a) Testing efficacy of AMC in handling public health issue and b) developing integrated protocols for major communicable and non-communicable diseases, particularly for life style diseases like diabetes, HTN.

For this the "**National Strategy And Action Plan of AMC**" proposed that established a) national ethics committee for AMC research, b) to establish "Bangladesh AMC research challenge fund", c) sponsor for PG courses, d) setup a **"Center for Coordination Applied Research in Alternative Medical Care"** in the BCSIR. For this now we suggest to develop production and research unit in GUAMCH and GHMCH and set up a production & research unit in Govt. Tibbia (Unani) College.

Activities:

1. Formation of Ethics committee for research.
2. Supply of Equipment for research, quality control and production of medicine.
3. To build up of skilled manpower.
4. Purchase of raw materials (herbs and medicinal plants).
5. Research and survey for determining the situation of Unani, Ayurvedic and Homoeopathy in NCD and CDC services.
6. Establish herbal garden in collaboration with concern ministry/ divisions.

Compotent-4: Awareness buildup.

Homoeopathy and Traditional Medicine, which are used in this country for years together & is handed down generation to generation. Those provide health care mostly in the rural community. Our country is very rich in medicinal flora & these Systems are closed at our culture, diet & regimen. The rural people of Bangladesh accept the Alternative medicine along with allopathic medicine due to.

- It is cheap, simple & generally without serious side effects,
- It involves Indigenous technology & labor.
- It is locally available & culturally acceptable.

It is an effective extension of home remedies quit prevalent in rural areas. Alternative medicine (AM) playing a significant role in health care delivery not only in developing countries but also in the developed countries including USA, UK, Canada and others. In Bangladesh AMC means Homoeopathy

and Traditional Medicine (Unani, Ayurvedic.). Homeopathy is low-priced, less side-effected available treatment system which is popular in rural areas in case of PHC sector as well as in case of chronic metastatic conditions. But lack of awareness about AMC (Unani, Ayurvedic and Homoeopathy) huge amount of malpractice occurred by quack level in throughout the country by the name of about AMC (Unani, Ayurvedic and Homoeopathy).

Activities:

1. To make a new herbal garden in different MCH and UHC.
2. To setup Billboard in different health centers for awareness and advertisement in electronic and press media.
3. To prepare leaflet, festoon and impart training to the service provider for creating awareness among the mass people on AMC services.
4. Research and survey for development of Unani, Ayurvedic and Homoeopathic system of medicine.

Compotent-5: National Strategy and Action Plan implementation in phases.

National strategy of AMC has recommended various actions- on service deliveries, educations and training, Regulation of education & practice, quality control of drugs, cultivation & conservation of medicinal plants, research & Programme Management. These recommendations will be implemented in phases.

Activities:

1. Formation of different committee for different activities.
2. Support for holding regular meeting,
3. Organize workshop/seminars.
4. TA support for implementation of different activities under AMC action plan.

6. Cross-Cutting Issues:

1. Strengthening of infrastructure & Development- OP-PFD.
2. Strengthening of Education- OP- PSE.
3. Strengthening of AMC Unit in DGDA-OP-SDAM
4. Effective integration of AMC in Govt. health facilities-OP-CBHC, HSM, CDC, NCDC, TB-L& ASP, SDAM.

7. Proposed Manpower: Annexed in Volume-II

8. List of Works, Goods, Services etc.: Annexed in Volume-II

9. Indicators:

Sl. No.	Indicators	Unit of Measurement	Base line(with Year and Data Source)	Projected Target	
				Middle of Programme (By June-2020)	End of Programme (By June-2022)
1	2	3	4	5	6
1.	No. Of facilities introduced AMC	Number (Admin record)	51 DH, 5 MCH & 145 UHC's (also 3 DGHS, 27 Unani & Ayurvedic Colleges & Hospitals, 21 Homeopatic College & Hospital. 11Tibbia Colleges (APIR 2016)	63DH, 15MCH & 180UHC's	63DH, 26MCH & 200 UHC's
2.	No. Of AMC Pharmacopoeia & Formularies / Prepared Unani, Ayurvedic & Homeopathic Pharmacopoeia & Formularies	Number (Admin record)	05	10	15
3.	No. Of medicinal Herbal Garden/ Prepared herbal garden (plantation of medical plants)	Number (Admin record) (Admin record)	472	490	500

10. Budget of the Operational Plan

10.1. Total Estimated Cost:

(Taka in lakh)

GOB	PA			Grand Total	Source of PA
	RPA	DPA	Total		
39855.00	4200.00	0.00	4200.00	44055.00	

10.2. Component and activity wise physical and financial target of OP: AMC

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)					Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA						
						RPA	DPA							
1		2		3	4	5	6	7	8	9	10	11	12
Component-1: Strengthen AMC services in public hospitals in a phased manner													
1	Procurement of AMC medicines	347		7000.00	4000.00	3000.00	0.00	1000.00	1200.00	1200.00	1200.00	1200.00	1200.00
2	Procurement of equipment, MSR, Furniture.	1210		2050.00	2050.00	0.00	0.00	200.00	600.00	500.00	450.00	300.00	0.00
3	Pay and allowance.	1210		25000.00	25000.00	0.00	0.00	1600.00	4700.00	5000.00	5000.00	5000.00	3700.00
4	Petrol, lubricating oil, transport maintenance	51		300.00	300.00	0.00	0.00	30.00	60.00	60.00	60.00	60.00	30.00
5	Orientation, workshop and training. (Local-150, Foreign-10)	160		1500.00	500.00	1000.00	0.00	200.00	300.00	300.00	300.00	300.00	100.00
	Subtotal			35850.00	31850.00	4000.00	0.00	3030.00	6860.00	7060.00	7010.00	6860.00	5030.00
Component-2: Upgradation of Unani/Ayurvedic/Homoeopathic education system													
1	Prepared Pharmacopoeia and Formularies	9		100.00	100.00	0.00	0.00	10.00	20.00	20.00	20.00	20.00	10.00
2	Upgradation of Curriculum of BUMS/BAMS/BHMS.	3		95.00	95.00	0.00	0.00	0.00	15.00	17.00	20.00	20.00	23.00
3	Scholarship/Fellowship for PG courses; MD, PhD.	45		600.00	600.00	0.00	0.00	0.00	150.00	150.00	150.00	150.00	0.00
	Subtotal			795.00	795.00	0.00	0.00	10.00	185.00	187.00	190.00	190.00	33.00
Component-3: Functioning of production & research unit of GUAMCH, GHMCH and Govt. Tibbia (Unani) college													
1	Purchase of equipment for research/quality control/production of medicine.	4		750.00	750.00	0.00	0.00	0.00	100.00	200.00	200.00	200.00	50.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
2	Purchase of raw materials (herbs&medicinal plants) research&productions.	4		250.00	250.00	0.00	0.00	0.00	60.00	69.00	50.00	40.00	31.00
3	Research and survey for determining the situation of AMC in NCD&CDC (in coordination with PMR & MIS)	10		500.00	300.00	200.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
4	Post graduate training for production/resrarch/ QC purposes of AMC medicene.	10		200.00	200.00	0.00	0.00	0.00	50.00	100.00	50.00	0.00	0.00
5	Buildup central Herbal garden with collaboration	1		1300.00	1300.00	0.00	0.00	0.00	350.00	350.00	250.00	250.00	100.00
	Subtotal			3000.00	2800.00	200.00	0.00	50.00	660.00	819.00	650.00	590.00	231.00
Component-4: Awareness buildup													
1	New garden in MCH & UHC	31		600.00	600.00	0.00	0.00	0.00	150.00	262.50	100.00	87.50	0.00
2	Strengthening of existing Herbal Garden maintenance	467		1100.00	1100.00	0.00	0.00	50.00	250.00	250.00	200.00	225.00	125.00
3	Herbal Mannual preparations & AMC Treatment Guide Line	14Vol		900.00	900.00	0.00	0.00	0.00	200.00	250.00	175.00	175.00	100.00
4	BCC			1200.00	1200.00	0.00	0.00	0.00	400.00	500.00	150.00	150.00	0.00

(Taka in Lakh)

Name of the components & activities		Total Physical & Financial Target (Jan 2017-June 2022)						Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Phys. QTY/Unit		Total	GOB	PA							
						RPA	DPA						
1		2		3	4	5	6	7	8	9	10	11	12
5	Research and survey for development of Unani, Ayurvedic and Homoeopathy. (in coordination with PMR)	10		500.00	500.00	0.00	0.00	50.00	100.00	100.00	100.00	100.00	50.00
	Subtotal			4300.00	4300.00	0.00	0.00	100.00	1100.00	1362.50	725.00	737.50	275.00
Component-5: National Strategy and Action Plan implementation in phases													
1	Formation of different committee for different activities/recomondation	5		30.00	30.00	0.00	0.00	5.00	10.00	4.00	4.50	4.50	2.00
2	To form a committee for establish a AMC council	1		80.00	80.00	0.00	0.00	6.00	10.00	13.00	21.00	20.00	10.00
	Subtotal			110.00	110.00	0.00	0.00	11.00	20.00	17.00	25.50	24.50	12.00
	Total			44055.00	39855.00	4200.00	0.00	3201.00	8825.00	9445.50	8600.50	8402.00	5581.00

11. Budget support from other Operational Plan: Not applicable

CHAPTER V: EXPENDITURE PLAN

CHAPTER V: EXPENDITURE PLAN

5.1. Introduction

The MOHFW is financed from a combination of GOB non-development and development budgets, and external finance from development partners for supporting development expenditure. The MOHFW being a service delivery organization, the major portion of the cost is borne out of revenue budget for the service providers. The majority of the expenditure is therefore incurred through the non-development budget. Requirement of resources in the development budget is directly related to provision of quality health services, strengthening of the health systems and improvement of the governance and stewardship functions of the MOHFW. The 4th HPNSP has, therefore, focused on these issues and has set the budgetary requirements with a view to realizing the objective of gradually moving towards achieving universal health coverage.

The overall economy of Bangladesh is growing at around 6% per year leading to increased funding in health in absolute terms. Over the last five years there has been an absolute average yearly increase of development budget to the extent of about Tk. 500 crore. However, the percentage contribution of Gross Domestic Product (GDP) to health is still very low. Public health spending comprises less than 1% of the GDP and total health expenditure (THE) is 3.5% as of GDP. Per capita Government expenditure on health in Bangladesh was US$27 in 2012, whereas the same for India and Nepal was US$61 and US$36 respectively (BNHA, 2015).

5.2. Estimated Budget and Expenditure of the Previous Programme

Total estimated cost for the 3rd SWAp, i.e. HPNSDP (2011-16) was Tk. 56, 993 crore (about US$ 7.7 billion). Out of this, it was estimated that Tk. 43,420 crore (76%) will be contributed by the GOB and 24% to be financed by development partners in the form of project aid (PA). Development budget was estimated to be 39% of the HPNSDP cost, which was 44.3% for HNPSP (2003-2011) and 53% for HPSP (1998-2003). HPNSDP was revised following the mid-term review in 2014 at a total estimated cost of Tk. 51,082.41 crore (about US$ 6.5 billion), of which 78% was GOB's contribution and the rest 22% as PA. 38% of the total cost was earmarked for development budget expenditure. The total RADP allocation for 32 OPs under HPNSDP was Tk. 18,045.05 crore of which Tk. 17,326.18 crore had been released (96% of allocation) and Tk. 15334.77 crore was spent (85% of allocation and 89% of release). During the HPNSDP period, out of total OP expenditure, the contribution of GOB was Tk. 6388.98 crore, and that of PA was Tk. 8945.79 crore. Under HPNSDP the utilization of GOB & PA against allocation was 94% & 79% respectively. Under HNPSP (2003-2011) the total expenditure was Tk 13541.00 crore of which GOB& DP contribution was Tk 5409.31crore & Tk 8131.69 crore respectively.

The contribution from the DPs was estimated to be Tk. 11,333.72 crore (US$ 1,453.04 million), to be received from the World Bank (IDA) and JICA credits, and grants from DFID, JICA, SIDA, CIDA, USAID, WHO, UNICEF, UNFPA, EKN, KFW, GIZ, UNAIDS, GFATM, GAVI-HSS, etc. This was 58% of the total development budget. As of December 2016, the actual financing position by GOB and the DPs stood at Tk. 6388.98 crore and Tk. 8945.79 crore respectively. It is worth mentioning that the DP contribution to the development budget of the SWAp programmes of MOHFW had continuously been declining (from 72% in the 1st SWAp to 58% in the 3rd SWAp).

Table-1: Trend in GOB's Share in the HPSP, HNPSP, HPNSDP and 4th HPNSP

(Tk. in crore)

Source of Fund	HPSP Budget (% of Grand Total)	HNPSP Budget (% of Grand Total)	HPNSDP Budget (% of Grand Total)	4th HPNSP Budget (% of Grand Total)
(a) Development				
GOB	1,691.73 (15%)	6,299.12 (17%)	8,237.34 (16%)	24,639.13 (21.34%)
PA	4,425.40 (38%)	10,267.35 (27%)	11,333.72 (22%)	18,847.23 (16.32%)
Sub Total (Development)	6,117.13 (53%)	16,566.47 (44%)	19,571.06 (38%)	43,486.36 (37.66%)
(b) Non-Development (GOB)	5,403.21 (47%)	20,817.64 (56%)	31,511.35 (62%)	72,000.00 (62.34%)
(c) Total (GOB)	7,094.94 (62%)	27,116.76 (73%)	39,748.69 (78%)	96,637.13 (83.68%)
(d) Grand Total (a+b)	11,520.34	37,384.11	51,082.41	1,15,486.36

The above table (Table-1) reflects the trend of increasing size of the SWAps as well as GOB's share of Programme budget. It is seen that total GOB share in HPSP was 62%, which increased to 73% in HNPSP and 78% in HPNSDP. It is expected that GOB's share in the 4th HPNSP will further be increased to 83.69%.

5.3. Background and Basis of Budget Estimation of the Programme

The MOHFW's absorption capacity has increased during the 3rd SWAp implementation period (2011-16). Utilization of the development budget has increased from an average rate of 72% in the pre-SWAp period to around 80-85% during the three SWAp periods. During the HPNSDP implementation (2011-16)–the third SWAp, overall utilization of annual development programme budget was 85%. Utilization of non-development budget allocations (95%) has consistently remained high because of the permanent nature of its expendable items. In the first year of HPNSDP, the total RADP expenditure was Tk. 1,993 crore, which increased to Tk. 4214.69 crore in 2015-16, an increase by 111% over the five years of HPNSDP implementation.

The economy of Bangladesh has been growing at a rate of over 6% for a decade or so and the macro-economic indicators are showing positive signs of sustained economic growth for the next decade. The GDP growth rate for FY 2015-16 has been estimated at 7.11% by the Bangladesh Bureau of Statistics (BBS), the highest ever. It is likely to have a sustained GDP growth of around 7% over the next five years. Moreover, domestic resource mobilization is expected to increase as a result of various measures taken by the National Board of Revenue (NBR). Over the next five years, both the number of tax payers and the coverage of VAT collection are expected to increase. All these provide the basis for a fair

assumption that resource availability will increase over the next five years. The resource requirement for the 4th HPNSP therefore has been estimated based on these forecasts.

The MOHFW is likely to get a higher allocation than that mentioned in the 7th FYP in both the development and non-development budgets of MOHFW. The 7th FYP of Bangladesh projects a total development budget of Tk. 41,340 crore to be channeled to the health sector. As 97% of the total health budget is being allocated for the MOHFW, the development budget for MOHFW for the next five years is expected to be Tk. 40,100 crore as per the 7th FYP. It is therefore expected that in the 4th HPNSP, the MOHFW's budget will be increased by 10% as a low case scenario, 15% as a moderate case scenario and 20% as an optimistic case scenario respectively during the next five years. The HNP sector is likely to be enriched further from the DPs' off-budget contributions channeled through the NGOs and other non-state actors. Discussion with DPs indicates that off-budget DP contributions are also likely to increase to the extent of two to five percent over the next five years. Irrespective of DP financing and potential private sector investment, GOB financing to the HNP sector has to be increased substantially during the next five years with a view to:

(a) Reducing out-of-pocket expenditures from the current level of about 63% and implementing health protection schemes, particularly for the lowest two quintile income groups and thus enhancing equity;

(b) Strengthening governance and stewardship of MOHFW and agencies under it by updating existing laws, formulating new laws, rules & regulations and strengthening institutional capacity for ensuring compliance;

(c) Strengthening the health systems (e.g., CMSD for procurement, DGDA for rational drug use, FMAU for transparency and accountability, MIS and eHealth for strong supervision and evidence based decision making, medical and nursing education, etc.);

(d) Focusing on NCDC (both prevention and cure), urban health, public health, tribal health, geriatric health, mental health and autism, environmental health and life-style change; and

(e) Improving service quality at all stages of service delivery, enhancing efficiency gains and reducing wastage and duplications.

5.4. Resource Envelope for the 4th HPNSP

MOHFW needs to achieve efficiency gains through improved budget management, which in turn will bring additional benefit to the sector. Efficiency gains can be realized from an improved procurement process, needs-based infrastructure development, and appropriate maintenance of equipment. Deciding on new methods of payment may help enhance efficiency in resource allocation. Moreover, allocating resources based on a resource allocation formula can enhance efficiency in resource use. Reducing absenteeism of staff, ensuring an appropriate staff-mix and enhancing quality of care can also contribute to efficiency gain. In addition to the efforts in gaining efficiency and thereby reducing the resource burden to some extent, the MOHFW's resource envelope for the 4th HPNSP will be much higher than the previous Sector Programme.

The projected MTBF allocation for MOHFW covers the financial years 2017-18, 2018-19 and 2019-20, which may be seen below (Table-5.1). The budget for FY 2020-21 and 2021-22 has been projected based on an annual increase of 15% over the FY 2019-20 budgets.

Table-5.1: Allocation in the MTBF for MOHFW Budget (Revenue and Development)

(Tk. in crore)

Budget by Type	Budget for 2016-17	MTBF Projection			15% increase on the projection of 2019-20		Total
		2017-18	2018-19	2019-20	2020-21	2021-22	
Revenue	11,281.51	12,271.40	14,320.84	15,752.93	18,115.87	20,833.25	9,2375.80
Development	6,234.54	6,996.26	6,873.54	7,560.94	8,695.08	9,999.34	46,359.70
Total	17,516.05	19,267.66	21,194.42	23,313.87	26,790.95	30,832.39	138,935.50

Of the total budget requirement (both revenue and development) for the 4th HPNSP, the development budget is estimated at Tk. 43,486.36 crore to be distributed amongst 29 OPs for implementation during the period of five and half years. However, considering the expenditure trend and duration of the programme period, the non-development is estimated Tk. 72,000.00.

Table 5.2: Summary of estimated budget for the Sector Programme by sources of financing:

(Tk. in crore)

Sl. No.	Financing Pattern	Total	% of Grand Total	Source of PA
1.	GOB Non-Development (Revenue)	72,000.00	62.34%	Credits from IDA & JICA and Grants from DPs (DFID, GAC, USAID, SIDA, EKN, WHO, UNICEF, GFATM, Gavi-HSS, WB (GFF), UNFPA, etc.)
2.	GOB Development	24,639.13	21.34%	
3.	Sub-Total of GOB(1+2)	96,639.13	83.68%	
4.	RPA	11,676.07	10.11%	
5.	DPA	7171.16	6.21%	
6.	Sub-Total of PA (4+5)	18,847.23	16.32%	
7.	Total of Development (2+ 6)	43,486.36	37.66%	
8.	Grand Total (1 + 7)	1,15,486.36	100.00%	

Rate of US$ and Date: 1US$ = 78.50 BDT, Date: 11 November 2016

5.5. Estimated Development Budget Requirements by the OPs

The OP wise distribution of development budget of the 4th HPNSP has been derived to address the strategic objectives, guiding principles, outputs and major activities with a view to gradually moving towards achieving UHC. The OP-wise estimated cost (total, GOB and PA) is given below (Table 5.3).

Table 5.3: Operational Plan (OP) wise estimated cost

(Taka in Lakh)

SL	Name of the Operational Plan	GOB	RPA	DPA	Sub-Total PA (4+5)	Total (3+6)	% of Total
1	2	3	4	5	6	7	8
A) Governance and Stewardship							

(Taka in Lakh)

SL	Name of the Operational Plan	GOB	RPA	DPA	Sub-Total PA (4+5)	Total (3+6)	% of Total
1	2	3	4	5	6	7	8
1	Sector-Wide Programme Management and Monitoring (SWPMM)	2882.00	2342.00	16905.00	19247.00	22129.00	0.51
2	Planning, Monitoring and Research (PMR)	6754.40	3587.80	1385.00	4972.80	11727.20	0.27
3	Planning ,Monitoring and Evaluation (PME)	551.50	1934.50	0.00	1934.50	2486.00	0.06
4	Health Economics and Financing(HEF)	13518.45	7763.20	901.00	8664.20	22182.65	0.51
5	Strengthening of Drug Administration and Management (SDAM)	3160.00	3165.00	0.00	3165.00	6325.00	0.15
	Sub-Total	26866.35	18792.50	19191.00	37983.50	64849.85	1.49
B) Health Systems Strengthening							
6	Health Information Systems and E-Health (HIS& e-health)	52292.00	23466.00	2872.00	26338.00	78630.00	1.81
7	Management Information Systems(MIS)	6068.00	7272.00	0.00	7272.00	13340.00	0.31
8	Procurement, Storage and Supplies Management-HS (PSSM-HS)	82972.00	8776.00	0.00	8776.00	91748.00	2.11
9	Procurement, Storage and Supply Management-FP (PSSM-FP)	14935.00	710.00	0.00	710.00	15645.00	0.36
10	Human Resource Development (HRD)	2737.97	3552.50	0.00	3552.50	6290.47	0.14
11	Medical Education and Health Manpower Development (ME&HMD)	142247.00	26410.00	0.00	26410.00	168657.00	3.88
12	Nursing and Midwifery Education Services (NMES)	9417.00	16570.00	14698.00	31268.00	40685.00	0.94
13	Training, Research and Development(TRD)	9607.51	15280.94	0.00	15280.94	24888.44	0.57
14	Physical Facilities Development (PFD)	1145111.70	22514.31	0.00	22514.31	1167626.01	26.85
15	Improved Financial Management (IFM)	1738.00	1090.00	0.00	1090.00	2828.00	0.07
	Sub-Total	1467126.18	125641.75	17570.00	143211.75	1610337.93	37.03
C) Provision of Quality Health Services							
16	Maternal, Neonatal, Child and Adolescent Health (MNCAH)	60086.96	185812.25	533234.25	719046.50	779133.46	17.92
17	Maternal, Child, Reproductive and Adolescent Health (MCRAH)	38650.80	80738.00	17362.00	98100.00	136750.80	3.14
18	National Nutrition Services (NNS)	7089.45	53717.65	12107.08	65824.73	72914.18	1.68
19	Communicable Diseases Control (CDC)	41292.00	44283.00	13260.00	57543.00	98835.00	2.27
20	TB-Leprosy & AIDS/STD Programme (TBL & ASP)	28426.39	48973.50	88252.83	137226.33	165652.72	3.81
21	Non-Communicable Diseases Control (NCDC)	72765.20	32462.07	6600.00	39062.07	111827.27	2.57
22	National Eye Care (NEC)	2187.00	6098.00	0.00	6098.00	8285.00	0.19
23	Community Based Health Care (CBHC)	358054.45	146533.50	2010.00	148543.50	506597.95	11.65
24	Hospital Services Management (HSM)	150019.00	251153.00	2939.00	254092.00	404111.00	9.29
25	Clinical Contraception Services Delivery Programme (CCSDP)	107073.97	40264.85	2502.98	42767.83	149841.80	3.45
26	Family Planning Field Services Delivery (FP-FSD)	35346.00	109242.00	350.00	109592.00	144938.00	3.33
27	Life Style and Health Education & Promotion (LHEP)	14067.07	6226.00	867.00	7093.00	21160.07	0.49
28	Information, Education and Communication (IEC)	15007.00	13469.00	870.00	14339.00	29346.00	0.67
29	Alternative Medical Care (AMC)	39855.00	4200.00	0.00	4200.00	44055.00	1.01

(Taka in Lakh)

SL	Name of the Operational Plan	GOB	RPA	DPA	Sub-Total PA (4+5)	Total (3+6)	% of Total
1	2	3	4	5	6	7	8
	Sub-Total	969920.29	1023172.82	680355.14	1703527.96	2673448.25	61.48
	Total	2463912.82	1167607.07	717116.14	1884723.21	4348636.03	100.00

According to the OP-wise distribution of budget, highest allocation goes for PFD OP (26.85%), followed by MNCAH OP (17.92%), CBHC OP (11.65%), HSM (9.29%), ME&HMD (3.88%), TB-L & ASP (3.81%), CCSDP (3.45%), FPFSD (3.33%), MCRAH (3.14%), and NCDC (2.57%). Out of the 29 OPs, the estimated budget for these 10 OPs constitutes 86% of the total development budget of the 4th HPNSP. These 10 OPs are considered to be the anchor OPs for expediting physical and financial progress of the Programme. Year-wise estimated cost of all OPs of the 4th HPNSP is shown below (Table 5.4).

Table 5.4: Year wise estimated cost of all Operational Plans

(Taka in Lakh)

SL	Name of the Operational Plan	Estimated Cost of 4th HPNSP				Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Total	GOB	PA							
				RPA	DPA						
1	2	4	5	6	7	8	9	10	11	12	13
A) Governance and Stewardship											
1	SWPMM	22129.00	2882.00	2342.00	16905.00	594.00	3646.00	4713.00	4707.00	4977.00	3492.00
2	PMR	11727.20	6754.40	3587.80	1385.00	528.70	2504.14	2345.26	2307.68	2186.40	1855.02
3	PME-FP	2486.00	551.50	1934.50	0.00	101.90	469.50	527.75	478.50	471.80	436.55
4	HEF	22182.65	13518.45	7763.20	901.00	1901.78	4115.91	4224.01	4176.25	3953.35	3811.35
5	SDAM	6325.00	3160.00	3165.00	0.00	70.00	826.00	1353.00	2020.00	965.00	1091.00
	Sub-Total	64849.85	26866.35	18792.50	19191.00	3196.38	11561.55	13163.02	13689.43	12553.55	10685.92
B) Health Systems Strengthening											
6	HIS& e-Health	78630.00	52292.00	23466.00	2872.00	3242.00	11684.40	19379.90	14939.90	18569.90	10813.90
7	MIS-FP	13340.00	6068.00	7272.00	0.00	306.00	4483.60	3975.60	1729.60	1422.60	1422.60
8	PSSM-HS	91748.00	82972.00	8776.00	0.00	6067.00	19605.00	18134.00	17681.00	18977.00	11284.00
9	PSSM-FP	15645.00	14935.00	710.00	0.00	1153.00	2977.00	3023.00	3091.00	2856.00	2545.00
10	HRD	6290.47	2737.97	3552.50	0.00	325.42	989.79	1469.16	1375.59	1307.47	823.04
11	ME&HMPD	168657.00	142247.00	26410.00	0.00	27824.00	31143.00	30899.00	28141.00	27837.00	22813.00
12	NMES	40685.00	9417.00	16570.00	14698.00	5590.50	8209.00	8234.00	7906.50	7504.00	3241.00
13	TRD-NIPORT	24888.44	9607.51	15280.94	0.00	1115.75	5475.13	5153.19	4033.44	3076.61	6034.33
14	PFD	1167626.01	1145111.70	22514.31	0.00	153789.00	241133.94	258465.54	243782.78	177445.56	93009.19
15	IFM	2828.00	1738.00	1090.00	0.00	222.96	546.90	542.52	536.38	481.69	497.55
	Sub-Total	1610337.93	1467126.18	125641.75	17570.00	199635.63	326247.76	349275.91	323217.19	259477.82	152483.61
C) Provision of Quality Health Services											
16	MNCAH	779133.46	60086.96	185812.25	533234.25	56943.21	165837.62	154909.13	138616.24	140071.13	122756.13
17	MCRAH	136750.80	38650.80	80738.00	17362.00	17126.14	23400.46	23510.26	23518.96	23683.24	25511.75
18	NNS	72914.18	7089.45	53717.65	12107.08	8715.83	16552.40	15924.95	11800.48	11127.08	8793.44
19	CDC	98835.00	41292.00	44283.00	13260.00	9316.50	22794.80	20543.80	22044.80	13276.80	10858.30
20	TBL & ASP	165652.7	28426.39	48973.50	88252.83	12670.6	28816.08	33507.06	32096.13	30355.16	28207.65

(Taka in Lakh)

SL	Name of the Operational Plan	Estimated Cost of 4th HPNSP				Year-1	Year-2	Year-3	Year-4	Year-5	Year-6
		Total	GOB	PA							
				RPA	DPA						
1	2	4	5	6	7	8	9	10	11	12	13
		2				4					
21	NCDC	111827.27	72765.20	32462.07	6600.00	5042.00	21724.00	24433.00	23469.67	21013.00	16145.60
22	NEC	8285.00	2187.00	6098.00	0.00	220.00	2157.20	2386.00	1535.00	1380.20	606.60
23	CBHC	506597.95	358054.45	146533.50	2010.00	31930.52	92396.67	96175.17	98753.87	102055.37	85286.35
24	HSM	404111.00	150019.00	251153.00	2939.00	29352.00	71417.00	78069.00	82202.00	81049.00	62022.00
25	CCSDP	149841.80	107073.97	40264.85	2502.98	8322.79	31516.51	31866.91	28615.40	25686.92	23833.27
26	FP-FSD	144938.00	35346.00	109242.00	350.00	1800.20	25792.68	29302.55	29962.48	30804.22	27275.87
27	LHEP	21160.07	14067.07	6226.00	867.00	2469.67	4092.40	4020.40	3935.00	3779.00	2863.60
28	IEC	29346.00	15007.00	13469.00	870.00	2435.00	5863.00	5075.00	5597.00	5194.00	5182.00
29	AMC	44055.00	39855.00	4200.00	0.00	3201.00	8825.00	9445.50	8600.50	8402.00	5581.00
	Sub-Total	2673448.25	969920.29	1023172.82	680355.14	189545.50	521185.82	529168.74	510747.53	497877.12	424923.55
	Total	4348636.03	2463912.82	1167607.07	717116.14	392377.52	858995.13	891607.67	847654.14	769908.49	588093.08

5.6. DP's Support for the Sector Programme

As of December 2016, written communication is available with respect to IDA credit amounting US$ 500 million, Gavi grant amounting US$ 584 million, GFATM grant of US$ 146 million and UNFPA grant of US$ 11 million. However, during interactions with the IDA Identification and Preparatory Missions, and as per the recorded Minutes of the 14th LCG WG on Health Meeting held on 04 December 2016 other DPs working in the HNP sector indicated their probable financial contributions as given in the table below (Table 5.5).

