Health System Strengthening (HSS) Cash Support

Application Package – Proposal Form

COUNTRY NAME: Bangladesh DATE OF APPLICATION: 08 September 2015 (Revised 12 October)
This proposal form is for use by applicants seeking to request Health System Strengthening (HSS) cash support from Gavi, the Vaccine Alliance (Gavi). Countries are encouraged to participate in an iterative process with Gavi partners, including civil society organisations (CSOs), in the development of HSS proposals prior to submission of this application for funding.

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As an important supplement to this document, please also see the '*General Guidelines for Expressions of Interest and Applications for All Types of Gavi Support*, available on the Gavi web site:
http://www.gavi.org/support/apply/

The General Guidelines serve as an introduction to the principles, policies and processes that are applicable to all types of Gavi support, both Health Systems Strengthening (HSS) and New and Underused Vaccines Support (NVS).

All applicants are encouraged to read and follow the accompanying '*Supplementary Guidelines for Health System Strengthening Applications in 2014*' in order to correctly fill out this form. Each corresponding section within the Supplementary HSS Guidelines provides more detailed instructions and illustrative instructions on how to fill out the HSS proposal form.

Please note that, if approved, your application for HSS support will be made available on the Gavi website and may be shared at workshops and training sessions. Applications may also be shared with Gavi partners and Gavi's civil society constituency for post-submission assessment, review and evaluation.

Gavi's Key Elements for Health System Strengthening Grants

The following key elements outline Gavi's approach to health system strengthening and should be reflected in an HSS grant. They are presented as being either 'required' for a Gavi HSS Grant or 'recommended' for a Gavi HSS Grant:

Required Elements:

- One of Gavi's strategic goals is to "contribute to strengthening the capacity of integrated health systems to deliver immunisation". The objective of Gavi HSS support is to address system bottlenecks to achieve better immunisation outcomes, including increased vaccination coverage and more equitable access to immunisation. As such, it is necessary for the application to be based on a strong bottleneck and gap analysis, and present a clear results chain demonstrating the link between proposed activities and improved immunisation outcomes.
- Performance based funding (PBF) is a core approach of Gavi HSS support. All applications must align with the Gavi performance based funding approach introduced in 2012. Countries' performance will be measured based on a predefined set of PBF indicators against which additional payments will be made to reward good performance in improving immunisation outcomes. Under the PBF approach for HSS, the programmed portion of HSS grants must be used solely to fund HSS activities. Countries have more flexibility on how they wish to spend their reward payments, as long as they are still spent within the health sector. Neither programmed nor performance payments may be used to purchase vaccines or meet Gavi's requirements to co-finance vaccine purchases, and shall not be used to pay any taxes, customs, duties, toll or other charges imposed on the importation of vaccines and related supplies.
- Gavi's HSS application requires a strong M&E framework, measurement and documentation of results, and an end of grant evaluation. The performance of the HSS grant will be measured through intermediate results as well as immunisation outcomes including diphtheria tetanus pertussis (DTP3) coverage, measles-containing vaccine first dose (MCV1) coverage, fully immunised child coverage, difference in DTP3 coverage between top and bottom wealth quintiles, and percent of districts reporting at least 80% coverage of DTP3. Additionally, so as to systematically measure and document immunisation data quality and data system improvement efforts, independent and recurrent data quality assessments and surveys will be required for all HSS applications.
- Gavi's approach to HSS includes support for strengthening information systems and improving data quality. Strong information systems are of fundamental importance both to countries and to Gavi. Gavi requires that countries have in place routine mechanisms to independently assess the quality of administrative data and track changes in data quality over time. Countries are strongly encouraged to include in their proposals actions to strengthen data systems, and to demonstrate how their grant will be used to help implement recommendations or agreed action items coming from previous data quality assessments. The process of conducting periodic data quality assessments and monitoring trends should be credible and nationally agreed. For example, incorporating an independent element to the assessments could involve national institutions that are external to the programme that collects or oversees the data collection. Comprehensive information on reporting and data quality requirements are provided in the NVS/HSS General Guidelines for 2015. Please refer to section 3 on Monitoring and Reporting and Annex E on Data Quality.
- Gavi recognises the importance of effective and efficient supply chain systems for the management of existing and new vaccines and health commodities. Gavi has therefore developed and approved

in June 2014 a supply chain strategy[1]. (For more information about the strategy initiatives, see the factsheet http://www.gavi.org/Library/Publications/*Gavi*-fact-sheets/Gavi-Supply-Chain-Strategy/). The Effective Vaccine Management (EVM) assessment and improvement plan are essential steps in the strategic approach to supply chain improvement in countries.

  - **New Requirement**: As approved by the Gavi Board in June 2014 all future proposals (2015 and beyond) that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure pre-qualified equipment by WHO through the Performance Quality and Safety (PQS) programme. The purchase of non-PQS pre-qualified equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi.

- Gavi supports the principles of alignment and harmonisation (in keeping with Paris, Accra and Busan declarations and the International Health Partnership, IHP+). The application must demonstrate how Gavi support is aligned with country health plans and processes, complementary to other donor funding, and uses existing country systems, such as for financial management and M&E. The IHP+ Common Monitoring and Evaluation Framework is used as a reference framework in the supplementary HSS guidelines.
- Gavi requests countries to identify and build linkages between HSS support and new vaccines implementation (Gavi NVS) – linkages to routine immunisation strengthening, new vaccine introduction, and campaign planning and implementation must be demonstrated in the application. Countries should demonstrate alignment between HSS grant activities and activities funded through other Gavi cash support, including vaccine introduction grants and operational support for campaigns.
- As part of vaccine introduction, Gavi HSS support should be used during pre-and post-introduction for strengthening the routine immunisation system to increase the coverage e.g. through social mobilisation, training, supply chain management etc. (see grant categories in table 1 of the Supplementary HSS Guidelines) for all the vaccines supported. This should complement other sources of funding including vaccine introduction grants from Gavi.
- Applications must include details on lessons learned from previous HSS grants from Gavi or support from other sources such as previous New and Underused Vaccine Support, the EVM assessment or PIE tools, EPI reviews etc.
- Applications must include information on how sustainability of activities and results will be addressed from a financial and programmatic perspective beyond the period of support from Gavi.
- Applications must include information on how equity (including geographic, socio-economic, and gender equity) will be addressed.
- Applications will need to show the complementarity and added value of Gavi support to reducing bottlenecks and strengthening the health system, relative to support from other partners and funding sources and relative to other funding from Gavi specific to new vaccines and/or campaigns.

Recommended Elements:

- Gavi supports the use of Joint Assessment of National Strategies (JANS). If a country has conducted a JANS assessment the findings can be included in the HSS application. The Independent Review Committee (IRC) will use the findings of a JANS assessment to gain an understanding of the policy and health sector context that will inform their assessment of the credibility and feasibility of the HSS proposal.

[1] See Gavi supply chain strategy section 3.5, http://www.gavi.org/About/Governance/Gavi-Board/Minutes/2014/18-June/Minutes/05--Gavi-Alliance-immunisation-supply-chain-strategy/

- Gavi's approach to HSS includes support for community mobilisation, demand generation, and communication, including Communication for Immunisation (C4I) approach.
- Gavi supports innovation. Countries are encouraged to think of innovative and catalytic activities for inclusion in their grants to address HSS bottlenecks to improving immunisation outcomes.
- Gavi strongly encourages countries to include funding for CSOs in implementation of Gavi HSS support to improve immunisation outcomes. CSOs can receive Gavi funding through two channels: (i) funding from Gavi to Ministry of Health (MOH) and then transferred to CSO, or (ii) direct from Gavi to CSO. Please refer to Table 1 for potential categories of activities to include in budget for CSOs and Annex 4 of the Supplementary HSS Guidelines for further details of Gavi support to CSOs.
- Recommended: Countries can incorporate new strategy elements in their NVS and HSS proposals that begin to address the three key elements of supply chain management fundamentals (supply chain managers, supply chain performance dashboards, and comprehensive supply chain management plans) and can use existing resources such as:
    - The EVM, EVM improvement plan and the Progress report on the EVM improvement plan which shall be submitted with applications, if available; and, which should contribute to providing evidence on the existing cold chain status and the country plans to address supply chain bottlenecks and inform the development of a comprehensive supply chain management plan.
- While Gavi's current PBF approach is applied to HSS grants at the national level, Gavi also encourages countries to consider using performance-based funding at sub-national levels. Where appropriate, countries may decide to align with other PBF programmes, such as the World Bank's results-based financing (RBF) programmes, and if so, sufficient information must be included with the Gavi HSS proposal on how funding will be aligned. If aligning to a World Bank RBF programme, please provide the concept note or programme design document. Describe which of the objectives of the grant are for the PBF/RBF programme. Please also attach the results framework and budget for the RBF programme. Please note that more than one immunisation-related indicator is expected to be part of any such PBF/RBF programme, if the Gavi HSS grant is proposed to be aligned with it (please see part IV of the Introduction to the Supplementary HSS Guidelines).
- Applicants are encouraged to identify technical assistance (TA) and capacity building needs for implementation and monitoring of the HSS grants. Applicants are required to include details of short term and long term TA if they are requesting TA as part of the HSS application to ensure strong implementation and effectiveness of Gavi HSS support.

PART A - SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

For further instructions, please refer to the Supplementary Guidelines for HSS Applications

Checklist for a Complete Application

A completed application comprises the following documents. Countries may wish to attach additional national documents as necessary.

HSS Proposal Forms and Mandatory Gavi attachments *→ Please place an 'X' in the box when the attachment is included*		
No.	*Attachment*	***X***
1.	HSS Proposal Form	*X*
2.	Signature Sheet for Ministry of Health, Ministry of Finance and Health Sector Coordinating Committee (HSCC) members	*X*
3.	Minutes of HSCC meeting endorsing Proposal	*X*
4.	Minutes of three most recent HSCC meetings	*X*
5.	HSS Monitoring & Evaluation Framework	*X*
6.	Detailed budget, gap analysis and work plan	*X*
7.	Detailed Procurement Plan (18-month)	*X*
Existing National Documents - Mandatory Attachments Where possible, please attach approved national documents rather than drafts. For a decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents. *→ Please place an 'X' in the box when the attachment is included*		
No.	*Attachment*	***X***
8.	National health strategy, plan or national health policy, or other documents attached to the proposal, which highlight strategic HSS interventions	*X*
9.	National M&E Plan (for the health sector/strategy)	*X*
10.	National Immunisation Plan	*X*
11.	Country Comprehensive Multi-Year Plan for Immunisation (cMYP)	*X*
12.	Effective Vaccine Management (EVM) Assessment report (from an EVM conducted within the preceding 36 months). In addition the related documents must be attached if available. : if this is not available, please indicate when the next EVM is anticipated. ▪ Latest EVM Improvement Plan. In case an EVM Improvement Plan is not provided, the country shall provide a justification and identify a plan for developing the improvement plan. ▪ Latest Progress Report on the EVM Improvement Plan Implementation (no older than 6 months prior to proposal submission). In case a Progress Report on the Improvement Plan Implementation is not provided, the country shall provide a justification.	*X*
13.	Terms of Reference (TOR) of Health Sector Coordinating Committee (HSCC)	*X*
Existing National Documents - Additional Attachments Where possible, please attach approved national documents rather than drafts. For a decentralised country, provide relevant state/provincial level plan as well as any relevant national level documents. *→ Please place an 'X' in the box when the attachment is included*		
No.	*Attachment*	***X***
14.	Joint Assessment of National Health Strategy (JANS) (if available)	*X*
15.	Response to Joint Assessment of National Health Strategy (if available)	*X*
16.	If funds transfers are to go directly to a Civil Society Organisation (CSO) or CSO Network, please provide the 3 most recent years of published financial statements of the lead CSO, audited by a qualified independent external auditor	
17.	Health Supply Chain Strategy and/or national health implementation supply chain plans, please provide latest documents (final or draft). Other key supply chain analysis and/or activities including but not limited to supply chain network design & optimization, human resource assessments, supply chain information systems, etc.	
18.	Cold chain equipment inventory list and/or cold chain storage capacity analysis (if available)	*12*
19.	Coverage Improvement Plan if available	
20.	Equity Analysis and Plan if available	
21.	Evaluation of previous HSS grant	*X*
22.	List of target populations/districts, and criteria for selection	

23.	Post Introduction Evaluation Report	*X*
24.	EPI Review/evaluation Report	*X*
25.	Report from last completed household survey	*X*
26.	Concept note or programme design document (including results framework and budget) of any World Bank Results-Based Financing (RBF) programme, or other PBF/RBF programme document, if the Gavi HSS grant is proposed to be aligning with such programme.	

1. Applicant Information	
Applicant:	***Ministry of Health and Family Welfare***
Country:	***BANGLADESH***
Proposal title:	***Health System Strengthening for Vaccine Preventable Diseases Surveillance and Effective Vaccine Management.***
Proposed start date:	***July 2016***
Duration of support requested:	***Three years***
Total funding requested from Gavi:	***USD 33,922,732***
Contact Details	
Name:	***Mr Md Healal UddinTo be filled in***
Organisation and title:	***Joint Chief, Planning Wing, Ministry of Health and Family Welfare***
Mailing address:	***Bangladesh Secretariant, Dhaka***
Telephone:	***+88029540685***
Fax:	***+88029559216***
E-mail addresses:	***Helalu06@yahoo.comTo be filled in***

2. The Proposal Development Process

The proposal development process for Gavi HSS–II has begun in early 2014 with the conduct of the Effective Vaccine Management (EVM) Assessment and the development of the roadmap. The process was led by the Planning Wing of the Ministry of Health and Family Welfare (MOHFW), under the guidance of the Secretary, MOHFW, the Director-General of Health Services (DGHS) and the Director-General of Family Planning (DGFP). Technical leadership was provided by the National Expanded Program on Immunization (EPI) Unit of the Primary Health Care (PHC) wing of Directorate General of Health Services. The process also involved the Local Government Division (LGD) of the Ministry of Local Government, Rural Development and Cooperatives (MLGRDC), which is the Ministry in charge of providing primary health care services in the urban areas of Bangladesh.

During the development of this proposal, several Departments / Units provided significant contribution to the overall process: the Planning Commission, Economic Relations Division of Finance Ministry, Implementation, Monitoring and Evaluation Division of Ministry of Planning, Line Director of Maternal, Neonatal, Child and Adolescent Health (MNCAH) under DGHS, Maternal, Child, Reproductive and Adolescent Health under DGFP, the Management Information Systems (MIS) unit of the DGHS, Health Information System of the DGHS, Community Clinics (CC) Program, Procurement, logistics and supply chain management unit, Human Resources Development (HRD) Unit of MOHFW, Program Management and Monitoring Unit (PMMU) under the Planning Wing of MOHFW, Financial Management and Audit Unit (FMAU) of MOHFW, Directorate General of Drug Administration (DGDA), Central Medical Store Depot, In -Service training unit of DGHS, the National Institute for Population Research and Training.

At the sub-national level, the proposal development involved a cross-section of District and sub-District level

officials, and City Corporations and Municipalities.

The following development partners (DPs) are part of the health consortium in Bangladesh and were consulted during proposal development at meetings held on 10 December, 2014, 21 December, 2014 and on 12 and 19 January 2015: Department for Foreign Affairs and Trade (Australia), Department for Foreign Affairs, Trade and Development (Canada), Department for International Development (United Kingdom), The Embassy of the Kingdom of Netherlands, The Embassy of Japan, The European Union, The Food and Agriculture Organization, Gavi, Gesellschaft für Internationale Zusammenarbeit, Japan International Cooperation Agency, KfW Development Bank, Korea International Cooperation Agency, Swedish International Development Agency, United Nations Joint Program on HIV and AIDS, United Nations Development Program, United Nations Population Fund, United Nations Children's Fund (UNICEF), US Agency for International Development, The World Bank Group, and the World Health Organization (WHO), Several CSOs in the country involved in immunization also participated.

The external consultants provided by WHO and UNICEF were on board from early December 2014 and worked with the Coordination Committee of the MOHFW, to implement the roadmap drawn up by that committee, including an analysis of bottlenecks and gaps, formulation of objectives, identification of activities and decision on implementation arrangements including monitoring and evaluation. The process was enriched by available analytical work, the national health sector strategy and plan, as reflected in the HPNSDP, its Monitoring and Evaluation Framework, and the report of its mid-term program implementation review, the National Immunization Policy (NIP), the comprehensive Multi-Year Plan on Immunization (CMYP) for 2011-16 currently under implementation, the draft CMYP (2014-18) and the Urban Immunization Strategy under preparation, the EVM assessment and Comprehensive EVM Improvement Plan (CEVMIP), the report of WHO EPI and Vaccine Preventable Diseases (VPD) Surveillance Review and Post-Introduction Evaluation of Hib (Pentavalent) vaccine and the EPI Coverage Evaluation Survey (CES) 2013.

The initial proposal was reviewed and endorsed on 21 January, 2015 by the Health Sector Working Group of the Local Consultative Group (LCG) Health, which, in Bangladesh, serves as the Health Sector Coordination Committee (Attachments 3, 4 and 13).

Gavi IRC comments on the initial proposal were received in May 2015 which recommended resubmission of the proposal. Main observation was to choose whether to embed the HSS fully within the pooled funding mechanism or operate it as a separate project.

Subsequently several teleconferences were conducted between Gavi secretariat, planning wing of MoHFW, National EPI, WHO and UNICEF on the way forward. Four options were emerged from the teleconference:

- Option 1: Improve the current proposal and resubmit the whole proposal by September, 2015, for inclusion in the Pooled Fund of the next SWAp (commencing July 2016)
- Option 2: Bifurcate the current proposal - resubmit by September 2015, a smaller proposal only for EVM and surveillance component as a stand-alone project (non-pooled), and once next SWAp is finalized submit another application for the rest of the activities to be part of the Pooled Fund under the next SWAp
- Option 3: Wait until January 2016 and submit a new application with the whole proposal as part of the Pooled Fund under the next SWAp
- Option 4: Resubmit the whole proposal by the deadline of September 8, 2015 - changing all components into DPA (non-pooled project mode).

These options were placed in the LCG meeting and the meeting decided to go for Option 2 and approved the decision to submit bifurcate proposal and submit in September 2015, only for EVM and surveillance component as a Direct Project Aid (DPA) (non-pooled, and submit another application for the rest of the activities to be part of the Pooled Fund once next SWAp strategic investment plan is finalized.

