4th HEALTH, POPULATION AND NUTRITION SECTOR PROGRAM (4th HPNSP)

January 2017 - June 2022

PROGRAM IMPLEMENTATION REPORT (PIR) 2017

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PREFACE

The Program Implementation Plan (PIP) of the 4th HPNSP requires the PMMU of the Ministry of Health and Family Welfare (MOHFW) to produce both six-monthly and annual program implementation reports and share those with the policy makers of MOHFW, the supervisors and implementing managers of the Directorates and the Development Partners (DPs).

The Program Implementation Report – 2017 (PIR-2017) is the first progress report of 4th HPNSP covering the period of January – June 2017. The Report has been prepared based on the physical progress measured by OP-level indicators and other information received from the Line Directors (LDs) and the ADP financial progress review of MOHFW done by the Planning Wing, HSD and the Planning Branch, ME&FWD respectively.

The PIR - 2017 has tried to capture some features of program implementation undertaken during the short period of time available to the LDs/ OPs. It has also recorded the activities and processes through which the Planning Wing moved between January to March 2017 to facilitate the finalization and approval of the PIP for the 4th HPNSP. Subsequently the key steps taken for the approval of 29 OPs and their operationalization during March to June 2017 have been highlighted in the Report as lessons for future program preparation. All these activities performed during January – June 2017 are part of the process of initiation and implementation of the 4th HPNSP.

This six-monthly review provides an opportunity for internal stocktaking. This is especially so for the Line Directors and other stakeholders who are involved in program implementation, and for developing a roadmap for the way forward to speed up implementation progress. Consistent with this objective, the PIR-2017 includes a review of unfinished activities of HPNSDP and the issues needing attention of the policymakers as well as of the implementers.

I hope that the findings, analysis, and suggestions contained in the PIR – 2017 will help the stakeholders in making realistic decisions, improving implementation performance of the Program, and encouraging steps to be taken on a priority basis to achieve better results.

The Technical Assistance Support Team (TAST) of PMMU deserves credit for producing a factual and insightful review of program performance in this six-monthly report (January – June 2017). I congratulate them for this achievement and appreciate their hard work. Thanks are also due to the MEASURE Evaluation Team at icddr,b who contributed to the preparation of this Report.

I also thank the Line Directors, other staff of DGHS, DGFP, etc. agencies under MOHFW, and my colleagues in the Planning Wing, HSD and the Planning Branch, ME&FWD for their cooperation in providing relevant information and data required for preparation of the Report.

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ABBREVIATIONS & ACRONYMS

ADP	Annual Development Program
AHI	Assistant Health Inspector
AMC	Alternative Medical Care
ANC	Antenatal Care
APIR	Annual Program Implementation Report
APR	Annual Program Review
ARH	Adolescent Reproductive Health
ARV	Anti-Retroviral Drugs
AWP	Annual Work Plan
BBS	Bangladesh Bureau of Statistics
BCC	Behavior Change Communication
CAG	Comptroller and Auditor General
CBHC	Community Based Health Care
CC	Community Clinic
CCSDP	Clinical Contraceptive Service Delivery Programme
CDC	Communicable Disease Control
CES	Coverage Evaluation Survey
CHCP	Community Health Care Provider
CMSD	Central Medical Stores Department
CRS	Congenital Rubella Syndrome
CSBA	Community Skilled Birth Attendant
DAAR	Disbursement for Accelerated Achievement of Results
DDS	Drugs and Dietary Supplies
DFID	Department for International Development
DG	Director General
DGDA	Department General of Drug Administration
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DGNM	Directorate General of Nursing and Midwifery
DH	District Hospital
DLI	Disbursement Linked Indicator
DLR	Disbursement Linked Result
DP	Development Partner
DPA	Direct Project Aid
DPM	Deputy Program Manager
DSF	demand-side financing
ECNEC	Executive Committee of the National Economic Council
EmOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
ERD	Economic Relations Division
ESD	Essential Services Delivery
ESP	Essential Services Package
FMA	Financial Management and Audit
FMAU	Financial Management and Audit Unit
FP	Family Planning
FP-FSD	Family Planning Field Services Delivery
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FY	Financial year
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GEVA	Gender, Equity, Voice and Accountability
GNI	Gross National Income
GOB	Government of Bangladesh
GRS	Grievances Redressal System
HA	Health Assistant
HEF	Health Economics and Financing
HEU	Health Economics Unit
HI	Health Inspector
HIS & eH	Health Information System and e-Health
HIS	Health Information System
HLPF	High Level Political Forum
HNP	Health, Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Program
HPNSDP	Health, Population and Nutrition Sector Development Program
HPNSP	Health, Population and Nutrition Sector Program
HPSP	Health and Population Sector Program
HRD	Human Resource Development
HSD	Health Service Division
HSM	Hospital Services Management
iBAS	Integrated Budget and Accounting System
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IDA	International Development Association
IEC	Information Education & Communication
IEDCR	Institute of Epidemiology, Disease Control and Research
IFA	Integrated Fiduciary Assessment (IFA)
IFM	Improved Financial Management
IHS	Improving Health Services
IMCI	Integrated Management of Childhood Illnesses
IMED	Implementation Monitoring & Evaluation Division
IMR	Infant Mortality Rate
IPF	Investment Project Financing
IPH	Institute of Public Health
IPHN	Institute of Public Health and Nutrition
IUD	Intra Uterine Device
IVA	Independent Verification Agency
IYCF	infant and young child feeding
JDTAF	Joint Donor Technical Assistance Support Fund
JE	Japananese Enchaphalaties
JICA	Japan International Cooperation Agency
L&HEP	Lifestyle and Health Education & Promotion
LAPM	Long acting and permanent methods
LCG	Local Consultative Group
LD	Line Director
LLP	Local Level Planning
M&E	Monitoring & Evaluation
MA	Medical Assistant
MCH	Maternal and Child Health
MCH&IW	Maternal Child Health & Immunization Worker
MCRAH	Maternal, Child and Reproductive & Adolescent Health
MCWC	Maternal and Child Welfare Center
ME&FWD	Medical Education & Family Welfare Division
ME&HMD	Medical Education and Health Manpower Development
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCAH	Maternal, Neonatal, Child and Adolescent Health
MNH	Maternal and Newborn Health
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural

Development and Co-operatives

MOSW	Ministry of Social Welfare
MR	measles-rubella
NCD	Non-Communicable Disease
NCDC	Non-Communicable Disease Control
NEC	National Eye Care
NGO	Non-Government Organization
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive & Social Medicine
NMES	Nursing and Midwifery Education Services
NMR	Neo-Natal Mortality Rate
NNS	National Nutrition Services
NSV	No-scalpel Vasectomy
OI	Opportunistic Infection
OP	Operational Plan
PA	Project Aid
PAD	Project Appraisal Document
PAP	Prioritized Action Plan
PB	Planning Branch
PEC	Project Evaluation Committee
PFD	Physical Facilities Development
PHC	Primary Health Care
PIP	Program Implementation Plan
PIR	Program Implementation Report
PLHIV	People Living with HIV and AIDS
PLMC	Procurement and Logistics Monitoring Cell
PM	Program Manager
PME	Planning, Monitoring and Evaluation
PMMU	Program Management and Monitoring Unit
PMR	Planning, Monitoring and Research
PNC	Prenatal Care
PPFP	Postpartum Family Planning
PSC	Project Scrutiny Committee
PSSM	Procurement, Storage and Supplies Management
PW	Planning Wing
RADP	Revised Annual Development Program
RFW	Results Framework
RH	Reproductive Health
RPA	Reimbursable Project Aid
SACMO	Sub-Assistant Community Medical Officer
SBCC	Social and Behavioral Change Communications
SC	Steering Committee
SCANU	Special Care Newborn Unit
SDAM	Strengthening of Drug Administration and Management
SDG	Sustainable Development Goal
SEI	Socio-Economic Infrastructure
SGS	Strengthening Governance & Stewardship
SHS	Strengthening Health Systems
SIMO	Surveillance & Immunization Medical Officer
SIP	Strategic Investment Plan
SRH	Sexual & Reproductive Health
SSK	Shasthyo Shurokhsha Karmasuchi
STG	Strategic Thematic Group
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
SWPMM	Sector Wide Program Management and Monitoring
TA	Technical Assistance
TAST	Technical Assistance Support Team
TB	Tuberculosis
TBL&ASP	TB-Leprosy & AIDS/STD Program
TBLC	Tuberculosis and Leprosy Control
TFR	Total Fertility Rate
TIC	Training Implementation Committee
TLCA	TB Leprosy Control Assistant
TOT	Training of Trainers
TRD	Training, Research and Development
U-5MR	Under-5 Mortality Rate
UH&FWC	Union Health and Family Welfare Center
UHC	Universal Health Coverage
UHC	Upazila Health Complex
UHSSP	Urban Health Systems Strengthening Project
UIMS	Upazila Inventory Management System
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VNR	Voluntary National Review
WB	World Bank
WHO	World Health Organization
WIMS	Warehouse Inventory Management System

EXECUTIVE SUMMARY

This is the first Program Implementation Report (PIR) for the 4th Health, Population and Nutrition Sector Program (4th HPNSP) for the period of January-June 2017. It was prepared by the Program Management and Monitoring Unit (PMMU) of the Planning Wing (PW) of the Ministry of Health and Family Welfare (MOHFW), to assess progress of implementation of the Operational Plans (OPs). It may be noted that the 4th HPNSP was approved for the period of January 2017 to June 2022. So, the end of FY 2016-17 officially marks a six-monthly period of implementation of the new Program, even though-in reality-the OPs got little time to implement their approved plan of activities. However, given the constraints of circumstances, the LDs and other program implementers chose to adjust their plans so that the activities for which funds could be reasonably spent within end-June were taken up for implementation. Thus, a modest but much-needed beginning of the 4th HPNSP implementation was accomplished.

The Program Implementation Report - 2017 (PIR - 2017) has tried to capture some features of program implementation undertaken during the short period available to the LDs/OPs. It has also recorded the activities and processes through which the Planning Wing moved between January to March 2017 to facilitate the finalization and approval of the PIP for the 4th HPNSP. Subsequently the key steps taken for the approval of 29 OPs and their operationalization during March to June 2017, have been highlighted in the Report as lessons for future program preparation. PIR 2017 provides program highlights, updates on financial performance, OP-level indicators and training as well as the key implementation challenges and issues needing attention. The information for the PIR was collected from the Line Directors (LDs) on a structured data reporting template customized for individual OPs. PMMU staff and the PMMU Technical Assistance Support Team (TAST) members closely liaised with the LDs and their core staff, e.g. Program Managers (PMs), Deputy Program Managers (DPMs), and Accountants, to complete the data collection templates in time. The PIR was finalized based on the inputs from Planning Wing & Planning Branch of MOHFW and the LDs.

The Sector program functions through 29 OPs, 14 of which are under the component Improving Health Services (IHS), 11 under Strengthening Health Systems (SHS) and the rest 4 OPs are under Strengthening Governance and Stewardship (SGS) component, which is a new component in the 4th HPNSP.

Major Findings

Budget Allocation and Spending Patterns:

The total Revised Annual Development Program (RADP) fund allocation for the period of January-June 2017 of 4th HPNSP was Tk. 1,091.9 crore. Only GOB fund was available during the reporting period. The allocation of funds among the OPs shows that more than 83% of the ADP allocation for the first six-months of the 4th HPNSP was concentrated in 4 OPs, 3 of which are under HSD (i.e. PFD, CBHC and HSM) and 1 under ME&FWD (i.e. ME&HMD). Physical Facilities Development (PFD) OP alone accounted for 40% of the allocated budget of the year under review.

The spending rate is generally considered to be a good indicator of program performance. During the period under report, the overall spending rate was 95% against both release and allocation and 22 OPs fulfilled the 4th HPNSP's Result Framework Indicator (number of OPs with annual budget execution over 80%) which surpassed its target of 19 OPs. However, 5 OPs under HSD (HEF, HRD,

IFM, MNCAH and TB&ASP) and 2 OPs under ME&FWD (MIS and TRD) couldn't achieve the target for this indicator.

Programmatic Achievements Measured by Indicators:

Out of the 131 indicators used at the OP-level, the report found 31 indicators (24%) as fully achieved and 18 indicators (14%) as partially achieved. In terms of individual OPs, four (TB-L&ASP, CDC, PSSM-FP and CCSDP) out of 29 OPs were able to achieve >=80% of their targets of the OP-level indicators during January-June 2017.

Training and Workshop:

The 4th HPNSP devotes considerable effort to improve HR capacity through trainings (local and foreign) and workshops/seminars/orientations. Out of total expenditure of January-June 2017, 16.3 crore (1.54%) was spent on capacity building programs. Around 12.5 crore (76.6% of the total training cost) was spent on training and rest of the amount, 3.8 crore (23.4%) was spent on workshop/seminar/advocacy related programs involving a total of 31,682 participants. During this period, no GOB participant attended foreign training/workshop/seminar. Most participants attended local trainings which were conducted by CDC (54% of total participants), followed by NCDC (16%).

Progress in Strengthening Institutions and Services:

Some of the activities undertaken during January-June 2017 were:

- DGHS achieved 49% of annual target (children immunized for measles and rubella) in 4 districts in Sylhet division and 54% of annual target for the same in 11 districts in Chittagong division
- 50,557 normal deliveries took place in the public facilities of Sylhet and Chittagong divisions under DGFP and DGHS
- final draft of revised 'National Child Health Strategy' had been developed and is waiting for approval by the technical committee
- DGHS introduced an open-access data dashboard on DHIS2 platform to present health data on real-time basis
- MOHFW completed five disseminations of research/survey results through TRD
- baseline survey on facility readiness for PPFP services was initiated by DGFP
- the proposal for restructuring of CMSD was sent to MOPA through MOHFW
- a committee was formed to strengthen the financial management system
- procurement process through e-GP had been initiated in DGHS
- 87% of DGFP contracts were awarded within initial tender validity period
- as part of improving performance of institutions and its human resources, monitoring, evaluation and supervision activities were conducted by a task force in 30 medical colleges, 01 dental college, 08 MATS & 08 IHTs under Medical Education and Health Manpower Development.
- construction of 6 EPI stores in 6 districts were completed
- construction of Maligaon 50 Bed Hospital in Comilla, 01 Nursing College, 23 Mother and Child Welfare Centers (MCWCs), Ladies hostel for Dhaka Dental College, Health Bhaban at Mohakhali were completed.
- upgradation of 09 Upazila Health Complexes to 50-bedded hospital and expansion of 10 UHCs to accommodate the Upazila Family Planning Offices, Stores and Services were completed.

Key Implementation challenges:
Out of 29 OPs, 9 OPs (HSD-5, ME&FWD-4) did not report on having faced challenges, while 14 OPs from HSD and 6 OPs from ME&FWD mentioned their challenges as summarized below:

- delayed receipt of fund which hindered implementation of planned activities
- insufficient fund allocation
- unavailability of a robust system of monitoring and supervision
- issues with HR including shortage, retention and vacancy in sanctioned position etc.

Issues needing attention:

The end-line evaluation report of HPNSDP found 3 out of 8 goal-level indicators to be off-track, e.g., MMR, NMR and TFR. Unmet need of Family Planning, delivery by SBA, ANC (4) and PNC coverage, and IYCF practices also could not achieve the targets within the HPNSDP period (December 2016). These off-track indicators as mentioned above constitute carried-over unfinished agenda which needs to be adequately addressed during the implementation of current sector program. In addition, there is need for: improved institutional coordination between health, nutrition and population services to avoid duplication, training, nursing services, quality assurance, synchronization of physical facilities with the supply of HR and needed equipment, asset management including their maintenance and waste management and availability of HR at the facilities including doctors, nurses/midwives and technicians. Although significant improvements in urban health had taken place over the past few years, steps will have to be taken to close gaps in coordination among different service providers, improve access to services, attend to the problems of quality and equity and the need for improving regulatory environment.

Given the enormity of the new Program and the change to the DLI-based financing modality which vastly increased the role of managerial oversight, serious attention is called for: to strengthen internal financial control, undertake regular field-level supervision and improve reporting and monitoring of OP implementation by the two Division within MOHFW.

CHAPTER I. INTRODUCTION

1.1 Country and Sectoral Context

Bangladesh has been undergoing steady social and economic changes since 1990. Over the past two and half decades, the country registered significant rise in both gross domestic product (GDP) and gross national income (GNI). The economy of Bangladesh has been growing more consistently in recent years, averaging 6.5% since 2010, with growth of 7.11% in FY 2016 (Bangladesh Economic review, Ministry of Finance, 2017). Per capita income was estimated at US$ 1,602 in FY 2016. Bangladesh with a total population of 163 million reached the lower-middle-income country group in 2014. Though there has been a reduction in the extent of poverty, a considerable proportion of the population still lives below the poverty-line (23.2%) (BBS, 2016).