Table 5.5: Indicative DP contribution

Sl. No.	Source	Amount in million US $	Amount in Lac BDT	RPA (in Lac BDT)	Other than RPA (DPA) (in Lac BDT)
1	IDA Credit	500.00	392500.00	392500.00	0.00
2	World Bank GFF	15.00	11775.00	0.00	11775.00
3	GAC	TBD*	-	-	-
4	JICA Credit	51.71	40592.35	37232.55	3359.80
5	SIDA (200mlcroner)	21.70	17034.50	17034.50	0.00
6	DFID	TBD*	-	-	-
7	USAID	40.00	31400.00	31400.00	0.00
8	UNICEF	15.00	11775.00	0.00	11775.00
9	WHO	30.00	23550.00	0.00	23550.00
10	EKN (7.7 ml. Euro)	8.13	6382.05	6382.05	0.00
11	Gavi-HSS	84.00	65940.00	0.00	65940.00
12	Gavi-ISS+ MR	500.00	392500.00	0.00	392500.00
13	GFATM	146.00	114610.00	0.00	114610.00

Sl. No.	Source	Amount in million US $	Amount in Lac BDT	RPA (in Lac BDT)	Other than RPA (DPA) (in Lac BDT)
14	UNFPA	11.00	8635.00	0.00	8635.00
	Total	1422.54	1116693.90	484549.10	632144.80

*GAC and DFID have expressed their willingness to remain in the 4th HPNSP, but are yet to decide on their probable contributions.

Rate of US$ and Date: 1US$ = Tk. 78.50, Date: 11 November 2016

5.7. Expected GOB and DP share and the Resource Gap (if any)

The MOHFW's budgetary requirement for implementing the 4th HPNSP, combining development and non-development budgets stands at Tk. 1,15,486.36 crore, equivalent to US$ 14,711.64 million. The GOB bears the entire responsibility of funding MOHFW's non-development budget (Tk. 72,000.00 crore equivalent to US$ 9,171.97 million) and part of the development budget. However, GOB and DP share is about 83.68: 16.32 of the MOHFW's total budget for the Programme.

Out of the total development budget of Tk. 43486.36 crore (US$ 5539.66 million), about 57% (Tk. 24,639.13 crore equivalent to US$ 3138.74 million) will be contributed from GOB's own resources and the rest 43% (Tk. 18,847.23 crore equivalent to US$ 2400.92 million) is considered to be the resource gap which will need to be funded externally.

The World Bank including a number of DPs has continuously been funding the HNP sector development efforts of GOB. It is expected that the funding gap will be covered by the DPs (both credits from IDA & JICA and grants from other bilateral DPs). By this time there has been an indication of DP commitment to the extent of Tk. 11166.93crore (US$ 1422.54 million) and DFID & GAC are likely to contribute approximately US$ 250.00 million. There remains a resource gap of Tk. 7680.28 crore (US$ 978.38 million). New sources of funding may crop up, e.g., The Gates Foundation, WB's Global Fund Facility and DPs like China & Korea. However, the challenge of resource gap can be further minimized by increasing GOB's contribution as well as gaining efficiency in both rational fund allocation and utilization.

APPENDIX-I

Results Framework for the 4th HPNSP (2017-2022)

RESULT	INDICATOR[8]	MEANS OF VERIFICATION & TIMING	BASELINE & SOURCE	TARGET 2022
Goal: *All citizens of Bangladesh enjoy health and well-being.*	GI 1. Under 5 Mortality Rate (U5MR)	BDHS, every 3 years	46, BDHS 2014	34
	GI 2. Neonatal Mortality Rate (NMR)	BDHS, every 3 years	28, BDHS 2014	18
	GI 3. Maternal Mortality Ratio (MMR)	BMMS/MPDR/ MMEIG[9], every year	176, WHO 2015[10]	121
	GI 4. Total Fertility Rate (TFR)	BDHS, every 3 years	2.3, BDHS 2014	2.0
	GI 5. Prevalence of stunting among under-five children	BDHS, every 3 years/UESD, every non-DHS years	36.1%, BDHS 2014	25%
	GI 6. Prevalence[11] of hypertension among adult population	BDHS, every 3 years/NCD-RF, every 2 years	Female 32%, Male 19%, BDHS 2011	Female 32%, Male 19%
	GI 7. % of public facilities with key service readiness[12] as per approved Essential Service Package (ESP)	BHFS, every 2 years	FP: 38.2; ANC 7.8%; CH 6.7%, BHFS 2014	FP: 70%; ANC 50%; CH 50%
	GI 8. % of total health expenditure (THE) financed from public sector[13]	BNHA, every 3 years	23.1%, BNHA 2012	26.2%
Program Objective: *To have focused improvements in increasing access to quality health care and improving equity along with efficiency by gradually achieving UHC*				
Component 1: MOHFW's governance and stewardship roles strengthened				
Result 1.1 Legal and operational framework on governance and stewardship in place	1.1.1 Governance and Stewardship Action Plan implemented in line with milestones	Admin records/APIR, every year	GSAP developed and approved, Planning Wing 2016	GSAP implemented
Result 1.2 Overall sector governance improved	1.2.1 Number of public and non-public facilities accredited	Admin records/ APIR, every year	Process initiated, Planning Wing 2016	a) Accreditation mechanism established; b) 22 MCH, 59 DH and 50 non-public hospitals accredited
	1.2.2 % of DPs submitting annual performance reports on off-budget activities	Admin records/ APIR, every year	54%, MPIR 2014	100%

[8] Indicators in general would be stratified (where applicable) by age, gender, geographic area and wealth quintiles

[9] MMEIG: Maternal Mortality Estimation Inter-agency Group, created by WHO, UNICEF, UNFPA, UN Population Division and The World Bank

[10] http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/

[11] Estimated as elevated blood pressure among women and men aged 35 years or older

[12] Defined as facilities (excl. CCs) having a) for FP: guidelines, trained staff, BP machine, OCP and condom; b) for ANC: guidelines, trained staff, BP machine, hemoglobin and urine protein testing capacity, Fe/folic acid tablets; c) for CH: IMCI guideline and trained staff, child scale, thermometer, growth chart, ORS, zinc, Amoxicillin, Paracetamol, Anthelmintics

[13] Government schemes and compulsory health care financing schemes

RESULT	INDICATOR[8]	MEANS OF VERIFICATION & TIMING	BASELINE & SOURCE	TARGET 2022
	1.2.3 Incremental budget for MOHFW ensured	APIR/MOF's Budget Book, every year	14.0% increase of MOHFW Budget in FY '15-16, MOF	Annual increment of MOHFW budget >15%
Component 2: Health systems strengthened to increase performance and efficiency				
Result 2.1 Quality workforce made available in health sector	2.1.1 % of service provider positions functionally vacant in district and upazila-level public facilities, by category (physician, nurse/midwife)	BHFS, every 2 years	Physician: 37.8%, Nurse/MW: 19.3%, BHFS 2014	Physician: 19%, Nurse/midwife: 10%
Result 2.2 Core systems (FM, infrastructure, procurement) strengthened	2.2.1 Increase in the number of Operational Plans (OPs) with annual budget execution over 80%	ADP/APIR, every year	13, APIR 2015	19
	2.2.3 Procurement lead time reduced for the packages tracked through SCMP	Admin records/ SCMP, every year	57.3 weeks, SCMP 2014-15	40 weeks
Result 2.3 Strengthened Performance monitoring to promote evidence-based decision making	2.3.1 Number of performance monitoring reports prepared and disseminated annually	Reports/APIR, every year	3 (HB, APIR, SmPR), APIR 2015	08 (APIR, SmPR, MISs, NIPORT, DGDA, DGNM, HEU[14])
	2.3.2 Number of UHFWCs under e-MIS scale up	Admin records, every year	30 2016 (E-MIS/ DGFP)	1,500
	2.3.3 Number of districts implementing comprehensive maternal perinatal and newborn death review	Admin records/ APIR, every year	10, CIPRB/DGHS 2014[15]	64
Component 3: Quality basic services reach the disadvantaged population to progress towards UHC				
Result 3.1 Public health services strengthened to promote healthy behavior	3.1.1 % of newborn received essential newborn care (ENC)	BDHS, every 3 years/UESD, every non-DHS years	6.1% BDHS 2014	25%
	3.1.2 % of infants age 6-23 month are fed with minimum acceptable diet	BDHS, every 3 years/UESD, every non-DHS years	22.8%, BDHS 2014	45%
	3.1.3 % of women age 15-19 who have begun childbearing	BDHS, every 3 years/UESD, every non-DHS years	30.8%, BDHS 2014	25%
	3.1.4 % of population of age 25 years or above use tobacco	BDHS, every 3 years; NCD-RF, every 2 years/ GATS, every 3 years	51%, NCD-RF 2011[16]	45%

[14] For HEU, the report will be Public Expenditure Review (PER)
[15] http://www.ciprb.org/wp-content/uploads/2015/01/MPDR-Fact-Sheet.pdf
[16] Repeat Global Adult Tobacco Survey (GATS) is scheduled to take place in 2016

RESULT	INDICATOR[8]	MEANS OF VERIFICATION & TIMING	BASELINE & SOURCE	TARGET 2022
Result 3.2 Equitable coverage of ESP ensured	3.2.1 Contraceptive Prevalence Rate (CPR)	BDHS, every 3 years/UESD, every non-DHS years	62.4%, BDHS 2014	75%
	3.2.2 CPR (modern methods) in lagging regions	BDHS, every 3 years/UESD, every non-DHS years	Syl: 40.9%, Ctg: 47.2%, BDHS 2014	60%
	3.2.3 Antenatal care coverage (at least 4 visits)	BDHS, every 3 years/UESD, every non-DHS years	31.2%, BDHS 2014	50%
	3.2.4 % of delivery by skilled birth attendant (SBA)	BDHS, every 3 years/UESD, every non-DHS years	42.1%, BDHS 2014	65%
	3.2.5 % mothers with non-institutional deliveries receiving postnatal care from a medically trained provider within 2 days of delivery	BDHS, every 3 years/UESD, every non-DHS years	5.4%, BDHS 2014	10%
	3.2.6 Ratio of births in health facilities of the richest wealth quintile to the poorest quintile (Q1:Q5)	BDHS, every 3 years/UESD, every non-DHS years	14.9% : 70.2% = 1 :4.7, BDHS 2014	1 : 3.5
	3.2.7 % of public health facilities/public service delivery points without stock-outs of essential medicines/FP supplies	Essential medicines, BHFS, every 2 years; FP supplies, E-LMIS/DGFP, every year	Drugs[17]: 66%, BHFS 2014; FP methods[18]: >98%, E-LMIS/DGFP	Drugs: 75%, FP methods: >98%
	3.2.8 Tuberculosis case detection rate	NTP MIS, every year	53%, GTBR[19] 2014	75%
	3.2.9 Measles-Rubella (MR) immunization coverage among children under 12 months	CES, every year	86.6%, CES 2014	90%
Result 3.3 Quality of care improved	3.3.1 % of public health facilities with at least one staff trained in IMPAC (integrated management of child birth and pregnancy)in the last 24 months	BHFS, every 2 years	9.9%[20], BHFS 2014	50%
	3.3.2 % of public facilities implement and monitor quality improvement activities[21]	Admin records/ APIR, every year	2 (1 MCH, 1 DH), APIR 2015	100% MCHs & DHs, 70% UHCs

[17] Defined as availability of at least six of eight essential medicines of a DDS kit: amoxicillin tablet/capsule, amoxicillin syrup, cotrimoxazole, paracetamol tablet, paracetamol syrup, tetracycline eye ointment, iron tablet, and vitamin A capsule.

[18] Service delivery points include family planning field workers

[19] Global Tuberculosis Report 2014 by the World Health Organization (WHO)

[20] Staff in facilities up to union-level trained in integrated management of pregnancy and child birth (IMPAC) during the last 24 months

[21] QA activity to be specified by HEU/HSM; check baseline with HEU

APPENDIX-II

Compliance of the PEC decisions

স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক প্রস্তাবিত 4th Health, Population and Nutrition Sector Program (4th HPNSP) শীর্ষক সেক্টর কর্মসূচির উপর ১৯/০২/২০১৭, ২২/০২/২০১৭, ২৩/০২/২০১৭ এবং ০১/০৩/২০১৭ তারিখে পরিকল্পনা কমিশনে অনুষ্ঠিত পিইসি সভার সিদ্ধান্তের প্রেক্ষিতে গৃহীত ব্যবস্থা

ক্রঃ নং	পিইসি সভার সিদ্ধান্ত	স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
৪.১	স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক বাস্তবায়িত কর্মসূচি/প্রকল্পসমূহের কার্যক্রমের মধ্যে দ্বৈততা পরিহার এবং বিভিন্ন মন্ত্রণালয় ও বেসরকারী সংস্থা/এনজিও কর্তৃক বাস্তবায়িত কার্যক্রম যথাযথ মনিটরিং এর লক্ষ্যে কার্যকর ব্যবস্থা গ্রহণ করতে হবে।	বিভিন্ন সময়ে সরকার কর্তৃক চিহ্নিত বিভিন্ন অগ্রাধিকারমূলক ও নির্মাণ-ধর্মী বিষয়ে ধরণের কর্মকান্ড বাস্তবায়নের জন্য আলাদা প্রকল্প গ্রহণ করার প্রয়োজনীয়তা দেখা দেয়। এ সকল প্রকল্পের সাথে সেক্টর কর্মসূচির আওতায় গৃহীত কর্মকান্ডের মধ্যে কোন দ্বৈততা নেই। উপরন্তু এ সকল প্রকল্প সেক্টর কর্মসূচির লক্ষ্য ও উদ্দেশ্য অর্জনে সহায়ক ভূমিকা পালন করে থাকে। বিভিন্ন মন্ত্রণালয় ও বেসরকারী সংস্থা/এনজিও প্রয়োজনীয়তার নিরিখে এলাকাভিত্তিকি স্বাস্থ্য সেবামূলক বিভিন্ন প্রকল্প গ্রহণ করে থাকে। অন্যান্য বিভিন্ন মন্ত্রণালয়/বিভাগ কর্তৃক গৃহীত প্রকল্প পরিকল্পনা কমিশন কর্তৃক অনুমোদনকালে স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়কে সম্পৃক্ত করা হয়ে থাকে। এছাড়া, বিভিন্ন এনজিও কর্তৃক বাস্তবায়িতব্য প্রকল্প এ মন্ত্রণালয়ের মতামতের জন্য প্রেরণ করা হলে এ বিষয়ে সংশ্লিষ্টদের সাথে আলোচনাক্রমে মতামত দেয়া হয় বিধায় দ্বৈততা পরিহার করা সম্ভব হয়। উল্লেখ্য, বিভিন্ন মন্ত্রণালয়/বিভাগ ও বেসরকারী সংস্থা/এনজিও কর্তৃক বাস্তবায়িত এ সকল প্রকল্প স্বাস্থ্য সেবা প্রদানসহ স্বাস্থ্য খাতে সরকারের বিনিয়োগের পরিপূরক হিসাবে কাজ করে, যা সরকারের বাজেটের উপর চাপ হ্রাস করে। কার্যক্রমের দ্বৈততা পরিহারসহ বিভিন্ন মন্ত্রণালয় ও বেসরকারী সংস্থা/এনজিও কর্তৃক বাস্তবায়িত কার্যক্রম যথাযথ মনিটরিং এর লক্ষ্যে কার্যকর ব্যবস্থা গ্রহণ করা হবে।
৪.২	স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক বাস্তবায়িতব্য ৪র্থ সেক্টর কর্মসূচির পরবর্তী সেক্টর কর্মসূচি হতে GoB (Non-development) এর ব্যয় সেক্টর কর্মসূচিতে অন্তর্ভুক্ত না করার ব্যবস্থা গ্রহণ করতে হবে।	উন্নয়ন সহযোগী সংস্থা এবং মন্ত্রণালয়ের উর্দ্ধতন কর্তৃপক্ষের সাথে আলোচনাক্রমে এ ব্যাপারে প্রয়োজনীয় ব্যবস্থা গ্রহণ করা হবে।
৪.৩	বর্তমান কর্মসূচির জন্য বৈদেশিক সহায়তার যে নিশ্চয়তা পাওয়া গিয়েছে তার প্রমাণাদি পিআইপি	পুনর্গঠিত পিআইপির ভলিউম-২ তে প্রয়োজনীয় তথ্যাদি সন্নিবেশ করা হয়েছে।

ক্রঃ নং	পইিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	উল্লখে করতে হবে। একইসাথে মৌখকিভাবে আশ্বাসকৃত বদৈশেকি সহায়তা দ্রুত প্রাপ্তরি লক্ষ্যে প্রয়োজনীয় কার্যক্রম গ্রহণ করতে হবে।	
৪.৪	বদৈশেকি সহায়তায় বাস্তবায়নরে জন্য প্রস্তাবতি কার্যক্রমসমূহ বদৈশেকি সহায়তার অর্থ পাওয়া না গলেে জওিবি অর্থে বাস্তবায়ন করা যাবে না।	সদ্ধিান্ত অনুযায়ী প্রয়োজনীয় পদক্ষপে গ্রহণ করা হবে।
৪.৫	আইএমইডি'র নর্দিশেনা মোতাবকে মন্ত্রণালয় কর্তৃক স্বল্পতম সময়ে কার্যকরভাবে বগিত সক্টেরে কর্মসূচরি মূল্যায়ন প্রতবিদেন প্রণয়ন করতে হবে।	মূল্যায়ন প্রতবিদেনরে খসড়া প্রতবিদেন প্রণয়ন করা হয়ছে। আশা করা যায় চূড়ান্ত প্রতবিদেন মার্চ ২০১৭ এর মধ্যে প্রণয়ন করা সম্ভব হবে।
৪.৬	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক বাস্তবায়তিব্য সক্টেরে কর্মসূচরি জাতীয় গুরুত্ব ববিচেনায় অর্থ বভিাগ জরুরী ভত্তিতিে জনবল নর্ধিারণ কমটিরি সুপারশি চূড়ান্ত করব।	এ বষিয়ে অর্থ বভিাগরে সাথে সার্বক্ষণকি যোগাযোগ রক্ষা করা হচ্ছ।
৪.৭	বর্তমান সক্টেরে কর্মসূচরি ওপসিমূহ অনুমোদনরে সময় পরকিল্পনা কমশিনসহ সকল গুরুত্বপূর্ণ Stakeholder-দরে প্রয়োজনীয় সময় দয়িে তাদরে কার্যকর মতামতরে ভত্তিতিে ওপি অনুমোদনে কার্যক্রম গ্রহণ করতে হবে।	বর্তমান সক্টেরে কর্মসূচরি ওপসিমূহ অনুমোদনরে সময় পরকিল্পনা কমশিনসহ সকল গুরুত্বপূর্ণ Stakeholder-দরে প্রয়োজনীয় সময় দয়িে তাদরে কার্যকর মতামতরে ভত্তিতিে ওপি অনুমোদনরে ব্যবস্থা গ্রহণ করা হবে।
৪.৮	ওপসিমূহ ২য় বার সংশোধন সংক্রান্ত কার্যক্রম পরকিল্পনা কমশিনরে মাধ্যমে প্রক্রয়িাকরণরে বষিয়ে পআিইপি একনকে সভায় উপস্থাপনরে সময় একনকে সভার ববিচেনার জন্য সার-সংক্ষপে উল্লখে করতে হবে। একনকে সভার নর্দিশেনা অনুযায়ী পরবর্তী কার্যক্রম গ্রহণ করতে হবে।	পরকিল্পনা বভিাগ কর্তৃক জারীকৃত পরপিত্র অনুসারে এ ব্যাপারে প্রয়োজনীয় পদক্ষপে গ্রহণ করা হবে।
৪.৯	বগিত সক্টেরে কর্মসূচি (HPNSDP) যে আঙ্গকিে বা প্রকৃত ব্যয়ে সমাপ্ত হয়ছেে এবং যে সকল কার্যক্রম বাস্তবায়তি হয়ছেে তা PIP 'র আদলে একটি ডকুমন্টে তরৈি করে বর্তমানে প্রস্তাবতি কর্মসূচটিি অনুমোদনরে পর সুবধিাজনক সময়ে একনকে সভার সদয় অবগতরি জন্য উপস্থাপন করতে হবে।	HPNSDP এর আওতায় সদ্য সমাপ্ত ওপসিমূহরে পসিআির প্রণয়ন করা হচ্ছ। পসিআির চূড়ান্ত হওয়ার পর এ ব্যাপারে একটি প্রতবিদেন আইএমইডি'র মাধ্যমে একনকে সভায় উপস্থাপনরে পদক্ষপে গ্রহণ করা হবে।
৪.১০	ইতোমধ্যে বাস্তবায়তি HPNSDP'র উদ্দশ্যে ও টার্গটে এবং প্রস্তাবতি HPNSP'র নর্ধিারতি উদ্দশ্যে ও টার্গটেরে সুস্পষ্ট তুলনামূলকচত্রি পআিইপতিে উল্লখে করতে হবে।	পুনর্গঠতি পআিইপরি ভলউিম-২ এ তুলনামূলকচত্রি সংযুক্ত করা হয়ছে।

ক্রঃ নং	পহিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
৪.১১	বগিত তনি অর্থ বছররে (২০১৩-১৪ হতে ২০১৫-১৬ পর্যন্ত) APR একনকে সভায় উপস্থাপনরে জন্য মন্ত্রণালয়কে প্রয়োজনীয় ব্যবস্থা গ্রহণ করতে হবে।	প্রয়োজনীয় ব্যবস্থা গ্রহণ করা হবে।
৪.১২	ইতোমধ্যে সমাপ্ত স্বাস্থ্য সবো প্রতষ্ঠিানসমূহ রাজস্ব বাজটেে স্থানান্তররে প্রয়োজনীয় কার্যক্রম জরুরী ভত্তিতি গ্রহণ করতে হবে। এছাড়া যে সকল প্রতষ্ঠিানসমূহরে কাজ খুব দ্রুত সমাপ্ত করা সম্ভব তা দ্রুত সমাপ্ত করার বশিষে উদ্যোগ গ্রহণ করে সগেুলোও রাজস্ব বাজটেে স্থানান্তররে উদ্যোগ গ্রহণ করতে হবে। উক্ত প্রতষ্ঠিানসমূহ রাজস্ব বাজটেে স্থানান্তরতি হলে তাদরে জন্য প্রাক্কলতি ব্যয় পআিইপি সংশোধনরে সময় বাদ দতিে হবে।	পরকিল্পনা কমশিনরে সাথে এ বষিয়ে মন্ত্রণালয় একমত পোষণ কর। উন্নয়ন বাজটেরে আওতায় পরচিালতি স্বাস্থ্য সবো প্রতষ্ঠিানসমূহ রাজস্ব খাতে স্থানান্তররে ব্যাপারে মন্ত্রণালয় নরিলস প্রয়াস চালয়িে যাচ্ছে এবং ইতোমধ্যে কছিু প্রতষ্ঠিান রাজস্বখাতে স্থানান্তরতি হয়ছে। আশা করা যায় যে পর্যায়ক্রমে এ সকল প্রতষ্ঠিান রাজস্ব খাতে স্থানান্তরতি হবে।
৪.১৩	বাংলাদশেে স্বাস্থ্য সবোর ক্ষত্রেে আঞ্চলকি বষৈম্য দূরীকরণার্থে জাতীয় পর্যায়ে স্বাস্থ্য সক্টেররে আওতায় বাস্তবায়তিব্য সকল নর্মিাণ কাজরে একটি সুনর্দিষ্টি গাইড লাইন পআিইপতিে উল্লখে থাকতে হবে। তাছাড়া স্বাস্থ্য সবো প্রদানরে জন্য এলাকা নর্বিাচনরে ক্ষত্রেে এলাকার অবস্থান, জনসংখ্যা, দারদ্রি, বদ্যিমান স্বাস্থ্য সুবধিা ইত্যাদি ববিচেনাপূর্বক উক্ত গাইড লাইন প্রণয়ন করতে হবে।	পরকিল্পনা কমশিনরে সাথে এ ব্যাপারে মন্ত্রণালয় একমত পোষণ কর। উল্লখ্যে সদ্য সমাপ্ত HPNSDP'র আওতায় অবকাঠামো নর্মিাণ, মরোমত ও রক্ষণাবক্ষেণরে বষিয়ে একটি মাস্টার প্ল্যান প্রণয়নরে উদ্যোগ নয়ো হলওে অনবিার্য কারণে কাজটি সম্পন্ন করা সম্ভব হয় নাই। পরকিল্পনা কমশিনরে সুপারশি অনুসারে ৪র্থ সক্টের কর্মসূচরি আওতায় একটি গাইড লাইন প্রণয়ন করা হবে।
৪.১৪	বদৈশেকি সহায়তা প্রাপ্তি ও ব্যবহাররে Challenge সমূহ চহ্নিতি করে এর প্রতকিাররে ব্যবস্থা গ্রহণরে বষিয়ে সভায় গুরুত্বারোপ করা হয়।	অর্থনতৈকি সর্ম্পক বভিাগরে সাথে আলোচনাক্রমে এ ব্যাপারে সম্ভাব্য করণীয় বষিয় চহ্নিতি করে তদানুসারে পদক্ষপে গ্রহণ করা হবে।
৪.১৫	সক্টের কর্মসূচরি আওতায় বাস্তবায়তিব্য কার্যক্রমরে ক্ষত্রেে জণ্ডিবি ও প্রকল্প সাহায্যে বাস্তবায়তিব্য কার্যক্রমসমূহ সম্পূর্ণ আলাদা করার বষিয়ে পরবর্তীতে প্রয়োজনীয় ব্যবস্থা গ্রহণ করতে হবে।	৪র্থ সক্টের কর্মসূচতিে উন্নয়ন সহযোগীদরে অর্থায়নরে ধরণ অনুসারে সকল কর্মকান্ড জণ্ডিবি পদ্ধতি অনুসরণে বাস্তবায়তি হবে। তাই জণ্ডিবি ও প্রকল্প সাহায্যরে মাধ্যমে বাস্তবায়তিব্য কার্যক্রমরে অগ্রগতরি মধ্যে তমেন কোন ব্যবধান হবে বলে মনে হয় না। যাহোক, বষিয়টরি সম্ভাব্যতা যাচাই করে পরবর্তীতে ব্যবস্থা নয়ো যতেে পার।
৪.১৬	প্রস্তাবতি সক্টের কর্মসূচরি কোন্ ওপতিে, কোন্ কার্যক্রমরে জন্য, কোন্ দাতা সংস্থা কত অর্থ প্রদান করব (ঋণ ও অনুদান) তা নর্ধিারণরে একটি প্রক্রয়িা বরে করার উদ্যগে গ্রহণ করতে হবে।	সক্টের কর্মসূচতিে উন্নয়ন সহযোগীরা প্রধানতঃ পুল ফান্ডরে মাধ্যমে অর্থায়ন করে থাক। পুল ফান্ডে উন্নয়ন সহযোগীদরে কার্যক্রমভত্তিকি অর্থায়ন সনাক্ত করার সুযোগ থাকে না এবং তা সক্টের কর্মসূচরি মূল নীতরি সাথে সঙ্গতপূর্ণ নয়। অর্থনতৈকি সর্ম্পক বভিাগরে সাথে আলোচনা করে ভবষ্যিতে এ ব্যাপারে একটি প্রক্রয়িা বরে