Hence, this version of the proposal contains surveillance and EVM as a DPA project and has been revised to take

account of comments received from the Independent Review Committee appointed by Gavi.

Even though the duration of activities according to this proposal is five years, considering cMYP duration 2014-18, likely possibly that next SWAp will come from fiscal year 2017 the funding request to Gavi is only for the three years from 2016; the fourth and fifth year activities are intended to be covered by the next application under the pooled fund.

WHO and UNICEF provided active Technical Assistance (TA) to the process, through their staff based in country. Also, in July, 2015 upon the request of the Ministry, WHO hired two consultants (one in country and another remotely) to support development of the bifurcated proposal.

The revised proposal on EVM and surveillance was endorsed by the LCG on 01 September 2015 and was submitted to Gavi secretariat on 08, September 2015.

TWO PAGES MAXIMUM

Signatures: Government endorsement

Please note that this application will not be reviewed or approved by Gavi without the signatures of both the Ministers of Health & Finance and their delegated authority.

Minister of Health	Minister of Finance
Name:	Name:
Signature:	Signature:
Date:	Date:

Signatures: Health Sector Coordinating Committee endorsement

We the members of the HSCC, or equivalent committee met on the _____ (date) to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.

Please list all HSCC members	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	To be filled in			
Secretary				
MOH members				
Development partners				
CSO members				
WHO				
UNICEF				
Other				

Please tick the relevant box to indicate whether the signatories above include representation from a broader CSO platform: Yes ☐ No ☐

Individual members of the HSCC may wish to send informal comments to: gavihss@gavi.org
All comments will be treated confidentially.

PART B – EXECUTIVE SUMMARY

3. Executive Summary

Bangladesh developed the present Gavi HSS proposal in response to Gavi IRC recommendations (March 2015). After a series of consultations with the Gavi Secretariat and Development Partners (DPs), the Government of Bangladesh decided: a) to bifurcate the original HSS proposal (endorsed and submitted to Gavi in January 2015) and to submit a stand-alone proposal focusing on effective vaccine management (EVM) and vaccine preventable diseases (VPD) surveillance, and b) once next Sector Wide Approach program is finalized, to submit another proposal addressing the rest of health system bottlenecks for achieving immunization outcomes.

Bangladesh requests Gavi HSS support for 3 years (2016-2018) considering that the current five-year health sector plan (Health, Population and Nutrition Sector Program Development) end in 2016 and the current cMYP covers 2014-2018 period.

The following main bottlenecks for achieving immunization outcomes are addressed within this proposal (presented by Health System building blocks):

- VPD surveillance related bottlenecks:
  - Health financing – the lack of funds to support transportation of samples, train health care professionals and managers in VPD surveillance
  - Essential medical products and technologies – the lack of appropriate laboratory equipment and inadequate biosafety level
  - Human workforce - difficulties in retaining the VPD surveillance related staff and the lack of skills necessary to perform core VPD surveillance functions
  - Health management Information systems – decentralized, fragmented and paper based recording and reporting of data, insufficient supervision and data quality problems, the lack of integration between immunization and VPD surveillance data flows with HMIS
- Effective vaccine management including supply chain and logistics:
  - Essential medical products and technologies - Insufficient storage space (both cold and dry), lack of routine maintenance of equipment and facilities, inadequate temperature monitoring, cold chain infrastructure gaps and capacity deficit to introduce new vaccines, difficulties in the transportation of vaccines especially to hard-to-reach areas, high wastage rates for some vaccines
  - Health management information systems: manual systems of supply chain and logistics information management
  - Health financing – the lack of funds to expand the physical infrastructure, upgrade cold chain equipment and maintain operation at the required level

There are no gender disparities in immunization coverage in the country. However, there are inequities in coverage between the highest and lowest wealth quantiles. Relatively low coverage in hard to reach areas and urban slams is caused by the gaps in immunization health workforce and infrastructure. The proposal intends to address these types of inequity along with the support to effective vaccine management improvement that is essential for the introduction of Rotavirus vaccine in January 2018.

The current proposal plans:

Objective 1: to strengthen VPD surveillance and immunization information system as an integral part of HMIS through the following major interventions (sub-components):

1.A Develop and introduce VPD surveillance web-based information system in 552 healthcare facilities

1.B Improve Laboratory performance for VPD surveillance including the procurement of lab equipment and

goods and support to the collection and transportation of specimens (3800 per year in average)

1.C Improve the management and operation of VPD surveillance system through direct support to professional staff in performing key VPD related tasks, conducting epidemiological studies and operational research, and regular supervision and monitoring of the VPD system performance

Objective 2: To ensure Effective Vaccine Management (EVM) in terms of the cold chain and supply chain management system through the following major interventions (sub-components):

2.A Improve vaccine supply management by the introduction of ISQL management information system

2.B In accordance with the EVM improvement plan, expand and upgrade cold chain/logistic infrastructure by renovating physical infrastructure in 32 districts, procuring and installing the cold chain equipment (considering the introduction of new vaccines: HPV and Rotavirus) at all levels

2.C Support supply and logistic system operation by establishing effective mechanisms of cold chain maintenance and vaccine storage management, conducting operational research, improving the regulatory framework, training personnel in EVM, supporting transportation of vaccines to outreach service delivery sites

Under objective 3 “Program Management” evaluation of immunization coverage is planned in year 1 and 3 along with mid-term and final evaluation of the implementation of the Gavi HSS-II grant.

The proposed objectives are closely aligned with the respective priorities of the Strategic Plan for HPNSDP (2011-2016) and HPNSDP Program Implementation Plans.

The proposed interventions are expected to contribute directly to immunization outcomes in terms of sustaining and increasing vaccine coverage, enabling effective introduction of new vaccines and addressing geographical inequities in uninterrupted supply of vaccines, quality and safety of immunization.

The proposal is expected to benefit the entire immunization target population throughout the country and especially those living in remote, hard-to-reach areas and urban settings.

The total budget of this proposal is $ **33,922,732**. The total budget of the 3 year program The greatest proportion of GAVI HSS-II funds are allocated to EVM part under objective 2 - $19,327,890.2 (57% of the total budget), secondly to VPD surveillance system under objective 1 - $ 12,176,977.2 (36% of the total budget) and, finally, program management - $2,417,864.2 (7% of the total budget)

Three lead implementers are proposed:

- WHO Bangladesh Country Office (CO) will implement all activities under Objective 1 (VPD surveillance) and two activities under Objective 3 (Program management) including the evaluation of immunization coverage (total budget 13,175,274 US$, or 38.8% of the project budget),
- UNICEF Bangladesh will implement all activities under Objective 2 (EVM/ISCL) and one activity under objective 3 (Program management) (total budget 20,395,457 US$, or 60.1% of the project budget)
- The Ministry of Health and Family Welfare (MOHFW) will conduct two activities under objective 3 (Program Management): final evaluation of the grant implementation and activities for monitoring and coordination of the grant implementation. (total budget 352,000 US$, or 1.0% of the project budget)

The decision of implementing through UN agencies is based on past experience of GAVI HSS 1, proven capacity of WHO and UNICEF to implement programs and close collaboration between the Government, WHO and UNICEF in the National EPI, in effective vaccine management and vaccine preventable disease surveillance in particular.

MOHFW is willing to start financing partially some of recurrent activities in Year 3 and ensure the sustainability of the Gavi HSS support by financing operational, maintenance, human resource and commodity supply costs from the new Sector program and pool funds after the end of Gavi HSS-II funding. The proposed activities also envisage to safeguard investment in physical infrastructure, equipment and vehicles through adequate maintenance and development and skills transfer to qualified personnel necessary to translate the investment into better immunization

system performance.

WHO and UNICEF will use agency specific financial management and procurement mechanisms, and MOHFW will use national public expenditure management and procurement procedures. As to Monitoring and Evaluation, the MOHFW will be in charge of collecting data and reporting on outcome level indicators in addition to the final evaluation of the project implementation in Year 3 (activity 3.3), while WHO and UNICEF will be in charge of collecting data and reporting on output level indicators in respective areas of responsibility.

4. Acronyms	
AEFI	Adverse events following immunization
APR	Annual Program Review
BBF	Bangladesh Breastfeeding Foundation
BDHS	Bangladesh Demographic Health Survey
BSL	Bio-safety level
CBHC	Community-Based Health Care
CC	Community Clinic
CDC	Center for Disease Control
CES	Coverage Evaluation Survey
CEVMIP	Comprehensive Effective Vaccine Management Improvement Plan
CHCP	Community Health Care Provider
CHT	Chittagong Hill Tracts
CMSD	Central Medical Stores Depot
CMYP	Comprehensive Multi-Year Plan
CO	Country office
CSO	Civil Society Organization
DC	Divisional coordinator
DGDA	Director-General of Drug Administration
DGFP	Director-General of Family Planning
DGHS	Director-General of Health Services
DHIS	District health information system
DMCHIO	District Maternal Child Health and Immunization Officer
DP	Development Partner
DTP	Diphtheria, Tetanus, Pertussis vaccine
EPI	Expanded Program on Immunization
ESD	Essential Service Delivery
EVM	Effective Vaccine Management
FCE	Full country evaluation
FMAU	Financial Management and Audit Unit
FMR	Financial Management Reports
FP	Family Planning
FWA	Family Welfare Assistant
Gavi	The Vaccine Alliance
GDP	Gross Domestic Product
GFATM	Global Fund for the fight against AIDS, TB and Malaria
GOB	Government of Bangladesh
HA	Health Assistant
HCWM	Health Care Waste Management
HepB	Hepatitis B
Hib	Hemophillus Influenza b
HMIS	Health Management Information System

HPN	Health, Population and Nutrition
HPNSPD	Health, Population and Nutrition Sector Program Development
HPV	Human Papilloma Virus vaccine
HRD	Human Resource Development
HSCC	Health Sector Coordinating Committee
HSS	Health System Strengthening
IBD	Invasive bacterial disease
ICC	Inter-agency Coordination Committee
ICDDR,B	International Center for Diarrhoeal Disease Research, Bangladesh
IEDCR	Institute of Epidemiology, Disease Control and Research
IPCSB	Immunization Platform for Civil Society in Bangladesh
IPH	Institute of Public Health
IPV	Inactivated poliovirus vaccine
IRT	Independent Review Team
IT	Information technology
ITA	International technical assistance
ISCL	Immunization supply chain and logistics
JANS	Joint Assessment of National Health Strategy
LCG	Local Consultative Group
LD	Line Director
LGD	Local Government Division
LLP	Local Level Planning
LTA	Local technical assistance
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCHTA	Ministry of Chittagong Hill Tract Affairs
MDG	Millennium Development Goal
MDTF	Multi-Donor Trust Fund
MESAP	M&E Strategy and Action Plan
MICS	Multi-Indicator Cluster Survey
MIS	Management Information System
MLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MNCAH	Maternal Neonatal Child and Adolescent Health
MNCH	Maternal, Neonatal and Child Health
MOEF	Ministry of Environment and Forests
MOHFW	Ministry of Health and Family Welfare
MR	Measles rubella
MTR	Mid-Term Review
NC	National coordinator
NIP	National Immunization Policy
NPML	National polio and measles laboratory
NVS	New Vaccines Support
OP	Operational Plan

PCV	Pneumococcal conjugate vaccine
Penta	Five doses of the Pentavalent Vaccine (against Diphtheria, Pertussis, Tetanus, HepB, Hib)
PHC	Primary Health Care
PIC	Program Implementation Committee
PMMU	Program Management and Monitoring Unit
PPE	Personal protective equipment
REC	Reaching Every Community
RED	Reaching Every District
SMO	Surveillance Medical Officer
SOPs	Standard operational procedures
SWAp	Sector-Wide Approach
TA	Technical Assistance
TOR	Terms of Reference
UHC	Universal Health Coverage
UHFWC	Union Health and Family Welfare Centre
UHS	Upazilla Health System
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
VPD	Vaccine-Preventable Disease
WHO	World Health Organization

PART C– SITUATION ANALYSIS

For further instructions, please refer to the Supplementary Guidelines for HSS Applications

5. Key Relevant Health and Health System Statistics

Vaccines Currently Used by the Immunisation Programme

Vaccine	**Year of introduction**	**Comments** (including planned product switches, wastage etc.)
PCV	2015	*Introduced m March 2015*
IPV	2015	*Introduced in March 2015*
Measles - Rubella	2012	*MCV 1 at 9 months switched to MR*
Measles	1986	*Measles second dose was introduced in 2012, switched to MR second dose in June 2015*
Pentavalent	2009	*Replaced DTP which was introduced in 1982*
HepB mono	2003	
BCG	1965	
Tetanus Toxoid (TT)	1986	*TT was introduced for Pregnant Women in 1986.* *In 1993, it was expanded to cover all women of reproductive age group (15-49 yrs) with five doses of TT vaccine (TT5)*

Vaccines Planned for Future Use by the Immunisation Programme

Note: This section should include any future vaccines currently under consideration by the country and does not represent a commitment by the country to introduce the vaccines listed below.

Vaccine	**Month / Year of Introduction**	**Comments** (including planned product switches, wastage etc.)	**Plan for vaccine introduction taken into account in HSS application? If not, why not?**
HPV	Jan 2016		*Yes*
bOPV	April 2016	*Swich from tOPV to bOPV*	*Yes*
Rota Virus (2 dose liq)	Jan 2018		*Yes*
HepB (1 dose liquid)	Jan 2018		*Yes*

Bangladesh has already met some Millennium Development Goal (MDG) targets such as reducing under-five mortality, headcount poverty and poverty gap ratio, attaining gender parity at primary and secondary education, containing HIV infection with access to antiretroviral drugs, children under five sleeping under insecticide-treated bed nets, detection and cure rate of tuberculosis under Directly Observed Treatment Short-Course (MDG Report Bangladesh 2013). Bangladesh has made considerable progress in increasing child survival rate; the successful programs for EPI, control of diarrhooeal diseases and Vitamin-A supplementation are considered to be the most significant contributors to the decline in childhood deaths. Bangladesh has also achieved polio free and maternal and neonatal tetanus elimination status; now the challenge is maintain this status (Bangladesh EPI CES 2013) while ensuring equity. The latest Health Bulletin (2014) provides the following basic data (only selected indicators presented here):

- Population (in million): 150.6 as of 1 July 2011 (BBS 2011); Estimated as of 1 July 2014: 156.06
- Urban population: 26%
- Population density per sq. km: 1,203
- % of male-headed households: 86.7%; % of female-headed households: 13.3%
- Crude birth rate (Per 1,000 population): 19.2
- Crude death rate: Per 1,000 population 5.5
- Under-5 mortality rate (per 1,000 live-births): 46 (Bangladesh Demographic & Health Survey (BDHS) - 2014); 60 (Multi-Indicator Cluster Survey (MICS) - 2012-13); 41 (UNICEF 2015)
- Infant mortality rate (per 1,000 live-births): 38 (BDHS 2014); 46 (MICS 2012-13); 33 (UNICEF 2015)

- Neonatal mortality rate (per 1,000 live-births): 28 (BDHS 2014); 24 (UNICEF 2013)
- Maternal mortality ratio (per 100,000 live-births): 194 (BMMS 2010); 170 (UN 2013)
- Births attended by skilled health personnel (%): 26.5 (BMMS 2010); 42.1 (BDHS 2014); 43.5 (MICS 2012-13);
- Antenatal care coverage (at least four visits) (%): 31.2 (BDHS 2014); 24.7 (MICS 2012-13);
- Post-natal care received by mothers from a trained care provider within 2 days after delivery: 33.9% (BDHS 2014); 41.2 (MICS 2012-13);
- Institutional delivery rate (%): 37.4%; Public facility: 12.8%; Private facility: 22.4%; CSO facility: 2.2% (BDHS 2014)
- Home delivery rate: 62.2.0% (BDHS 2014)
- No. of sanctioned posts under DGHS: 124,216 (DGHS 2014)
- No. of personnel and staff under DGHS (existing): 103,840 (DGHS 2013) (83.5% of sanctioned posts)

Bangladesh has high immunization coverage: BCG at 95%; DTP1 at 99% and DTP3 at 96%; polio3 at 96%; MCV at 96%; HepB3 at 96%; Hib3 at 96%; and new-borns protected against tetanus at 94% (UNICEF: State of the World's Children, 2014). DTP3 coverage is high; in 2013, 98% of all districts reporting >80% coverage and 0.0% of districts reporting <50%, though there are communities that are not reached in a timely manner. Reaching every district (RED) and reaching every community (REC) initiatives have been undertaken to address geographic inequities in coverage.

Invalid doses, i.e., those vaccinations which were given but not in a timely manner according to the prescribed schedule, have resulted in a significantly lower rate of fully immunized children at 82% according to CES 2014.

Recent surveys indicate that education and income influenced immunization coverage as did geographic location; valid coverage was slightly higher in rural areas than urban.

Equity issues:

One of the core ideas of the proposed grant is to promote equity in access to health services, regardless of demography, geography, socio-economic or ethnic state of the individuals. The EPI-CES, 2014 showed that there are gaps of immunization coverage in urban and rural areas, among the districts and upper & lower quintile.

Strengthening Community Clinics (CC) is another way of promoting equity, especially the gender related equity. One of the primary objectives behind establishing the Community Based Health Care (CBHC) Operational Plan (OP) in HPNSDP was to strengthen Community Groups (CG) associated with these CCs for promoting gender participation and equity. A recent study found CCs addressing gender and equity issues in delivering health care services.[2] The study found service recipients to be women, children, the poor and marginalised, persons with disabilities, socially excluded and older people. The service recipients were found quite satisfied with the services like antenatal care, postnatal care, family planning, growth monitoring, immunisation, treatment of common ailments, detection of tuberculosis, etc.

A recent study reviewed the activities under HPNSDP for assessing coverage and effectiveness in providing quality health care for the entire tribal population and ethnic minority living in hill areas and flatlands. The study identified shortage of technical staffs in the locality where these tribal population and ethnic minorities live, especially in the CHT areas. It also identified weak monitoring and supervision failed to use the existing human resource and to ensure quality health service. Lack of facilities for the health staffs like good accommodation, risk allowance/rewards and training were identified to be reasons for decreasing interest to work in hard to reach areas.

