Bangladesh Health, Nutrition and Population Sector Programme (HNPSP)

ANNUAL PROGRAMME REVIEW (APR)

VOLUME I

Main Consolidated Report

Key Findings, Conclusions and Recommendations

By the Independent Review Team (IRT)

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Abbreviations and Acronyms

ABCN	Area Based Community Nutrition
ACPR	Associates for Community and Population Research
ADB	Asian Development Bank
ADP	Annual Development Programme
AG	Auditor General
AHUB	Ayurvedic, Homeopathy and Unani Board
AIDS	Acquired Immune Deficiency Syndrome
AM	Aide Memoire
ANC	Ante Natal Care
APR	Annual Programme Review
APIR	Annual Programme Implementation Report
ARI	Acute Respiratory Infection
ASCON	Annual Scientific Conference
BBS	Bangladesh Bureau of Statistics
BCC	Behaviour, Change and Communication
BCS	Bangladesh Civil Service
BDHS	Bangladesh Demographic and Health Survey
BEC	Bid Evaluation Committee
BHFS	Bangladesh Health Facility Survey
BINP	Bangladesh Integrated Nutrition Project
BMA	Bangladesh Medical Association
BMC	Budget Management Committee
BMDC	Bangladesh Medical and Dental Council
BMI	Body Mass Index
BMMS	Bangladesh Maternal Mortality Survey
BNHA	Bangladesh National Health Accounts 1999-2001
BNC	Bangladesh Nursing Council
BPC	Bangladesh Pharmacy Council
BRAC	Bangladesh Rural Advancement Committee
C&AG / CAG	Comptroller & Auditor General
CAO	Chief Accounts Officer
CB	Capacity Building
CBO	Community Based Organisation
CC	Community Clinic / Coordination Committee
CCGP	Cabinet Committee for Government Purchase
CCR	Citizens' Charter of Rights
CD	Communicable Diseases
CDC	Communicable Disease Control
CDD	Control of Diarrhoeal Diseases
CGA	Controller General of Accounts
CHT	Chittagong Hill Tracks
CIA	Chief Internal Auditor
CIDA	Canadian International Development Agency
CMA	Common Management Arrangements
CMMU	Construction Management and Maintenance Unit
CMSD	Central Medical Stores Depot
CNC	Community Nutrition Centre
CNO	Community Nutrition Organiser/Officer

CNP	Community Nutrition Promoter
CPR	Contraceptive Prevalence Rate
CPTU	Central Procurement Technical Unit
CSBA	Community Skilled Birth Attendants
CSO	Central Statistical Office
DAO	District Accounts Officer
DART	Decentralised, Action-Oriented, Responsive to needs and Transparent
DC	District Commissioner
DCA	Divisional Controller of Accounts
DDO	Drawing and Disbursement Officer
DDS	Drugs and Dietary Supplements
DELIVER	USAID project for strengthening health and family planning supply chains
DEMEW	District Electro-Medical Equipment Maintenance Workshop
DFID	Department for International Development (UK)
DG	Director General
DGFP	Directorate General of Family Planning
DGHS	Directorate General Health Services
DH	District Hospital
DHS	District Health Services
DMCH	Dhaka Medical College Hospital
DMIS	Data Management Information System
DNA	Deoxyribonucleic Acid
DNS	Directorate of Nursing Services
DOTS	Directly Observed Treatment Short Course (TB)
DP	Development Partner
DPA	Direct Project Aid
DPM	Deputy Project/Programme Manager
DS	Deputy Secretary
DSF	Demand Side Financing
DSP	Diversification of Service Provision
EC / EU	European Commission / European Union
ECNEC	Executive Committee of the National Economic Council
ED	Executive Directorate
EmOC / EOC	Emergency Obstetric Care (basic and comprehensive)
EoI	Expression of Interest
EPI	Expanded Programme for Immunisation
ESP / ESD	Essential Service Package / Delivery
FAPAD	Foreign Aided Projects Audit Directorate
FPAB	Family Planning Association of Bangladesh
FES	Facilities Efficiency Study
FGD	Focus Group Discussions
FM	Financial Management
FMAU	Financial Management Accounting / Audit Unit
FMR	Financial Monitoring Reports
FMRP	Financial Management Reforms Programme / Project
FAO	Food and Agricultural Organisation
FP	Family Planning
FSW	Female Sex Worker
FWA	Family Welfare Assistant (community level)
FWC	Family Welfare Centre

FWV	Family Welfare Visitor
FY	Fiscal Year
GAC	Gender Advisory Committee
GAO	General Accounting Office
GAVI	Global Alliance for Vaccines and Immunisation
GES	Gender Equity Strategy
GEV	Gender, Equity and Voice
GFATM	Global Fund for AIDS, TB and Malaria
GIO	Gender Issues Office
GIS	Geographical Information System
GMP	Growth Monitoring and Promotion
GR	Growth Rate
GOB	Government of Bangladesh
GTZ	Gesellschaft für Technische Zusammenarbeit (Germany)
HA	Health Assistant / Assistance (community level)
HAC	Health Advisory Committee
H&A	Harmonisation and Alignment
HAPP	HIV/AIDS Prevention Project
HCWMP	Health Care Waste Management Plan
HDI	Human Development Index
HDS	Health and Demographic Survey
HDSS	Helath and Demographic Surveillance
HEP	Health Education and Promotion|
HEU	Health Economics Unit
HF	Health Facility
HFRG	Health Financing Resource Group`
HFWC	Health and Family Welfare Centre
HH	House Hold
HIES	Household Income and Expenditure Survey
HIS	Health Information Systems
HISP	
HIV	Human Immuno-deficiency Virus
HKI	Helen Keller International
HMIS	Health Management Information Systems
HMN	Health Metrics Network
HNP	Health Nutrition and Population (sector / forum)
HNPCC	Health Nutrition and Population Coordination Committee
HNPRF	Health Nutrition and Population Results Framework
HNPSP	Health Nutrition and Population Sector Programme
HNPSP CC	Health Nutrition and Population Sector Programme Coordinating Committee
HPI	Human Poverty Index
HPSP	Health and Population Sector Programme
HQ	Headquarters
HR	Human Resources
HRD	Human Resource Development
HRH	Human Resources for Health
HRM	Human Resources Management
HRMIS	Human Resources Management Information System
HRS	Human Resources Strategy
HS	Health Service
HSUF	Health Service Users Forum