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
		করার উদ্যোগ নয়ো হবে।
৪.১৭	বগিত কর্মসূচরি আওতায় ওপি ভত্তিকি মোট কত জন কর্মকর্তা বদৈশেকি প্রশকি্ষণে গয়িছে, এর মধ্যে কতজন মন্ত্রণালয় হত, কতজন অধদিপ্তর হতে এবং কতজন Field level হতে গয়িছে তার বস্তিারতি PIP-র ভলউিম-২-তে উল্লখে থাকা প্রয়োজন।	বগিত কর্মসূচতিে বদৈশেকি প্রশকি্ষণ সংক্রান্ত কোন ডাটাবজে না থাকায় বদৈশেকি প্রশকি্ষণে অংশগ্রহণকারী কর্মকর্তাদরে তালকিা এ পর্যায়ে পআিইপতিে উল্লখে করা দুরূহ। তবে ৪র্থ সক্টের কর্মসূচরি আওতায় বদৈশেকি প্রশকি্ষণ সংক্রান্ত একটি ডাটাবজে তরৈীর উদ্যোগ নয়ো হয়ছে। ফলে ভবষি্যতে এ সংক্রান্ত তথ্য পআিইপতিে উল্লখে করা যাব।
৪.১৮	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে সক্টের কর্মসূচরি আওতাধীন বদৈশেকি প্রশকি্ষণরে ক্ষত্রেে স্ব স্ব সংস্থা কর্তৃক বাস্তবায়তি ওপরি আওতায় ৭০% স্বাস্থ্য অধদিপ্তর, পরবিার পরকিল্পনা অধদিপ্তর এবং অন্যান্য অধদিপ্তর/সংস্থার Field level-এ কর্মরত চকিি□সক/কর্মকর্তাগণরে মধ্য হত, ১৫% স্ব স্ব অধদিপ্তর হতে এবং ১৫% বভিন্নি মন্ত্রণালয় হতে মনোনয়ন প্রদান করতে হব।	প্রস্তাবতি ৪র্থ এইচপএিনএসপতিে মন্ত্রণালয়রে অতরিক্তি সচবিরে সভাপতত্বিে একটি Training Implementation Committee গঠনরে প্রস্তাব করা হয়ছে। উক্ত কমটিতিে মাঠ পর্যায়রে কর্মকর্তাদরে অধকিতর অংশগ্রহণরে বষিয়টি ববিচেনা করে প্রয়োজনীয় পদক্ষপে নয়ো হব।
৪.১৯	সক্টের কর্মসূচরি আওতায় বদৈশেকি প্রশকি্ষণে কর্মকর্তা মনোনয়নরে জন্য মন্ত্রণালয়রে অতরিক্তি সচবিরে নতেৃত্বে অনুবভিাগ প্রধান (মন্ত্রণালয়), সংশ্লষি্ট সংস্থা প্রধান, যুগ্ম-প্রধান (স্বাস্থ্য/জনসংখ্যা উইং, পরকিল্পনা কমশিন), মহাপরচিালক (শকি্ষা ও সামাজকি সক্টের, আইএমইড), লাইন ডাইরক্টের এবং উপ-প্রধান (মন্ত্রণালয়, সদস্য সচবি) এর সমন্বয়ে একটি Training Implementation Committee গঠন করা যতেে পার। উক্ত কমটিি উপরোক্ত নর্দিশেনার আলোকে বদৈশেকি প্রশকি্ষণে কর্মকর্তা মনোনয়ন প্রদান করবনে।	প্রস্তাবতি ৪র্থ এইচপএিনএসপতিে মন্ত্রণালয়রে অতরিক্তি সচবিরে সভাপতত্বিে নতেৃত্বে অনুবভিাগ প্রধান (মন্ত্রণালয়), সংশ্লষি্ট সংস্থা প্রধান, যুগ্ম-প্রধান (স্বাস্থ্য/জনসংখ্যা উইং, পরকিল্পনা কমশিন), মহাপরচিালক (শকি্ষা ও সামাজকি সক্টের, আইএমইড), লাইন ডাইরক্টের এবং উপ-প্রধান (মন্ত্রণালয়, সদস্য সচবি) এর সমন্বয়ে একটি Training Implementation Committee গঠনরে প্রস্তাব করা হয়ছে। উক্ত কমটিরি মাধ্যমে মাঠ পর্যায়রে কর্মকর্তাদরে অধকিতর অংশগ্রহণরে বষিয়ে প্রয়োজনীয় পদক্ষপে নয়ো হব।
৪.২০	স্থানীয় প্রশকি্ষণে স্বাস্থ্য ও পরবিার পরকিল্পনা কর্মকর্তা/মাঠ পর্যায়রে কর্মীদরে অংশগ্রহণরে ফলে যনে সবো দান কার্যক্রমরে কোন ব্যাঘাত না ঘট তা সদেকিে বশিষে নজর রাখতে হব।	সবো দান কার্যক্রম নর্বিঘ্নি রখেে স্বাস্থ্য ও পরবিার পরকিল্পনা কর্মকর্তা/মাঠ পর্যায়রে কর্মীদরে স্থানীয় প্রশকি্ষণে অংশগ্রহণ নশ্চিতি করা হব।
৪.২১	স্থানীয় প্রশকি্ষণরে ক্ষত্রেবেভিন্নি ওপরি কার্যক্রমরে মধ্যে দ্বতৈতা পরহিার করতে হব। এছাড়া স্থানীয় প্রশকি্ষণ অংগরে ব্যয় যথাসম্ভব হ্রাস করতে হব।	বভিন্নি ওপি কর্তৃক প্রণীত বছরভত্তিকি প্রশকি্ষণ পরকিল্পনা প্রস্তাবতি Training Implementation Committee-এর মাধ্যমে অনুমোদন করে স্থানীয় প্রশকি্ষণরে ক্ষত্রেে দ্বতৈতা পরহিার করা হব।

ক্রঃ নং	পহিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
৪.২২	পূর্বরে সক্টের কর্মসূচতিে যে সকল বষিয়ে বা খাতে স্থানীয় প্রশক্ষিণ দয়ো হয়ছে তার সাথে নতুন কী ধরনরে প্রশক্ষিণ যুক্ত হবে তার ববিরণ পআিইপতিে উল্লখে করতে হবে। স্থানীয় প্রশক্ষিণরে সংখ্যা ও ধরণ Need based করতে হবে।	বভিন্নি ওপি কর্তৃক প্রণীত বছরভত্তিকি প্রশক্ষিণ পরকিল্পনায় এ সকল বষিয় ববিচেনা করে নতুন ধরণরে প্রশক্ষিণ অন্তর্ভুক্ত করা হব। স্থানীয় প্রশক্ষিণরে সংখ্যা ও ধরণ Need based করা হব।
৪.২৩	বগিত দুটি সক্টের কর্মসূচরি (HNPSP ও HPNSDP) আওতায় মোট কতটি, কি ধরনরে মটরযান সংগ্রহ করা হয়ছে এবং তা বর্তমানে কী কাজে, কোথায় ব্যবহৃত হচ্ছে তার বস্তিারতি ববিরণ পআিইপি'র ভলউিম-২ তে উল্লখে করতে হবে।	পআিইপি'র ভলউিম-২ বগিত সক্টের কর্মসূচরি আওতায় সংগৃহীত মোটরযান সংক্রান্ত তথ্য সন্নবিশে করা হয়ছে।
৪.২৪	প্রয়োজনীয়তার নরিখিে বর্তমান PIP-তে প্রস্তাবতি মটরযানরে সংখ্যা হ্রাস করতে হবে।	পহিসি সভার সদ্ধিান্তরে আলোকে PIP-তে প্রস্তাবতি মটরযানরে সংখ্যা যুক্তযিুক্ত করা হয়ছে।
৪.২৫	বর্তমান PIP-তে ওপি ভত্তিকি যে সকল মটরযান সংগ্রহ করা হবে তা কী কাজে/কোথায়/কে ব্যবহার করবনে তার বস্তিারতি ববিরণ পআিইপি'র ভলউিম-২ তে উল্লখে করতে হবে।	পআিইপি'র ভলউিম-২ তে এ সংক্রান্ত তথ্য সন্নবিশে করা হয়ছে।
৪.২৬	একটি সক্টের কর্মসূচরি আওতায় প্রস্তাবতি সকল নর্মিাণ কাজ উক্ত কর্মসূচি ময়োদইে সম্পন্ন করতে হবে। প্রস্তাবতি কর্মসূচরি আওতায় হাসপাতাল নর্মিাণ তথা হাসপাতাল Upgradation এর ক্ষত্রেে হাসপাতালরে ড্রইং/ডজিাইন ও স্পসেফিকিশেন যথার্থ ও আধুনকি মানরে হতে হবে।	পহিসি সভার সদ্ধিান্তরে আলোকে প্রয়োজনীয় ব্যবস্থা নয়ো হব।
৪.২৭	ইউনয়িন পর্যায়ে অবকাঠামো নর্মিাণে কম গুরুত্ব প্রদান করে চাহদিা ও প্রয়োজনীয়তার নরিখিে উপজলো ও জলো পর্যায়রে অবকাঠামো নর্মিাণে বশেী গুরুত্ব প্রদান করতে হবে। অবকাঠামো নর্মিাণে গুণগত মান বজায় রাখতে হবে।	এ বষিয়ে সম্ভাব্যতা যাচাইপূর্বক প্রয়োজনীয় ব্যবস্থা নয়ো হব।
৪.২৮	যে সকল উপজলো পরষিদরে ডরমটিরতিে স্থান সংকুলানরে সমস্যা রয়ছে সখোনে স্থানীয় চাহদিা ববিচেনায় স্বাস্থ্য কর্মকর্তাদরে জন্য উপজলো স্বাস্থ্য কমপ্লক্সে--এর অভ্যন্তরে পৃথকভাবে ২০টি উপজলোয় ডরমটিরি নর্মিাণরে লক্ষ্যে কার্যকরী পদক্ষপে গ্রহণ করতে হবে।	ডরমটেরী নর্মিাণরে বষিয়কে অধকিতর গুরুত্ব প্রদান করে একটি পৃথক প্রকল্প প্রস্তাব অনুমোদনরে প্রক্রয়িাধীন রয়ছে।
৪.২৯	সরকারি মূল্যবান অর্থরে যথাযথ ব্যবহার নশ্চিতি করার লক্ষ্যে প্রস্তাবতি কর্মসূচরি আওতায়	এ বষিয়কে অধকিতর গুরুত্ব প্রদান করে প্রয়োজনীয় ব্যবস্থা নয়ো হচ্ছে। এ বষিয়ে মন্ত্রণালয়ে একটি কমটিি কাজ করে

ক্রঃ নং	পহিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	হাসপাতাল নর্মিাণ তথা হাসপাতাল Up-gradation, যন্ত্রপাতি ও আসবাবপত্র স্থাপনরে সাথে সাথইে জনবল নয়িোগ ও হাসপাতাল এর কার্যক্রম চালু করার উদ্যোগ গ্রহণ করতে হবে।	যাচ্ছে।
৪.৩০	ওপি ভত্তিকি Monitoring অংগরে ব্যয় যৌক্তকি পর্যায়ে হ্রাস করতে হবে।	ওপি ভত্তিকি Monitoring অংগরে ব্যয় যৌক্তকি পর্যায়ে হ্রাস করা হয়ছে।
৪.৩১	সংশ্লষ্টি সকল মন্ত্রণালয়/বভিাগ/অধদিপ্তর/পরকিল্পনা কমশিন/আইএমইডি/লাইন ডাইরক্টেরটে এর প্রতনিধিদিরে সমন্বয়ে একটি কমটিি করে প্রতি ০১ বছর অন্তর পআিইপি'র একটি মূল্যায়ন এবং সকল ওপসিমূহরে মধ্যবর্তী মূল্যায়ন করতে হবে। এ সকল কাজরে জন্য প্রয়োজনীয় বরাদ্দরে সংস্থান পআিইপতিে রাখতে হবে।	যহেতেু জাতীয় ও আন্তর্জাতকি বশিষেজ্ঞরে সমন্বয়ে গঠতি নরিপক্ষে টমিরে মাধ্যমে এপআিার কার্যক্রম নবিড়িভাবে সম্পন্ন করা হয়, সহেতেু পৃথক কোন টমিরে মাধ্যমে বছরভত্তিকি/ এক বছর অন্তর আরকেটি মূল্যায়ন করার আবশ্যকতা নইে। এপআিার পরচিালনার সকল পর্যায়ে পরকিল্পনা কমশিন, আইএমইডি, ইআরডসিহ সংশ্লষ্টি সকল সংস্থার প্রতনিধিি সম্পৃক্ত থাকে।
৪.৩২	স্বাস্থ্য সবো প্রদানকারী প্রতষ্ঠিানরে অটোমশেনরে কার্যক্রম আধুনকিায়নরে মাধ্যমে যুগোপযোগী করার লক্ষ্যে একটি টার্গটে নর্ধিারণ করে তা অর্জনরে জন্য প্রয়োজনীয় পদক্ষপে অব্যাহত রাখতে হবে।	হাসপাতাল অটোমশেনরে কার্যক্রম কয়কেটি স্বাস্থ্য প্রতষ্ঠিানে পাইলট আকারে পরচিালনা করা হচ্ছে, যা ক্রমান্বয়ে সম্প্রসারণ করা হবে। ৪র্থ সক্টের কর্মসূচতিে এ বষিয়টি অন্যতম কার্যক্রম হসিবেে অন্তর্ভুক্ত রয়ছে।
৪.৩৩	বসেরকারি সংস্থা কর্তৃক সরকারি অনুদানে বাস্তবায়নরে জন্য প্রস্তাবতি উন্নয়ন প্রকল্পসমূহ স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে মাধ্যমে প্রক্রয়িাকরণ করতে হবে।	বসেরকারি সংস্থা কর্তৃক সরকারি অনুদানে বাস্তবায়নরে জন্য প্রস্তাবতি উন্নয়ন প্রকল্পসমূহ স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে মাধ্যমে প্রক্রয়িাকরণ করা হবে।
৪.৩৪	বসেরকারি মডেকিলে কলজেরে সংখ্যা সীমতিকরণ এবং বদ্যিমান কলজেসমূহরে শক্ষিার মান উন্নয়নরে লক্ষ্যে কার্যকর পদক্ষপে গ্রহণ করতে হবে। এছাড়া, প্রাইভটে সক্টেররে সবোর মান তদারকরি মাধ্যমে সাশ্রয়ী মূল্যে চকিৎিসা সবো নশ্চিতি করার জন্য কার্যকর পদক্ষপে গ্রহণ করতে হবে।	বদ্যিমান মডেকিলে কলজেসমূহে শক্ষিার মানোন্নয়নরে জন্য এ্যাক্রডিটিশেন প্রণয়ন, এসওপি প্রণয়ন, প্রয়োজনীয় জনবল তরৈী ইত্যাদি সার্বকি কার্যক্রম চলমান রয়ছে। পহিসি সভার সদ্ধিান্ত অনুযায়ী কার্যকর পদক্ষপে গ্রহণ করা হবে।
৪.৩৫	নার্সংি শক্ষিার ক্ষত্রে বৃদ্ধি ও মান উন্নয়নরে লক্ষ্যে পর্যাপ্ত কার্যক্রম গ্রহণ করতে হবে।	নার্সংি ও মডিওয়াইফারি সবোর মানোন্নয়নরে নমিত্তি ইতোমধ্যে সবো পরদিপ্তরকে নার্সংি ও মডিওয়াইফারি অধদিপ্তরে উন্নীত করা হয়ছে। ৩য় সক্টের কর্মসূচরি আওতায় সরকারী নার্সংি ইনস্টটিউটিরে সংখ্যা ৩১ হতে ৪৩-এ উন্নীত করা হয়ছে, আসন সংখ্যা ১,৫৮০ হতে ২,৫৮০-তে উন্নীত করা হয়ছে। তাছাড়া, বর্তমানে নর্মিতব্য সকল নতুন মডেকিলে কলজে নার্সংি ইনস্টটিউট প্রতষ্ঠিার সংস্থান রাখা

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
		হয়ছে। এছাড়া বভিন্নি কো্রসে শক্ষিার্থীর সংখ্যা ক্রমান্বয়ে বৃদ্ধি করা হচ্ছ। নার্সংি শক্ষিার পরসির বৃদ্ধি ও মানো্ন্নয়নরে জন্য গৃহীত উন্নয়ন কার্যক্রম যথাযথভাবে সম্পন্ন করার পাশাপাশি পরবর্তীতওে কার্যকর কার্যক্রম গ্রহণ করা হব।
৪.৩৬	প্রস্তাবতি কর্মসূচভিুক্ত কার্যক্রম বাস্তবায়নরে ক্ষত্রে DGHS ও DGFP-এর মধ্যে যথাযথ সমন্বয়রে জন্য একটি রূপরখো পিআইপতিে উল্লখে করতে হব।	৪র্থ সক্টের কর্মসূচতিে আলো্চ্য বষিয়টরি গুরুত্ব অনুধাবন করে ২টি প্রতষ্ঠিানরে মাঠ পর্যায়রে সমন্বতি কার্যক্রমরে রূপরখো পিআইপতিে অন্তর্ভুক্ত করা হয়ছে।
৪.৩৭	নগররে মানুষরে প্রাথমকি স্বাস্থ্য সবোর মানকে আরো কার্যকর ও বস্তিৃত করার জন্য স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে ভূমকিা আরো বৃদ্ধি করতে হব।	আরবান হলেথরে কার্যক্রম সমন্বয়রে জন্য উভয় মন্ত্রণালয়/বভিাগরে সচবিদরে সভাপতত্বিে গঠতি কমটিি কাজ করছ। পইিসি সিভার সদ্ধিান্তরে আলো্কে এ বষিয়ে অধকিতর কার্যক্রম গ্রহণ করা হব।
৪.৩৮	সক্টের কর্মসূচি বাস্তবায়নে বভিন্নি অধদিপ্তররে দক্ষ ও যো্গ্য যে সকল কর্মকর্তা দীর্ঘদনি লাইন ডাইরক্টেরে (এলডি) হসিবে দায়ত্বি পালন করতে পারবে তাদরে এলডি পদায়ন নশ্চিতি করতে হব। ওপসিমূহরে কাজরে সাথে সংগতি রখেে লাইন ডাইরক্টেরে (LD) নয়িো্গরে পাশাপাশি তাদরে দক্ষতা বৃদ্ধরি জন্য নয়িমতি প্রশক্ষিণরে ব্যবস্থা করতে হব।	পরকিল্পনা বভিাগরে নর্দিশেনা অনুযায়ী উন্নয়ন প্রকল্প/কর্মসূচতিে প্রকল্প পরচিালক/লাইন ডাইরক্টেরে নয়িো্গরে জন্য স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়ে একটি কমটিি গঠন করা হয়ছে। ৪র্থ সক্টেরে কর্মসূচি বাস্তবায়নে উক্ত কমটিরি সুপারশিরে মাধ্যমে উপযুক্ত লাইন ডাইরক্টেরে নর্বিাচন করা হব। লাইন ডাইরক্টেরে (LD)-দরে দক্ষতা বৃদ্ধরি জন্য নয়িমতি প্রশক্ষিণরে ব্যবস্থা গ্রহণ করা হব।
৪.৩৯	প্রস্তাবতি সক্টেরে কর্মসূচি বাস্তবায়নরে ক্ষত্রে অর্থরে Low Utilization রো্ধ করার জন্য যথাযথ ব্যবস্থা গ্রহণ করতে হব।	বষিয়টরি গুরুত্ব ববিচেনায় বাস্তবায়ন পরবীক্ষণ কার্যক্রম জো্রদার করার পাশাপাশি অর্থ ব্যবহার বৃদ্ধরি জন্য ৪র্থ সক্টেরে কর্মসূচরি Results Framework-এ একটি ইন্ডকিটেরে অন্তর্ভুক্ত করা হয়ছে।
৪.৪০	সক্টেরে কর্মসূচরি বভিন্নি ওপি'র আওতায় প্রস্তাবতি সকল Physical works এবং অবকাঠামো মরোমত ও রক্ষণাবক্ষেণ সংক্রান্ত কার্যক্রম সমন্বতিভাবে Physical Facilities Development অপারশেনাল প্ল্যানরে আওতায় বাস্তবায়ন করতে হব।	সক্টেরে কর্মসূচরি বভিন্নি ওপি'র আওতায় প্রস্তাবতি নতুন Physical works এবং অবকাঠামো মরোমত ও রক্ষণাবক্ষেণ সংক্রান্ত কার্যক্রম সমন্বতিভাবে Physical Facilities Development অপারশেনাল প্ল্যানরে আওতায় বাস্তবায়ন করা হব।
৪.৪১	প্রস্তাবতি সক্টেরে কর্মসূচরি নবিড়ি ও কার্যকর Monitoring ও Evaluation–এর জন্য IMED-এর তত্ত্বাবধানে আউট সো্র্সংি-এর মাধ্যমে কার্যক্রম গ্রহণ করতে হবে এবং এ খাতে প্রয়ো্জনীয় বরাদ্দরে সংস্থান রাখতে হব।	IMED-এর নজিস্ব বাজটেরে আওতায় কো্ন প্রকল্প/কর্মসূচরি নবিড়ি ও কার্যকর Monitoring ও Evaluation করে থাক। এ ক্ষত্রেওে অনুরূপ পদ্ধতি অনুসৃত হতে পার।
৪.৪২	প্রস্তাবতি পিআইপতিে অধকি মাত্রায় বদৈশেকি	৪র্থ সক্টেরে কর্মসূচতিে স্থানীয় পরামর্শক নয়িো্গে

ক্রঃ নং	পহিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	পরামর্শক নয়িোগরে পরবির্তে দশেীয় পরামর্শক নয়িোগে অগ্রাধকিার/গুরুত্ব প্রদান করতে হবে এবং Need based ও সীমতিভাবে পরামর্শক নয়িোগ দতিে হবে। প্রয়োজনীয়তার নরীখে ও কাজরে প্রকৃতি ববিচেনা করে যথাসম্ভব দ্রুততার সাথে পরামর্শক নয়িোগ প্রক্রয়িা সম্পন্ন করার জন্য একটি কমটিি গঠন করতে হবে। এছাড়া পত্রিকাপত্রিতে পরামর্শকরে ধরণ (স্থানীয়/আন্তর্জাতকি) উল্লখেসহ ওপি ভত্তিকি পরামর্শকরে সংখ্যা, জনমাস, ব্যয় ও কাজরে সংক্ষপ্তি বর্ণনা সুস্পষ্টভাবে টবেলি আকারে উপস্থাপন করতে হবে।	অগ্রাধকিার/গুরুত্ব প্রদান করা হবে এবং বাস্তবতার নরিখিে সীমতিভাবে পরামর্শক নয়িোগ প্রদান করা হবে। দ্বতৈতো পরহিার করে প্রয়োজনীয়তার নরিখিে ও কাজরে প্রকৃতি ববিচেনা করে পরামর্শক নয়িোগরে নমিত্তি উন্নয়ন সহযোগী ও জওিবি প্রতনিধিরি সমন্বয়ে ৩য় সক্টের কর্মসূচরি আওতায় একটি টত্রি কমটিি গঠন করা হয়। ৪র্থ সক্টের কর্মসূচতিওে অনুরূপ কমটিি গঠনরে প্রস্তাব রয়ছে। উল্লখ্যে, ওপি বাস্তবায়ন পর্যায়ে সময় সময় উদ্ভূত চাহদিার আলোকে টত্রি কমটিরি মাধ্যমে পরামর্শক নয়িোগ করা হয়ে থাকে, সে কারণে এ পর্যায়ে পরামর্শকরে ধরণ (স্থানীয়/আন্তর্জাতকি), সংখ্যা, জনমাস, ব্যয় ও কাজরে সংক্ষপ্তি বর্ণনা প্রদান করা বাস্তব সম্মত হবে না।
৪.৪৩	পত্রিকাপত্রিতে উপস্থাপতি সকল বাজটে টবেলিে কার্যক্রমসমূহরে কোড ও সাব-কোডসহ সুস্পষ্ট ববিরণ, সংখ্যা, পরমিাণ ও ব্যয় উল্লখে করতে হবে।	পত্রিকাপত্রিতে সকল ওপরি কার্যক্রমভত্তিকি বাজটে/ব্যয় প্রাক্কলন করা হয়ছে। উল্লখিতি বাজটেরে কোড ও সাব-কোডভত্তিকি ববিরণ, সংখ্যা, পরমিাণ ও প্রাক্কলতি ব্যয় সংশ্লষ্টি ওপতিে উল্লখে করা হবে।
৪.৪৪	স্বাস্থ্য সবো খাতে কর্মরত বভিন্নি NGO এর কার্যক্রম যথাযথভাবে মনটিরংি করতে হবে এবং এদরে মধ্যে যথার্থ সমন্বয় করতে হবে।	পহিসি সিভার সদ্ধিান্ত অনুযায়ী প্রয়োজনীয় ব্যবস্থা গ্রহণ করা হবে।
৪.৪৫	স্বাস্থ্য সক্টেররে নর্মিাণ কাজরে ড্রয়ংি, ডজিাইন প্রণয়ন ও তদারকী সম্পর্কতি কার্যক্রম সম্পাদনরে জন্য পরামর্শক নয়িোগরে পরবির্তে যথাসম্ভব সরকাররে নজিস্ব জনবল (স্থাপত্য অধদিপ্তর, গণপূর্ত অধদিপ্তর ও স্বাস্থ্য প্রকৌশল অধদিপ্তররে অভজি্ঞ জনবল) ব্যবহার করতে হবে। একান্ত অনবিার্য কারণে ন্যূনতম পর্যায়ে পরামর্শক নয়িোগরে প্রয়োজন হলে অপারশেনাল প্ল্যানরে সংস্থানরে ভত্তিতিে সবো ক্রয় সংক্রান্ত আইন/বধিানাবলী অনুসরণ করে পরামর্শক নয়িোগ দতিে হবে।	পহিসি সিভার সদ্ধিান্ত অনুযায়ী প্রয়োজনীয় ব্যবস্থা গ্রহণ করা হবে।
৪.৪৬	সক্টেরে কর্মসূচরি বভিন্নি ওপরি যন্ত্রপাতি সংগ্রহরে মধ্যে দ্বতৈতো পরহিার করতে হবে। বভিন্নি ওপতিে যে সকল যন্ত্রপাতি ও আসবাবপত্র সংগ্রহরে প্রস্তাব করা হয়ছে তা কোন্ কোন্ স্বাস্থ্য সবো প্রতষ্ঠিান, কী কী যন্ত্রপাতি ব্যবহার করা হবে তার বস্তিারতি তালকিা পত্রিকাপত্রি'র ভলউিম-২ তে সংযুক্ত করতে হবে।	সক্টেরে কর্মসূচরি বভিন্নি ওপরি যন্ত্রপাতি সংগ্রহরে মধ্যে দ্বতৈতো পরহিাররে নমিত্তি কার্যকর ব্যবস্থা গ্রহণ করা হবে। কোন্ কোন্ স্বাস্থ্য সবো প্রতষ্ঠিান, কী কী যন্ত্রপাতি ব্যবহার করা হবে তার বস্তিারতি তালকিা সংশ্লষ্টি ওপতিে সংযুক্ত করা হবে।