Some data on equity of immunization coverage are provided in the table below:

[2] Faiz, L, 2014, "Assessment of Gender, Equity, Voice and Accountability Situation of Community Groups", Study conducted by CBHC OP as Technical Assistance from the Joint Donor Technical Assistance Fund under HPNSDP

Indicator	Male / Female (%)	Urban / Rural (%)
DTP3 (Pentavalent) coverage	93.1 / 92.9	93.5 / 92.9
Measles vaccination coverage	86.8 / 86.3	84.7 / 87.1
Fully Immunized Children	81.6 / 81.6	78.8 / 82.3
Drop-out rate	Penta-1 to Penta-3: 1.8% (male) and 2.0% (female) Penta-1 to Measles: 5.6% (male) and 6.3% (female)	Penta-1 to Penta-3: 1.9% (rural) and 1.8% (urban) Penta-1 to Measles: 5.7% (rural) and 6.5% (urban)
Socio-Economic Equity of coverage	Penta-3 coverage: 89.8% among children of illiterate mother / 92.2% to mothers who completed primary school Fully Immunized Children: 80.1% in the lowest wealth quintile // 83.0% in middle quintile // 83.1% in the highest quintile	
Source: Bangladesh EPI CES 2014		

New Vaccine Introduction and linkage to HSS proposal:

Having achieved high coverage of the routine immunizations, Bangladesh is aiming higher in its National EPI goals. In addition to focusing on quality and equity, new vaccines such as PCV-10 and IPV have been introduced in 2015,and HPV, HepB birth dose and Rotvirus are being introduced into the immunization schedule. Such new vaccine introduction is also being supported by Gavi grants.

This requires significantly enhanced system capacity, in terms of dry and cold storage, training of personnel, monitoring and surveillance and overall service delivery. Thus, this HSS application is very closely linked to the ongoing Gavi grants and planned introduction of new vaccines (HPV and Rota) with Gavi NVS. Requested funding for the upgrade of cold chain equipment and the proposed investment in the effective vaccine management is recognized as a precondition for the effective introduction of expensive new vaccines along with the strengthening the VPD surveillance system, especially in relation to Rotavirus.

ONE PAGE MAXIMUM

6. Description of the National Health Sector

Overview

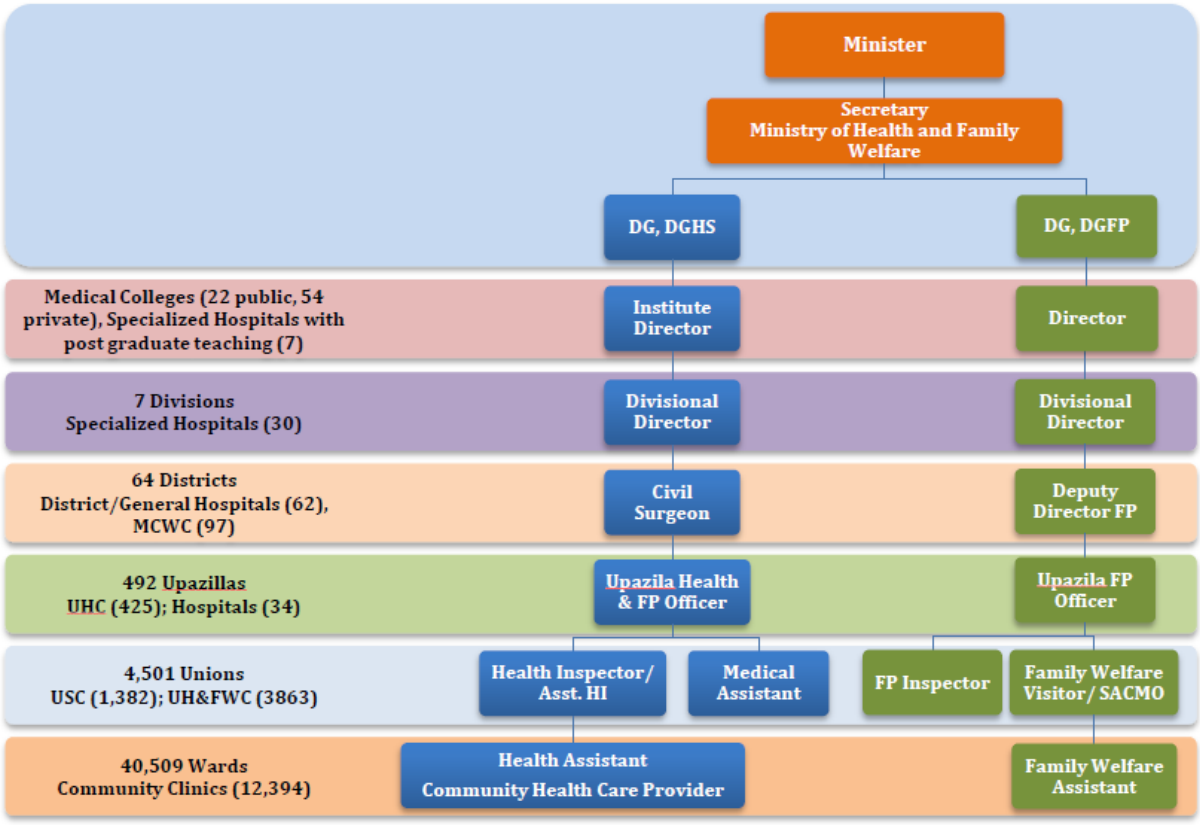
The Ministry of Health and Family Welfare (MOHFW) is responsible for policy, planning and overall management of health and family planning activities. Under the Ministry, four Directorates are responsible for service delivery: Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), Directorate of Nursing Services and Directorate General of Drug Administration (DGDA).

With more than 100,000 officers and staff, DGHS operates the national health care delivery system from the central to the village level. DGHS also provides technical guidance to the Ministry. Recurrent expenditures come from the Revenue Budget and capital expenditures from the Development Budget. The DGFP oversees the family planning program through its own officers at the Divisional, District, and Upazilla (sub-district) levels and below; family planning services are provided through Doctors, Family Welfare Visitors, and a large cadre of family welfare assistants (FWA) supervised by Assistant Family Planning Officers and by Family Planning Inspectors.

In urban areas, PHC services, including immunization, are provided by 11 City Corporations and 92 Municipalities under the Ministry of Local Government, Rural Development and Cooperatives (MLGRDC). MOHFW provides vaccines for the immunization services in the urban areas. The coordination between MOHFW and MLGRDC for providing PHC services needs to be strengthened.

Service Delivery

There are six tiers in health care services in Bangladesh: National, Divisional, District, Upazilla (sub-district), Union, and Ward as shown on the diagram below. CCs are the grass-root level entry point to the health system in the rural areas and are supported by a range of community-based health-care promoters who also make referrals to vaccination sites. Union-level health care facilities include union health and family welfare centers (UHFWC) and union sub-centers. The Upazilla Health System (UHS) comprising these facilities along with the Upazilla



Health Complexes provides PHC services, as well as family planning and curative care to the rural population.

The health structure in urban areas, in which about 53 million people reside, is different. The City Corporations

and Municipalities hire staff to provide a range of PHC services; but staff levels are often inadequate. The establishment of new City Corporations is not always accompanied by the assignment of adequate human and financial resources. Filling vacancies and retaining qualified health care staff and volunteers is a significant challenge. As a result, most of the urban PHC services have been contracted out to CSOs – either under the Urban PHC Project or under the USAID-funded CSO Health Services Delivery Project. As in many countries, the relationship between the public and private sectors needs to be enhanced.

CSOs report frequent understaffing and turn-over at the community level. As with the public sector, finding replacement staff for the health workers who are on their maternity leave or those who quit due to their temporary contracts is a challenge.

Human Resources:

Bangladesh has a nationwide network of medical colleges, nursing and paramedical institutes, medical assistant training schools, and institutes of health technology. However, there are health workforce shortages and geographical imbalances; there is a shortage of health workers at the sub-national level, a high vacancy rate in hard to reach areas and in the public sector facilities of urban areas. According to the World Development Indicators, there were 4 physicians per 10,000 people in 2011 (up from 3 in 2010).

Procurement & Supply Chain Management

All vaccines are procured through UNICEF, from WHO pre-qualified suppliers and consigned directly to Central Medical Stores Depot (CMSD); the DGHS is responsible for clearing the shipments using their appointed clearing agent.

According to the attached 2014 Bangladesh Effective Vaccine Management (EVM) Assessment (Annex 12a), out of the nine criteria assessed, seven meet or exceed the WHO minimum levels of performance and the other two criteria has to be improved. The attached 2014-2018 Comprehensive Multi-Year Plan (CMYP) for the immunization program (Annex 11b) cited problems with the human resource shortages, insufficient capacity at the district levels to store vaccines (especially the envisioned new vaccines to be introduced), and outdated or old equipment. The Comprehensive EVM Improvement Plan provides details of the recommendations to address the above problems.

Health Information System

The GOB has taken significant steps to improve the health information system at all levels so as to deliver timely reliable information to the planners, managers and professionals of the health sector for evidence-based decision making, planning and monitoring. However, currently much of the reporting at the sub-national level is done manually. Efforts are ongoing to reduce the varied reporting forms and health cards supplied to the clients. DPs have been working with the DGHS to streamline the current reporting system and are supporting capacity-strengthening activities, so that reliable data are collected, analyzed and used. There is a need for better coordination between different units and agencies that generate data to make the system comprehensive, consistent and reliable. Data generated by CSOs are not routinely integrated into the HMIS. Reporting forms and systems specific to individual donors / agencies need to be integrated.

The community and other local actors

GOB has maintained a supportive policy environment and regulations for CSOs to operate; the number, type and scope of CSOs at all levels are significant. Building on the 2013 Gavi award to Catholic Relief Services to support CSOs, as seen in the attached document, the Immunization Platform of Civil Society in Bangladesh (IPCSB), is a network formed under the leadership of the BBF in April 2014, concentrating initially on the Dhaka City Corporation. As of December 2014, IPCSB includes 12 full members and 25 associate members.

Most of the urban PHC services are provided by contracted CSOs, through internationally funded projects. These CSOs provide MNCH services including immunization, and their clinics and outreach posts are networked across the City Corporations.

Under city corporation areas, 58% of slum and 53% of non-slum communities have a CSO facility within one

kilometer (Urban Health Strategy, 2013). Other urban dwellers receive services from government health facilities and private facilities. EPI services are managed through the City Corporation's / Municipality's public health administration at Zone and Ward levels. Services are programmatically supported (logistics and vaccines) through EPI unit of DGHS.

The Urban Primary Health Care Service Delivery Project (2012-17) and the CSO Health Service Delivery Project (2013-17) have their subcontracted CSOs working in prearranged geographic boundaries and catchment population with a view to avoiding duplication of services or overlap of coverage areas. There are other CSOs and some Service Delivery Points of the City Corporation providing EPI services which fill the catchment gaps of the two above mentioned projects but, there is uneven availability of human and financial resources. Mapping the coverage and scope of the CSOs is part of the annual micro-planning conducted at the sub-national level. However, the results of the mapping can be further strengthened to maximize CSO involvement, reduce CSO overlap and identify underserved areas, whilst also ensuring CSOs' contributions are reflected in the health information system and opportunities to enhance their technical and management capacity are fully utilized.

Legal, Policy and Regulatory Environments

Steps are being taken by GOB to improve its leadership and regulatory role to enhance equity and quality of services, especially to reach the poor and the disadvantaged. Significant multi-party effort has produced the country's National Immunization Policy (NIP), expected to be adopted later this year. The Policy identifies the government ministries and DGs responsible for technical and managerial areas, immunization reporting, surveillance and research; regulation and coordination; vaccines policy; vaccine security; immunization service delivery in the urban and rural areas, high risk groups, facility- and school-based services; user fees; and gender.

Health care Financing

The health sector is financed by a combination of sources, including the GOB's revenues, external development partners who finance either through the Pooled Fund of HPNSDP or through parallel financing, or directly finance some CSOs, in-country donations, corporate contributions, and out-of pocket expenditures by individuals and households, The attached Health Care Financing Strategy 2012-2032 (annex 34) provides a framework for developing and advancing health financing towards UHC. The strategy addresses the complementary role of private sector, both for-profit and non-profit, and DPs.

Historically, supply-side financing by the GOB has funded most efforts to improve access of poor households to PHC services. Almost two thirds of total health expenditures are from out-of-pocket spending, 67% of which is on medicines. Out of the public financing of health care, GOB funds about 80% and DPs fund 20% (see annex 59 for the country's health system financing profile).

Community financing mechanisms and risk-pooling systems are limited except in small pockets of CSO innovation. But of note is the maternal health care voucher scheme piloted in 53 Upazillas which sought to impact access and utilization of maternal health services by the poor pregnant women. The evidence generated by the evaluation of this scheme (which suggests that the poor are being reached, but administration and transparency are issues) could form the basis for scale-up of the current initiative and extension of the mechanism in other areas during the next health sector program.

THREE PAGES MAXIMUM

7. National Health Strategy and Joint Assessment of National Health Strategy (JANS)

The Government of Bangladesh's (GOB) current five-year program (July 2011 - June 2016) HPNSDP is a sector-wide effort, jointly financed by GOB and Development Partners (DPs) (Annex 08a).

For improving effectiveness of the public sector interventions and for providing services responsive to the needs and demands of the population, the GOB has been pursuing the sector-wide approach (SWAp). The Health and

Population Sector Program (1998-2003) was followed by the Health, Nutrition and Population Sector Program (2003-2011) and then by the HPNSDP (2011-2016), which is currently being implemented as per its Program Implementation Plan covering 32 OPs each under a Line Director (LD) (see annex 08c).

The Strategic Plan for HPNSDP document indicates GOB's policy intentions for 2011-2016. The goal of HPNSDP is to ensure quality and equitable health care for all citizens by improving access to and utilization of health, population and nutrition services, particularly for the poor.

The details of priorities and interventions along with their implementation mechanisms are described in the Program Implementation Plan and detailed out in operational plans (Ops). Previous sector program efforts resulted in reducing the gap between rich and poor with respect to outcomes in rural areas but less so the quality and accessibility of PHC services in urban areas. The strategic plan specifies the following strategies to achieve its objectives: (i) expanding the access and quality of MNCH services especially to the poor; (ii) revitalizing various family planning interventions to attain replacement level fertility, (iii) mainstreaming nutrition within the regular DGHS and DGFP services, (iv) strengthening preventive approaches as well as control of communicable and non-communicable diseases, (v) strengthening the various support systems by increasing the health workforce at Upazilla, Union and CC levels and improving their skills in technical areas and communication, (vi) improving MIS with information and communication technology, and establishing M&E system, (vii) strengthening drug management and improving quality drug provision, (viii) increasing coverage and quality of services by strengthening intra and inter-sectoral and private sector coordination, and (ix) pursuing priority institutional and policy reforms, e.g., decentralization and LLP, incentives for service providers in hard to reach areas, or public-private partnerships.

HPNSDP gives priority to address hard-to-reach populations through motivating and counselling the service providers for giving adequate care to the marginalized and socially excluded population, strengthening collaboration with the Ministry of Social Welfare, MCHTA, the CHT Board, CSOs and private sector. The Essential Services Package would be provided in the hard-to-reach areas through CSOs to overcome the shortage of public sector human resources.

The present HSS application is fully aligned with the priority areas of the HPNSDP such as strengthening health information system, research and development, strengthening of human resources for health (through pre-service education and in-service training, nurse/midwifery services and training), establishing quality assurance system, improvement of the procurement and supply chain management, and maintenance of physical facilities.

Resource Envelope for HPNSDP

Currently the combined public and private sources of health financing are insufficient to achieve full coverage of health services. On average, 4%-5% of GDP is spent on the Health, Population and Nutrition (HPN) sector in Bangladesh, of which about 1% of GDP is allocated by the public sector.

Joint Assessment of the National Strategy (JANS).

The most recent JANS was the Mid-Term Review (MTR) of HPNSDP, conducted in 2014 (annex 14b). The MTR concluded that Bangladesh made good progress in terms of addressing population issues and providing FP services and on maternal and child health. The report highlights some of the remaining challenges such as neonatal health, regulation and the need for improvements in quality of services.

The attached Joint Aide Memoire of the MTR (annex 15), documents improvements and areas still in need of attention. This grant will support some areas of continuing concern such as status of facilities, equipment and logistics (para 14); uneven immunization coverage in certain geographic areas, cold chain capacity and procurement (paras 20, 37 and 45); M&E and HMIS (para 44).

ONE PAGE MAXIMUM

8. Monitoring and Evaluation Plan for the National Health Plan

The HPNSDP emphasized strengthening overall health system and governance by establishing a sustainable M&E system as one of the key drivers. In response to recommendations from the 2012 and 2013 Annual Program Reviews (annex 14 and 14b), the MOHFW developed an M&E Strategy and Action Plan (MESAP) to ensure that key health information systems can operate complimentarily (annex 09). MESAP outlines roles and responsibilities with a view to track progress, make programmatic adjustments as needed, and demonstrate results.

MESAP was informed by lessons from the Annual Program Reviews of the current and the previous HNP sector assessments conducted by development partners (DPs) as well as technical agencies during the last few years. The technical approach and methodology followed for development of the MESAP was highly consultative and participatory in nature – a Technical Working Group was responsible for overseeing its development, and it was finalized through stakeholder consultations involving MOHFW agencies, DPs, Civil Society, private sector and academia working in the HNP sector in Bangladesh. Annex 3, page 46, of the MESAP provides an indicative timetable (2006-2017) of the various surveys, frequency and funding sources.

Implementation of the National M&E Plan: Under the Planning Wing of MOHFW, the Program Management and Monitoring Unit (PMMU), established in 2011, works in close collaboration with Planning and MIS Units of the Directorate of Health, and Directorate of Family Planning. The PMMU oversees capacity building, data quality assessments, and data utilization processes under the supervision of the Planning Wing. It is envisaged that timely implementation of the action plan will help the MOHFW and other stakeholders institutionalize M&E mechanisms for strengthening the quality and use of monitoring information both from and at the national and sub-national levels.

Data quality: There are numerous data sources in the HPN sector. Efforts are underway to reduce the data reporting burden, encourage CSOs and others in the private sector to provide their data to the MOHFW, and strengthen the quality of the service statistics. Data quality assurance efforts and processes are described on pages 19-20 of the MESAP and the Data Quality Assessment Tool is provided on pages 47-49.

