Application GAVI Alliance Health System Strengthening (HSS) Applications

Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

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Email submissions are highly recommended, including scanned documents containing the required signatures. Please send the completed application to:

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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour Change Communication
BDHS	Bangladesh Demographic and Health Survey
BHE	Bureau of Health Education
CC	Community Clinic
CES	Coverage Evaluation Survey
CHT	Chittagong Hill Tracts
CMMU	Construction Maintenance and Monitoring Unit
cMYP	Comprehensive Multi Year Plan
CS	Civil Surgeon
CSO	Civil Society Organisation
DDFP	Deputy Director Family planning
DGHS	Director General of Health Services
DGFP	Director General of Family Planning
DHS	Demographic and Health Survey
DP	Development Partner
DSF	Demand Side Financing
ECNEC	Executive Committee of National Economic Council
EOC	Essential Obstetric Care
EPI	Expanded Programme on Immunization
ESD	Essential Service Delivery
EU	European Union
FAPAD	Foreign Aided Project Audit Department
FWA	Family Welfare Assistant
FY	Fiscal Year
GDP	Gross Domestic Product
GOB	Government of Bangladesh
GTZ	Gesellschaft fur Technische Zusammenarbeit (German Technical Assistance)
HA	Health Assistant
HFWC	Health and Family Welfare Centre
HIV	Human Immune Deficiency Virus
HMIS	Health Management Information System
HNP	Health, Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Programme
HPSP	Health and Population Sector Programme
IDA	International Development Agency
IEDCR	Institute of Epidemiological Disease Centre and Research
IMCI	Integrated Management of Childhood Illness
IMED	Implementation Monitoring and Evaluation Division
IMR	Infant Mortality Rate
LCG	Local Consultative Group
LLP	Local Level Planning
MCV1	Measles Containing Vaccine Dose-1
MDG	Millennium Development Goal
MDTF	Multi Donor trust fund
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MOHFW	Ministry of Health and Family Welfare
MOF	Ministry of Finance
MP	Member of Parliament
MTBF	Medium Term Budget Framework
NIPORT	National Institute of population research and Training
NGO	Non Government Organization
NPRC	National Poverty reduction Council
NSAPC	National Strategy for Anaemia Prevention and Control
OGSB	Obstetrical and Gynaecological Society of Bangladesh
ORC	Out Reach Centre
PDC	Proposal Development Committee
PIC	Programme Implementation Committee
PNC	Post Natal Care

PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
PSO	Programme Support Office
SBA	Skilled Birth Attendant
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UHC	Upazila Health Complex
UP	Union Parishad
UPHCP	Urban Primary Health Care Programme
VHW	Village Health Worker

Executive Summary

1. Country Background

Bangladesh made noteworthy progress in poverty reduction and the attainment of "Millennium Development Goals" during the 1990-2000. Child mortality was dropped from 151 deaths per thousand live births in 1990 to 82 in 2001 and 65 in 2007. Life expectancy increased to 65 years, net primary enrolment went up significantly, gender parity achieved in primary and secondary education, and depletion of tree cover reversed. However, aggregate poverty rates remain dauntingly high, pockets of extreme poverty persist, and inequality is a rising concern.

Within the broader context of Bangladesh National Strategy for Economic Growth, Poverty Reduction and Social Development (Bangladesh PRSD), the Government's vision for improving the health of the population is articulated in the strategic goal of the Ministry of Health and Family Welfare (MOHFW). The MOHFW seeks to "create conditions whereby the people will have the opportunity to reach and maintain the highest level of health. It is a mission that recognizes health as a fundamental human right"[1].

As a vehicle to deliver essential development goals, the Government of Bangladesh (GOB) established a Health and Population Sector Program (HPSP) in 1998. This aimed to increase the availability of and utilization of user-centred effective, efficient, equitable, and affordable quality services for a defined Essential Services Delivery (ESD) package, which includes immunization.

2. Health System Context

Policy framework

The HNP Strategic Investment Plan (2003-2010) is the overarching strategic framework for the health sector in Bangladesh. It is the basis of the Health, Nutrition and Population Sector Programme Revised Programme Implementation Plan, (HNPSP-RPIP) July 2003-June 2010. The HNPSP is also aligned with the Government of Bangladesh's other social development goals in especially as laid out in the Poverty Reduction Strategy Paper (PRSP). The HNPSP-RPIP therefore is also in line with the Millennium Development Goals (MDGs).

The goal of the HNPSP is to "achieve sustainable improvement in health, nutrition and reproductive health, including family planning status of the people, particularly of vulnerable groups, including women children, the elderly, and the poor with the ultimate aim of their economic emancipation and physical, social, mental and spiritual well being and this contribute to the poverty reduction strategy."

Priority objectives, by which the success of HNPSP will be measured, are:

1. Reducing Maternal Mortality
2. Reducing the Total Fertility Rate
3. Reducing Malnutrition
4. Reducing Infant and Under-five Mortality
5. Reducing the Burden of HIV/AIDS, TB, Malaria and other diseases
6. Prevention and Control of major Non-communicable diseases

The strategic direction of this GAVI HSS proposal flows from a consideration of the above mentioned MDGs, PRSP and HNPSP goals and targets. In addition, the proposal is built on an iterative consultation process with a broad range of stakeholders throughout its formulation process.

[1] MOHFW (2003). Health Nutrition and Population Sector Programme (HNPSP)

The GAVI HSS proposal's objectives will contribute to the following HNPSP targets:

- Reduce infant and under-five mortality rates by 65 percent, and eliminate gender disparities in child mortality;
- Reduce maternal mortality by 75 percent;
- Speed up the transition from outreach-based to facility-based provision of MCH, immunization and other PHC services;
- Accelerate the development of an effective, community-based public health infrastructure and motivated workforce capable of providing universal and equitable access to the ESD.
- Exploring innovative ways to recruit, develop and retain staff in Community Clinics;
- Increase the motivation and effectiveness of the village health worker to increase demand for and utilization of facility-based services;
- Increase awareness of and demand for MCH and other PHC services by communities and households; and
- Strengthen health system components common to other public health efforts, such as combating HIV/AIDS, Malaria, TB and other communicable and non-communicable diseases;

3. Process of HSS Proposal Development

The GAVI HSS proposal submitted in March 2008 was developed in a participatory and inclusive process led by the planning wing of the Ministry of Health & Family Welfare, development partners, NGOs and sub-national health officers. For example, a series of consultative meetings (six sub-national and one national) held during 13-Dec-07 to 21-Jan-08, to provide feedback on Health System Strengthening, were organized by the Ministry of Health and Family Welfare. Participants in these meetings included representatives from District and Upazila health teams, community-based NGOs and CSOs, other ministries and development partners.

The resubmission process built upon the same inclusive framework. A series of meetings were held with MOHFW and representatives from Development partner (DP) and NGOs to fully revise the GAVI HSS proposal in response to each comment, recommendation and clarification requested for by the GAVI HSS IRC.

The fully revised proposal has been endorsed by the Health, Nutrition and Population (HNP) Forum on 1 September 2008. The forum is the HSCC equivalent, chaired by the Secretary of the MOHFW and is composed of representatives from relevant ministries, DPs, UN departments and specialised agencies (e.g. World Bank), NGOs.

4. HSS Goal, Objectives and Expected Outcomes

The opportunity of GAVI HSS funding will be used to address critical gaps that constrain the ability of the Government of Bangladesh to achieve HNPSP targets and implement annual work plans based upon these targets. The overarching HSS operational aim is to ensure Community Clinics (CCs), which are the back-bone of the new operational strategy for delivering PHC, have the minimum functional capacities and infrastructure to deliver safe and effective MCH and immunization services.

Goal of GAVI HSS support

"The goal of Health System Strengthening in Bangladesh is to provide universal MCH services delivery through strengthened human resources management, improved logistics management, and increased community participation and demand, which will contribute to achieving MDGs 4 and 5."

Rationale:

Given Bangladesh's budget and HR constraints, the MOHFW has decided to make PHC service delivery at community level more effective and accessible by re-establishing Community Clinics, 1 per 6,000 populations. This is in line with the HNPSP objective to transition from the existing primarily out-reach based PHC service delivery platform to a primarily facility-based one. This transition is supported in the other districts of Bangladesh through the pooled funding mechanism of HNPSP[2].

GAVI HSS support will be used to accelerate, in 13 districts, this comprehensive plan to restore CC functional capacity through a mix of supply and demand side strategies. At present, only 1,821 CCs exist in these 13 districts, or one per 13,400 populations, which is below the national norm of 1 to 6,000 populations for rural areas. Moreover, many of these CCs are in poor condition, lacking equipment and sufficient staff. In addition, all of these 13 districts have remote areas with few roads or areas only accessible by boat. All of this contributes to persistent low immunization coverage in these districts and formed the basis for selecting these districts for GAVI HSS support.

The purpose of the HSS strategy in these 13 high priority districts is to ensure appropriate and high quality delivery of PHC interventions, in particular MCH services at the community level. The initial short-term emphasis for Phase-one (2008-10) support is to ensure each existing CC is renovated and has the functional capacity required to supply essential MCH and immunization services. This includes that each CC will be staffed with a Health Assistants (HA) and a Family Welfare Assistant (FWA). Under Phase-2 of GAVI HSS support it is proposed to construct and operationalize additional CCs required to achieve the national norm of 1 per 6000 population.

This supply-side approach will be complemented by a demand-side strategy, in especially to strengthen the capacity of Village Health Workers and GOB front-line workers to generate demand for facility-based MCH services at community level. They will be trained in communication, social mobilization and marketing strategies proven to be effective in increasing awareness of MCH and immunization interventions.

Expected impact and outcomes from achieving this goal:

Achieving the HSS goal will substantially assist the achievement of HNPSP priority objectives in these 13 districts. In particular, it will contribute to attaining national targets for reducing under-five and infant mortality rates, as well as reducing the Maternal Mortality Ratio.

The HSS objectives and activities to achieve the HSS goal:

The revised HSS proposal has a total of four SMART objectives, which in combination will deliver the HSS goal for these 13 districts.

[2] Pool funding include DFID, the EC, the Netherlands, UNFPA, SIDA, CIDA, German Cooperation + WB IDA into the Multi-Donor Trust Fund (MDTF) since October 2006

Objective # 1:

In 13 districts by calendar year 2010, ensure that >90% of Health Assistants (HA) and Family Welfare Assistant (FWA) posts are filled to permit gender-appropriate provision of Maternal and Child Health (MCH) services.

Rationale:

Lack of sufficient FWAs in CCs constrains provision of ANC and PNC for women, while lack of HAs constrains provision of immunizations. The overall indicator for this objective will be the percentage of HAs and FWAs posts filled, as this is critical to achieving high immunization coverage targets and MDGs 4 and 5.

Expected outcome:

By 2010 in the 13 targeted districts, i) 1188 HAs & 452 FWAs will be hired, and ii) DTP3 > 90%.

NB: GAVI to pay for salary, government commits to taking over salary payment after GAVI support is over.

Objective # 2:

In 13 targeted districts by 2010, to ensure at each administrative level that critical gaps in logistics, supervision, and management and skills development have begun to be filled, to ensure effective district management of MCH services delivery.

Rationale:

This objective addresses identified gaps in the situation analysis which call for a review of local level MCH services and associated information management in especially with focus on the inaccurate and fragmented pregnancy and birth registration data. The completeness and timeliness of supervisory reports, combined with trends in the MCV1 coverage rate, will be used as proxy indicator to help measure improvements in staffing pattern, the effectiveness of supervisory visits, the adoption of effective communication practices, and, the improvement in information/data management and dissemination.

Expected outcomes:

By 2010 at Upazila level, i) a computer for HMIS obtained for 101 Upazilas; and ii) for each of the 13 districts, 90% of monthly supervisory and performance reports are available by the 15th of the following month.

Objective # 3:

In 13 targeted districts by 2010, to ensure that critical gaps in equipment and physical infrastructure have begun to be filled, to ensure CCs can deliver appropriate MCH services.

Rationale:

This lays the foundation for a gradual transition from primarily outreach-based to fixed post-based delivery of essential PHC services, for which a system of Community Clinics will be the centrepiece (Phase-1 will focus on rehabilitating the exiting 1821 CCs while under phase-2 new CCs will be constructed subject to lessons learnt in Phase-1).

Expected outcomes:

By 2010, in the 13 targeted districts, 1821 Community Clinics (CCs) are fully equipped as per MOHFW norm so that they can provide the appropriate level PHC services, MCH and including immunization

Objective # 4:

By 2010, increase access to high quality and appropriate MCH services in the 13 targeted districts through a combination of improved supply (e.g. MCH training for HAs and FWAs) and increased demand (e.g. community mobilization and immunization awareness provided by VHWs).

Rationale:

At current time, there are insufficient numbers of Staff in these 13 districts, including an acute shortage of trained Skilled Birth Attendants (SBAs) and Village Health Worker (VHW)`. Due to geographic remoteness and difficult terrains, current incentives are insufficient to attract sufficient numbers of workers to these districts. Furthermore, existing staff have not received updated training on micro-planning, to help them effectively manage the transition from out-reach based provision of services to facility based provision of the ESD package. This effort will also complement a national strategy to role out community-based IMCI, by reinforcing MCH best practices through updated training and improved supervision.

Expected outcomes:
i) Percentage of reproductive aged married couples using any contraceptives will increase from 55.8% to 70% in all 13 district by 2010, ii) Percentage of women who receive a post-partum visit within 2 days, will increase from 19.5% to 25% in all 13 targeted districts by 2010; and iii) 1640 newly hired HAs/FWAs will have received training on MCH best practices.

5. Results expected

After the completion of the first phase of GAVI HSS support in 2010 there will be at district level:

(i) better efficiency in personnel management and supervision;
(ii) better quality of MCH and immunization services;
(iii) more effective and accountable community-based service provision; and
(iv) increased access to facility-based childhood survival and safe motherhood services.

Through training and engagement of Village Health Workers, this HSS proposal will enhance community demand for services which will contribute to increase the number of fully immunized children. GAVI HSS funds also will help pilot operational research activities in these 13 targeted districts, as well as nationally-focused studies, to increase the evidence base.

Lessons learnt in Phase-1 will guide revision and finalization of Phase-2 objectives and activities.

6. Implementation Arrangements

Duration of the GAVI HSS funding

The First Phase of GAVI HSS support will run from January 2009 through December 2010. The Second Phase, 2011-2013, will tie with the (currently proposed) one year extension up to December 2011 of the Health, Nutrition and Population Sector Program (HNPSP), and then link to the successor sector programme estimated to run from 2012 to 2017.

Budget

The total budget requested for Phase-1 of GAVI HSS support is US$ 13,671,418. The target population in the 13 districts is 24.4 million. Funds are planned to commence in the first quarter of 2009. Phase-1 asks for a conservative amount of funds, to ensure that MOHFW has sufficient capacity to absorb and fully utilise the funds.

Based on successful implementation of Phase-1, it might be feasible to scale-up interventions to cover an additional 2 to 4 districts in Phase-2. The budget estimates for Phase-2 in this proposal do not yet take into account this potential scale-up. It is therefore a conservative estimate, subject to a potential upward revision upon submission in 2010.

Assessments

Indicators linked to the objectives and activities will be used to evaluate the performance of the HSS strategies in this proposal. They are summarised below:

Indicator *Impact and outcome*	**Baseline (Year)**	**Indicator: *Output***	**Baseline**
1. National DTP3 coverage (%)	**87% (2007)**	1) 90% of monthly supervisory and performance reports are 100% complete and are available at the district level by the 15th of the following month.	**Less than 50% in the 13 target districts**
2. % of districts achieving ≥80% DTP3 coverage	**39% (2006)**	2) % of women receiving post-natal care and information on childhood immunization schedules	**22% (2007)**
3. Under five mortality rate (per 1000)	**65 (2007)**	3) Number of Community Clinics that are fully equipped	**50% (2007)**
4. Vitamin A coverage among post partum women (%)	**35% (2007)**	4) No of CCs renovated and/or constructed per year	**0 (2007)** **(In the 13 target districts)**
5. TT1 and TT5 coverage rate (%)	**TT1-87%** **TT5- 36%**	5) % of deliveries attended by SBA	**17.8% (2007)**
6. Percentage of reproductive aged married couples using any contraceptives (%)	**55.8% (2007)**	6) % of HAs and FWAs posts that are filled in each district.	**None**

Strengthening Monitoring and Evaluation:

While data for these indicators are already being collected routinely under Health and Management Information System (HMIS) of the HNPSP, the quality and timeliness of the very data collection system will be improved. This proposal therefore is in line with work by other actors (e.g. World Bank, UNICEF, WHO, ADB, etc.) to improve the quality of sub-national data management. In addition it is proposed to initiate operational research on issues such as performance-based incentives structures and their impact on the use of data for Local Level Planning (LLP) / decision making.

In addition to the outcome and output indicator, each activity has process indicators that will be monitored.

Tracking performance and disseminating lessons learnt:

Members of the HSS Programme Implementation Committee (which will report to the HNP Forum on HSS progress) will visit each of the 13 districts yearly for a 2 day assessment of experiences and challenges in implementing the HSS strategy, as well as to assess any issues with the flow of funds. The information obtained will serve three purposes:

i. form the basis of annual HSS performance and progress reports for the HNP Forum and the GAVI Alliance Secretariat:
ii. be used to identify financial and operational management best practices, which can be used to improve the effectiveness of CCs in achieving universal coverage targets for the ESD package; and
iii. form the basis for any needed revision in the following years annual health work plan.

7. Sustainability and Complementarities

HNP services expenditure is financed from two budgets: the Revenue Budget of mainly recurrent expenditures from government generated revenues; and the Development Budget, which finances both recurrent and investment expenditure from both government sources and from Development Partners (DP) contributions. (HNP-SIP, p. 51, 52-71). Total budgetary spending on the Health Sector is projected to grow by 10.26 percent annually during FY 2008/09 - 2010/11 and to increase from 7.81 percent to 7.85 percent of total programme spending (MTBF - SF p. 11-12]).

The HSS objectives will contribute directly to improving the sustainability of high immunization coverage, by strengthening the supply of all MCH services as well as creating awareness in the community on the importance of completing the vaccination schedules.

The financial sustainability strategy for the immunization programme seeks to increase Government support of vaccine purchases, with the bulk of the remaining immunization operational costs covered by support mobilized from other sources (cMYP p. ix) Page 16 of the cMYP lists the immunization programme strategic objective 3.1, which is to 'ensure sufficient and sustainable immunization program financing'. Measuring the indicator '% of funding for vaccines', it sets a target of an increase in government purchases of vaccine by 10% each year. This aims to ensure timely financial support to sub-national health sector levels, to prevent disruptions of vaccine supplies. The cMYP's strategic objective 3.4 is to 'Ensure efficiency in use and accountability for immunization program funds', by preparing a fully costed annual immunization work plan and striving for transparency in allocation and use of funds.

Technical sustainability will be achieved through institutionalization of lessons learnt from these and other interventions, such as the World Bank's support for pro-poor demand generation for services or the multi donor supported Second Urban Primary Health Care Project (UPHCPII). The UPHCP-II is implemented by the Local Government Division, Ministry of Local Government, Rural Development and Cooperatives (MLGRD&C) in all the six city corporations and five municipalities. In addition an USAID funded Smiling Sun Franchising system of NGO run PHC clinics serves a large part of the rural and urban areas of the country. Lessons learnt from these projects will be constantly assessed and used to improve implementation of activities under GAVI funding.

Complementarities:

The HNP forum is the supreme committee of GOB to monitor and steer the Health Sector including the implementation of GAVI HSS support. The HNP Forum also steers the programs and the activities of the HNPSP and facilitates the exchange of information and policy dialogue between DPs, NGOs and the government on all matters related to the HNP sectoral policies, strategies and

plans. The Forum is headed by the Secretary of the MOHFW, and includes in its membership senior-level government and development partner (DP) officials including the chairperson of the HNP Consortium and the World Bank representative.

Development Partner linkages to the HNP Forum:

The Local Consultative Group (LCG) is the highest body of Development Partners (DP) facilitating donor-government coordination. It covers all areas of Bangladesh's development priorities with a number of sub-groups to coordinate activities in each sub-sector. The Health, Nutrition and Population (HNP) Consortium is a sub-group of the LCG and deals with all matters relating to HNP sectoral policies and strategies. It is primarily a mechanism to `coordinate support to the government. The members of the HNP consortium are invited to the HNP forum meetings.

Specific complementarities of HSS proposed activities and objectives:

The HSS proposal works with other initiatives to achieve the Government of Bangladesh's social development goals in the HNPSP, as well as the MDGs. For example, it complements financing of DPs to assist the implementation of the HNP Strategic Investment Plan (2003-2010). It is also aligned with the United Nations Development Assistance Framework (UNDAF), which targets poverty reduction through social, economic development and environmental protection.

This proposal will also support and benefit from synergies with other development initiatives. For example, the government's safe motherhood voucher scheme has had great success. Utilization of ANC, PNC and safe delivery services, including the successful management of pregnancy complications has increased significantly in the target areas.

The present Caretaker Government and all political parties of the country have agreed and committed to decentralize power by progressively strengthening local government systems. This decision will impact on improving MCH delivery system at local levels, as elected people can be held accountable by the population for the delivery of appropriate services. In the future, these local government bodies will be capable of co-financing selected MCH activities out of their regular budget.

Section 1: Application Development Process

1.1: The HSCC: the country equivalent is the HNP Forum.

Health, Nutrition and Population Forum (HNP Forum) will be the over-arching committee in charge of monitoring Health System Strengthening (HSS) policies, strategies, implementation and the HSS budget.

The HNP Forum will monitor and evaluate performance against HSS indicators, decide on technical recommendations for revising HSS strategy as needed, and ensure time GAVI annual progress Report submission.

Organisational structure (e.g., sub-committee, stand-alone):

The HNP Forum is a stand-alone committee that is chaired by the Secretary, MOHFW. Its members are drawn from relevant ministries of the Government of the People's Republic of Bangladesh (GOB), Development Partner (DP) involved in the health sector of Bangladesh, UN agencies, NGOs and Civil Society Organization (CSO).

Frequency of meetings:

The Forum is scheduled to meet every quarter. In 2007, three meetings were held. In 2008, so far two meetings have been held (the last of which endorsed this resubmission application on 01 September 2008; minutes attached).