ক্রঃ নং	পইিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
৫.০	**অপারশেনাল প্ল্যানভত্তিকি সদ্ধিান্ত**	
	অপারশেনাল প্ল্যান-০১ (Sector Wide Program Management & Monitoring)	
১।	সক্টের কর্মসূচরি কার্যক্রমরে যথাযথ বাস্তবায়ন নশ্চিতি করার স্বার্থে আলোচ্য ওপরি মাধ্যমে বাস্তবায়তিব্য Program Monitoring কার্যক্রম আরো জোরদার করতে হবে।	সক্টের কর্মসূচরি কার্যক্রমরে যথাযথ বাস্তবায়ন নশ্চিতি করার স্বার্থে বাস্তবায়তিব্য Program Monitoring কার্যক্রম আরো জোরদার করা হবে।
২।	সক্টের কর্মসূচরি Planning and budgeting কার্যক্রম যুগোপযোগী করে Resource distribution-এ Regional disparity হ্রাস করা এবং এক সক্টের কর্মসূচরি কাজ পরবর্তী কর্মসূচতিে Carried over বন্ধ করতে হবে।	সক্টের কর্মসূচি সারা দশেব্যাপী বাস্তবায়তি হয়ে থাকে। এর আওতায় কোন অঞ্চলভত্তিকি বরাদ্দ প্রদানরে তমেন কোন সুযোগ নইে। তবে, স্বাস্থ্য সূচকরে ভত্তিতিে অনগ্রসর এলাকায় উন্নয়ন কার্যক্রম বাস্তবায়নরে জন্য বশিষে কার্যক্রম গ্রহণ করা হয়ে থাকে, যমেন- সলিটে ও চট্টগ্রাম বভিাগরে টএিফআর, মাতৃমৃত্যু হার হ্রাস করা। ৩য় সক্টের কর্মসূচরি আওতায় প্রণীত resource allocation formula পাইলটংি করে এর ফলাফলরে ভত্তিতিে সম্পদ বন্টনরে উদ্যোগ নয়ো হবে। সদ্ধিান্ত অনুযায়ী এক সক্টের কর্মসূচরি কাজ পরবর্তী কর্মসূচতিে Carried over পর্যায়ক্রমে বন্ধ করা হবে।
৩।	জাতীয় অর্থনতৈকি পরষিদ (এনইসি)-এর সভার নর্দিশেনার আলোকে স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে প্রকল্প অনুমোদনসহ প্রকল্প সংশ্লষ্টি অন্যান্য কর্মকান্ড পরকিল্পনা উইং থকেে সম্পন্ন করার প্রয়োজনীয় ব্যবস্থা গ্রহণ করতে হবে।	এনইসি সভার নর্দিশেনার আলোকে স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে প্রকল্প অনুমোদনসহ প্রকল্প সংশ্লষ্টি অন্যান্য কর্মকান্ড পরকিল্পনা উইং থকেে সম্পন্ন করার প্রয়োজনীয় ব্যবস্থা গ্রহণ করা হবে।
৪।	আলোচ্য ওপরি আওতায় বগিত কর্মসূচরি একটি End line evaluation প্রতবিদেন তরৈি করতে হবে।	আলোচ্য ওপরি আওতায় বগিত কর্মসূচরি একটি End line evaluation প্রতবিদেন তরৈি করা হচ্ছে, যা মার্চ ২০১৭ এর মধ্যে চূড়ান্ত করা হবে।
৫।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ৫ কোটি টাকায় নর্দিধারণ করতে হবে।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ৫ কোটি টাকায় নর্দিধারণ করা হয়ছে।
৬।	আলোচ্য ওপতিে সংগ্রহরে জন্য প্রস্তাবতি ২টি মাইক্রোবাসরে অতরিক্তি একটি মাইক্রোবাস কর্মসূচরি কার্যক্রম মনটিরংি-এর কাজে পরকিল্পনা কমশিনিরে স্বাস্থ্য উইং-এর জন্য সংগ্রহ করতে হবে।	সদ্ধিান্ত অনুযায়ী প্রয়োজনীয় ব্যবস্থা নয়ো হবে।
৭।	শুধুমাত্র DPA অর্থরে আওতায় যে পরমিাণ TA Assistance কার্যক্রম বাস্তবায়ন করা সম্ভব সে সকল কার্যক্রম পআিইপতিে অন্তর্ভুক্ত করতে হবে।	TA Assistance কার্যক্রম প্রধানতঃ DPA অর্থরে আওতায় বাস্তবায়ন করা হয়ে থাকে। তবে, বশিষে ববিচেনায় কোন কোন ক্ষত্রেে DPA অর্থ না পাওয়া গলেে TA Assistance কার্যক্রম জওিবি বা আরপএি-এর আওতায় বাস্তবায়ন করা প্রয়োজন

ক্রঃ নং	পইিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
		হতে পারে। সক্ষেত্রে প্রচলতি পরকিল্পনা পদ্ধতি অনুসরণ করে এ সকল কার্যক্রম জওিবি বা আরপএি-এর আওতায় অন্তর্ভুক্ত করা হবে।
৮।	Review the capacity of agencies and statutory bodies etc. [কম্পোনেন্ট xi(৭), পৃষ্ঠা ১২৬] অংগরে ব্যয় ৩ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	Review the capacity of agencies and statutory bodies etc. [কম্পোনেন্ট xi (৭)] অংগরে ব্যয় ৩ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৯।	Revitalized the different committee under MOHFW etc. [কম্পোনেন্ট xi(৩), পৃষ্ঠা ১২৬] অংগরে ব্যয় ৮ কোটি টাকায় নর্িধারণ করতে হবে।	Revitalized the different committee under MOHFW etc. [কম্পোনেন্ট xi(৩)] অংগরে ব্যয় ৮ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১০।	সক্টের কর্মসূচরি বাস্তবায়ন কার্যক্রম আরো গতশিীল ও যথার্থ করার জন্য এবং এর মনটিরিং কার্যক্রম Effective করার জন্য আলোচ্য ওপতি পরকিল্পনা কমশিনরে স্বাস্থ্য উইং এর আওতায় একটি Program Support and Facilitation শরিোনামে একটি অংগ অমত্মর্ভুক্ত করতে হবে। এ অংগরে ব্যয় ১০ কোটি টাকায় নর্িধারণ করতে হবে।	আলোচ্য ওপতি পরকিল্পনা কমশিনরে স্বাস্থ্য উইং এর আওতায় একটি Program Support and Facilitation শরিোনামে একটি অংগ ওপরি কম্পোনেন্ট (Capacity Development of MOHFW along with the Implementing Agencies and Concerned Sectors of Planning Commission)-এর আওতায় ১০ কোটি টাকা প্রাক্কলতি ব্যয়সসহ অন্তর্ভুক্ত করা হয়ছে।
	অপারশেনাল প্ল্যান-০২ (Planning, Monitoring & Research)	
১।	আলোচ্য ওপরি আওতায় সক্টের কর্মসূচরি কার্যক্রম যথার্থ ও বাস্তব ভত্তিকি মনটিরিং এর ব্যবস্থা গ্রহণ করতে হবে।	আলোচ্য ওপরি আওতায় সক্টের কর্মসূচরি কার্যক্রম যথার্থ ও বাস্তব ভত্তিকি মনটিরিং এর ব্যবস্থা নয়ো হয়ছে।
২।	বগিত সক্টের কর্মসূচরি আলোচ্য ওপরি আওতায় যে সকল Research কার্যক্রম বাস্তবায়ন করা হয়ছে তার একটি তালকিা পআিইপি'র ভলউিম-২ এ সংযুক্ত করতে হবে।	বগিত সক্টের কর্মসূচরি আলোচ্য ওপরি আওতায় যে সকল Research কার্যক্রম বাস্তবায়ন করা হয়ছে তার একটি তালকিা বস্তিারতি ওপতি সংযুক্ত করা হবে।
৩।	Support to upazilla Manager via district Manager [কম্পোনেন্ট C(7), পৃষ্ঠা ১৩৩] অংগরে ব্যয় ১০.০০ কোটি টাকায় নর্িধারণ করতে হবে।	Support to upazilla Manager via district Manager অংগরে ব্যয় ১০.০০ কোটি টাকায় নর্িধারণ করা হয়ছে।
৪।	Training on Field level monitoring and supervision [কম্পোনেন্ট D(2), পৃষ্ঠা ১৩৫] অংগটি পআিইপি থকেে বাদ দতিে হবে।	Training on Field level monitoring and supervision অংগটি পআিইপি থকেে বাদ দয়ো হয়ছে।
৫।	Health system operationality assessment at different level [কম্পোনেন্ট C(1), পৃষ্ঠা ১৩২] অংগরে ব্যয় ৪.০০ কোটি টাকায় নর্িধারণ করতে হবে।	Health system operationality assessment at different level অংগরে ব্যয় ৪.০০ কোটি টাকায় নর্িধারণ করা হয়ছে।
৬।	Coordination meeting with counterpart of DGFP	Coordination meeting with counterpart of DGFP managers

ক্রঃ নং	পহিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	managers and NGOs at field [কম্পোনেন্ট D(3), পৃষ্ঠা ১৩৫] অংগরে ব্যয় ৩.০০ কোটি টাকায় নর্িধারণ করতে হবে।	and NGOs at field অংগরে ব্যয় ৩.০০ কোটি টাকায় নর্িধারণ করা হয়ছে।
৭।	BMRC will be cost centers under this OP and receive grant etc. [কম্পোনেন্ট 3(a), পৃষ্ঠা ১৩৬] অংগরে ব্যয় ৩০.০০ কোটি টাকায় নর্িধারণ করতে হবে।	BMRC will be cost centers under this OP and receive grant etc.অংগরে ব্যয় ৩০.০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৮।	Short term training on research methodology/Long term training on research methodology [কম্পোনেন্ট 3b (3) (4), পৃষ্ঠা ১৩৭] অংগদ্বয়রে ব্যয় ৫০.০০ লক্ষ টাকা করে মোট ১.০০ কোটি টাকায় নর্িধারণ করতে হবে।	Short term training on research methodology/Long term training on research methodology ৩৭] অংগদ্বয়রে ব্যয় ৫০.০০ লক্ষ টাকা করে মোট ১.০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৯।	Survey on DLI, Gender issues etc. [কম্পোনেন্ট 3b (3) (4), পৃষ্ঠা ১৩৭] অংগরে ব্যয় ৭০.০০ লক্ষ টাকায় নর্িধারণ করতে হবে।	Survey on DLI, Gender issues etc. অংগরে ব্যয় ৭০.০০ লক্ষ টাকায় পুনঃনর্িধারণ করা হয়ছে।
১০।	Capacity building of health Professionals on health diplomacy [Page-138 Component 4 a(1)] অংগরে ব্যয় ১.৫০ কোটি টাকায় নর্িধারণ করতে হবে।	Capacity building of health Professionals on health diplomacy অংগরে ব্যয় ১.৫০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১১।	Mid and Long term fellowship program [Page-138 Component 4a (2)] অংগরে ব্যয় ৩.০০ কোটি টাকায় নর্িধারণ করতে হবে।	Mid and Long term fellowship program অংগরে ব্যয় ৩.০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১২।	Short term training on planning, monitoring and research etc. [Page-139 Component 4a (3)] অংগরে ব্যয় ৪.০০ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Short term training on planning, monitoring and research etc. অংগরে ব্যয় ৪.০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৩।	Support to office Management [Page-139, C (1)] অংগরে ব্যয় ২.০০ কোটি টাকায় নর্িধারণ করতে হবে।	Support to office Management অংগরে ব্যয় ২.০০ কোটি টাকায় নর্িধারণ করা হয়ছে।
১৪।	Foundation of a technical Group to achieve SDGs by formulating policies and directives [Page-139, C (2)] অংগরে ব্যয় ২.০০ কোটি টাকায় নর্িধারণ করতে হবে।	Formation of a technical Group to achieve SDGs by formulating policies and directives অংগরে ব্যয় ২.০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৫।	আলোচ্য ওপতিে বদৈশেকি প্রশক্ষিণ অংগটি আলাদাভাবে প্রদর্শনপূর্বক ব্যয় ৬.০০ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	আলোচ্য ওপরি বদৈশেকি প্রশক্ষিণ বাবদ ব্যয় ৬.০০ কোটি টাকার মধ্যে সীমাবদ্ধ রখেে প্রাক্কলন করা হয়ছে। বস্তিারতি ওপতিে বদৈশেকি প্রশক্ষিণ বাবদ ব্যয় বশিদভাবে প্রতফিলন করা হবে।
	অপারশেনাল প্ল্যান -০৩ (Planning Monitoring and Evaluation**)**	

ক্রঃ নং	পইিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
১।	পূর্বরে কর্মসূচরি পারফরমন্যেস, ওয়ার্কশপরে সংখ্যা, মোট বরাদ্দ ও বাস্তব ব্যয়রে তথ্যাদি বর্তমান পত্মিাইপতিে সংযুক্ত করতে হবে।	পূর্বরে কর্মসূচরি পারফরমন্যেস, ওয়ার্কশপরে সংখ্যা, মোট বরাদ্দ ও বাস্তব ব্যয়রে তথ্যাদি বস্তিারতি ওপতিে দেয়া হবে।
২।	কম্পউিটাররে inventory উল্লখে করতে হবে। এ খাতরে বরাদ্দ যৌক্তকিভাবে হ্রাস করতে হবে।	বস্তিারতি ওপতিে কম্পউিটাররে inventory উল্লখে করা হবে। এ বাবদ প্রাক্কলতি ব্যয় যৌক্তকিভাবে হ্রাস করে ২৭.৯০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৩।	৬ নং কম্পোনন্টেরে ২ নং ক্রমকিরে Operating Cost বাবদ প্রস্তাবতি ১.১০ কোটি টাকা বাদ দতিে হবে।	সদ্ধিান্ত অনুযায়ী Operating Cost বাবদ প্রস্তাবতি ১.১০ কোটি টাকা বাদ দয়ো হয়ছে। তবে, ওপি যথাযথভাবে বাস্তবায়নরে স্বার্থে বাস্তবতার নরিখিে Stationary and maintenance cost for OP implementation বাবদ ১.০৫ কোটি টাকা ব্যয় প্রাক্কলন করা হয়ছে, যার মাধ্যমে ওপি বাস্তবায়নরে জন্য অপরহিার্য অফসি স্টশেনারী, গাড়ীর পট্রোল, মোবলি গ্যাস, মরোমত ও রক্ষণাবক্ষেণ ইত্যাদি ব্যয় নর্িবাহ করা হবে।
৪।	আলোচ্য ওপরি জীপ গাড়ীর বদলে একটি মাইক্রোবাসরে সংস্থান রাখা যতেে পারে এবং সে মোতাবকে বরাদ্দ সংশোধন করতে হবে।	সদ্ধিান্ত অনুযায়ী মাইক্রোবাসরে সংস্থান রাখা হয়ছে এবং সে মোতাবকে বরাদ্দ সংশোধন করা হয়ছে।
৫।	বদৈশেকি প্রশক্ষিণ বাবদ বরাদ্দ যৌক্তকিভাবে কমাতে হবে। বদৈশেকি প্রশক্ষিণরে ৭০% ফল্ডি পর্যায়রে জন্য সংরক্ষণ করতে হবে।	বদৈশেকি প্রশক্ষিণ বাবদ বরাদ্দ যৌক্তকিভাবে হ্রাস করা হয়ছে। প্রস্তাবতি ৪র্থ এইচপএিনএসপতিে স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে অতরিক্তি সচবিরে সভাপতত্বিে একটি Training Implementation Committee গঠনরে প্রস্তাব করা হয়ছে। উক্ত কমটিতিে মাঠ পর্যায়রে কর্মকর্তাদরে অধকিতর অংশগ্রহণরে বষিয়টি ববিচেনা করে প্রয়োজনীয় পদক্ষপে নয়ো হবে।
৬।	৫ নং কম্পোনন্টেরে Petty repair and maintenance বাবদ বরাদ্দ হ্রাস করে আলাদা করতে হবে।	সদ্ধিান্ত অনুযায়ী ৫ নং কম্পোনন্টেটরি কার্যক্রম পরবিার পরকিল্পনা অধদিপ্তররে ফল্ডি সার্ভসিসে ডলেভিারি (FP-FSD) ওপরি আওতায় প্রস্তাব করা হয়ছে।
৭।	ওপি ব্যয় সর্বমোট ২৫ কোটি টাকায় সীমাবদ্ধ করতে হবে।	ওপি'র সর্বমোট ব্যয় ২৫ কোটি টাকায় সীমাবদ্ধ রাখা হয়ছে।
	অপারশেনাল প্ল্যান-০৪ (Health Economics and Financing**)**	
১।	আলোচ্য ওপরি জনবলরে বতেন-ভাতাদি অর্থ বভিাগরে জনবল নর্িধারণ কমটিরি সুপারশি অনুসারে অনুমোদতি জনবলরে আলোকে বতেন-ভাতাদি যথাযথভাবে নর্িধারণ করতে হবে।	অর্থ বভিাগরে জনবল নর্িধারণ কমটিরি সুপারশি অনুযায়ী জনবলরে বতেন-ভাতাদি বস্তিারতি ওপতিে যথাযথভাবে নর্িধারণ করা হবে।
২।	বভিন্নি অংগে প্রাক্কলতি Office Running Cost মোট ৫ কোটি টাকায় নর্িধারণ করতে হবে। এর	বভিন্নি অংগে প্রাক্কলতি Office Running Cost মোট ৫.০০ কোটি টাকায় নর্িধারণ করা হয়ছে। Hiring of Vehicles অংগরে

ক্রঃ নং	পরিষদ সভার সদ্ধিান্ত	স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	মধ্যে Hiring of Vehicles অংগরে ব্যয় ১.০০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	ব্যয় ১.০০ কোটি টাকার মধ্যে সীমতি রাখা হয়ছে।
৩।	বভিন্নি কম্পোনেন্টে প্রাক্কলতি Consultancy অংগরে ব্যয় মোট ৫.০০ কোটি টাকায় নরি্ধারণ করতে হবে।	বভিন্নি কম্পোনেন্টে প্রাক্কলতি Consultancy অংগরে ব্যয় মোট ৫.০০ কোটি টাকায় পুনঃনরি্ধারণ করা হয়ছে।
৪।	বভিন্নি অংগে প্রাক্কলতি Policy Advice অংগরে ব্যয় মোট ৮.০০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	বভিন্নি অংগে প্রাক্কলতি Policy Advice অংগরে ব্যয় মোট ৮.০০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৫।	আলোচ্য ওপি'র বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় মোট ২.০০ কোটি টাকায় নরি্ধারণ করতে হবে।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় মোট ২.০০ কোটি টাকায় পুনঃনরি্ধারণ করা হয়ছে।
৬।	প্রস্তাবতি Repair and Maintenance অংগটি আলোচ্য ওপি'র আওতায় বাস্তবায়ন না করে সক্টের কর্মসূচরি Physical Facilities Development (PFD) ওপি'র আওতায় বাস্তবায়ন করতে হবে। এ অংগরে ব্যয় ২.০০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	SSK-এর আওতায় প্রস্তাবতি Repair and Maintenance অঙ্গরে প্রাক্কলতি ব্যয় ২.০০ কোটি টাকায় পুনঃনরি্ধারণ করে অঙ্গটি সক্টের কর্মসূচরি Physical Facilities Development (PFD) ওপি'র আওতায় অন্তর্ভুক্ত করা হয়ছে।
	অপারশেনাল প্ল্যান ০৫ (Strengthening of Drug Administration & Management)	
১।	DGDA এর হড়ে অফসি ভবনরে উর্দ্ধমুখী সম্প্রসারণরে ব্যয় Physical Facilities Development ওপতিে অন্তর্ভুক্ত করা হয়ছে বধিায় এ সংক্রান্ত নরি্মাণ ব্যয়]কম্পোনেন্ট ৩ (১১), পৃষ্ঠা ১৭৩] আলোচ্য ওপি থকেে বাদ দতিে হবে।	সদ্ধিান্ত অনুযায়ী DGDA এর হড়ে অফসি ভবনরে উর্দ্ধমুখী সম্প্রসারণরে ব্যয় Physical Facilities Development ওপতিে অন্তর্ভুক্ত করা হয়ছে এবং এ বাবদ প্রাক্কলতি ব্যয় Strengthening of Drug Administration & Management ওপি থকেে বাদ দয়ো হয়ছে।
২।	আলোচ্য ওপরি আওতায় শুধুমাত্র ৮টি মাইক্রোবাস সংগ্রহ করতে হবে। তবে অর্থ বভিাগরে জনবল নরি্ধারণ কমটিি কর্তৃক ড্রাইভার পাওয়ার নশ্চিয়তা ব্যতীত গাড়ী সংগ্রহ করা যাবে না।	আলোচ্য ওপরি আওতায় মাইক্রোবাসরে সংখ্যা ১৬টরি পরবির্তে ৮টি প্রস্তাব করা হয়ছে। অর্থ বভিাগরে জনবল নরি্ধারণ কমটিি কর্তৃক ড্রাইভার পাওয়ার নশ্চিয়তা ব্যতীত গাড়ী সংগ্রহ করা হবে না।
৩।	বদৈশেকি প্রশক্ষিণ অঙ্গরে ব্যয় ৫০.০০ লক্ষ টাকায় নরি্ধারণ করতে হবে।	বদৈশেকি প্রশক্ষিণ অঙ্গরে ব্যয় ৫০.০০ লক্ষ টাকায় পুনঃনরি্ধারণ করা হয়ছে।
৪।	আলোচ্য ওপরি আওতায় শুধুমাত্র মোট ২০টি ল্যাপটপ সংগ্রহরে সংস্থান রাখতে হবে।	প্রস্তাবতি ওপতিে কোন ল্যাপটপরে সংস্থান ছলি না, তবে Computer, Hardware & Accessories (Computer, Printer, UPS) বাবদ মোট ৬৪.০০ লক্ষ টাকা ব্যয় প্রাক্কলন করা হয়ছেলি। বাস্তবতার নরিখিে ইউপএিস, প্রন্টিারসহ ৩০ সটে ডস্কেটপ কম্পউিটার সংগ্রহরে জন্য আলোচ্য ওপতিে ২১.০০ লক্ষ টাকা ব্যয়রে প্রস্তাব করা হয়ছে।
	অপারশেনাল প্ল্যান-০৬ (Health Information System and e-Health)	

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
১।	বগিত কর্মসূচরি আলোচ্য ওপি'র মাধ্যমে Health System এর আধুনকিায়ন বা Health System এর ICT ব্যবস্থা উন্নয়নে কী কী পদক্ষপে গ্রহণ করা হয়ছে তার একটি ববিরণ পত্রিাইপতিে উল্লখে করতে হব। বগিত কর্মসূচরি এ সংক্রান্ত কার্যক্রমরে সাথে বর্তমান কর্মসূচরি কার্যক্রমরে উল্লখেযোগ্য কী পার্থক্য রয়ছে তা পত্রিাইপতিে উল্লখে করতে হব। বর্তমান কর্মসূচরি মাধ্যমে Health Information System or e-health আরো কী আধুনকিায়ন হবে তা উল্লখে করতে হব।	যাচতি তথ্যাদি পত্রিাইপতিে অন্তর্ভুক্ত ওপি'র সংক্ষপ্তি-সার-এ অন্তর্ভুক্ত করা হয়ছে।
২।	স্বাস্থ্য অধদিপ্তররে বভিন্নি ওপি'র আওতায় বচ্ছিন্নিভাবে কম্পউিটার/ এক্সসেরজি/ টলেকিমউিনকিশেন/ভডিওি কনফারন্সেং যন্ত্রপাত সংগ্রহ না কর Health Information System and e-Health ওপি'র আওতায় সংগ্রহ করতে হব। বাংলাদশে কম্পউিটার কাউন্সলিরে সাথে সমন্বয় করে এ ধরণরে কার্যক্রম বাস্তবায়নরে উদ্যোগ নয়ো প্রয়োজন।	কর্মসূচ বাস্তবায়নকালে স্বাস্থ্য অধদিপ্তররে বভিন্নি ওপি'র প্রয়োজনীয় কম্পউিটার/ এক্সসেরজি/ টলেকিমউিনকিশেন/ ভডিওি কনফারন্সেং ইত্যাদি যন্ত্রপাত Health Information System and e-Health ওপি'র আওতায় সংগ্রহরে ব্যবস্থা গ্রহণ করা হব। বর্ণতি যন্ত্রপাতসিমূহ বাংলাদশে কম্পউিটার কাউন্সলিরে সাথে পরামর্শ করে সংগ্রহ করা হব।
৩।	প্রস্তাবতি স্থানীয় প্রশকি্ষণ অংগরে ব্যয় ১০৫ কোটি টাকার মধ্যে এবং বদৈশেকি প্রশকি্ষণ অঙ্গরে ব্যয় মোট ৬ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হব।	স্থানীয় প্রশকি্ষণ অংগরে মোট ব্যয় ১০৫ কোটি টাকা এবং বদৈশেকি প্রশকি্ষণ অংগরে ব্যয় ৬ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৪।	Internet Connections' bill [কম্পোনেন্ট ১(২), পৃষ্ঠা ১৮৩] অংগরে ব্যয় ৯০.০০ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হব।	Internet Connections' bill অংগরে ব্যয় ৯০.০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৫।	Hardware repair and maintenance [কম্পোনেন্ট ১(৬), পৃষ্ঠা ১৮৩] অংগরে ব্যয় ১০.০০ কোটি টাকায় নর্িধারণ করতে হব।	Hardware repair and maintenance অংগরে ব্যয় ১০.০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৬।	আলোচ্য ওপরি আওতায় ২টি Cross country vehicle এবং ৪০০ মটর সাইকলে ক্রয়রে সংস্থান রাখতে হব।	আলোচ্য ওপরি আওতায় ২টি Cross country vehicle এবং ৪০০ মটর সাইকলে ক্রয়রে সংস্থান রাখা হয়ছে।
৭।	Local area network (LAN) [কম্পোনেন্ট ১(১৬), পৃষ্ঠা ১৮৪] অংগরে ব্যয় ৩০.০০ কোটি টাকায় নর্িধারণ করতে হব।	Local area network (LAN) অংগরে ব্যয় ৩০.০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৮।	Telephone, Petrol and Oil, Books and Periodicals, Computer Stationery etc	Telephone, Petrol and Oil, Books and Periodicals, Computer Stationery etc অংগরে ব্যয় ৫০.০০ কোটি টাকায়