Linkages of the immunization program reviews to the M&E plan: The HPN targets and indicators are provided in Annex 8 (pages 65 and 66) of the MESAP. This Annex describes the importance of the M&E data for reporting Bangladesh's accomplishments toward the MDGs, the Commission on Information and Accountability, UN General Assembly Special Session, and United States Global Health Initiative. In addition, data are needed to monitor and report on program accomplishments to GFATM and Gavi.

MESAP formulated two action plans outlining transitional adjustments required during HPNSDP and medium- to long-term activities to have an effective and sustainable M&E system, in which the following interventions were identified: a) strengthen M&E coordination within HNP sector program; b) carry out performance reviews at regular intervals; c) implement Data Quality Assurance mechanisms; and d) build capacity for M&E among MOHFW staff. MESAP includes a) Capacity Building Plan to facilitate and promote the development of monitoring and evaluation knowledge, skills and competence of MOHFW staff; b) Data Quality Plan; and c) Data Utilization Plan. As a member of HPNSP Gavi secretariat has involved in previous sector reviews and future sector programme reviews

Immunization data being a significant part of MESAP will also inform decision-making related to policies, programs, planning, budgeting, monitoring and management of the sector. Immunization coverage, quality and equity are a critical piece of the MCH data and they are also an indicator of how well the health system as a whole is functioning, as immunization services are delivered through the routine PHC set-up. For instance if immunization coverage is low, it could indicate shortages in human resources to deliver MCH services, as they are the same personnel delivering immunization as part of MCH. In summary, immunization information is vitally linked to the overall health system performance and will impact on health sector decisions more broadly.

ONE PAGE MAXIMUM

9. Health System Bottlenecks to Achieving Immunisation Outcomes

The results of recent bottleneck analysis related to immunization program in Bangladesh are presented below to understand broader challenges in National EPI. However, this proposal is mainly focus on two aspects of immunization: VPD surveillance and EVM program.

Demand side bottlenecks

The recent coverage evaluation survey 2014 (CES) (annex 25 a), carried out in Bangladesh, highlighted about inadequate population education in immunization area that directly has an impact on immunization coverage . The CES explored the main reasons why children were never vaccinated. Of the respondents, 31 % reported about their fear of side effects. About 19% reported they do not believe in vaccination or could not take their children to health complex for immunizations due to the child's sickness. Other respondents admitted that they did not know that the child should be given vaccine (7.0%), were complacent in getting their children vaccinated (7.0%), were busy (3.3%), or could not give him/her vaccine because the child cries (3.3%). Another group of respondents reported that the FP workers did not vaccinate the child because of childwassick (4.2%). The reasons for partial vaccination, that is, when a child fails to receive all the doses or antigen after receiving at least one dose of any antigen was also investigated. The finding shows some mothers did not take their children to the health complex because their child was ill (16.3%), didn't know the schedule for measles vaccines (15%), were too busy to take their child to the vaccinator (13.9%), were fearful of side effects (5.8%) or did not know that the child should be given vaccine (4.0%). In order to increase coverage, it is recommended to involve CSO in increasing population awareness about immunization benefits.

It was also revealed that supporting supervision by health managers remains weak and not fully in place. The current VPD surveillance system needs to be enhanced at health provider level through implementation of default tracking with HMIS system.

Bottlenecks identified in health systems building blocks and specific National EPI

In July 2014 a bottleneck analyses of broader MNCH interventions were carried out, in particular analysis of implementation of Every Newborn Action Plan for Bangladesh (annex 27). This analysis demonstrates that each of nine critical MNCH interventions had at least four major health system bottlenecks and that of seven health system building blocks, at least five were significant or major. The table below summarizes the key HS building blocks that need to be given more attention such as health workforce (7 interventions), leadership and governance (6 interventions) and community ownership and partnership (5 interventions).

Interventions to Scale-up Newborn Care	Health System Building Blocks						
	Leadership and Governance	Health Financing	**Health Workforce**	Essential Medical Products and Technologies	Health Service Delivery	Health Management Information Systems	**Community Ownership and Partnership**
Management of Preterm Birth							
Skilled Care at Birth							
Basic Emergency Obstetric Care							
Comprehensive Emergency Obstetric Care							
Basic Newborn Care							
Neonatal Resuscitation							
Kangaroo Mother Care							
Treatment of Severe Infections							
Inpatient Care for Sick and Small/LBW Babies							

Not a bottleneck	Minor Bottleneck	Significant Bottleneck	Major bottleneck

In December 2014 a bottleneck analysis specifically for this GAVI HSS-II grant proposal were done applying the same July 2014 methodology. The analysis demonstrates that the critical interventions in terms of number of health system bottlenecks are vaccine Introduction (all 7 health system building blocks), surveillance (5 health system building blocks) and cold chain and EVM (6 health system building blocks). The table below demonstrates the following health system building blocks that need to be given more attention: health workforce (4 interventions), health service delivery (4 interventions) and health management information systems (4 interventions) and essential medical products and technologies (3 interventions).

Interventions for Health System Strengthening through the Gavi Alliance	**Health System Building Blocks**						
	Leadership and Governance	**Health Financing**	**Health Workforce**	**Essential Medical Products and Technologies**	**Health Service Delivery**	**Health Management Information Systems**	**Community Ownership and Partnership**
Vaccine Introduction			*	*	*	*	*
Vaccine Security							
Service Delivery							
Surveillance							
Cold Chain and Effective Vaccine Management							
Data improvement							
*Depicted as significant because the group listed these as Major/Significant/Mild							

Not a bottleneck	**Mild Bottleneck**	**Significant Bottleneck**	**Major bottleneck**

Based on both analysis, the main HSS bottlenecks in National EPI are the following:

- ***Information/Data:***
  - Data quality issues, e.g., discrepancies in the denominator
  - Lack of integration between Immunization information and VPD surveillance with HMIS
  - Data generated by CSOs is not routinely captured;
  - Lack of effective default tracking
- ***Supply chain/goods and equipment***
  - Manual systems of supply chain management, logistics and information management
  - Lack of routine preventive maintenance of equipment and facilities
  - Cold chain infrastructure gaps and capacity deficit to introduce new vaccines
  - Inadequate temperature monitoring and follow-up action
  - High vaccine wastage – due to the use of 10-dose or 20-dose vials
  - Insufficient storage space (both cold and dry),
- ***Human resource***: i.e., skill – gaps, vacant posts, temporary contracts and frequent transfers resulting in high turn-over, work-load issues, multiple responsibilities, geographic imbalance
- ***Service Delivery***:
  - Inadequate communication efforts – particularly low proportion of caregivers with increased access to information and media to promote appropriate immunization and child care behaviours; low proportion of community promoters / care-givers trained on immunization-related communication skills
  - Geographic gaps in PHC service delivery: some remote wards, and in some urban areas
  - Some CSOs charge for immunization, which could be a constraint to the utilization of services
  - Newly created city corporations have inadequate capacity to deliver urban primary health care
  - Weak Health Care Waste Management (HCWM), including safe disposal of used syringes and needles
  - Scope for further integration of immunization activities into MNCH
  - High proportion of home deliveries (71%) resulting in difficulty to provide the “zero dose” vaccines, i.e., those which are to be given at birth. This calls for an adjustment in service delivery modalities
- ***Leadership/Governance/Health Financing***:
  - Need for higher financial allocation for EPI; dependence on external aid for vaccine procurement
  - The division of responsibilities for rural and urban areas between MOHFW and MLGRDC respectively
  - Need for stronger collaboration with CSOs on community mobilization, empowerment, and awareness.

In June-July 2014 an Effective Vaccine Management (EVM) Assessment was conducted and provided an

aggregate performance rate of 82% (see attachment #12 (a-b)). Following it, a comprehensive Effective Vaccine Management Improvement Plan were developed and approved by National EPI team. The estimated budget for the EVM Improvement Plan for 4-year period (2014–18) is $21.9 million and it addresses all vaccine supply and logistics activities indicated in the CMYP (2011-2016) that are yet to be completed and takes EPI into activities beyond 2016, including systemic improvements and program efficacy.

Additionally, in 2012 a joint MOHFW, UNICEF andWHO EPI and VDP Surveillance Review and Post-Introduction Evaluation of Hib Vaccine was done (annex 23). The key findings identified by this review were the following: determining correct denominators (being addressed under the requirements for the Commission on Information and Accountability); filling vacant positions of field workers and supervisors; creating designated disease control medical officer posts in all districts and upazilas and providing appropriate in-service training for EPI staff, including mid-level managers. The main challenges relate to human resources, for instance, having designated medical officers in all districts and Upazillas to work alongside the Surveillance Medical Officers and District MCH Immunization Officers.

Equity bottlenecks

Provision of immunization services in urban areas is defined as one of the main bottlenecks as well. It was highlighted in EPI and VDP Surveillance Review carried out jointly by MOHFW UNICEF and WHO in 2012. It is recommended to pay attention to urban areas to increase and sustain immunization in that setting. Also, some population in hard to reach and Chittagong areas don't have proper access to vaccines due to harsh climate and poor communication infrastructure.

Bottlenecks addressed by current proposal

This GAVI HSS-II proposal focuses on health care system bottlenecks in two areas of the immunization system, VPD surveillance and EVM/Immunization Supply Chain and Logistics (ISCL) :

- VPD surveillance system, in particular, development VPD surveillance web-based information system, strengthening of laboratory system and improvement management and operation of surveillance system.
- EVM area, in particular, improvement vaccine management including equipment, infrastructure support, outsourced services, technical assistance, management actions, capacity building, workshops and international exchanges, operation research and demonstration projects.

As for equity, the proposal includes specific activities in urban areas to strengthen immunization service provision in this areas. Additionally, the proposed activities include development a special surveillance and monitoring system for CHT and hard-to-reach areas, which covers the geographical location of the Tribal population and ethnic minorities. It will be a part of a broader VPD surveillance web-based system to be integrated into HMIS (developed under this proposal).

Bottlenecks addressed by other national or external program

The bottlenecks highlighted above have being already addressed in other national or external program, such as Bangladesh Every Newborn Action Plan (2014), Urban Health Strategy, Urban Primary Health Care Service Deliver Project (2012-2017), the CSO Health Service Delivery Project (2013-2017) and the Immunization Platform of Civil Society in Bangladesh (2014).

Also, MOHFW is already in the process of addressing these issues through the efforts of various OPs under the HPNSDP. The draft HRH plan developed by the HRM unit of the ministry covered these issues. This plan will ensure the proper placement of health staff in CHT and other hard-to-reach areas. An action plan will be developed from the MNCAH OP to ensure delivery of services in hard-to-reach areas under HPNSDP.

Finally, the activities defined under next GAVI HSS-II pooled funds within SWAp will also address the bottlenecks described above.

FOUR PAGES MAXIMUM

10. Lessons Learned and Past Experience

The current Gavi/HSS grant provided USD 13 million and USD 7.885 million has been spent up to 30 June 2015. Out of the remaining balance of 5.115 million majority amount of USD 2.5 million is to complete on going constructions work. The Gavi HSS 1 grant is evaluated as a part of Gavi Full Country Evaluation (FCE) conducted by International Centre for Diarrhoeal Disease Research, Bangladesh ICDDRB in collaboration with external institutions. According to initial draft report available

- Although further analyses of data is required, existing data showed that the Gavi HSS 1 fund has contributed in improving immunization coverage rapidly in 13 initial Gavi HSS supported districts compared to non-Gavi/HSS districts.
- Construction of EPI stores in 12 low performing and hard to reach districts enhanced the current storage capacity to facilitate the introduction of new vaccines and better vaccine management with improvement of quality of vaccines and logistics. In addition 14 more EPI stores are being constructed.
- HSS fund also contributed in infrastructure development, such as construction of 106 birthing rooms at community clinics (69 of them are already functioning).
- Family Welfare Assistants, Community Health Care Providers (CHCPs), and Health Assistants from 13 selected districts have been receiving training so that they can serve as skilled birth attendants. Ensuring deliveries at a facility by skilled birth attendants is one of the major steps in this program, which has contributed to improvements in both maternal and neonatal and child health including immunization coverage.
- Involvement of Community Groups and Community Support Groups members of Community Clinic management committee through regular orientation, monthly meeting and group meeting increase the ownership of the community to ensure timely child and maternal health services in their community.

The table below provides information related to major issues identified in the FCE and risk mitigation measures in the Gavi/HSS 2 proposal:

Key Issues identified in HSS-1	Risk mitigating measures in the HSS-II proposal
Quality issues in the proposal development process	The HSS-II proposal development process was inclusive of all stake holders and technical support from partners were provided at all stages.
Delay in fund disbursement and reporting delays were mentioned as key bottlenecks in the previous HSS **Delayed start of implementation (by two years) can be attributed to the fact that the funded activities were across 3 different OPs of the then HNPSP (2003-11). When the GAVI grant was approved in 2009 HNPSP OPs were passing it's 6th years of implementation. It was difficult to incorporate GAVI activities into the concerned OPs of HNPSP by revising those and had to wait until 2011 for new SWAp HPNSDP for the period 2011-2016.**	To avoid similar situation as current HNPSP will complete in 2016 MoHFW has decided to bifurcate the proposal and submit essential EVM and Surveillance components in September 2015. Once the next SWAp is finalized the remaining part of the GAVI HSS II will be submitted. The Financial management and procurement mechanism suggested in the bifurcated proposal mitigates the risk of delay in funds disbursement as well as procurement procedures. Both UNICEF and WHO have proven competencies in Bangladesh since the beginning of EPI program and have the human resources and infrastructure capacities to absorb the funds planned in the proposal. Also, both the Country offices follow very stringent system of scrutiny for release of funds to programme activities and are able to handle planning, implementation, monitoring and reporting of all activities in both technical and financial aspects.

Lengthy recruitment procedures and high staff turnover	MoHFW has identified the bottlenecks in recruitment in National coordinator and MCHIOs and streamlined the process during the last two years and now there are 32 MCHIOs. In addition both UNICEF and WHO has good experience in recruiting national staff for field work. These two organizations in consultation with MoHFW will expedite the recruitments.
Inadequate logistics resulted in high staff turnover.	Sufficient operational support is planned for staff in the new proposal to accomplish their tasks in time.
There has been delays in infrastructure development I.e. EPI store rooms and birthing rooms	The construction work related to EVM improvement will be implemented by UNICEF under the guidance of government with intensive technical support, monitoring and coordination of UNICEF
Lack of coordination among the implementers	Considering this, an improved coordination mechanism under the MoHFW is planned (activity number 3.5 in the proposal) to support implementation of activities by WHO and UNICEF. UNICEF and WHO also will involve appropriate staff for coordination and monitoring of activities as explained in activity section 3.1 and 3.3 of the proposal.

Having current experience with GAVI HSS-I, in order to mitigate slow implementation of the proposing GAVI HSS-II grant, MOHFW decided to get technical and managerial support from traditional EPI partners: WHO and UNICEF and nominated them as lead implementers in their respective areas of competence (see WHO and UNICEF contributions to the National EPI in annex 38) while assuming the responsibility for oversight and coordination of the implementation of Gavi HSS-II activities.

The following table demonstrates the applicability of lessons learned to the objectives of this application:

Objective	Lessons learned, highlighting both successes and challenges
#1. To strengthen Surveillance System and Immunization Information System, as an integral part of HMIS	Bangladesh has quite strong VPD surveillance system which is extensively supported by development partners and need to be sustained.. However, the multiple databases and data collection tools lead to inconsistent results reported by the public and private sectors. There is a need to align their surveillance and reporting systems with the MOHFW's system to ensure consistency, higher quality and reliability.
#2. To ensure Effective Vaccine Management (EVM) in terms of the cold chain and supply chain management system	The EVM assessment rated Bangladesh an average of 82%, which is a success story about how the cold chain and supply chain systems have been functioning quite well. However, the cold chain is inadequate to meet the growing demands of the immunization program and to meet the immunization targets. This proposal covers most of the activities defined in recent EVM improvement plan (attachment 12 (a-b)).
#3. Project management	Considering slow and low implementation of current GAVI HSS-I grant (only 38% during two years), it is proposed management and coordination of this proposal is done by two lead implementers, WHO and UNICEF. Though it is proposed that the representatives from the MOHFW and National EPI will monitor and supervise the proposed activities.

TWO PAGES MAXIMUM

PART D - PROPOSAL DETAILS

11. Objectives of the Proposal

Impact: Reduced morbidity and mortality from vaccine-preventable diseases (VPD) among women and children.

Immunization outcomes:

(a) Valid coverage rates of vaccines currently in the program improved (measured by increased coverage rates of pentavalent and measles vaccines, fully immunized children and reduced drop-out rates);

(b) Improved equity of immunization coverage – by gender, ethnicity, residence and socio-economic status;

(c) New vaccines (e.g., PCV, Rotavirus, HPV) introduced and their coverage increased over time; and

(d) Quality and safety of immunization enhanced.

Health System Objectives

This grant aims to achieve the impact through the immunization outcomes stated above by strengthening the health system in the following areas of the WHO-recommended HSS building blocks: information systems and supply chain.

Objective 1: To strengthen Surveillance System and Immunization Information System, as an integral part of HMIS

The objective contributes to improving quality and reliability of VPD surveillance data across the country to measure morbidity and mortality rates reflecting the impact goal of this project (through strengthening information system, capacity of laboratory system, operation and management of surveillance system). Additionally, this objective addresses the equity issues such as geographic and urban/rural disparities. The services in urban and the CHT areas will be better reflected in national statistics; birth data will be more reliable thereby allowing for more evidence informed decisions on resource allocation and focus of programmatic interventions.

The GAVI HSS-II Objective #1 is aligned with the HPNSDP (annex 8 A):

- One of the drivers of strategic plan: *"Strengthening overall health system and governance including establishing a sustainable Monitoring and Evaluation System along with Health Information System (HIS)." (p.6)*
- One of priority interventions to improve Child Health: *"Strengthening and sustaining of routine immunization and **disease surveillance** along with Supplementary Immunization Activities, NID, Measles/ MNT Campaigns etc." (p.10)*

Furthermore, the strategic plan for HPNSDP (annex 08a) under strategic component 1a "Improving health services", section 3.6 "Disease Surveillance" states the following (page 21):

- "IEDCR will be strengthened to carry out epidemiological surveillance of communicable diseases with laboratory support along with non-communicable diseases to turn it into an apex Institute for epidemiological surveillance in the country"
- "Necessary support such as equipment, soft ware and training will be provided to these institutes for data generation, analysis and reporting, to be coordinated by InfoBase and Ban Net centre of NCD in collaboration with the MIS of DGHS"

HPNSDP Program Implementation Plan (annex 08c, page 16) identified inter alia the following cross-cutting priorities (necessary to implement specific operational plans):

"1) To support the development of effective integrated disease surveillance for communicable and noncommunicable disease that is reliable, timely and accessible to program managers and policy-makers…

3) Procurement of necessary laboratory, clinical and medical supplies"

Objective 2: To ensure Effective Vaccine Management (EVM) in terms of the cold chain and supply chain management system

This objective directly contributes to maintaining high immunization coverage and equity across the country mainly through strengthening supply chain management and increasing the safety and quality of immunization service delivery. In particular, this objective addresses such issues as inadequate cold chain facilities and maintenance, inefficient distribution of vaccines throughout the country and weak vaccine supply and management, inequity in coverage. The activities under this objective will be carried out in close coordination with ongoing efforts, especially the EVM initiatives being supported by Canada.