Overall role and function:

The HNP Forum is the highest policy body for implementing health sector policies and strategies. Headed by the Secretary of the MOHFW, it facilitates the policy dialogue between DPs and senior government officials on HNP sectoral strategies and plans. Specific activities includes monitoring and reviewing of sector performance, identifying problems and lessons learnt, and facilitating implementation of programs and activities.

Development Partner linkages to the HNP Forum

The Local Consultative Group (LCG) is the highest consultative body for DPs. It facilitates DP-GOB coordination and covers all social welfare and economic development aspects, including the HNP sub-sector. The HNP Consortium is a sub-group of the LCG, which deals with HNP sectoral policies and strategies. It is composed of DPs providing support and funds to the HNPSP, in part through the 'pooled funding mechanism'.

1.2: Overview of application development process

Who coordinated and provided oversight to the application development process?

The Planning Wing of the MOHFW, and the HNP Forum.

Who led the drafting of the application and was any technical assistance provided?

Technical assistance was given by the Programme Development Committee (PDC), formed by the MOHFW with representation from NGOs and DPs. In addition an external national consultant and the WHO country office provided technical assistance.

Give a brief time line of activities, meetings and reviews that led to the proposal submission.

Original Submission for HSS support:

Background: Prior to the GAVI HSS proposal development, the MOHFW was in March 2007 awarded US$ 50,000 TA funds in support of the proposal development process. These funds were to be managed by the WHO Bangladesh Country Office but were only allotted to the WHO country office in November 2007. Meanwhile, the WHO and the MOHFW had agreed that for GAVI HSS the Joint Chief Planning of the MOHFW would be the focal point.

19 June 2007: On 19 June 2007, the first meeting on GAVI HSS proposal development was conducted, chaired by Joint Chief Planning. During that meeting it was decided to present in the next HNP consortium meeting the rational of applying for GAVI HSS, and to invite DPs participation in the proposal development process.

27 June 2007: At the HNP consortium meeting on 27 June 2007 the Joint Chief, Planning informed the Consortium that GAVI offers a new funding stream that focuses on health systems strengthening and that the MOHFW was keen to develop a proposal with input from Development Partners. DPs were requested to nominate suitable representatives for a GAVI HSS proposal development team. However, DP's present felt unable to commit sufficient time but proposed instead that UNICEF and WHO could represent the Consortium and keep it updated.

25 July 2007: Based on the agreement reached in the HNP consortium, the MOHFW with a notification dated 25 July 2007 officially constituted the GAVI HSS proposal team. This team subsequently met 12 times until the final draft proposal was submitted for DPs comments in February 2008.

13 December 2007 – 5 January 2008: To ensure that the core of the proposal was developed with sufficient local level participation, the team conducted between 13 December 2007 and 5 January 2008 six sub-national consultative meetings in each of the six administrative divisions of Bangladesh. These workshops had to be delayed by one month due to the impact of Cyclone "Sidr" which caused havoc in the coastal areas on 15 November 2007.

21 January 2008: After all six sub-national workshops were held, on 21 January 2008 a national consensus workshop was called by Joint Chief planning to discuss the findings and reach a consensus on how relevant findings of these stakeholder participation meetings could best be integrated into the GAVI HSS proposal design. All HNP consortium and forum members were invited to participate.

27 - 30 January 2008: During the 12th and final official meeting of the GAVI HSS proposal development team, which lasted 4 days, the recommendations of the national consensus workshop were integrated into the final draft proposal.

17 February 2008: Following dissemination of the draft proposal, a HNP forum meeting to discuss the proposal was held on 17 February 2008.

6 March 2008: After the HNP forum meeting, relevant suggestions were included into the proposal through the Joint Chiefs office. On 6 March the proposal was submitted to GAVI secretariat.

Resubmission process:

8 May 2008: With letter dated 8 May 2008 the Executive Secretary GAVI notified the Minister of Health and Family Welfare that the Bangladesh GAVI HSS proposal had been reviewed by the IRC with the recommendation for resubmission.

21 May 2008: At a HNP consortium meeting on 21 May 2008, the decision by the GAVI board to request for resubmission and possible next steps were discussed. The DPs proposed that the composition of the old GAVI HSS proposal development team should remain but promised a stronger participation in resubmission process. The DPs were also informed by WHO that the MOHFW had not yet taken a formal decision whether to resubmit or not.

10 June 2008: On 10 June 2008 WHO called a Video Conference (VC) between members of the proposal development team, chaired by Joint Chief Planning, and WHO SEARO HSD specialists to discuss the way forward in the light of GAVI IRC comments and recommendations. By this time the MOHFW had opted for resubmission. As per proceedings of the HNP consortium meeting on 21 May 2008, the chair of the HNP consortium was invited by the Joint Chief to participate in the VC but declined to do so. During the VC it was agreed to block one week beginning of August for developing the revised proposal.

28 July 2008: At a subsequent meeting of the GAVI HSS proposal development team on 28 July 2008, it was agreed to request WHO to contract a national expert to support the GAVI HSS proposal development team during the resubmission process. From 11 – 15 August the proposal development team would meet in a conference room of the MOHFW and re-write/develop the proposal. In between, or on the 14 August, a national workshop should be called to which all HNP consortium / HNP forum members will be invited to ensure their input into the final draft document.

11 – 17 August 2008: The proposal development team met on a full time basis during this period and redeveloped the proposal. On **14 August** all HNP consortium/forum members were invited to a national workshop chaired by the Secretary for Health to discuss the revised GAVI HSS draft proposal which had been circulated two days earlier by e-mail. After a PowerPoint presentation on how the IRC comments and recommendations had been addressed in the revised draft, the audience commented on a number of issues to be addressed / clarified.

24 August 2008: The draft proposal was presented for discussion at the monthly HNP consortium meeting. Members requested an additional extraordinary HNP consortium meeting for in-depth discussion.

28 August 2008: On this day the special HNP consortium meeting was held and the draft proposal discussed in detail. Only minor changes were suggested which subsequently were incorporated into the final proposal to be presented at the HNP forum meeting.

01 September 2008: The final draft proposal was presented and endorsed in the HNP forum for review and endorsement.

11 September 2008: Resubmission of new HSS proposal to GAVI Alliance Secretariat.

Who was involved in reviewing the application, and what was the process that was adopted?

For initial GAVI HSS proposal submitted March 2008:
Review was done at several levels. First, at the level of the PDC, Second, the Community Clinic (CC) aspects of the proposal were presented for discussion at six sub-national level stakeholder meetings and one national level stakeholder consultative meeting over the period of December 2007 to January 2008. (Please see meeting notes summaries in Annex-3). Third, the HNP Forum reviewed and endorsed the final version of the HSS proposal.

For Proposal resubmission in September 2008:

The first level review for the resubmission was again done by PDC members. In addition, external peer review was done by a video conference with WHO SEARO, by direct consultation with WHO HQ HSD staff, and three discussions round with DPs. Finally the HNP forum endorsed the final draft proposal on 1 September 2008.

Who approved and endorsed the application before submission to the GAVI Secretariat?

For initial GAVI HSS proposal submitted March 2008:

The final draft was submitted to the HNP Forum, chaired by the Secretary, MOHFW, on 17 February, 2008. The application was reviewed, corrections put forth and incorporated, and then endorsed by the MOHFW and the Ministry of Finance (MOF).

For Proposal resubmission in September 2008:

The final recommendations of the consultative meeting on 24th and 28th August, where integrated into the proposal, following which the same was submitted to and endorsed by the HNP forum meeting on 1st September 2008.

The final version of the proposal was endorsed by the MOHFW on 4th September and the MOF on 7th September 2008.

3: Roles and responsibilities of key partners (HNP Forum members and others)

A) HNP Forum:

The HNP forum is for the health sector the highest policy and programme supervisory instrument of the GOB. It was constituted to liaise and coordinate Government policies and programme activities with DPs and other key stakeholder.

Title / Post	Organisation	Roles and responsibilities of this partner in the GAVI HSS application development
Secretary, MOHFW	**Ministry of Health & Family Welfare**	**HNP Forum Chair, and accountable for overall HSS proposal development. Provides leadership and policy direction in planning process.**
Secretary	Local Government Division, Ministry of Local Government, Rural Development and Cooperatives (MLGRD&C)	Linking national planning to sub-national implementation
Secretary	Economic Relations Division, MOF	Linking HSS strategy to overall macroeconomic development goals
Secretary	Finance Division, MOF	Advice on financial sustainability planning
Secretary	Ministry of Social Welfare	Assessing areas and groups with low social welfare indicators
Secretary	Ministry of Women and Children Affairs	Linking MCH with family health and immunization needs
Secretary	Inspection, Monitoring and Evaluation Division, Ministry of Planning	Feedback on data quality and use
Secretary	Ministry of Agriculture	Linking health with environmental planning
Member	Socio-economic and Infrastructure Division, Planning Commission	Macroeconomic factors relevant to HSS
Additional Secretary	MOHFW	Guidance on national health strategy
Director General	National Institute of Population, Research and Training	Guidance on training needs and resources
Director General	Directorate General of Health Services (DGHS)	Assessment of services delivery needs and support in identification of gaps at sub-national level
Director General	Directorate General of Family Planning (DGFP)	To provide guidance on family health & planning
Joint Chief (Planning)	**MOHFW**	**Chair, HSS PDC, and accountable for overall achievement of the GAVI HSS objectives. Overall responsibility of GAVI HSS supports proposal planning.**
Joint Secretary (Administration)	MOHFW	Feedback on incentive and hiring schemes
Joint Secretary (Development & Medical Education)	MOHFW	Linking HSS activities to existing health planning and implementation
Joint Secretary (WHO & Public Health)	MOHFW	Linking HSS to public health priorities
Joint Secretary (Family Planning & Program)	MOHFW	Linking HSS objectives to overall family welfare efforts
Joint Secretary	MOHFW	Linking HSS to efforts to build up facility-

(Hospital & Nursing)		based services
Joint Chief (Health Economics Unit)	MOHFW	Assessing HSS plan in light of health budget and financing gaps
Executive Director	National Nutrition Programme	Linking HSS to support of Vitamin A and other nutritional supplementation
Director	Institute of Public Health Nutrition	Linking HSS to support of Vitamin A and other nutritional supplementation
Director	Directorate of Drug Administration	Advice on relevant drug regulations
Director	Directorate of Nursing	Advice on HR needs
Chairperson	HNP Consortium	Linking GAVI-based HSS efforts to other partner and government HSS efforts
President	Private Practitioners' Association	Linking HSS work to private sector efforts
Chair	The Federation of NGOs in Bangladesh	Ensuing community-based input into HSS planning
Health Specialist	World Bank	To optimise synergies between GAVI HSS work and World Bank support
President	Bangladesh Medical Association	Guidance on medical constraints to health services
President	Bangladesh Pharmaceutical Industries Association	Advice on issues with medicines

b) GAVI HSS Proposal Development Committee (PDC)

The PDC, equivalent to Technical Working Committee (TWC), was officially constituted by the MOHFW with notice dated 25th July 2007. In the HNP consortium meeting dated 27th June 2007, the Development Partners agreed that UNICEF and WHO shall represent the HNP consortium in the PDC.

Title / Post	Organisation	Roles and responsibilities of this partner in the GAVI HSS application development
Joint Chief Planning	**MOHFW**	**GAVI HSS PDC Chair, and accountable for overall HSS proposal development**
Senior Assistant Chief	MOHFW	Secretary of the GAVI HSS PDC
Medical Officer EPI	DGHS	Related with other GAVI initiatives
Medical Officer Health Systems / Public Health	WHO	Lead TA and Representative of Development Partner
Health Manager	UNICEF	TA and Representative of Development Partner
Country Director	Helen Keller / NGO	Liaison with non-Government stakeholder

1.4: Additional comments on the GAVI HSS application development process

Bangladesh utilized the bulk of the US$ 50,000 received for support of HSS proposal development to convene six sub-national (one in each division) and one national stakeholder workshops, to obtain the views of civil society, community-based NGOs and the private sector.

For the resubmission parts of the remaining funds were utilized for the procurement of national consultant and for conducting meetings and for forwarding the proposal to GAVI secretariat through DHL.

Section 2: Country Background Information

2.1: Current socio-demographic and economic country information

Bangladesh made clear progress in poverty reduction and the attainment of MDGs during the 1990-2000 period. Child mortality was halved, life expectancy increased to 65 years, net primary enrolment went up significantly, gender parity was achieved in primary and secondary education, and tree cover expanded (rising from 7 to 15 percent, using a social forestry approach). Infrastructure investments, focused on rural roads, substantially increased access for the majority of villages[3].

Notwithstanding this progress, aggregate poverty rates remain high, with pockets of extreme poverty persisting and inequality a rising concern. Women continue to face entrenched barriers on social and economic indicators.

Table 1: national data

	Measure	Date	Source
Total population	141,553,741	2006	Bangladesh Bureau of Statistics
Surviving Infants*	3,798,525	2006	UNICEF : State of World's Children 2006
GNI per capita (US$)	470	2006	UNICEF : State of World's Children 2006
Percentage of GDP allocated to Health	0.57 %	2006	HNPSP
Percentage of Government expenditure on Health	6.6 %	2006	HNPSP
Under five mortality rate	65 / 1000	2007	Bangladesh Demographic and Health Survey 2007
Infant mortality rate	52 / 1000	2007	Bangladesh Demographic and Health Survey 2007
** Surviving infants = Infants surviving the first 12 months of life			

Data on the thirteen target districts that will be the focus of the first phase of HSS support is in Annex 4.

2.2: Overview of the National Health Sector Strategic Plan

The revised program implementation plan (RPIP) 2003-2010 of the HNPSP defines as its goal to "achieve sustainable improvement in health, nutrition and reproductive health, including family planning status of the people, particularly of vulnerable groups, including women, children, the elderly, and the poor with the ultimate aim of their economic emancipation and physical, social, mental and spiritual well being and this contribute to the poverty reduction strategy."

The **priority objectives of the HNPSP** are "reducing severe malnutrition, high mortality, and fertility, promoting healthy life styles, and reducing risk factors to human health from environmental, economic, social and behavioural causes with a sharp focus on improving health of the poor".

Progress towards achieving this goal is measured through the following sector performance indicators:

[3] Unlocking the Potential: National Strategy for Accelerated Poverty Reduction, General Economics Division, Planning Commission, Government of People's Republic of Bangla

- Reduce infant and under-five mortality rates by 65 percent, and eliminate gender disparities in child mortality
- Reduce the proportion of malnourished children under five by 50 percent and eliminate gender disparity in child malnutrition
- Reduce maternal mortality by 75 percent
- Ensure access to reproductive health services to all
- Combat HIV/AIDS, malaria and other diseases
- Reduce population growth through earliest possible achievements of NRR=1."

At the strategic level goals and objectives of the HNP SIP 2003-2010 are defined through:

1) The 10 policy responses for the HNP sector:

1. Improving health responses to catastrophes
2. **Improving disease surveillance**
3. Urban health services development
4. Health care waste management
5. **Decentralization and local level planning**
6. **Diversifying service provision**
7. **Expanding demand-side financing initiatives**
8. Improving budget management
9. Improving sector management
10. Improving aid management

The HSS objectives in this proposal are envisioned to support implementation of policies # 2, 5, 6 and 7 above.

2) The 7 long term strategies:

1. **Stimulating informed demand for HNP services**
2. **Improving the quality and scope of HNP services**
3. **Restructuring the way services are provided**
4. Mobilising more resources for HNP services
5. Improving equity
6. Improving HNP service efficiency
7. Improving sector governance and management.

For this HSS proposal, the first three long-term strategies from above are directly addressed.

3) The 5 accelerated service priorities:

1. **Reducing maternal & neonatal mortality & improving maternal and childhood nutrition**
2. **Reducing total fertility to replacement level**
3. **Reducing the burden of TB, Malaria & other communicable diseases**
4. The prevention and control of major non-communicable diseases
5. Reducing injuries & implementing improvements in emergency services

For this HSS proposal, the first and second accelerated service priority is directly addressed, though benefits of the HSS strategy will also support accelerated service priority # 3.

Organization of the public health sector

The basic structure of the public health sector is shown below. Under the MOHFW, there are two complementary administrative structures relevant to the provision of MCH services. The DGFP, which oversees reproductive health and safe motherhood, and the DGHS, with oversight of other elements of ESD.

Table 2: Organization of the public health sector

Directorate of Family Planning	**Public health sector functional unit**	**Directorate of Health Services**
Divisional Directors of Family Planning (6)	6 Divisions	Divisional Directors of Health Services (6)
Deputy Director Family Planning (64)	64 Districts	Civil Surgeons (64)
Upazila Family Planning Officer (480)	480 Upazila	Upazila Health & Family Planning Officer (480)
Family Planning Inspectors (4,466)	4,466 Unions	Assistant Health Inspector (4,500)
Family Welfare Assistant (all FWAs are females) 1 per CC (Planned Target)	13,398 Wards (each with 2 to 5 CCs)	Health Assistant (HAs are Male) 1 per CC (Planned target)
Note: MOHFW norm is 1 HA and 1 FWA per Community Clinic		

2.3: The immunization Comprehensive Multi-Year Plan (cMYP)

The current cMYP (2008-2010) is in line with the HNPSP, and is based on Global Immunization Mission & Strategy (GIVS) of WHO and UNICEF. EPI is one of several programs of the ESD, administered by the Director, Primary Health Care and Line Director, ESD. Under them, the Program Manager, Child Health & Limited Curative Care, and Deputy Program Managers (EPI, ARI, CDD and School Health) assist in managing EPI and other child health activities. However, cold chain, logistics, training, surveillance, and communication elements are the responsibilities of the various Line Directors (e.g. Logistics, Training, etc).

Table 3: Summary of the immunization system strengths and weakness [p. vi cMYP]

	Key Barriers (Areas in Bold are targets for GAVI HSS)	Key Enablers
Immunization program –Specific\\ Issues	**Access to immunization and other health services**	
	• **Sustaining outreach visits due to inadequate staff, logistics and funds** • **Vacant posts, especially at lower levels** • **Weak monitoring, performance review and incentive systems**	• Wide network of CCs and Outreach Sites to support immunization services in rural areas • Strong linkage with communities • Motivated/committed staff at service delivery level • Availability of review meetings at all levels • Availability of regular supportive supervision from higher levels to be ensured through facilitating travelling by the supervisors • Availability of trained manpower, many of whom have had Mid Level Manager (MLM) training • **GAVI funds for staff recruitment at lower levels** • Provision of incentives for better performance
	Immunization Coverage and Performance	
	• **Low TT5+ coverage** • **16/64 districts having less than 80% coverage for DTP3 and 35/64 for Measles** • 25 districts have FIC less than 70% • **High staff turnover in some districts**	• Implementation of TT-5 dose schedule • 39/64 districts are high-performing districts • Consistent national BCG coverage more than 95% • Improving OPV3 coverage (>90% in 2006)
	EPI Logistics	
	• Inadequate training for newly employed or deployed logistics / cold chain staff • Lack of coordination with Central Medical Stores department • **Delays in procurement, requisition and delivery of logistic equipment and materials**	• Availability of computerized logistics management system • Trained logistics staff in most districts • Logistics reporting, requisition, and distribution mechanism in place
	Injection Safety	
	• Inadequate waste disposal system • Challenge: securing funds injection safety at end of GAVI funding	• Use of AD syringes for all vaccination • Local production of AD syringes • AEFI surveillance system in place
	Accelerated Disease Control	
	• Polio importation from neighbouring countries • **Significant measles morbidity and mortality**	• High quality and high coverage Supplementary Immunization Activities (SIAs) • Good routine coverage • Strong active EPI surveillance system with high consistently quality indicators
	Financing	
	• Funding gap likely, with the end of GAVI Phase I support • Resource requirements especially for new vaccines introduction	• **GOB support for immunization through the Project Implementation Plan (PIP) mechanism** • Opportunities for EPI funding through GAVI Phase II and HSS facilities

2.4: Public Health Challenges and Assets

Selected strengths and weaknesses identified through health sector analyses, described in table 3.1. **Bolded items** are of particular relevance to this new HSS proposal.

Strengths:

1) *Safe motherhood services*: (i) some initiatives in pilot stage have received attention or support, e.g., women friendly hospital initiatives and establishment of gender issues office, (ii) **demand generation has been improved in maternal, neonatal and child health, particularly in antenatal care and vaccination**, (iii) **quality improvement has included DSF (demand side financing) for safe motherhood services to the marginal poor, which is being piloted in 33 of the 480 Upazila of the country** (iv) Higher proportion of health expenditures now goes to FP (family planning) outreach workers, effective in providing FP and ANC (antenatal care) services to rural poor, as a result of which the contraceptive prevalence rate has increased.

2) *Child health care*: (i) **the EPI vaccination rate has increased appreciably** and response to the polio outbreak was fast and effective. The impact has been a reduction in childhood mortality, (ii) quality has been operationalized at service level for IMCI (integrated management of childhood infections), (iii) there is fair to good progress in child nutrition, (iv) use of iodized salt is almost universal at family level, (v) the vitamin A administration rate is improved, (vi) improvements in exclusive breastfeeding and weaning practices.

3) *Disease control*: (i) TB detection rate and cure rate have increased appreciably, (ii) death from malaria has decreased, (iii) HIV/AIDS prevalence remains low, (iv) death rates from diarrhoea and pneumonia show further decline, (v) **training manuals have been developed for different categories of health sector personnel and community leaders on HIV/AIDS control**.

4) *Knowledge, attitude and practices of the community*: (i) People are more informed about causation of common diseases and their prevention. (ii) the rate of children receiving ORT is higher, (iii) the literacy rate is increasing at a good pace, (iv) **DGHS and DGFP services are used predominantly by adult women and their socio-economic background is like that of the wider rural population** (Social Sector Performance Survey 2005),

5) *Public-private partnership*: (i) the Urban Primary Health Care Project (UPHCP) provides a partial response to needs of urban dwellers through contracted parties, (ii) **there is increasing involvement of NGOs in health programmes**, e.g., National Nutrition Program, National AIDS Control Program, National TB Control Program etc. **A public-private partnership between MOHFW and the Obstetric and Gynaecological Society of Bangladesh (OGSB) has been implementing a plan to increase skilled birth attendance (SBA) through training and accrediting existing staff**.