Commendable progress has been achieved by Bangladesh in bringing in improvements in key health, nutrition and population (HNP) outcomes. There exists a high level of commitment from the Government of Bangladesh (GOB) to bringing in primary health care (PHC) services close to the communities. Focus on pro-poor Essential Service Package (ESP) and provision of PHC services at the door steps of people through the Community Clinics (CC) are among factors which contributed to reducing the gap between rich and poor with respect to health outcomes in rural areas. Mainstreaming of nutrition services through the regular service channels of DGHS and DGFP has made service provision cost-effective and led to improved coordination at different stages of service delivery including at the CCs. The decline in total fertility rate (TFR) with increase in contraceptive prevalence rate through implementation of effective and continuous family planning programs, is also commendable.

Significant improvement took place in the overall health systems as well. Improvement in procurement, budget planning, sector coordination and management, fund utilization, monitoring, and MIS are now more visible. The success in the use of information and communication technology for health is also recognized widely. Specific progress in Gender, Equity, Voice and Accountability (GEVA) issues has made the HNP services more gender-friendly. The implementation of CC-based services, provision of separate toilets, breast feeding and nutrition corners and other facilities in the women-friendly hospitals etc. have contributed to increasing access of the poor women to HNP services.

All the above-mentioned steps – among others - have led to reduction in NMR, IMR, U-5MR, MMR, TFR, stunting, under-weight, etc. and have resulted in increasing life expectancy at birth, thereby creating a platform for a population with better health and a prosperous society.

1.2 SWAp Based Programs in the HNP Sector

The Health and Population Strategy of 1997 marked the decision to move away from the project-based modality followed for so long, to a sector-wide approach (SWAp) in the HNP sector of the Fifth Five-Year Plan, which began in 1998 for five years and was known as the Health and Population Sector Program (HPSP). The main focus of HPSP was to decentralize delivery of the essential service package (ESP) using a “one-stop” service model, and deliver basic health and family planning services to the rural community from static community-based CCs.

The second SWAp, titled Health, Nutrition and Population Sector Program (HNPSP), was implemented for eight years starting July 2003 with the overall objective of increasing availability and utilisation of user-friendly, affordable and accessible quality HNP services. The third SWAp entitled Health, Population, and Nutrition Sector Development Program (HPNSDP) was implemented for five and half years between July 2011 and December 2016. HPNSDP was implemented with the intention to strengthen health systems and improve health services. Table 1-1 below illustrates the duration, size and the estimated financial outlay including GOB and DP contribution to three successive SWAps in the HNP sector of Bangladesh. It transpires from the table that GOB's contribution to the HNP SWAp is on a continuous rise and the DPs' share is comparatively declining. Falling trend continues in financing the current fourth SWAp by the DPs, where GOB contribution is projected to increase further to 84%.

Table 1-1. SWAps in Bangladesh HNP Sector, 1998–2016[1]

Name	Duration	Fund (Billion US$)	GOB Contribution	DP Contribution
Health and Population Sector Program (HPSP)	1998–2003	2.2	62%	38%
Health, Nutrition and Population Sector Program (HNPSP)	2003–11	5.4	67%	33%
Health, Population and Nutrition Sector Development Program (HPNSDP)	2011–16	6.6	78%	22%

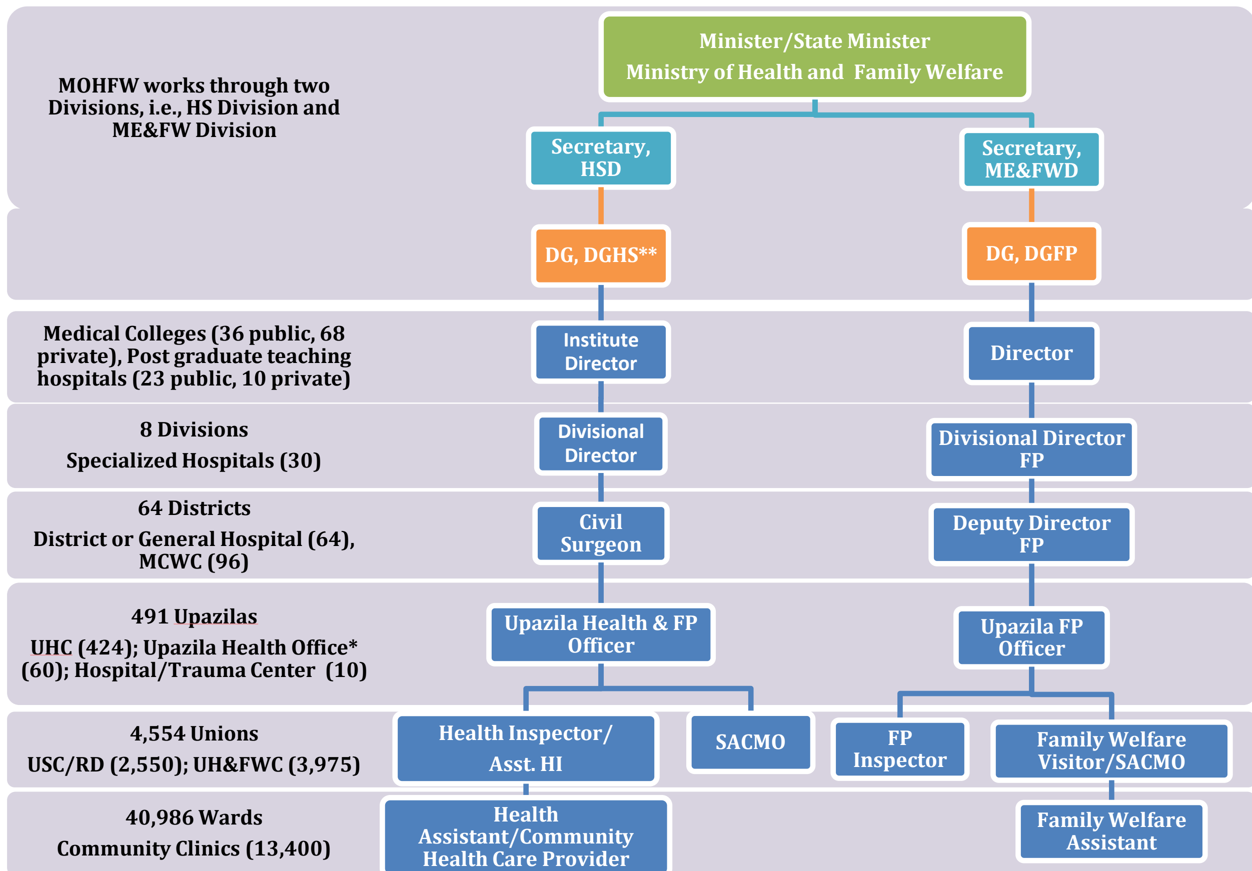
1.3 Structure of HNP Service Delivery through two Divisions of MOHFW

The Ministry of Health and Family Welfare (MOHFW) is responsible for policy formulation, program designing, implementation, management, coordination, and regulation of national health and family planning related activities and programs. The GOB through a gazette notification of the Cabinet Division dated 16 March 2017 created two separate Divisions, namely Health Services Division (HSD) and Medical Education & Family Welfare Division (ME&FWD) under the MOHFW for intensifying government oversight, improving stewardship role and speeding up progress of work.

One Program Implementation Plan (PIP) - government's planning document for SWAp - called the 4th HPNSP was approved by the Executive Committee of the National Economic Council (ECNEC) on 21st March 2017 keeping provision for 29 Operational Plans (OPs). Later MOHFW delegated the responsibility of 19 OPs to HSD and 10 OPs to ME&FWD, with the Sector-Wide Program Management and Monitoring OP continuing its earlier role of overall coordination, monitoring and evaluation of all the OPs. [Two separate notes on the approval of PIP and the OPs have been presented at chapter 2, sections 2.5 and 2.6]. Figure 1-1 below illustrates the structure of public sector HNP services (not the entire organizational structure of MOHFW) following the country's administrative pattern.

[1] IMED, 2003; GOB, 2005; GOB, 2014

Figure 1-1. MOHFW's Structure of HNP Services Delivery[2]



In line with the general system of public administration in Bangladesh, the MOHFW management structure comprises of the following groupings:

- each Division is headed by a Secretary, and each is responsible for policy development and administration comprising nine functional wings for HSD and six wings for ME&FWD headed by an Additional Secretary or Joint Secretary/Joint Chief respectively and a Planning Branch under ME&FWD headed by a Deputy Chief.
- the Directorates, which work as agencies for implementation up to the field level. The DGHS and DGFP are the two-main service-providing agencies, through which HSD and ME&FWD of MOHFW implement the program's development activities.
- Responsibilities of providing services are also shared by the Directorate General of Nursing and Midwifery (DGNM), the Directorate General of Drug Administration (DGDA), Health Engineering Department, National Institute of Population Research and Training (NIPORT), National Institute of Preventive and Social Medicine (NIPSOM), Institute of Epidemiology, Disease Control and Research (IEDCR), Institute of Public Health and Nutrition (IPHN), Institute of Public Health (IPH), and other relevant institutes.

[2] Source: DGHS Health Bulletin, 2016. This service delivery structure is a part of the overall administrative structure of MOHFW

* Situated at 'sadar upazila' which do not have indoor facilities because their headquarters are co-located in the district town

** DGHS also operates through ME&FWD in matters relating to medical education

1.4 Program Implementation Report (PIR) - 2017

The Program Implementation Report (PIR)—2017 is the first end-of-financial year progress report of implementation of the 4th HPNSP, prepared by the Planning Wing, HSD of MOHFW with technical support from the Technical Assistance Support Team (TAST) of Program Management and Monitoring Unit (PMMU). The PIR 2017 covers progress of the 29 OPs implemented by the two Divisions of MOHFW (HSD for 19 OPs and ME&FWD for 10 OPs) during January – June 2017. Since the 4th HPNSP is a mega Program with a single PIP, the PIR 2017 is intended for both HSD and ME&FWD to review progress for achieving goals and results as approved for the 4th HPNSP.

The MOHFW uses performance information not only to assess the Program's progress but also to utilize the information as the basis of its resource request for subsequent years. The lessons of implementation also form the basis for next year's program planning and for fine-tuning of investment decisions.

It may be noted that the 4th HPNSP was approved for the period of January 2017 to June 2022. So, the end of FY 2016-17 officially marks a six-monthly period of implementation of the new Program, even though-in reality- the OPs got little time to implement their approved plan of activities. However, given the constraints of circumstances, the LDs and other program implementers chose to adjust their plans so that the activities for which funds could be reasonably spent within end-June were taken up for implementation. Thus, a modest but much-needed beginning of the 4th HPNSP implementation was accomplished.

The Program Implementation Report - 2017 (PIR - 2017) has tried to capture some features of program implementation undertaken during the short period available to the LDs/OPs. It has also recorded the activities and processes through which the Planning Wing moved between January to March 2017 to facilitate the finalization and approval of the PIP for the 4th HPNSP. Subsequently the key steps taken for the approval of 29 OPs and their operationalization during March to June 2017, have been highlighted in the Report as lessons for future program preparation.

The PIR reports on a number of aspects of the Program implementation common to those in the earlier annual/ six-monthly progress implementation reports. The common areas covered in the Report are as follows:

(i) fund utilization based on the expenditure of the Revised ADP (RADP) allocation for each OP for January to June 2017;
(ii) main activities against which funds were spent by each OP;
(iii) achievement of the OP indicators, some of which reflect the DLIs;
(iv) training and capacity development activities carried out during the period under review; and
(v) implementation challenges faced by the LDs.

1.5 Methodology for Preparation of the PIR - 2017

The preparation process of the PIR – 2017 usually involves data collection, analysis, report drafting, sharing with the stakeholders, dissemination workshops, and finalization of the report.

Data Collection

The 4th HPNSP has 29 OPs wherein each OP document lays out the general objective, specific objectives, strategies, priority activities, and financial and administrative management details specific to that OP. It also specifies the indicators on which the progress of the OP would be measured. To collect data for the PIR - 2017 and capture information for the last six months of FY 2016–17 (January – June 2017), a structured data-reporting template was designed. The reporting template was customized for each OP and sent to the LDs. Annex A includes a blank data collection template used for PIR - 2017.

The template contains six major sections- Financial information, Update on Indicators, Physical progress, Training data, Implementation Challenges and Unfinished Activities of HPNSDP. The template, after preparation, was shared with Planning Wing officials and also field-tested with a few Line Directors.

Data Processing

Each filled-in template was checked for completion, accuracy, and consistency of information by the PMMU TAST with support of a technical group from the MEASURE Evaluation at icddr,b. Clarifications were sought on LD's feedback in case of certain OPs. The LDs or their representatives were also contacted by phone to get further information when necessary, after data in the templates were checked, and the information was updated to make the final data set.

Data Analysis

Data analysis for the PIR - 2017 involved analysis of performance of the OPs measured by (a) the respective indicators, and (b) the rate of fund utilization. For example, the progress of an indicator is calculated based on the baseline, target and achievement, later on divided into five categories as below:

1. **Achieved:** Equal or more than 80%
2. **Partially Achieved:** Ranges from more than 20% to less than 80%
3. **Not Achieved:** Less than or equal to 20%
4. **Not available:** Data was not provided by the OP
5. **Not Applicable:** Inapplicable for this reporting period

The quantitative analysis also included financial progress by calculating the percentage of expenditure related to ADP allocation and release of funds, whereas the qualitative analysis described the achievement of physical activities and identified factors associated with achievement as well as challenges faced by the OPs during January-June 2017.

Finalization of PIR- 2017

Based on the analyses, the initial draft of the report was prepared and shared with the Planning Wing & Planning Branch of MOHFW and the LDs for their review and feedback. PMMU staff and the PMMU TAST members also met as needed with the LDs for update and clarification of different data points, in addition to email communications. The report was finalized in discussion with Planning Wing and Planning Branch officials, the LDs, and the DPs.

Organization of the Report

In this report, Chapter 1 has described the country and sectoral contexts, and methodology used for collecting information from the 29 OPs for the PIR -2017. It also explained how the categories for

performance for each OP were determined. In Chapter 2, the 4th HPNSP goals, objectives, strategies and financial outlay have been introduced. In chapter 3, financial progress of 4th HPNSP for January-June 2017 is presented. Chapter 4 presents information on the performance of the 29 OPs measured by OP-level indicators for the same period. Consolidated physical progress made by 29 OPs is presented in Chapter 5. Chapter 6 discusses progress made in training and Chapter 7 highlights the key challenges in program implementation as reported by the LDs. Finally, Chapter 8 highlights some strategic issues needing attention for improving implementation of the program in future.

CHAPTER 2. 4th HEALTH, POPULATION AND NUTRITION SECTOR PROGRAM (4th HPNSP)

2.1 Vision, Mission, Goal and Development Objective of 4th HPNSP

The 4th Health Population and Nutrition Sector Program (4th HPNSP) was approved in the ECNEC meeting of 21 March 2017 for a period of five and half years from January 2017 to June 2022. After HPSP (1998-2003), HNPSP (2003-11) and HPNSDP (2011-16), the 4th HPNSP has been prepared following the SWAp modality for overall improvement of the HNP sector.

The *Vision* is to see the people healthier, happier and economically productive to make Bangladesh a middle-income country by 2021. The ***Mission*** is to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. The ***Goal*** is 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. The ***Development Objective*** is to have focused improvements in increasing access to quality health care and improvement in equity along with efficiency by gradually achieving UHC.

2.2 Program Components and Strategies of 4th HPNSP

There are three ***Components*** of the 4th HPNSP against which eight goal level and 25 intermediate level indicators (not mentioned here) have been set. The three components of 4th HPNSP are (i) strengthening of governance and stewardship; (ii) strengthening of health systems; and (iii) improvement of service quality.

The ***Strategies*** of the 4th HPNSP are as follows: -

- building capacities in leadership, management and regulation with stronger governance and stewardship role of the MOHFW for better quality services;
- restructuring the MOHFW, to increase performance, efficiency and accountability while removing duplication and waste;
- rolling out an upgraded Essential Services Package (ESP) with greater functional coordination of services at the field level and a functional referral system;
- 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;
- focusing on improvement in quality of care, including ensuring the implementation of a comprehensive health workforce strategy and action plan;
- promoting the importance of public health and increased investment in prevention, primary care and strengthening community engagement;
- tackling the rising burden of NCDs through cross-sectoral interventions on public health awareness and to establish healthy lifestyles and healthy environment;
- tackling the burden of established and new communicable diseases;
- adopting new technologies to strengthen surveillance, data quality and information systems for evidence based decision making; and

- increasing investment in health, ensuring a focus on managing demand, increasing efficiency and creating strong case for health funding.