The GAVI HSS-II Objective #2 is fully aligned with HPNSDP:

- *"Building on the current success efforts will be strengthened to maintain and increase coverage of the immunization program, incorporating vaccines for greater number of diseases with especial focus on low performing areas. Policy dialogue will be initiated for the introduction of new and under used vaccines." (p.10)*

According the Strategic Plan for HPNSDP (annex 08a):

- "New and updated facilities will be synchronized with the provision of manpower, logistics and supplies" (page 46).
- "The next sector program will ensure that adequate budget provision is made for post purchase maintenance and repair on an annual basis. It is expected that repair and maintenance status of facilities, electro-medical equipment and vehicles will improve significantly" (page 47)

The activities proposed under this objective are aligned with the HPNSDP Implementation Plan (PIP), section 4.16 "Procurement, Logistics and Supplies Management (PLSM-DGHS)" (annex 08c, page 162). In addition, PIP considers "Strengthening procurement systems for essential commodities/supplies: Procurement Logistics and Supplies Management, DGFP, Procurement Storage and Supply Management, DGHS (CMSD)" as cross-cutting priority for the implementation of two OPs – Maternal Neonatal Child and Adolescent Health of DHGS (OP(1)) and OP(18) – Maternal Child and Reproductive Health of DGFP.

Objective 3: Project management

This objective directly contributes to management and coordination of project that indirectly contributes to the immunization outcomes through the support to government's stewardship and coordination role and through evidence generation (operational research):

- WHO will be responsible to conduct Immunization coverage evaluation study in year 1 and Year 3
- The MoHFW will be responsible to assess the progress in the implementation of the activities under objective 1 and objective 2 by conducting an independent mid-term and final evaluation

The proposed mid-term and final evaluations are aligned with the responsibilities of MoHFW and provisions of the Strategic Plan for HPNSDP (annex 08a, pages 36-37). As to the importance of household based surveys, the HPNSDP requests to use routine nationally representative surveys ("annual service utilization and intervention coverage surveys for Essential Service Delivery") to be used for monitoring and evaluation (page 39).

TWO PAGES MAXIMUM

12. Description of Activities

A detailed description of activities (including implementation modalities, explanation of work plan and budget assumptions) is provided in annex 50 ("Bangladesh Gavi HSS-II key components and activities – narrative").

The table below presents activities grouped under relevant thematic/intervention components of each objective.

Objective / Activity	Explanation of link to improving immunisation outcomes
Objective 1: To strengthen Surveillance System and Immunization Information System, as an integral part of HMIS	
1.A. VPD Surveillance information system (web-based system)	These activities are contribute to the improvement of VPD surveillance monitoring system in urban, Chittagong and hard to reach areas that directly contribute to the reduction of geographical inequities in immunization coverage. The proposed activities focus on developing VPD surveillance web-based software to be integrated into existing routine HMIS allowing policy decision makers at the central level to get surveillance data along with immunization and other health related data for timely policy decision making to act according to situation. Furthermore, it should increase reliability and accuracy of surveillance data reporting to the central level substantially. Having such evidence-based decision-making process in place, it would contribute to strengthening the capacity within Government to analyze routinely collected surveillance and HMIS data with a view of enhancing their skills in interpreting trends and evidence and using information in planning and implementation to increase the effectiveness of EPI and ultimately the immunization outcomes in the country. HMIS in Bangladesh uses DHIS-2 and the linking of immunization data with HMIS will therefore benefit both EPI and the overall health system.
1.1. *(1.1)[3] Design and develop VPD surveillance system (web-based software) to integrate into routine HMIS, pilot it and assist in software (system) modifications based on needs*	
1.2. *(1.2) Procure necessary equipment to install software in the health facilities*	
1.3. *(1.3) Install VPD surveillance system in the health facilities*	
1.4. *(1.4) Support VPD surveillance information system operation and maintenance*	
1.5. *(1.5) Train health personnel and mid-level managers in newly developed VPD surveillance system, EPI and other surveillance issues*	
1.B. Laboratory performance improvement	This group of activities aim at improving the capacity of laboratories contributing to attain better immunization outcomes through stronger monitoring and early warning systems in respect of VPD. Laboratory capacity is a critical element of any communicable disease surveillance system. Currently National Polio and measles laboratory (NPML) of the institute of public health (IPH) provided laboratory support for polio eradication and measles elimination. Additionally, NPML
1.6. *(1.7) Renovation of NPML laboratories, IPH (8 sections/laboratories)*	
1.7. *(1.8) Procure laboratory equipment and consumable goods (PPEs), and calibration of this equipment*	
1.8. *(1.9) Upgrade BSL-2 to BSL-3 lab and support the maintenance and calibration of this lab*	
1.9. *(1.10) Transportation of specimens from field to NPML, IPH and shipment to international reference lab*	
1.10. *(1.11) Train lab personnel in international good lab practices and biosafety, biosecurity and infection control (internationally and internally)*	

[3] Numbers in brackets correspond to the numbering of activities in the HSS Gap Analysis and Workplan tool and are provided for easy reference

1.11. (1.12) Procure office equipment (furniture's, air conditioner, computer, scanner, etc.) for labs and meeting emergency room in NPML, IPH(1.12)	should start to monitor other vaccine preventable disease like Japanese encephalitis, Rota virus infections, and invasive bacterial dieses once its enhancement will be completed under the proposed activities. Additionally, these activities are expected to contribute to better quality and bio safety of NPML.
1.C. Improve management and operation of VPD surveillance system	These activities will strengthen the management and operation of the VPD surveillance system. Regular performance review field visits, meetings and discussions on key achievements and challenges in the performance of VPD surveillance system at central, urban, zones would institutionalize evidence based management practices. A few activities aim to improve the quality and reliability of the evidence base produced via epidemiological studies, IBDS and Rota virus surveillance are critically contribute to all immunization outcomes and broader universal health coverage area. Finally, a set of proposed activities supporting the operation of VPD surveillance will be taken up by the Government (medical officer/public health and nutrition) after completion of this GAVI HSS-II grant: During implementation of the HPNSDP *"…a medical officer of the UHC has been introduced as medical officer (public health and nutrition) who responsible for coordinating NNS activities at upazila level and below..."* (p 7).
1.12. (1.6) Conduct regular monitoring of VPD surveillance system's performance and dissemination of monitoring' results	
1.13. (1.13) Discuss and review the performance of routine surveillance in urban areas (city cooperation, zones)	
1.14. (1.15) Support the operation of VPD surveillance system at central, district and upazila levels (e.g. national consultant, divisional coordinators and district SMO)	
1.15. (1.17) Purchase vehicles for surveillance and supervision visits conducted by DMCHIOs / SMOs and relevant officers	
1.16. (1.14) Support DMCHIOs/SMOs to carry out regular routine surveillance activities (hiring drivers)	
1.17. (1.16) Support the operational costs of DMCHIOS/SMOs (internet, mobiles, office equipment etc.)	
1.18. (1.18) Technical assistance to conduct epidemiological studies/analysis based on surveillance data and linking with HSS area incl. UHC	
1.19. (1.19) Conduct IBDS (Invasive Bacterial Disease Surveillance) and Rotavirus surveillance	
Objective 2: To ensure Effective Vaccine Management (EVM) in terms of the cold chain and supply chain management system	
2.A. Improve vaccine supply management	These activities will enhance vaccine supply management information system by tailoring vaccine supply data and its integration into DHIS2. It would provide more accurate and real time data on vaccine supply for better management of the National EPI, in particular vaccine supply. Additionally, vaccine supply management system would be digitized at district and upazila levels.
2.1 (2.2) Development of ISCL management information system (MIS)	
2.2 (2.1) Data management monitoring to support the process of transition to computerized real time data management	
2.3 (2.10) Procure necessary equipment to support IT and data communication at district and upazila levels and its maintenance	
2.B. Expand and upgrade cold chain/logistic infrastructure	These proposed activities will fully cover the need for cold chain expansion due introduction of
2.4 (2.18) Construction of infrastructure for cold rooms and	

cold chain	new vaccines HPV (2016) and Rotavirus (2018). Cold chain infrastructure is essential to ensure storage and uninterrupted supply of quality vaccines for the sake of maintaining immunization coverage and equity.
2.5 (2.7) Procure necessary cold chain equipment and spare parts	
2.6 (2.8) Install new cold chain equipment at all levels	
2.7 (2.9) Transportation of new cold chain equipment (to district and upazila levels)	
2.8 (2.11) Procure necessary vehicles and their spare parts	
2.9 (2.14) Conduct cold chain and logistic assessment in urban settings and rehabilitate cold chain infrastructure according to the improvement plan	
2.C. Support supply/logistic system operation	This group activities aim to the efficient and effective operation of vaccine supply and supply chain management through the investment in human resources, improvement of the regulatory framework, information collection (operational research) as recommended in the EVM Improvement plan. These activities would directly contribute to improving coverage and quality of immunization.
2.10 (2.15) Conduct a survey on vaccine wastage to develop strategies to reduce vaccine wastage & vial optimization and dissemination	
2.11 (2.19) Conduct operational study on use of cool packs for outreach and dissemination	
2.12 (2.5) Carry on workshops related to EVM area (incl. MIS, ISCL indicators, e-health/ISCL) at national and district level	
2.13 (2.4) Design ISCL motivation/incentive mechanisms and develop M&E indicators	
2.14 (2.3) Revise and develop regulatory framework (e.g. SOPS for EVM team, outsourced performance based contracts, update equipment inventory and maintain stock)	
2.15 (2.6) Support participation at international conferences and events	
2.16 (2.13) Train technical personnel in selected areas of EVM (in accordance with the EVM improvement plan) at central, district and upazila levels	
2.17 (2.12) Support maintenance of cold chain incl. cold rooms at all three levels (central, district and upazila) through different mechanisms	
2.18 (2.16) Support transportation of vaccine to outreach service delivery sites	
2.19 (2.17) Procurement of melamine containers to bring vaccines to reduce wastage	
Objective 3: *Project management*	
3.A. Operational research/evidence generation for decision making	The operation research (coverage) is proposed to assess immunization system performance and its determinants. The empirical information obtained would benefit directly different areas of immunization system (e.g. VPD surveillance system and supply/logistics). Together with a previous set of activities, the proposed efforts should lead to minimizing the gap between surveyed and reported coverage figures, and increasing confidence in the evidence among policy makers and development partners.
3.1.(3.2) Conduct evaluation of immunization coverage inclusing dissemination	
3.2.(3.3) Conduct mid-term and final evaluation of the grant implementation	

	Additionally, two evaluations of implementation of this GAV HSS-II grant are planned to assess if proposed activities under this grant are on track or needs to be re-programmed and improve implementation of this grant.
3.B. Administration (management)	Management of the grant is rather critical and needs to be carefully carried out. Each lead implementer will manage directly the implementation of the respective component, while the MoHFW will conduct oversight and ensure coordination between lead implementers and healthcare officials at all levels.
3.3. (3.1) Coordination and technical oversight of the implementation of objective #2	
3.4. (3.4) Coordination and technical oversight of the implementation of objective #1	
3.5.(3.5) Coordination and technical oversight of implementation of this project from the MOHFW Bangladesh	
Note: each activity is described in detail in HSS main components and activities narrative (see attachment #50)	
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13. Results Chain

Objective 1: To strengthen Surveillance System and Immunization Information System, as an integral part of HMIS

Key Activities:

1.A. Surveillance information system (web-based system)
1.B. Lab enhancement
1.C. Improve management and operation of surveillance system

Related Key Activities Indicators:

- *% health facilities with updated surveillance system installed*
- *No. of personnel who have completed the HMIS training*
- *No. of managers trained on HMIS and information use*
- *% of AFP and suspected measles cases tested in the laboratory.*
- *% City Corporations & Municipalities with the updated system, synchronized with HMIS*

Intermediate Results:

- *Stronger VPD surveillance*
- *More consistent evidence-base (synchronized between EPI database and HMIS, and between urban and rural areas)*
- *Timely and reliable availability of high quality data*

Related Intermediate Results Indicators:

- *% health facilities sending timely & complete surveillance reports*
- *% health facilities sending timely coverage reports*
- *% districts providing surveillance reports on time*
- *% of city corporations sending timely & complete reports*
- *% of municipalities sending timely & complete reports*
- *All polio and measles surveillance indicators are met*
- *The use of common denominator introduced and implemented nation-wide, both in urban and rural areas*

Immunisation Outcomes:

- **Improved immunization coverage**
- **Reduced drop-out rates**
- **Increased equity of coverage**

Indicators (more details in the Results Framework)

- Penta-3 (including DTP) coverage
- MCV1 coverage
- Geographic equity of DTP 3 coverage -
- Socio-economic equity in immunization coverage - difference between lowest and highest wealth quintile
- Drop out rate - difference between DTP1 and DTP3 coverage
- Proportion of children fully immunized

Objective 2: To ensure Effective Vaccine Management (EVM) in terms of the cold chain and supply chain management system

Key Activities:

2.A. Improve vaccine supply management
2.B. Expand and upgrade cold chain/logistic infrastructure
2.C. Support supply/logistic system operation

Related Key Activities Indicators:

- *# of vacant positions in EVM coordination team*
- *% cold chain infrastructure completed as per plan*
- *% personnel trained on equipment maintenance*
- *% City Corporations assessed to have satisfactory EVM systems in place*
- *% of Municipalities assessed to have satisfactory EVM*

Intermediate Results:

- *Adequate capacity and effective functioning of the cold chain*
- *More effective preservation and transportation of vaccines*
- *Reduced national wastage rate*

Related Intermediate Results Indicators:

- *No. of districts with upgraded EVM system functioning*
- *% vaccine stock-out at urban health facilities (City Corporations & Municipalities)*
- *EVM Evaluation average score: the proportion of vaccine stores and facilities with EVM criteria E2-E6 scores at or above 80% (national average | national | district | upazila levels)*

Immunisation Outcomes:

- **Improved immunization coverage**
- **Reduced drop-out rates**
- **Increased quality and safety**

Indicators – See above.

Objective 3: Project management

Key Activities:	Intermediate Results:	Immunisation Outcomes:
3.A. Operational research/evidence generation for decision making **3.B. Administration (management)**	▪ *Reliability and accuracy of the MCH related routine data collection and reporting improved*	▪ **Improved immunization coverage** ▪ **Reduced drop-out rates** ▪ **Equity of coverage** ▪ **Improved quality and safety** ▪ *The effectiveness of the implementation of MCH and immunization related components of the national health strategy increased*
Related Key Activities Indicators: ▪ *The number of the assessments conducted that meet international standards*	**Related 'Intermediate Results Indicators:** ▪ *Number of LCG meetings where Gavi-HSS grant implementation is reviewed* ▪ *Percentage point difference between reported and surveyed Penta 3 coverage rates*	**Indicators;** ▪ *% of children aged 12-23 months who receive all basic vaccinations in a country's routine immunization schedule* ▪ *Drop out rate - percentage point difference between DTP1 and DTP3 coverage*

IMPACT:

- *Reduced morbidity and mortality from vaccine-preventable diseases among women and under-five children*

Indicators to be used: *Under-five mortality rate, Neonatal mortality rate and Maternal mortality ratio, incidence of poliomyelitis, , neonatal tetanus, incidence of measles, incidence of rubella*

ASSUMPTIONS:

- *Government commitment to the immunization program continues to be strong and political changes will not affect this commitment.*
- *Development partners' commitment to the sector-wide approach continues beyond 2016.*
- *Program implementation and monitoring are effective, with strong technical support from WHO and UNICEF.*
- *Sufficient coordination between various departments and units within MOHFW and its Directorates.*
- *Adequate financial and human resources are available to support the provision of immunization through an integrated health system.*

FOUR PAGES MAXIMUM

14. Monitoring and Evaluation

Description of M&E process and alignment with HPNSDP's results framework

The Ministry of Health and Family Welfare (MOHFW) has a Planning Unit that responsible for Monitoring and Evaluation of HPNSDP and collects data for all impact and most of outcome level indicators routinely (see attachment #9: M&E strategy and action plan for HPNSDP). In addition to administrative data collection and reporting, the MOHFW collects data on immunization coverage and equity indicators from household surveys such as immunization coverage evaluation surveys and DHS.

Also, within SWAp an Annual Program Review (APR) is being jointly conducted by the MOHFW and the DPs to assess performance, identify gaps and define the Program priorities for the following year. The APR process includes several steps as detailed below.

(a) A **Technical Review** is carried out by an Independent Review Team (IRT) comprising international and national consultants who analyse data from routine sources of MOHFW as well as available surveys, analytical studies, qualitative data, and conduct fact-finding activities to review the progress of HPNSDP. The Annual Program Implementation Report (APIR) is prepared by the MOHFW and made available to IRT prior to the Technical Review. The IRT:

- Reviews available information and assists the Task Groups in analyzing data and recommending next steps (TORs pertaining to specific thematic areas have been developed separately). The IRT prepares a technical report (IRT Report) drawing on various inputs, including the reports mentioned in (b) and(c) below and the other sources of information described in section 14, to be discussed in the Task Groups. Based on these discussions, an action plan is developed to be followed up in the next year;
- Reviews implementation of the HPNSDP and provide a detailed analysis of a selected thematic areas of the program, focusing on Health Services Utilization and Nutrition to highlight the challenges and possibility of achieving the objectives and targets of HPNSDP (including those on reducing inequities);
- Reviews the risk assessment of HNPSP and set the baseline for HPNSDP.