ক্রঃ নং	পহিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	[কম্পো·নেন্ট ১(১৭), পৃষ্ঠা ১৮৪] অংগরে ব্যয় ৫০.০০ কো·টি টাকায় নর্িধারণ করতে হবে।	পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-০৭ (Management Information System (MIS)	
১।	পূর্ববর্তী ফজে যে সকল যন্ত্রপাতি-সাজসরঞ্জাম কনো হয়ছে সগেুলো·র ইনভনেটরী পত্রিাইপতি সংযুক্ত করতে হবে।অ	পূর্ববর্তী ফজে ৮৫৫টি ডস্কেটপ কম্পউিটার, ২০৭৬টি ল্যাপটপ, ১৮৪৯টি প্রন্টিার, ৭৪০টি মডমে, ৩টি স্ক্যানার, ৪টি কালার প্রন্টিার, ৫২০টি ট্যাব, ২১টি ইউপত্রিস এবং ৬৫টি মাল্টমিডিয়া প্রজক্টের ক্রয় করা হয়ছে। এ সকল যন্ত্রপাতি ও সাজসরঞ্জামরে তালকিা বস্তিারতি ওপতি সংযুক্ত করা হবে।
২।	সারাদশে অন-লাইন সস্টিমে চালু না করে পাইলটভত্তিতি সলিটে ও চট্রগ্রাম বভিাগরে কয়কেটি জলোয় পরীক্ষামূলকভাবে ডজিটিাল পদ্ধতিতি ডাটা কালকেশন ও ট্রান্সফার সস্টিমে চালু করে তার ফলাফলরে উপর ভত্তিি করে অন্যত্র কার্যক্রম চালু করতে হবে। সে মো·তাবকে ট্যাব ও কম্পউিটার সংখ্যা হ্রাস করতে হবে।	সদ্ধিান্ত অনুযায়ী এ পর্যায়ে সলিটে ও চট্টগ্রাম বভিাগে ই-রজেস্টিার কার্যক্রম চালু করা হবে। সে অনুযায়ী ট্যাব-এর সংখ্যা ও ব্যয় হ্রাস করা হয়ছে। ৩য় সক্টের কর্মসূচীর আওতায় সংগৃহীত ডস্কেটপ কম্পউিটার/কম্পউিটার সামগ্রী ৪র্থ সক্টের কর্মসূচরি আওতায় প্রতস্থিাপন করা হবে। কর্মসূচি বাস্তবায়নরে শষোর্ধে প্রস্তাবতি কম্পউিটার/কম্পউিটার সামগ্রী সংগ্রহ করা হবে। সে কারণে বাস্তবতার নরিখিে কম্পউিটার/কম্পউিটার সামগ্রী বাবদ ব্যয় প্রাক্কলন করা হয়ছে।
৩।	অন-লাইন তথ্য সংগ্রহ ও বশেি পরমিাণে কম্পউিটার ও এক্সসেরজি ক্রয়রে ক্ষত্রেে আইসটিি বভিাগরে মতামত নতিে হবে।	সরকাররে আইসটিি নীতমিালা অনুযায়ী অন-লাইন তথ্য সংগ্রহ করা হয়ে থাক। এ বষিয়ে আইসটিি বভিাগরে পরামর্শ ও সহায়তা গ্রহণ করা হবে। একসঙ্গে অধকি পরমিাণে কম্পউিটার ও কম্পউিটার সামগ্রী ক্রয়রে ক্ষত্রেে আইসটিি বভিাগরে মতামতও গ্রহণ করা হবে।
৪।	আলো·চ্য ওপরি আওতায় গাড়ি ও যানবাহন ক্রয় বাদ দতিে হবে।	গাড়ি ও যানবাহন ক্রয়রে প্রস্তাব বাদ দয়ো হয়ছে।
৫।	৩ নং কম্পো·নেন্টরে ১ ক্রমকিরে ৬০০টি মাল্টমিডিয়া প্রজক্টের বাবদ বরাদ্দ বাদ দতিে হবে।	মাল্টমিডিয়া প্রজক্টের বাবদ বরাদ্দ বাদ দয়ো হয়ছে।
৬।	৭ নং কম্পো·নেন্টরে ৩ ক্রমকিরে supply and services বাবদ ৪৪.৫৫ কো·টি টাকা বাদ দতিে হবে।	supply and services বাবদ প্রাক্কলতি ৪৪.৫৫ কো·টি টাকা বাদ দয়ো হয়ছে।
৭।	৯ নং কম্পো·নেন্টরে অধীন প্রস্তাবতি ট্রনেংি এর সংখ্যা ও বরাদ্দ পাইলট প্রো·গ্রামরে ভত্তিতিে পুনঃনর্িধারণ করতে হবে।	সলিটে ও চট্টগ্রাম বভিাগে ই-রজেষ্টিার পাইলট প্রো·গ্রামরে সাথে সঙ্গতি রখেে ট্রনেংি এর সংখ্যা ও বরাদ্দ পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-০৮ (Procurement, Storage and Supplies Management of HS)	
১।	আলো·চ্য ওপরি আওতায় কম্পউিটার/এক্সসেরজি/টলেকিমউিনকিশেন/ভডিওি	কর্মসূচি বাস্তবায়নকালে প্রয়ো·জনীয় কম্পউিটার/ এক্সসেরজি/ টলেকিমউিনকিশেন/ ভডিওি কনফারন্সেংি ইত্যাদি

ক্রঃ নং	পহিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	কনফারন্সেং যন্ত্রপাতি সংগ্রহ না করে Health Information System and e-Health ওপি'র আওতায় সংগৃহীতব্য এ ধরনরে যন্ত্রপাতি হতে তা সংগ্রহ করতে হবে।	যন্ত্রপাতি Health Information System and e-Health ওপি'র আওতায় সংগ্রহরে ব্যবস্থা গ্রহণ করা হবে।
২।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ১.০০ কো:টি টাকায় নর্িধারণ করতে হবে।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ১.০০ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৩।	ওপি'র আওতায় শুধুমাত্র ১টি জীপ ও ৩টি মাইক্রো:বাস সংগ্রহ করতে হবে। তবে অর্থ বভিাগরে জনবল নর্িধারণ কমটিি কর্তৃক ড্রাইভার পাওয়ার নশ্চিয়তা ব্যতত গাড়ী সংগ্রহ করা যাবে না। মটরযানরে সংখ্যার আনুপাতকি হারে পট্রেো:ল/গ্যাস/ফুয়লে অংগরে ব্যয় হ্রাস করতে হবে।	ওপি'র আওতায় ১টি জীপ ও ৩টি মাইক্রো:বাস সংগ্রহরে প্রস্তাব করা হয়ছে। মটরযানরে সংখ্যার আনুপাতকি হারে পট্রেো:ল/গ্যাস/ফুয়লে অংগরে ব্যয় হ্রাস করা হয়ছে। অর্থ বভিাগরে জনবল নর্িধারণ কমটিি কর্তৃক ড্রাইভার পাওয়ার নশ্চিয়তা সাপক্ষে গাড়ী সংগ্রহ করা হবে।
৪।	Service Procurement [কম্পো:নন্টে ৪(৫), পৃষ্ঠা ২০৪] অংগরে ব্যয় ১.০০ কো:টি টাকায় নর্িধারণ করতে হবে।	Service Procurement অংগরে ব্যয় ১.০০ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৫।	Furniture and Fixtures [কম্পো:নন্টে ৪(১৭), পৃষ্ঠা ২০৪] অংগরে ব্যয় ১.০০ কো:টি টাকায় নর্িধারণ করতে হবে।	Furniture and Fixtures অংগরে ব্যয় ১.০০ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৬।	Additional Civil Works [কম্পো:নন্টে ৪(২১), পৃষ্ঠা ২০৫] অংগরে ব্যয় ৫.০০ কো:টি টাকায় নর্িধারণ করতে হবে।	Additional Civil Works অংগরে ব্যয় ৫.০০ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৭।	Additional Cost [কম্পো:নন্টে ৪(২১), পৃষ্ঠা ২০৫] অংগরে ব্যয় ১০.০০ কো:টি টাকায় নর্িধারণ করতে হবে।	Additional Cost অংগরে [কম্পো:নন্টে ৪(২২)] ব্যয় ১০.০০ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-০৯ (Procurement Storage and Supply Management (PSSM-FP)	
১।	অর্থবভিাগরে জনবল নর্িধারণ কমটিি থকেে ড্রাইভাররে সম্মতি পাওয়া সাপক্ষে আলো:চ্য ওপতিে গাড়রি সংস্থান রাখা যাবে।	পহিসি সভার সদ্ধিান্তরে প্রক্ষেতিে জনবল কমটিতিে প্রস্তাবতি ১৭টি ড্রাইভাররে পদরে বপিরীতে ওপতিে ১৭টি গাড়ি ক্রয়রে সংস্থান রখেে সে অনুযায়ী প্রাক্কলতি ব্যয় পুনঃনর্িধারণ করা হয়ছে। উল্লখ্যে, ড্রাইভাররে সংস্থান ব্যতীত গাড়ি ক্রয় করা হবে না।
২।	কম্পো:নন্টে ৩ এর ২ ও ৩ ক্রমকিে যথাক্রমে ৫১০ টি Dehumidifier থাকব। তবে ৫১০টি এসি ক্রয়রে প্রস্তাব বাদ যাবে।	সদ্ধিান্ত অনুযায়ী ৫১০ টি Dehumidifier এর সংস্থান অপরবির্তত রাখা হয়ছে এবং ৫১০টি এসি ক্রয়রে প্রস্তাব বাদ দয়ো হয়ছে।
৩।	কম্পো:নন্টে ৫ এর ১ ক্রমকিে প্রস্তাবতি Computer Accessories, ৬ ক্রমকিে প্রস্তাবতি Multimedia Projector এবং ৭ ক্রমকিে	পহিসি সভার ৪ নং সদ্ধিান্ত অনুযায়ী ওপি থকেে ১২০০ ল্যাপটপ ক্রয়রে প্রস্তাব বাদ দয়োর কারণে এ পর্যায়ে আনুষঙ্গকি Computer Accessories এবং Multimedia

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	প্রস্তাবতি Procurement of Computer and accessories ক্রয় বাবদ ব্যয় ১.৫০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	Projector ক্রয়রে সংস্থান রাখার প্রয়োজন নইে। তবে, ৭ ক্রমকিে প্রস্তাবতি Procurement of Computer and accessories বাবদ প্রাক্কলতি ব্যয় হ্রাস করে ১.৫০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৪।	কম্পোনেন্টে ৬ এর ২ ক্রমকিে প্রস্তাবতি ১২০০ ল্যাপটপ বাদ দতিে হবে। ৩ ক্রমকিে প্রস্তাবতি Logistics-MIS বাবদ প্রস্তাবতি ৭৫.০০ লক্ষ টাকা যৌক্তকিভাবে হ্রাস করতে হবে।	সদ্ধিান্ত অনুযায়ী ১২০০ ল্যাপটপ ক্রয়রে প্রস্তাব বাদ দয়ো হয়ছে। ৩ ক্রমকিে প্রস্তাবতি Logistics-MIS বাবদ প্রস্তাবতি ব্যয় হ্রাস করা হয়ছে।
৫।	কম্পোনেন্টে ৭-এর ১ ক্রমকিে প্রস্তাবতি ট্রনেংি বাবদ বরাদ্দ ১.৫০ কোটি টাকায় সীমাবদ্ধ রাখতে হবে এবং ৩ ক্রমকিে প্রস্তাবতি Software Training বাবদ ৬০.০০ লক্ষ টাকায় সীমাবদ্ধ রাখতে হবে। ৪ নং ক্রমকিে প্রস্তাবতি Workshop বাবদ প্রস্তাবতি ৯০.০০ লক্ষ টাকা কময়িে ৫৫.০০ লক্ষ টাকা করার এবং ৫ ক্রমকিরে Study Tour বাবদ প্রস্তাবতি ৫০.০০ লক্ষ টাকা বাড়য়িে ৭৫.০০ লক্ষ টাকা করতে হবে।	কম্পোনেন্টে ৭-এর ১ ক্রমকিে প্রস্তাবতি ট্রনেংি বাবদ ব্যয় ১.৫০ কোটি টাকায় এবং ৩ ক্রমকিে প্রস্তাবতি Software Training বাবদ প্রস্তাবতি ব্যয় ৬০.০০ লক্ষ টাকায় সীমাবদ্ধ রাখা হয়ছে। ৪ নং ক্রমকিে প্রস্তাবতি Workshop বাবদ প্রস্তাবতি ব্যয় ৫৫.০০ লক্ষ টাকায় এবং ৫ ক্রমকিরে Study Tour বাবদ প্রস্তাবতি ব্যয় ৭৫.০০ লক্ষ টাকায় পুনঃনর্িধারণ করা হয়ছে।
৬।	কম্পোনেন্টে ৯-এ প্রস্তাবতি পূর্ত নর্িমাণ এর দর গণপূর্ত অধদিপ্তররে বদ্যিমান রটে সডিউিল অনুযায়ী ধার্য্য করতে হবে।	প্রস্তাবতি পূর্ত নর্িমাণ এর দর গণপূর্ত অধদিপ্তররে বদ্যিমান রটে সডিউিল (পডিব্লউিডি রটে সডিউিল-২০১৪) অনুযায়ী নর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-১০ (Human Resource Development)	
১।	বগিত কর্মসূচরি আলোচ্য ওপরি আওতায় যে সকল Strategy, Plan ও Policy প্রণয়ন করা হয়ছে তার একটি তালকিা পআিইপি'র ভলউিম-২ এ সংযুক্ত করতে হবে।	বগিত কর্মসূচরি HRM ওপরি আওতায় প্রণীত Strategy, Plan ও Policy এর তালকিা বস্তিারতি ওপতিে সংযুক্ত করা হবে।
২।	বগিত কর্মসূচরি আলোচ্য ওপরি আওতায় যে সকল Research/Survey/Study করা হয়ছে তার একটি তালকিা পআিইপি'র ভলউিম-২ এ সংযুক্ত করতে হবে।	বগিত কর্মসূচরি HRM ওপরি আওতায় সম্পাদতি Research/Survey/Study এর তালকিা বস্তিারতি ওপতিে সংযুক্ত করা হবে।
৩।	আলোচ্য ওপরি বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় মোট ৪ কোটি টাকায় র্নধিারণ করতে হবে।	আলোচ্য ওপরি বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় মোট ৪ কোটি টাকায় পুনঃর্নধিারণ করা হয়ছে।
৪।	আলোচ্য ওপরি Supply and Services অংগরে ব্যয় ১৫ কোটি টাকায় নর্িধারণ করতে হবে।	সদ্ধিান্ত অনুযায়ী Supply and Services অংগরে ব্যয় ১৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৫।	কম্পোনেন্টে ১(১-৯) (পৃষ্ঠা ২২৮-২২৯) অংগসমূহরে ব্যয় ২ কোটি টাকায়, কম্পোনেন্টে ২ (১,২,৪,৫,৬) (পৃষ্ঠা ২২৯-২৩০) অংগসমূহরে ব্যয় ২ কোটি টাকায়, কম্পোনেন্টে ৩ (১-৫) (পৃষ্ঠা	সদ্ধিান্ত অনুযায়ী উল্লখিতি কম্পোনেন্টে ও অংগসমূহরে ব্যয় যথাযথভাবে পুনঃনর্িধারণপূর্বক এ সকল অংগরে মোট ব্যয় ৮ কোটি টাকায় প্রাক্কলন করা হয়ছে।

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	২৩০-২৩১) অংগসমূহরে ব্যয় ২ কো·টি টাকায়, এবং কম্পো·নেন্ট ৪ (১-৫) (পৃষ্ঠা ২৩১-২৩২) অংগসমূহরে ব্যয় ২ কো·টি টাকায় অর্থা□ এ সকল অংগসমূহরে মো·ট ব্যয় ৮ কো·টি টাকায় র্নধিারণ করতে হবে।	
৬।	আলো·চ্য ওপরি Research/ Survey/ Study কম্পো·নেন্ট [৫(৪), পৃষ্ঠা ২৩২] অংগরে ব্যয় ৮ কো·টি টাকায় নর্িধারণ করতে হবে।	ওপরি Research/Survey/Study বাবদ ব্যয় ৮.০০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৭।	আলো·চ্য ওপরি Seminar/ Conference/ Training required for implementation of HWF কম্পো·নেন্ট [৫(৫), পৃষ্ঠা ২৩২] অঙ্গরে ব্যয় ২.৫০ কো·টি টাকায় নর্িধারণ করতে হবে।	সদ্ধিান্ত অনুযায়ী Seminar/ Conference/ Training required for implementation of HWF অঙ্গরে ব্যয় ২.৫০ কো·টি টাকায় নর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-১১ (Medical Education and Health Manpower Development)	
১	আলো·চ্য ওপতি লাইব্ররেীর মান উন্নয়নরে জন্য প্রাক্কলতি ৫০.০০ কো·টি টাকার মধ্যে সকল মডেকিলে কলজেরে শক্ষিার্থীদরে জন্য একটি Unique e-library তরৈরি উদ্যো·গ গ্রহণ করতে হবে।	আলো·চ্য ওপতি লাইব্ররেীর মান উন্নয়নরে জন্য প্রাক্কলতি ৫০.০০ কো·টি টাকার মধ্যে সকল মডেকিলে কলজেরে শক্ষিার্থীদরে জন্য একটি Unique e-library তরৈরি প্রস্তাব করা হয়ছে।
২	Need based support etc. [কম্পো·নেন্ট ১(৪), পৃষ্ঠা ২৪১] অংগরে ব্যয় ৪৫.০০ কো·টি টাকায় নর্িধারণ করতে হবে।	Need based support etc. অংগরে ব্যয় ৪৫.০০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৩	Expansion of public health education covering different levels and discipline [কম্পো·নেন্ট ২(১), পৃষ্ঠা ২৪১] অংগরে ব্যয় ১৫.০০ কো·টি টাকায় নর্িধারণ করতে হবে।	Expansion of public health education covering different levels and discipline অংগরে ব্যয় ১৫.০০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৪	আলো·চ্য ওপরি স্থানীয় প্রশক্ষিণ অংগরে ব্যয় ২০০.০০ কো·টি টাকায় এবং বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ৫০.০০ কো·টি টাকায় নর্িধারণ করতে হবে।	আলো·চ্য ওপরি স্থানীয় প্রশক্ষিণ অংগরে ব্যয় হ্রাস করে ২০০.০০ কো·টি টাকায় এবং বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ৫০.০০ কো·টি টাকায় প্রাক্কলন করা হয়ছে।
৫	Supply and Services [কম্পো·নেন্ট ৩(১০), পৃষ্ঠা ২৪২] অংগরে ব্যয় ৩০০.০০ কো·টি টাকায় নর্িধারণ করতে হবে।	Supply and Services অংগরে ব্যয় হ্রাস করে ৩০০.০০ কো·টি টাকা প্রস্তাব করা হয়ছে।
৬	বভিন্নি প্রকল্পরে আওতায় নর্িমতি/নর্িমতিব্য মডেকিলে কলজেে প্রকল্প হতইে যন্ত্রপাতি ও ফার্নচিার সংগ্রহ করা হয়ে থাকে বধিায় ঐ সকল মডেকিলে কলজেে আলো·চ্য ওপি হতে যন্ত্রপাতি ও ফার্নচিার সরবরাহরে প্রয়ো·জন নইে। এ	সদ্ধিান্ত অনুযায়ী Procurement of Machinery etc. অংগরে ব্যয় ৭৯০.০০ কো·টি টাকা হতে হ্রাস করে ৬০০.০০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	ববিচেনায় Procurement of Machinery etc. [কম্পে·োনেন্টে ৩(১২), পৃষ্ঠা ২৪৩] অংগরে ব্যয় হ্রাস করে পুনঃনর্িধারণ করতে হবে।	
৭	Community Oriented Medical Education [কম্পে·োনেন্টে ৩(১৬), পৃষ্ঠা ২৪৩] অংগরে ব্যয় ২০ কে·োটি টাকায় নর্িধারণ করতে হবে।	সদ্ধিান্ত অনুযায়ী Community Oriented Medical Education অংগরে ব্যয় ২০ কে·োটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৮	Ensure quality of teaching for all Existing and newly setup Govt. Medical College [কম্পে·োনেন্টে ৩(১৮), পৃষ্ঠা ২৪৪] অংগরে ব্যয় ৫.০০ কে·োটি টাকায় নর্িধারণ করতে হবে।	Ensure quality of teaching for all Existing and newly setup Govt. Medical College অংগরে ব্যয় হ্রাস করে ৫.০০ কে·োটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৯	Establish utilization of updated IT for modernization of all govt. medical and dental college/unit [কম্পে·োনেন্টে ৩(১৯), পৃষ্ঠা ২৪৪] অংগটি পিআইপি হতে বাদ দতিে হবে।	সদ্ধিান্ত অনুযায়ী Establish utilization of updated IT for modernization of all govt. medical and dental college/unit অংগটি পিআইপি হতে বাদ দয়ো হয়ছে।
১০	Strengthening Educational Facilities for IHT and MATS [কম্পে·োনেন্টে ৪(৪), পৃষ্ঠা ২৪৪] অংগরে ব্যয় ৯০.০০ কে·োটি টাকায় নর্িধারণ করতে হবে।	Strengthening Educational Facilities for IHT and MATS অংগরে ব্যয় ৯০.০০ কে·োটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১১।	A Crash program to incorporate past in-service training information of different categories of HWF under DGHS in TMIS [কম্পে·োনেন্টে ৫(৯), পৃষ্ঠা ২৪৫] অংগটি পিআইপি হতে বাদ দতিে হবে।	A Crash program to incorporate past in-service training information of different categories of HWF under DGHS in TMIS অংগটি পিআইপি হতে বাদ দয়ো হয়ছে।
১২।	Develop and maintain Training management information systems (TMIS) [কম্পে·োনেন্টে ৫(৮), পৃষ্ঠা ২৪৫] অংগরে ব্যয় ২.০০ কে·োটি টাকায় নর্িধারণ করতে হবে।	Develop and maintain Training management information systems (TMIS) অংগরে ব্যয় হ্রাস করে ২.০০ কে·োটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৩।	2 days user level hands on training on operation for data entry [কম্পে·োনেন্টে ৫(১০), পৃষ্ঠা ২৪৬] অংগরে ব্যয় ২.০০ কে·োটি টাকায় নর্িধারণ করতে হবে।	2 days user level hands on training on operation for data entry অংগরে ব্যয় হ্রাস করে ২.০০ কে·োটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৪।	Training need assessment (TNA) for different categories and tiers of health personnel [কম্পে·োনেন্টে ৫(১১), পৃষ্ঠা ২৪৬] অংগরে ব্যয় ৩০.০০ লক্ষ টাকায় নর্িধারণ করতে হবে।	Training need assessment (TNA) for different categories and tiers of health personnel অংগরে ব্যয় হ্রাস করে ৩০.০০ লক্ষ টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৫।	Develop and review of curriculum [কম্পে·োনেন্টে ৫(১২), পৃষ্ঠা ২৪৬] অংগরে ব্যয় ৭০.০০ লক্ষ টাকায় নর্িধারণ করতে হবে।	Develop and review of curriculum [কম্পে·োনেন্টে ৫(১২), পৃষ্ঠা ২৪৬] অংগরে ব্যয় ৭০.০০ লক্ষ টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৬।	আলে·োচ্য ওপরি আওতায় শুধুমাত্র বভিন্নি মডেকিলে কলজেরে প্রন্সিপ্যিালদরে জন্য মটরযান	আলে·োচ্য ওপরি আওতায় শুধুমাত্র বভিন্নি মডেকিলে কলজেরে প্রন্সিপ্যিালদরে জন্য মটরযান সংগ্রহরে প্রস্তাব করা

ক্রঃ নং	পরিসংসভার সদ্ধিান্ত	স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	সংগ্রহ করতে হবে। অন্য কোন কাজে কোন মটরযান ক্রয় করা যাবে না।	হয়েছে।
১৭।	আলোচ্য ওপতিে প্রস্তাবতি Autonomous accreditation body এর কার্যক্রম যথাযথভাবে মনটিরিং-এর ব্যবস্থা করতে হবে।	নির্দেশনা অনুযায়ী Autonomous accreditation body এর কার্যক্রম যথাযথভাবে মনটির করা হবে।
	অপারেশনাল **প্ল্যান**-১২ (Nursing & Midwifery Education Services**)**	
১।	নার্সিং সেবার মান উন্নয়ন এবং দেশের ভবিষ্যত চাহিদার কথা বিবেচনা করে গুণগতমান সম্পন্ন নার্স তৈরির লক্ষ্যে কার্যকর পদক্ষেপ গ্রহণ করতে হবে।	নার্সিং সেবার মান উন্নয়ন এবং দেশের ভবিষ্যত চাহিদার কথা বিবেচনা করে গুণগতমান সম্পন্ন নার্স তৈরির লক্ষ্যে প্রয়োজনীয় ব্যবস্থা নেয়া হচ্ছে।
২।	আলোচ্য ওপরি Orientation and refreshment training for newly recruited nurses and midwives etc. [কম্পোনেন্ট ২(২), পৃষ্ঠা ২৫৭] অংগরে ব্যয় ১০০.০০ কোটি টাকায় নির্ধারণ করতে হবে।	আলোচ্য ওপরি Orientation and refreshment training for newly recruited nurses and midwives etc. অংগরে ব্যয় ১০০.০০ কোটি টাকায় পুনঃনির্ধারণ করা হয়েছে।
৩।	Production of increased number of registered midwives [কম্পোনেন্ট ২(৪), পৃষ্ঠা ২৫৭] অংগরে ব্যয় ৫০.০০ কোটি টাকায় নির্ধারণ করতে হবে।	Production of increased number of registered midwives অংগরে ব্যয় ৫০.০০ কোটি টাকায় পুনঃনির্ধারণ করা হয়েছে।
৪।	Strengthen and continuation of Masters-160, and PhD program in nursing and midwifery [কম্পোনেন্ট ২(১১), পৃষ্ঠা ২৫৮] অংগরে ব্যয় ৩০.০০ কোটি টাকায় নির্ধারণ করতে হবে।	Strengthen and continuation of Masters-160, and PhD program in nursing and midwifery অংগরে ব্যয় ৩০.০০ কোটি টাকায় নির্ধারণ করা হয়েছে।
৫।	আলোচ্য ওপরি আওতায় ১টি জিপ, ২০টি মিনিবাস এবং ১টি মাইক্রোবাস সংগ্রহরে সংস্থান রাখতে হবে।	ওপরি আওতায় ১টি জিপ, ২০টি মিনিবাস এবং ১টি মাইক্রোবাস সংগ্রহরে সংস্থান রাখা হয়েছে।
৬।	Procure furniture's, vehicles, equipment, OMR machine and others [কম্পোনেন্ট ৫(২), পৃষ্ঠা ২৬১] অংগরে ব্যয় ৮০.০০ কোটি টাকায় নির্ধারণ করতে হবে।	Procure furniture's, vehicles, equipment, OMR machine and others অংগরে ব্যয় ৮০.০০ কোটি টাকায় পুনঃনির্ধারণ করা হয়েছে।
৭।	সকল বৈদেশিক প্রশিক্ষণ (Short, Medium and Long Term) অংগরে ব্যয় ৭০.০০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	সকল বৈদেশিক প্রশিক্ষণ (Short, Medium and Long Term) অংগরে ব্যয় ৭০.০০ কোটি টাকার মধ্যে প্রাক্কলন করা হয়েছে। বিস্তারিত ওপতিে বৈদেশিক প্রশিক্ষণরে ব্যয় বিশদভাবে প্রতিফলন করা হবে।
	অপারেশনাল প্ল্যান-১৩ (Training Research and Development)	
১।	কম্পোনেন্ট ১ (Training) এ বর্ণিত ১৩ ধরনরে ট্রেনিং এর ব্যবস্থা অপরবির্তিত থাকবে।	কম্পোনেন্ট ১ (Training) এ বর্ণিত ১৩ ধরনরে ট্রেনিং এর ব্যবস্থা অপরবির্তিত রাখা হয়েছে।