2.3 Valued Elements of 4th HPNSP

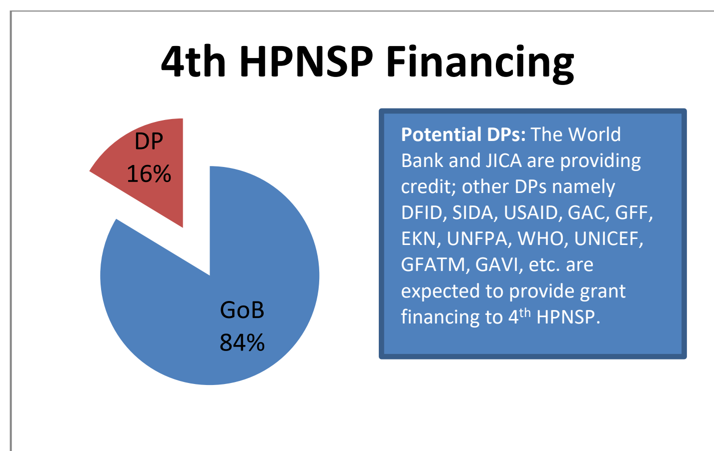
The 4th HPNSP has elements that are different and or add value to the Program, particularly in reproductive, maternal, newborn, child & adolescent health; nutrition & food safety; and non-communicable diseases. The objectives of the valued elements/focus are to address the unfinished agenda of HPNSDP;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

- Governance and stewardship have been placed as the first component of 4th HPNSP for urgent intervention for ensuring that all citizens receive quality service at affordable cost.
- The 4th HPNSP is the first SWAp for achieving the SDGs with outcomes like improved equity, better quality and efficiency with a view to gradually moving towards UHC.
- A regional focus has been given in the program design for reducing MMR and TFR of Chittagong and Sylhet Divisions.
- The new focus is to restore centrality to Essential Service Package (ESP) in primary health care service delivery and to emphasize on equity, gender sensitivity and efficiency in resource use.
- Combined approaches to nutrition services and awareness building activities provided by a host of sources have been highlighted.
- NCD issues have been prioritized setting one goal level indicator on NCDs. Emphasis has also been given to public health education and life style & environment changes.
- MOHFW will make additional interventions and strengthen coordination with the MOLGRDC, local government institutions, NGOs, etc. for expanding access to PHC services by urban dwellers.
- Partnership with the NGOs will be augmented to raise public awareness about appropriate attitude towards mental, autistic and geriatric – friendly health care.
- Community-supported PHC service will be consolidated further along with special emphasis on under-served clientele including those in hard-to-reach areas.
- Adoption of new technology through digital data generation, M&E and evidence-based decision-making has been emphasized for improving and expanding HIS.
- Importance is given on improved facility management using best practices-e.g. Jhenidha /Chaugacha practices and Narshingdi model; asset management; waste management; etc.
- Result-based new funding modality (Disbursement Linked Indicators -DLIs) with improved financial management and internal control is a key management focus introduced in the 4th HPNSP.

2.4 Financial Outlay of 4th HPNSP

The 4th HPNSP total budget along with source of financing is given in the table below.

Budget	Amount (Taka in crore)	Amount (USD in Billion)
Total Estimated Cost	1,15,486.36	14.71
Revenue Budget	72,000.00	9.17
Development Budget	43,486.36	5.54
GOB Contribution	96,639.13	12.31
DP Contribution	18,847.23	2.40



2.5 Development and Approval of the PIP of 4th HPNSP

The development of the 4th HPNSP followed a long process of internal discussion, reflection and consultation with different stakeholders- both among the government and development partners. This section records key milestones of the various stages through which it was processed, with focus on the period leading to its submission to the Planning Commission for government approval and their guidance relating to its implementation.

2.5.1 Major activities leading to submission of PIP to Planning Commission

The preparation process of the Program Implementation Plan (PIP) commenced with a launching workshop held in January 2015. The Concept Paper of the 4th HPNSP was approved by the MOHFW in May 2015, providing the basis for preparation of Strategic Investment Plan (SIP).

During development of the SIP, 11 Strategic Thematic Groups (STGs) consisting of GOB-DP Task Group members and others concerned developed 11 thematic reports as background papers of the SIP. One International Consultant was involved in preparation of the SIP, which was subsequently finalized by the Planning Wing with support from PMMU-TAST. The SIP was approved in April 2016 identifying the strategic objectives and key program areas required to be pursued by the MOHFW.

The Program Implementation Plan (PIP) was drafted following the SIP by the Planning Wing with support from PMMU-TAST and a team of consultants supported by the Joint Donor Technical Assistance Support Fund (JDTAF). During preparation of the PIP, three Divisional Stakeholder Consultation workshops were conducted by the Planning Wing in Khulna, Sylhet and Chittagong on 15 May, 24 July and 28 August 2016 respectively. The draft was shared with the development partners for their comments & inputs in October 2016 and was presented at a workshop on 23 November 2016. The PIP was then further enriched reflecting valuable inputs from the development partners.

The recast PIP was placed before the MOHFW's Project Scrutiny Committee (PSC) on 15 December 2016 for the committee's review and recommendation. Then with approval of the Hon'ble Minister, the PIP was sent to the Socio-Economic Infrastructure (SEI) Division of the Planning Commission on 28 December 2016. Afterwards, the Planning Wing, MOHFW submitted a manpower proposal to the Finance Division for recommendation of OP-wise number and type of posts under the 4th HPNSP. The manpower proposal was developed by the MOHFW through a committee which conducted a number of meetings to finalize the proposal.

It may be mentioned here that the GOB's 'Project Preparation, Appraisal, Processing, Approval and Revision Procedure' of 2008 did not include any template/structure of PIP. Therefore, the initial draft of the PIP followed the outline developed by the MOHFW. However, in October 2016, a new 'Project preparation, processing, approval and revision procedure' was approved and issued by the Planning Division, Ministry of Planning which included template/structure of both PIP volume I and II. Furthermore, the initial draft involving 27 OPs had to be amended when it was decided to increase the number of OPs to 29. Therefore, both the volumes of the PIP were recast in November-early December 2016 to reflect these changes and the PIP was submitted to the Planning Commission on 28 December 2016.

2.5.2 PIP processing: Planning Commission's directions

Relevant Wings (Health Wing and Population Wing) of SEI Division reviewed the PIP and developed a working paper for discussion in the Project Evaluation Committee (PEC) meeting to be held under the chairmanship of Member, SEI Division. There were 275 comments/observations in the working paper, out of which 37 were on general issues, 42 on Governance and Stewardship, 82 on Systems Strengthening and 114 on Service Improvement. The Planning Wing of MOHFW developed responses to these issues, based on consultations with the relevant wings/agencies of MOHFW.

The PIP was discussed in the PEC meetings on 19, 22 & 23 February and 1 March 2017. Usually a project is reviewed in one PEC meeting, however, considering the volume of the 4th HPNSP and the complexity of involved issues, four PEC meetings were needed to review and discuss the PIP intensively. The PEC recommended for submitting the PIP to the Executive Committee of the National Economic Council (ECNEC) for approval subject to reflection of the PEC decisions in the PIP. Some major decisions of the PEC regarding Program implementation can be seen at Annex B.

Steps were taken to reflect the PEC decisions in the relevant chapters of the PIP, including the OP budgets. The recast PIP was submitted to the Planning Commission on 16 March 2017. A consolidated paper mentioning the actions taken on PEC decisions is attached to PIP volume-I. The PIP was then approved by the ECNEC, chaired by hon'ble Prime Minister on 21 March 2017, with three conditions- (i) the PIP would need to be recast following the instructions included in the latest circular of the Ministry of Planning; (ii) ERD would take necessary steps to reduce the financing gap and the MOHFW as well as ERD would maintain regular communication with the development partners to address financing gap issue; and (iii) manpower included in the HPNSDP would be carried over in the 4th HPNSP and new manpower would need to be recommended by the Finance Division.

Following the third condition, 16,221 personnel of different categories were included in the 4th HPNSP as carried over from the HPNSDP. The Finance Division's Manpower Recommendation Committee's meeting took place on 12 April 2017 to review new manpower proposal. The committee recommended 4,416 new posts- making provision for a total of 20,637 posts under the 4th HPNSP. This is reflected in PIP Volume-I and the OP-wise manpower list is attached in PIP volume-II. The recast PIP reflecting the ECNEC's decisions received final approval of the NEC-ECNEC Wing of the Planning Division, Ministry of Planning on 30 April 2017, followed by the issuance of the administrative order of PIP approval.

2.6 Operationalization of 4th HPNSP after Bifurcation of MOHFW

This section describes some of the steps taken by the two Divisions of MOHFW to operationalize the newly approved program in a changed administrative environment. While the PIP preparation and approval process was going on, the Planning Wing of the MOHFW simultaneously carried out detailed OP preparation activities. The draft OPs were developed by the relevant wings of MOHFW/agencies with support from a team of consultants supported by JDTAF and then reviewed by the Planning Wing.

Bifurcation of MOHFW and OP approval process

On 16 March 2017, the MOHFW was bifurcated into two Divisions- (i) Health Services Division (HSD); and (ii) Medical Education and Family Welfare Division (ME&FWD). Therefore, while sending the recast PIP to Planning Commission on 25 April 2017 for final approval order, the PIP was signed by both the Secretaries of HSDP and ME&FWD. Moreover, due to bifurcation, the allocation of business within MOHFW was amended following which the OPs and projects of the MOHFW were divided under two Divisions. Out of the 29 OPs, 19 were placed under the HSD and 10 under the ME&FWD. Both the Divisions formed Steering Committee (SC) under the chairmanship of respective Secretary following the terms of reference mentioned in PIP Volume-II. Following the issuance of administrative order of approval of the PIP on 30 April 2017, the Planning Wing of HSD and the Planning Branch of ME&FWD reviewed the relevant OPs and placed those before the SC for recommendation. SC meetings of HSD were held on 2, 3 and 4 May 2017, where the 19 OPs under the HSD were recommended for approval subject to recasting the OPs in line with the observations made by the SC. Similarly, SC meetings of the ME&FWD took place on 7 and 8 May 2017 where the 10 OPs under the ME&FWD were recommended for approval. All the recast OPs reflecting the decisions of the SC meetings were then approved by the Hon'ble Minister, MOHFW within mid-May 2017.

RADP fund allocation and release

One of the critical issues to get the 4th HPNSP operationalized was to get allocation of fund to the OPs from the Revised Annual Development Program (RADP) 2016-17. Usually, RADP preparation activities commence in November-December of any financial year (FY) and get finalized by March of the same FY. The MOHFW proposed on 8 January 2017 in the call-notice (issued on 20 December 2016 by the Planning Commission) of RADP 2016-17 to allocate required GOB, RPA and DPA fund to the OPs of the 4th HPNSP. MOHFW also maintained communication at higher level to ensure proposed funds in the RADP. However, according to the ADP/RADP guidelines, unapproved projects/programs cannot be included in ADP/RADP with allocation. Therefore, OP-wise fund could not be allocated in RADP 2016-17 since the PIP as well as the OPs were not approved before finalization of RADP. Moreover, according to RADP preparation guidelines, there was no provision of retaining block allocation for any unapproved projects/OPs. Knowing these facts, the MOHFW took an alternative measure in advance- i.e., during finalization of RADP in February 2017, MOHFW reserved some GOB funds in some of the on-going projects' RADP allocation so that this fund could be transferred to the OPs once approved.

After approval of the OPs, HSD on behalf of the MOHFW, requested the Planning Commission to allocate GOB funds preserved in some projects' RADP allocation to the OPs through re-appropriation; and also requested the Planning Commission and ERD to allocate required RPA and DPA to the OPs. ERD consented to the Planning Commission to allocate proposed RPA and DPA to the OPs. The Planning Commission allocated the proposed GOB fund through re-appropriation and also agreed to release the said fund on 28 May 2017, but could not allocate funds required for RPA or DPA. Therefore, the planned activities of the OPs under DPA and RPA funding could not be implemented during the reporting period.

The Line Directors (LDs) then submitted fund release proposals to respective Divisions of MOHFW. These proposals were reviewed by the Financial Management and Audit (FMA) Wings of the respective Divisions and sent to the Finance Division for clearance. After getting clearance from the Finance Division, the FMA wings issued government order for release of funds. Finally, fund was released by the Comptroller and Auditor General's (CAG) office in June 2017 to implement the planned activities of FY 2016-17.

2.6.1 Orientation to officials of HSD and ME&FWD on the new Program

An Orientation Workshop was held on 11 June 2017 under the chairmanship of Secretary, HSD to orient the officials of the HSD on the salient features of the 4th HPNSP and its preparation process. A similar Orientation Workshop was held on 13 June 2017 under the chairmanship of Secretary, ME&FWD. Moreover, orientation Workshop on '4th HPNSP and roles of the LDs, PMs and DPMs' was held on 21 June 2017 under the chairmanship of Secretary, HSD; where all the LDs and some of the PMs and DPMs of the 19 OPs under the HSD participated. A similar workshop also took place with the LDs/PMs/DPMs of the 10 OPs under the ME&FWD with Secretary, ME&FWD in the chair.

2.6.2 Template of Annual Work Plan for the OPs was developed and circulated to the LDs in June as part of steps for systematic implementation of the Program in the next FY, i.e., 2017-18.

CHAPTER 3. FINANCIAL PROGRESS OF 4th HPNSP

3.1 Fund Release Against Budget Allocation

The total Revised Annual Development Program (RADP) fund allocation for FY 2016-17 covering the period of January-June 2017 of 4th HPNSP was Tk. 1,091.9 crore. Only GOB fund was available during the reporting period.

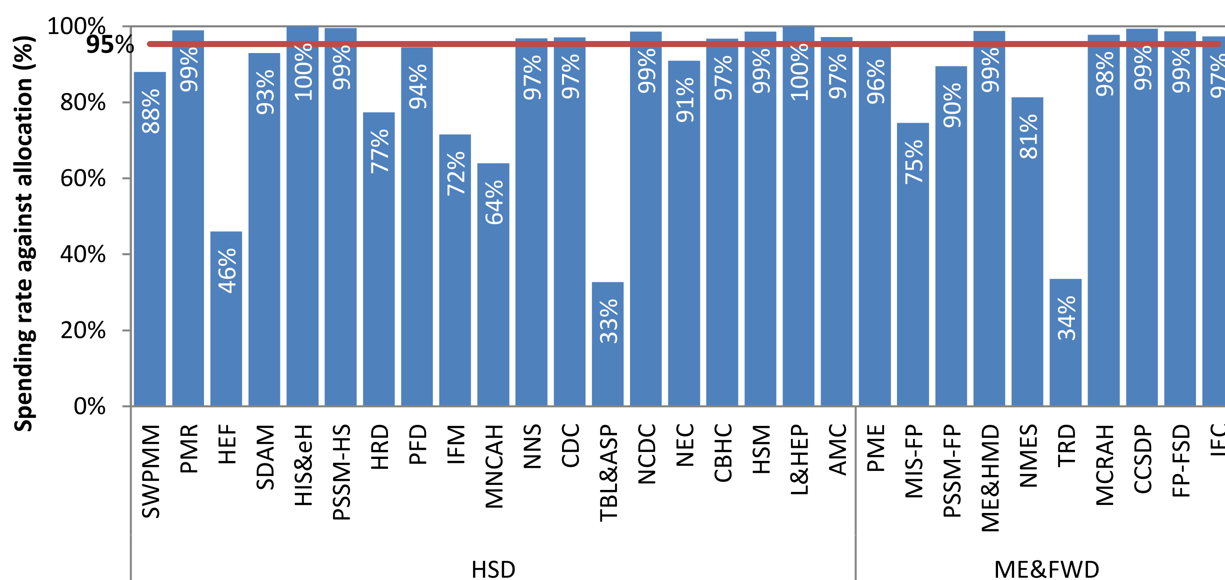
The allocation of funds among the OPs shows that more than 83% of the RADP allocation was concentrated in 4 OPs, 3 of which are under HSD (i.e. PFD, CBHC and HSM) and 1 under ME&FWD (i.e. ME&HMD). PFD alone received 40% of the total allocation. The pattern in allocation could have been generated by the perceived capacity of the OPs for fund utilization within a very short period of time. The details of OP-wise allocation, release and expenditure during the period may be seen at Table 3.2.

During the period under review, Tk. 1,091.3 crore was released to the OPs, which is almost 100% of the allocated fund for the financial year. Overall, the release of funds for each OP was 100% of allocation except that for TRD (44%).

3.2 Expenditure Pattern

The spending rate is generally considered to be a good indicator of program performance. During the period under report, Tk. 1,041 crore was spent in total by the OPs, which is 95.34% of allocated fund and 95% of released fund. Figure 3-1 below presents the OP-wise spending rates against allocation.