(b) Nine task groups (viz. Equity, Gender and Voice; Monitoring and Evaluation; Procurement; Financial Management; Human Resources; Nutrition; Health Financing Resources Group; MNCH-FP and Sector Management) have been formed, which include members from GOB and DPs. The issues identified in the technical review, stakeholder consultation and field visits form the agenda for discussion in the Task Groups. Each Task Group identifies a set of actions, with time lines and responsibilities. These actions are consolidated for further discussion and endorsement at the higher level of MOHFW. Task Group meetings are held on regular basis. The issues of Gavi-HSS program will also be discussed and monitored in the Task Group meeting.

(c) APR includes **field level discussions** to understand implementation realities at the field level. A 7-member team consisting of 3 MOHFW, 3 DPs and 1 IRT representative visits field with a focus on identifying solutions to service delivery bottlenecks to improve utilization of services. During the field visits, emphasis is also given to strategies for improving utilization of HPN services and nutritional status of poor women and children on the basis of discussions at the field levels. The process is managed by the Planning Wing of MoHFW and a brief report on issues identified during the field visit is included in the IRT Report. A separate TOR for field visit is developed in consultation with DPs and IRT leader.

(d) On the basis of the IRT report, a **Policy Dialogue** takes place between the senior representatives of MOHFW and the DPs. The Key Objectives of the policy dialogue is defined by the APR SC with the aim to:

- Discuss key findings and recommendations proposed by the IRT report;
- Discuss MOHFW's and DP comments on IRT's report;
- Prioritize HPNSDP issues and recommendations to prepare the action plan; and
- Agree on proposed actions required for moving the HPNSDP forward and to achieve the program objectives and targets.

(e) The **Aide Memoire** for the 2012 APR is jointly written by the GOB and DPs. A drafting committee will deliver the first draft for discussions to the MoHFW. The final Aide Memoire is discussed and agreed upon in the Wrap up meeting. The LCG -Health group is appraised of the overall situation.

Following the policy dialogue and an agreed Aide Memoire with an Action Plan is developed and agreed upon. Action Plan implementation might require revision of Operational Plan, budget and procurement plan for the following year. LCG - Health group reviews progress of implementation of agreed upon Action Plan following the APR.

Subnational monitoring is conducted at the Divisional, District and Upazilla (sub-district) levels by the respective managers, who hold quarterly reviews of program performance for the respective jurisdiction one month ahead of the national level quarterly review. Subnational review findings and recommendations inform the national level reviews and feedback / guidance provided by the national level management to sub-national managers prior to their next review meeting.

National EPI conducts CES every year to assess the vaccination coverage at national and subnational levels. The survey findings provide an overall picture of EPI performance, both qualitative and quantitative aspects, which enables MOHFW to analyse the performances of divisions, districts and City Corporations. Quantitative findings of CES include level of crude as well as valid coverage of EPI vaccines by regions, hard-to-reach areas and socio-economic status, vaccination drop-out rates and incidence of invalid doses. Qualitative aspects such as reasons for never or partial vaccination and knowledge level for important immunization practices among caregivers are also collected by CES.

In addition, routine administrative reports from subnational level (ward/ union/ Municipality/ Zone of City Corporation) are regularly analysed by doses of antigens given to children, by geographical area, and by sex and find out dropout and left outs children. The analysed data are shared in weekly supervisor's meeting and monthly field workers and supervisors meeting and quarterly coordination meeting with multi-sectoral partners to reach every child irrespective of gender, geographical area and socioeconomic equity.

All sub-national reporting units are linked with DHIS-2, the national health information management system under DGHS. All policy makers and national EPI has access to this DHIS-2 for using this data for decision making and also for monitoring purpose. These data feed into the joint GOB-DP APR to update relevant results framework indicators and monitor performance of EPI program with special emphasis on regional and equity issues. The APR findings based on CES data are being used by the planners, policy makers, national and local managers, and field personnel to compare and analyze the situation in terms of EPI coverage and other related information in their respective areas, to make realistic plan and undertake necessary action for improving the coverage of target districts and City Corporations.

Alignment with the national health plan results framework

The M&E of this GAVI HSS-II grant will be carried out as part of routine M&E activities of HPNSDP and will be mainstreamed into SWAp to strengthen the health system in overall.

The indicators included into results chain (developed for this GAVI HSS-II grant, presented above) is in line with those chosen for the HPNSDP. The EPI and MOHFW team will be directly involved into M&E process of this grant. Notably, VPD surveillance system based on web-software will be developed and integrated into routine HMIS. Consequently, data will be collected as part of the country's MIS [HMIS] (supplemented by the EPI unit's own data sources until they are integrated). The data collection will be automated – with financial support from the grant – as well as from regular surveys such as the DHS, MICS, the CES and the Immunization Program Reviews. LGD/MLGRDC will collect the relevant data from City Corporations and municipalities.

M&E Budget

Activities that are directly related to HSS project M&E constitutes $ 691,085 that is approximately 2% of the total budget. The list of M&E activities and their budget are presented in attachment #52 (see activities marked as

"Direct").

Most of indirect budget related to M&E is under surveillance activities, such as development and installation of VPD surveillance web-based system, review of performance of routine surveillance and dissemination of results (objective 1). The special focus is on improving quality of routine surveillance data collection and reporting as well as case detection and reporting of VPD. There are a few activities related to M&E budgeted under EVM part (objective 2). The estimated budget of activities strengthening mainly national VPD surveillance and M&E system totals $11,063,567 (see the list of activities in Attachment #52 marked as "Indirect").

Grant evaluation

The proposal envisages the grant to be evaluated in the third Year (see activity #3.3). This evaluation will be commissioned by MoHFW, and the evaluation methodology will be discussed and agreed upon with the Gavi Secretariat.

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PART E – BUDGET, GAP ANALYSIS AND WORKPLAN

15. Detailed Budget and Workplan Narrative

This GAVI HSS-II grant proposal is for 3 years because the cMYP in Bangladesh is valid until 2018 and the HPNSDP is valid until 2016. The total budget of this proposal is $ **33,922,732**. The disbursement of this fund is presented below.

The greatest proportion of GAVI HSS-II funds are allocated to EVM part under objective 2 - $19,327,890.2 (57% of the total budget), secondly to VPD surveillance system under objective 1 - $ 12,176,977.2 (36% of the total budget) and, finally, program management - $2,417,864.2 (7% of the total budget). The composition of funds allocation is stipulated for main cost drivers, such as construction and rehabilitation, cold chain and lab equipment and its transportation, international and local consultancy fee, vehicle and maintenance of all equipment.

The scale of support and investments in improvement of surveillance system and cold chain is based on historical reporting data within the country, the EVM improvement plan (2015-2018) recommendations and WHO and UNICEF rates (historical). The budget of WHO and UNICEF implemented activities includes WHO and UNICEF overhead, 7% and 8% correspondingly (agency specific overheads were factored in each unit cost for the inputs/activities implemented either by WHO or UNICEF). WHO and UNICEF overheads costs are presented separately in the budget summary table below and details by each activity are provided in Annex 61.

	2016	2017	2018	Total
1 Strengthen VPD surveillance and its integration into HMIS	$3,597,930	$4,784,101	$2,998,321	**$11,380,352**
2 Improve cold chain and supply chain management system performance	$4,563,907	$7,022,399	$6,309,889	**$17,896,195**
3 Program management	$774,492	$624,492	$874,492	**$2,273,476**
WHO Overhead	$277,125	$349,657	$235,152	**$861,934**
UNICEF Overhead	$391,472	$588,152	$531,151	**$1,510,775**
Total	**$9,604,926**	**$13,368,800**	**$10,949,005**	**$33,922,732**

Assumptions within the budget for each activity is described in detail in HSS main components and activities narrative (see annex 50). Assumptions for main cost drivers are as follow:

Unit costs	Justification
Construction – 382,592,2$, Rehabilitation – 85,600$	Construction cost of new cold rooms at the central level to accommodate new vaccines is based on the EVM Implementation plan (see attachment #12 (a-b)). According to the EVM improvement plan, the cost of construction of one 430m2 building was estimated at $354,252, whereas the other constructions' cost vary from $168,251 to $5,715 (see attachment #55). The cost of rehabilitation of laboratories are based on the Laboratory improvement plan (2014) and the cost of one section is $85,600 (see attachment 57 (a-d)).
Cold Chain equipment unit costs and its transportation to district and upazila levels 4,903,513$	Prices of specified cold chain equipment include in this proposal are based on UNICEF supply division catalogue and EVM improvement plan, and further adjusted to 20% shipment expenditures if equipment is procured via UNICEF international procurement or no shipment expenditures if locally procured (as shown in Attachment #53). The cost of transportation within the country is about 3% of cold chain equipment's budget as per UNICEF's recommendations (as shown in Attachment #53).
Vehicle unit costs 3,028,204$	Vehicle unit costs as presented in Attachment #54 reflect the prices of imported vehicles available in the global market and UNICEF/WHO catalogues; spare parts were factored as 5% of the vehicle costs with an exception of one set of vehicles (their spare parts will be covered by the Government).

Consultancy fees: ITA – 17,120$ per month and 486$ - per day; LTA – 4,503$ per month and 108$ per day; Labor – 8,100$ per month	International technical assistance (ITA) costs are calculated based on WHO and UNICEF accepted rates for remuneration of international consulting companies and an international consultant/expert. Per diems and travel cost units reflect WHO and UNICEF historical expenditure rates. Local technical assistance (LTA), the proposed unit cost is widely accepted rate for remuneration of local consultants/experts or local consulting companies. These unit costs are based on the WHO Country Office Bangladesh and UNICEF Country Office Bangladesh historical expenditures. Labor – a person providing services on monthly salary base and the costs are based on WHO and UNICEF rates. For more details on ITA and LTA see attachment # 51.
Lab equipment: lump – sum: $335,017	The lump-sum cost of laboratory equipment are estimated expenditures based on market and WHO provided prices reflected in Laboratory improvement plan (2014) (see attachment #57 (a-d)).
Services: lump sum	Services, mainly reflects the maintenance or any operational costs reflected in HSS main components and activities narrative (see attachment #59). The lump sum cost of maintenance are based on the WHO Country Office Bangladesh and UNICEF Country Office Bangladesh historical expenditures.
Training and workshop costs from $232.1 to $386 per person-day	The cost of trainings and workshops at national, district and upazila levels covers fees of trainers, participants travel and accommodation expenditures, venue rent and training material expenses. The cost structure is presented in detail in Attachment #56.
IBD and Rota Surveillaancce lump-sum costs - $398,990.2	The average cost of two surveillances, Invasive Bacterial diseases (IBD) and Rota virus ($252,888 and $120,000 correspondingly) are based on historical expenditures born by the WHO Country Office Bangladesh, USAID and US CDC.

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16. Gap Analysis and Complementarity

Two types of gap analysis are presented here. The first one deals with the resource gaps in the sector as a whole, based on the 7th Five Year Plan and with the estimated resource gaps for the immunization program, as presented in the CMYP (2014-18). The second deals with the gap related to two health system bottlenecks the current application proposes to address.

Resource gaps for the health sector and the national immunization programme

HPNSDP will be completed by the end of June, 2016. MOHFW is in the process of developing the strategic plan for the subsequent sector development program– anticipated to begin in July 2016. As that process has just been initiated, future financial commitments from the Government as well as various DPs are yet to be made.

However, the 7th Five year plan has projected funding requirement for Health Nutrition and Population (HNP). Hence, a preliminary gap analysis is provided herewith, considering the 7th Five year plan as basis and factoring in trends from HPNSDP expenditure. Considerations for the analysis includes availability of resources, MOHFW's absorption capacity and expenditure track record, efficiency gain in fund utilization, etc. A more thorough and comprehensive gap analysis will be finalized during the design of the sector program that would succeed HPNSDP. As this Gavi-HSS Grant is proposed to be part of the pooled funds under the next SWAp, if it is approved, the financing provided by it will certainly be taken into account in such analysis. It is envisaged that being a significant

contributor to the SWAp, Gavi will be an active partner in developing the successor to HPNSDP.

It is estimated that more than 10 billion USD are required to implement the health sector strengthening plans of GOB as per the 7th Five year plan. Within this projected amount, around 61% will be derived from Government Non-development (revenue) budget and around 17% from Government development budget. This means that around 78% of the total estimated amount required for the proposed health sector strengthening will be obtained from government sources. That leaves a funding gap of 22% in the estimated amount, worth around 2,291.67 Million USD.

From the experience of the previous three sector development programs, the MOHFW is expecting to fill this gap through project aid from various development partners. GAVI-HSS grant of around 100 million USD (out of which 33.9 million is budgeted as per the proposal, approximately 51 million will be requested for contributing health sector pooled funds in the second part and rest is expected as performance grant) is one of the sources that is expected to fill this gap. Apart from GAVI-HSS, assistance is expected from various bilateral and UN project supports, grants and technical cooperation. The exact amount is difficult to be ascertained at this moment, however, that will be done in discussion with various development agencies during the design of the next sector program.

Relevant Health System Strengthening Programs proposed in the 7th Five Year Plan	Total Funding Required in Million USD	Funding Source			Fund requested from GAVI-HSS (Million USD)	Duration	Geographical Coverage
		GOB Non-Development (Revenue)	GOB Development	Funding Gap			
Maternal, neonatal, child, adolescent and reproductive health care programs	2,691.38	1,641.74	457.53	592.10	35.1	2016-2021	Nation Wide
Population and family planning programs, inclusive of field service delivery, clinical contraception service delivery	864.54	527.37	146.97	190.20		2016-2021	Nation Wide
Primary health care service programs including (a) Urban PHC; (b) Tribal health care; (c) Geriatric care for elderly population; (d) Mental health care; and (e) Alternative medical care	298.45	182.05	50.74	65.66		2016-2021	Nation Wide
Nutrition and food safety programs, inclusive of nutrition promotion through multi-sector and regulatory activities for food safety	250.38	152.73	42.56	55.08		2016-2021	Nation Wide
Communicable diseases (including Malaria, TB, HIV, STD/AIDS) and epidemic control program	315.48	192.44	53.63	69.41		2016-2021	Nation Wide
Non-communicable disease control program (inclusive of preventive and curative care for cancer, diabetes, heart diseases, eye care, etc.)	362.58	221.17	61.64	79.77		2016-2021	Nation Wide
Hospital services delivery program including Quality Assurance and hospital waste management	534.28	325.91	90.83	117.54		2016-2021	Nation Wide
Infrastructure development program	3,437.60	2,096.94	584.39	756.27		2016-2021	Nation Wide
Human resources (HR management and capacity building)	452.68	276.13	76.96	99.59	21.47	2016-2021	Nation Wide
Planning, Monitoring & Evaluation inclusive of governance and stewardship; and sector wide program management	93.50	57.04	15.90	20.57	7.45	2016-2021	Nation Wide
Research and development for health and FP	98.13	59.86	16.68	21.59		2016-2021	Nation Wide

Health sector financing (including universal health coverage, GEVA and financial management) program	95.33	58.15	16.21	20.97		2016-2021	Nation Wide
Health and FP Information systems improvement program	323.35	197.24	54.97	71.14	6.89	2016-2021	Nation Wide
Supply chain management (procurement, storage, logistics, supply management including capacity building)	361.60	220.58	61.47	79.55	13.08	2016-2021	Nation Wide
Health education and promotion program (IEC/BCC activities for awareness raising and prevention of health hazards)	237.40	144.81	40.36	52.23		2016-2021	Nation Wide
Total	**10,416.68**	**6,354.17**	**1,770.84**	**2,291.67**	**83.99**		

The draft CMYP (2014-18) includes a gap analysis for the Immunization Program as a whole (not the HSS objectives), which is presented here.

Resource Requirements, Financing and Gaps (Secure Funding)

Resource Requirements, Financing And Gaps*		2014	2015	2016	2017	2018	Avg. 2014 - 2018
Total Resource Requirements		$202,291,927	$214,932,342	$222,414,162	$205,517,051	$214,934,532	$1,060,090,014
Total Resource Requirements (Routine Only)		$164,574,916	$176,708,877	$183,658,919	$166,203,441	$175,034,637	$866,180,789
	Per Capita	$1.05	$1.12	$1.14	$1.02	$1.06	$1.08
	Per DTP Targeted Child	$54.90	$58.98	$60.44	$53.91	$55.96	$56.82
Total Secure Funding		**$102,910,733**	**$186,642,386**	**$198,082,166**	**$209,602,965**	**$164,224,107**	**$861,462,357**
Government		$20,899,112	$97,030,063	$105,127,689	$114,851,341	$51,380,375	$389,288,580
Sub-National Government		$0	$0	$0	$0	$0	$0
Gov. Co-Financing Of Gavi Vaccine		$1,295,000	$4,878,363	$6,327,286	$6,299,987	$6,444,730	$25,245,366
GAVI		$34,112,831	$34,607,499	$35,109,308	$35,618,393	$36,134,859	$175,582,889
Pooled Funding		$43,592,169	$50,126,461	$51,517,884	$52,833,244	$67,290,055	$265,359,813
WHO		$756,972	$0	$0	$0	$2,324,326	$3,081,298
UNICEF		$2,254,648	$0	$0	$0	$649,762	$2,904,410
Funding Gap (With Secured Funds Only)		**$99,381,194**	**$28,289,956**	**$24,331,996**	**($4,085,914)**	**$50,710,425**	**$198,627,657**
% Of Total Needs		**49%**	**13%**	**11%**	**-2%**	**24%**	**19%**

The requirements for vaccines and injection supplies are expected to be financed from two sources: Gavi and the GOB (through Pooled Funds).

GAVI is expected to finance $175.6M in 2014-2018 provided that Bangladesh's request for the New Vaccines Support for PCV and Rota are approved. The Government of Bangladesh intends to allocate about $414,5M during the same period including co-financing obligations. Contribution of GAVI to traditional vaccines is associated with the possible support of PCV Rota, HPV and introduction of the new vaccines in Bangladesh. The rest of the costs of traditional vaccines will be covered by the Governments as well as cost of OPV for polio and Vitamin A campaigns.

Average funding gap (with secure and probable funds) is estimated 19% for the entire period of 2014-2018 as shown in the table above.

Government contribution to secure funds is approximately 48.12% and together with Pooled Funding accounts for about a half of total secured financing.

Most of GAVI financing is treated as probable funding, rather than secured funding (conditional upon approval of NVS support by the GAVI Board), and that explains GAVI's 27.61% in probable financing. Overall, Government of Bangladesh from its own revenues as well as through the pooled funding is expected to provide around 19.76% of the total resource requirements for the NIP during 2014-2018, GAVI funds are expected to account for

approximately 34.1% of the total needs and WHO and UNICEF for around 1.31% of total financing.