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
২।	কম্পো·নেন্ট ২ এর ১নং ক্রমকিে রসিার্চ স্টাডি/ বাবদ বরাদ্দ অপরবির্ততি থাকবে।	কম্পো·নেন্ট ২ এর ১নং ক্রমকিে রসিার্চ স্টাডি/বাবদ বরাদ্দ অপরবির্ততি রাখা হয়ছে।
৩।	কম্পো·নেন্ট ৩ এর ক্রমকি ৮ এ Furniture, Fixture মরোমত বাবদ ৫৫ লাখ, ক্রমকি ৯ এ Office building renovation বাবদ ১৩৫ লাখ এবং ক্রমকি ১০ এ renovation of residential building বাবদ ১০৫ লাখ বরাদ্দ প্রস্তাব বাদ দতিে হব।	কম্পো·নেন্ট ৩ এর ক্রমকি ৮ এ Furniture, Fixture মরোমত বাবদ ৫৫ লাখ, ক্রমকি ৯ এ Office building renovation বাবদ ১৩৫ লাখ এবং ক্রমকি ১০ এ renovation of residential building বাবদ ১০৫ লাখ বরাদ্দ প্রস্তাব বাদ দয়ো হয়ছে।
৪।	কম্পো·নেন্ট ৩ এর ক্রমকি ১৪ এ প্রস্তাবতি ৩১ টি গাড়রি বদলে ১ টি জীপ ও ২০ টি মাইক্রো·বাস এবং নপিো·র্ট সদর দপ্তররে জন্য ১টি এবং পরকিল্পনা কমশিনরে জনসংখ্যা উইং এর জন্য ১টি মাইক্রো·বাসরে সংস্থান থাকব। এছাড়া, অফসি ইকুইপমন্টে ও ফার্নচিার বাবদ বরাদ্দ যৌক্তকিভাবে হ্রাস করতে হব।	সদ্ধিান্ত অনুযায়ী যানবাহনরে সংখ্যা পুনঃর্নধিারণ করা হয়ছে এবং সে অনুযায়ী ব্যয় প্রাক্কলন করা হয়ছে। অফসি ইকুইপমন্টে ও ফার্নচিার বাবদ বরাদ্দ যৌক্তকিভাবে হ্রাস করা হয়ছে।
৫।	পুর্বরে সক্টের কর্মসূচতিে একই OP তে ক্রয়কৃত Furniture, Fixture, Vehicle, Office Equipment এর Inventory পত্রিাইপি তে সংযুক্ত করতে হব।	পুর্বরে সক্টের কর্মসূচতিে একই OP তে ক্রয়কৃত Furniture, Fixture, Vehicle, Office Equipment এর Inventory বস্তিারতি ওপতিে সংযুক্ত করা হব।
	অপারশেনাল প্ল্যান - ১৪ (Physical Facilities Development)	
১।	ওপতিে প্রস্তাবতি নর্মিাণ কাজরে মধ্যে একই ধরণরে স্থাপনার Proto-type ডজিাইন ওপরি অনুমো·দন প্রক্রয়িাকরণকালে ওপতিে সংযুক্ত করতে হব।	ওপতিে প্রস্তাবতি নর্মিাণ কাজরে মধ্যে একই ধরণরে স্থাপনার Proto-type ডজিাইন ওপরি অনুমো·দন প্রক্রয়িাকরণকালে ওপতিে সংযুক্ত করা হব।
২।	আলো·চ্য OP'র আওতায় যে সকল জলো, উপজলো ও ইউনয়িনে বভিন্নি কাজ করা হবে সে সকল জলো, উপজলো ও ইউনয়িনরে চূড়ান্ত নাম এবং এ সকল স্থানে নর্দিষ্টিভাবে যে কাজ করা হবে তার ববিরণ ওপতিে উল্লখে করতে হব।	আলো·চ্য OP'র আওতায় যে সকল জলো, উপজলো ও ইউনয়িনে বভিন্নি কাজ করা হবে সে সকল জলো, উপজলো ও ইউনয়িনরে চূড়ান্ত নাম এবং এ সকল স্থানে নর্দিষ্টিভাবে যে কাজ করা হবে তার ববিরণ বস্তিারতি ওপতিে উল্লখে করা হব।
৩।	স্বাস্থ্য সবো প্রদানরে লক্ষ্যে নতুন হাসপাতাল নর্মিাণ এবং পুরাতন বভিন্নি প্রতষ্ঠিানরে উর্দ্ধমুখী সম্প্রসারণরে ক্ষত্রেে BNBC অনুসরণ করতে হব। Vertical Extension এর ক্ষত্রেে বদ্যিমান ভবনরে সক্ষমতা আছে কনিা তা পরীক্ষা করে ভবন নর্মিাণ করতে হব।	সদ্ধিান্ত অনুযায়ী প্রয়ো·জনীয় ব্যবস্থা নয়ো হব।
৪।	আলো·চ্য ওপতিে Consultancy অংগরে ব্যয় ৫ কো·টি টাকার মধ্যে সীমাবদ্ধ থাকতে হব। এ ব্যয় কো·ন্ কো·ন্ ক্ষত্রেে ব্যবহার করা হবে তা ওপতিে নর্দিষ্টি করে দতিে হব। এর বাইরে বভিন্নি ভবন	আলো·চ্য ওপতিে Consultancy অংগরে ব্যয় ৫ কো·টি টাকার মধ্যে সীমাবদ্ধ রাখা আছ। এ ব্যয় কো·ন্ কো·ন্ ক্ষত্রেে ব্যবহার করা হবে তা বস্তিারতি ওপতিে উল্লখে করা হব। এর বাইরে বভিন্নি ভবন নর্মিাণ অংগরে ব্যয় প্রাক্কলনরে সাথে

ক্রঃ নং	পহিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	নর্মিাণ অংগরে ব্যয় প্রাক্কলনরে সাথে কোনভাবইে Consultancy ব্যয় অন্তর্ভুক্ত করা যাবে না।	Consultancy ব্যয় অন্তর্ভুক্ত করা হবে না।
৫।	স্বাস্থ্য প্রকৌশল অধদিপ্তররে স্থায়ী জনবল বৃদ্ধরি জন্য প্রয়োজনীয় কার্যক্রম গ্রহণ করতে হবে।	স্বাস্থ্য প্রকৌশল অধদিপ্তররে স্থায়ী জনবল বৃদ্ধরি জন্য প্রয়োজনীয় কার্যক্রম চলমান রয়ছে।
৬।	পআিইপতিে উল্লখিতি নদীগর্ভে বলিীন হওয়া বভিন্নি স্বাস্থ্য সবো প্রতষ্ঠিানরে তালকিা ওপতিে সংযুক্ত করতে হবে।	পআিইপতিে উল্লখিতি নদীগর্ভে বলিীন হওয়া বভিন্নি স্বাস্থ্য সবো প্রতষ্ঠিানরে তালকিা বস্তিারতি ওপতিে সংযুক্ত করা হবে।
৭।	আলোচ্য ওপরি আওতায় দুটি Trauma Center নর্মিাণরে কার্যক্রম গ্রহণ করতে হবে।	আলোচ্য ওপরি আওতায় দুটি Trauma Center নর্মিাণরে কার্যক্রম গ্রহণ করা হয়ছে।
৮।	নার্সংি সবোর মান উন্নয়ন এবং পরধিি বৃদ্ধরি লক্ষ্যে নার্সংি ট্রনেংি ইনস্টটিউিটসমূহকে নার্সংি কলজেে রূপান্তররে প্রয়োজনীয় উদ্যোগ গ্রহণ করতে হবে।	নার্সংি সবোর মান উন্নয়ন এবং পরধিি বৃদ্ধরি লক্ষ্যে নার্সংি ট্রনেংি ইনস্টটিউিটসমূহকে নার্সংি কলজেে রূপান্তররে প্রয়োজনীয় উদ্যোগ গ্রহণ করা হচ্ছ।
৯।	Bangladesh Institute of Health Management at Savar এর নর্মিাণ কাজ দ্রুত সম্পাদন করে তা যথাযথভাবে ফাংশনংি করতে হবে।	HPNSDP এর আওতায় Bangladesh Institute of Health Management at Savar এ দুটি বজেমন্টে নর্মিাণরে কাজ সমাপ্ত করা হয়ছে। অবশষ্টি কাজ প্রস্তাবতি ওপরি আওতায় সম্পন্ন করে প্রতষ্ঠিানটি ফাংশনংি করার ব্যবস্থা নয়ো হয়ছে।
১০।	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে হলেথ ইকোনমক্সি ইউনটিরে মাধ্যমে পরচিালতি Survey/Research এর সুপারশিরে আলোকে ১০ শয্যা বশিষ্টি MCWC স্থাপনরে কার্যক্রম গ্রহণ করতে হবে। প্রাথমকিভাবে বর্তমান সক্টের কর্মসূচরি আওতায় প্রয়োজনীয়তা অনুসারে সর্বাধকি গুরুত্বপূর্ণ স্থানে সর্বোচ্চ ১০টি MCWC স্থাপন করা যতেে পার।	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয়রে হলেথ ইকোনমক্সি ইউনটিরে মাধ্যমে পরচিালতি Survey/Research এর সুপারশিরে আলোকে ১০ শয্যা বশিষ্টি MCWC স্থাপন করা হবে। পহিসি সভার ১৯ নং সদ্ধিান্তরে প্রক্ষেতিে Construction of 10 Bed Mother and Child Welfare Center এর সংখ্যা ১০টরি পরবির্তে ৫০-এ উন্নীত করে সে অনুযায়ী ব্যয় প্রাক্কলন করা হয়ছে।
১১।	একটি কর্মসূচরি আওতায় প্রস্তাবতি নর্মিাণ কাজসমূহ ঐ কর্মসূচরি আওতায়ই সম্পাদন নশ্চিতি করা প্রয়োজন। সে অনুযায়ীই কর্মসূচি ডজিাইন করা প্রয়োজন। ৪র্থ সক্টেরর কর্মসূচরি পর যে কর্মসূচি গ্রহণ করা হবে তাতে বর্তমান সক্টেরর কর্মসূচরি কোন নর্মিাণধর্মী কার্যক্রম Carried over works হসিবেে পরবর্তী সক্টেরর কর্মসূচতিে স্থানান্তর করা যাবে না। বষিয়টি ববিচেনা করইে নর্মিাণ কাজরে Work Plan তরৈি	সদ্ধিান্ত অনুযায়ী ৪র্থ সক্টেরর কর্মসূচরি আওতায় প্রস্তাবতি নর্মিাণধর্মী কার্যক্রমসমূহ Carried over works হসিবেে পরবর্তী সক্টেরর কর্মসূচতিে স্থানান্তর করা হবে না। প্রস্তাবতি নর্মিাণ কার্যক্রমসমূহ সক্টেরর কর্মসূচরি নর্ধিারতি সময়রে মধ্যইে সম্পাদনরে লক্ষ্যে নর্মিাণ কাজরে Work Plan বস্তিারতি ওপি তিে সংযুক্ত করা হবে।

ক্রঃ নং	পহিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	করতে হবে।	
১২।	আলোচ্য ওপরি আওতায় বভিন্নি অধদিপ্তর/সংস্থার জন্য ৫টি জীপ এবং ২০টি মটর সাইকলে ক্রয় করার উদ্যোগ গ্রহণ করতে হবে। এর অতরিক্তি কোন মটরযান সংগ্রহ করা যাবে না। উক্ত জীপসমূহ যাদরে জন্য ক্রয় করা হবে তাদরে জন্য কোন ধরনরে মটরযান পরবর্তীতে সংস্থার রাজস্ব বাজটে হতে ক্রয় করা যাবে না।	আলোচ্য ওপরি আওতায় স্বাস্থ্য প্রকৌশল অধদিপ্তররে জন্য ৫টি জীপ এবং ২০টি মটর সাইকলে ক্রয় করার প্রস্তাব করা হয়ছে। জীপ ক্রয়রে বষিয়ে প্রদত্ত নর্দিশেনা অনুসরণ করা হবে।
১৩।	নার্সং কলজে নর্মিাণরে সকল প্রস্তাব একটি অংগরে আওতায় অন্তর্ভুক্ত করতে হবে।	নার্সং কলজে নর্মিাণরে সকল প্রস্তাব একটি অংগরে আওতায় প্রস্তাব করা হয়ছে।
১৪।	আলোচ্য ওপরি আওতায় কোন বদৈশেকি প্রশক্ষিণ অংগ অন্তর্ভুক্ত করা যাবে না।	পহিসি সভার ২১ নং সদ্ধিান্ত অনুযায়ী capacity building of HED এবং capacity building of PWD বাবদ ব্যয় পুনঃনর্ধিারণ করা হয়ছে, যার মধ্যে বদৈশেকি প্রশক্ষিণ বাবদ ব্যয় প্রাক্কলতি রয়ছে। মানব সম্পদ উন্নয়নরে জন্য বদৈশেকি প্রশক্ষিণরে আবশ্যকতা রয়ছে। ৪র্থ সক্টের কর্মসূচরি আওতায় প্রস্তাবতি Training Implementation Committee-এর মাধ্যমে বদৈশেকি প্রশক্ষিণরে প্রশক্ষিণার্থী, প্রশক্ষিণরে স্থান, বষিয় ইত্যাদি যৌক্তকিভাবে নর্ধিারণরে মাধ্যমে আলোচ্য ওপরি আওতায় বদৈশেকি প্রশক্ষিণ বাস্তবায়ন করা হবে।
১৫।	কমউিনটিি ক্লনিকি নর্মিাণ ও পুনঃনর্মিাণরে (Reconstruction) ক্ষত্রেে কোন ধরণরে দ্বতৈতা (Duplication) করা যাবে না।	কমউিনটিি ক্লনিকি নর্মিাণ ও পুনঃনর্মিাণরে (Reconstruction) ক্ষত্রেে কোন দ্বতৈতা (Duplication) নইে।
১৬।	বর্তমান সক্টের কর্মসূচরি আওতায় Upgradation of UH&FWC এর আওতায় ২০০টি কন্দ্রে এবং Reconstruction of Old Existing UH&FWC এর আওতায় ১০০টি কন্দ্রে এর নর্মিাণ কার্যক্রম গ্রহণ করতে হবে।	বাস্তবতার নরিখিে Upgradation of UH&FWC এর আওতায় ৫০টি কন্দ্রে এবং Reconstruction of Old Existing UH&FWC এর আওতায় ১০০টি কন্দ্রে এর নর্মিাণ কার্যক্রম প্রস্তাব করা হয়ছে।
১৭।	Vertical/Horizontal Extension of Different Health and Family Planning Facilities [কম্পোনন্টে ১(১১), পৃষ্ঠাঃ ২৮০] এবং Remodeling and Construction of Different Health and Family Planning Infrastructure [কম্পোনন্টে ১(১৭), পৃষ্ঠাঃ ২৮১] অংগ দুটরি কাজরে প্রকৃতি একই ববিচেনায় একটি অংগ বর্তমান পআিইপতিে অন্তর্ভুক্ত করে অন্যটি বাদ দতিে হবে।	সদ্ধিান্ত অনুযায়ী একটি অংগ অন্তর্ভুক্ত করা হয়ছে।
১৮।	পূর্বরে সক্টেরর কর্মসূচরি Performance মূল্যায়ন	বাস্তবতার নরিখিে Construction of UH&FWC এর সংখ্যা

ক্রঃ নং	পহিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	সাপক্ষে Construction of UH&FWC [কম্পে·নন্টে ২(১), পৃষ্ঠাঃ ২৮১] এর সংখ্যা ২০০টি থকেে কমিয়ে ৫০টি করতে হবে।	২০০-তে পুনঃনর্িধারণ করা হয়ছে।
১৯।	Construction of 10 Bed Mother and Child Welfare Center [কম্পে·নন্টে ২(৭), পৃষ্ঠাঃ ২৮৮] ৫০টি করতে হবে। এছাড়া Construction of 20 Bed Mother and Child Welfare Center [কম্পে·নন্টে ২(৮), পৃষ্ঠাঃ ২৮৮] ৪টি করতে হবে।	নর্িদশেনা অনুযায়ী Construction of 10 Bed Mother and Child Welfare Center এর সংখ্যা ৫০-এ পুনঃনর্িধারণ করা হয়ছে। এছাড়া পহিসি সভার আলে·াচনা অনুযায়ী ৪টি 20 Bed Hospital নর্িমাণরে প্রস্তাব করা হয়ছে।
২০।	যে সকল উপজলো পরষিদরে ডরমটিরতিে স্থান সংকুলানরে সমস্যা রয়ছেে সখোনে স্থানীয় চাহদিা ববিচেনায় স্বাস্থ্য কর্মকর্তাদরে জন্য উপজলো স্বাস্থ্য কমপ্লক্সেরে অভ্যন্তরে ২০টি উপজলোয় পৃথকভাবে ডরমটিরি নর্িমাণরে লক্ষ্যে কার্যকরী পদক্ষপে গ্রহণ করতে হবে।	ডরমটেরী নর্িমাণরে বষিয়কে অধকিতর গুরুত্ব প্রদান করে একটি পৃথক প্রকল্প প্রস্তাব অনুমে·াদনরে প্রক্রয়িাধীন রয়ছে।
২১।	Procurement of Goods and Operational Expenses of HED [কম্পে·নন্টে ৪(১), পৃষ্ঠা ২৯২] অংগরে ব্যয় ১৫ কে·াটি টাকায়, Capacity Building (HED) [কম্পে·নন্টে ৪(২), পৃষ্ঠা ২৯২] অংগরে ব্যয় ৫ কে·াটি টাকায়, Procurement of Goods, Operational Expenses of PWD and Capacity Building [কম্পে·নন্টে ৪(৭), পৃষ্ঠা ২৯৩] অংগরে ব্যয় ১০ কে·াটি টাকায় নর্িধারণ করতে হবে।	প্রকল্প বাস্তবায়ন, পরদির্শন ও পর্যবক্ষেণ কাজ সুচারুরূপে সম্পন্নরে লক্ষ্যে Procurement of Goods and Operational Expenses of HED অংগরে ব্যয় ১৫ কে·াটি টাকায়, Capacity Building (HED) অংগরে ব্যয় ৫ কে·াটি টাকায়, Procurement of Goods, Operational Expenses of PWD and Capacity Building অংগরে ব্যয় ১০ কে·াটি টাকায় নর্িধারণ করা হয়ছে।
২২।	সরকারি মূল্যবান জমরি সর্বে·াত্তম ব্যবহার নশ্চিতি করার স্বার্থে সক্টের কর্মসূচরি আওতায় পরকিল্পতিভাবে সকল ভবন নর্িমাণ করতে হবে। জমরি সর্বে·াত্তম ব্যবহার নশ্চিতি করার লক্ষ্যে অনকে ভবন নর্িমাণ না করে বশেী উচ্চতার ভবন নর্িমাণ করে একই ভবনে বভিন্নি কার্যক্রম পরচিালনা করা যতেে পার।	সরকারি মূল্যবান জমরি সর্বে·াত্তম ব্যবহার নশ্চিতি করার স্বার্থে সক্টের কর্মসূচরি আওতায় পরকিল্পতিভাবে সকল ভবন নর্িমাণ করা হব।
	অপারশেনাল প্ল্যান ১৫ ((Improved Financial Management)	
১।	All LD, PM, DPM & DDOs & others অঙ্গরে ব্যয় ১.৫০ কে·াটি টাকায় নর্িধারণ করতে হবে।	সদ্ধিান্ত অনুযায়ী এ অঙ্গরে ব্যয় ১.৫০ কে·াটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২।	বদৈশেকি প্রশক্ষিণ অঙ্গরে ব্যয় ১.২০ কে·াটি টাকায় নর্িধারণ করতে হবে।	সদ্ধিান্ত অনুযায়ী বদৈশেকি প্রশক্ষিণ অঙ্গরে ব্যয় ১.২০ কে·াটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-১৬ (Maternal, Neonatal Child and Adolescent Health)	
১।	স্বাস্থ্য সবো খাতে উপজলো পর্যায়ে কর্মরত চকিি□সকদরে Anaesthesia বষিয়ে প্রশক্ষিণ	স্বাস্থ্য সবো খাতে উপজলো পর্যায়ে কর্মরত চকিি□সকদরে Anaesthesia বষিয়ে প্রশক্ষিণ কার্যক্রম আরে·া গতশিীল করা

ক্রঃ নং	পইিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	কার্যক্রম আরো গতশীল করতে হবে এবং প্রশক্ষিণপ্রাপ্ত চকিি□সকদরে উপজলো পর্যায়ে কাজ করা নশ্চিতি করতে হবে।	হবে। প্রশক্ষিণপ্রাপ্ত চকিি□সকদরে উপজলো পর্যায়ে কাজ করার বষিয়ে প্রয়োজনীয় ব্যবস্থা গ্রহণ করা হবে।
২।	Procurement of Consumable stores, MSR, Medicine and instrument [কম্পোনেন্ট i (a) (6), পৃষ্ঠা ৩১১] অংগরে ব্যয় ৫৫ কোটি টাকায় নর্িধারণ করতে হবে।	Procurement of Consumable stores, MSR, Medicine and instrument অংগরে ব্যয় হ্রাস করে ৫৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৩।	Demand side Financing (DSF) [কম্পোনেন্ট i (a) (10), পৃষ্ঠা ৩১১] অংগরে ব্যয় ১৪০ কোটি টাকায় নর্িধারণ করতে হবে।	Demand side Financing (DSF) অংগরে ব্যয় হ্রাস করে ১৪০ কোটি টাকায় পুনঃনর্িধারণ করা হলো।
৪।	Support to the fields for ensuring quality vaccination session [কম্পোনেন্ট ii (a) (5), পৃষ্ঠা ৩১২] অংগরে ব্যয় ১২০ কোটি টাকায় নর্িধারণ করতে হবে।	Support to the fields for ensuring quality vaccination session অংগরে ব্যয় হ্রাস করে ১২০ কোটি টাকায় পুনঃনর্িধারণ করা হলো।
৫।	Operation cost [কম্পোনেন্ট ii (a) (5), পৃষ্ঠা ৩১২] অংগরে ব্যয় ৮৫ কোটি টাকায় নর্িধারণ করতে হবে।	Operation cost অংগরে ব্যয় ৮৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৬।	আলোচ্য ওপি'র আওতায় শুধুমাত্র DPA অর্থে যে সকল যানবাহন ক্রয়রে প্রস্তাব করা হয়ছে তা সংগ্রহ করতে হবে।	আলোচ্য ওপি'র আওতায় শুধুমাত্র DPA অর্থায়নে যানবাহন সংগ্রহরে প্রস্তাব করা হয়ছে।
৭।	আলোচ্য ওপতিে Colposcopy, VIA, Cancer Cervix বষিয়ে যে সকল কার্যক্রম প্রস্তাব করা হয়ছে তা জাতীয় ক্যান্সার রসিার্চ ইনষ্টটিউিট ও হাসপাতাল, ঢাকা এর সাথে সমন্বয় করে বাস্তবায়ন করতে হবে।	আলোচ্য ওপতিে Colposcopy, VIA, Cancer Cervix বষিয়ে যে সকল কার্যক্রম প্রস্তাব করা হয়ছে তা জাতীয় ক্যান্সার রসিার্চ ইনষ্টটিউিট ও হাসপাতাল, ঢাকা এর সাথে সমন্বয় করে বাস্তবায়ন করা হবে।
৮।	আলোচ্য ওপরি আওতায় কোন বদৈশেকি প্রশক্ষিণ অংগ অন্তর্ভুক্ত করা যাবে না।	মাতৃ ও শশিু স্বাস্থ্যরে কাঙ্ক্ষতি লক্ষ্যমাত্রা অর্জনরে নমিত্তি মানব সম্পদ উন্নয়নরে অপরহিার্যতা ববিচেনায় কবেল আবশ্যকীয় ক্ষত্রেে যৌক্তকিভাবে বদৈশেকি প্রশক্ষিণরে সংস্থান রাখা হয়ছে।
	অপারশেনাল প্ল্যান-১৭ (Maternal, Child, Reproductive and Adolescent Health)	
১।	কম্পোনেন্ট ১ (Strengthening Health Care Series) এর সাবকম্পোনেন্ট a এর আওতায় বরাদ্দসমূহ অপরবির্ততি থাকব।	কম্পোনেন্ট ১ (Strengthening Health Care Services) এর সাবকম্পোনেন্ট a এর বরাদ্দ অপরবির্ততি রাখা হয়ছে।
২।	সাবকম্পোনেন্ট c (adolescent health care services) এর প্রস্তাবতি বরাদ্দ যৌক্তকিভাবে হ্রাস করতে হবে।	সাবকম্পোনেন্ট c (adolescent health care services) এর প্রস্তাবতি বরাদ্দ যৌক্তকিভাবে হ্রাস করা হয়ছে।
৩।	কম্পোনেন্ট-৩ (Capacity building of Service	সদ্ধিান্ত অনুযায়ী মাঠ পর্যায়রে কর্মীদরে প্রাধান্য দয়ো হবে।

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	provider) এ ১ ক্রমকিে Overseas Conference এবং ২ ক্রমকিে workshop এ মাঠ পর্যায়রে কর্মীদরে প্রাধান্য দতিে হবে।	
৪।	কম্পে·ানন্টে ৯ (Miscellaneous & Support Service) এর ১০ ক্রমকিে প্রস্তাবতি ৩৬ টি যানবহন ক্রয়রে প্রস্তাব অপরবির্ততি থাকব।	কম্পে·ানন্টে ৯ (Miscellaneous & Support Service) এর ১০ ক্রমকিে প্রস্তাবতি ৩৬ টি যানবাহন ক্রয়রে প্রস্তাব অপরবির্ততি রাখা হয়ছে।
	অপারশেনাল প্ল্যান-১৮ (National Nutrition Services)	
১।	স্বাস্থ্য অধদিপ্তর ও পরবিার পরকিল্পনা অধদিপ্তররে সাথে যথাযথভাবে সমন্বয় করে আলে·াচ্য ওপরি কার্যক্রম বাস্তবায়ন করতে হবে।	স্বাস্থ্য অধদিপ্তর ও পরবিার পরকিল্পনা অধদিপ্তররে সাথে যথাযথভাবে সমন্বয় করে আলে·াচ্য ওপরি কার্যক্রম বাস্তবায়ন করা হব।
২।	Multi sectoral Coordination [Page-353, C-2] অংগরে ব্যয় ৫.০০ কে·াটি টাকায় নর্িধারণ করতে হবে।	Multi sectoral Coordination অংগরে ব্যয় ৫.০০ কে·াটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৩।	Training [Page-351, A.5 (2)] অংগরে ব্যয় ২০.০০ কে·াটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Training অংগরে ব্যয় ২০.০০ কে·াটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৪।	Orientation [Page-352, A.6 (2)] অংগরে ব্যয় ৭.০০ কে·াটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Orientation অংগরে ব্যয় ৭.০০ কে·াটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৫।	Orientation [Page-353, A.9 (4)] অংগরে ব্যয় ৫.০০ কে·াটি টাকায় নর্িধারণ করতে হবে।	Orientation অংগরে ব্যয় ৫.০০ কে·াটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৬।	SBCC related Campaign [Page-353, A.11 (3)] অংগরে ব্যয় ৩৫.০০ কে·াটি টাকায় নর্িধারণ করতে হবে।	SBCC related Campaign অংগরে ব্যয় ৩৫.০০ কে·াটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৭।	Supportive Supervision [Page-356, C3 (3)] অংগরে ব্যয় ৩০.০০ কে·াটি টাকায় নর্িধারণ করতে হবে।	Supportive Supervision অংগরে ব্যয় ৩০.০০ কে·াটি টাকায় নর্িধারণ করা হয়ছে।
৮।	Office Management Cost [Page-356, C3 (7)] অংগরে ব্যয় ২৫.০০ কে·াটি টাকায় নর্িধারণ করতে হবে।	Office Maintenance Cost অংগরে ব্যয় ২৫.০০ কে·াটি টাকায় নর্িধারণ করা হয়ছে।
৯।	Monitoring [Page-357, C7 (1)] অংগরে ব্যয় ৪.০০ কে·াটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Monitoring অংগরে ব্যয় ৪.০০ কে·াটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১০।	Survey, Surveillance and Research [Page-357, C7 (2)] অংগরে ব্যয় ৭.০০ কে·াটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Survey, Surveillance and Research অংগরে ব্যয় ৭.০০ কে·াটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১১।	আলে·াচ্য ওপরি আওতায় কে·ান বদৈশেকি প্রশকি্ষণ অংগ অন্তর্ভুক্ত করা যাবে না।	পুষ্টি উপ-খাতরে কাঙ্ক্ষতি লক্ষ্যমাত্রা অর্জনরে নমিত্তি মানব সম্পদ উন্নয়নরে অপরহিার্যতা ববিচেনায় কবেল আবশ্যকীয় ক্ষত্রেে যে·ৌক্তকিভাবে বদৈশেকি প্রশকি্ষণরে