Figure 3-1: Spending rate by OPs



Although the approval of the OPs and the release of funds took place in May and June respectively, the Planning Wing had advised the LDs earlier to take steps to complete prior preparations for realistic fund utilization. The high utilization rate achieved possibly reflects the result of that initiative taken by the Planning Wing. It is relevant here to point out that the Program's RFW includes as an indicator "the number of OPs with annual budget execution over 80%" with the target of 19 OPs meeting the criteria by the end-program. During the reporting period, however, 22 OPs fulfilled the indicator requirement. Seven OPs which achieved below 80% fund utilization were HEF, HRD, IFM, MNCAH, TB-L&ASP, MIS, and TRD.

3.3 Component-Wise Financial Performance

The OPs are divided into three components – those relating to "strengthening governance and stewardship (SGS)", those relating to "strengthening health systems (SHS)" and those referring to "improving health services (IHS)". Less than a percent (0.4%) of funds was allocated to the SGS OPs, 54% of funds was allocated to SHS OPs and 46% to IHS OPs. Table 3-1 shows budget allocation, release and spending patterns, by source of fund and the OP types.

Table 3-1: Overall financial performance: SGS, SHS and IHS OPs

(Tk. in crore)

OP Type	Strengthening Governance and Stewardship (SGS)	Strengthening Health Systems (SHS)	Improving Health Services (IHS)	Total
Fund allocation	4.2 (0.4%)	585.4 (53.6%)	502.4 (46.0%)	1,091.9 (100%)
Fund released	4.2 (0.4%)	584.7 (53.6%)	502.4 (46.0%)	1,091.3 (100%)
Expenditure	3.0 (0.3%)	557.4 (51.0%)	480.6 (44.0%)	1,041.0 (100%)
Number of OPs	***5***	***10***	***14***	***29***

3.4 OP-Wise Financial Performance

The actual RADP allocation, release and expenditure of each OP under HSD and under ME&FWD can be seen at Table 3-2.

Table 3-2: Overall OP-wise Allocation, Release and Expenditure

(in crore Tk.)

Divisions	OP	Allocation	Percent share of RADP Allocation	Release	Expenditure
Health Service Division	AMC	19.00	1.74%	19.00	18.46
	CBHC	240.85	22.06%	240.85	233.02
	CDC	25.00	2.29%	25.00	24.28
	HEF	2.00	0.18%	2.00	0.92
	HIS&eH	10.00	0.92%	10.00	10.00
	HRD	0.26	0.02%	0.26	0.20
	HSM	123.00	11.26%	123.00	121.24
	IFM	0.31	0.03%	0.31	0.22
	L&HEP	0.80	0.07%	0.80	0.80
	MNCAH	20.00	1.83%	20.00	12.79
	NCDC	2.86	0.26%	2.86	2.82
	NEC	0.45	0.04%	0.45	0.41
	NNS	2.60	0.24%	2.60	2.52
	PFD	438.61	40.17%	438.61	414.28
	PMR	1.00	0.09%	1.00	0.99
	PSSM-HS	15.00	1.37%	15.00	14.92
	SDAM	0.50	0.05%	0.50	0.47
	SWPMM	0.33	0.03%	0.33	0.29
	TBL&ASP	4.00	0.37%	4.00	1.31

Divisions	OP	Allocation	Percent share of RADP Allocation	Release	Expenditure
Medical Education & Family Welfare Division	CCSDP	31.00	2.84%	31.00	30.81
	FP-FSD	12.80	1.17%	12.80	12.63
	IEC	10.00	0.92%	10.00	9.73
	MCRAH	10.00	0.92%	10.00	9.78
	ME&HMD	108.29	9.92%	108.29	107.01
	MIS-FP	0.88	0.08%	0.88	0.66
	NMES	1.00	0.09%	1.00	0.81
	PME	0.37	0.03%	0.37	0.35
	PSSM-FP	10.00	0.92%	9.93	8.95
	TRD	1.00	0.09%	0.44	0.34
	Grand Total	**1091.91**	**100.00%**	**1091.28**	**1041.01**

Even though high utilization rates were achieved on average, each Division had a number of OPs performing substantially below Average e.g. TRD and MIS under the ME&FWD. While, TB-L&ASP, HEF, MNCAH, IFM and HRD are under HSD.

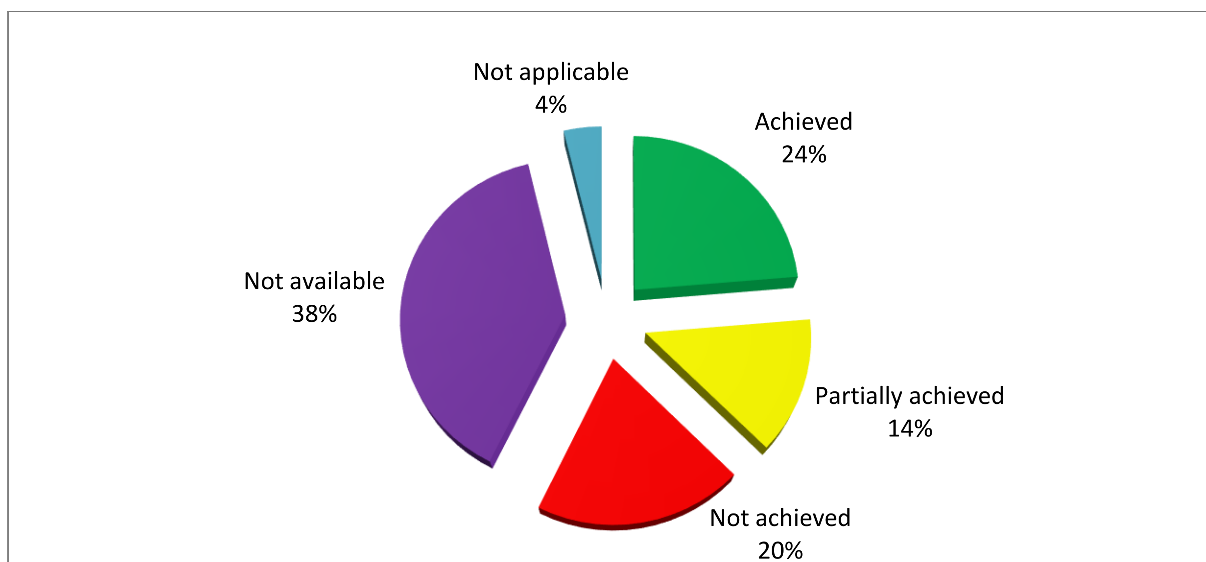
CHAPTER 4. PROGRESS MEASURED BY OP-LEVEL INDICATORS

4.1 Overall Progress Measured by OP-level Indicators

The OP-level indicators are calculated based on the baseline, target (Mid-2020) and achievement. The current progress is measured against the calculated target for the reporting period (January-June 2017). The achievement of OP-level indicators during January-June 2017 was found to be 24%. Out of the 131 indicators used at the OP-level, 31 indicators (24%) were fully achieved and 18 indicators (14%) were partially achieved.

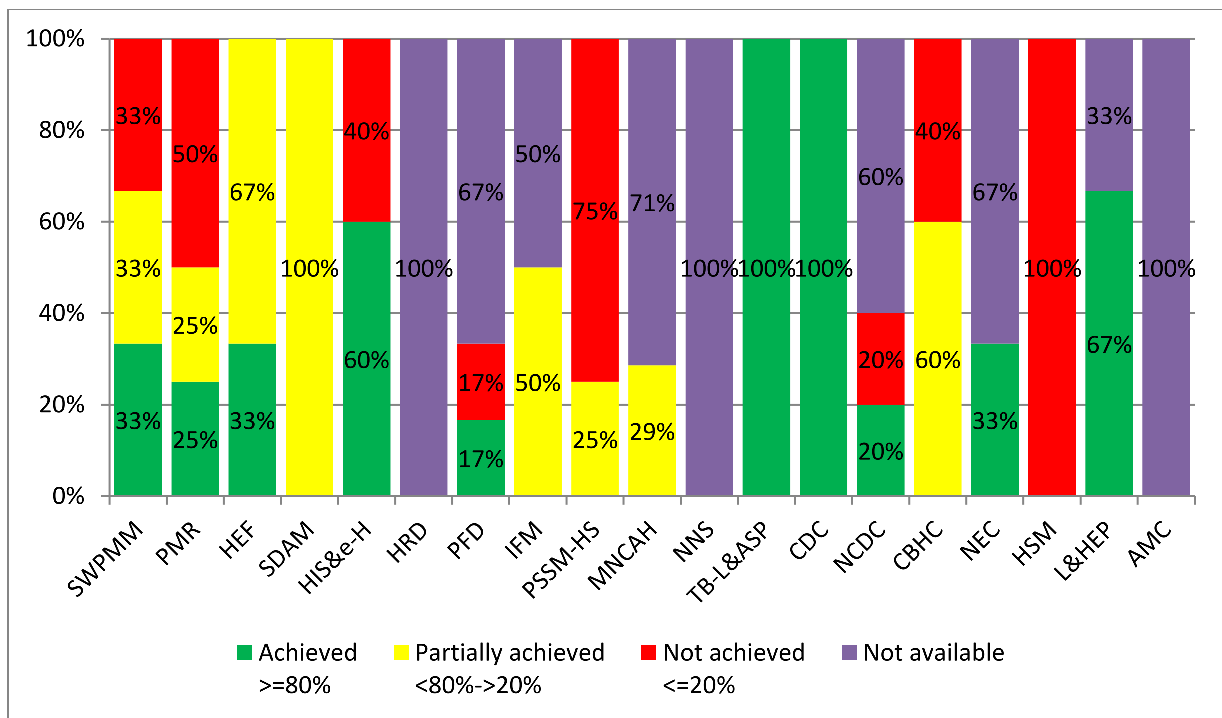
Twenty-six indicators (20%) were found “not achieved”, meaning 20% or less progress made in January-June 2017 and five indicators (4%) were found “not applicable” as the targeted timeline doesn’t fall under this reporting period to produce results on those indicators; and hence were deliberately eliminated from the denominator during calculation (Figure 4-1). In addition, Indicators with “not applicable” status were not considered into the bar charts that presents the distribution of progress of OP level indicators (Figure 4-2 and Figure 4-3)

Figure 4-1: Overall achievement measured by OP-level indicators



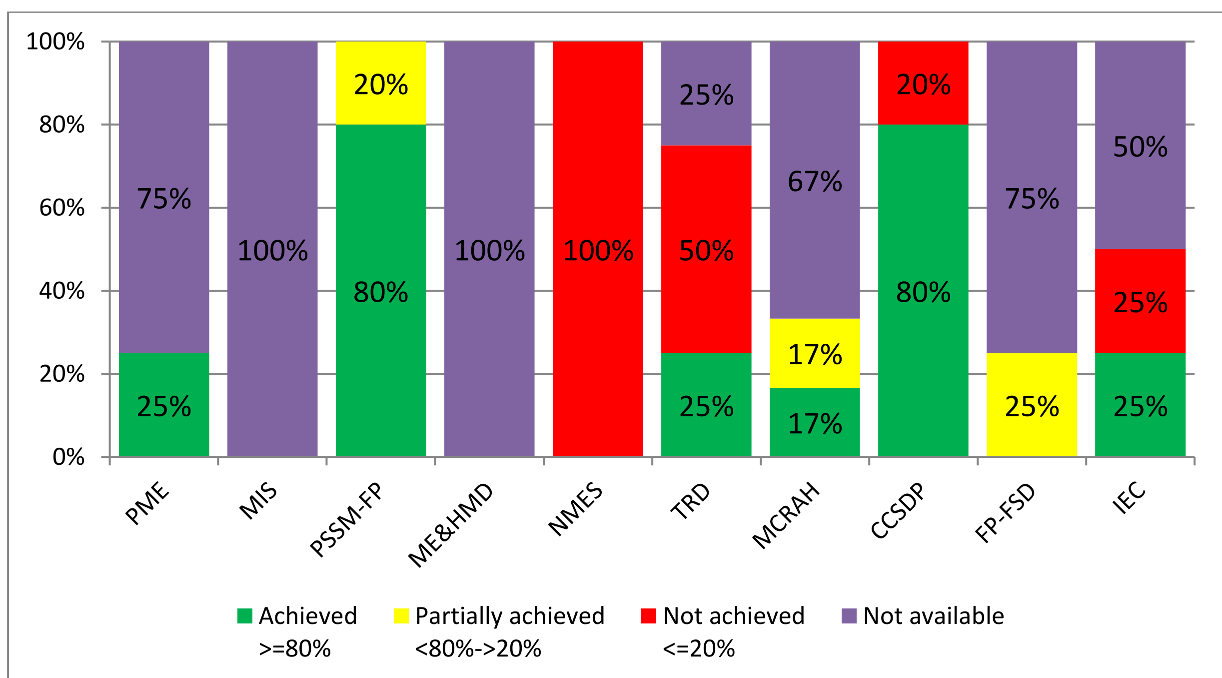
In terms of individual OPs under HSD, two (TB-L&ASP and CDC) out of 19 OPs have fully achieved their targets of the OP-level indicators during January-June 2017. OPs with weak progress are PMR, SDAM, PFD, IFM, PSSM-HS, MNCAH, NNS, NCDC, CBHC, HSM and AMC with 25% or less OP-level indicators fully achieved (Figure 4-2).

Figure 4-2: Distribution of progress in HSD OP-level indicators during January-June 2017



In terms of individual OPs under ME&FWD, two (PSSM-FP and CCSDP) out of 10 OPs have been able to achieve >=80% of their targets of the OP-level indicators during January-June 2017. OPs with weak progress are PME, MIS, ME&HMD, NMES, TRD, MCRAH, FP-FSD and IEC with 25% or less OP-level indicators fully achieved (Figure 4-3).

Figure 4-3: Distribution of progress in ME&FWD OP-level indicators during January-June 2017



INDICATOR PROGRESS BY OP TYPES

Table 4-1 shows that the indicator achievement of IHS related OPs measured by OP-level indicators are higher than SGS and SHS related OPs (29% vs.19 %) and (29% vs. 19%). Noteworthy, delay in receipt of funds led to delay in OP implementation which ultimately affected achievement of the indicators (38% of the indicators either fully or partially achieved). 38% of total indicators couldn't claim achievement of progress during the reporting period.

Table 4-1: Overall OP-level indicators Progress: SGS, SHS, and IHS

Type of Progress	SGS	SHS	IHS	All OPs
Number of indicators	21	47	63	131
Achieved	19% (4)	19% (9)	29% (18)	24% (31)
Partially achieved	38% (8)	6% (3)	11% (7)	14% (18)
Not achieved	14% (3)	28% (13)	16% (10)	20% (26)
Not available	14% (3)	43% (20)	44% (28)	38% (51)
Not applicable	14% (3)	4% (2)	0% (0)	4% (5)

4.2 Progress of Disbursement Linked Indicators (DLIs)

(a) DLI achievement during HPNSDP additional financing:

During the implementation of the HPNSDP (July 2011-December 2016), several fiduciary governance risks were documented such as poor application of procurement procedures and insufficient financial management controls. In response to this, the World Bank in 2015 undertook an Integrated Fiduciary Assessment (IFA) of the sector program with the support of the MOHFW in coordination with the pooling partners. Consequently, an Action Plan was agreed to strengthen fiduciary oversight and systems. Implementation of the IFA Action Plan was supported by additional financing to the HPNSDP, approved in June 2016, to the amount of US$150 million, which linked disbursement to achievement of the agreed actions (disbursement linked indicators, DLIs). This represented a change in financing modality of the HNP SWAp in Bangladesh from input-based financing to results-based financing. The additional financing supported 15 DLIs, of which 11 DLIs were related to fiduciary and system development — including 6 from the 2015 IFA Action Plan — and 4 reflected service delivery improvements. In spite of considerable premonition regarding the working of a new system of financing, the performance of MOHFW in achieving the DLI targets was 100%. Between January and June 2017, US$95 million were disbursed by the Bank for achievement of 11 DLIs. (Earlier in October 2016, the Bank disbursed US$50 million for achievement of 4 DLIs. In July 2017, the Bank disbursed US$5 million for the achievement of the one remaining DLI.)

(b) DLIs in the 4th HPNSP:

The World Bank had agreed to provide financing to support the implementation of 4th HPNSP based on the achievement of pre-defined results in the three component areas of the new Sector Program: governance and stewardship, health systems strengthening and delivery of quality HNP services particularly in the regions of Sylhet and Chittagong where health outcomes have been considerably below par. GOB and the World Bank signed the financing agreement for 4th HPNSP on 28 August 2017. The new financing arrangement continues the shift towards a result-focus while strengthening governance and fiduciary management systems. As was the case with the additional financing phase of the HPNSDP, this arrangement focuses on support to a mix of actions, processes, outputs, and service delivery results. Service delivery output and outcome-oriented DLIs are meant to reflect the fact that technical strategies and required inputs are needed to deliver essential services. The more process-oriented DLIs, particularly under Components 1 and 2, reflect both the fact that a continued

focus on system reforms is needed and that a step-by-step approach is required to achieve them. In all there are 16 DLIs, which were agreed upon through a long process of consultations with all relevant stakeholders.