GAVI HSS application specific gap:

The total amount of required funds to cover HSS expenses for three year period is about $36,929,872.

The activities under surveillance part (objective 1) are covered by GAVI "MR supplementary campaign grant" (6%) and by foreseen GAVI HSS-II grant (about 94%).

The EVM part of GAVI HSS-II (objective 2), the GAVI HSS-II grant will cover about 87% of the required funds whereas the rest EVM activities will be funded through UNICEF while supporting EVM improvement plan (13%). The programme management is fully covered by GAVI HSS-II either through WHO or UNICEF.

Based on gap analysis there is no any funding gap during three year while implementing activities under GAVI HSS-II. After 2018, the Government of Bangladesh will take the responsibility to finance the cost of activities envisaged in 5-year HSS-II workplan as part of SWAp framework (see attachment #06b).

See Annex #06a for the details of the gap analysis.

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17. Sustainability

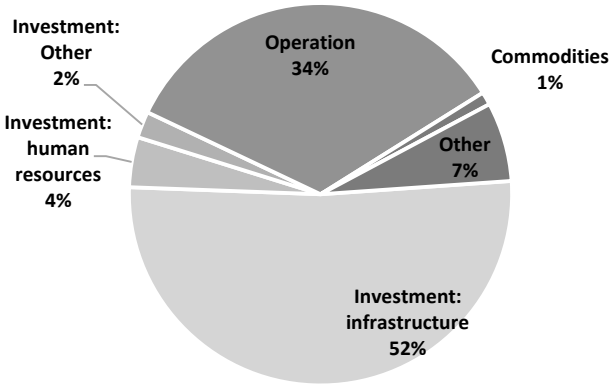
Opportunities

The Government of Bangladesh is committed to sustain the excellent results achieved by its immunization program over the past decades. The current proposal grant is expected to address the immediate needs in specific areas of the national immunization program such as EVM and VPD surveillance, that are important to ensure the successful introduction of Rotavirus vaccine in January 2018. Therefore, GOB is willing to provide adequate resources from its own revenue as well as DPs' financial assistance to the health sector to support the system capacity and operation beyond the Gavi HSS-II grant period. This applies to maintenance of infrastructure, vehicles and equipment, operational costs, human resources which are temporarily being financed from the grant and any other resources that will be needed to sustain the HSS inputs and enhance the achievements of the immunization program.

HPNSDP will be completed by the end of June, 2016. MOHFW is in the process of developing the strategic plan for the subsequent sector development program– anticipated to begin in 2017. As that process has just been initiated, future financial commitments from the Government as well as various DPs are yet to be made. However, during preparation of this GVAI HSS-II proposal for three years with focus only on surveillance and EVM, the Government has made a commitment to take financial responsibility after 2018 as part of SWAp.

Sustainability profile and challenges of the application

A simple analysis of the project budget (see annex 60) shows that 58% of the requested funding will be allocated to the investment in infrastructure (buildings, equipment, vehicles, etc.), human resources and information management systems ("Other"). Approximately 35% of the requested funding ($11.8 million) will cover cold chain and surveillance related operations. This stricture implies to challenges for programmatic and financial sustainability:



- Programmatic sustainability: is the project capable to translate the investment into performance benefits and maintain it? The project will address this challenge in two ways:

- the requested investment is based on accurate projections of system expansion and upgrade needs, and the benefits of improved supply chain management and disease surveillance are demanded and measurable;
- the functioning of upgraded infrastructure and new ICT solutions will be guaranteed through investing in human resources (e.g trainings in EVM or VPD surveillance information system funded by the project) and allocation of operational funds from in-country sources and through the project. It was estimated that 8% of the total requested funding ($2.8 million) would be spent on activities that safeguard the investment (e.g. cover equipment and infrastructure maintenance costs, hire drivers to keep the new transport fleet running, or related operational expenditures).

- Financial sustainability: is the country capable to take over the financing of operational and commodity supplies after the Gavi HSS funding comes to the end? The MoHFW is willing to assume the responsibility for the financing of certain project activities in Year 4 and Year 5 as shown in the project work plan and budget for 5 years (annex 6b) – the recurrent costs (requirements for funding) of most of operational activities decrease because of MoHFW financing is planned to phase in. The remaining resource requirements from Y4 onwards will be financed from the new SWAp pooled funds.

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PART F – IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

For further instructions, please refer to the Supplementary Guidelines for HSS Applications

18. Implementation Arrangements

Overview

There are three lead implementers to conduct the activities mentioned in the proposal. MoHFW, UNICEF and WHO Country offices; MoHFW will act as the coordination and overseeing body; MoHFW will be responsible for activities 3 and 5 under Program management, WHO CO will be responsible for all activities mentioned under Surveillance (objective1) and the activities 2 and 4 under Program Management (objective 3). UNICEF CO will manage all activities mentioned under EVM (objective 2) and activity 1 under program management. This arrangement (direct transfer to UN agencies) was done due to the delay in the next SWAp and also to consider the urgency in implementing the EVM improvement plan in order to introduce the new vaccines according to cMYP and to support the ongoing VPD surveillance activities. WHO Bangladesh has a comparative advantage on implementing VPD surveillance in the country as it has an extensive network of surveillance medical officers employed in the country, ability to generate external technical assistance and surveillance indicators of Vaccine preventable diseases are achieved and sustained over the years. On EVM related activities UNCEF has been taking the lead since the beginning of EPI program in the country and has proven its competencies in Bangladesh since the beginning of EPI program (see annex 38 on WHO and UNICEF contributions to the National EPI and country specific experience).

WHO will provide local and international technical assistance to the National EPI team to implement objective 1 of this GAVI HSS-II grant and overall surveillance issues. The MoHFW and National EPI team will be thoroughly involved in coordination and overseeing this GVAI HSS-II grant implementation including monitoring in the field.

UNICEF will provide local and international technical assistance to the EPI team to implement objective 2 of this GAVI HSS-II grant and overall EVM improvement plan (*annex 12b*).

Implementation of Objective (project component) 1- Surveillance:

There are 19 activities planned under this objective to be implemented through WHO's standard mechanisms for the implementation of projects with the Government Of Bangladesh. All activities will be included in Government of Bangladesh and WHO biannual work plans. The main outputs of objectives 1 are; Establishment of web based surveillance system and improved use of data at all levels; Strengthened Laboratory Capacity and Quality, including National Polio, Measles and AMES laboratory; Ensuring availability of sufficient numbers of relevant categories of skilled personnel available at all levels. All these outputs are aimed to improve the national health system and hence will be implemented with guidance and collaborations of responsible officials at National, district and sub district levels. The two main mechanisms that will be used for implementation are direct financial contribution (DFC), agreements of performance of work (APW. There are stringent rules on both DFCs and APW's. For DFC's, there must be a formal agreement that is linked to an approved work plan for a WHO activity; this agreement must be in place before committing any funds. Accountability is ensured through several mechanisms like technical report and a financial certification within three months of completion of the activity. The designated program or project leader will have primary responsibility for ensuring the submission of acceptable post-activity reports. Moreover, on-site monitoring, spot checks of activities and audit by WHO is routinely performed. The Agreement for Performance of Work (APW) is used in arrangements where a specific product such as a report, an article, or technical services such as organizing a seminar, or translation and editing, is prepared and delivered by an individual or a firm, without direct supervision by an officer of the Organization. For all APWs, irrespective of the value involved, a justifying memorandum or "adjudication report" must be prepared by the unit requiring the service. All human resources related to implementation of above will be through staff contracts or special services agreements (SSA). The selection process is competitive and extension of contracts is subjected to yearly performance reviews based on quantifiable deliverables. All procurements for goods will be directly procured if they are in WHO supply catalogue (i.e Vehicles, computers, laboratory equipment) and

competitive bidding will be done for non-catalogue items as per WHO procurement guidelines.

Implementation of objective (project component) 2 - EVM:

Strategic partnerships will be built with national counterparts (MOH&FW, Directorate General of Health Services (DGHS)), National EPI Head Quarters, UN partners, NGOs as well as strengthen existing partnerships on EPI. The project component 2 will be managed and administered under the leadership of UNICEF, in collaboration with DGHS as the lead implementing governing body. The Director Primary Health Care and Line Director (Maternal Neonatal Child and Adolescent Health (MNA&CH), will be the focal point for the project component 2.

As an element of HPNSDP, the operational details of the Project will be reflected in the Operational Plans of the Line Director, MNC&AH. Implementation of project activities will be guided by a signed joint bi-annual work plan with MoHFW and UNICEF and the progress of the project will be reviewed with government and partners at the highest levels.

To an extent, the existing management and coordination mechanisms of the GoB at national, district and upazila level will be used. At the national level, EVM Coordination Committee lead by the Program Manager (PM) EPI will be used for overall coordination and the Director PHC will provide management leadership and policy guidance. Cold chain capacity at central, district and sub-district level will be strengthened in partnership with WHO. The construction work will be implemented either through Health Engineer Department, MOHFW or, by contracting with UNOPS or through contracting a local construction agency. Services of expert technical organizations (like International Center for Diarrhoeal Disease Research, Bangladesh ICDDR,B) will be availed for conducting operational study or survey and for developing necessary technical materials, tools, modules and training support.

Cold chain equipment and spare parts will be procured through UNICEF supply division following Supply Manual of UNICEF Copenhagen Division. UNICEF procurement policies and procedures will be applied for all local procurement. The supply and procurement section of UNICEF country office, has dedicated staffs for Procurement Services both offshore and local. The recruitment of human resources will be implemented through HR section of UNICEF following competitive examination.

At district level, the Civil Surgeon and at Upazila level, the Upazila Health and Family Planning Officer (UH&FPO), will be responsible for implementation and management of the project. However, the existing coordination platform at district and upazila levels will be used for multi-sectoral coordination and cooperation including monitoring the implementation.

At the policy level, the UNICEF Chief of Health will liaise with the MoHFW, and the Health, Nutrition and Population Donor Consortium. The project component will be led by a senior professional officer, who will work under the supervision of the Chief of the Section.

Coordination and oversight:

The three lead implementers, MoHFW, WHO and UNICEF will work in close collaboration and monitor the progress of the proposed activities with the overall stewardship of the planning wing of MOHFW. The process will be monitored by Local Consultative Group (LCG) Health with Secretary of Health as chairperson and development partner representative as co-chairperson. The LCG meets quarterly.

The senior professional officers of WHO and UNICEF will provide technical oversight in to respective components of the project (including program planning, implementation, monitoring, evaluation and reporting). S/He will be assisted by a team of other professional officers including specialists in procurement & cold chain and epidemiologists. They will liaise with the line directors and program managers of the DGHS and with health managers at the district and sub-district level regarding technical and managerial issues related to the Project. Field level activities will be supported and monitored by WHO Divisional coordinators and SMOs and UNICEF Zonal Health Officers. In addition, short term national/international consultants will be hired on specific focus areas for smooth implementation of the project activities.

Risk assessment and management will be an integral part of Project management. An on-going process of risk identification, analysis, planning and control will be ensured through local level planning and periodic review

meetings. Risks of each district/upazila will be unique and shall be managed in consultation with the local level committees.

The current HSS-grant Program Implementation Committee (PIC) headed by Joint Chief Planning (Health) will monitor the activities of partners. The committee will have 15 members. The committee will meet -monthly to appraise the progress and to update LCG on quarterly basis. All the three lead implementers will assign focal persons for implementation of activities planned. There will be regular coordination and monitoring meetings between MoH, WHO, UNICEF and other partners to share lessons learned and best practices. The frequency of coordination meetings would be decided on need basis. The members of PIC will visit GAVI/HSS project implementation sites at national , district and sub district levels.

In addition to regular monitoring and coordination activities the MoHFW will evaluate in Year 3 the progress against targets and the effectiveness and efficiency of the implementation of planned activities by WHO and UNICEF. As described under activity #3.3, The MoHFW will identify an appropriate organization and methodology (in consultations with the Gavi Secretariat) to conduct independent mid-term and final evaluations of the implementation of this GAVI HSS-II grant.

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19. Involvement of CSOs

This GAVI HSS-II grant doesn't have any component that should involve CSOs because the two areas that this proposal focus don't envisage to involve CSOs. The other GAVI HSS-II proposal to be prepared for pooled funding within SWAp will involve CSOs.

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20. Technical Assistance

WHO and UNICEF provided TA in preparing of this grant proposal and they will be leading implementers.

The lead implementers will mobilize international and local technical assistance in accordance with their policies and country specific practices.

In total 14 short and long term TA contracts are envisaged (6 ITA and 8 LTA) with the face value of approximately 2.7 million US$.

TA in envisaged for the following activities (numbering corresponds to the Gap Analysis and Work plan):

1.1 Design and develop VPD surveillance system (web based software) to integrate into routine HMIS, pilot it and assist in software (system) modifications based on needs – see a detailed description of TA under activity 1.1 in Annex 50 (page 1)

1.3 Install VPD surveillance information system in the health facilities - see a detailed description of TA under activity 1.3 in Annex 50 (page 2)

1.18 Technical assistance to conduct epidemiological studies/analysis based on surveillance data and linking with HSS area incl. UHC - see a detailed description of TA under activity 1.18 in Annex 50 (page 8)

3.1 Coordination and technical oversight of the implementation of objective #2 - see a detailed description of TA under activity 3.3 in Annex 50 (page 13)

2.1 Data management monitoring to support the process of transition to computerized real time data management see a detailed description of TA under activity 2.2 in Annex 50 (page 8)

2.2 Development of ISCL management information system (MIS) see a detailed description of TA under activity 2.1 in Annex 50 (page 8)

2.3 Revise and develop regulatory framework (e.g. SOPS for EVM team, outsourced performance based contracts, update equipment inventory and maintain stock) - see a detailed description of TA under activity 2.14 in

Annex 50 (page 12)

2.4 Design ISCL motivation/incentive mechanisms and develop M&E indicators - see a detailed description of TA under activity 2.13 in Annex 50 (page 11)

2.14 Conduct cold chain and logistic assessment in urban settings and develop cold chain infrastructure according to improvement plan - see a detailed description of TA under activity 2.9 in Annex 50 (page 10)

3.3 Conduct mid-term and final evaluation of the grant implementation - see a detailed description of TA under activity 3.2 in Annex 50 (page 14)

3.4 Coordination and technical oversight of the implementation of objective #1 - - see a detailed description of TA under activity 3.4 in Annex 50 (page 14)

Detailed description of the planned TA (by input type, cost units, unit costs, volume, activities, total cost and lead implementers) is provided in annex 51.

ONE PAGE MAXIMUM

21. Risks and Mitigation Measures

This information reflects the risk of a country not being able to implement the proposed activities within this grant proposal and/or spend the funds as approved by Gavi. It is expected that the Lead Implementer will be responsible for assessing and ensuring that risk mitigation measures are actually implemented.

- ➔ *If the country has existing health sector risk analysis, please attach these assessments and provide a brief reference to the relevant sections.*
- ➔ *If the country does not have existing health sector risk analysis, please complete the table below for each of the proposed objectives. Please refer to the Supplementary Guidelines for HSS Applications for a description of the various types of risk. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.*

The World Bank rated Health Sector Development Program as a substantially risky (medium-I) operation in 2011 due to the weaknesses relating to governance and regulatory frameworks, management and human resources, M&E and fiduciary oversight (annex 41, page 13). However, the risk to development outcome was rated moderate 3 years later (annex 14c, page 38).

However, most of thes risks identified in 2011 are not pertinent to the Gavi HSS-II project due its implementation arrangements and design. At the same time, some risks and weaknesses highlighted in the HNPSP performance assessment are worth of consideration: "The reports on infrastructure and on medical equipment show that maintenance remains an issue. While infrastructure is generally used as intended, it is not always well maintained. Medical equipment is not always maintained or used as intended, putting the investment at risk." (annex 14c, page 38). These risks will be mitigated by proposing equipment maintenance activities (for cold chain see activity 2.17) and procurement of spare parts for relevant cold chain equipment and vehicles.

The recent rating of the operational risks of Health Sector Development Program (in August 2015, annex 14d, page 3) concluded macroeconomic, sector strategies and policies related risks as Low, but institutional capacity for implementation and sustainability – as moderate. As long as most of activities will be implemented by WHO and UNICEF, these risks are not applicable to Gavi HSS-II project.

Description of risk	***PROBABILITY (high, medium, low)***	***IMPACT (high, medium, low)***	***Mitigation Measures***
Objective 1: To strengthen Surveillance System and Immunization Information System, as an integral part of HMIS			
Institutional Risks:	LOW	LOW	Continuous monitoring by programme implementation committee of MoH and jointly work with WHO to rectify any delays
Fiduciary Risks:	LOW	LOW	Regular auditing by WHO internal and external audits
Operational Risks:	LOW	LOW	The risk for the implementation of activities 1.1 and 1.13 is related to the bifurcation of responsibilities for urban

			and rural areas between MOHFW and MLGRDC, resulting in challenges of coordination as well as more severe capacity constraints in MLGRDC – which would be mitigated by specific coordination activities and capacity-building inputs provided for under the grant.
Programmatic and Performance Risks:	-	-	
Other Risks:	-	-	
Overall Risk Rating for Objective 1	-	-	
Objective 2: To ensure Effective Vaccine Management (EVM) in terms of the cold chain and supply chain management system			
Institutional Risks:	LOW	LOW	Continuous monitoring by programme implementation committee of MoH and jointly work with UNICEF to rectify any delays
Fiduciary Risks:	LOW	LOW	Regular auditing by UNICEF internal and external audits
Operational Risks:	LOW	LOW	The risk for the implementation of activity 2.9 is related to the bifurcation of responsibilities for urban and rural areas between MOHFW and MLGRDC, resulting in challenges of coordination as well as more severe capacity constraints in MLGRDC – which would be mitigated by specific coordination activities and capacity-building inputs provided for under the grant.
Programmatic and Performance Risks:			
Other Risks:	-	-	
Overall Risk Rating for Objective 2	-	-	
Objective 3:Project management			
Institutional Risks:	LOW	LOW	Continuous monitoring by LCG health and address any institutional delays through identifying solutions.