Weaknesses:

1) *Safe motherhood related*: (i) **the rate of pregnancy and birth registration is very poor**, (ii) **the rate of vitamin A administration among the post partum women still low**, (iii) **acceleration is required for "(a) coverage by skilled birth attendants,** (b) timely interventions in obstetric emergencies" and ante post natal care. **"postnatal visiting within the first twenty-four hours of every home birth, by a SBA, FWA and HA should be given higher priority**" (iv) Guidelines for Accreditation of Women Friendly Hospital (WFH) forwarded to the MOHFW in December 2006 has not been approved" (v) "inadequate progress for maternal and newborn mortality". The **rate of institutional delivery is poor (<18% nationally)** which hampers efforts at controlling neonatal tetanus and maternal death

2) *Child health care related*: (i) the rate of exclusive breastfeeding among the children up to 6 months of age need improvement, (ii) malnutrition rate is still high in <5 years old.

3) *Knowledge, attitude and practices of the community:* **(i) communication program is still not very effective, e.g., among those who were never vaccinated 24% said that lack of knowledge of vaccination was the cause of non-vaccination, 18% said they were afraid of the side effects, 8% each were either too busy or said that their children were sick, 8% thought that vaccinators will come to their homes. ii) Poor knowledge about the exact date and place of vaccination (EPI Coverage Evaluation Survey 2006).**

4) *Management issues*:
   a) Vacant posts at wards, union, and upazilas need to be filled
   b) **Delays are (to be) eliminated in receipt of drugs**, micronutrients and EOC equipment, **and contracting of NGO and other outsourced services**.
   c) "management structures and processes are (to be) rationalized at National, District and Upazila levels",
   d) "Improve operational focus (is needed) on reaching the poor" "poverty focus not defined operationally". "the poorest 20% receive only 16% of the public health resources",
   e) Service user's forum (is) not being pursued and the reactivation of existing structures to increase voice and stakeholder participation has not taken place.
   f) "lack of a monitoring culture within MOHFW and its Directorates, weak programme implementation structures, lack of performance review arrangements, blurred lines of accountability in programme implementation and weaknesses in the Results Framework (indicators to measure goal attainment)",
   g) **supervision and monitoring visits are too few and focus mainly on administrative matters**,
   h) "poor accountability of service providers, stock-outs and other barriers still frequent" on the other hand there is "little incentive to perform well"
   i) allegations of underhand charging for services in public facilities,
   j) "absence of a realistic work plan to improve financial reporting and strengthen financial management including who will take responsibility, by when and what sequencing",
   k) "**Reduced donor harmonisation either through delays and disruptions to the flow of funds or emerging differences in approaches and/or prioritisation", while "forecast of DPs (development partners) plans and budgets is not consistent"**
   l) "continued low disbursements from the pool fund," "delays in implementing the program," The first and the third allotments arrive up to two months late for a number of DGHS facilities, and for DGFP less than 23% of total annual allotment was received in the first six months of the financial year ("Service users forum not being pursued"
   m) **"poor HR management and frequent turnover of staff in senior positions"**,
   n) "No changes (have occurred) to workforce productivity, provider comparative advantage or improving efficiency of infrastructure"
   o) **"Little effort has been made to draw lessons from contracting to NGOs"**
   p) Budgetary allotment: Many facilities do not get the allocated amounts of budget, which already is low (Social Sector Performance Survey). Less than 1% of the overall MOHFW budget is allocated for maintenance. Upazila level managers have managerial discretion over less than 9% of their total allotment (Social Sector Performance Survey)

5) *Quality and service coverage issues*:
   a) **"No service quality improvements are being pursued systematically".** There are **substantial concerns about** service quality, particularly around consultation time and thoroughness, **key workers' knowledge** and prescribing practices (Social Sector Performance Survey),
   b) in service, refreshers and continuous education practices are infrequent at the peripheral levels,
   c) only 2% of storerooms meet WHO storage guidelines (Social Sector Performance Survey),

d) shortage of medicine, especially for maternal care in Upazila and lower level health facilities,
e) Biomedical equipment is scarce at Upazila health complexes and there are specific problems with blood transfusion, sterilization, incineration and power generation equipment, (vi) **buildings often fail to meet seven basic standards including, for instance, a functioning sewerage system or a leak-free roof** (Social Sector Performance Survey)
f) Ratio of population to key workers is high, and for medical officers this ratio has deteriorated in financial year 2003-2004. There is inequitable distribution of deployment geographically and sex-wise (Social Sector Performance Survey)

6) *Cross cutting issues*: (i) **Upazila health offices are often missing vital management tools**, such as vehicles, computers and printers (Social Sector Performance Survey).

The strengths and weaknesses of the health sector are reflected in the progress made against the national Social development strategy, shown in table below.

Table 4 MDGs as linked to an Accelerated Social Development Strategy (2000 as Benchmark Year)

Indicators	1990	2000 (Benchmark data)	Annual progress over 1990-00 (%)	2004 status	2006 target	2010 target	2015 goal	Annual progress over 2000-15 (%)
Income Poverty	59	50	-1.5	45	43	35	25	-3.3
Extreme Poverty	28	19	-3.2	15	13	9	5	-4.9
Adult Literacy	35	56	6.0	64	69	79	90	4.0
Primary Enrolment	56	75	3.4	81	84	92	100	2.2
Secondary Enrolment	28	65	13.2	71	80	85	95	3.1
Infant Mortality Rate (IMR)	94	66	-3.0	56	48	37	31	-4.4
Under-Five Mortality Rate	144	94	-1.3	80	70	52	48	-4.5
Maternal Mortality Ratio (MMR)[4]	570	320	-3.3	295	275	240	143	-3.6
Life Expectancy	56	61	0.9	64	66	69	73	1.3
Population Growth	2.1	1.6	..	1.5	1.5	1.4	1.3	..
% Children Underweight	67	51	-2.4	48	42	34	26	-3.3
Female Mortality, 1-4 Years (% of Male)	133	Eradicate by 2010-2015						
Source: A National Strategy for Economic Growth, Reduction and Social Development; Economic Relations Div Ministry of Finance Government of; HNPSP, RPIP 2005, Revised RPIP 2005								

[4] **Maternal mortality rate** equals the number of maternal deaths in one year per 100,000 women of reproductive age, reflecting the frequency with which women are exposed to risk through fertility.

Section 3: Situation Analysis / Needs Assessment

3.1: Recent health system assessments[5]

Title of the assessment	Participating agencies	Areas / themes covered	Dates	Main Findings pertinent to HSS goals, with key findings in **BOLD**
Multiple Indicator Cluster Survey (MICS), Bangladesh 2006: Key Findings (Progotir Pathey 2006).	(1) Bureau of Statistics, Government of Bangladesh (2) UNICEF, Bangladesh	Demographics, nutrition, literacy, child health, reproductive health, HIV/AIDS and sexual behaviour, environment, etc.	May 07	• About four in 10 infants aged 0-5 months are exclusively breastfed; 8 out of 10 households consume iodized salt; about 8 in 10 primary school age children attend school; and about 9 in 10 children aged 12-23 months are protected against measles through immunization. • **Only 2 in 10 women are assisted by skilled health personnel at delivery; only about 1 in 10 women aged 15-49 years has comprehensive knowledge of HIV/AIDS**; and four in 10 households have access to improved sanitation. • **The proportion of 12-23 month-olds immunized against measles increased from 83 per cent to 87 per cent from 2003 to 2006**. • **delivery assisted by skilled health personnel remains 17.8 %** and access to improved sanitation coverage is still at 39 %
Bangladesh HNPSP: Annual Programme Review 2006: Main Consolidated Report, Key Findings, Conclusions and Recommendations	Independent Review Team funded by the Development Partners of HNP Sector of Bangladesh	Health systems management, policies and strategies, objectives and implementation of operational plans, financing issues, human resource related issues, procurement etc.	April 06	Priority Indicators Value and comments: 1. Share of total government expenditure allocated to MOHFW *The value was 6.5% of annual budget or 5.7% of revised budget*. HNP Comments: the *2005/6 budget allocation was used as a proxy for expenditure. Methodology used should be reviewed and validated before this value is accepted for future reference.* 2. Proportion of total MOHFW expenditure allocated to 25% poorer districts *The value found was = 21%* HNP Comments: The methodology and accuracy of this indicator should be validated before it can be accepted for future reference. 3. Utilization rate of ESD among the 2 lowest quintiles *NOT AVAILABLE* HNP Comments: a survey would be needed for collecting this indicators and this had not been done. 4. Proportion of contracts awarded within initial bid validity period The *value provided was 90%, but this refers to the 2004/05 period i.e. before the official starting of the HNPSP.* **5. % of births attended by skilled personnel** ***Value: 17.8% (Source BDHS 2007)*** 6. TB Case detection rate *Value;= 46% in 2004 (Source NTP 2004)*

[5] Within the last 3 years.

Title of the assessment	Participating agencies	Areas / themes covered	Dates	Main Findings pertinent to HSS goals, with key findings in **BOLD**
EPI Coverage Evaluation Survey 2006 (***See following table for a summary of EPI indicators***)	EPI. DGHS, AC Nielsen, UNICEF and WHO	Vaccination and Vitamin A coverage in 2006	Dec 06	• DTP3 86%; MCV1 80% [Card only rates, p.66] • National DTP1-measles drop-out 9.4% [p.78]; but in some poor districts reached **40%** [p.182] • Most common reasons for **never vaccinated: lack of knowledge (24%), fear of side effect (18%);** Child illness (8%) [p. 86-87] • **Only 21% of mothers know 4 visits needed to fully vaccinate child** • **37% women not aware of need for TT**. For women receiving TT1: 87% TT received at Government outreach centres & 10% Government hospitals [p134] • 71% fully immunized at 12 months • **Key problem areas**: Lost EPI cards (33% of mothers); age misreporting; weak internal district communication networks; low maternal literacy rates correlated with low child immunization status [pp. 176-177] • "Huge" difference between crude & valid coverage figures [p.178]: **some causes**: lack of supervision & monitoring, and/or communication barriers due to geographical remoteness; low incentive of EPI sub-national managers; low demand for child immunization by mothers [pp. 178-179] • **Policy recommendations:** 1) Promotion of EPI card retention; 2) improve supervision & monitoring to reduce drop-out, especially in poor districts; 3) improve data quality by reducing gap between crude & valid coverage figures; 4) Strengthen frequency & quality of EPI supervisory visits to low performing districts, to identify & resolve barriers to better coverage [p. 176-181]
Comprehensive Multi-year Plan: 2008-2010 (Immunization Program of Bangladesh) based on GIVS	EPI, DGHS, MOHFW	Mission and goals of EPI, situation analysis, strategic objectives, costing and financial plan, Barriers and enabling factors to immunization; plans for polio, tetanus and measles eradication, elimination and control and implementation and monitoring issues	April 07	**see p vi – vii** Access to immunization and other health services • Sustaining outreach visits due to inadequate staff, logistics and funds • Vacant posts, especially at lower levels Immunization Coverage and Performance • **Only 71% children are fully immunized**, though the trend is positive: the % fully immunized children went from 52% in 1991 to 71% in 2006 • **Low TT2+ & TT5 coverage** • **16/64 districts having less than 80% coverage for DTP3 and 35/64 for Measles** EPI Logistics • Inadequate training for newly employed or deployed logistics / cold chain staff • Delays in procurement, requisition and delivery of logistic equipment and materials cMYP Goals (p 15-17) I) To protect people & save children's lives by widespread use of safe vaccines II) To accelerate reduction of morbidity and mortality from vaccine preventable diseases III) To introduce new & under-utilized vaccines IV) To strengthen EPI surveillance in the health system context **V) Integrate EPI with other interventions in the context of Health System Development**

Title of the assessment	Participating agencies	Areas / themes covered	Dates	Main Findings pertinent to HSS goals, with key findings in **BOLD**
National Strategy for Anaemia Prevention and Control in Bangladesh (NSAPC)	Institute of Public Health Nutrition, MOHFW	Review of recent data (HMIS and surveys) on causes of anaemia	2004	• Anaemia affects 46% of pregnant women, 64% of children 6-23 months,; 42% children age 24-59 months; 30% adolescent girls; 33% non-pregnant women [p.11] • Causes: adolescent pregnancy as 68% girls marry by 18 years of age [p15]; Iron deficient diets; only 15% of rural pregnant women take full iron-folate (IFA) supplement while 46% take no IFA; **only 27% of women make 3 or more antenatal care visits** (where IFA is provided); little awareness of need for IFA; [p.21] • Objectives: 1) Micronutrient supplements, 2) improved diets, 3) parasite control, 4) family planning & **safe motherhood**, 5) food fortification, 6) household production micronutrient-rich foodstuffs (p28) • **Strategies**: encourage Antenatal Care visits (ANC) and Post-natal care visits (PNC): **at least 3 ANCs and 1 PNC<42 days post partum through mix of increased awareness/demand and training HAs and FWAs [p.46-50]**
National Strategy for infant & young child feeding in Bangladesh (IYCF)	Institute of Public Health Nutrition, MOHFW	Review of recent data (HMIS and surveys) on causes of infant/child malnutrition	2006	• Underweight prevalence rises from 22% at 6 months to 60% at 12 months • Causes: Lack of exclusive breast feeding before 6 months and unsafe/nutritionally inadequate complementary feeding at 6 – 12 months [p.11] • Targets: early & exclusive breastfeeding for 60% of all 0-6 month olds by 2010, 90% all children breastfed 20-23 months old, safe & nutrient adequate complementary feeding for 50% of children 6-9 months [p.20] • S**trategies: revise pre-service and in-service training of health workers; develop M&E framework to assess community feeding practices, & incorporate indicators into expanded surveillance system [p 47-54],**
HSS district stakeholder consultative meeting: Mushhiganj	National MOHFW, DGHS, DGFP Divisional Director Health & Family Planning, District level health managers, Upazila level health managers, District Health and Family Planning managers, EPI technicians, NGO staff (BRAC, NSDP funded by USAID, CARE, etc) **See Annex 3**	Sub-national consultative workshops to elicit feedback on service-delivery level and other sub-national system constraints to sustaining and maintaining high immunization coverage and high access to MCH services	13-DEC-2007	**Lack of proper vital statistics registration**, e.g. for pregnant mother; **lack of SBA**; **inadequate ANC & PNC service; lack of awareness about maternal health service**, social barriers,
HSS district stakeholder consultative meeting: Lalmonirhat			15-DEC-2007	**Field level infrastructure is not good, community clinics not functioning, overload of health workers due to increase population, no updated training of new & old workers, reporting is not done by computer data base**, less salary & **number of vaccine porters inadequate**,
HSS district stakeholder consultative meeting: Sunamganj			18-DEC-2007	Shortage of skill manpower, Seasonal migration of population, Religious constraints, Lack of manpower, **Lack of coordination of activities and responsibilities between Health (e.g. HAs) and Family Planning (e.g. FWAs)**
HSS district stakeholder consultative meeting: Noakhali			29-DEC-2007	HW posts vacant; **lack of supervision due to inadequate funding**, & **number of 1st line supervisor is too low**; in some union no post for HWs, insufficient SBAs,
HSS district stakeholder consultative meeting: Barisal City Corporation			01-JAN-2008	Shortage of manpower, skill personnel, lack of supportive supervision and co ordination with GOB & NGOs; **lack of one stop service at community clinics**, since current system relies on disease-specific and programme-specific outreach and mobile services; lack of accountability

Title of the assessment	Participating agencies	Areas / themes covered	Dates	Main Findings pertinent to HSS goals, with key findings in **BOLD**
HSS district stakeholder consultative meeting: Bandarban			05-JAN-2008	**Human resource deficits**, recruitment, transportation, health education, **need national curriculum regarding safe motherhood & EPI**, **lack of vaccine porter**,
HSS National stakeholder consensus meeting: Dhaka	MOHFW	Priority HSS targets that should be addressed through GAVI HSS funding opportunity	**21-JAN-2008**	**National consensus on major barriers:** **1. Lack of one stop service at community clinics, since current system relies on disease-specific and programme-specific outreach and mobile services** 2. **Shortage of skill manpower**: **insufficient recruitment and retention, out-dated skills unable to provide best practices for ESD, and in particular provision of MCH and immunization services** **3.** Surveillance system required expansion to integrate other public health surveillance needs **4. Involve community in management** **5.** Expand public private partnership **6. Strengthen personnel management capacity of the managers** **7. Strengthen logistics management system**.
HNPSP. Annual Programme Review 2007: Main Consolidated Report, Key Finings, Conclusions and Recommendations,	Independent Review Committee (IRC)	Evaluating effectiveness of Implementation of HNPSP, and results obtained	26 March 2007	1. HNPSP programme has failed to address three most critical areas: programme management and leadership; financial management, and procurement 2. Clear mismatch between the scope and level of ambition depicted in the programme documents (PAD, SIP and RPIP) and what the HNPSP is actually doing. 3. key reason why progress is so low is that there are far too many objectives and very little clarity about how or who will be responsible for implementing each **4. Achieving MDGs possible only if, vacant posts for family front-line workers, nurses and doctors at union and upazilas level are filled within a short time frame** **5. Imperative to accelerate (a) coverage by skilled birth attendants.**

Table 5 shows immunization data summarized from the WHO/UNICEF Joint Reporting Forms of 2005 and 2006

Table- 5 Trends of routine immunization coverage and disease burden[##]

Trends of immunization coverage (in percentage)						Vaccine preventable disease burden		
Vaccine		Reported		Survey		Disease	Number of reported cases	
		2005	2006	2005	2006		2005	2006
BCG		91	90	96	98	Tuberculosis		
DTP	DTP1	96	95	95	97	Diphtheria	125	34
	DTP3	96	93	87	84	Pertussis	125	46
Polio 3		96	93	88	92	Polio	00	18
Measles (first dose)		94	92	81	84	Measles	25,934	6,180
TT2+ (Pregnant women)		48	59	91	94	Neonatal Tetanus	341	256
HepB3		84	94	NA	NA	Hepatitis B sero-prevalence*	NA	NA
Vit A supplement	Mothers (within 42 days after delivery)	ND	42	ND	29			
	Infants (>6 months)	87	86	68	73			
[##] WHO/UNICEF Joint Reporting Forms 2005 & 2006								

3.2: Major barriers to improving immunisation coverage identified in recent assessments

Note: those in **Bold** are of relevance to the current HSS proposal, as shown in summary table at the end of section 3.4.

Human Resource Related

1. No separate medical officer for disease control, surveillance and outbreak containment
2. No incentives for satellite clinic owners
3. **No incentives to care takers for retaining vaccination cards**
4. Lack of female doctors in rural areas
5. Frequent transfer of staff
6. Absence of mother and child health committees at Upazila and Union levels
7. **No fund for recruiting retired field workers as volunteers against vacant posts**
8. **Review of local level MCH services do not occur in presence of relevant supervisory staff**
9. **No training to health assistants and family welfare assistants on the basis of a common module emphasizing on ANC and PNC, pregnancy, birth and death registration**
10. **No incentives for good performance**
11. **Shortage of vaccine porters (by 25% or one per union) and transports for them**
12. Activities addressed to overcome religious constraints is inadequate
13. **Infrequent family level meetings to sensitize the family members on different health related issues (EPI Coverage Evaluation Survey 2006).**
14. No support to the formation of public bodies with representation of the poor to make allocations and expenditure public and ward-wise sensitization of mothers with literature on public rights
15. Few staff with skill in local language in tribal areas
16. Inadequate training of Store Keeper on EPI store management
17. Many medical technologist (EPI) appointed informally
18. Insufficient attempt made for conducting Crash programs in remote areas, where staff might stay for an extended period. Forestry department's support is crucial in this matter.

19. No well organized conduction of geographical reconnaissance updating.
20. **Poor involvement of local elected representatives including female Union Parishod members and there is no system to reward/encourage them**
21. Non- active union porishod[6] standing committee on health and family planning
22. No system of rewarding those mothers who have vaccinated their children and adolescents most regularly
23. Quality of vaccination is poor, as there is still an unacceptable level of vaccine side effects, (EPI Coverage Evaluation Survey 2006).
24. **Skill in personnel, financial, logistics and contract-management is poor**, leading to little emphasis on vaccine wastage.
25. **In-service, refresher or continuous training or education are few at the fringe level of the health care system (Social Sector Performance Survey 2005).** Training has become overdue for the district EPI supervisors, medical technologists (EPI technicians), EPI store-keepers and field workers; (cMYP 2008-2010). **Training is necessary for traditional birth attendants in hill districts**.
26. **Pregnancy and birth registration are also quite poor, therefore the actual target population for vaccination is not known perfectly.** The weakness in the birth registration has also weakened the estimation of the post partum vaccination and vitamin A administration targets. It is not known how many mothers will have to be approached for advising on nutrition education, e.g., exclusive breastfeeding and other child rearing practices.
27. Lack of decentralization of financial and personnel management authority come in the way of managerial and staff commitment and appropriate and timely decision making, which hinder performance quality and coverage.