Even though the DLI-based World Bank financing is expected to become effective by October 2017, it has provision for retroactive financing (upto a maximum of SDR 57.8 million) to pay for results achieved as of June 2017. A list of the Disbursement-Linked Results (DLR), with unit price and indicative targets to qualify for this special financing arrangement may be seen at Annex C.

HSD has set up a DLI Monitoring Committee while the IMED has been selected to perform the role of the Independent Verification Agency (IVA). In a departure from the system of fund disbursement for the DLIs under the additional financing for the extended period of HPNSDP, the IPF-DLIs under the 4th HPNSP require the claimed results to be subjected to a verification process through an independent third entity/entities to qualify for reimbursement by the World Bank. The method of claiming reimbursement by MOHFW and that of verification have been detailed in the Project Appraisal Document (PAD) of the World Bank and have been made part of the recently-signed Financing Agreement.

CHAPTER 5. OP-WISE PHYSICAL PROGRESS

The LDs were requested to report on their physical progress of work made during January –June 2017, which called for highlighting progress in major physical activities. In this chapter, OP progress in selected areas and major activities of 4th HNPSP are highlighted. Progress is reported under three components: governance and stewardship related OPs, strengthening health system related OPs and improving health services related OPs.

5.1 Governance and Stewardship (SGS) Related OPs

OP 01: Sector-Wide Program Management and Monitoring (SWPMM):

Sector coordination

During the reporting period, the Program Implementation Plan (PIP) of the 4th HPNSP was finalized complying with the decisions of the PEC meetings. The PIP was approved by the ECNEC on 21 March 2017. The HNP Steering Committee (SC) and Training Implementation Committee (TIC) were formed under the HSD and ME&FWD of MOHFW. All 29 OPs were reviewed and guidelines were provided to the LDs to finalize the OPs. All the OPs were approved by the Hon'ble Minister of MOHFW after being recommended by the SCs. Aid modality of the World Bank in the 4th HPNSP and the Disbursement-Linked Indicators were finalized through extensive consultation with the World Bank Missions, other DPs and relevant GOB officials. Bi-lateral meetings with other DPs also took place with regard to funding the 4th HPNSP.

Program Review, Monitoring and Evaluation

One of the major tasks of this OP is to prepare different progress reports of the sector program. This OP prepared and disseminated the Light-touch APR 2016 report and finalized the End-line evaluation report of the third Sector Program (HPNSDP). Meanwhile, a template for the Program Implementation Report (PIR) 2017 was developed and shared with LDs to collect progress of OP implementation. Health-related SDG Monitoring & Evaluation Framework was updated with recent data and the development of an action plan is also underway.

Capacity Development of MOHFW along with the Implementing Agencies and Concerned Sectors of Planning Commission

Orientation of the officials of the HSD and ME&FWD on the 4th HPNSP was successfully conducted. A total of 313 personnel participated in 10 orientations and workshops during the reporting period. It has been observed that due to successful coordination with 29 OPs, the RADP utilization rate was 95%. A field visit in Jessore took place in April 2017 to observe the activities of the Urban Health Systems Strengthening Project (UHSSP)- a pilot project of MOHFW.

OP 02: Planning, Monitoring, and Research (PMR):

The PMR has already developed training modules and is planning to organize orientation workshops for managers at different levels. A monitoring guideline and checklist for field-level managers was prepared and training on planning and implementation of health programs and research methodology were conducted. Two briefs were prepared on researches conducted by the Planning Unit of the DGHS. The OP facilitated five progress monitoring meetings for the DGHS. BMRC as a cost-center under this OP has received fund for building research capacity.

OP 03: Planning, Monitoring, and Evaluation (PME):

The objective of PME OP is to assist in formulation and implementation of different OPs under DGFP through effective coordination, monitoring and evaluation of field programs' performance. From the support of PME, seven AWPs with budgets were prepared and submitted to the MOHFW. A total of 16 MOHFW personnel participated in a short-term local training on development & planning. Procurement of 2 sets of computers, 2 sets Air-condition, 2 sets scanner and furniture- 35 pieces of chair, 1 set (10 pieces) of table was completed.

OP 04: Health Economics and Financing (HEF):

With an aim to attain sustainable health financing, the HEF is conducting training programs for the MOHFW officials. A total of 38 personnel attended training on gender responsive budgeting and 40 personnel attended in another training on health sector response to GBV. One equity, gender, and voice (EGV) training program was also conducted for field officials. The pilot implementation of social health protection schemes (Shasthyo Shurokhsha Karmasuchi (SSK) is going on in one upazila and as part of roll-out, the enrolment and registration of the beneficiaries for other 2 upazilas was also started. A protocol on health sector response to GBV was finalized.

OP 05: Strengthening of Drug Administration and Management (SDAM):

The SDAM OP's objective is to ensure quality, efficacious and safe pharmaceutical products for improving health of the people. Presently, 40,489 brands of medicines are being registered to DGDA and a total of 2,385 drug samples were tested during the reporting period by National Control Laboratory, Dhaka & Chittagong Drug Testing Laboratory. In addition, 516 pharmaceutical manufacturing units were inspected by DGDA inspectors. Presently 1,23,811 licensed retail pharmacies & depots of drugs are available in Bangladesh and out of that DGDA inspectors inspected 31,273 retail drug shops during this reporting period. Moreover, 435 Adverse Drug Event Reports (ADR Reports) were collected from different hospitals & pharmaceutical industries by Adverse Drug Reaction Monitoring Cell of DGDA.

5.2 Strengthening Health Systems (SHS) Related OPs

OP 06: Health Information Systems and e-Health (HIS&eH): HIS&eH OP is responsible to strengthen the national health information system, e-Health and medical biotechnology. There is a DLI conditioned on this OP to work on the collection of gender dis-aggregated data. In response, the OP developed reporting form and incorporated it into the DHIS2 platform. However, the testing process is still undergoing.

During the reporting period, 100% of facilities (Upazila level & above) and 90% of community-level government health facilities submitted the routine reports timely. This OP introduced an open-access data dashboard on DHIS2 platform to present data on real-time basis. The major expenditure of this OP was on procurement of computer accessories, internet services, consultancy, machinery and other equipment. This OP is also responsible to strengthen citizen feedback system which was conditioned as DLI 1. Accordingly, this OP enhanced the GRS and formulated a draft guideline for responses and tracking system.

OP 07: Management Information System (MIS):

This OP falls under DGFP and is mandated to develop and strengthen information management system through adoption of new technologies and tools for ensuring the data quality and improving evidence based decision-making. 1000 copies of annual reports and 800 copies of monthly reports

(LMIS) have been published and disseminated. Computer consumable items and customized software have been procured. A total of 100 DGFP personnel attended training on e-filing.

OP 08: Procurement, Storage and Supplies Management-HS (PSSM-HS):

PSSM-HS has conducted supply chain management activities to enhance procurement capacity and supplies management for health services. Partial implementation has started to add comprehensive maintenance management in the tender documents for high-tech equipment. This OP is responsible to improve the procurement management using adoption of an information technology platform, addressing DLI 5. As part of that, this OP initiatedthe procurement process for one NCB package through e-GP. This OP is also responsible to develop an institutional capacity for procurement and supply management for HSD, addressing DLI 6 under component 2. In that light, a proposal for restructuring of CMSD was prepared and sent to MOPA for review through MOHFW.

OP 09: Procurement, Storage and Supply Management-FP (PSSM-FP):

The objectives of PSSM OP is to ensure availability of quality contraceptives, medicines and reproductive health commodities all over the country through an effective, efficient and transparent procurement, storage and supply management process. As part of security improvement at regional warehouses and Upazila stores, a pool of Ansar/VDP members have been deployed. Contraceptives and RH commodities have been supplied to 20 warehouses and 486 Upazila stores. A clearing and forwarding agent has been appointed to release commodities from sea/airports. 87% of contracts were awarded within initial tender validity period. During the reporting period, 99.23% of public health facilities/public service delivery points were without stock-outs of essential medicines/FP supplies and 100% of (a) WIMS and (b) UIMS were functional. Moreover, 80% of Upazila had no 'unusable' items that were lying at the warehouses which enabled DGFP to make use of extra space for commodity management. In addition, a total of 40 personnel attended training on e-Procurement (e-GP).

OP 10: Human Resources Development (HRD):

The HRD OP is responsible to support availability of a skilled and responsive health workforce at all public and private sector health facilities. A total of 47 personnel (41 MOHFW+ 6 non-MOHFW) attended a workshop meeting on HPNSP steering committee.

OP 11: Medical Education and Health Manpower Development (MEHMD):

The ME&HMD OP aims to strengthen the medical education and health manpower development system for developing medical professionals and health workforce to deliver high standard and high-quality services for achieving the universal health coverage. To do so, a total of 126 personnel (3 MOHFW +123 non-MOHFW) attended workshop for review and development of 07 training curriculums. This OP also provided need-based assistance for the development of quality post-graduate medical education in 08 medical colleges and 01 dental college.

Machineries & equipment, furniture & fixture were procured for 30 medical colleges, 01 dental college, 08 MATS & 08 IHTs. Medical education unit and medical skill centre were strengthened in 30 medical colleges, 01 dental college and 08 dental units. Educational facilities for 08 MATS & 08 IHTs have also been strengthened. Monitoring, supervision & evaluation related activities are being conducted through task force in 30 medical colleges, 01 dental college, 08 MATS & 08 IHTs for improving performance.

OP 12: Nursing and Midwifery Education Services (NMES):

With a view to improve the quality of nursing & midwifery services in Bangladesh, procurement of furniture, vehicles, equipment, OMR machine has been completed. This OP is responsible to increase availability of midwives for maternal care, addressing DLI 7 and to achieve the DLI's target, 975 participants completed their midwifery training during the reporting period.

OP 13: Training, Research and Development (TRD)

Imparting pre-service and in-service training to service providers and conducting research, evaluation, and surveys for providing up-to-date information for improvement of programs are the key activities of TRD OP. During the reporting period, the OP completed disseminations of five research/survey results through workshop, seminar, policy brief and newsletter. A total of 117 (77 MOHFW personnel+40 non-MOHFW) personnel participated in the annual dissemination seminar. Moreover, a total of 74 (62 MOHFW personnel+12 non-MOHFW) personnel attended workshop on research priority identification. A basic training was also conducted for 439 FWVs.

OP 14: Physical Facilities Development (PFD)

The PFD OP is mainly responsible to develop, upgrade and maintain the health facilities, equipment and vehicles. It implements its activities through two departments under MOHFW- Health Engineering Department and Public Works Department.

1. HED (Health Engineering Department)

During the reporting period, this OP has fully/partially completed the construction of Maligaon 50 Bed Hospital in Comilla, 01 Nursing College, 23 Mother and Child Welfare Centers (MCWCs), Ladies hostel for Dhaka Dental College, Health Bhaban at Mohakhali and renovated the existing Family Planning stores. This OP also took initiatives to upgrade 09 Upazila Health Complexes to 50-bedded hospital and expanded 10 UHCs to accommodate the Upazila Family Planning Offices, Stores and Services. During the same period, construction of 01 Nursing Training Institutes, 01 Nursing Colleges, 05 Institute of Health Technology (IHTs) and 03 Medical Assistant Training School (MATS). Overall, the OP has completed 89% procurement of goods.

2. PWD (Public Works Department)

During the reporting period, the remaining works for establishment of Cox's bazar, Noakhali and Jessore Medical Colleges were completed. In addition, renovation/remodelling and supply, installation or replacement of passenger and bed lifts of Mymensingh Medical College, Rajshahi Medical College and Barisal SB Medical College Hospital were completed. 93% of physical progress of vertical extension over 4th floor (5th to 9th) of Cardiac Surgery building in Chittagong Medical College Hospital also completed. The OP started the construction of Government Shishu Hospital in Rajshahi and vertical extension of female hostel and construction of male hostel at Mymensingh Medical College were ongoing (50% progress). Moreover, 82% progress has been made for remaining works for construction of Trauma Centre in Munshigonj and construction of auditorium building at Khulna Medical College (89% progress) and male and female student hostel at Pabna Medical College (95% progress) were also ongoing.

Upgradation of nursing training institute at Pabna, Patuakhali and Kustia and upgradation of district hospital from 50/100/200 bed to 250 bed in Bhola, Sunamgonj, Chuadanga,Magura,Chapai Nawabgonj, Naogaon, Sirajgonj, Thakurgaon, Nilphamari, Hobigonj, Sherpur, Lalmonirhat, Kurigram, Madaripur, Jhenaidah were ongoing. Up gradation of District Hospital (DHs) in Barguna, Bagerhat, Manikgonj, Munshigonj and Gazipur were also ongoing.

OP 15: Improved Financial Management (IFM)

The IFM OP aims to improve the governance in financial management and audit system. The OP implemented activities related to operating cost, supplies and services etc. This OP is also responsible to strengthen the financial management system; addressing the DLI 3. As part of that, a committee had been formed which sat twice to discuss ways to take forward to strengthen the internal audit system.

5.3 Improving Health Services (IHS) Related OPs

OP 16: Maternal, Neonatal, Child, and Adolescent Health (MNCAH):

With a view to improve the maternal, newborn, and child health (MNCH) status of the population of Bangladesh, MNCAH OP has contributed to an increase in coverage and utilization of the quality MNCH services at the facility and community levels.

Maternal and Neonatal Health (MNH)

An annual work plan (AWP) along with a procurement plan was developed and approved for MNH program. The OP distributed 40,270 vouchers among poor pregnant women in 53 Upazilas under DSF activities. 29,089 normal deliveries have been performed in the public facilities of DGHS in Sylhet and Chittagong divisions during the reporting period.

Expanded Program of Immunization (EPI)

Construction of 6 EPI stores in 6 districts completed. HPV pilot project in Gazipur district is going on which will be ended in 2017. On the job training on EVM has been provided to all concerned personnel and necessary equipment was supplied as per EVM assessment's recommendations. Review on Congenital Rubella Syndrom (CRS) Surveillance was conducted by an international team. Orientation on Japananese Enchaphalaties (JE) for all concerned has been completed. Routine AEFI surveillance is going on along with VPD surveillance under EPI. Data analysis of Coverage Evaluation Survey (CES)-2016 is going on. Maternal Child Health & Immunization Worker (MCH&IW) and volunteers were deployed against the vacant post of Health Assistant (HA). The OP ensured regular monitoring and supportive supervision at all levels. The OP strengthened Maternal and Neonatal Tetanus (MNT) surveillance and increased TT Vaccination coverage among child-bearing age group. This OP is responsible to enhance immunization coverage and equity, addressing DLI 12 under component 3 (Improving Health Services) and the OP achieved 49% of annual target (children immunized for measles and rubella) in 4 districts in Sylhet division and 54% of annual target for the same in 11 districts in Chittagong division.

NNHP and Integrated Management of Childhood Illness (IMCI)

The OP completed 1 batch of KMC training for doctors and another batch for nurses. One batch of ETAT and sick new-born care training for nurses was also completed. Twelve set of new-born resuscitation device (Bag & Mask) have been supplied in 3 districts. Final draft of revised 'National Child Health Strategy' has been developed and is waiting for approval by the technical committee.

Adolescent Reproductive Health (ARH)

Training manuals regarding Adolescent Health have been developed and 2000 copies have been printed.

School Health Program

Training manuals have been developed and 3000 copies have been printed regarding School Health. In addition. School based adolescent health and nutrition services have been developed in Sylhet and Chittagong divisions to address DLI 15 under component 3 (Improving Health Services). Five districts of Sylhet and Chittagong division have been selected and preparatory work has been finalized for action.

OP 17: Maternal, Child, Reproductive, and Adolescent Health (MCRAH):

The MCRAH OP is primarily responsible to deliver appropriate, effective and responsive quality maternal, newborn, child, adolescent and reproductive health services for improving overall health status with attention to marginalized and vulnerable groups. 21,468 normal deliveries have been performed in the public facilities of Sylhet and Chittagong divisions under DGFP during the reporting period. Moreover, 80 FWVs got training to enhance skill on midwifery and among them 1 FWV was from Sylhet division and 24 FWVs were from Chittagong division. During the reporting period, 110 health facilities (MCWC/UH &FWC) were made functional for Adolescent-friendly health services.

120 personnel attended training on the reporting of nutrition component. 28 personnel attended ToT on adolescent health services in ADOHEARTS area and 53 personnel attended ToT on Adolescent-friendly Health Services. The OP organized several workshops on Adolescent-friendly Health Services, accreditation guidelines for adolescent friendly health services, district evidence-based plan for Adolescent-friendly Health Services and on operational research and intervention design of adolescent health. A total of 493 personnel attended four workshops on above mentioned subjects.

Moreover, 106 personnel attended the launching ceremony of ADOHEARTS wherein the logo of Adolescent-friendly Services was introduced. 250 personnel attended the launching of Adolescent Health Strategy. 31 personnel participated in consultative meeting on IEC & e-based materials and 98 personnel participated in advocacy meeting on Adolescent-friendly Health Services.