Fiduciary Risks:	-	-	
Operational Risks:	-	-	
Programmatic and Performance Risks:	-	-	
Other Risks:		-	
Overall Risk Rating for Objective 3	-	-	
TWO PAGES MAXIMUM			

22. Financial Management and Procurement Arrangements

Question (a): applicants should indicate whether an existing financial management mechanism or modality will be employed (pooled funding, joint financing arrangements or other), or if a new approach is proposed. If an agency-specific financial arrangement will be used, specify which one. A rationale for this choice should be provided.	WHO and UNICEF specific financial arrangements will be used for the Gavi HSS-II funds except 352,000 US$ to finance activities #3.3 and #3.5 implemented by MoHFW: • WHO will use its existing financial management mechanism: ▪ A specific Award number will be given to GAVI funds. Use of funds can be monitored and tracked using this number. ▪ The fund, as usual will flow into WHO accounts at HQ level and WCO-Bangladesh can use it as per the plan. This is the easiest method as no additional system or staff is required to manage funds. • UNICEF will use its existing financial management mechanism: ▪ The Gavi fund will be deposited in UNUCEF HQ. A specific grant number will be given to Gavi funds. Use of funds can be monitored and tracked using this grant number. ▪ The fund, as usual will flow into UNICEF accounts at HQ level and UNICEF Country Office-Bangladesh can use it as per the approved plan. • MoHFW will use public expenditure management rules to reflect the indicated amount as respective item in the health budget, and spend it in accordance with annual budget and operational plan. The proposed financial management mechanisms for 352,200$ are similar to Gavi HSS-1 grant implementation.

Question (b): Financial Management Arrangements Data Sheet

WHO

1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	Mr Prem Pal Singh, Budget and Finance Officer, WHO-SEARO, New Delhi, India singhpp@who.int
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	**YES**
3. **If YES** • Please state the name of the grant, years and grant amount. • **For completed or closed Grants of Gavi and other Development Partners:** Please provide a brief description of the main conclusions	Through WHO Regional office from the GAVI allocation to WHO South-East Asia Region under following awards: Award # | Award Name 61969 | VCS S GAVI2014 HSS,HIS,PED,QSS

with regard to use of funds in terms of financial management performance. • **For on-going Grants of Gavi and other Development Partners:** Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	61970 VCS S GAVI2014 MR,MENA,HPV,TAG 61973 VCS S GAVI2014 NV,OPS,FIN,CE 63299 VCS S GAVI 2015 HSF, SURV, JE 63301 VCS S GAVI 2015 NRATAGMENAIICC 63302 VCS S GAVI 2015 HPV, NV, OPS 62134 VCS S GAVI RI & IPV
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	The overall oversight of the programme rests with the WHO Representative in Bangladesh, who is supported by team of Technical officers and administrative staff both at Country and Regional Office level. The decision making and approval process is based on an approved delegation of authority from Regional Director to the Country Representatives. WHO's own systems such as routine compliance reviews and audits conducted by both internal auditors and external auditors. WHO has routine internal compliance reviews for both financials expenditures and procedures.
5. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	WHO Representative to Bangladesh in consultation with MoHFW
6. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	The work plans will be prepared as part of WHO's work plan in the country based on actual requirements at the country level. The planned activities in the GAVI/HSS proposal will be included in to that. The plans are peer reviewed by all concerned technical staff in the Region. The Regional Director approves the biennial work plans.
7. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	Yes. As part of the contribution received from Gavi through WHO.
Budget Execution (incl. treasury management and funds flow)	
8. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	Funds will be deposited into the WHO bank account in Geneva preferable in US Dollars. Funds will be channelized to WCO-Bangladesh account through replenishment of funds via WHO Headquarters and Regional Office. There is an authorized Panel of Signatories to WHO Country Office and Regional Office bank accounts are approved by the Regional Director. The approval mechanism follows WHO's delegation of authority vested to Country Office and the Regional Office. WHO Representative will be the signatory for country level.
9. Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	No. WHO do not open separate bank account for voluntary contributions. Funds received from donor are deposited into central bank at Geneva. Funds received and expensed under the grant agreement though will be recorded in the books of the

	Organization separately. At the country level bank account will be in the name of WHO. Funds will then be released for the programme activities case by case based on financial and technical approvals.
10. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	No. The account will also hold other WHO funds.
11. Within the HSS programme, are funds planned to be transferred from central to decentralised levels (provinces, districts etc.)? **If YES**, please describe how fund transfers will be executed and controlled.	No. As mentioned under 9 above.
Procurement	
12. What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	WHO's procurement system will be followed for the GAVI funds entrusted to WHO. WHO has its own procurement systems and delegation of authority for procurement. WHO has a robust and comprehensive procurement policy and e-Manual. This ensures internal compliance and enhances transparency in procurement process. The procurement of commodities such as those listed in the proposal, laboratory equipment, laboratory consumables, office equipment, furniture are some of the commodities that WHO procures very often. Locally available, high weight and volume commodities such as office furniture are recommended for local purchase from the vendors in the vicinity of the project.
13. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	WHO and UNICEF are implementing this project on behalf of the government. Hence all the planned procurements under WHO component will be procured by WHO.
14. What is the staffing arrangement of the organisation in procurement?	WHO has its own procurement staff at country, regional and global level. All levels work in close coordination to achieve best value for money.
15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	Yes. Physical inspection is carried out by the requestor himself after delivery. WHO ensures highest level of quality through collaborative efforts. Services are procured through specially designed service contracts with specific deliverable against which payments are disbursed. Payments can be processed only after delivery of goods/services after the receipt is confirmed by responsible office.
16. Is there a functioning complaint mechanism? Please provide a brief description.	Yes. If the procurements are not as per quotes, the goods can be returned to the supplier as per the provisions of the supply order. Further, most of the goods are returnable if quality related problems crop up during warranty period. There is a standard receipt recording procedure, insurance coverage, and liaising with MSO/SEARO and Global Service Center for global orders

17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	Yes. WHO follows ICC (International Chamber of Commerce) guidelines in case of any disputes. WHO Purchase Order contains clause for dispute resolution and arbitration if not resolved.
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	In order to ensure effective internal control and efficiency of business operations, accounting and reporting is done at Country, Regional and HQ level. WHO has a global processing Centre at Kuala Lumpur which is processing and recording payments in our books except for small ad-hoc local payments which are recorded by WCO Office. WHO has adequate staff at the country level in finance area. This is further supported by the whole budget and finance unit at the Regional Office. We also have the planning unit responsible for reporting.
19. What accounting system is used or will be used for the Gavi HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?)	WHO's own ERP system, Global Management System (GSM). This system is able to handle planning, implementation, monitoring and reporting of all activities in both technical and financial aspects.
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Any time as the system is real-time. The interim reports are generated as per the specific clauses in the donor agreement and is normally covers a six monthly period. However, GSM being a real time system, the reports can be generated for any period. The certified financial statements are issued under the signature of Chief Finance/WHO, thus, restricted to one per year.
Internal control and internal audit	
21. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	WHO has a strong Internal Control framework supported by WHO financial Rules and Regulations, WHO's eManual and Standard Operating Procedures. .
22. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	The Internal Oversight Services Office (IOS) at WHO is responsible for internal audit, inspection, monitoring and evaluation of the adequacy and effectiveness of the Organization's overall system of internal control. This helps the Organization accomplish its objectives by bringing a systematic, disciplined approach to evaluating and improving the effectiveness of processes for risk management, control, and governance. It performs internal audits, investigations, inspections and provides advice to strengthen the functioning of WHO.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	Yes. All three levels of the Organization take the audit recommendations very seriously and the country office is supported by the other two levels in its efforts to rectify the

	problems in the shortest period of time. Director of Administration and Finance (DAF) in the Regional Office, in consultation with budget, finance, programme, HR and administrative staff, provides guidance on the implementation of internal audit recommendations. IOS department as explained under clause 22 is responsible for follow-up on the open audit recommendations. Status of open audit recommendations is also presented in the World Health Assembly of the WHO.
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[4]	The World Health Assembly appoints an External Auditor, who shall be the "the Auditor-General (or an officer holding equivalent title or status) of a Member government". The term of office shall be four years, covering two budgetary periods, and can be renewed once for an additional term of four years. The External Auditor issue a report on the audit of the annual financial statements and make observations with respect to the efficiency of the financial procedures, the accounting system, the internal financial controls and, in general, the administration and management of the Organization.
25. Who is responsible for the implementation of audit recommendations?	WCO Bangladesh, if the audits are carried out for this Office. But as mentioned, the Regional Office monitors the improvement and provides the support required to make the Office able to address the audit observations.

UNICEF			
26. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	Ali Omar Hussein, Finance and Accounts Manager UNICEF Bangladesh, Email: aohussein@unicef.org		
27. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	**YES**		
28. **If YES** • Please state the name of the grant, years and grant amount. • **For completed or closed Grants of Gavi and other Development Partners:** Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • **For on-going Grants of Gavi and other Development Partners:** Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible	**Name of the grant**	**Years**	**Amount ($)**
	SC150092 (KOICA)	2015-2018	7,407,407.41
	SC130192 (DFATD)	2013-2017	15,892,509.01
	SC110271 (DFATD-MNHI)	2011-2016	7,759,657.37
	SC130478 (Swiss Comm)	2013-2016	776,973.96
	SC150470 (BMGF)	2015-2017	1,396,012.04

[4] If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.

expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	
Oversight, Planning and Budgeting	
29. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	Country management Team (CMT) and Programme Management Team (PMT) of UNICEF is responsible for in-country oversight of the programme. CMT is headed by Representative with all sections chiefs as members. PMT is headed by Deputy Representative with Programme section chiefs as members. The frequency of PMT and CMT meeting is monthly. PMT makes decisions on the day to day programme related matters and makes recommendations to Country Management Team (CMT) on more complex issues.
30. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	UNICEF Representative
31. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	Annual planning and budgeting for each sector is approved by the UNICEF Representative and Government counterpart. Deputy Representative and Health Section Chief are engaged in planning, implementation and monitoring of the approved plan.
32. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	Yes
Budget Execution (incl. treasury management and funds flow)	
33. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	UNICEF Bangladesh has bank accounts in both BDT and USD. Fund is replenished from UNICEF HQ Treasury within established cash management system. Fund disbursement to the government is in local currency, BDT. As per UNICEF's financial policy two signatures are needed on any payment. Titles of authorized first signatories for payment and release and fund replenishment are: 1 Finance Manager 2 Chief of Operations
34. Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	Fund transferred to a bank account opened at Commercial Bank in the name of UNICEF
35. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	The account holds fund from GAVI as well as other sources
36. Within the HSS programme, are funds planned to be transferred from central to decentralised levels (provinces, districts etc.)? **If YES**, please describe how fund transfers will be executed and controlled.	No. Funds will then be transferred to implementing partner's account for the programme activities based on financial and technical approvals
Procurement	
37. What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other	UNICEF Supply Division Copenhagen Supply Manual will be used for the Gavi HSS Programme whereby UNICEF procurement policies and procedures will be applied.

Development Partners' procurement procedures)	
38. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	All items will be procured through UNICEF
39. What is the staffing arrangement of the organisation in procurement?	UNICEF's own procurement staff. The supply and procurement section has staffs dedicated for Procurement Services both offshore and local
40. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES, there are procedure in place for physical inspection and quality control. All orders are subject to production monitoring and/or pre-delivery inspection For offshore procurement the quality assurance is handled by Supply Division Copenhagen , for locally procurement inspection and quality control is done through a local independent inspection company
41. Is there a functioning complaint mechanism? Please provide a brief description.	Yes. A complaint management system that clearly describes the actions to be taken by all responsible parties in order to ensure the proper receipt, recording, review, follow up, closing, reporting and analysis of complaints received
42. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	Yes. Every contract, be they for goods, work or services, contains clauses for dispute resolution / Amicable Settlement and arbitration if not resolved.
Accounting and financial reporting (incl. fixed asset management)	
43. What is the staffing arrangement of the organisation in accounting, and reporting?	UNICEF has Finance Section and Administration Section for accounting and reporting the financial information including fixed asset management.
44. What accounting system is used or will be used for the Gavi HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?)	SAP software is used for accounting and reporting which is a comprehensive solution for accounting, reporting, grant management, human resources management, supply and procurement management and other business purposes.
45. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Quarterly and annual financial reports are common for the implementing entity.
Internal control and internal audit	
46. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	Yes
47. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	Yes. UNICEF has Office of Internal Audit and Investigation (OIAI) based at New York Head Quarters. OIAI conducts audit of all Country Offices and Head Quarters on a regular basis based on the size of the country office. UNICEF Bangladesh is audited in every two years.
48. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	Yes
External audit	

49. Are the annual financial statements planned to be audited by a private external audit firm or a GOB audit institution (e.g. Auditor General)?[5]	UNICEF's financial statements are audited by Government Board of auditors regularly.
50. Who is responsible for the implementation of audit recommendations?	UNICEF Country Representative is responsible for ensuring the implementation and closure of audit recommendations for the country office.

MOHFW	
51. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	Mr. Md. Nazrul Islam Additional Secretary (Financial Management and Audit) MOHFW
52. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
53. **If YES** • Please state the name of the grant, years and grant amount. • **For completed or closed Grants of Gavi and other Development Partners:** Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. • **For on-going Grants of Gavi and other Development Partners:** Please provide a brief description of any financial management (FM) and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	For Gavi grants, please see the following link: http://www.gavi.org/country/bangladesh/ Also useful would be the report of Internal Appraisal conducted by Gavi (Senior Country Manager) from 28 to 30 October, 2014 (attachment 35)
Oversight, Planning and Budgeting	
54. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	The Local Consultative Group (LCG) Health, which meets quarterly. It is chaired by the Secretary, MOHFW, and includes members from relevant ministries, departments and development partners. The detailed membership can be seen in the attached TOR.
55. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	Joint-Chief of Planning, MOHFW
56. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	It is the GOB's regular process of planning and budgeting. The Planning Wing of MOHFW, headed by the Joint-Chief is responsible for the planning and budgeting process. The Annual Work Plan and Budget are approved by the Secretary, MOHFW, after endorsement by the Program Implementation Committee (PIC), headed by the Joint Chief, Planning.
57. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES

Budget Execution (incl. treasury management and funds flow)	
58. What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	Upon receiving the fund from Gavi alliance, the fund is deposited to a foreign currency account with the Sonali bank, Local Branch, opened for Gavi–HSS run by joint signatures of Joint Chief, MOHFW and Line Director, MOHFW. This fund is then transferred to a local currency account of Gavi–HSS (run by joint signature of Joint Chief, MOHFW and Line Director, MNACH with the approval from secretary, MOHFW. Finally, the Fund is transferred from local currency account to the designated account (opened for Gavi-HSS activities) of the concerned Line Directors. The fund is transferred through Account Payee Cheque with the Joint Signature of Joint Chief (MOHFW) and Line Director, MNCAH. For activities supported by UNICEF or WHO, funds will flow from MDTF (or from Gavi HQ) directly to the UN agency, on instructions from MOHFW – for each such transfer
59. Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	Yes, as described above, the funds will be transferred from the Foreign Exchange Account to the MOHFW consolidated account, both maintained at the Central Bank of the country (The Bangladesh Bank).
60. Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	The MDTF account managed by the World Bank holds other DPs' contributions to the Pooled Fund as well. The MOHFW consolidated account holds Government's own funds as well as funds received from the Development Partners.
61. Within the HSS programme, are funds planned to be transferred from central to decentralised levels (provinces, districts etc.)? **If YES**, please describe how fund transfers will be executed and controlled.	YES. These fund-flows will follow standard Government procedures and regular Government channels as for Government's own funds. .
Procurement	
62. What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	National procurement system as per procedures laid out for the HPNSDP
63. Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Yes
64. What is the staffing arrangement of the organisation in procurement?	Procurement process is initiated by a designated officer assigned for Gavi-HSS and ends up with the Secretary, MoHFW through Deputy Chief and Joint Chief following GOB's Public Procurement Regulations.
65. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES
66. Is there a functioning complaint mechanism? Please provide a brief description.	YES. Under the Public Procurement Act (2006), and the Public Procurement Regulations (2008) there is complaint mechanism. Any aggrieved party can file their complaint either to Central Procurement Technical Unit (Ministry of Planning) or

	to the Secretary, MOHFW (as the head of the procuring entity). Complaints may also be forwarded to the World Bank, as the manager of the Pooled Fund.
67. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES. The contract document always contains provisions for dispute resolution and redress. The Central Procurement Technical Unit has a Jury Board to adjudicate disputes and deliver a binding verdict. If this mechanism does not resolve the dispute satisfactorily, a court of law can be approached.
Accounting and financial reporting (incl. fixed asset management)	
68. What is the staffing arrangement of the organisation in accounting, and reporting?	There is a Financial Management and Audit Unit (FMAU) in the MOHFW, which is responsible for all accounting and reporting related to the Ministry's expenditures.
69. What accounting system is used or will be used for the Gavi HSS Programme? (i.e. Is it a specific accounting software or a manual accounting system?)	The same accounting system as being used for the Pooled Funds under the sector program, HPNSDP
70. How often does the implementing entity produce interim financial reports and to whom are those submitted?	Annual Performance Report to Gavi HQ yearly, quarterly financial report to FMAU, Chief Accounts Office,
Internal control and internal audit	
71. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES
72. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	YES. There are internal audit units in MOHFW The internal audit unit in MOHFW is called FMAU, headed by a Joint-Secretary. In DGHS and DGFP, the units are headed by Directors.
73. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES
External audit	
74. Are the annual financial statements planned to be audited by a private external audit firm or a GOB audit institution (e.g. Auditor General)?[6]	YES (by the Auditor-General)
75. Who is responsible for the implementation of audit recommendations?	Secretary, MOHFW

THREE PAGES MAXIMUM
Question (c): Please indicate the main constraints in the (health sector's) financial management system. Does the country plan to address these constraints/ issues? If so, please describe the Technical Assistance needs in order to fulfil the above functions
WHO
In the financial area, WHO has a stringent system of scrutiny for release of funds to programme activities. WHO

[6] If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.

also takes note that the counterparts in the Government are aware of WHO's strict financial requirements and follow all the requirement. The health sector's financial management system in WHO experience has been acceptable as far as WHO funds are concerned as we have good checks and balances.

UNICEF

One of the challenges in health sector financial management system is disbursement of fund and collecting the information from filed locations. As the Annual Work Plan is signed at the Ministry level and money is transferred at the central level, it takes time for the money to reach to field. And after the implementation, it also takes more time to receive data by the Ministry for reporting purpose.

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