Logistics related:

1. Non use of school health service as an effective entry point in the health systems. This is more visible due to shortage of physical infrastructure, logistics and improper training
2. No provision of logistics, e.g., umbrella, gum-boot, uniform for the field workers.
3. There is delay in needs-identification, needs-forecasting, procurement and distribution of logistics (cMYP 2008-2010).
4. No fund allocated to register existing motor bikes
5. **No furniture for satellite centres/NNP sites for MCH service provision**
6. Inadequate equipment and furniture for normal delivery at union level health facilities
7. **Paucity of fund for communication materials, e.g., bill boards and transports and fund for exhibiting film shows. Communication activities are taken up on an ad hoc basis (cMYP 2008-2010).**
8. **Paucity of allocation for stationeries, maintenance, procurement of computers and photocopiers**
9. **No fund for locally pliable emergency travel/ transportation/ transports**
10. No provision for fuel to run generator for maintaining EPI stores and logistics
11. No fund for bearing travel cost of referred patients of acute flaccid paralysis, poor pregnant women and vaccine induced side effects etc.
12. **No logistical and monetary support for effective monitoring**
13. Storage capacity for EPI logistics is inadequate (cMYP 2008-2010).
14. Non availability of public address system
15. No support given for internet connections at Upazila or community level
16. No signboards for satellite stations
17. Fewer health facilities (one/ward) and field workers (one field staff per new ward)
18. No sitting arrangements in outdoors of health facilities that hampers provision of health education to the waiting patients or care takers.
19. No special provision for the poor
20. **Inadequate incentive fund for volunteers (e.g. VHW) to cover their tea and lunch and certificates to acknowledge their contribution**
21. **No effective tools for monitoring and evaluation**
22. Storage of vaccines fails to maintain the required temperature sometimes, due to frequent and prolonged power failure. Local generation of power is weak. (solar panel as an alternative to generators)

[6] Porishod is a council at union level

23. Meagre EPI session cost (needs increment from Taka 16.25 to at least Taka 50/session).
24. Poor GOB-NGO and GOB-GOB coordination. (A standardized instruction based on an MoU with the NGOs from the national level and order for DGHS and DGFP collaboration with clear specifications are required)
25. **No studies done on local attitudes, behaviour, staffing needs, incentives and facilities for an effective need based plan, as well as to determine an effective ratio of field workers versus population to be served**
26. **Community Clinics remains unused and require repair. There is no effective local Community Management group with incentive to manage it.**
27. No post vaccine surveillance is conducted to know about the effect of vaccination (cMYP 2008-2010).
28. Disease surveillance system is episodic and restricted to non-EPI epidemic diseases only. Surveillance needs to be strengthened and integrated in particular on reporting (cMYP 2008-2010)
29. **Supervision, monitoring and accountability have not been entrenched as administrative and management culture. Formats and forms for record keeping and reporting are out-dated and the inventory system is maintained irregularly without any automation** (cMYP 2008-2010).
30. **Supervisory system for facilitating quality is poor mainly due to shortage of equipment and transports and mind set of the managers.** No mobile phones given to staff in hard to reach areas for effective communication for emergency services.
31. **The rate of institutional delivery or delivery in trained hands is also negligible. This hampers efforts in eliminating neonatal tetanus** (cMYP 2008-2010).

3.3: Barriers that are being adequately addressed with existing resources

1. Other GAVI funds have (NVS, ISS, INS) been applied successfully to increase staff recruitment at sub-national levels (cMYP p. vi)
2. The ADB-funded UPHCP-II supported construction of 64 health facilities, upgrading of 4, and purchase of 12 apartments and/or buildings for PHC facilities in Dhaka city corporation
3. GOB spending is targeting weakness in pregnancy and birth registration to fix targets for estimation of the post partum services including vaccination and vitamin A administration targets. [HNP-SIP p. 38]
4. Delays in contracting partners, e.g., volunteers and NGOs and equitable distribution of staff, are being addressed through the ADB-funded UPHCP-II, the World Bank support to implementation of the HNPSP, and also government internal audits of performance-based contracting with NGOs.
5. Improvements in Health Management Information System (HMIS) include the automation of the inventory, as well as a more complete and consistent data management approach.
6. Improvement in quality of vaccination, especially addressing the vaccine side effects, e.g., formation of abscess after vaccination with DPT/measles through (i) improvement of supervisory system and monitoring tools for facilitating quality, (ii) training to improve quality of the vaccination program including that for the district EPI supervisors, medical technologists (EPI technicians), store-keepers and field workers, and (iii) training for managers on financial, budgetary, logistics, personnel and contract management.
7. Development of a common job description for health, family planning and NGO workers, development of joint local level plan involving all stakeholders including the community representatives and representatives of the poor and involving all the stakeholders in regular joint performance review program and rewarding system.
8. Review and revision of EPI recording and reporting formats and dosage schedules to reduce drop out and estimation of valid vaccinations has been accelerated, with the support of UNICEF, WHO and other partners.
9. Action to gauge the voice of the poor, e.g., formation of the Health Services User's Forum, has increased the participation of civil society and community-based NGOs.
10. Broad support form DPs for rehabilitating and making functional the Community Clinic system for ESD delivery (e.g. WB and ADB support for construction or urban health clinics and facilities to increase access to service among the poor and vulnerable)

11. The government's 'Competency-based 6-month training on basic midwifery for community health workers', which has already been instituted. Training to a National SBA Training and Service Programme has been adopted by the MOHFW, though funding is not sufficient for needs. [HNP-SIP p. 37]
12. A Public Procurement Act was approved by Parliament in 2006. The Government has implemented a procurement tracking and monitoring system through an integrated management information system in IMED within the MOF. Uniform procurement regulations and standard bidding documents were introduced for all public sector entities, consistent with international practices.

3.4: Barriers not being adequately addressed that require additional support from GAVI HSS

Of the barriers not be adequately addressed, criteria to select the highest priority ones were based on the situation and health sector performance evaluations as listed in table 3.1, plus input from the six regional and one national level stakeholder workshops (see Annex 3). These were used to determine which gaps were most appropriate to be addressed with GAVI HSS funding support.

The following criteria were applied:

1) Improve immunization coverage (DTP3)
2) Improve delivery of MCH services at the District level and below, and in particular at the community level.
3) Inclusion of demand and supply side strategies that are mutually reinforcing and complement and are in line with on-going national health sector strategies.
4) Clearly contribute to achieving MDGs 4 and 5, to reduce maternal, child and infant illness and death.
5) Financial and technical sustainability of achievements, so that system performance improvements and new capacities can be sustained.

The weaknesses identified in the various situation analyses (table 3.1) were then reviewed against these criteria by the proposal writing committee (in consultation with DPs and the HNP Forum), to come up with specific areas that should have priority in receiving HSS support:

- Reduce infant and under-five mortality rates, and eliminate gender disparities in child mortality;
- Reduce maternal mortality;
- Accelerate development of an effective, community-based public health infrastructure capable of providing universal and equitable access to critical components of the ESD, with a particular emphasis on immunization and MCH services.
- Improve capacity of districts to recruit, develop and retain vaccine porters, VHWs and front-line staff.
- GAVI HSS objectives/activities must be consistent with government and DP agreed upon priorities and strategies for the other 51 districts.

The above criteria guided development of the HSS Goal and the four HSS Objectives, described in sections 4 and 5.

Section 4: Goals and Objectives of GAVI HSS Support

4.1: Goals of GAVI HSS support

The goal of Health System Strengthening in Bangladesh is to provide universal MCH services delivery through strengthened human resources management, improved logistics management, and increased community participation and demand, which will contribute to achieving MDGs 4 and 5.

Rationale[7]*:*

The service delivery mechanism for providing EPI and MCH services in rural areas relies on a system of 64 Districts, 480 Upazila, 4,466 Unions, 13,398 Wards, and 108,000 sub-blocks within the wards. Each sub-block has an EPI outreach site where routine EPI services are provided monthly for catchments of approximately 1,000 populations. Vaccination at rural wards is provided primarily by the Health Assistant (HA), a (usually) male employee of the health wing of MOHFW and often assisted by a female Family Welfare Assistant (FWA), an employee of family planning wing of MOHFW. Wherever the post of HA is vacant, the primary responsibility of vaccination is carried out by FWA.

At the present time, HAs and FWAs operate out of home-based or donated Outreach Health Centres (ORCs), with minimal supplies or capacity to provide core Maternal and Child Health (MCH) services of the ESD.

The government is currently transitioning the ESD service delivery platform from the current out-reach based mechanism, where services are supplied independently by HAs and FWAs at ORCs to a fixed facility based one, the CC concept.

At the present time, only 1,821 CCs exist in these 13 districts, or about one per 13,400 persons, which is below the national standard of 1 to 6,000 persons. Most CCs are in poor condition, lacking equipment and sufficient staff. The initial emphasis of GAVI HSS support will be to ensure CCs have the functional capacity required to supply essential MCH and immunization services.

The thirteen targeted districts were chosen to address: i) low immunization coverage rates (primary criteria). This was supplemented by the following secondary criteria: ii) Low score on BBS/UNICEF Child Risk Measure; iii) difficult terrain including road access.

Expected impact and outcomes:

i) Contribute to reducing under 5 mortality rate to 52/1000 by 2010 and 48/1000 by 2015 and infant mortality rate to 37/1000 and 31/1000 live births respectively;
ii) ii) contribute to lowering Maternal Mortality Ratio to 240 per 100,000 women of child bearing age (15-49) by 2010 and to 143 per 100,000 by 2015 (see table 4).

[7] Linkage- MDG Progress report February 2005, p. 27,cMYP Goal V, SO 5.1 and 5.2, p 17.,HNP-SIP (HNP Strategic Investment Plan) p. 19, 36 –39

4.2: Objectives of GAVI HSS Support

The Objectives and the related strategic actions of GAVI-HSS funding will be as follows:

Objective #1 & Activities	Expected outcome	Linkages	Rationale & discussion	Responsible party
Objective #1: In 13 districts by calendar year 2010 ensure that 90% of HA and FWA posts are filled to permit gender-appropriate provision of MCH services.	By 2010 in the 13 targeted districts, i) 1,188 HAs & 452 FWAs will be hired, and ii) DTP3 > 90%.	• Achievement of Social Development goal of reducing gender disparity in female mortality rates of 1 – 4 year olds [p. 25 of 2003 IPRSP] • cMYP p. vi, 15-17 • HNP-SIP p. 24-23, 31-31, 36 - 39	Lack of sufficient FWAs in CCs constrains provision of ANC and PNC for women, while lack of HAs constrains provision of immunizations. 20% of CCs in targeted districts lack at least one worker. In these 13 districts, the MOHFW will accelerate implementation of the national strategy to transition to demand-based access to all MCH and PHC services using fixed post CCs ("one-stop care provision") The overall indicator for this objective will be the percentage of HAs and FWAs posts filled in each district.	Chair of the HSS PIC
Activity 1.1: Fill vacant HA and FWA posts in targeted 13 districts, then use consolidated pay system for salaries (all in Q1 2009)	By 2010, hired workers will fill 50% of vacant posts in 13 targeted districts, to achieve 1 male and 1 female skilled staff target	cMYP SO 1.1, p 15 HNP-SIP p. 31-32, 36 - 39	The 2000 strategic plan for CCs calls for one HA and one FWA for every 6,000 rural persons, to provide gender appropriate services.	District Health management teams are responsible for hiring and salary of HAs and FWAs Civil Surgeon
Activity 1.2 MCH training curriculum for CC staff ready for use by end of 2008.	Training team set up by December 2008 and a modular training programme developed by April 2009	cMYP p. 15-17 HNP-SIP p. 24, 31-32, 36 – 39	Quality assurance activity. Modules to be used developed will incorporate best practices and latest evidence for providing MCH services. Sections include nutrition (micronutrients), immunization, Ante-Natal and Post-Natal Care, etc.	Line Director-IST (In-Service Training)
Activity 1.3 Newly recruited HAs and FWAs in the 13 districts will be trained on best practices for delivery of MCH services by 2010	100% of HAs and FWAs will receive MCH training within 3 months of being hired	cMYP p. 15-17 HNP-SIP p. 23, 31-32, 36 – 39	By early 2009, development of modules and training of trainers for Upazila level will be underway.	Line Director-IST

Objective #1 & Activities	Expected outcome	Linkages	Rationale & discussion	Responsible party
Activity 1.4: 1-day training of VHW to increase community demand for MCH services.	By 2010, 100% of VHWs will receive a 1-day orientation on increasing community awareness of MCH services	cMYP SO 1.1, p 15 HNP-SIP p. 31-32, 36 - 39 cMYP P8-9 NSAPC p.46-50 IYCF p. 47-54	Only 71% children are fully immunized, though the trend is positive: the % of fully immunized children went from 52% in 1991 to 71% in 2006. Weaknesses are due to lost EPI cards, and lack of knowledge on full immunization schedule. This seeks to develop a pool of trained VHWs, so that after 5 years, and once transition process complete, the villages health worker are very well trained in how to mobilise demand for facility-based provision of services. Assessing this activity will be done by looking to see if the MCV1 – DTP3 drop-out rate reduces in 13 districts by 2010	Local CC management committees
Activity 1.5 Put into place an incentive scheme to provide each HA and FWA 1000 Taka, and each VHW 250 Taka, to hold semi-annual Health Promotion days, to be used to raise community awareness of the need for MCH services.	By 2010, all wards in the 13 districts have semi-annual health promotion days.	cMYP p.15 HNP-SIP p.27, 32	Lack of awareness of need for TT to protect newborns is a factor in low TT5 coverage. Semi-annual health promotion days will help raise awareness and increase demand for MCH services, including immunization. By providing incentives for VHWs to participate in health promotion days, this will help increase participation by remote communities. Line Directors (LD) will work with sub-national supervisors and community committees to ensure semi-annual Heath Promotion Days occur. TT1 and TT5 coverage rate (%) to > 90% for TT1 and >45% for TT% in 13 target districts will be used as a proxy *indicator of improved demand*	Civil surgeon UHFPO
Activity 1.6 Pilot a scheme to recruit additional vaccine porters (VP) at taka 200/EPI session to ensure at least 1 vaccine porter per 3 unions for plains, and I VP per 1 union for CHTs.	At least 1 vaccine porter for every 3 unions in the 13 districts in place by 2010	cMYP p. 15-17 HNP-SIP p.27	The present honorarium for vaccines porters (VP) is taka 120 per vaccine day. Also, the number of porters is less than optimum, which delays distribution of vaccines to vaccination centres, with some deleterious effects on the quality of vaccine and also client enthusiasm. These 13 districts have many communities in remote and hard to reach locations, which adds to difficulty in retaining sufficient numbers of VPs. This adds an incentive by increasing remuneration by 80 Taka per immunization session, to assist in recruitment and retention of sufficient VPs.	UHFPO

Objective #2 & Activities	Expected outcome	Linkages	Rationale & discussion	Responsible party
Objective #2: In 13 targeted districts by 2010, to ensure at each administrative level that critical gaps in logistics, supervision, and management and skills development have begun to be filled, to ensure effective district management of MCH services delivery.	By 2010 i) at Upazila level, a computer for HMIS obtained for 101 Upazilas; and ii) for each of the 13 districts, 90% of monthly supervisory and performance reports are available by the 15th of the following month.	cMYP p. 15-17 HNP-SIP p.20, 31	This addresses HR gap # 8, to strengthen review of local level MCH services, and HR gap # 26, to address missing and inaccurate pregnancy and birth registration data. Activities in this objective also address logistics gaps, e.g. # 2-5, and 29-31 Supervisory reports will be a proxy to measure supervisory visits, adoption of effective communication practices, and information/data management and dissemination. The performance measures for GAVI APRs, which will be monitored under this proposal, are: 1. Monthly District supervisory visits to each Upazila 2. Semi-monthly visits by Upazila to each union 3. Weekly supervisory visit by Union to each CC	Chair of the HSS PIC
Activity 2.1: For each administrative level revise/develop a supervisory tool to assist supervisors to monitor problems with the supply of and access to MCH services.	District, Upazila and union supervisory tools for measuring quality, coverage and effectiveness of MCH and other priority PHC services finalised by March 2009	IYCF p. 50-54 cMYP P 15-17 HNP-SIP p. 25, 31	Addresses Logistics gap # 21, the lack of effective tools for monitoring and evaluation, and # 30, weak supervisory practices. Supervisory checklists will be revised and updated to measure and report on performance on: Safe motherhood and IMCI delivery, immunization coverage & safety, presence of a local level plan, presence and completeness of up-to-date vital statistics registrars; implementation of Community Health days; # of staff trained on MCH service delivery; # of SBAs present, Logistics and equipment gaps; maintenance needs, Functioning hand well at CC, physical integrity of CCs (intact roof, doors, windows), presence and utilization of surveillance and HMIS supplies, and other measures of facility functionality and service quality.	Line Director - IST
Activity 2.2: Annual orientation for Upazila and front-line supervisors on how to use supervisory tools to assess if CC is functional and capable of delivering necessary MCH services.	By May 2009, all supervisors in 13 districts trained on assessing CCs and MCH services with tool.	HNP-SIP p. 31-32	This training will be carried out for Upazila and lower level supervisors, as part of the on-going effort to implement the 'accountability and performance management' component of the 2003 Human Resource Strategy [HNP-SIP p. 28]. The government will cover the costs of training division and districts supervisors.	Civil Surgeon UHFPO

Objective #2 & Activities	Expected outcome	Linkages	Rationale & discussion	Responsible party
Activity 2.3: Pilot joint monthly reporting, on performance of CCs, between Upazilas Family Planning and Health Service Directorates' (AHI & HI & FPI), with monthly review meetings jointly chaired by UHFPO & UFPO**.**	By 2010, monthly meetings occur in all Upazilas, and issues identified in reports addressed in following month.	cMYP P.8-9 HNP-SIP p. 20, 31, 39-40	Currently, the FWAs and HAs rarely collaborate on cross-checking birth and immunization registrars. This seeks to address this gap.	UHFPO UFPO
Activity 2.4 CC management committee (10 persons + HA + FWA) semi-annual 2-day workshop on CC management at Upazila level.	Workshops held semi-annually.	cMYP P.8-9 HNP-SIP p. 20, 31, 39-40	This complements national efforts to implement the Bureau of Health Education's IEC strategy to increase demand for TT 5 and post partum vitamin A, especially in remote, rural and poor areas. Semi-annual meetings of Community Clinic Management Committee plus HA, FWA, FPI (links to Activity 4.2), will be held to assess progress on annual CC workplan and make any needed changes to achieve annual targets, including TT and Vitamin A. A further aim is to ensure all Women of Child Bearing Age (CBA) posses a TT card. Indicator: By 2010, ensure 50% of Women of CBA (15-49 years of age) receive TT5 coverage. 2006 Baseline: TT5 for Women CBA: 16.4% (valid) 30.9% crude	UHFPO
Activity 2.5 CC management committee (10 persons + HA + FWA) hold monthly management review meetings.	90% of monthly management review meetings occur in all functional and staffed CCs by 2010	cMYP P.8-9 HNP-SIP p. 20, 31, 39-40 1999 CC guidelines p 8-9	Reinforces Activities 2.4 and 4.2, by supporting national efforts to implement the Bureau of Health Education's IEC strategy to increase demand for TT 5 and post partum vitamin A. Indicator: By 2010, help reduce neonatal mortality by ensuring 99 % of neonates are protected at birth Baseline data: PAB: baseline is 93% of neonates protected at birth in 2006 NB: Each child should have a separate EPI card	UP Chairman UHFPO HI
Activity 2.6: Production and distribution of materials for training HA, FWA & other staff on MCH best practices to prepare for transition to CC-based service provision.	Training materials will be delivered to district and Upazila trainers by April 2009	HNP-SIP p. 20, 31	Immunization and other heath sector surveys have shown there is a lack of awareness on the part of mothers that they themselves need five TT injections to protect their newborns. Training of CC staff will focus on generating awareness of the need to encourage mothers to carefully retain TT and EPI cards, and bring them to each visit to a health post (outreach or fixed) Indicator: By 2010, ensure 50% of Women of CBA (15-49 years of age) receive TT5 coverage.	LD IST (in-service Training)

Objective #3 & Activities	Expected outcome	Linkages	Rationale & discussion	Responsible party
Objective #3: In 13 targeted districts by 2010, to ensure that critical gaps in equipment and physical infrastructure have begun to be filled, to ensure CCs can deliver appropriate MCH services.	By 2010, in the 13 targeted districts, 1,821 CCs are fully equipped so that they can provide the appropriate level of MCH and PHC services, including immunization, needed by the communities which they serve.	CMYP p. vi HNP-SIP p. 21 1999 CC Guidelines	Few CCs are being utilized, having been largely neglected in past 6 years. The resulting facility deterioration, plus lack of equipment and staff has led to a: 1. Lack of logistics prevents carrying out outreach activities or promote use of fixed posts (where available) 2. Lack of computerized stores and inventory management systems, 3. Lack of routine facility maintenance and repairs NOTE: After renovation, recurrent maintenance costs will be covered by the regular government budget.	Chair of the HSS PIC
Activity 3.1: All 1,821 CCs receive required renovation to make them fully functional in terms of providing MCH services.	Physical security established by provision of doors, windows and intact roof.	CMYP p. vi HNP-SIP p. 21	Basic physical security, water and electric must be assured.	LD Physical Facilities
Activity 3.2: Obtain 2 sets (computer/printer/UPS) per district and 1 set for each Upazila.	100 % of functional CCs in target districts have complete vital statistics registrars by 2009, and all new CCs have complete vital statistics registrars by 2010.	cMYP p. 15-17	To support full introduction of HMIS at district level, and prepare for expanded surveillance system. Having sufficient supplies has been shown to be a useful incentive to encourage staff to work in remote areas. This will also support the introduction of an expanded and integrated national surveillance system, for which the government has made a commitment to put into place.	LD ESD
Activity 3.3: Update 2001 transition plan to phase in CCs, based on lessons learnt.	Plan updated by 2009 Q1	1999 CC guidelines p. 7	Lesson learnt in Phase 1, in renovating CCs, and other current and past studies on reinvigorating CC system will inform revision of guidelines and Phase 2 efforts to construct CCs.	LD ESD and Director-MCH
Activity 3.4: All CCs in target districts to have examination equipment to staff one male and one female exam room.	By 2009, both male and female examination rooms staffed and equipped	HNP-SIP p. 21	At present, most of the existing 1,821 CC's lack furniture for MCH service provision. Equipment to be supplied is based on a standard list, which is the same as that approved by the World Bank for use in CC rehabilitation under the Bank's HNP support.	LD Physical Facilities
Activity 3.5: Solar powered electrical supply for lights and water pump for all operational CCs.	All 1,821 CCs receive solar power installation.	1999 CC guidelines p. 7	Pilot studies on use of solar energy have indicated this is a long-term and feasible solution to energy costs.	LD Physical Facilities

Activity 3.6: Priority water and sanitation repairs for all CCs, including water (arsenic) filters supplied to all CCs with arsenic contamination.	i) Functioning hand washing capacity in examination room in all 1,821 existing CCs, measured by presence of function hand-well ii) 100% of CCs with arsenic contamination will have filters by 2009	HNP-SIP p. 21	This meets basic standards for patient safety and quality of service improvements. Without hand washing capability, safe ANC and PNC can not be carried out. A national survey of arsenic contamination has already been completed by the Dept. of Public Health Engineering. Results show that on average, 40% of CCs have arsenic contamination	LD Physical Facilities
Activity 3.7: Critical gaps in transportation vehicles are filled (vehicle, boat, and bike).	In 13 targeted districts, by FY 2009-2010, all vehicle gaps in these 3 categories are filled.	cMYP p. 15-17	Aim is to allow staff to carry out 100% of planned community outreach and mobilization activities, as well as all trips required for supervision and supplies management. This will provide sub-national managers with the logistics and transportation support required to investigative visits. One aim is to achieve an improved response to suspected measles and other disease outbreaks.	LD ESD
Activity 3.8: 2246 CCs constructed, to provide appropriate MCH services.	Complete transition from primarily mobile provision to facility-based provision of MCH services by 2013	HNP-SIP p. 21	This is projected for the second phase of GAVI HSS support, from 2011 to 2013	LD Physical Facilities