OP 18: National Nutrition Services (NNS):

NNS OP aims to deliver nutrition services countrywide through the existing DGHS and DGFP mechanism to reduce the prevalence of malnutrition in Bangladesh. Under the maternal nutrition promotion program, 168 persons (mothers, mother-in-laws, adolescents, pregnant mothers, traditional dai–midwives) received training. A total of 600 sanitary inspectors attended training on food safety program. In addition, 392 intern doctors were trained on promotion, protection and support of Infant and Young Child Feeding (IYCF) practices.

OP 19: Communicable Disease Control (CDC):

CDC OP deals with reduction in mortality and morbidity of communicable diseases such as malaria, filariasis, etc. This OP also works on the control of helminthiasis, rabies, avian flu, and pandemic influenza diseases. In the malaria program, 500 field staff attended training on early diagnosis and prompt treatment (EDPT), 200 doctors and 180 nurses attended training on severe malaria management, 240 newly appointed doctors attended training on management of severe malaria in

the hospital. 270 private practitioners' attended orientation on malaria management. Moreover, training of community health care providers on malaria, strengthening surveillance system (MIS & LMIS reporting) of malaria control program, and Indoor Residual Spraying (IRS) were conducted and a total of 1200 officials attended these four trainings. A total of 600 participants from malaria endemic districts attended advocacy meetings. For kala-Azar elimination program, 1750 TL, spray man and first line supervisor attended workshop/training activities on IRS. Under the Soil Transmitted Helminthiasis (STH) and Little Doctors (LD) programs, a total of 3900 participants attended different events on advocacy, orientation, training etc.

For Zoonotic Diseases Program, 250 staff attended mass dog vaccination program and 180 staff participated training on Animal Bite Management. During the reporting period, the human rabies death was 38. Moreover, 1500 doctors attended orientation on Hepatitis –B infection. 2760 MOHFW and 500 non-MOHFW officials attended awareness program on Chikungunya and 30 health staff participated in disease surveillance training.

OP 20: TB-Leprosy & AIDS/STD Program (TBL & ASP):

A total of 105 field level staff e.g. HI, AHI, HA, TLCA and 60 program organizers attended training on TB. A total of 114,891 all forms of TB cases were notified. In addition, a total of 5061 child TB cases were detected during the reporting period. A total of 416 Multi Drug Resistant (MDR) TB cases have been enrolled. The OP started shorter treatment regimen [9 month] of MDR TB from April 2017. Meanwhile, reporting forms such as TB 10-case finding report, TB 11-treatment outcome report and TB12 sputum conversion report have been incorporated as part of electronic reporting of TB data in DHIS2platform. To strengthen the supervision and monitoring, 573 visits were conducted by central team, divisional experts & POs and 152 quarterly monitoring meetings held. Procurement of 87 LED microscope machine for TB diagnosis has been completed and installation has been progressed. Moreover, procurement and installation of 10 Gene Xpert machines have been completed.

Several orientations, workshops and advocacy meetings on leprosy control program were conducted and a total of 2,141 (941 MOHFW+1200 non MOHFW) participants attended. Prevalence rate of leprosy has been reported: 0.19 per 10000 population.

A total of 98 health service providers have been trained up on different issues of HIV/ AIDS e.g. HIV testing and counseling, STI, ARV and OI (Opportunistic Infection) management, gender and HIV. A total of 2,283 people living with HIV/ AIDS (PLHIV) received treatment service along ARV drugs. The national AIDS M&E plan (2018-2022) has also been developed.

OP 21: Non-Communicable Diseases Control (NCDC):

This OP has completed one central level awareness campaign on road traffic injuries and childhood drowning. The OP has also set-up a cancer registry in Medical College Hospitals. A total of 5,200 officials attended seminar on major NCDs (Cardiovascular diseases, Diabetes, COPD, Cancer). Procurement of medicines for major NCDs was completed. This OP is also responsible to address emerging challenges, addressing DLI 16 under component 3 (Improving Health Services). During the reporting period, the NCD management model (diabetes and hypertension) at community clinics with referrals to Upazila Health Complexes has been developed and implemented in 27 CCs and 9 Upazilas.

OP 22: National Eye Care (NEC):

With an aim to creating awareness on blindness and its prevention, the NEC OP has conducted cataract screening and surgical camps at Bhuiyapur upazila in Tangail district. A total of 210 adult cataract patients have undergone surgery during the reporting period. Moreover, the OP supported repair & maintenance of the eye units at Naogaon Sadar Hospital and Madaripur Sadar Hospital. A total of 32 officials attended OP steering committee meeting.

OP 23: Community-Based Health Care (CBHC):

The CBHC OP aims to ensure healthy lives and promote well-being for all at all ages by increasing accessibility, affordability and utilization of quality Primary Health Care Services within the stipulated time. For ensuring functional referral system, the CBHC OP ensured printing &distribution of referral register at 432 UHCs. Moreover, procurement & supply of Medical Waste Management logistics at 432 UHCs was completed. Procurement of furniture for 432 UHCs and procurement and supply of medicine & Medical & Surgical Supplies (MSR) for CCs were completed. CC activities are being telecast by airing television spots and television scrolls. One planning meeting was held in Rangamati district for delivering tribal health services. 50 staff and officers attended training on new CBHC Operation Plan.

OP 24: Hospital Service Management (HSM):

The HSM OP is to provide equitable and accessible healthcare services at district hospitals, medical college hospitals and specialized hospitals of Bangladesh. Hence diet, medicine and MSR have been distributed to the public hospitals. Support for cleaning and security has been continuing. In addition, procurement of instruments through CMSD started during the reporting period.

Kurigram and Lalmonirhat hospitals were accredited as women-friendly facilities. Moreover, during this reporting period, technical support was given to four district hospitals– Bandarban, Rangamati, Tangail and Netrokona. Fifteen Shishu Bikash Kendras were supported for their pay and allowance, training, supplies and maintenance. National Clubfoot Care Strategic Plan was submitted to the MOHFW for approval.

As part of digitization of licensing and renewal of private clinics and diagnostic centers, the HSM OP conducted 4 meetings in collaboration with DGHS MIS to develop a software. As part of the activities of Safe Blood Transfusion, World Blood Donor day was observed.

OP 25: Clinical Contraception Service Delivery (CCSD):

The CCSD OP aims to shift contraceptive use patterns to more effective long-acting and permanent methods (LAPMs) based on informed choice. During the reporting period, the following LAPM services were provided: 40,223 tubectomies; 25,519 no-scalpel vasectomies (NSVs); 105,880 intrauterine devices (IUDs); and 178,958 implants. Procurement of 200,000 sets of Implanon (1 stick) was completed. Funds have been placed with the NGOs for providing LAPM services. In addition to provide the quality of care of Family Planning LARC & PM, funds have been placed to Upazila Manager/DDO for procurement of hospital/medical equipment, office equipment, furniture, etc.

A basic training was conducted for 20 doctors to develop practical skills necessary for conducting the LARC & PM methods.135 officials attended advocacy on revitalization of FP Model Clinics at Medical College Hospitals (Advocacy meeting, workshop & practice sharing) and 171 officials participated workshops on divisional family planning performances review (LARC-PM, PPFP & MCH activities

monitoring).During the reporting period, 5% of health facilities were visited by Quality Improvement Team (QIT) formed with 10 regional FP-CST for ensuring the quality of LARC & PM Services. This OP is also responsible to improve post-partum family planning services; addressing DLI 9 under component 3 (Improving Health Services). During the reporting period, the OP started to conduct the baseline survey of facility readiness for PPFP. In addition, the development of training guidelines and curriculum to identify the characteristics of facility readiness for PPFP has also started.

OP 26: Family Planning Field Service Delivery (FP-FSD):

The OP is mandated to provide FP and MCH services. Under the FP-FSD OP, 164,160 satellite clinics were held during the reporting period. The OP covered nine Upazilas for orientation of DGFP service providers on FP-MCH issues during the reporting period. Piloting of Urban FP Program in Sylhet City Corporation has been completed. 150 persons in 10 Upazilas participated in the volunteer initiative. A total of 908 officials participated in capacity building programs on Injectables methods, monitoring/supervision and GO-NGO coordination. The OP has also organized orientation program for the 490 newly wed couples.

OP 27: Life Style and Health Education & Promotion (LHEP):

The LHEP OP observed the World Health Day-2017 and conducted HNP co-ordination meetings and BCC working group meetings. Moreover, SBCC materials developed according to the guideline specified in the strategy. During the reporting period, a total of 80,000 SBCC materials (leaflet on World Health Day 2017, Chikungunya, Dengue & Nipah Virus) was produced and distributed. As part of capacity development and logistic support for SBCC, the OP ensured the maintenance of motor vehicle and regular maintenance of printing press to print quality SBCC materials.

OP 28: Information, Education, and Communication (IEC):

During the reporting period, the IEC OP organized one "FP, MCH and Nutrition" campaign. Six community mobilization, sensitization & advocacy meetings were held. The OP produced, distributed & displayed 3 SBCC materials and completed 5217 media campaigns through BTV & Bangladesh Betar. 144 support service/logistics and two monitoring and research activities were also completed. A total of 50 DGFP, Betar and BTV Population Cell officials (41 MOHFW and 09 non MOHFW) attended training on strategic SBCC. The OP organized workshop to develop and share annual work plan at the beginning of each year involving BTV, Betar and other key stakeholders and a five-day message development workshop (once a year) was held for HQ and field level managers on FP-MNCH, PPFP, LAPM, child marriage, adolescent fertility, nutrition. Moreover, another workshop was held to integrate SBCC monitoring checklist in DGFP MIS to reflect the progress and achievements of SBCC initiatives and to monitor the program. In total 135 officials attended workshops.

OP 29: Alternative Medical Care (AMC):

AMC OP provides Unani, Ayurvedic And Homeopathic medicinal services throughout the country and has completed the procurement of medical requisites, MSR, Unani, Ayurvedic And Homeopathy at District Hospitals & UHCs. A total of 241 non-MOHFW officers received five-day training on management of AMC services and Unani/Ayurvedic/Homeopathic medicines. One orientation on AMC services among CS, UH&FPO, RMO and one workshop on management of herbal garden & use of herbs were held and 345 persons (114 MOHFW officials and 231 non-MOHFW officials) participated.

CHAPTER 6. PROGRESS IN TRAINING

The 4th HPNSP promotes considerable effort to improve HR capacity through trainings (local and international/foreign) and workshops/seminars/orientations. Out of total expenditure of Jan-Jun 2017, Tk 1041 crore, 16.3 crore (1.54%) was spent on capacity building programs (Figure 6-1). Of the total training cost, 12.5 crore (76.60%) was spent on training and rest of the amount, 3.8 crore (23.40%) was spent on workshop/seminar/advocacy related programs.

Figure 6-1: Share of training and workshop/seminar in relation to expenditure

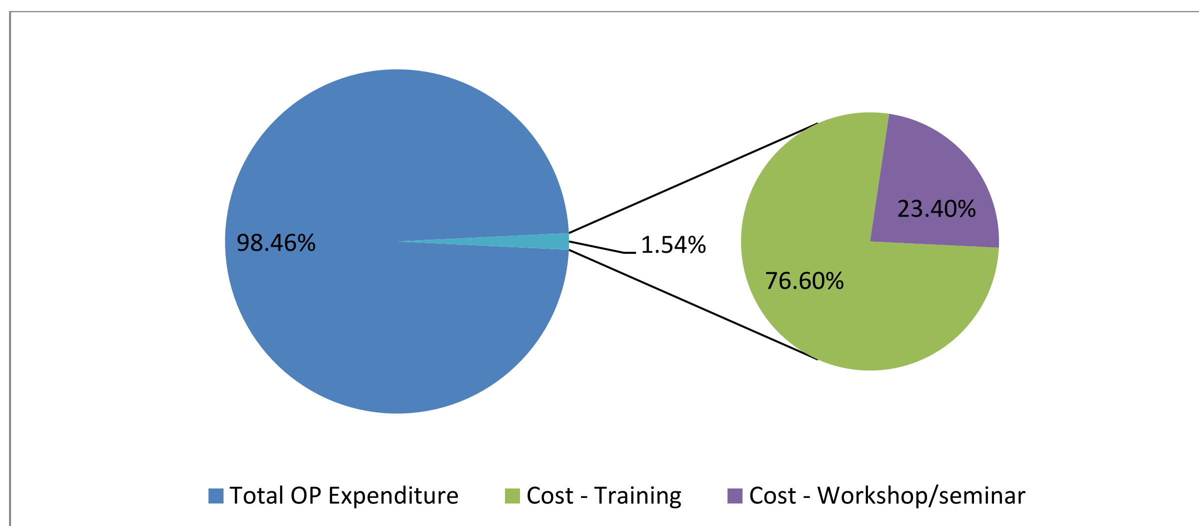


Table 6-1 shows the distribution of 29 OPs by cost of training. Out of 29 OPs, 9 OPs reported that they didn't conduct any trainings/workshops/seminars.

Table 6-1: Distribution of training cost by Operational Plan

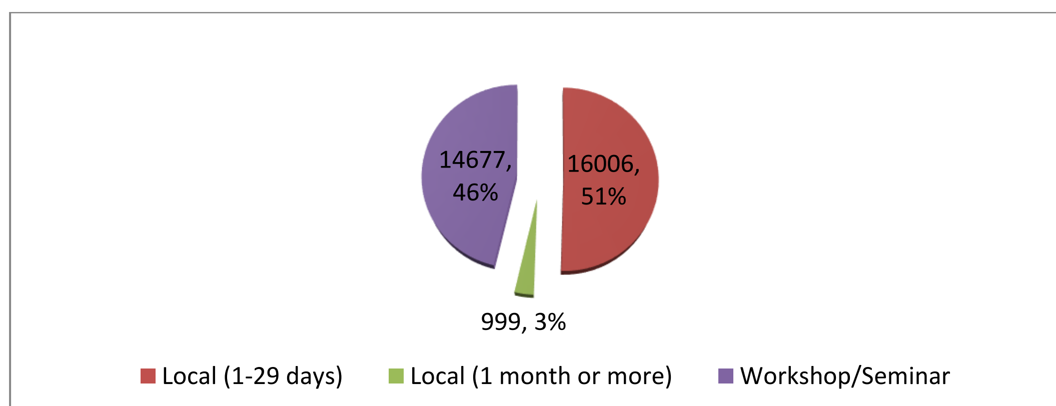
(Taka in crore)

OP	Total OP expenditure	Total cost for training and workshop	Training as % of total OP expenditure
All OPs	**1,041.0**	**16.3**	***2%***
SWPMM	0.3	0.1	31%
PMR	1.0	0.4	42%
PME	0.4	0.0	7%
HEF	0.9	0.2	19%
SDAM	0.5	0.0	0%
HIS&eH	10.0	0.0	0%
MIS	0.7	0.1	8%
PSSM-HS	14.9	0.0	0%
PSSM-FP	9.0	0.1	1%
HRD	0.2	0.0	4%
ME&HMD	107.0	0.2	0%
NMES	0.8	0.0	0%
TRD	0.3	0.1	34%
PFD	414.3	0.0	0%
IFM	0.2	0.0	0%

OP	Total OP expenditure	Total cost for training and workshop	Training as % of total OP expenditure
MNCAH	12.8	0.0	0%
MCRAH	9.8	0.5	5%
NNS	2.5	1.2	46%
CDC	24.3	10.4	43%
TBL&ASP	1.3	0.3	26%
NCDC	2.8	1.4	49%
NEC	0.4	0.0	2%
CBHC	233.0	0.1	0%
HSM	121.2	0.0	0%
CCSDP	30.8	0.2	1%
FP-FSD	12.6	0.4	3%
L&HEP	0.8	0.0	0%
IEC	9.7	0.2	2%
AMC	18.5	0.5	3%

A total of 31,682 participants took part in the capacity building programs during Jan-Jun 2017. During this period, no GOB participants attended any foreign training/workshop/seminar. 51% of total participants attended short-term trainings, while 46% of total participants attended workshop/seminar and 3% participants attended mid and long-term training (Figure 6-1). The MOHFW provides training to both MOHFW and non- MOHFW staff and it reveals that 83% of total participants represented MOHFW.

Figure 6-1: Participants of training and workshops



Most of the participants attended at the local trainings which were conducted by CDC (n=17010, 54% of total participants); followed by NCDC (n=5200, 16%) under improving health services (Table 6-2).