ক্রঃ নং	পইিসি সিভার সদি্ধান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
		সংস্থান রাখা হয়ছে।
	অপারশেনাল প্ল্যান-১৯ (Communicable Disease Control)	
১	আলে াচ্য ওপি'র Research/Survey অংগে ২০.০০ কে াটি টাকা ব্যয় প্রাক্কলন করতে হব। প্রতি তনি মাস অন্তর Research/Survey ফলাফল Disseminate করার জন্য সমেনিার আয়ে াজন করতে হব।	আলে াচ্য ওপি'র Research/Survey অংগরে ব্যয় হ্রাস করে ২০.০০ কে াটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে। প্রতি তনি মাস অন্তর Research/Survey ফলাফল Disseminate করার জন্য সমেনিার আয়ে াজন করা হব।
২	ওপতিে ১টি জীপ, ২টি ডাবল কবেনি পকি-আপ এবং ৪টি মাইক্রে াবাস সংগ্রহ করার ব্যয় প্রাক্কলন করতে হব। এর অতরিক্তি কে ান যানবাহন আলে াচ্য ওপরি আওতায় সংগ্রহ করা যাবে না।	ওপতিে ১টি জীপ, ২টি ডাবল কবেনি পকি-আপ এবং ৪টি মাইক্রে াবাস সংগ্রহ করার ব্যয় প্রাক্কলন কর হয়ছে।
৩	স্থানীয় ও বদৈশেকি প্রশক্ষিণ অংগসমূহ আলাদাভাবে অন্তর্ভুক্তপূর্বক স্থানীয় প্রশক্ষিণ অংগরে প্রশক্ষিণ অংগরে ব্যয় যৌক্তকি পর্যায়ে হ্রাস করতে হবে এবং বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ২.০০ কে াটি টাকার মধ্যে সীমাবদ্ধ রাখতে হব।	সদি্ধান্ত অনুযায়ী স্থানীয় প্রশক্ষিণ এবং বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় হ্রাস করা হয়ছে। বস্তিারতি ওপতিে স্থানীয় ও বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় যথাযথভাবে প্রতফিলন করা হব।
৪।	পট্রেে াল/গ্যাস/ফুয়লে অংগরে ব্যয় ৫.০০ কে াটি টাকার মধ্যে সীমাবদ্ধ রাখতে হব।	সদি্ধান্ত অনুযায়ী পট্রেে াল/গ্যাস/ফুয়লে অংগরে ব্যয় ৫.০০ কে াটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৫।	আলে াচ্য ওপরি Acquisition of Asset অংগরে ব্যয় ১৫.০০ কে াটি টাকায় নর্িধারণ করতে হব।	আলে াচ্য ওপরি Acquisition of Asset অংগরে ব্যয় হ্রাস করে ১৫.০০ কে াটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৬।	Other Expenses [কম্পে ানেন্টে ১(১২), পৃষ্ঠা ৩৬৮] অংগরে ব্যয় ১৫.০০ কে াটি টাকায় নর্িধারণ করতে হব।	Other Expenses অংগরে ব্যয় হ্রাস করে ১৫.০০ কে াটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৭।	আলে াচ্য ওপি'র Surveillance অংগরে ব্যয় মে াট ১০.০০ কে াটি টাকায় নর্িধারণ করতে হব।	আলে াচ্য ওপি'র Surveillance অংগরে ব্যয় হ্রাস করে ১০.০০ কে াটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৮।	Capacity Building etc. [কম্পে ানেন্টে iv(৯), পৃষ্ঠা ৩৭৩] অংগরে ব্যয় ৭.০০ কে াটি টাকায় নর্িধারণ করতে হব। এছাড়া Sensitization of Doctors etc. [কম্পে ানেন্টে iv(১০), পৃষ্ঠা ৩৭৩] অংগরে ব্যয় ৪.০০ কে াটি টাকার মধ্যে সীমাবদ্ধ রাখতে হব।	Capacity Building etc. অংগরে ব্যয় হ্রাস করে ৫.৯০ কে াটি টাকায় পুনঃ নর্িধারণ করা হয়ছে। এছাড়া Sensitization of Doctors etc. অংগরে ব্যয় হ্রাস করে ৪.০০ কে াটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৯।	Containment emerging health problems etc. [কম্পে ানেন্টে iv(১৫), পৃষ্ঠা ৩৭৪] অংগরে ব্যয় ৮.০০ কে াটি টাকায় নর্িধারণ করতে হব।	Containment emerging health problems etc. অংগরে ব্যয় হ্রাস করে ৮.০০ কে াটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-২০ (Tuberculosis Leprosy and Aids/STD Program)	
১।	আলে াচ্য ওপরি আওতায় যে সকল NGO সরকাররে সাথে কাজ করবে তাদরে performance মূল্যায়নে	সদি্ধান্ত অনুযায়ী যে সকল NGO সরকাররে সাথে কাজ করবে তাদরে performance মূল্যায়নে যথাযথ ব্যবস্থা গ্রহণ করা

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	যথাযথ ব্যবস্থা গ্রহণ করতে হবে।	হবে।
২।	বশ্বি স্বাস্থ্য সংস্থার ভশিন অনুযায়ী যক্ষা ও কুষ্ঠ রোগ নর্িমূলে আলোচ্য ওপরি আওতায় যথাযথ পদক্ষপে গ্রহণ করতে হবে।	বশ্বি স্বাস্থ্য সংস্থার ভশিন অনুযায়ী যক্ষা ও কুষ্ঠ রোগ নর্িমূলে যথাযথ পদক্ষপে গ্রহণ করা হবে।
৩।	Program Monitoring and Supervision [Page-356, Component i (5)] অংগরে ব্যয় ৪৫.০০ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Program Monitoring and Supervision অংগরে ব্যয় হ্রাস করে ৪৫.০০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৪।	Others [Page-356, Component i (13)] অংগরে ব্যয় ২.৫০ কোটি টাকায় নর্িধারণ করতে হবে।	Others অংগরে ব্যয় হ্রাস করে ২.৫০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৫।	STD and HIV prevention program for brothel based sex workers [Page-387, Component B (i) (1)] অংগরে ব্যয় ১৫ কোটি টাকায় নর্িধারণ করতে হবে।	STD and HIV prevention program for brothel based sex workers অংগরে ব্যয় হ্রাস করে ১৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৬।	STD and HIV prevention package for street based female sex workers and their clients [Page-387, Component B (i) (2)] অংগরে ব্যয় ১৫ কোটি টাকায় নর্িধারণ করতে হবে।	STD and HIV prevention package for street based female sex workers and their clients অংগরে ব্যয় হ্রাস করে ১৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৭।	STD and HIV prevention package for hotel and residence based female sex workers and their clients [Page-388, Component B (i) (3)] অংগরে ব্যয় ১৫ কোটি টাকায় নর্িধারণ করতে হবে।	STD and HIV prevention package for hotel and residence based female sex workers and their clients অংগরে ব্যয় হ্রাস করে ১৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৮।	STD and HIV prevention package for MSM/MSW/TG and their clients [Page-388, Component B (i) (4)] অংগরে ব্যয় ১৫ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	STD and HIV prevention package for MSM/MSW/TG and their clients অংগরে ব্যয় হ্রাস করে ১৫ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৯।	Harm reduction package for male and female PWID [Page-388, Component B (i) (5)] অংগরে ব্যয় ৩৫ কোটি টাকায় নর্িধারণ করতে হবে।	Harm reduction package for male and female PWID অংগরে ব্যয় হ্রাস করে ৩৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১০।	Opioid substitution therapy (OST) package for male and female PWID [Page-388, Component B (i) (6)] অংগরে ব্যয় ১৫ কোটি টাকায় নর্িধারণ করতে হবে।	Opioid substitution therapy (OST) package for male and female PWID অংগরে ব্যয় হ্রাস করে ১৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১১।	HIV prevention program for External Migrant workers and their partners [Page-388, Component B (i) (7)] অংগরে ব্যয় ২৫ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	HIV prevention program for External Migrant workers and their partners [Page-388, Component B (i) (7)] অংগরে ব্যয় ২৫ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১২।	Migration and development: Cross border	Migration and development: Cross border intervention

ক্রঃ নং	পহিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	intervention [Page-388, Component B (i) (8)] অংগরে ব্যয় ১০ কো:টি টাকায় নর্িধারণ করতে হবে।	অংগরে ব্যয় হ্রাস করে ১০ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৩।	HTC center established and continuation as per geographical priorities areas [Page-389, Component B (ii) (1)] অংগরে ব্যয় ১৫ কো:টি টাকায় নর্িধারণ করতে হবে।	HTC center established and continuation as per geographical priorities areas অংগরে ব্যয় হ্রাস করে ১৫ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৪।	CST service with drug adherence, monitoring and community sencitization [Page-389, Component B (ii) (2)] অংগরে ব্যয় ১০ কো:টি টাকায় নর্িধারণ করতে হবে।	CST service with drug adherence, monitoring and community sencitization অংগরে ব্যয় হ্রাস করে ১০ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৫।	Higher level advocacy for creating enabling environment monitoring and supervision [Page-390, Component B (ii) (2)] অংগরে ব্যয় ৭ কো:টি টাকায় নর্িধারণ করতে হবে।	Higher level advocacy for creating enabling environment monitoring and supervision অংগরে ব্যয় হ্রাস করে ৭ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৬।	স্থানীয় ও বদৈশেকি প্রশক্ষিণ অংগসমূহ আলাদাভাবে অন্তর্ভুক্ত করতে হবে। বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় মো:ট ১ কো:টি টাকায় নর্িধারণ করতে হবে।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ১ কো:টি টাকায় প্রাক্কলন করা হয়ছে। বস্তিারতি ওপতিে স্থানীয় ও বদৈশেকি প্রশক্ষিণ অংগসমূহ আলাদাভাবে প্রতফিলন করা হবে।
১৭।	আলো:চ্য ওপরি আওতায় শুধুমাত্র ১টি জীপ ও ১টি মাইক্রো:বাস সংগ্রহ করতে হবে। এর অতরিক্তি মটরযান সংগ্রহ করা যাবে না। গাড়ীর সংখ্যার অনুপাতে গ্যাস/ফুয়লে/পট্রো:ল অংগরে ব্যয় নর্িধারণ করতে হবে।	আলো:চ্য ওপরি আওতায় ১টি জীপ ও ১টি মাইক্রো:বাস সংগ্রহরে প্রস্তাব করা হয়ছে। গাড়ীর সংখ্যার অনুপাতে গ্যাস/ফুয়লে/পট্রো:ল অংগরে ব্যয় পুনঃনর্িধারণ করা হয়ছে।
১৮।	Office Maintenance cost এর আওতায় Advocacy/seminar cost [Page-392, Component B (iv) (6)] অংগরে ব্যয় ৪ কো:টি টাকায় নর্িধারণ করতে হবে।	Office Maintenance cost এর আওতায় অংগরে ব্যয় হ্রাস করে ৪ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৯।	Office Maintenance cost এর আওতায় World AIDS day celebration across the country [Page-392, Component B (iv) (7)] অংগরে ব্যয় ৪ কো:টি টাকায় নর্িধারণ করতে হবে।	Office Maintenance cost (Advocacy/seminar (এর আওতায় World AIDS day celebration across the country অংগরে ব্যয় হ্রাস করে ৪ কো:টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-২১ (Non-Communicable Disease Control)	
১।	অটজিম ও Neuro Disorder বষিয়ে বশিষে নজর দতিে হবে এবং উন্নত সবো প্রদানে জো:র পদক্ষপে গ্রহণ করতে হবে।	অটজিম ও Neuro Disorder বষিয়ে বশিষে নজর দয়িে উন্নত সবো প্রদানে জো:র পদক্ষপে গ্রহণ করা হচ্ছ।
২।	দশেরে প্রান্তকি জনগো:ষ্ঠীকে বভিন্নি নন-কমউিনকিবেল ডজিজিজে (হৃদরো:গ, ডায়াবটেকি,	দশেরে প্রান্তকি জনগো:ষ্ঠীকে বভিন্নি নন-কমউিনকিবেল ডজিজিজে (হৃদরো:গ, ডায়াবটেকি, ক্যান্সার ও সওিপডি) এর

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	ক্যান্সার ও সিওপডিি) এর পর্যাপ্ত উন্নত সবো প্রদানরে জন্য আলোচ্য ওপরি আওতায় কার্যকর পদক্ষপে গ্রহণ করতে হবে।	পর্যাপ্ত উন্নত সবো প্রদানরে জন্য আলোচ্য ওপরি আওতায় কার্যকর পদক্ষপে গ্রহণ করা হয়ছে।
৩।	Monitoring and Evaluation [Page-417, Component i (8)] অংগরে ব্যয় ৭ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Monitoring and Evaluation অংগরে ব্যয় হ্রাস করে ৭ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৪।	Referral [Page-417, Component i(3)] অংগরে ব্যয় ৩.৮০ কোটি টাকায় এবং Multi-Sectoral Coordination [Page-417, Component i (5)] অংগরে ব্যয় ১৫ লক্ষ টাকায় নর্িধারণ করতে হবে।	Referral অংগরে ব্যয় ৩.৮০ কোটি টাকায় এবং Multi-Sectoral Coordination অংগরে ব্যয় ১৫ লক্ষ টাকায় পুনঃনর্িধারণ করা হয়ছে।
৫।	Formation of Mental Health Team, Development of Mental Health Strategy, Supply of Psychotropic and antiepileptic Drugs [Page-417, Component ii (3, 6, 7, 11, 14, 15)] অংগসমূহরে ব্যয় একবার করে প্রাক্কলন করে ব্যয় যথাক্রমে ৪.৬০ কোটি টাকা, ১ কোটি টাকা এবং ৩.৯০ কোটি টাকায় নর্িধারণ করতে হবে।	Formation of Mental Health Team, Development of Mental Health Strategy, Supply of Psychotropic and antiepileptic Drugs অংগসমূহরে ব্যয় একবার করে প্রাক্কলন করে ব্যয় যথাক্রমে ৪.৬০ কোটি টাকা, ১ কোটি টাকা এবং ৩.৯০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৬।	Public awareness program [Page-417, Component ii (5)] অংগরে ব্যয় ৬ কোটি টাকায় নর্িধারণ করতে হবে।	Public awareness program অংগরে ব্যয় হ্রাস করে ৬ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৭।	Post disaster mental health and psychosocial support [Page-417, Component ii (8)] অংগরে ব্যয় ৬ কোটি টাকায় নর্িধারণ করতে হবে।	Post disaster mental health and psychosocial support অংগরে ব্যয় হ্রাস করে ৬ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৮।	Mental & Neurological Health, Autism & Neurodevelopment Disorder and Alcohol [Page: 418-420, Component ii] এর ১১-৩৬ পর্যন্ত Activities গুলোর মধ্যে অসামঞ্জস্যতা পরলিক্ষতি হয় বধিায় তা দূর করতে হবে। এ সকল অংগরে ব্যয় যৌক্তকি পর্যায়ে হ্রাস করতে হবে।	Mental & Neurological Health, Autism & Neurodevelopment Disorder and Alcohol এর ১১-৩৬ পর্যন্ত Activities গুলোর মধ্যে অসামঞ্জস্যতা দূর করা হয়ছে। এ সকল অংগরে ব্যয় যৌক্তকিভাবে হ্রাস করে ৭৪.৫১ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৯।	Awareness building on common people on Alcohol [Page: 420, Component (1-4)] অংগরে ব্যয় ২০ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Awareness building on common people on Alcohol অংগরে ব্যয় হ্রাস করে ২০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১০।	Education and publicity-improved knowledge and behaviour of road user etc. [Page-420, Component iii (a) (1)] অংগরে ব্যয় ১০ কোটি টাকায় নর্িধারণ করতে হবে।	Education and publicity-improved knowledge and behaviour of road user etc. অংগরে ব্যয় হ্রাস করে ১০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১১।	Education and publicity-improved knowledge	Education and publicity-improved knowledge and

ক্রঃ নং	পরিসংসভার সিদ্ধান্ত	স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	and behaviour of road user etc. [Page-420, Component iii (a) (1)] অংগরে ব্যয় ১০ কোটি টাকায় নির্ধারণ করতে হবে।	behaviour of road user etc. অংগরে ব্যয় হ্রাস করে ১০ কোটি টাকায় পুনঃনির্ধারণ করা হয়ছে।
১২।	Training on pre hospital care by the first responder and comprehensive training etc. [Page-421, Component iii (a) (2)] অংগরে ব্যয় ৭ কোটি টাকায় নির্ধারণ করতে হবে।	Training on pre hospital care by the first responder and comprehensive training etc. অংগরে ব্যয় হ্রাস করে ৭ কোটি টাকায় পুনঃনির্ধারণ করা হয়ছে।
১৩।	Collaboration between relevant sectors/ department/ agencies for injury information etc. [Page-421, Component iii (b) (1)] অংগরে ব্যয় ১ কোটি টাকায় নির্ধারণ করতে হবে।	Collaboration between relevant sectors/department/agencies for injury information etc. অংগরে ব্যয় হ্রাস করে ১ কোটি টাকায় পুনঃনির্ধারণ করা হয়ছে।
১৪।	Prevention of Drowning [Page: 421-422, Component iii (c) (1-3)] অংগরে ব্যয় ১০.০০ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Prevention of Drowning অংগরে ব্যয় হ্রাস করে ১০.০০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১৫।	Prevention and treatment of snakebite including animal injury [Page: 423-424, Component iii (f) (1-6)] অংগরে ব্যয় ৩৫ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Prevention and treatment of snakebite including animal injury অংগরে ব্যয় হ্রাস করে ৩৫ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১৬।	Emergency Preparedness and Response (EPR), post disaster health management অংগরে Establishment of Buffer stock of drugs and logistics for EPR [Page: 425, Component iii (i) (3)] অংগরে ব্যয় ২০ কোটি টাকায় নির্ধারণ করতে হবে। এছাড়া Emergency Preparedness and Response (EPR), post disaster health management অংগরে [Page: 425-426, Component iii (i) (1-2, 4-9)] অংগসমূহরে ব্যয় ১৫ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Emergency Preparedness and Response (EPR), post disaster health management অংগরে Establishment of Buffer stock of drugs and logistics for EPR অংগরে ব্যয় হ্রাস করে ২০ কোটি টাকায় পুনঃনির্ধারণ করা হয়ছে। এছাড়া Emergency Preparedness and Response (EPR), post disaster health management অংগরে অংগসমূহরে ব্যয় হ্রাস করে ১৫ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১৭।	Strengthening of mass awareness programs on arsenic free safe water drinking water [Page: 427, Component iv, Arsenicosis (3)] অংগরে ব্যয় ২ কোটি টাকায় এবং Refresher's trainging [Page: 427, Component iv, Arsenicosis (4)] অংগরে ব্যয় ৩ কোটি টাকায় নির্ধারণ করতে হবে।	Strengthening of mass awareness program on arsenic free safe water drinking water অংগরে ব্যয় হ্রাস করে ২ কোটি টাকায় এবং Refresher's training অংগরে ব্যয় হ্রাস করে ৩ কোটি টাকায় পুনঃনির্ধারণ করা হয়ছে।
১৮।	Climate Change [Page: 427-428, Component (1-4)] অংগরে ব্যয় ১০ কোটি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Climate Change অংগরে ব্যয় ১০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১৯।	Tobacco [Page: 428, Component (1-4)] অংগরে	Tobacco অংগরে ব্যয় হ্রাস করে ২৫ কোটি টাকার মধ্যে

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	ব্যয় ২৫ কো·টি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	সীমাবদ্ধ রাখা হয়ছে।
২০।	Occupational Health Injury [Page: 429, Component (1-3)] অংগরে ব্যয় ৮ কো·টি টাকার মধ্যে সীমাবদ্ধ থাকতে হবে।	Occupational Health Injury অংগরে ব্যয় হ্রাস করে ৮ কো·টি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
২১।	আলো·চ্য ওপতিে শুধুমাত্র ১টি জপি, ২টি মাইক্রো·া, ২টি পকি-আপ এবং ৩টি মটর সাইকলে সংগ্রহ করতে হবে।	আলো·চ্য ওপতিে ক্রয়রে জন্য সংস্থানকৃত ১টি জপি, ২টি মাইক্রো·াবাস, ২টি পকি-আপ এবং ৩টি মটর সাইকলে বস্তিারতি ওপতিে যথাযথভাবে প্রতফিলন করা হবে।
২২।	আলো·চ্য ওপতিে বদৈশেকি প্রশক্ষিণ অংগটি আলাদাভাবে প্রদর্শনপূর্বক এর ব্যয় ৪ কো·টি টাকায় নর্িধারণ করতে হবে।	বদৈশেকি প্রশক্ষিণ বাবদ ৪.০০ কো·টি ব্যয় প্রাক্কলন করা হয়ছে। বস্তিারতি ওপতিে বদৈশেকি প্রশক্ষিণ বাবদ ব্যয় বশিদভাবে প্রতফিলন করা হবে।
	অপারশেনাল প্ল্যান-২২ (National Eye Care)	
১।	আলো·চ্য ওপরি National Eye Care Strategy এর শরিো·নাম পরবির্তন করে National Eye Care Strategy Dissemination করতে হবে।	আলো·চ্য ওপরি 'Finalization National Eye care Strategic Plan' অংগরে শরিো·নাম পরবির্তন করে Finalization and Dissemination of National Eye care Strategic Plan করা হয়ছে।
২।	Service delivery [component 8 (9), page: 440] Demand side financing অংগরে ব্যয় ৩.০০ কো·টি টাকায় নর্িধারণ করতে হবে।	Service delivery Demand side financing অংগরে ব্যয় হ্রাস করে ৩.০০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-২৩ (Community Based Health Care)	
১।	সারাদশেরে যে সকল স্থানে এখনো·া কমউিনটিি ক্লনিকি নর্িমাণ করা সম্ভব হয়নি সে সকল কমউিনটিি ক্লনিকিসমূহ দ্রুততার সাথে নর্িমাণ সম্পন্ন করে প্রান্তকি জনগো·ষ্ঠীর প্রাথমকি স্বাস্থ্য সবো নশ্চিতি করতে হবে।	সারাদশেরে যে সকল স্থানে এখনো·া কমউিনটিি ক্লনিকি নর্িমাণ করা সম্ভব হয়নি সে সকল স্থানে দ্রুততার সাথে কমউিনটিি ক্লনিকি নর্িমাণ করে প্রান্তকি জনগো·ষ্ঠীর প্রাথমকি স্বাস্থ্য সবো নশ্চিতি করা হবে।
২।	Training at the field [Page: 455, Component A (i) (11)] অংগটি পআিইপি হতে বাদ দতিে হবে।	Training at the field অংগটি পআিইপি হতে বাদ দয়ো হয়ছে।
৩।	Training of CG and CSG with area assignment [Page: 455, Component A (i) (13)] অংগটি পআিইপি হতে বাদ দতিে হবে।	Training of CG and CSG with area assignment অংগটি পআিইপি হতে বাদ দয়ো হয়ছে।
৪।	Initiatives to undertake for proper staffing of the CC to deliver services assigned by the CC [Page: 455, Component (ii) (1)] অংগটি পআিইপি হতে বাদ দতিে হবে।	Initiatives to undertake for proper staffing of the CC to deliver services assigned by the CC অংগে কমউিনটিি ক্লনিকিসমূহে প্রাথমকি স্বাস্থ্য সবো প্রদানে নয়িো·াজতি CHCP-দরে বতেন-ভাতা বাবদ প্রয়ো·াজনীয় ব্যয় অন্তর্ভুক্ত রয়ছে। এ অংগ বাদ দয়ো হলে সরকাররে অন্যতম প্রাধকিারপ্রাপ্ত কমউিনটিি ক্লনিকি কার্যক্রম বাধাগ্রস্ত হবে। এ কারণে এ অংগটি পআিইপতিে অন্তর্ভুক্ত রাখা হয়ছে।

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
৫।	They need to be properly trained to equip them for delivering etc. [Page: 456, Component (ii) (8)] অংগরে ব্যয় ৮ কো·টি টাকায় নর্িধারণ করতে হবে।	They need to be properly trained to equip them for delivering etc. অংগরে ব্যয় ৮ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৬।	Page: 456-457 এর Component (ii) (9-12) অংগসমূহ পআিইপি হতে বাদ দতিে হবে।	Page: 456-457 এর Component (ii) (9-12) অংগসমূহ পআিইপি হতে বাদ দয়ো হয়ছে।
৭।	Supervisory lines also need to be reviewed etc. [Page: 457, Component (ii) (13)] অংগরে ব্যয় ৩০ কো·টি টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	Supervisory lines also need to be reviewed etc. অংগরে ব্যয় ৩০ কো·টি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৮।	Page: 457 এর Component (ii) (14-17) অংগসমূহ পআিইপি হতে বাদ দতিে হবে।	Page: 457 এর Component (ii) (14-17) অংগসমূহ পআিইপি হতে বাদ দয়ো হয়ছে।
৯।	আলো·চ্য ওপরি Motor vehicle [Page: 457, Component (ii) (18)] ক্রয়রে প্রস্তাব পআিইপি থকেে বাদ দতিে হবে।	আলো·চ্য ওপরি Component (ii) (18)-এ উল্লখিতি Motor vehicle ক্রয়রে প্রস্তাব পআিইপি থকেে বাদ দয়ো হয়ছে।
১০।	বদৈশেকি প্রশক্ষিণ অংগটি আলাদাভাবে প্রদর্শনপূর্বক এর ব্যয় ১৫ কো·টি টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ১৫ কো·টি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে। বস্তিারতি ওপতিে বদৈশেকি প্রশক্ষিণ কার্যক্রম যথাযথভাবে প্রতফিলন করা হবে।
১১।	A community engagement manual will be prepared etc. [Page: 458, Component (iii) (1)] অংগরে ব্যয় ১১০ কো·টি টাকায় নর্িধারণ করতে হবে। সে অনুযায়ী Page: 458-460, Component (iii) এর অন্যান্য অংগরে ব্যয় পুনঃনর্িধারণ করতে হবে।	A community engagement manual will be prepared etc. অংগরে ব্যয় ১১০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে। অনুযায়ী বাস্তবতার নরিখিে Page: 458-460, Component (iii) এর অন্যান্য অংগরে ব্যয়ও পুনঃনর্িধারণ করা হয়ছে।
১২।	Engaged periodically with the referred etc. [Page: 461, Component (iv) (7)] অংগটি পআিইপি হতে বাদ দতিে হবে।	Engaged periodically with the referred etc. অংগটি পআিইপি হতে বাদ দয়ো হয়ছে।
১৩।	Office Management Cost [Page: 462, Component (v) (10)] অংগরে ব্যয় হ্রাস করে ৬০ কো·টি টাকায় নর্িধারণ করতে হবে।	Office Management বাবদ প্রাক্কলতি ব্যয় হ্রাস করে ৬০ কো·টি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১৪।	Consultancy/TA [Page: 463, Component (v) (27)] অংগরে ব্যয় হ্রাস করে ৫ কো·টি টাকায় নর্িধারণ করতে হবে।	Consultancy/TA অংগরে ব্যয় হ্রাস করে ৫ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৫।	Day/Ceremony observation [Page: 463, Component (v) (33)] অংগরে ব্যয় ১০ কো·টি টাকায় নর্িধারণ করতে হবে।	Day/Ceremony observation অংগরে ব্যয় ১০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৬।	Other expenses [Page: 463, Component (v) (35)] অংগরে ব্যয় ৮.০০ কো·টি টাকায় নর্িধারণ	Other expenses অংগরে ব্যয় ৫.৫০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।

ক্রঃ নং	পহিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	করতে হবে।	
১৭।	Newly Recruited CHCPs will require training [Page: 464, Component (viii) (5)] অংগরে ব্যয় ২০ কো·টি টাকায় নর্িধারণ করতে হবে।	Newly Recruited CHCPs will require training অংগরে ব্যয় ২০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৮।	Repair and renovation of CC [Page: 464, Component (viii) (9)] অংগরে ব্যয় ১৫ কো·টি টাকায় নর্িধারণ করতে হবে।	Repair and renovation of CC অংগরে ব্যয় ১৫ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৯।	Repair and renovation of CC [Page: 464, Component (viii) (9)] অংগরে ব্যয় ১৫ কো·টি টাকায় নর্িধারণ করতে হবে।	Repair and renovation of CC অংগরে ব্যয় ১৫ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২০।	Operation cost of the HQ [Page: 466, Component B (i) (15)] অংগরে ব্যয় ৪ কো·টি টাকায় নর্িধারণ করতে হবে।	Operation cost of the HQ অংগরে ব্যয় ৪ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২১।	TOT and other training workshop [Page: 466, Component B (i) (17)] অংগরে ব্যয় ১০ কো·টি টাকায় নর্িধারণ করতে হবে।	TOT and other training workshop অংগরে ব্যয় ১০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২২।	Orientation and awareness meeting etc. [Page: 466, Component B (i) (21)] অংগরে ব্যয় ৫.০০ কো·টি টাকায় নর্িধারণ করতে হবে।	Orientation and awareness meeting etc. অংগরে ব্যয় ৫.০০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২৩।	Leadership training for Upazila level managers and service provider [Page: 466, Component B (i) (22)] অংগরে ব্যয় ৫ কো·টি টাকায় নর্িধারণ করতে হবে।	Leadership training for Upazila level managers and service provider অংগরে ব্যয় ৫ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২৪।	Procurement and supply medical equipment [Page: 465, Component B (i) (1)] অংগরে ব্যয় ২২০ কো·টি টাকায় নর্িধারণ করতে হবে।	Procurement and supply medical equipment অংগরে ব্যয় ২২০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২৫।	Operating cost to the newly constructed & upgraded hospital at primary level [Page: 465, Component B (i) (4)] অংগরে ব্যয় ৫০০ কো·টি টাকায় নর্িধারণ করতে হবে।	Operating cost to the newly constructed & upgraded hospital at primary level অংগরে ব্যয় ৫০০ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২৬।	আলো·চ্য ওপি ক্রয়রে জন্য প্রস্তাবতি ২টি Cross Country vehicle (Jeep) এবং ৩টি Cross Country Vehicle (Pick up) মটরযানসমূহ পআিইপি থকেে বাদ দতিে হবে।	আলো·চ্য ওপি ক্রয়রে জন্য প্রস্তাবতি ২টি Cross Country vehicle (Jeep) এবং ৩টি Cross Country Vehicle (Pick up) মটরযানসমূহ পআিইপি থকেে বাদ দয়ো হয়ছে।
২৭।	Satellite clinics [Page: 468, Component B (iv) (5)] অংগরে ব্যয় ৩ কো·টি টাকায় নর্িধারণ করতে হবে।	Satellite clinics অংগরে ব্যয় ৩ কো·টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-২৪ (Hospital Services Management)	