Objective #4 & Activities	Expected outcome	Linkages	Rationale & discussion	Responsible party
Objective #4: By 2010, increase access to high quality and appropriate MCH services in the 13 targeted districts through a combination of improved supply (e.g. MCH training for HAs and FWAs) and increased demand (e.g. community mobilization and immunization awareness provided by VHWs).	i) Percentage of reproductive aged married couples use any contraceptive will increase to 70% from 55.5% by 2010 ii) Percentage of women who receive a post-partum visit within 2 days, will increase from 19.5% to 25% in all 13 targeted districts by 2010; and ii) 1640 newly hired HAs/FWAs will have received training on MCH best practices	cMYP p9, 15-17 HNPSP-RPIP p.18, 46, 63 NSAPC p.46-50 IYPF p. 47-54 HNP-SIP p. 20, 31	At current time, there are insufficient numbers of SBAs in these 13 districts, due to low incentives, inadequate training (e.g. on microplanning), and lack of sufficient equipment. In addition, social mobilization and demand generation is largely absent. Among selected 13 districts, 9 districts are from Chittagong and Sylhet division. The total fertility rate (TFR) in these two division is very high, 3.2 and 3.7 respectively compared to national 2.7. All coordinated efforts through GAVI HSS support will help to reduce an acceptable level. By the end of GAVI HSS support, the overall objective is to increase the % of women receiving a Post-Partum visit within 2 days from 19.5 to 25 % by 2010, and to 40% by 2013. This will also contribute to reducing under five mortality, and in particular, neonatal mortality, which could be estimated using an output to purpose review linked to higher level indicator of U5 mortality.	Chair of the HSS PIC
Activity 4.1: Upazila and front-line supervisors trained on how to plan to improve CC utilization rates.	By 2009, all functioning CCs are routinely evaluated on DPT1 to DTP3 dropout rate and Number of routine immunization sessions held per month.	HNP-SIP p.27-28, 31-32	With the transition to facility-based provision of services, supervisors will need to have new skills for assessing problems with access and demand for MCH services. This assessment will be included in the supervisory checklist, developed in activity 2.1, as a routine step in every supervisory visit. This would also include training in measuring the % of post-partum women receiving vitamin A & TT, and other core MCH services.	Civil Surgeon UHFPO

Objective #4 & Activities	Expected outcome	Linkages	Rationale & discussion	Responsible party
Activity 4.2: Ensure harmonization of birth registrations between FWAs and HAs by during monthly CC meetings, by providing incentive to FPI to verify accuracy of birth registrars.	By 2010, 95% of 1,821 CCs have joint verification of vital data monthly.	cMYP p9, 15-17 HNPSP-RPIP p.18, 46, 63	Justification: i) Reinforces activity 2.5, ii) HA and FWA record births separately and often do not take time to cross check and verify records. This will provide an incentive for verification of accuracy and completeness of birth registration. In addition, the FPI (Family Planning Inspector) will have an incentive to ensure post-partum home visits by FWAs occur for all births. Post-partum visits providing a post-partum vitamin A capsule to women which contributes to implementing the Bureau of Health Education's IEC strategy to increase demand for TT 5 and post partum vitamin A especially in remote, rural and poor areas.	UHFPO UFPO
Activity 4.3: Use Local Level Planning (LLP) at union level (Health & Family Welfare Centre - H&FWC) to implement anaemia prevention strategy in 13 districts.	Anaemia rates among pregnant women reduced from 60% to 35%	Infant and young child feeding strategy [IYCF] Anaemia prevention strategy document [NSAPC] HNP-SIP p. 31	Supervisory checklist will assess for presence of anaemia strategy and its implementation.	UHFPO UFPO
Activity 4.4: Institute routine 6-month training program for upgrading eligible FWAs into SBAs at the 13 district hospitals by 2010.	Ensure at least 25% of FWAs are trained as SBAs in each of the 5 high-need districts by 2010	HNP-SIP p. 36 – 37	Of the 13 districts targeted, training of SBAs for 3 CHT districts are covered by the CHTDF (pooled funding mechanism). Of the remaining 10, 5 have an acute shortage of SBAs. These 5 districts will be targeted in Phase-1 of GAVI HSS support. NOTE: all 13 districts will be covered under Phase-2, with a goal of ensuring at least 1 SBA per CC. This will address the HR gap listed in section 3.2, on the need to train "family welfare assistants on the basis of a common module emphasizing on ANC and PNC, pregnancy, birth and death registration". The training is based on government's 'Competency-based 6-month training on basic midwifery for community health workers', which has already been instituted. [HNP-SIP p. 37].This is four months of intensive, in-hospital training followed by 2 months field practice at workplace.	Line Director-ESD

Objective #4 & Activities	Expected outcome	Linkages	Rationale & discussion	Responsible party
Activity 4.5: Reprint and disseminate IEC messages for MCH, nutrition and IMCI to generate demand for SBAs and other safe motherhood services.	45 % of deliveries in 13 districts with an SBA attending by 2010	NSAPC p.46-50 IYCF p. 47-54 HNP-SIP p. 20, 31, 39-40	This seeks to encourage the use of SBAs over traditional Birth Attendants. It complements the Government strategy to extend facility-based IMCI to 100 additional Upazilas (based on Upazilas with high under 5 Mortality Rate), as well as the desire to cover all Upazilas under one district with a consistent set of MCH messages. This will also help support recent efforts to introduce community-based IMCI to more communities.	Chief, Bureau of Health Education

Table 6 below shows how priority gaps link to the HSS objectives, detailed in sections 4 and 5.

Table 6: Linkages between priority Health System gaps and SMART objectives

HSS Objective	Selected list of Gaps directly addressed by new HSS proposal
Objective 1 In 13 districts[8] by calendar year 2010 ensure that 90% of HA and FWA posts are filled to permit gender-appropriate provision of MCH services.	• HR gap # 7: No fund for recruiting volunteers against vacant posts • HR Gap #10 No incentives for good performance • HR gap # 11 Shortage of vaccine porters (by 25% or one per union) and transport (Bicycles) for them • Logistics gap # 20: Inadequate incentive fund for VHWs. • Logistics gap # 25: No studies done on workforce attitudes, behaviour, staffing needs, incentives and tools; lack of data on workforce quantity and distribution (also addressed by operational research)
Objectives 2 In 13 targeted districts by 2010, to ensure at each administrative level that critical gaps in logistics, supervision, and management and skills development have begun to be filled, to ensure effective district management of MCH services delivery.	• HR gap # 8: Inadequate review of local level MCH services do not occur by supervisory staff • Logistics gap # 3: lack of needs-identification, needs-forecasting for procurement and logistics (CMYP p. vi). • Logistics Gap # 21: No effective tools for monitoring and evaluation • Logistics gap # 29: Supervision, monitoring and accountability not entrenched. Supervisory record keeping out-dated, inventory system paper-based & inaccurate (cMYP 2008-2010). • Logistics gap # 30: Supervisory system is poor: shortage of equipment, transport, supervisory tools, training, and incentives. • Logistics gap # 31.: The rate of institutional delivery & SBA presence low; hampering control of neonatal tetanus (cMYP 2008-2010).
Objective 3 In 13 targeted districts by 2010, to ensure that critical gaps in equipment and physical infrastructure have begun to be filled, to ensure CCs can deliver appropriate MCH services.	• Logistics Gap # 26: Most Community Clinics require repair. There is no local effective Community management group to manage them. • Logistics gap # 5: No furniture for satellite centres/NNP sites for MCH service provision • Logistics gap # 15: No support given for internet connections at Upazila or community level
Objective 4 By 2010, increase access to high quality and appropriate MCH services in the 13 targeted districts through a combination of improved supply (e.g. MCH training for HAs and FWAs) and increased demand (e.g. community mobilization and immunization awareness provided by VHWs).	• HR gap # 26: Pregnancy and birth registration quite poor: denominator not known accurately. • HR gap # 3: No incentives to care takers for retaining vaccination cards • HR gap # 9: There is need to train “health assistants and family welfare assistants on the basis of a common module emphasizing on ANC and PNC, pregnancy, birth and death registration” • HR gap # 13: Need to sensitize the family members on different health related issues (EPI Coverage Evaluation Survey 2006). • HR gap # 25: In-service training/education insufficient (Social Sector Performance Survey 2005). • Logistics gap # 7: Inadequate funds for communication materials; most IEC activities are ad hoc (cMYP 2008-2010).

[8] Selection criteria for the 13 districts included Low Measles & DTP3 coverage, remoteness/accessibility/Supervisory visits, lack of sufficient CCs and health workers, as well as complementing other donor and government efforts to revitalize Public Health care services delivery. ESD includes (for CC): MCH services, Family Planning package, etc

Section 5: GAVI HSS Activities and Implementation Schedule

5.1: Sustainability of GAVI HSS support

Government funding

The 2007 Annual programme review notes that "Government spending on HNPSP shows some modest growth relative to the overall government budget: total spending on MOHFW including project aid represents around 7% of the total spending (up from 5.9% in 03/04) while own resource spending (excluding project aid) represents around 5.4% (up from 4.8% in 03/04)." Total budgetary spending on the Health Sector is projected to grow by 10.26 percent annually during FY08-10 and to increase from 7.81 percent to 7.85 percent of total programme spending [**MTBF-SF p. 11-12**][9].

HNP services expenditure is financed from two budgets: the Revenue Budget of mainly recurrent expenditures from government generated revenues; and the Development Budget, which finance both recurrent and investment expenditure from both government sources and from DP contributions. (**HNP-SIP p. 51, 52-71**). DPs estimated contribution for HNPSP (2003-2010) amounts to US$ 1,799 million. The World Bank manages a pooled support for HNPSP with the Multi Donor Trust Fund (MDTF) to which DFID, EC, The Netherlands, UNFPA, CIDA and SIDA contribute.

The draft FY08 Budget has been prepared under new guidelines and in line with the new three-year Medium-Term Budget Framework (MTBF). These new procedures now provide a solid basis for a policy-led approach to budget planning where resource allocations are linked to strategic objectives and priorities.

GAVI HSS funds will be managed as parallel support to HNPSP. They will be deposited in a dedicated account at a national bank and from there disbursed to the various operational levels.

Financial Sustainability of immunization-related activities

The financial sustainability strategy for the immunization programme seeks to increase Government support of vaccine purchases, with the bulk of the remaining immunization operational costs covered by support mobilized from other sources (**cMYP p. ix**).

Strategic objective 3.1 of the cMYP (p.16) is to 'ensure sufficient and sustainable immunization program financing'. It sets a target of an increase in government purchases of vaccine by 10% each year. The cMYP's strategic objective 3.4 is to 'Ensure efficiency in use and accountability for immunization program funds', by preparing a fully costed annual immunization workplan and striving for transparency in allocation and use of funds. The GOB procures routine EPI vaccines through pool fund and IDA credit. From 2007-08 Government is planning to gradually include the vaccine cost in the revenue budget.

Logistics expenditures under this HSS proposal will be supported by recent increases in the funding of infrastructure rehabilitation and construction made by the government, as well as new funding from ADB cofinanced UPHCP-II. In the FY 2008-09 Operational budgets, Physical Facilities spending was increased to cover additional CC overheads.

Sustainability also will be assisted by improving the efficiency of service delivery. First, demand generation (e.g. routine immunization days and immunization awareness campaigns) will reduce some overheads for outreach, and likely reduce wastage. Second, improved coverage will reduce the financial burden of vaccine preventable diseases at the government and household levels. Equally, improved access to MCH services should lead to social and economic benefits from reductions in U5 and maternal mortality and morbidity.

Success in achieving the HSS proposal should encourage a greater willingness on the part of both the Government and the DPs to fund expanded provision of the full ESD package, increasing long-term predictability of financing.

[9] Medium Term Budget Framework 2007-2010: Salient Features.

In addition, the HSS proposal will be supported by other DP and government initiatives. In 2005, the WB began implementing an US$ 300 million assistance to the HNPSP and the HNP SIP. The first component accelerates achievement of health-related MDGs and PRSP strategies and of population policy objectives. The second component focuses on the development of strategies and policies for emerging HNP sector challenges. A third component addresses major policy reforms in the health sector to increase management and stewardship capacity, diversification of service provision, and stimulation of demand for HNP services in Bangladesh.

Finally, the private sector will have a substantive stake in the development of local level plans and a larger role in Phase-2 implementation of the plan. Renovated CCs will be more easily outsourced for management, one of the key Public Private Partnership (PPP) strategies, pursued in other districts, and supported by the pooled funding mechanism.

Technical sustainability

Technical sustainability will be achieved through lessons learnt in other donor and government supported pilot projects, such as the World Bank's support for pro-poor mobilization of demand for community services, and other pilot studies on rehabilitating Community Clinics as a means for improving fixed-post provision of core ESD components. Another example is support provided by the ADB funded UPHCP-II has been implemented by the MLGRD&C in six city corporations: Dhaka, Chittagong, Khulna, Rajshahi, Syllhet and Barisal---and five municipalities-Bogra, Comilla, Sirajgonj, Madhabdi and Savar. Lessons learnt in ADB-supported districts will be used to improve implementation of HSS efforts in the 13 districts targeted for GAVI funding.

There is a significant component of operational research included, to identify lessons learnt and best practices, which will be applied to revising the strategy to transition to fixed post provision of services.

Another example is the use of public-private partnerships. These not only help leverage public sector funding, but promote sharing of management and operational expertise between private and public health officials. For example, a PPP between MOHFW and the Obstetric and Gynaecological Society of Bangladesh has been implementing a plan to increase skilled attendance through training and accrediting existing staff. Lessons learned from this and other performance-based contracting experiences will inform efforts to promote PPPs in the 13 districts.

GAVI HSS activities will also be complemented by support from the government's safe motherhood/demand side voucher scheme which aims to increase utilization of ANC and PNC services and promote institutional delivery.

Post-funding Transition Strategy

The HSS Programme Implementation Committee (PIC), under the supervision of the HNP Forum, will be the lead agent for identifying and clarifying options to manage the transition to the post-GAVI HSS funding period. The aim will be to ensure that performance gains and improved health outcomes can be maintained once the period if GAVI HSS support ends. In the same light, it will also identify ways how successful experiences in these 13 districts can be replicated or scaled-up.

The HNP Forum is the decision-making body to which the HSS PIC reports to, and which will be ultimately responsible for ensuring the sustainability of HSS-linked accomplishments.

5.2: Major Activities and Implementation Schedule

Note: the timeline is based on the Calendar year in Bangladesh, in line with timing of GAVI Annual Progress Reports are structured. However, the fiscal year and annual plans of the MOHFW and health programmes run from July 1 to June 31.

Key: **R:** recruitment cost, with subsequent '**x'** denoting on-going outlays for recurrent salary, incentives, or per diem costs.
P: Purchase or Development cost, with subsequent '**x'** denoting on-going outlays for recurrent costs.

Phase 1 covers this HSS proposal, from 2009 to 2010; Phase-2 is the planned continuation and expansion of Phase-1 activities over the period of the next National Health Strategy, from 2011 to 2015. As Phase-2 is tentative, planned activities are not indicated below.

Major Activities	Expected outcome	Year 1 (2009)				Year 2 (2010)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective # 1: In 13 districts by calendar year 2010 ensure that 90% of HA and FWA posts are filled to permit gender-appropriate provision of MCH services.	By 2010 in the 13 targeted districts, i) 1188 HAs & 452 FWAs will be hired and ii) DTP3 > 90%.								
Activity 1.1 Fill vacant HA and FWA posts in targeted 13 districts, then use consolidated pay system for salaries (all hires in Q1 2009)	By 2010, hired worker will fill 50% of vacant posts in 13 targeted districts, to achieve 1 male and 1 female skilled staff	**R**	**R**	**x**	**x**	**x**	**x**	**x**	**x**
Activity 1.2 MCH training curriculum for CC staff ready for use by end of 2008.	Training team set up by December 2008 and a modular training programme developed by April 2009	**x**							
Activity 1.3 Newly recruited HAs and FWAs in the 13 districts will be trained on best practices for delivery of MCH services by 2010	100% of HAs and FWAs will receive MCH training within 3 months of being hired		**x**	**x**		**x**			
Activity 1.4 1-day Train VHW to increase community demand for MCH services.	By 2010, 100% of VHWs will receive a 1-day orientation on increasing community awareness of MCH services		**x**				**x**		
Activity 1.5 Put into place an incentive scheme to provide each HA and FWA 1000 Taka, and each VHW 250 Taka, to hold semi-annual Health Promotion days, to be used to raise community awareness of the need for MCH services.	By 2010, all wards in the 13 districts have semi-annual health promotion days.		**x**		**x**		**x**		**x**
Activity 1.6 Pilot a scheme to recruit additional vaccine porters at taka 200/EPI session to ensure at least 1 vaccine porter per 3 unions for plains, and I VP per 1 union for CHTs.	At least 1 vaccine porter for every 3 unions in the 13 districts by 2010	**R**	**R**	**x**	**x**	**x**	**x**	**x**	**x**

Major Activities	Expected outcome	Year 1 (2009)				Year 2 (2010)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective # 2: In 13 targeted districts by 2010, to ensure at each administrative level that critical gaps in logistics, supervision, and management and skills development have begun to be filled, to ensure effective district management of MCH services delivery.	By 2010 at Upazila level, i) a computer for HMIS obtained for 101 Upazilas; and ii) for each of the 13 districts, 90% of monthly supervisory and performance reports are available by the 15th of the following month.								
Activity 2.1 For each administrative level develop a supervisory tool to assist supervisors to monitor problems with the supply of and access to MCH services.	District, Upazila and union supervisory tools for measuring quality, coverage and effectiveness of MCH and other priority PHC services finalised by March 2009	**x**							
Activity 2.2: Annual orientation for Upazila and front-line supervisors on how to use supervisory tools to assess if CC is functional and capable of delivering necessary MCH services.	By May 2009, all supervisors in 13 districts trained on assessing CCs and MCH services with tool.		**x**				**x**		
Activity 2.3 Pilot joint monthly reporting, on performance of CCs, between Upazilas Family Planning and Health Service Directorates' (AHI & HI & FPI), with monthly review meetings jointly chaired by UHFPO & UFPO**.**	By 2010, monthly meetings occur in all Upazilas, and issues identified in reports addressed in following month.	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
Activity 2.4 CC management committee (10 + HA + FWA) semi-annual 2-day workshop on CC management at Upazila level.	Workshops held semi-annually.		**x**		**x**		**x**		**x**
Activity 2.5 CC management committee (10 persons + HA + FWA) hold monthly management review meetings.	90% of monthly management review meetings occur in all functional and staffed CCs by 2010	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
Activity 2.6 Production and distribution of materials for training HA, FWA & other staff on MCH best practices to prepare for transition to CC-based service provision.	Training materials will be delivered to district and Upazila trainers by April 2009		**x**	**x**			**x**	**x**	

Major Activities	Expected outcome	Year 1 (2009)				Year 2 (2010)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective # 3: In 13 targeted districts by 2010, to ensure that critical gaps in equipment and physical infrastructure have begun to be filled, to ensure CCs can deliver appropriate MCH services.	By 2010, in the 13 targeted districts, 1821 CCs are fully equipped so that they can provide the appropriate level of MCH and PHC services, including immunization, needed by the communities which they serve.								
Activity 3.1 All 1821 CCs receive required renovation to make them fully functional in terms of providing MCH services.	Physical security established by provision of doors, windows and intact roof.		**x**	**x**		**x**	**x**		
Activity 3.2 Obtain 2 sets (computer/printer/UPS) per district and 1 set for each Upazila.	100 % of functional CCs in target districts have complete vital statistics registrars by 2009, and all new CCs have complete vital statistics registrars by 2010.		**x**						
Activity 3.3 Update 2001 transition plan to phase in CCs, based on lessons learnt.	Plan updated by 2009 Q1				**x**				
Activity 3.4 All CCs in target districts to have examination equipment to staff one male and one female exam room.	By 2009, both male and female examination rooms staffed and equipped		**x**	**x**		**x**	**x**		
Activity 3.5 Solar powered electrical supply for lights and water pump for all operational CCs.	All 1,821 CCs receive solar power installation.			**x**			**x**		
Activity 3.6 Priority water and sanitation repairs for all CCs, including water (arsenic) filters supplied to all CCs with arsenic contamination.	i) Functioning hand washing capacity in examination room in all 1,821 existing CCs, measured by presence of function hand-well ii) 100% of CCs with arsenic contamination will have filters by 2009	**P**	**P**						
Activity 3.7 Critical gaps in transportation vehicles are filled (vehicle, boat, bikes).	In 13 targeted districts, by FY 2009-2010, all vehicle gaps in these 3 categories are filled.	**P**	**P**	**x**	**x**	**x**	**x**	**x**	**x**

Activity 3.8 2,246 CCs constructed, to provide appropriate MCH services.	Complete transition from primarily mobile provision to facility-based provision of MCH services by 2013								

Major Activities	**Expected outcome**	Year 1 (2009)				Year 2 (2010)			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective # 4: By 2010, increase access to high quality and appropriate MCH services in the 13 targeted districts through a combination of improved supply (e.g. MCH training for HAs and FWAs) and increased demand (e.g. community mobilization and immunization awareness provided by VHWs).	Percentage of reproductive aged married couples using any contraceptives will increase from 55.8% to 70% by 2010 Percentage of women who receive a post-partum visit within 2 days , will increase from 19.5% to 25% in all 13 targeted districts by 2010								
Activity 4.1 Upazila and front-line supervisors trained on how to plan to improve CC utilization rates.	By 2009, all functioning CCs are routinely evaluated on DTP3 to 1 dropout rate and Number of routine immunization sessions held per month.			**x**				**x**	
Activity 4.2 Ensure harmonization of birth registrations between FWAs and HAs during monthly CC meetings, by providing incentive to FPI to verify accuracy of birth registrars.	By 2010, 95% of 1,821 CCs have joint verification of vital data monthly.	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**
Activity 4.3 Use Local Level Planning (LLP) at union level to implement anaemia prevention strategy in 13 districts.	Anaemia rates among pregnant women reduced from 60% to 35%				**x**				**x**
Activity 4.4 Institute routine 6-month training program for upgrading eligible FWAs into SBAs at the 13 district hospitals by 2010.	Ensure at least 25% of FWAs are trained as SBAs in each of the 5 high-need districts by 2010			**x**	**x**	**x**	**x**	**x**	**x**
Activity 4.5 Reprint and disseminate IEC messages for MCH, nutrition and IMCI to generate demand for SBAs and other safe motherhood services.	45 % of deliveries in 13 districts with an SBA attending by 2010		**x**						