Table 6-2: Training and workshop participants by OPs

OP	Number of training participants (Local)	Number of training participants (Foreign)	Number of workshop/seminar participants
All OPs	**17,005**	**0**	**14,677**
Governance & Stewardship (G&S)			
SWPMM	0	0	313
PMR	247	0	302

OP	Number of training participants (Local)	Number of training participants (Foreign)	Number of workshop/seminar participants
PME	16	0	0
HEF	78	0	219
SDAM	0	0	0
G&S total	***341***	***0***	***834***
Strengthening Health Systems (SHS)			
HIS&eH	0	0	0
MIS	100	0	0
PSSM-HS	0	0	0
PSSM-FP	40	0	0
HRD	0	0	47
ME&HMD	0	0	126
NMES	0	0	0
TRD	439	0	191
PFD	0	0	0
IFM	0	0	0
SHS total	***579***	***0***	***364***
Improving Health Services (IHS)			
MNCAH	0	0	0
MCRAH	201	0	978
NNS	1,160	0	0
CDC	14,100	0	2,910
TBL&ASP	263	0	2,141
NCDC	0	0	5,200
NEC	0	0	37
CBHC	50	0	0
HSM	0	0	0
CCSDP	20	0	306
FP-FSD	0	0	1,422
L&HEP	0	0	0
IEC	50	0	140
AMC	241	0	345
IHS Total	***16,085***	***0***	***13,479***

Out of 31,682; 17,005 (55%) participants attended the local training that held from 1 day through more than 6 months. Out of 17,005 participants, 43.5% attended day long training while 11.1% participants received 2-day long training and 39.5% received 3-29 days long (Table 6-3).

Table 6-3: Distribution of local training by duration

Training duration	Training participants		Cost of training (Taka in crore)	
	Number	*%*	*Total*	*%*
1 day	7,395	43.5	2.3	18.5
2 days	1,894	11.1	1.4	11.5
3-29 days	6,717	39.5	7.8	62.9
1-6 months	560	3.3	0.9	7.2
6+ months	439	2.6	-	-
Total	**17,005**	**100.0**	**12.5**	**100.0**

CHAPTER 7. IMPLEMENTATION CHALLENGES

The reporting template used for obtaining information on the implementation progress of the OPs also collected information on the major challenges faced by the LDs during the first six-months of 4th HPNSP implementation. This chapter summarizes the challenges reported by the LDs which have been classified under six categories: implementation, procurement, financing, human resources, and monitoring and supervision and others. Table 7-1 below provides a summary of the major challenges faced by the LDs.

Table 7-1. Summary of the key challenges faced by the LDs

Areas	Key Challenges	Number of LDs reporting
Implementation	Time constraints	5
	Lack of training for doctors (e.g. EmOC)	2
	Inadequate coordination	1
Procurement	Insufficient funds	4
Fund release	Receipt of funds towards the end of FY	10
	Unavailability of funds	3
	Not allocated according to work plan	1
Monitoring and supervision	Insufficient resources for monitoring & supervision	3
	No/weak system of monitoring & supervision in place	3
Human Resources	Shortage of manpower	5
	Vacancy in sanctioned position	4
	Retention of trained manpower	1
	Recruitment of manpower	2
	Insufficient skilled manpower	2
Other	Coordination with different stakeholders on urban health	1
	Incorporation of quality of care in the programmatic management	1

Among the key challenges, 10 LDs reported delayed approval of OPs led to receipt of funds towards the end of FY, which subsequently hindered on-time implementation of planned activities. Moreover, 6 LDs reported that insufficient resources and unavailability of a robust system for monitoring and supervision remain as another challenge. Insufficient fund allocation also mentioned as one of the key challenges for procurement and financing. For example, 4 LDs also reported that unavailability/insufficient funds posed challenge for implementation of planned activities.

In summary, release of fund towards the end of FY posed a challenge to the LDs in the areas of implementation, procurement, and financing. On the other hand, many LDs (n=11) reported the issues of human resource as a major barrier to implement the activities smoothly. One LD mentioned that coordination with different stakeholders on urban health is a major drawback to improve the health status of the vulnerable population living in the urban slums. Notably, out of 29 OPs; 9 OPs (HSD-5, ME&FWD-4) reported that they faced no challenges. On the other hand, 14 OPs from HSD and 6 OPs from ME&FWD mentioned to have faced challenges.

CHAPTER 8. ISSUES NEEDING ATTENTION

8.1 Unfinished Activities of HPNSDP

The MOHFW is currently engaged in implementing the 4th HPNSP as the first step towards achieving universal health coverage (UHC) by 2030. It is, therefore, important to briefly record the major unfinished activities of HPNSDP so that the gaps are kept in view while implementing the 4th HPNSP.

A few MDG indicators and targets were found off-track/needing attention. Moreover, three goal-level indicators of HPNSDP out of total of 8 were found to be off-track, e.g., MMR, NMR and TFR. In case of both the indicators, the MDG targets could not be reached within 2016 (MMR is currently 176 against the target of 143 and NMR is 23.3 against 21). Unmet need (12.0 against the target of 7.6), delivery by SBA, ANC (4) and PNC coverage, and IYCF practices also could not achieve the targets within the HPNSDP period (December 2016). Some other service indicators fell short of target and need acceleration e.g. CPR, immunization, measles and contraceptive use in low-performing areas. In addition, BDHS 2014 found Vitamin-A supplementation, and ARI treatment with antibiotics as being far below HPNSDP target. The TFR is found to have stalled at the 2011 level, i.e., 2.3 (against the target of 2.0) births per woman. Prevalence of both Malaria and TB as well as detection rate of TB were also identified as needing attention.

The off-track indicators as mentioned above constitute the unfinished agenda and would need to be addressed in the current sector program. Special attention is also called for to address critical shortfall in FP performance relating to stalled TFR, unmet need and use of contraception. It is worth mentioning that the 4th HPNSP has been designed appropriately linking the issues with regional focus for development and the disbursement linked indicators (DLIs) for IDA financing. It is, therefore, high time to effectively implement the designed programs/activities by the concerned LDs so that Bangladesh can move ahead in realizing the targets of the SDGs.

Considerable gains were made in strengthening the health systems, e.g., financial management, supply chain management, HIS, planning & budgeting, etc. during the HPNSDP period. However, a number of areas made 'limited progress' e.g. HRH, training, nursing services, quality assurance, synchronization of physical facilities with the supply of HR and needed equipment, asset management including their maintenance and waste management, etc. Gains made in strengthening health systems need to be protected and consolidated. The identified 'limited-progress' areas need to be continuously nursed and consistent interventions will have to be taken to accelerate their progress and improve outcome.

Bangladesh Health Facility Survey (BHFS) 2014 shed light on the state of general service readiness and staffing of the facilities at district, upazila, union and CC level providing three kinds of services: FP, Child Health and Maternal Health by the public, NGO and the private sector facilities. These three services have been the core of HNP sector interventions in Bangladesh for decades.

The BHFS 2014 pointed to the need for improving service 'readiness' at all levels of service delivery - from CCs to DHs. This would require improvement not merely in the supply of needed equipment, medicine and laboratory facilities but also providing treatment/service guidelines and relevant skill training for specific service delivery. It is now high time to go for effective implementation of all those activities for provision of quality service.

The LDs were also asked to report on OP-wise activities carried over to 4th HPNSP. Response of some LDs may be seen at Annex D.

8.2 Community Clinic Based PHC Services

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. 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-sectorality, 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.

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". Under the 4th HPNSP, the prime importance of PHC is highlighted as a strategy for improving service provision and increasing utilization of services by the population. The Community Based Health Care (CBHC) initiative has already been mainstreamed with the PHC system of DGHS's regular service delivery mechanism. Moreover, the essential service package (ESP) introduced in 1998 with the start of first SWAp, has also been updated and included in the 4th HPNSP. A mapping of the ESP components by OPs of the 4th HPNSP is given in the table below.

Table 8.2-1: Bangladesh Essential Service Package Mapping by OP

ESP Component	Lead Operational Plan (s)	Associated OP(s)	Support OP(s)
Maternal, Neonatal, Child and Adolescent Healthcare (MNCAH)	MNCAH, MCRAH	CBHC, NNS, HSM, NCDC, CDC	IEC, LHEP, CCSDP, FPFSD, CDC
Family Planning (FP)	CCSDP, FPFSD	MNCAH, MCRAH, CBHC, HSM	IEC, NNS, LHEP
Nutrition Service	NNS	MNCAH, MCRAH, CBHC, HSM	IEC, LHEP, CDC, NCDC
Communicable Diseases	CDC	CBHC, HSM, MNCAH, MCRAH, NCDC, TB & LASP	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 conditions etc.)	CBHC, NCDC	HSM	LHEP, IEC,

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 community clinics (CCs) deserve special mention as the cornerstone of PHC strategy in Bangladesh providing basic health care to the population. There are 13,400 CCs which have been made functional with trained community health care providers (CHCP), medical and surgical requisites (MSR) and medicines. In addition to the CHCPs, the existing domiciliary staff members of the DGHS and DGFP also provide service to the CCs 3-working days a week alternately. All the CCs have internet connection through 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 number of CC level service seekers has increased over time during HPNSDP implementation period and it is estimated that an average of 38 patients/day, receive service from each CC. Since re-inception in 2009, about 15 million patients were served from the CCs. The CC is an outstanding instance of community participation and public-private partnership. 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. However, there is ample scope for further improvement in institutional coordination between health, nutrition and population services to avoid duplication, wastage and missed opportunities. Although the CCs constitute the first tier of the PHC system, still there are organizational and implementation issues which, when resolved, would contribute further to service coverage and quality.

Some of these issues are: improved co-ordination between CHCPs and other categories of service providers at the CC; review of drug list for CCs to ensure rational dispensing of drugs by service providers at CCs; addressing local shortage of drugs supply in the CC by adjustment from another CC under the same Upazila to meet temporary shortage, etc. Besides, 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. 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 the CCs.

8.3 Urban PHC Service by MOHFW

Bangladesh has been experiencing rapid urbanization especially during the period and consequently large number of slums sprang up during the period to accommodate the steady inflow of rural migrants to urban areas. 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. Moreover, outbreaks of emerging diseases like dengue, chikungunya created extra pressure on the Government, particularly on MOHFW which is responsible for policy, planning and implementation of the country’s overall health service.

The HNP services in urban areas are provided broadly by three categories of service providers – public, NGOs (supported by DPs and often in collaboration with public service delivery system) and private providers. According to Local Government (City Corporation) Act, 2009 and Local Government (Municipalities) Act, 2009, city corporations and municipalities under the Ministry of Local Government, Rural Development & Cooperatives (MOLGRDC) are responsible for providing PHC services to the urban dwellers. But all the commodities (vaccines, immunization supplies & equipment, contraceptives, etc.) of immunization and family planning respectively required for urban service delivery, being distributed by the City Corporations through the NGOs, are supplied by MOHFW free of cost. Besides, 648[3] public facilities of MOHFW located in the urban settings, are providing primary, secondary, tertiary and specialized health care services to urban, peri-urban and rural populations. Moreover, 4,000 satellite centres provide EPI, maternal and child health services to the urban population. MOHFW carries out its responsibilities through the executing agencies (e.g.,

[3]14 MCHs, 13 GHs, 59 DHs /sadar hospitals, 21 specialized hospitals, 425 UHCs, 14 TB hospitals, 62, MCWCs, 35 urban dispensaries, 3 leprosy hospitals, and 2 MCHTIs.

DGHS, DGFP) and statutory bodies under it. It is therefore evident that substantial portion of the country's urban population benefit from the MOHFW facilities and services.

There are also parallel programs implemented by NGOs with support from DPs in urban areas for provision of PHC services. The private sector constitutes the largest segment of health service providers – both in urban and peri-urban areas. Profit driven expansion of these services are continuing apace with growing urbanization and this calls for more visible stewardship role by MOHFW. The private health care providers include private hospitals, pathology laboratories, diagnostic centres and private practitioners. In slums, quite often the pharmacies/ drug stores are the first point of care, followed by private hospitals/ clinics.

It has been recognized that because of extensive network of facilities from different service providers, health care service provisions are widely available for urban population, even though in an ad-hoc manner. The last urban health survey found that on average there is a heath facility within 2 km of residence of an urban dweller. Although significant improvements in urban health had taken place over the past few years, further developments are challenged due to constraints like gap in coordination among different service providers, accessibility of services, problems of quality and equity, etc. These weaknesses are obstacles to the provision of urban PHC services, creating adverse effect on those with limited income and on the urban poor.

The stewardship and regulatory responsibilities (both in urban and rural areas) in HNP sector fully lies on MOHFW. Moreover, very recent experience shows that when there is outbreak of communicable diseases like dengue, chikungunya, etc., the city dwellers want effective and urgent treatment and expect the service to come from MOHFW, irrespective of legal provisions.

A few development partners are providing urban health services through the NGOs as part of their off-budget activities in the HNP sector. The targeted free-of-cost service seekers are the ultra-poor and different types of "Health Cards" are used for each program led by the DPs to identify the poor. The government has traditionally encouraged such programs with a view to reducing cost of health burden of the urban poor. However, a rational approach to the use of health cards by different NGOs needs to be adopted, so that the government doesn't have to face any difficulty in inclusion of the programs into the national program in case of withdrawal of DP financing.

MOHFW being the designated Ministry of the government for providing HNP services, in addition to continuing with existing service provision in urban areas, may need to take conscious efforts in pursuing some key activities for improving the urban PHC service delivery as follows:

(i). coordination between MOHFW and MOLGRDC through holding regular meetings of the existing Urban Health Coordination Committee. Both the Divisions of MOHFW also need to strengthen coordination and collaboration with the private sector and NGOs in extending and consolidating the health care service network in urban slums;

(ii). MOHFW will need to work for enhancing capacity of the various service providers under MOLGRDC, NGOs and private sector working in urban slum areas for improving service quality in urban areas;

(iii). stewardship role of MOHFW will have to be strengthened for proper and updated licensing and registrations of the private service providers and for standardization of service quality and cost;

(iv). a uniform system may have to be introduced for use by the diverse service providers in the urban areas for covering the (ultra) poor's health needs free-of-cost;

(v). reporting of service statistics by all providers would need to be coordinated by MOHFW to get reasonably accurate data for planning and delivering appropriate health services to the steadily expanding urban population; and

(vi). the DGDA needs to ensure that customers can buy quality drugs at reasonable price from a drug shop, in view of the fact that about 65% of the out-of-cost expenditure nationally is due to cost of drugs. MOHFW has also to take both legal and administrative steps – in cooperation with the professional associations – to establish ethical standards for prescribing drugs by the physicians.

8.4 Implementation of DLI Related Activities

16 DLIs have been agreed to by GOB and the World Bank (WB) for financing of US $ 515 million for implementation of the 4th HPNSP. Effective implementation of DLI related activities will not only help achieving the DLIs and subsequent receipt of funds by GOB earmarked against the DLI (s), but also help improving overall performance of the 4th HPNSP. Progress of implementation of the DLI related activities have become an important management issue in the current sector program, which needs to be monitored by the senior management of both HSD and ME&FWD on a regular basis.

Program component-wise DLIs along with the activities needed for achieving results are reflected below to pay adequate attention by the implementers as well as supervising authorities so that the DLI related activities are performed and results are achieved. The matrix is based on the one in the project appraisal document (PAD) prepared by the World Bank.