ক্রঃ নং	পইিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
১।	গত সক্টের কর্মসূচরি আলোচ্য ওপি'র আওতায় যে সকল যন্ত্রপাতি ও ফার্নচিার সংগ্রহ করা হয়ছে এবং এ সকল যন্ত্রপাতি কোথায় ব্যবহৃত হচ্ছে তার একটি তালকিা পআিইপি'র ভলউিম-২ তে সংযুক্ত করতে হব।	গত সক্টের কর্মসূচরি আলোচ্য ওপি'র আওতায় যে সকল যন্ত্রপাতি ও ফার্নচিার সংগ্রহ করা হয়ছে এবং এ সকল যন্ত্রপাতি কোথায় ব্যবহৃত হচ্ছে তার একটি তালকিা বস্তিারতি ওপতিে সংযুক্ত করা হব।
২।	গত সক্টের কর্মসূচরি আওতায় যে সকল যন্ত্রপাতি সংগ্রহ করা হয়ছে তা সচল ও ব্যবহারযোগ্য রাখার জন্য প্রয়োজনীয় ব্যবস্থা গ্রহণ করতে হব।	গত সক্টের কর্মসূচরি আওতায় যে সকল যন্ত্রপাতি সংগ্রহ করা হয়ছে তা সচল ও ব্যবহারযোগ্য রাখার জন্য প্রয়োজনীয় ব্যবস্থা গ্রহণ করা হব।
৩।	আলোচ্য কর্মসূচতিে এ ওপরি আওতায় যে সকল যন্ত্রপাতি ও আসবাবপত্র সংগ্রহ করা হবে তা দশেরে কোন্ কোন্ স্বাস্থ্য সবো প্রতষ্ঠিানে কী কী যন্ত্রপাতি ও আসবাবপত্র ব্যবহৃত হবে তার একটি তালকিা পআিইপি'র ভলউিম-২ তে সংযুক্ত করতে হব।	আলোচ্য ওপরি আওতায় সংগৃহীতব্য যন্ত্রপাতি ও আসবাবপত্ররে প্রতষ্ঠিানভত্তিকি তালকিা পআিইপি'র ভলউিম-২ এ সংযুক্ত করা হয়ছে। এ তালকিা আরো বশিদভাবে প্রণয়ন করে বস্তিারতি ওপতিে সংযুক্ত করা হব।
৪।	Instrument, equipment, vehicles and other assets [Page: 482, Component (1) (6)] অংগরে ব্যয় ১৫০০ কোটি টাকায় নর্িধারণ করতে হব।	Instrument, equipment, vehicles and other assets অংগরে ব্যয় ১৫০০ কোটি টাকায় পুনঃ নর্িধারণ করা হয়ছে।
৫।	Bedding and clothing [Page: 482, Component (1) (5)], MSR supplies [Page: 482, Component (1) (4)] এর অংশ বধিায় তা পআিইপি হতে বাদ দতিে হব।	Bedding and clothing এর অংশ পআিইপি হতে বাদ দয়ো হয়ছে।
৬।	Stationeries, other consumables [Page: 482, Component (1) (12)] অংগরে ব্যয় ৫০ কোটি টাকায় নর্িধারণ করতে হব।	Stationeries, other consumables অংগরে ব্যয় ৫০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৭।	Others [Page: 483, Component (1) (18)] অংগরে ব্যয় ২৫ কোটি টাকায় নর্িধারণ করতে হব।	Others [Page: 483, Component (1) (18)] অংগরে ব্যয় ২৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৮।	Bone Marrow Transport Unit-টি একটি স্বায়ত্বশাসতি প্রতষ্ঠিান BSMMU এর পরবির্তে সরকারি জাতীয় ক্যান্সার গবষেনা ইনস্টটিউিট ও হাসপাতাল ঢাকায় স্থাপন করতে হব। এর ফলে এ রোগরে চকিি□সা সবো সাশ্রয়ী মূল্যে পাওয়া যাবে বলে মনে হয়।	মাননীয় প্রধানমন্ত্রীর নর্িদশেনা অনুযায়ী BSMMU –তে একটি Bone Marrow Transport Unit স্থাপন করা হব। পাশাপাশি গুরুত্ব ববিচেনায় জাতীয় ক্যান্সার গবষেণা ইনস্টটিউিট ও হাসপাতালওে একটি Bone Marrow Transport Unit স্থাপন করা হব। এ বাবদ মোট ৪০ কোটি টাকা ব্যয়রে সংস্থান রাখা হয়ছে।
৯।	আলোচ্য ওপতিে Consultants-দরে Honorarium অংগরে ব্যয় ১.৫০ কোটি টাকায় নর্িধারণ করতে হব।	আলোচ্য ওপতিে Consultants-দরে Honorarium অংগরে ব্যয় ১.৫০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১০।	আলোচ্য ওপতিে ক্রয়রে জন্য প্রস্তাবতি Cross-	আলোচ্য ওপতিে ক্রয়রে জন্য প্রস্তাবতি Cross-country

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	country vehicle এবং mobile operation theater সংগ্রহরে প্রস্তাব পআিইপি হতে বাদ দতিে হবে।	vehicle এবং mobile operation theater সংগ্রহরে প্রস্তাব পআিইপি হতে বাদ দয়ো হয়ছে।
১১।	বভিন্নি হাসপাতালে স্থাপতিব্য ICU, CCU, NICU and Dialysis unit এ প্রয়োজনীয় দক্ষ জনবল পদায়নরে ব্যবস্থা গ্রহণ করতে হবে।	বভিন্নি হাসপাতালে স্থাপতিব্য ICU, CCU, NICU and Dialysis unit এ প্রয়োজনীয় দক্ষ জনবল পদায়নরে ব্যবস্থা গ্রহণ করা হবে।
১২।	Voluntary blood donor pool [Page: 486, Component (5) (2)] অংগরে ব্যয় ১২ কোটি টাকায় নর্িধারণ করতে হবে।	Voluntary blood donor pool অংগরে ব্যয় ১২ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৩।	Transfusion transmissible infection & Quality Control [Page: 486, Component (5) (5)] অংগরে ব্যয় ১০ কোটি টাকায় নর্িধারণ করতে হবে।	Transfusion transmissible infection & Quality Control অংগরে ব্যয় ১০ কোটি টাকায় পুনঃনর্িধারণ করা হবে।
১৪।	Supply of logistics and consumables [Page: 486, Component (5) (6)] অংগরে ব্যয় ২০০ কোটি টাকায় নর্িধারণ করতে হবে।	Supply of logistics and consumables অংগরে ব্যয় ২০০ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৫।	Orientation and capacity development of all stakeholders [Page: 487, Component (7) (3)] অংগরে ব্যয় ৫ কোটি টাকায় নর্িধারণ করতে হবে।	Orientation and capacity development of all stakeholders অংগরে ব্যয় ৫ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৬।	Workshop and orientation of service providers regarding patient safety issues [Page: 488, Component (8) (2)] অংগরে ব্যয় ৩ কোটি টাকায় নর্িধারণ করতে হবে।	Workshop and orientation of service providers regarding patient safety issues অংগরে ব্যয় ৩ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৭।	বদৈশেকি প্রশক্ষিণ অংগটি আলাদাভাবে প্রদর্শনপূর্বক এর ব্যয় ৪.০০ কোটি টাকায় নর্িধারণ করতে হবে।	বদৈশেকি প্রশক্ষিণ বাবদ ৪.০০ কোটি টাকা ব্যয় প্রাক্কলন করা হয়ছে। বস্তিারতি ওপতিে বদৈশেকি প্রশক্ষিণ বাবদ প্রাক্কলতি ব্যয় বশিদভাবে প্রতফিলন করা হবে।
১৮।	Capacity development of LD offices এর Supplies and others [Page: 489, Component (2)] অংগরে ব্যয় ৭ কোটি টাকায় নর্িধারণ করতে হবে।	Capacity development of LD offices এর Supplies and others অংগরে ব্যয় ৭ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
১৯।	রাজস্বধর্মী কাজরে [Water and electricity {Page: 482, Component (1) (11)}] ব্যয় রাজস্ব খাত থকেে নর্িবাহরে ব্যবস্থা গ্রহণ করতে হবে।	রাজস্বধর্মী কাজরে Water and electricity ব্যয় রাজস্ব খাত থকেে নর্িবাহরে জন্য প্রয়োজনীয় ব্যবস্থা নয়ো হচ্ছ। মধ্যবর্তী সময়রে জন্য ওপতিে যৌক্তকিভাবে প্রয়োজনীয় ব্যয়রে সংস্থান রাখা হয়ছে।
	অপারশেনাল প্ল্যান-২৫ (Clinical Contraception Services Delivery Program)	
১।	কম্পোনেন্ট ১ ও ২ (Ensuring availability of LARC and PM Contraceptives & MSR) এর ভৌত পরমিাণ ও বরাদ্দসমূহ যৌক্তকিভাবে প্রয়োজনরে নরিখিে নর্িধারণ করতে হবে।	সদ্ধিান্ত অনুযায়ী কম্পোনেন্ট ১ ও ২ এর ভৌত পরমিাণ ও বরাদ্দ যৌক্তকিভাবে পুনঃনর্িধারণ করা হয়ছে।
২।	কম্পোনেন্ট ৩ এর ১ ক্রমকিে (Peer activities	কম্পোনেন্ট ৩ এর ১ ক্রমকিে বর্ণতি Peer activities paid

ক্রঃ নং	পহিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	paid volunteer) এবং ২নং ক্রমকিে উঠান বঠৈক ডজিএিইচএস এর সাথে সমন্বয় করে একসাথে করার প্রয়াস নতিে হবে এবং এ বাবদ বরাদ্দ যৌক্তকিভাবে হ্রাস করতে হবে।	volunteer কার্যক্রম পর্যায়ক্রমে দশেরে ৯০টি উপজলোয় (দুর্গম ও কম অগ্রগতি সম্পন্ন এলাকা) বাস্তবায়ন করা হবে। Regional Services Package এর আওতায় Peer activities paid volunteer এর কার্যক্রম বাস্তবায়ন করা হবে। পহিসি সভার সদ্ধিান্ত অনুযায়ী বাস্তবতার নরিখিে এ বাবদ লক্ষ্যমাত্রা যৌক্তকিভাবে পুনঃনর্িধারণ করা হয়ছে। অর্থ বভিাগ কর্তৃক অনুমোদতি হারে Peer activities paid volunteer-দরে ব্যয় যৌক্তকিভাবে প্রস্তাব করা হয়ছে। এ কার্যক্রমরে বরাদ্দ হ্রাস করা হলে Regional Services Package এর কার্যক্রম বাস্তবায়ন বাধাগ্রস্থ হবে। কম্পোনেন্ট ৩ এর ২ ক্রমকিরে আওতায় Young Married Couple (YMC) -দরে নয়িে উঠান বঠৈক কার্যক্রম বাস্তবায়ন করা হবে। সমমনা YMC -দরে নয়িে অনুষ্ঠতি উঠান বঠৈকে YMC-দরে LARC কার্যক্রম গ্রহণে উদ্বুদ্ধকরা হয়ে থাকে। 8র্থ সক্টের কর্মসূচতিে মাঠ পর্যায়ে ডজিএিইচএস এবং ডজিএিফপরি কার্যক্রমরে সমন্বয়রে ক্ষত্রে সম্পর্কে প্রদত্ত নর্িদশেনার আলোকে স্বাস্থ্য অধদিপ্তররে সাথে সমন্বয় করে এ কার্যক্রম বাস্তবায়ন করা হবে।
৩।	কম্পোনেন্টে 8 এর ১নং ক্রমকিে প্রস্তাবতি ৯৫ সংখ্যক যানবাহনরে পরবির্তে ৭৬টি (৬৪টি জীপ ও ১২টি মাইক্রোবাস) ক্রয় করা যাবে এবং সে মতে রক্ষণাবক্ষেণ ব্যয় যৌক্তকিভাবে হ্রাস করতে হবে। অর্থ বভিাগ হতে ড্রাইভার আউটসোর্সিং এর সম্মতি পাওয়া সাপক্ষেে এসব যানবাহন ক্রয় করা যাবে।	পরকিল্পনা কমশিনরে সদ্ধিান্ত অনুযায়ী ৭৬টি গাড়রি সংস্থান রখেে এ বাবদ প্রাক্কলতি ব্যয় যৌক্তকিভাবে হ্রাস করা হয়ছে। রক্ষণাবক্ষেণ ব্যয়ও বাস্তবতার নরিখিে হ্রাস করা হয়ছে। অর্থ বভিাগ হতে ড্রাইভার আউটসোর্সিং-এর সম্মতি পাওয়া সাপক্ষেে এসব যানবাহন ক্রয় করা হবে।
৪।	কম্পোনেন্ট 8 এর ১নং ক্রমকিে প্রস্তাবতি বদৈশেকি প্রশক্ষিণরে সংখ্যা/ব্যাচ পআিইপি-তে উল্লখে করতে হবে। অন্যান্য ট্রনেংি এ মাঠপর্যায়রে কর্মীদরে প্রাধান্য দতিে হবে।	কম্পোনেন্ট 8-এর ১নং ক্রমকিে প্রস্তাবতি বদৈশেকি প্রশক্ষিণরে সংখ্যা/ব্যাচ (৩০০ জন প্রশক্ষিণার্থী, ২৫ ব্যাচ) পআিইপি-তে উল্লখে করা হয়ছে। অন্যান্য ট্রনেংি এ মাঠপর্যায়রে কর্মীদরে প্রাধান্য দয়ো হবে।
	অপারশেনাল প্ল্যান- ২৬ (Family Planning Field Service Delivery)	
১।	ওপি ২৫ (Clinical Contraception Services Delivery Program) এবং ওপি ২৬ (Family Planning Field Service Delivery) এর কার্যক্রম একই ধরনরে হওয়ায় দুটি ওপরি কার্যক্রম সমন্বয়পূর্বক একসাথে পরচিালনা করা হলে সময় ও ব্যয় দুটোই সাশ্রয় হবে। এ বষিয়ে DGFP প্রয়োজনীয় কার্যক্রম গ্রহণ করবে।	পরবিার পরকিল্পনা অধদিপ্তররে Clinical Contraception Services Delivery Program (ওপি ২৫) এর আওতায় স্থায়ী ও দীর্ঘ ময়োদী পরবিার পরকিল্পনা পদ্ধতি (আইইউডি, ইমপ্ল্যান্ট, ইঞ্জক্টেবেল ইত্যাদি) গ্রহীতার হার বৃদ্ধরি জন্য প্রয়োজনীয় কার্যক্রম বাস্তবায়ন করা হয়ে থাকে। অপরদকিে Family Planning Field Service Delivery ওপরি (ওপি ২৬) আওতায় পরবিার পরকিল্পনার অস্থায়ী জন্মনয়িন্ত্রণ

ক্রঃ নং	পইিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
		সামগ্রী (ইনজকেশন, খাবার বড়ি ও কনডম) ক্রয় ও বতিরণ করা হয়ে থাকে। যথাযথ সমন্বয়রে মাধ্যমে এ দু'টি ওপরি কার্যক্রম চহ্নিতিকরণ ও ব্যয় প্রাক্কলন করা হয়ছে। পইিসি সভার সদ্ধিান্ত অনুযায়ী সময় ও ব্যয় সাশ্রয়রে জন্য বাস্তবায়ন পর্যায়ওে এ দু'টি ওপি'র যথাযথ সমন্বয় প্রক্রয়িা অব্যাহত থাকব। জন্ম নয়িন্ত্রণে পদ্ধতি গ্রহণে উদ্বুদ্ধকরণরে জন্য এ দু'টি ওপরি মধ্যে মাঠ পর্যায়রে কার্যক্রমসমূহ যথাযথভাবে সমন্বয়পূর্বক যৌথভাবে পরচিালনা করা হব।
	অপারশেনাল প্ল্যান-২৭ (Lifestyle, and Health Education and Promotion)	
১।	আলোচ্য ওপরি কার্যক্রমরে সাথে অন্য ওপরি কার্যক্রমরে যনে কোন দ্বতৈতা না হয় তা মন্ত্রণালয় নশ্চিতি করব।	আলোচ্য ওপরি কার্যক্রমরে সাথে অন্য ওপরি কার্যক্রমরে দ্বতৈতা পরহিাররে লক্ষ্যে মন্ত্রণালয়রে একটি কমটিি কাজ করছ। এছাড়া সম্প্রতি প্রণীত SBCC Strategy-এর আওতায় সমন্বতিভাবে কার্যক্রম বাস্তবায়ন করা সম্ভব হব।
২।	কর্মশালার বাহুল্য পরহিার করা আবশ্যক। সইে সাথে জনগুরুত্বপূর্ণ স্বাস্থ্য সংক্রান্ত বষিয়রে প্রচারণা প্রান্তকি জনগোষ্ঠীর কাছে পৌছানোর বশিষে ব্যবস্থা গ্রহণ করতে হব।	কর্মশালার বাহুল্য পরহিার করা হব। প্রান্তকি জনগোষ্ঠীর কাছে জনগুরুত্বপূর্ণ স্বাস্থ্য সংক্রান্ত বষিয়রে উপর প্রচারণা পৌঁছানোর বষিয়ে যথাযথ ব্যবস্থা গ্রহণ করা হচ্ছ।
৩।	Workshop to promote safe and healthy environments etc. [Page: 526, Component A (iv) (1)] এবং Awareness building for road, drawing and waterway safety [Page: 527, Component A (iv) (4)] অংগসমূহরে ব্যয় ১.৫০ কোটি টাকা করে মোট ৩ কোটি টাকায় নর্িধারণ করতে হব।	Workshop to promote safe and healthy environments etc. এবং Awareness building for road, drawing and waterway safety অংগসমূহরে ব্যয় ১.৫০ কোটি টাকা করে মোট ৩ কোটি টাকায় পুনঃনর্িধারণ করা হয়ছে।
৪।	Specific local level campaign for vulnerable and hard to reach groups etc. [Page: 526, Component A (iv) (1), under Communication Campaign through different medias etc.] অংগরে ব্যয় ১৫ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হব।	Specific local level campaign for vulnerable and hard to reach groups etc. under Communication Campaign through different medias etc. অংগরে ব্যয় হ্রাস করে ১৫ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৫।	Communication Campaign through different medias for behaviour change [Page: 527-529, Component (1-11)] অংগরে ব্যয় ৭০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখতে হব।	Communication Campaign through different medias for behaviour change অংগরে ব্যয় হ্রাস করে ৭০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৬।	Community Engagement and Mobilization [Page: 529-531, Component (1-13)] অংগরে	Community Engagement and Mobilization অংগরে ব্যয় হ্রাস করে ২০ কোটি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।

ক্রঃ নং	পইিসি সিভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
	ব্যয় ২০ টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	
৭।	Advocacy and Coordination [Page: 531-532, Component (1-7)] অংগরে ব্যয় ২৫ টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	Advocacy and Coordination অংগরে হ্রাস করে ২৫ টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৮।	Capacity Development and Logistics support for SBCC [Page: 532-533, Component (1-5)] অংগরে ব্যয় ১৩ টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	Capacity Development and Logistics support for SBCC হ্রাস ব্যয় হ্রাস ১৩ কো-টি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
৯।	Active Engagement in Social Media Group (Facebook, Twiter ইত্যাদি) [Page: 534, Component (5) under ICT and Innovation] অংগটি পিআইপি হতে বাদ দিতে হবে।	Active Engagement in Social Media Group (Facebook, Twitter ইত্যাদি) অংগটি পিআইপি হতে বাদ দয়ো হয়ছে।
১০।	Occupational and Environmental Health [Page: 534-535, Component (1-7)] অংগরে ব্যয় ৫০ টাকার মধ্যে সীমাবদ্ধ রাখতে হবে।	Occupational and Environmental Health অংগরে ব্যয় হ্রাস করে ৫০ কো-টি টাকার মধ্যে সীমাবদ্ধ রাখা হয়ছে।
১১।	আলোচ্য ওপতিে আলাদাভাবে কো-ন অংগে যানবাহন ক্রয়রে প্রস্তাব করা হয়নি বধিায় কো-ন যানবাহন ক্রয়রে সংস্থান ওপতিে রাখা যাবে না।	ওপতিে কো-ন যানবাহন ক্রয়রে সংস্থান রাখা হয়নি।
১২।	আলোচ্য ওপি'র বদৈশেকি প্রশকি্ষণ অংগটি আলাদাভাবে প্রদর্শনপূর্বক এর ব্যয় ১.৫০ কো-টি টাকায় নর্িধারণ করতে হবে।	বদৈশেকি প্রশকি্ষণ অংগ বাবদ ১.৫০ কো-টি টাকা ব্যয় প্রাক্কলন করা হয়ছে, যা বস্তিারতি ওপতিে যথাযথভাবে প্রতফিলন করা হবে।
	অপারশেনাল প্ল্যান- ২৮ (Information, Education and Communication)	
১।	দ্বতৈতো পরহিার করার শর্তে কম্পো-নেন্ট-১ এর আওতায় দশেব্যাপী সচতেনতামূলক অভযিান ও কর্মশালা বাবদ ৫.০০ কো-টি টাকা বরাদ্দ রাখা যাবে।	সদ্ধিান্ত অনুযায়ী কম্পো-নেন্ট-১ এর আওতাভুক্ত সচতেনতামূলক অভযিান ও কর্মশালা বাবদ ব্যয় ৫.০০ কো-টি টাকায় পুনঃনর্িধারণ করা হয়ছে।
২।	কম্পো-নেন্ট-৩ (Outdoor Media) তে প্রস্তাবতি বরাদ্দসমূহ অপরবির্ততি থাকবে।	কম্পো-নেন্ট ৩ (Outdoor Media)-এর আওতায় প্রস্তাবতি বরাদ্দ অপরবির্ততি রাখা হয়ছে।
৩।	কম্পো-নেন্ট ৪ (Capacity building for different service providers, supervisors and managers) এর অনধকি ৩০টি AV Van অপক্ষোকৃত হাল্কা ও কম মূল্যরে হওয়া সমীচীন।	জলো পরবিার পরকিল্পনা অফসি কর্তৃক বভিন্নি উপজলোর প্রত্যন্ত গ্রামে, ক্ষত্রে বশিষে দুর্গম এলাকায় AV Van -এর মাধ্যমে সচতেনতামূলক চলচ্চত্রি প্রদর্শনী করা হয়ে থাকে। প্রত্যন্ত ও দুর্গম এলাকায় যাতায়াতরে সুবধিার্থে AV Van হসিবেে মাইক্রো-বাস ক্রয়রে প্রস্তাব করা হয়ছে এবং অর্থ মন্ত্রণালয় কর্তৃক নর্িধারতি মূল্যে তা ক্রয় করা হবে।
৪।	কম্পো-নেন্ট ৪ এ প্রস্তাবতি কল সন্টোর DGHS এর বদ্যিমান কল সন্টোররে সাথে সমন্বয় করে পরচিালনা করা হবে এবং এ খাতে বরাদ্দ হ্রাস করে ২ কো-টি টাকা করতে হবে।	সদ্ধিান্ত অনুযায়ী প্রস্তাবতি কল সন্টোর DGHS এর বদ্যিমান কল সন্টোররে পরামর্শ ও সহযো-গতিা গ্রহণ করে স্থাপন করা হবে। এ জন্য কম্পো-নেন্ট ৪ এর আওতায় কল সন্টোর বাবদ ২ কো-টি টাকা ব্যয় প্রাক্কলন করা হয়ছে। অন্যান্য

ক্রঃ নং	পইিসি সভার সদ্ধিান্ত	স্বাস্থ্য ও পরবিার কল্যাণ মন্ত্রণালয় কর্তৃক গৃহীত ব্যবস্থা
		ইকুইপমন্টে বাবদ ২.৩৫ কো টি টাকা ব্যয় প্রাক্কলন করা হয়ছে। ফলশ্রুতিতে সংশ্লষ্টি কার্যক্রমরে ব্যয় ৪.৩৫ কো টি টাকায় পুনঃনর্িধারতি হয়ছে।
৫।	কম্পো নন্টে ৬ ও ৮ এর কার্যক্রম আলাদাভাবে পরচিালনা করা হব।	কম্পো নন্টে ৬ ও ৮ এর কার্যক্রম পৃথকভাবে পরচিালনা করা হব।
৬।	কম্পো নন্টে ৯ এর ব্যয়বরাদ্দ যৌক্তকিভাবে হ্রাস করতে হব।	কম্পো নন্টে ৯-এর প্রাক্কলতি ব্যয় যৌক্তকিভাবে পুনঃনর্িধারণ করা হয়ছে।
	অপারশেনাল প্ল্যান-২৯ (Alternative Medical Care)	
১।	বশ্বিরে সাথে তাল মলিয়িে Alternative Medical Care (AMC) কার্যক্রম আরো গতশীল ও কার্যকর করার জন্য প্রয়োজনীয় পদক্ষপে গ্রহণ করতে হব।	বশ্বিরে সাথে তাল মলিয়িে Alternative Medical Care (AMC) কার্যক্রম আরো গতশীল ও কার্যকর করার জন্য প্রয়োজনীয় পদক্ষপে গ্রহণ করা হচ্ছ।
২।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় ২.৫০ কো টি টাকায় নর্িধারণ করতে হব।	বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় মো ট ২.৫০ টাকায় পুনঃনর্িধারণ করা হয়ছে। বস্তিারতি ওপতিে বদৈশেকি প্রশক্ষিণ অংগরে ব্যয় বশিদভাবে প্রতফিলন করা হব।
৩।	আলোচ্য ওপরি আতওায় Research [Page: 556, Component 3(3) এবং Page: 556, Component 4(5)] কার্যক্রমরে জন্য মো ট ১০ কো টি টাকা ব্যয়রে সংস্থান রাখতে হব।	আলোচ্য ওপরি আওতায় Research এবং survey [Component 3(3) এবং 4(5)] কার্যক্রমরে জন্য মো ট ১০ কো টি টাকা ব্যয়রে সংস্থান রাখা হয়ছে।
৪।	Post Graduate Study এর Scholarship ও training [Page: 555, Component 2(3) এবং Page: 556, Component 3(4)] কার্যক্রমরে জন্য ৮ কো টি টাকা ব্যয় প্রাক্কলন করতে হব।	সদ্ধিান্ত অনুযায়ী Post Graduate Study এর Scholarship ও training [Component 2(3) এবং 3(4)] এর জন্য মো ট ৮ কো টি টাকার সংস্থান রাখা হয়ছে।
৫।	বগিত কর্মসূচরি এ ধরনরে ওপি'র আওতায় যে সকল স্থানে Herbal Garden করা হয়ছে তার একটি তালকিা ভলউিম-২ তে সংযুক্ত করতে হব।	বগিত কর্মসূচরি এ ধরনরে ওপি'র আওতায় যে সকল স্থানে Herbal Garden করা হয়ছে তার একটি তালকিা বস্তিারতি ওপতিে সংযুক্ত করা হব।