Section 6: Monitoring, Evaluation and Operational Research

6.1: Impact and Outcome Indicators

Indicator: impact and outcome	Data Source	Baseline Value[10]	Source[11]	Date of Baseline	Target (13 districts)	Date for Target
1. National DTP3 coverage (%)	HMIS, as corrected for WHO/UNICEF Joint Reporting Form through annual MOHFW EPI Coverage Evaluation Survey (CES)	87%	EPI CES (National and Division survey, not district survey)	2007	>90%	2010
2. % of districts achieving ≥80% DTP3 coverage	HMIS, as corrected for WHO/UNICEF Joint Reporting Form through annual MOHFW EPI (CES)	75%	EPI CES (includes district surveys)	2006	>80%	2010
3. Under five mortality rate (per 1000)	Bangladesh Demographic & Health Survey (BDHS)	65	DGFP	2007	<52	2010
4. Vitamin A coverage among post partum women (%)	BDHS	35%	WHO/UNICEF JRF 2008 data for 2007	2007	>55%	2010
5. TT1 and TT5 coverage rate (%)	HMIS, as corrected for WHO/UNICEF Joint Reporting Form through annual MOHFW EPI (CES)	TT1-87% TT5-36%	EPI CES	2007	TT1> 90 % TT5> 45%	2010
6. Percentage of reproductive aged married couples use any contraceptives (%)	HMIS, supplemented by BDHS	55.8%	DGFP	2007	70%	2010

[10] If baseline data is not available indicate whether baseline data collection is planned and when
[11] Important for easy accessing and cross referencing

6.2: Output Indicators

Indicator: output	Numerator	Denominator	Data Source	Baseline Value[10]	Source	Date of Baseline	Target	Date for Target
1) 90% of monthly supervisory and performance reports are 100% complete and are available at the district level by the 15th of the following month.	Total number of supervisory visits during the 12-month reporting period covered by the APR, for each of the three administrative levels	For Upazila supervisory visits: 12 For Union supervisory visits: 24 For CC supervisory visits: 52	Health facility survey, Monthly District supervisory report on each Upazila; Semi-monthly Upazila report on each union; Weekly supervisory Union report on each CC	Not available, but less than 50% in the 13 target districts at the level of CC supervisory visits	Monthly supervisory reports from Deputy Director of Family Planning and from Civil Surgeons	2008	1/month	2010
2) % of women receiving post-natal care and information on childhood immunization schedules	# of women giving birth that receive a post-natal care visit	# of births	BDHS	21.3%	DGFP	2007	40%	2010
3) Number of CCs that are fully equipped	# of HAs, and # of FWAs per CC	Number of CCs operational in a given year	Health facility survey, Monthly District supervisory report on each Upazila; Semi-monthly Upazila report on each union; Weekly supervisory Union report on each CC	1,821	DGFP & DGHS	2008	1,821	2010
4) No of CCs renovated and/or constructed per year	# of CCs operational	Annual total number of CCs in each district planned to be in operation by end of FY 2012-2013	Health facility survey, Monthly District supervisory report on each Upazila	0 (in these 13 districts, none of 1,821 have been renovated by GOB to full operational status).	DGFP & DGHS	2008	1,821 functional and fully staffed CCs by 2010	2010

Indicator: output	Numerator	Denominator	Data Source	Baseline Value[10]	Source	Date of Baseline	Target	Date for Target
5) % of deliveries with SBA attending	# of deliveries with SBA attending	# of deliveries	District level Surveillance report	17.8%	DGFP	2006	40 % of deliveries with SBA attending by 2010	2010
6) % of HAs and FWAs posts that are filled in each district.	# of HAs per district; # of FWAs per districts	Total # of HA posts desired (1 HA per 6,000 populations) Total # of FWA posts desired (1 FWA per 6,000 populations)	Health facility survey Monthly District supervisory report on each Upazila	Varies per district, see table in Annex 4	DGFP & DGHS	2008	95% of HA and of FWA posts in these 13 districts filled by 2010	2010

6.3: Data collection, analysis and use

Indicator ***Impact and outcome***	Data collection	Data analysis	Use of data
1) National DTP3 coverage (%)	HMIS data generated by EPI routine program coverage report. This will be supplemented by EPI Coverage Evaluation Surveys, funded by WHO/UNICEF and conducted independently.	The survey firm analyses the findings, which is finalized after presentation to a group of program managers, development partners, researchers and teaching faculty. The same approach will be used for this proposed project.	This data is and will be used to identify the districts and divisions for strengthening interventions, especially core ESD elements.
2) % of districts achieving ≥80% DTP3 coverage	HMIS data generated by EPI routine program coverage report. This will be supplemented by EPI Coverage Evaluation Surveys, funded by WHO/UNICEF and conducted independently.	Data is presented to and analysed with all the program managers, relevant partners, e.g., UN agencies, and other stakeholders.	This data is and will be used to assess effectiveness of increased supervisory contacts, and assess impact of new staffing and training, so as to identify best practices and lessons learnt relevant to increasing access to core ESD components.
3) Under five mortality rate (per 1000)	This will be collected by DHS conducted by Bangladesh Bureau of Statistics independently and BDHS conducted by National Institute for Population Research and training (NIPORT)	The survey firms provide an initial analysis. Results are evaluated by other researchers, donors, faculty members before finalization. At this time, subsequent analysis is largely carried out at national levels.	Data is used to review program performance, re-orientation, re-planning and reprogramming intervention strategies and prioritization at nodal levels. This figure is and will be used for future target setting.
4) Vitamin A coverage among post partum women (%)	HMIS data generated by EPI routine program. This will be supplemented by EPI CES, funded by WHO/UNICEF and conducted independently.	As described above for EPI CES	This data is and will be used to identify the districts for strengthening MCH and PNC supervisory and community awareness interventions, and to assess the quality and effectiveness of LLP at union level
5) TT1 and TT5 coverage rate (%)	HMIS data generated by EPI routine program coverage report. This will be supplemented by EPI CES, funded by WHO/UNICEF and conducted independently.	As described above for EPI CES	This will guide development and execution of IEC strategies to generate awareness of and demand for MCH services, and to ensure mothers know the full immunization schedule needed to protect neonates, infants and children

Indicator ***Impact and outcome***	Data collection	Data analysis	Use of data
6. Percentage of reproductive aged married couples use any contraceptives (%)	HMIS data generated from routine Family planning routine coverage report. This will be collected by DHS conducted by Bangladesh Bureau of Statistics independently and BDHS conducted by NIPORT.	At national level analysis will be done by NIPORT and Family planning Directorate	This data will be used in national and local level planning for effective programme implementation on different major activities on Family planning.

Indicator: *Output*	**Data collection**	**Data analysis**	**Use of data**
1) 90% of monthly supervisory and performance reports are 100% complete and are available at the district level by the 15th of the following month.	There is no consistent tool or supervisory checklist for collecting supervisory or monitoring performance at sub-national levels. Only performance data on vaccine coverage is now reported; the quality of which needs improvement. Supervisory and monitoring tools will be developed and supervisor training conducted under this HSS proposal. The performance measures for GAVI APRs, which will be monitored, are: 1. Monthly District supervisory visits to each Upazila 2. Semi-monthly visits by Upazila to each union 3. Weekly supervisory visit by Union to each CC	Currently, little analysis is done at district level to gauge the reasons of strong or weak performances. Under this proposal, supervisory tools development and provision of sufficient logistics and transportation to permit regular supervision is a main HSS target. Data should then be collected and analysed at each level for assessing reasons of success and failure in attaining targets at each level.	Supervisory reports will be a proxy to measure supervisory visits, adoption of effective MCH practices, and information management and use for LLP. Performance reports will be utilised for LLP by lower supervisory levels. National feedback is given from the national level. Instead the EPI CES is used for review and feed back. Assessed data will be used for decision making at applicable levels.
2) % of women receiving post-natal care provided	Data will be collected through BDHS surveys, CES or multiple indicators cluster survey	By DGFP and DGHS, to target areas with low PNC coverage.	Additional IEC and Safe Motherhood efforts will be included in LLP
3) Number of CCs that are staffed with 1 HA and 1 FWA	Through routine supervisory reports conducted by Union, Upazila, District and Division supervisors.	Currently, data is largely analyzed at national level. This HSS proposal provides for training of district and Upazila supervisors, to assess skills and staffing needs of CCs.	Based on the analysis of the findings necessary actions will be taken at the national level of recruitment and incentive schemes and at the sub-national level for supportive supervision and training of new and existing staff.

Indicator: *Output*	Data collection	Data analysis	Use of data
4) No of CCs renovated and/or constructed per year	Through routine supervisory reports conducted by Union, Upazila, District and Division supervisors.	Currently, data is largely analyzed at national level. This HSS proposal provides for training of district and Upazila supervisors, to assess infrastructure and equipment needs of CCs.	Based on the analysis and findings, necessary follow-up actions at national and local level.
5) % of deliveries attended by SBAs by 2010	HMIS data generated from routine Family planning routine coverage report. This will be collected by DHS conducted by Bangladesh Bureau of Statistics independently and BDHS conducted by NIPORT.	Institutional delivery and delivery in trained hands is the current goal of the Government. To what extent this is being materialized will be looked into.	Information will be used to provide feedback to Upazila Family Planning Officers and Upazila Health and Family Planning Officers, as part of the on-going effort to implement the 'accountability and performance management' component of the 2003 Human Resource Strategy [HNP-SIP p. 28].

6.4: Strengthening M&E system

Parallel reporting systems will not be established for GAVI HSS funding. However, since the national planning cycle & program review dates (June to July) do not match GAVI calendar-year based reporting requirements, there will be some additional opportunity cost associated with developing the GAVI Annual Progress Report.

For this reason, it is proposed that a small fraction of the HSS funds are allocated to support a Health System Strengthening National Coordinator [see ToRS for HSS-NC in section 7.2] to manage the additional administrative requirements of managing and tracking the flow and use of all HSS activities and funds (e.g. GAVI HSS, Global Fund HSS support, etc). For example, the HSS-NC would be responsible for holding regular meetings with District Health officials of the 13 districts to collect information on HSS implementation issues and progress. The HSS-NC also would facilitate the work of the HSS PIC (See section 7.2) to prepare GAVI APRs.

While all the indicators to be reported in the GAVI APR should be routinely collected under HNPSP and analysed, the quality, completeness and timeliness of HMIS data needs to be enhanced. Due to data gaps, HMIS data is routinely supplemented with survey data. This results in good data for management decision-making at the national level, but does not provide quality information that can be relied upon by sub-national level managers for effective decision-making.

This proposal and work by other partners (e.g. WB, UNICEF, WHO, ADB, etc) seeks to establish a stronger foundation for the development of performance-based incentives to promote the systematic use of data for LLP at all sub-national levels. For example, functional CCs, stronger HMIS systems and better trained supervisors are necessary to ensure CCs whose management is outsourced to NGOs will achieve national performance targets.

The table below shows selected M&E strengthening efforts by the government and its Development Partners to reinforce M&E capacity.

Table 7: National efforts to build up M&E capacity

Development Partner	M&E capacity Building
Government	Special Operational Plan for Line Director of HMIS to train staff on best practices for routine HMIS system and data management, plus developing a stronger functional structure for HMIS
IEDCR	Being equipped and trained to expand disease surveillance capacity and scope for some identified diseases;
MOHFW	Monitoring and Evaluation Unit under Joint Chief of Planning: annual programme review of SWAp and developing system and performance evaluation tools for all levels of public health system.
GTZ	Provides technical support to M&E Unit of MOHFW
Implementation Monitoring & Evaluation Division (IMED)	IMED has authority to monitor all development projects and annual development plans, reporting information on Cost-Effectiveness Analysis to Council of Ministries and to the Executive Committee of National Economic Council
WB supported Central Procurement Technical Unit under Ministry of Planning	Authorized to monitor and report on procurement-related issues.
Health Matrix Network (HMN) support	Establishment of a performance review and monitoring system at the HMIS
EPI Programme	RED approach: supports improved Local Level Planning, in part by improving local data collection and use of data for planning.
Procurement and Logistics Management Cell of MOHFW	Being established under the chairmanship of Joint Chief, Coordination at the Ministry to monitor and ensure transparency in procurement.

Process indicators here will also be monitored by other programmes seeking to assess areas of joint work: (1) LLPs with involvement of local NGOs and public leaders with the Division, District, and Upazila health sector structures; (2) Co-ordination and collaboration with (a) National Nutrition and the Micronutrient Programs, (b) Bureau of Health Education of DGHS and Information Education and Monitoring (IEM) of DGFP, (c) IEDCR, (iv) Director, Management Information Systems of the DGHS and DGFP; (3) Training on personnel, program and logistics management; (4) vaccine and medical commodities storage systems; and (5) availability of incentives for outreach and supervision.

The HSS proposal has specific activities designed to support improvements in the quality of data:

Activity 2.1: For each administrative level develop a supervisory tool to assist supervisors to monitor problems with the supply of and access to MCH services.

Activity 2.2: Annual orientation for Upazila and front-line supervisors on how to use supervisory tools to assess if CC is functional and capable of delivering necessary MCH services.

Activity 2.3: pilot joint monthly reporting on performance of CCs, between Upazila base staff of DGHS and DHFP', with monthly review meetings jointly chaired by Family Planning and Health Service Supervisors.

Activity 4.2: Ensure harmonization of birth registrations between FWAs and HAs during monthly CC meetings, by providing incentive to FPI to verify accuracy of birth registrars

6.5: Operational Research

Several studies have been proposed to be conducted, using the opportunity of GAVI-HSS funding to assess outcomes of piloting various performance improvement efforts in the 13 pilot districts.

1) Costing and feasibility study on requirements for IEDCR to manage an expanded national surveillance system. The Proposed Terms of Reference:
   a) cost scaling up to fully cover current needs of all 64 districts,
   b) estimate costs to go from current to expanded surveillance,
   c) estimate one-off costs for training and equipment,
   d) project annual recurrent costs to sustain expanded system.

2) Study on causes of poor not accessing health care services for EPI and maternal health
   a) Finding out the reason why exactly the poor do not access EPI and maternal health services, in particular vitamin A to women after child birth (link cMYP P 17, EPI CES 2006 p. 162-167) and TT5 vaccine among poor adolescents (EPI CES 2006 p. 126-138).
   b) Study will examine both supply-side and demand-side barriers; e.g., is it due to cultural barrier, economic barrier or geographical barrier or there are some other causes?

3) Cost Effectiveness Study to assess effectiveness of renovating CCs in terms of improved ESD access, to guide Phase-2 decisions on CC construction, distribution, and functioning

4) Retrospective studies to evaluate how effectively Community Committees were able to manage CCs
5) Study on incentive mechanisms for motivating VHWs, and front-line health workers (e.g. HAs and FWAs), and mid-funding evaluation of incentive schemes piloted through GAVI HSS funding (Activity 1.4, 1.5, 1.6)

6) A study on health worker motivation and incentives.
   a) Why are root causes of low motivation in rural areas (e.g. relative impact of pay, supervision, work in remote areas, etc
   b) Assess national, regional and global evidence on the use of performance-based incentives and performance-based contracting to improve the motivation and quality of work of front-line health workers.
   c) Results from this study will be used to improve mechanisms for recruiting and retaining health workers in CCs.

Section 7: Implementation Arrangements

7.1: Management of GAVI HSS support

Management mechanism	Description
Name of lead individual / unit responsible for managing GAVI HSS implementation / M&E etc.	Line Director ESD and Director PHC of the DGHS will be responsible for the programme management under the direct guidance of the GAVI HSS PIC chair.
Role of HNP Forum in implementation of GAVI HSS and M&E	HNP Forum, chaired by the Secretary, MOHFW will endorse the HSS budget proposal and will review, monitor, advise and facilitate program implementation and target achievement. It will also coordinate with the other programs, which are funded by the DPs of HNP sector of Bangladesh. Please see the TORs of HSS forum (Anex-5).
Mechanism for coordinating GAVI HSS with other system activities and programs	The Secretary of MOHFW is responsible for monitoring and managing coordination of HSS elements within various Health Sector programmes to ensure alignment with overarching national Health Sector Strategy. The Secretary of MOHFW heads the HNP Forum and the Country Coordination Mechanism (CCM) for Global Fund support, and the administrative focal point of the pooled funding mechanism. He thus oversees all planning strategies and policies relevant to HSS planning, implementation and financing. In addition, HNP forum and CCM have about 50% overlap in membership, ensuring systematic review of cross sectoral health strengthening policies and strategies. Quarterly meetings will be held of HNP Forum, where all the relevant development partners, technical agencies (e.g., UN bodies), other ministries and organizations that provide health care are members. These meetings will discuss implementation issues of the project. Members of the Forum are also expected to make occasional field visits to see how the project coordinates with other sister programs and with intra and inter-organizational activities at the operational level. The members may assist the operational level managers on strengthening coordination further if required. See TORs for HSS PIC (Section 7.2).

7.2: Roles and responsibilities of key partners (HSCC members and others)

A) HNP Forum:

The HNP forum is for the health sector the highest policy and programme supervisory instrument of the GOB, equivalent to the HSCC. It was constituted to liaise and coordinate Government policies and programme activities with DPs and other key stakeholder. It is in charge of overseeing HSS implementation and provides stewardship to the work of the PIC (see below).

b) The HSS PIC

The current PDC will be transitioned into the HSS PIC. It will be the lead technical group backstopping implementation of HSS strategies, including GAVI HSS. In addition, pilot districts will have two representatives in the PIC on a rotation basis.

Title / Post	Organisation	Roles and responsibilities of this partner in the GAVI HSS programme implementation
Joint Chief Planning	**MOHFW**	**PIC Chair, and responsible for overall HSS Programme implementation and supervision**
Senior Assistant Chief	MOHFW	Secretary of the PIC
Line Director-ESD & Director PHC	DGHS	Coordinating HSS field activities with other relevant programme activities and responsible for GAVI HSS implementation.
Line Director, Maternal, Child and Reproductive Health Service Delivery	DGFP	Coordinating HSS field activities with other relevant programme activities
Medical Officer EPI	DGHS	Related with other GAVI initiatives
HSS National Coordinator	MOHFW	Provide all sorts of supports to the PIC for effective field level implementation.
Medical Officer Health Systems / Public Health	WHO	Lead Technical Assistance and Representative of Development Partner
Health Manager	UNICEF	Technical Assistance and Representative of DPs
Country Director	Helen Keller / NGO	Liaison with non-Government stakeholder
Public Health Specialist	PSO / MOHFW	Provide technical assistance and programme support
Representative	Civil Surgeon/Deputy Director Family Planning	Provide feedback and advise operational issues

Note: In Bangladesh, Civil Society has traditionally been regularly involved in planning for social welfare. For example, the Bangladesh Rural Advancement Committee (BRAC), a leading NGO, organized and facilitated all consultations during the first stage of PRSP formulation, and CSOs sit on the National Poverty Reduction Council (NPRC) (e.g. women's and human rights organizations). Additionally, the private sector, (e.g. Chambers of Commerce and Industry) participated in PRSP consultations and sit on the NPRC.

HSS PIC

The proposed HSS PIC Terms of Reference are:

Roles and responsibilities of the HSS PIC:

1. Chair will be the Joint Chief of Planning, MOHFW.
2. Oversee management of HSS implementation and funding, and proactively resolve barriers to implementation.
3. Meet quarterly, one month prior to HNP Forum.
4. Evaluate and report on HSS implementation each quarter to the HNP Forum, by monitoring annual and overall progress towards HSS objectives.
5. Oversee development of the national health system strengthening strategy, and ensure its alignment with the "2003-2010 HNP SIP and subsequent HNPSPs.
6. Request technical inputs from MOHFW departments to inform HSS annual planning.

7. Provide annual reports on progress towards each objective and activity implementation of the HSS strategy, to help guide development of annual national health plans and budgets
8. Encourage coordination and alignment of all HSS efforts, such as Global Fund, those supported by bilaterals, and those involving NGOs and CSOs.
9. Facilitate appropriate involvement of the private sector and other non-government partners.
10. Discuss ways to coordinate budgets and external aid, to transition more funding through pooled funding mechanism as appropriate.
11. Monitor evolving financial, human resource and technical support needs, and determine how to ensure predictable flows of needed support.
12. Responsible, in coordination with immunization and the Intra-Agency Coordinating Committee, for developing the joint Annual Progress Reports to GAVI, as well as HSS performance reports for the government and DPs
13. Recruit a National Coordinator, who will act as the Secretariat for the HNP Forum and provide administrative support to the HSS PIC (please see the TOR of HSS NC below)

TOR for the HSS National Coordinator

A national coordinator will be recruited to assist the HNP Forum in managing its administrative tasks in overseeing all HSS activities. Under the supervision of HSS PIC, she/ he will have master degree in public health and at least 5 years experience in planning, program management and program review of the health sector.