Component 1. Governance and Stewardship (US $ 81.0 million)

Table: 8.4-1 Activities Needed for Achieving Results under Component 1

DLI	Activities Needed for Achieving the Results	Responsible OP
DLI 1. Citizen feedback system is strengthened	• Develop guidelines for GRS • Maintain the DGHS phone-, SMS- and web-based GRS • Re-coding of the automated system where needed, based on the guidelines • Train staff • Establish baseline for addressing the grievances in accordance with the guidelines • Monitor regularly to reduce average time taken to resolve grievances	**HIS & eHealth**
DLI 2. Budget planning and allocation are improved	• Effectively plan and budget for achievement of results under the OPs • Allocate more budget for repair and maintenance • Devote staff effort at the central and local level in the activities necessary to execute the resources • Raise awareness among necessary central and local level officials on planning and executing repair and maintenance budgets • Monitor regularly to ensure utilization of allocated funds	**SWPMM** **PFD**

Component 2. HNP Systems Strengthening (US $ 170.5 million)

Table 8.4-2. Activities Needed for Achieving Results under Component 2

DLI	Activities Needed for Achieving the Results	Responsible OP
DLI 3. Financial management system is strengthened	• The FMAU management recruits contract staff to perform internal audit functions • The FMAU management develops Recruitment Rules • The MOHFW follows-up with the MOPA to expedite the approval of the Recruitment Rules • After the MOPA approval, the MOHFW submits the Recruitment Rules to MOF for their approval • The FMAU initiates recruitment process following the MOF approval of the Rules • Staff are contracted • Firms/individuals are contracted to provide internal audit function as well as capacity building of newly appointed staff • Staff time and contractors undertake internal audits and monitoring of findings	**IFM**
DLI 4. Asset management is improved	• Conduct readiness assessment of facilities to use AMS. • Install the AMS software in the DHs. • With technical assistance, the MOHFW trains staff on the AMS • Hospital staff are involved in the inventory of major capital equipment, the input and the update of the AMS at the facility level • The MOHFW monitors use of the AMS	**PFD** **HSM**
DLI 5. Procurement process is improved using information technology	• MOHFW coordinates with the central procurement authorities on the roll out of the e-GP system. • The procuring entities train their staff on e-GP • The procuring entities arrange bidders' orientation session • The procuring entities invite bid through e-GP • The change to e-GP are communicated to all parties,	**PSSM-HS** **PSSM-FP** **PFD**

DLI	Activities Needed for Achieving the Results	Responsible OP
	including Ministry staff, contractors and others	
DLI 6. Institutional capacity is developed for procurement and supply management	• The MOHFW follows-up with the MOPA to expedite the approval process of the CMSD restructuring. • After the MOPA approval, the MOHFW processes approval from the MOF.	**PSSM-HS**
DLI 7. Availability of midwives for maternal care is increased	• Recruit midwives • Train midwives • Deploy and employ midwives • Monitor the retention and replace midwives if necessary	**NMES**
DLI 8. Information system is strengthened, including gender-disaggregated data	• The DGHS trains staff at the Community Clinics on the reporting requirements • Staff routinely populate the DHIS2 with data • The DGHS monitors staff • Completeness and quality of data are measured for improvement	**HIS & eHealth**

Component 3. Provision of Quality HNP Services (US $ 248.5 million)

Table 8.4-3. Activities Needed for Achieving Results under Component 3

DLI	Activities Needed for Achieving the Results	Responsible OP
DLI 9. Post-partum family planning services are improved	• Training guidelines developed, training-of-trainers implemented and training of providers done • Joint/individual instructive guidelines in the form of circulars sent out • Social and behavioral change communication conducted and micro plans at each district level prepared, with appropriate culturally sensitive messaging and communication channels • Improve the logistics coordination of ensuring the supply of contraceptives • Focus on Sylhet and Chittagong divisions	**CCSDP**
DLI 10. Utilization of maternal health care services is increased	• Train staff • Deploy trained medical staff • Undertake effective communication campaign, outreach • Procure the necessary medicines and equipment • Focus on Sylhet and Chittagong divisions	**MNCAH** **MCRAH**
DLI 11. Emergency obstetric care services are improved	• Rapid assessment done to determine the baseline values for CEmONC capacities at the DHs • MOHFW disseminates minimum standards and criteria to all 15 DHs in Sylhet and Chittagong divisions • Develop quality Improvement action plan in DHs for compliance with national standards • Train staff on the standards • Minor investments to address gaps • Monitor the progress towards the improvement, particularly involving the district health officers and representatives from the targeted facilities • Focus on Sylhet and Chittagong divisions	**HSM**
DLI 12. Immunization coverage and equity are enhanced	• Develop district-specific measles-rubella (MR) vaccination micro-plans for access to hard to reach and urban areas • Through the routine Expanded Program on Immunization, children under 12 months will be immunized against MR • Procure MR vaccines • Create awareness through Intensive communication campaign • Outreach to remote areas • Focus on Sylhet and Chittagong divisions	**MNCAH**

DLI	Activities Needed for Achieving the Results	Responsible OP
DLI 13. Maternal nutrition services are expanded	• Develop manual, training guideline, reporting tools and training materials • Orientation completed • Undertake quality survey • Undertake awareness-raising campaigns • Monitor and measure improvements in delivery • Implement individual records and case management for registered pregnant mothers • Focus on Sylhet and Chittagong divisions	**NNS**
DLI 14. Infant and child nutrition services are expanded	• National Nutrition Services (NNS) develops guidelines on growth monitoring and infant and young child feeding practices • Implement individual records and case management for registered infants and children • NNS develops quality assessment methodology • Train staff • Collect baseline data • Undertake quality assessment • Undertake awareness-raising campaigns • Focus on Sylhet and Chittagong divisions	**NNS**
DLI 15. School-based adolescent HNP program is developed and implemented	• Plan on school-focused adolescent health program • The DGHS develops a monitoring and evaluation framework with support from DGFP, partner NGOs and secondary education sector • Train trainers • Develop district-specific action plans • Orient teachers and peer girl students • Coordination with the education sector at the national and local level • Focus on Sylhet and Chittagong divisions	**MNCAH**
DLI 16. Emerging challenges are addressed	• Undertake the Coordination Meetings on urban health, including national and local city corporation stakeholders • Develop detailed guidelines/manuals/reporting tool and training materials for screening and referral of hypertension • Train staff • Undertake awareness-raising campaign • Screen patients for hypertension • Assess hypertension screening and management services for further roll-out	**NCDC** **SWPMM**

8.5 Management of OP Implementation

Chapter III of the PIP elaborates on the strategy and structure of implementation of 4th HPNSP as well as on the proposed system of monitoring. This section draws attention to a few process-related activities which can contribute to improved implementation of the Program interventions. Given the enormity of the Program activities and the change in financing modality, which has vastly increased the role of managerial oversight, serious attention to the three interventions below is called for.

a. Strengthening internal financial control

Both administrative and system improvement steps are needed to avoid any opportunity of repetition of fiduciary misconduct. The LDs need to aim to improve their individual capacity of financial management while their support system is enabled to play its due role. Action at three levels are needed: (i) since MOHFW had taken steps during the approval process of PIP for obtaining clearance of the Ministry of Finance for a number of posts to support the Accounts Section of most OPs, uniform standards of recruitment/training may be followed by the concerned Directorate (e.g., DGHS) in collaboration with FMAU for filling up the vacancies in the Accounts Section of the OPs

under it; (ii) training may be arranged – as soon as possible – for the LDs and PM/DPMs by FMAU to enable them to exercise due internal financial control and to familiarize them with the common audit issues; and (iii) Stern action may be taken by concerned Division against those committing financial irregularity.

b. Regular field-level Supervision

Supervision by managers at different levels should follow systematic and regular pattern. Both Divisions may issue detailed Supervision Manual for each supervisory level. The increased reliance on the government's system makes it more urgent for the supervisors to pay intensive attention to due processes followed at different-levels of program implementation.

c. Reporting on OP progress

Serious attention is to be paid by the LDs on regular reporting of OP implementation. Each Division may issue necessary guidance to the implementing agencies on the need for timely reporting. Each OP may have an identified reporting officer for the sake of continuity and consistency of facts/data presented in the Report and the concerned LD should vet it to convey its authenticity.

ANNEX A. DATA COLLECTION TEMPLATE FOR PROGRAM IMPLEMENTATION REPORT

(January-June 2017)

Name of the OP:

OBJECTIVE(S) OF THE OP

General objective: ……………………………………………………………………………………………
Specific objectives: ……………………………………………………………………………………

COMPONENT/ACTIVITY-WISE PHYSICAL PROGRESS

Please describe the OP's component-wise activities (in col. 1) and their actual progress (in col. 2). If there was shortfall associated with the progress of any activity, please specify the reasons (in col. 3).

Sl #	Major components/activities undertaken (during January-June 2017)	Progress made	Reasons for shortfall
	(1)	(2)	(3)

PROGRESS OF OP-LEVEL INDICATORS AS OF JUNE 30, 2017

Indicators of the OP are mentioned in the following table along with baseline values and target for 2020. Please provide information for columns 5 and 6 only.

Sl #	OP Indicators	Unit of Measurement/ Means of Verification	Baseline	Target Mid-2020	Achievements (During January-June, 2017)	Remarks (if any)*
	(1)	(2)	(3)	(4)	(5)	(6)
1						
2						
3						
4						

Sl #	OP Indicators	Unit of Measurement/ Means of Verification	Baseline	Target Mid-2020	Achievements (During January-June, 2017)	Remarks (if any)*
	(1)	(2)	(3)	(4)	(5)	(6)
5						

For cases where target was not achieved, please describe initiative taken to achieve the target and-or partial implementation started. .

TRAINING/ORIENTATION/WORKSHOP/SEMINAR/ADVOCACY

Category	Topic/subject/area	Duration	Number of participants		Cost of training (Tk. in Lac)	Remarks
			MOHFW personnel	Non MOHFW persons+		
(1)	(2)	(3)	(4)	(5)	(6)	(7)
(a) Local Training						
Short-term*						
Medium-term**						
Long-term***						
Subtotal (a)						
(b) Foreign Training						
Short-term						
Medium-term						
Long-term						
Subtotal (b)						
(c) Foreign study tour/experience sharing visit/exposure visit						
Subtotal (c)						
(d) Orientation/Workshop/Seminar/Advocacy						
Orientation						
Workshop						
Seminar						
Advocacy						
Subtotal (d)						
Grand Total (a+b+c+d)						

*Less than a month (upto 28 days) training refers to short-term; **29 days-6 months training refers to medium-term; *** 6+ month training refers to long-term; and + participants from other ministries, communities, students or teachers from school or college, etc.*

BRIEFLY DESCRIBE CHALLENGES FACED DURING JANUARY – JUNE 2017 AND POSSIBLE MITIGATION MEASURES

Areas	Challenges	Mitigation measures	
		Actions taken by the LD	Suggested additional measures
(1)	(2)	(3)	(4)
Implementation			
Procurement			
Fund release			
Monitoring and supervision			
Human resources			
Others (please specify)			

UNFINISHED ACTIVITIES OF THE HPNSDP (2011-16)

The activities that could not be completed during HPNSDP period and carried over to the 4th HPNSP are termed as "unfinished" activities.

[An OP might have experienced that it planned for one or more important activity during HPNSDP but could not fully complete, and the OP decided to carry that/those to the 4th HPNSP (2017-22).]

Please describe such unfinished important activity(s) below (if any):

Serial #	Unfinished activity of HPNSDP carried over to 4th HPNSP	Remarks
	(1)	(2)

FINANCIAL PROGRESS

The LDs are not required to provide separate information on financial progress. Relevant information (OP-wise RADP allocation, release and utilization figures) will be gathered by PMMU from the Planning Wing of HSD and the Planning Branch of ME&FWD.

Signature of LD with date

(Name of LD)
Phone no. (office):
Phone no. (cell):
E-mail address:

ANNEX B: SOME MAJOR DECISIONS OF THE PEC REGARDING PROGRAM IMPLEMENTATION

Decision no.	Major decisions of the PEC
4.1	The MOHFW would ensure that there is no duplication of activities between its program and projects; and would also take necessary steps to monitor the activities implemented by other ministries/divisions/private organizations/NGOs.
4.9	A document on the previous sector program HPNSDP would have to be prepared following the structure of the PIP where actual implementation cost and activities implemented would be mentioned. The document would be placed before the ECNEC for information after approval of the proposed sector program (i.e. 4th HPNSP).
4.11	The Ministry would take necessary steps to place Annual Program Reviews (APRs) of last three years (from FY 2013-14 to FY 2015-16) to the ECNEC.
4.13	The challenges in receiving and utilization of foreign aid would need to be identified and addressed accordingly.
4.33	Projects to be implemented by private organizations with GOB's grants would have to be processed through the MOHFW.
4.32	In order to strengthen automation process of health facilities, a target has to be set and necessary steps will need to be continued to achieve the target.
4.37	MOHFW's role has to be more effective and expanded to ensure quality and the expansion of primary health care (PHC) in urban areas.
4.34	Steps should be taken to limit the number of private medical colleges and improve quality of education in existing medical colleges. Moreover, necessary steps should be taken to ensure health services at reasonable cost through inspection of service quality of private sector.
4.35	Adequate activities would need to be adopted to expand and improve nursing education.
4.12	A specific guideline on all the physical constructions to be implemented by the Ministry would be included in the PIP to address regional disparity in health services. Moreover, the guideline would be prepared considering location of the area, population, poverty, and existing health facilities for area selection.
4.26	All the construction work started under a sector program would have to be completed under the same sector program. Drawing and design of the hospitals to be constructed or upgraded under the 4th HPNSP would have to be proper and of modern standard.
4.27	Importance should be given to construction at upazila and district levels based on demand and necessity. Quality must be ensured during construction.
4.29	Manpower recruitment and functioning of the hospitals will have to be started as soon as construction/upgradation of hospitals is completed and installation of equipment & furniture is done.
4.18	For foreign trainings under the OPs of the 4th HPNSP, 70% would need to be nominated from the field-level doctors/officials of DGHS/DGFP/other directorates or agencies; 15% from the relevant agencies; and 15% from different ministries.
4.19	To nominate officials in foreign trainings, a Committee under the chairmanship of Additional Secretary of the Ministry would be formed with Joint Chief (Planning Wing,

Decision no.	Major decisions of the PEC
	MOHFW), Joint Chief (Health/Population Wing, Planning Commission), DG (Education and Social Sector, IMED), head of concerned agency and relevant LD as members and relevant Deputy Chief as Member-Secretary. The Committee would recommend officials in foreign training following the instruction stated in decision no. 4.18
4.44	Activities of different NGOs working in the HNP sector would have to be monitored adequately and coordination among the NGOs would need to be ensured.

ANNEX C: DLRs TO BE ACHIEVED BY JUNE 2017

DLR	Description	Unit price		Indicative Target
		IDA credit	GFF	
2.1	OPs approved including activities and budgets for achievement of DLIs	US$2 million per OP		13 OPs
3.1	MOHFW submits FMAU recruitment rules to MOPA	US$3 million		Yes
4.1	Assessment and plan are approved for AMS scale-up	US$4.7 million		Yes
4.2	Number of District Hospitals in which AMS is implemented	US$0.3 million per DH		1 DH
7.1	At least 2,500 midwife posts are created by MOHFW and recruitment of midwives is underway	US$20 million		Yes
9.1	Facility readiness criteria and assessment instrument for PPFP services are approved	US$5 million		Yes
10.1	Number of normal deliveries in Public Health Facilities in Sylhet and Chittagong Divisions	US$0.25 million per 10,000 deliveries		130,000
11.1	Facility assessment instrument for CEmONC is approved	US$ 3 million		Yes
11.3	Number of District Hospitals with capacity to provide CEmONC services in Sylhet and Chittagong Divisions, reported for the previous CY	US$0.7 million per DH		5 DH
12.1	Immunization micro-plans for CY17 are approved for each district in Sylhet and Chittagong Divisions	US$ 5 million		Yes
12.2	Number of districts reaching at least 85% coverage of measles-rubella vaccination among children ages 0-12 months in Sylhet and Chittagong Divisions, reported for the previous CY	US$0.5 million per district		15 districts
13.1	Technical standards for maternal nutrition services are approved	US$3 million		Yes
14.1	Technical standards for infant and child nutrition services are approved	US$3 million		Yes
14.4	Percentage of registered infants and children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong Divisions, reported for the previous calendar year	US$0.11 million per 1% of registered infants and children aged under 2 years	US$0.05 million per 1% registered infants and children aged under 2 years	10%

ANNEX D: OP-WISE UNFINISHED ACTIVITIES OF HPNSDP CARRIED-OVER TO 4TH HPNSP

Name of OP	Unfinished activities of HPNSDP carried over to 4th HPNSP
SWPMM	Implementation of the Monitoring and Evaluation Strategy and Action Plan (MESAP).
PMR	Strengthening of Bangladesh Medical Research Council (BMRC).
HEF	• Initiation of Shasthya SurakKha Karmasuchi (SSK) in 3 upazilas: on-going in one upazila. • Preparation of a data-base on NGOs working in the HNP sector.
SDAM	Remaining construction work of Chittagong Divisional Office Building
HIS&eH	• Rolling out of Shared Health Record (SHR). • Rolling out of Civil Registration and Vital Statistics (CRVS) system initiated by MIS-Health. • Establishing video conferencing system at all UHCs, DHs, MCs, MCHs and THs.
PSSM-HS	Construction of 4 Storied Warehouse Cum Office Building.
IFM	Completing restructuring of FMAU started under HPNSDP.
MNCAH	• Finalization and approval of "Bangladesh National Strategy for Maternal Health, Revised 2015-2030" and the SOP.
MCRAH	• Mainstreaming of 203 AFHS Corners (93 already completed) • Continuing EOC & Midwifery Training for Doctors & FWVs.
CDC	Constructing building for IEDCR.
TB-Lep & ASP	Expansion of Gene Xpert sites for TB diagnosis, expansion of LED microscope sites for TB diagnosis, mandatory notification and involvement of private practitioners.
HSM	• Introduction of standard in-house and out-house medical waste management for all secondary and tertiary hospitals: 20 hospitals implemented, another 84 hospitals have been included in the 4th HPNSP. • Structured referral system has been introduced in 2 districts and 15 upazilas. Rest would be established within 2021. • Accreditation of public and private healthcare facilities. • All secondary and tertiary hospitals would be brought under the TQM approach of hospital management (22 done so far). • Women friendly hospital initiative: 16 district hospitals are accredited so far as women friendly. Rest of the district hospitals will be upgraded as women friendly by 2021. • Establishment of Shishu Bikash Kendra (SBK): 15 SBKs were established till date. Another 25 will be established by 2021.