Duties and responsibilities:

1. Hold regular discussions with District Health officials of the pilot districts to collect information on HSS implementation issues and progress.
2. In collaboration with child and reproductive health care programme managers, report progress towards the national HSS strategy and prepare Annual Program Implementation Reports.
3. Act as the administrative focal point for the HNP Forum and technical HSS PIC on the planning, management and financing of HSS implementation.
4. Manage administrative arrangements and facilitate work of International TA for HSS implementation and financial management.
5. Provide administrative support for distribution and oversight of GAVI HSS funds, including preparation of bi-annual audits on use of funds.
6. Work with MOHFW Planning Unit to progressively integrate evidence from performance evaluation into annual planning and policy-making.
7. Oversee fiduciary aspects of programme and budget management, in collaboration with Foreign Aid Project Audit Department.
8. Oversee operational research on the effectiveness of HSS strategies in pilot districts, and ensure results are collected and disseminated to HNP Forum prior to each meeting.
9. Any other responsibilities that may assigned to him by the HNP forum

7.3: Financial management of GAVI HSS support

Every fiscal year the GOB prepares a national budget with dedicated appropriation for each sector including the Health Sector. The MOHFW then prepares its own annual budget and operational plan in line with the goals and objectives of the HNPSP RPIP. The total budget envelope of the HNPSP is pre-approved by the Ministry of Finance. This means that line items of the health budget, including GAVI HSS spending, do not require direct approval from the Ministry of Finance.

Financial management of proposed GAVI HSS support will shadow the successful approaches developed for GAVI-ISS fund management:

Mechanism / procedure	Description
Mechanism for channelling GAVI HSS funds into the country.	According to GOB's Bangladesh Bank regulations, the GOB will, upon written confirmation of availability of GAVI HSS fund, open a dedicated foreign currency bank account and forward to the GAVI Alliance Secretariat the account details.
Mechanism for channelling GAVI HSS funds at national level.	From the dedicated Bangladesh Bank foreign currency account the funds will be transferred to another foreign currency account of a GOB appointed commercial bank, the head office of the Sonali Bank, foreign exchange branch. At national level, all funds will be managed jointly by Joint Chief, planning and LD ESD (who are the joint signatories for releasing GAVI HSS funds). Against programme based requisitions funds will then be transferred to a local currency accounts at the Sonali bank, Mohakhli branch. Programme based requisitions can be issued against activities which, as per GAVI HSS implementation plan, are included in the Policy Reforms Operational Plan under HNPSP. Under GAVI HSS, the following Line Directors / heads of institutions will issue programme based requisitions: LD In Service Training (IST): LD Physical facility: LD ESD: LD Maternal, Child and Reproductive Health Service delivery: LD Research and Development (R&D): Chief Bureau of Health Education (BHE): The requisition based budgets then can be transferred to sub-national operational and budget level.
Mechanism for channelling funds to sub-national, especially in District level.	Funds for all sub-national (district and below) level activities will be directly transferred from GAVI HSS local currency account in Sonali Bank Mohakhali branch to the local account of the Civil Surgeon (Head of the district health administration) according to GOB standard financial management procedures. As per GOB rules, each financial transaction will be complemented with an implementation guideline covering the procedure for disbursement of funds to Upazila managers, budget break-up, implementation schedule, financial accountability, end-use monitoring and deadline for submission of expenditure statement will be made available to all GAVI HSS sub-national budget holder. At the district level, all members of the existing District Health Coordination Committee will be involved in the planning, management and review of disbursement and utilization of GAVI HSS fund. Under this mechanism, all funds will be transferred to the Civil Surgeon.

Mechanism for channelling funds from District to Upazila level.	The Civil Surgeon in consultation with the members of the District Health Coordination Committee, and as per budget details & guidelines, will disburse money to the various Upazila Health and Family Planning officers (UHFPO) through bank drafts. The UHFPO will be fully responsible and accountable for GAVI HSS support fund use at the Upazila level. All members of the existing Upazila Health Coordination Committee will assist him in proper planning and utilization of GAVI HSS fund.
Mechanism of preparation of budget and approval process	Upazila budgets will be prepared locally through a process of local level microplanning, against an indicative budget ceiling given by the Line Director ESD. All members of the Upazila Health Coordination Committee, service providing agencies, technical personnel including Surveillance Medical Officer/District Immunization Medical Officer and local public representatives will participate in this local level microplanning exercise. Based on this planning exercise, the Upazila Health Coordination Committee will submit, through the Civil Surgeon, to the line Director ESD an annual budget for approval. Once approved, disbursements of funds to the district level will be effected quarterly, contingent upon submission of Statement of Expenditures for the preceding quarter.
Auditing procedures	As with other GAVI funding streams, and as per standard GOB financial management procedures, GAVI HSS funds will be audited annually by the Foreign Aided Project Audit Department of GOB. It is under control of Controller and Auditor General of Bangladesh and is mandated with the audit of all HNPSP fund utilisation.

7.4: Procurement mechanisms

There will be three types of procurements in the program:

1. Procurement of equipment
2. Procurement of vehicles
3. Procurement of works and services

All procurements will be done as per the Public Procurement Act 2006 of the GOB. This Act was developed in cooperation with the WB and was approved by the parliament. It is mandatory for all public procurement of Bangladesh. The Act specifies procurement methodologies according to monetary value and procurement type, i.e. goods, services and works.

The GAVI HSS proposal specifies four major areas of procurements:

1. Procurement of Equipments. Procurement of low unit cost equipments required for the running of CCs can be done by local shopping. This will encourage local level planning, ownership and maintenance of equipments procured. More expensive equipments will be procured via national or international competitive bidding as per Public Procurement Act.

2. Procurement of Logistics: The proposal contains investments in logistics facilities, mostly in vehicles and boats to improve referral and supervisory capacity for CC and Community-based PHC services. The items will be procured centrally in bulk through a national and/or international competitive bidding process.

3. Procurement of Works: The procurement of works for rehabilitation of CC will be managed at Upazila level through local competitive bidding process and, in the case of minor works through local shopping. The construction of new CC will be handled by the GOB's Construction, Maintenance and Monitoring Unit (CMMU). This department, in 2000-2001 contracted and supervised the construction of 14,000 CC country-wide.

4. Procurement of Services: Consultant and Technical Advisory services will be procured from the local market through an open and competitive process as feasible. A quality based rather then cost and quality based selection process might be used to ensure value for money. Special emphasis will also be given to the development of effective local level public private partnerships. Prior working experience with the EPI and other PHC outreach programmes will be considered an added advantage.

7.5: Reporting arrangements

The main mechanism for reporting on progress towards the HSS goal and objectives are divided into responding to national needs for performance data, and GAVI Alliance requirements.

Central, State and Division and District Level

Routine HMIS systems and annual surveys will be the data collection mechanisms for progress towards HSS annual milestones. These will operate on a fiscal year (July 1 to June 31) cycle, and thus will require interpretation to fit the needs of the GAVI APR. Attainment of the output and outcome targets will be reported based on the Multiple Indicator Cluster Survey, EPI CES, BDHS and other health sector studies, as well as HSS-specific reports. The latter will include the reviews on disbursement, procurement and performance. Annual surveillance reports will be compared against HSS activities, to assess the effectiveness of the proposed HSS strategies to increase and sustain high immunization coverage and improve provision of other MCH interventions.

The HNP generates an annul review of progress towards the goals of the HNPSP, the HNPSP-RPIP, and the HNP-SIP. These are reviewed in January to February (Q 3 of the Fiscal Year), and used to develop annual plans and budgets for the next Fiscal Year by May (Q4 of the Fiscal Year). The annual plans and budgets are approved by June, and implemented on 1 July.

Annual reviews by each Directorate (e.g. DGHS and DHFP) will supplement HMIS reporting, as will EPI CES and other annual surveys. These will be further supplemented by assessment reports by DP agencies.

International Level

Parallel reporting *systems* will not be established for GAVI HSS funding. However, as the national planning cycle does not match GAVI calendar-year based reporting requirements, there will be additional administrative and cost overheads associated with developing a joint GAVI APR on the use of all GAVI funding.

For this reason, it is proposed that a small fraction of the HSS funds go to support a HSS National Coordinator [see ToRS in section 7.2] to handle the administrative requirements of managing and tracking the flow and use of GAVI funds. For example, the HSS NC would be responsible for holding regular meetings with District Health officials of the pilot districts to collect information on HSS implementation issues and progress. And, in collaboration with immunization programme managers, the HSS NC would prepare progress reports on the outcomes of GAVI HSS funded activities in the thirteen target districts, which would form the basis of the GAVI APR on the use of funds against expected performance improvements.

Investments, TA and other resource inputs from other sources (Government, multilaterals, bilaterals, and NGOs) would complement the HMIS strengthening components of this proposed HSS support, so that the end result would be a systematic and sustainable improvement in the national capacity to evaluate and act upon data on health system performance.

APR and the quarterly meetings of the HSS PIC and the HNP Forum will provide the main opportunity for multi-partner and multi-disciplinary evaluation and dissemination of the knowledge gained form conducting operational research (e.g. the incentive scheme for FWAs and HAs to conduct semi-annual health promotion days).

7.6: Technical assistance requirements

Activities requiring technical assistance	Anticipated duration	Anticipated timing (year, quarter)	Anticipated source (local, partner etc.)	Anticipated Funding Source
1. Annual Service delivery survey to assess health systems performance and MCH services at CC and community levels	1 month	Annually	Competitive tender	GAVI HSS
2. National HSS Coordinator See TOR in Section 7.2	Throughout the initial phase of HSS funding	Throughout the HSS funding phase	MOHFW	GAVI HSS
3. Costing and feasibility study for expanding national surveillance system	3 months	2009	WHO & IEDCR (technical support); Competitive tender to choose firm	GAVI HSS,
4. Research studies	Varies	2009 and 2010, and at end of HSS support	Competitive tender	LD Planning and Research, plus GAVI-HSS.

Section 8: Costs and Funding for GAVI HSS

8.1: Cost of implementing GAVI HSS activities (in US $)

Notes: 1) the fiscal year of Bangladesh runs from 1 July to 30 June. Projections for CCs will be adjusted according to annual review 2) Phase-1 covers this HSS proposal, from 2009 to 2010; Phase-2 is indicative of the continuation and expansion of Phase-1 activities over the period of the next National Health Strategy, from 2011 to 2017.

GAVI HSS Projected Budget 2008-2013	Notes on costs	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Phase 1 totals	Phase 2 Totals	Grand Total P1 &P2
Calendar year 1 January to 31 December		2008	2009	2010			
Objective 1: In 13 districts by calendar year 2010 ensure that 90% of HA and FWA posts are filled to permit gender appropriate provision of MCH services.							
Activity 1.1: Fill vacant HA and FWA posts in targeted 13 districts, then use consolidated pay system for salaries (all hires in Q1)			$1,158,240	$1,158,240	*$2,316,481*	*$5,791,202*	$8,107,683
Activity 1.2 MCH training curriculum for CC staff ready for use by end of 2008	Print & disseminate 600,000 taka [Gov't pays for developme costs]		$8,824		*$8,824*	*$8,824*	$17,647
Activity 1.3: Newly recruited HAs and FWAs in the 13 districts will be trained on best practices for delivery of MCH services by 2010 [NB: 5 % each year to co turnover & new recruitment]			$241,300	$12,065	*$253,365*	*$60,325*	$313,690
Activity 1.4: 1-day Train VHV to increase community demand for MCH services			$717,645	$717,645	*$1,435,290*	*$3,588,226*	$5,023,517
Activity 1.5 Put into place an incentive scheme to provide each HA and FWA 1000 T each VHV 250 Taka, to hold semi-annual Health Promotion days, to be used raise community awareness of the need for MCH services			$717,645	$717,645	*$1,435,290*	*$3,588,226*	$5,023,517
Activity 1.6 Pilot a scheme to recruit additional vaccine porters (VP) at taka 200/EPI sessio to ensure at least 1 VP per 3 unions for plains, and 1 VP per 1 union for the Chittagong Hill Tracts.			$227,012	$227,012	*$454,024*	*$1,135,059*	$1,589,082

GAVI HSS Projected Budget 2008-2013	Notes on costs	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Phase 1 totals	Phase 2 Totals	Grand Total P1 &P2
Calendar year 1 January to 31 December		2008	2009	2010			
Objective 1 Subtotal		*$0*	*$3,070,666*	*$2,832,608*	*$5,903,274*	*$14,171,862*	$20,075,136
Objective 2: In 13 targeted districts by 2010, to ensure at each administr level that critical gaps in logistics, supervision and management and skills development have begun to be filled, to ensure effective district manage MCH services delivery.							
Activity 2.1: For each administrative level develop a supervisory tool to assist superv to monitor problems with the supply of and access to MCH services.			$22,515		*$22,515*	*$112,574*	$135,088
Activity 2.2: Annual orientation for Upazila and field supervisors on how to use supervisory tools to assess if CC is functional and capable of delivering necessary MCH services.			$10,397	$10,397	*$20,794*	*$51,985*	$72,779
Activity 2.3 Pilot joint monthly reporting, on performance of CCs, between Upazilas P Planning and Health Service Directorates' (AHI & HI & FPI), with monthly meetings jointly chaired by UHFPO & UFPO.	3000 Taka/month meeting/supplies + 1000 taka/month printing reports		$71,294	$71,294	*$142,588*	*$356,471*	$499,059
Activity 2.4 CCmanagement committee (10 + HA + FWA) annual 2 day workshop on CC management at Upazila level (25 Taka/person/day)			$160,676	$160,676	*$321,353*	*$803,382*	$1,124,735
Activity 2.5 CCmanagement committee (10 + HA + FWA) hold monthly managemen meetings (30 Taka/person/day)			$9,641	$9,641	*$19,281*	*$48,203*	$67,484
Activity 2.6: Production and distribution of materials for training HA, FWA & other staff MCH best practices to prepare for transition to CC based service provision			$89,706	$89,706	*$179,411*	*$89,706*	$269,117
Objective 2 Subtotal		*$0*	*$364,229*	*$341,714*	*$705,942*	*$1,462,320*	$2,168,263

GAVI HSS Projected Budget 2008-2013	Notes on costs	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Phase 1 totals	Phase 2 Totals	Grand Total P1 &P2
Calendar year 1 January to 31 December		2008	2009	2010			
Objective 3: In 13 targeted districts by 2010, to ensure that critical gaps i equipment and physical infrastructure have begun to be filled, to ensure can deliver appropriate MCH services.							
Activity 3.1: All 1821 CCs receive required renovation to make them fully functional in ter of providing MCH services.			$1,365,750	$1,365,750	*$2,731,500*	*$0*	$2,731,500
Activity 3.2: Obtain 2 sets (computer/printer/UPS) per district and 1 set for each Upaz			$228,600		*$228,600*	*$0*	$228,600
Activity 3.3: Update 2001 transition plan to phase in CCs, based on lessons leant			$50,000		*$50,000*	*$0*	$50,000
Activity 3.4: All CCs in target districts to have examination equipment to staff one ma one female exam room, by 2009			$602,537	$602,537	*$1,205,074*	*$0*	$1,205,074
Activity 3.5: Solar powered electrical supply for lights and water pump for all 1821 operational CCs.			$455,250	$455,250	*$910,500*	*$0*	$910,500
Activity 3.6: Priority water and sanitation repairs for all CCs, including water (arsenic) filters supplied to all CCs with arsenic contamination.			$14,162		*$14,162*	*$0*	$14,162
Activity 3.7: Critical gaps in transportation vehicles (boats and bicycles) are filled.	Bicycles		$139,471		*$139,471*	*$0*	$139,471
	Vehicle hire		$195,353	$195,353	*$390,706*	*$976,765*	$1,367,471
	Boats		$9,353	$9,353	*$18,706*	*$46,765*	$65,471
Activity 3.8: *2246 CCs constructed, to provide appropriate MCH services.*					*$0*	*$5,614,141*	$5,614,141
Objective 3 Subtotal		$0	$3,060,476	$2,628,243	*$5,688,719*	*$6,637,670*	$12,326,389

GAVI HSS Projected Budget 2008-2013	Notes on costs	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Phase 1 totals		Phase 2 Totals	Grand Total P1 &P2
Calendar year 1 January to 31 December		2008	2009	2010				
Objective 4: By 2010, increase access to high quality and appropriate services in the 13 targeted districts through a combination of improved supply (e.g. MCH training for HAs and FWAs) and increased demand (through community mobilization and immunization awareness provided by VHSW)								
Activity 4.1: Upazila and frontline supervisors trained on how to plan to improve CC utilization rates			$10,397	$10,397	*$20,794*		*$51,985*	$72,779
Activity 4.2: Ensure harmonization of birth registrations between FWAs and HAs by during monthly CC meetings, by providing incentive to FPI to verify accuracy of registrars			$268	$268	*$536*		*$1,339*	$1,875
Activity 4.3: Use LLP at union level (Health & Family Welfare Centre - H&FWC) to implement anaemia prevention strategy in 13 districts.			$19,434	$19,434	*$38,868*		*$97,169*	$136,037
Activity 4.4: Institute routine 6 month training program for upgrading eligible FWAs into SBAs at the 13 district hospitals by 2010.			*$229,386*	*$229,386*	*$458,771*		*$688,157*	$1,146,928
Activity 4.5: Reprint and disseminate IEC messages for MCH, nutrition and IMCI to generate demand for SBAs and other safe motherhood services.			$22,515		*$22,515*		*$45,029*	$67,544
Objective 4 Sub-total		$0	$281,999	$259,484	*$541,483*		*$883,680*	$1,425,163

GAVI HSS Projected Budget 2008-2013	Notes on costs	Year of GAVI application	Year 1 of implementation	Year 2 of implementation	Phase 1 totals		Phase 2 Totals	Grand Total P1 &P2
Calendar year 1 January to 31 December		2008	2009	2010				
Operational Research								
Costing and feasibility study on requirements for IEDCR to manage an e national surveillance system.			$100,000		*$100,000*		*$0*	$100,000
Cost Effectiveness Study to assess effectiveness of renovating CCs in terms o improved ESD access, to guide Phase 2 decisions on CC construction, and functioning			$50,000	$50,000	*$100,000*		*$0*	$100,000
Retrospective studies to evaluate how effectively Community Committee to manage CCs				$100,000	*$100,000*		*$100,000*	$200,000
A study on health worker motivation			$100,000		*$100,000*		*$0*	$100,000
Study on causes of poor not accessing health care services for EPI and health			$100,000		*$100,000*		*$0*	$100,000
Study on incentive mechanisms for motivating and front-line health workers (e.g. HAs and FWAs), and funding evaluation of incentive schemes pilote through GAVI HSS funding (Activity 1.4, 1.5, 1.6)				$100,000	*$100,000*		*$100,000*	$200,000
Research Sub-total		$0	$350,000	$250,000	*$600,000*		*$200,000*	$800,000
Support costs								
Management costs: funds for covering costs of GAVI Annual report deve (performance evaluation meetings, investigative visits to 18 districts)			$30,000	$30,000	*$60,000*		*$210,000*	$270,000
M&E support costs (funds to support tracking the completion and collect supervisory reports)			$50,000	$50,000	*$100,000*		*$250,000*	$350,000
Technical support: HSS National Coordinator ($6000/month for National Officer)			$36,000	$36,000	*$72,000*		*$180,000*	$252,000
Support costs Sub-total		$0	$116,000	$116,000	*$232,000*		*$640,000*	$872,000
GRAND TOTAL		$0	$7,243,370	$6,428,049	$13,671,41		$23,995,53	$37,666,95

Notes;

1. The experiences and lessons learnt from this exercises will guide efforts in other districts to implement facility-based provision of ESD, and in particular, provision of MCH service including immunization.

8.2: Calculation of GAVI HSS country allocation

Please note: Phase- 1 covers this HSS proposal, from 2009 to 2010.
Phase- 2 is indicative of the continuation and expansion of Phase-1 activities over the period of the next National Health Strategy, from 2011 to 2017.

Breakdown of Calculated GAVI HSS entitlement by Calendar Year										
	A	B	C	D	E	F	G	H	I	J
		Phase 1			Phase 2 (Rough projections, to be revise based on Phase 1 experience)					
	Calendar Year	Base year 2008	2009	2010	2011	2012	2013	2014	2015	Total
1	Birth cohort	4,210,773	4,288,671	4,369,276	4,452,726	4,539,167	4,618,376	4,700,460	4,782,544	21,860,613
2	Allocation per newbo	$0.00	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50	$2.50
3	Calendar Year calculated allocation	$0	$10,721,67	$10,923,19	$11,131,81	$11,347,91	$11,545,93	$11,751,15	$11,956,360	$54,651,53
4	Requested Annual Allocation	-	$7,243,37	$6,428,04	$6,516,90	$6,642,92	$3,729,83	$3,477,93	$3,627,93	$37,666,95
5	Cumulative totals	-	$7,243,37	$13,671,41	$20,188,32	$26,831,24	$30,561,08	$34,039,01	$37,666,95	$37,666,951

Note: The Fiscal Year (FY) in Bangladesh runs from 1 June to 31 July.

Source and date of GNI and birth cohort information:
GNI: US$ 470 (WB, 2006)
Birth cohort: WHO/.UNICEF Joint Reporting Form 2006
Total Other: BDHS, Sample Vital Registration Survey.

8.3: Sources of all expected funding for health systems strengthening activities

8.3.2 Long term projections of DP support:

An amount of USD 1,389 million from DPs was expected (per forecasts from cMYP of 2005 to support the HNPSP of MOHFW from January 2005 to December 2010, as shown in the Table below:

Table 8: HNP Consortium Support from 2005 to 2010

Sl. No.	Source	In million US$		Total	
		Pooled	Non- pooled	In million US$	In million Taka
1.	IDA	300		300	18,000
2.	DFID	188.7		188.7	11,322
3.	EU	130.1		130.1	7,806
4.	The Netherlands	53.1		53.1	3,186
5.	SIDA	74.6	3.8	78.4	4,704
6.	CIDA	12	64	76	4,560
7.	GTZ/KFW	49	15.9	64.9	3,894
8.	UNFPA	1	35	36	2,160
9.	UNICEF		48.5	48.5	2,910
10.	WHO		46	46	2,760
11.	Japan Govt.		160	160	9,600
12.	USAID		100	100	6,000
13.	GFATM		11.71	11.71	702.6
14.	GAVI		95.6	95.6	5,736
	Total	**808.5**	**580.51**	**1,389.01**	**83,340.6**

An amount of US$ 306.5 million (ADB and co-financier support of U$ 50 million; SIDA –US$ 5 million, DFID US$ 28.3 million USAID US$ 210 million and EU US$ 13.2) was committed for Urban Health, NGO, social marketing and family planning services to be implemented through MLGRD&C and MOF. Another amount of US$ 100 million is expected to be available from Japanese Debt Cancellation Fund.

The proposed GAVI HSS fund that is expected to be available by the beginning of 2009 will help the country to fill up the major gaps in health system in 13 selected districts. It is also expected that the achievement of the set targets in these districts will also help to improve many social development indicators of the country. In rest 51 districts of the country, similar type of GAVI HSS activities have already been taken. As soon as the availability of the GAVI HSS fund is confirmed for 13 districts, efforts will be made so that GOB and DPs take similar type of more activities and place fund in rest 51 districts. The current allocation and commitment from GOB and DPs in 51 districts for similar kind of activities are shown in table-9.

Table 9: GOB and DP's support in 51 districts similar to GAVI HSS support activities in 13 districts

Funding Sources	Type of activity	Allocation per year (US$ in million)								Total funds
		Year of GAVI application		Year 1 of implementation		Year 2 of implementation		Year 3 of implementation		
		2008		2009		2010		2011		
		13 Districts	51 Districts	13 Districts	51 Districts	13 Districts	51 Districts	13 Districts	51 Districts	
GAVI HSS (expected)				7.24		6.42				13.66
Pooled Fund	(A)		2.94		5.88		5.88		2.94	17.64
Government	(B)		1.20		2.36		2.36		1.20	7.12
WHO	(C)		0.26		0.26					0.52
UNFPA	(D)		0.57							0.57
Islamic Dev Bank	(D)				0.43		0.43			0.86
Government	(E)		0.02		0.02		0.02			0.06
Government	(G)				R		R			

A = Contracted out to NGOs of 378 CC in 15 Upazilas of 6 districts
B = Equipments, drugs for 378 CC in 15 Upazilas of 6 districts
C = Maternal and neonatal death prevention programme in 3 districts.
D = 6-months SBA training of 1,000 FWA in 24 districts
E = Special travel costs for effective mobility of the supervisors in 23 HTR districts.
G = (R) Recruitment against vacant posts of HA and FWA

Section 9: Endorsement of the Application

9.1: Government endorsement

The Government of Bangladesh commits itself to providing immunisation and other child and maternal health services on a sustainable basis. Performance on strengthening health systems will be reviewed annually through a transparent monitoring system. The Government requests that the GAVI Alliance funding partners contribute financial assistance to support the strengthening of health systems as outlined in this application.

Ministry of Health:	***Ministry of Finance:***
Name: Mr. A M M Nasir Uddin	Name: Mr. Arastoo Khan
Title / Post: Secretary	Title / Post: Joint secretary (Budget)
Signature:	Signature:
Date:	Date:

9.2: Endorsement by Health Sector Coordination Committee (HSCC) or country equivalent

Members of the Health Sector Coordination Committee or equivalent endorsed this application at a meeting on 01 September. The signed minutes are attached as Attachment 12.

Chair of HSCC (or equivalent):

Name: Mr. A M M Nasir Uddin

Post / Organisation: Secretary, Ministry of health and Family Welfare

Signature:

Date:

9.3: Person to contact in case of enquiries:

Name: Ms. Khodeza Begum
Title: Joint Chief, (Planning) & Focal point, MOHFW
Tel No: 88-02-7164685
Address: MOHFW, Bangladesh Secretariat
Fax No. 88-02-7164685
Email: khodeza_mohfw@yahoo.com

ANNEX 1 Documents Submitted in Support of the GAVI HSS Application

Document (with equivalent name used in-country)	Available (Yes/No)	Duration	Attachment Number
MTBF	Yes	2005	1
PRSP Unlock the Potential (2005)	Yes	2005	2
HNPSP RPIP	Yes	2003-2010	3
HNP SIP	Yes	2003-2010	4
cMYP[12]	Yes	2006	5
Social Assessment & Tribal Health Nutrition and Population Plan	Yes	2005-2010	6
Government Directive on Functioning of CCs, issued jointly by DGHS and DGFP	Yes	2007, ongoing	7
Operational Manual for CCs: Guidelines on Operation, Management and Functioning of CCs	Yes	2000, ongoing	8
Procurement of Health services (Bidding documents)	Yes	2008	9
EPI CES (2007)	Yes	2007	10
PDC minutes	Yes	2007	11
HNP Forum minutes	Yes	2008	12
UPHCP II	Yes	2005-2011	13
VHW Training Manual on MCH services	Yes	Revised 2007	14
BDHS	Yes	2007	15
EPI CES (2006)	Yes	2006	16
Infant and young child feeding strategy document	Yes	2007	17
National Anaemia prevention strategy document	Yes	2007	18
HNPSP APR	Yes	2007	19

Annex- 3 Summary of sub-national consultative meetings

Sub-National Consultative meetings to provide feedback on Health System Strengthening

Participants: Representatives from district and Upazila health teams, community-based NGOs and CSOs, elected representative, local elites, officials of different ministries and members of development partners etc.

List of places and dates of stakeholder meetings:

1. 13-Dec-2007 : Mushhiganj
2. 15-Dec-2007 : Lalmonirhat
3. 18-Dec-2007 : Sunamganj
4. 29-Dec-2007 : Noakhali
5. 01-Jan-2008 : Barisal City Corporation
6. 05-Jan-2008 : Bandarban
7. 21-Jan-2008 : National Workshop

1) Munshigong 13 Dec, 2007

Major Constraints identified by the participants:

Improper registration for pregnant mother, lack of SBA, inadequate ANC & PNC services, lack of awareness about maternal health services, social and religious barrier, lack of EOC service, less allocation for ambulance services, Improper registration of mother & children, less fund allocation for porter, no fund for volunteer, lack of awareness about exclusive breast feeding, Community Clinics are not functioning, Frequent staff transfer at Upazila level, Improper and under reporting of diseases, no child nutrition center & health education centre, no outdoor pathological centre at sadar Upazila, no urban dispensary & delivery centre at sadar Upazila, No children hospital at sadar Upazila, target population and service provider ratio is unrealistic.

Recommendations:

Ensure timely registration of newborn and pregnant mother, Increase number SBA, Fully functional MCH Committee at Upazila level, ensure timely allocation of fuel cost, coordination of heath & family planning worker in their working areas & reporting of cases, Implement appropriate policy for staffs transfer & posting, Ensure proper reporting, timely allocation of fund, promotion & reward for good workers, establishment of child nutrition centre & recruit nutrition specialist, develop & supply of health education materials, steps to function Community clinics, increase number of school health clinic, establish pathological centre for outdoor pathological service, establish urban dispensary & delivery centre & child hospital, define catchments area/population of service provider.

2) Lamonirhat: 15 Dec 2007

Major Constraints:

Field level infrastructure is not good, community clinics are not functioning, overload of health workers due to increase population, Workers are not provided with updated knowledge and skills, There is no computer data base, Inadequate number and remuneration for the vaccine porter, Unsafe home delivery, lack of coordination among GO & NGOs regarding maternal service delivery, Except EPI child health interventions are not properly implemented, Different kinds of problems faced during service delivery from outreach centres, Inadequate fund allocation for DSA, travel costs and fuel, no reward for best workers, Improper of birth registration, no transport facility or extra money for service delivery in hard to reach areas, Improper space in out reach centre, Inadequate participation of local people, Very few institutional delivery, early marriage, lack of health & reproductive health education, less retention of child & mother card

Recommendations:

Construction women friendly infrastructure at field level, Renovation of community clinics with appropriate service delivery, Fill up vacant posts of HAs and FWAs on an urgent basis, Arrange updated refresher's an training, Supply of computer and posting of computer operator to generate computer based data at upazila level, one porter /union & increase remuneration, proper coordination & accountability in case of reporting and return, training of FWA/female HA on SBA and adequate supply of medicine & equipments at community clinic & HFWC, updated service delivery from satellite clinics, increase TA & DSA, provision of reward for best workers, Maintenance of family register for each ward, fill up vacant posts of field workers according to population size & special recruitment of HAs in hard to reach areas, provision of boat fair/ transportation for HWs & porter, provide accommodation facility, arrangement of social mobilization meeting in each out reach centre quarterly, arrangement & ensure of institutional delivery in each HFWC, proper use of TBA & provide some kind of incentive for them, provide sufficient vehicle for mid level managers, Creation of awareness against early marriage and proper implementation of existing law, ensure reproductive health education, Linking of Immunization card with school admission, food ration, nutrition supplementation & other social activities for encouraging mother to retain immunization card.

3) Sunamgong: 18-Dec-2007

Major Constraints

More hard to reach areas, Shortage of manpower with porter, Difficulties during vaccine transportation, No EPI cold room in Sadar upazila, No modern method of data analysis, High birth rate, Insufficient interpersonal communication by the workers, Shortage of skilled manpower, Seasonal migration of population, Religious constraints, Lack of family commitment due to poverty & religious believes, Some administrative problem, Early marriage is very common, lack of skilled birth attendant, home delivery is almost universal, Insufficient medical facilities, Less utilization of health facilities, Low rate of literacy with high level poverty.

Recommendations

Special budget for Hard to reach areas, Recruitment of manpower as soon as possible, Special mobilization campaign, Increase the number of 1st line supervisor, provision of paid volunteer in each block, Ward level community awareness meeting quarterly, Ensure coordination among GOB & NGO workers, Regular logistic support, Awareness program regarding early marriage & frequent child birth, Coordination between health & FP staff & Proper utilization of infrastructure & logistics, recruitment & redistribution of manpower, Divisional training every 6 months for health workers & training for SBA, allocation of fund for this meeting, Ensure 100% birth registration, Use of modern instrument & establishment of air-condition EPI room, training of supervisor, fund for transportation, fuel & transport allowance, Own transport arrangement (tempo, motor cycle, engine boat), Own miking system, special budget for hoar, special bonus & supply of mobile phone for HWs, Supply of computer, posting of computer operator, provision of internet service, provision of health education, provide health card, supply uniform to HWs, Umbrella, bag, rain coat and Gumboot during special season, Allocation of budget for courtyard meeting with local elites & women & increase of daily subsistence allowance and travel costs.

4) Noakhali: 29-Dec-2007

Major Constraints:

Vacant post of health workers, lack of supervision due to inadequate fund & number of 1st line supervisor, no worker in some area, very few number of SBA, The policy of HA recruitment is not appropriate according to local need, no provision of fund for owner of house where out reach centre & satellite clinics held, no EOC service, Health education is not properly done during domiciliary visit, Registration is not done properly, Increase number of left & drop out children, Insufficient number of porter with poor remuneration, There is no fund provision for tackling disaster or emergency, Insufficient space for EPI store, high turn over of skilled staffs, no incentive for best worker, There is no GO & NGO worker in some hard to reach areas, no active health committee at union level.

Recommendations:

Fill up vacant post & creation of new post as per target population, supply of vehicle, SBA training, construction of infrastructure of EOC service, domiciliary visit prior to session, find out left out & drop out children & provision of incentives.

5) Barisal City Corporation: 01-01-2008

Major constraints:

Shortage of manpower especially skill personnel, Inadequate supportive supervision & coordination with GO & NGOs, lack of one stop service, lack of accountability, less number of health clinics compared to huge population, Frequent absence of manpower in duty station, lack of awareness of mother for taking service, Lack of infrastructure, insufficient Medical & Surgical Requisites, transportation problems & insufficient supply of BCC materials, evaluation & monitoring tools, shortage of logistics, under utilization of existing infrastructure, inadequate service delivery point, lack of need based assessment & medical equipment, Poor & extreme poor are not taking service from health centre, No supervision for qualitative service from health centre, No village health volunteer

Recommendations:

Create new posts, Recruitment (Qualitative & Quantities), training, supportive supervision should be increased, GO & NGOs co-ordination, incentive & promotion and group meeting, reactivate one stop service, ensure accountability, establish ward wise health centre, ensure health worker attendance in their assigned duty station, social mobilization of target group, Develop new infrastructure, To establish separate hospital as one stop service centre, supply sufficient MSR, provide vehicles, supply sufficient BCC materials, evaluation & monitoring tools, communication through IPC, electronic & printing media, ensure unused community clinics, improve well equipped GO & NGOs service delivery point, asses based on local demand during logistic, equipment & others, Free service & if possible medicine for poor, Establish ward advisory committee comprising from different sectors & representative from poor for supervision & monitoring, provision of honorarium & certificate for VHW

6) Bandarban 05-Jan 2008

Major Constraints

Insufficient manpower, no special criteria for recruitment of HWs in hilly area, insufficient transportation, Improper health education by HWs, Language barrier in some places, national curriculum regarding safe motherhood does not totally match with local need, Insufficient number of porter with low remuneration, Non availability of ambulance in case of emergency, Improper stores management, non availability of EOC services, lack of electricity, Insufficient number of HFWC, no skilled birth attendant, Community clinics are closed, satellite clinics are not functioning properly, Improper newborn and pregnant women registration , no special transport for HTR, inadequate medicine for primary health care, no proper maintenance of logistics, socio-economical, geographical & language problem from service provider.

Recommendations:

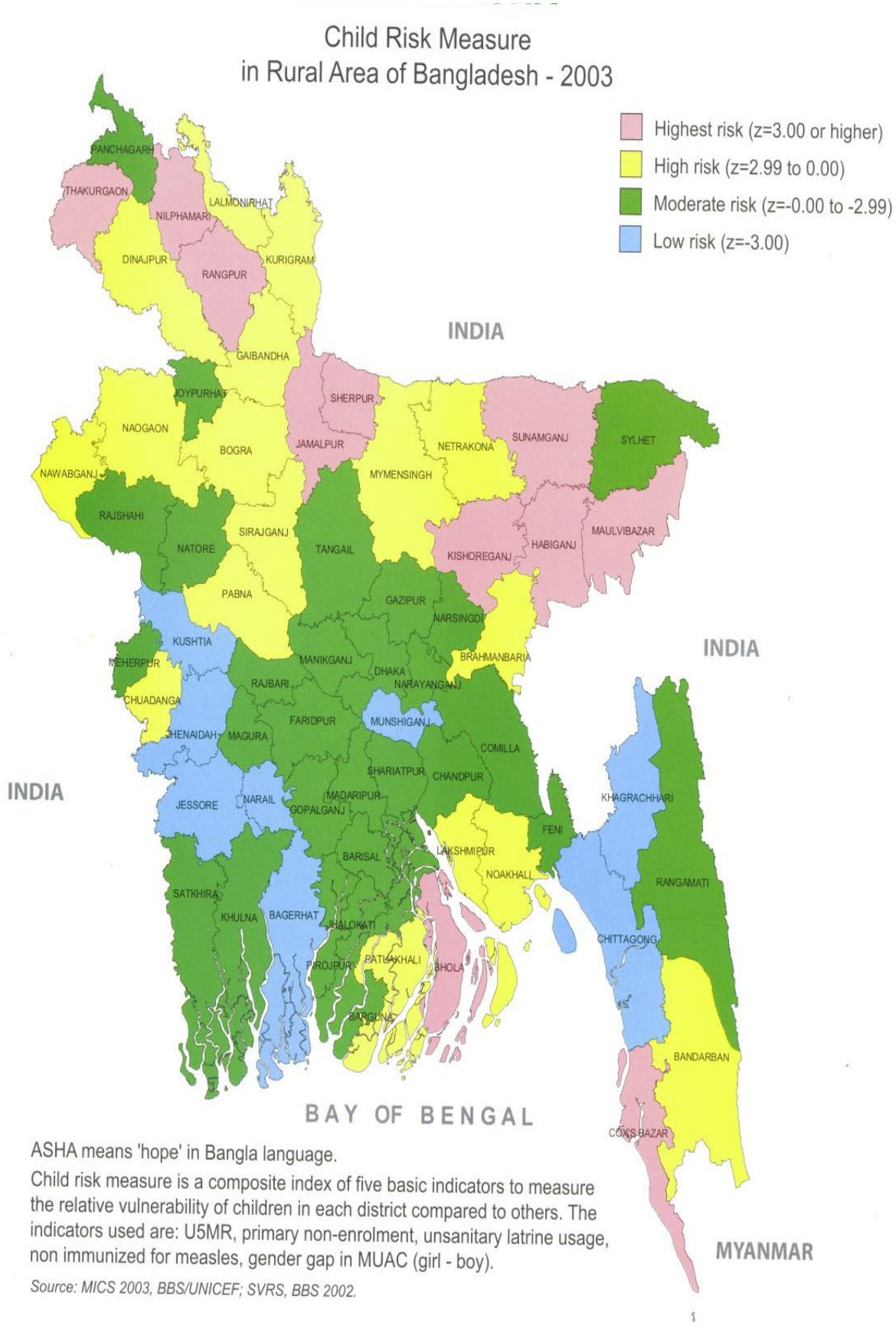
one porter per union with higher remuneration, provision of ambulance, ensure availability BCC materials, provision of generator, Construction of more community clinic and proper functioning of existing one, positing of consultant (anaesthetist & gynaecologists), strengthening skills of TBA by proper & systemic training & regular follow up, organize satellite clinics regularly specially in HTR, ensure proper birth registration, development of infrastructure, during recruitment of staff consideration should be given to overcome the problems of socio-economical, geographical & language problem of service provider.

Annex- 4 Data on thirteen target districts

Div (A)	District (B)	Population	Upazila (D)	Union (E)	Community Clinic			HA Posts				FWA post				DTP3 % (EPI CES 2006)	MCV1 % (EPI CES 2006)
					current (F)	desired (G)	Gap (H) (G-F)	Sanctioned (I)	desired (J) (From G)	current (K)	Gap L (J-K)	Sanctioned (M)	desired (N) (From G)	current (O)	Gap (P) (N-O)		
Barisal	Bhola	1,981,617	7	62	218	330	112	339	330	241	89	318	330	262	68	81.5	69.2
Chittagong	Bandaraban	375,475	7	29	29	63	34	144	63	134	0	102	63	85	0	78.3	69.9
Chittagong	B-Baria	2,702,012	7	98	157	450	293	480	450	313	137	509	450	421	29	59.4	63.0
Chittagong	Cox Bazar	2,159,633	7	72	133	360	227	314	360	231	129	284	360	213	147	72.9	65.0
Chittagong	Khagrachari	742,150	8	35	49	124	75	204	124	187	0	119	124	109	15	79.7	70.7
Chittagong	Noakhali	3,005,752	8	84	164	501	337	430	501	285	216	505	501	430	71	81.4	69.7
Chittagong	Rangamati	671,923	10	49	41	112	71	185	112	171	0	158	112	133	0	71.3	65.3
Dhaka	Netrokona	2,276,832	10	86	234	379	145	397	379	239	140	439	379	350	29	81.4	69.7
Rajshahi	Gaibandha	2,385,886	7	82	260	398	138	390	398	270	128	490	398	438	0	83.4	66.8
Rajshahi	Nilphamari	1,828,603	6	61	161	305	144	253	305	199	106	315	305	256	49	82.9	69.8
Sylhet	Habigonj	2,028,161	8	71	172	338	166	330	338	225	113	391	338	328	10	89.1	71.0
Sylhet	Moulvibazar	1,906,879	6	67	66	318	252	305	318	238	80	342	318	288	30	73.9	63.9
Sylhet	Sunamganj	2,335,015	10	85	137	389	252	435	389	339	50	411	389	385	4	68.1	51.1
Totals		**24,399,938**	**101**	**881**	**1821**	**4067**	**2246**	**4206**	**4067**	**3072**	**1188**[13]	**4383**	**4067**	**3698**	**452** [14]	**76.9%**	**66.0%**

Selection Criteria: ***Primary:***1) DTP3 coverage < 90%; MCV1 coverage < 75%: ***Supplementary selection criteria:*** 2) Existing CCs < 75 % of planned needs for fixed post delivery of MCH service 3) Difficult terrain and hard to reach districts 4) Score on Child Risk Measure (see map below)

[13] Maximum expected gap considering that inter-district relocation of HAs/FWAs is not conducive. (HA/FWA are to be recruited from same community).
[14] Maximum expected gap considering that inter-district relocation of HAs/FWAs is not conducive. (HA/FWA are to be recruited from same community).



ASHA means 'hope' in Bangla language.

Child risk measure is a composite index of five basic indicators to measure the relative vulnerability of children in each district compared to others. The indicators used are: U5MR, primary non-enrolment, unsanitary latrine usage, non immunized for measles, gender gap in MUAC (girl - boy).

Source: MICS 2003, BBS/UNICEF; SVRS, BBS 2002.

Annex- 5 TOR of the HNP Forum

i) The HNP Forum is a GOB-led mechanism established to facilitate the exchange of information on progress towards achievement of the HNPSP objectives. It aims to foster regular dialogue between the GOB and DPs and to focus discussions on realization of key HNPSP outputs and outcomes and major process-related issues.

ii) The HNP Forum is chaired by the Secretary of MOHFW (or his/her representative) and is attended by relevant senior-level MOHFW officials, all DPs supporting GOB's HNP sector as well as the head of the Health Users Forum. Representatives from other relevant Ministries/units, civil society, key stakeholders from the non-public sector may be co-opted as deemed necessary.

iii) The HNP Forum shall provide a platform to:

a) Review HNPSP progress based on the HNPSP Results and Monitoring Framework;
b) Discuss progress on the achievement of agreed action points from the last quarter or APR;
c) Review the MOHFW's annual progress report, the Operation Plans, as well as the supporting budgets, as appropriate;
d) Identify emerging HNP Sector challenges;
e) Resolve any misunderstandings that may emerge between DP and MOHFW during HNPSP implementation;
f) Discussion of audit reports and any outstanding audit observations.

iv) The following arrangements apply for the HNP Forum:

a) The HNP Forum will meet at least once every quarter;
b) Additional meetings may be called at any time by the Secretary, MOHFW (chair of the HNP Forum) in consultation with the World Bank Task Team Leader and Chair of the HNP Consortium as deemed necessary;
c) The Secretary, MOHFW will share its quarterly progress report with the WB Task Team Leader and Chair of the HNP Consortium at least one week before calling for the HNP Forum meeting;
d) Notices of meetings and agenda will be issued by the Member Secretary (Joint Chief Planning) at least one week before the scheduled meetings;
e) Items of the agenda will be finalized by the Secretary of MOHFW (Chair of the HNP Forum) in consultation with the WB HNPSP Task Team Leader and Chair of the HNP Consortium prior to the meeting;
f) Draft minutes will be circulated for comments within one week of a meeting and finalize minutes will be issued not later than two weeks after the meeting;
g) Chair of HNP Forum and WB Task Team Leader must formally inform their agreements on the minutes;
h) Meetings will take place during common office hours of GOB and the DPs
i) The Member Secretary shall provide secretarial services to the Forum.