HCWM	Health Care Waste Management
IBAS	Integrated Budgeting and Accounting System
ICB	International Competitive Bidding
ICDDR,B	International Centre for Diarrhoeal Research, Bangladesh
ICR	Implementation Completion Report
ICT	Information Communication Technology
IDA	Iron-deficiency Anaemia
IDD	Iodine-deficiency Disorder
IDU	Intravenous Drug User
IEC	Information, Education and Communication
IEDCR	Institute of Epidemiology and Disease Control & Research
IFA	Iron-Folic Acid
IFB	Invitation For Bids
IFMIS	Integrated Financial Management Information System
IFM	Improved Financial Management
IMCI	Integrated Management of Childhood Illness
IMED	Implementation, Monitoring and Evaluation Division
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IPHN	Institute of Public Health Nutrition
IPM	Individual Performance Management
IRT	Independent Review Team
IT	Information Technology
IUD / IUCD	Intra Uterine (Contraceptive) Device
JC	Joint Chief
JCP	Joint Chief Planning
JICA	Japan International Cooperation Agency
JS	Joint Secretary
JSI	John Snow International
KfW	Kredietanstalt Fur Wiederafbau (Germany)
LAN	Local Area Network
LBW	Low Birth Weight
LC	Letter of Credit
LD	Line Director
LF	Logical Framework
LFA	Logical Framework Approach
LMIS	Logistics Management Information System
LLP	Local Level Planning
LQ	Lowest Quintile
LSCS	Lower Segment Caesarean Section
LT	Long Term
MACS	Management Accounting Consolidation System
MATT2	Management at the top
MCH	Maternal and Child Health
MCPR	Modern (methods) Contraceptive Prevalence Rate
MCRHSD	Maternal, Child and Reproductive Health Service Delivery
MCWC	Maternal and Child Welfare Centre
MDA	Mass Drug Administration

MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
M&E TG	Monitoring and Evaluation Task Group
MEU	Monitoring and Evaluation Unit
MH	Maternal Health
MIS	Management Information System
MM	Maternal Mortality
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal and Neonatal Health
MO	Medical Officer
MOE	Ministry of Establishment
MOF	Ministry of Finance
MOFDM	Ministry of Food and Disaster Management
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MOWCA	Ministry of Women and Children Affairs
MOU	Memorandum of Understanding
MP	Member of Parliament
MSA	Management Support Agency
MSM	Men having Sex with Men
MSR	Medical and Surgical Requirements
MSW	Male Sex Workers
MTBF	Medium Term Budgeting Framework
MTR	Mid-Term Review
MUAC	Mid Upper Arm Circumference
NASP	National AIDS / STD Programme
NCAR	National Council for Administrative Reform
NCB	National Competitive Bidding
NCD	Non-Communicable Diseases
NEMEW	National Electro-Medical Equipment Maintenance Workshop
NFDPL	National Forensic DNA Profiling Laboratory
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NHUF	National Health Users Forum
NID	National Immunisation Days
NIPORT	National Institute of Population Research & Training
NIPSOM	National Institute of Preventive and Social Medicine
NMR	Neonatal Mortality Rate
NNP	National Nutrition Project / Programme
NSAPR	National Strategy for Accelerated Poverty Reduction
NTCP	National Tuberculosis Control Programme
O&M	Operations and Maintenance
OBGSB	Obstetric and Gynaecological Society of Bangladesh
OCC	One-stop Crisis Centre
OED	Operations and Evaluation Department (WB)
OP	Operational Plan
OPD	Outpatient Department
OPM	Oxford Policy Management
ORS	Oral Re-hydration Solution
ORT	Oral Rehydration Therapy

PA	Project Aid
PA	Performance Assessment
PAD	Project Appraisal Document
PBF	Performance Based Financing
PCB	Pharmacy Council of Bangladesh
PD	Policy Dialogue
PDS	Personal Data Sheets
PER	Public Expenditure Review
PFM	Public Financial Management
PH	Public Health
PHC	Primary Health Care
PIP	Programme Implementation Plan
PIU	Programme/Project Implementation Unit
PLAGE 2	Policy Leadership for Advocacy Gender and Equity
PLMC	Procurement and Logistic Monitoring Cell
PLTM	Permanent and Long-Term Measures
PMA	Performance Management Agency
PM	Prime Minister
PMIS	Personnel Management Information System
PMR	Programme Monitoring Reports
PMU	Programme Management Unit
PMO	Prime Minister's Office
PNC	Post Natal Care
PPFT	Project Preparation and Facilitation Team
PPR	Public Procurement Regulations
PRS	Poverty Reduction Strategy
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
PSO	Programme Support Office
PWD	People with Disabilities
PWD	Public Works Department
QA / QC	Quality Assurance / Quality Control
RFW	Results Framework
RH	Reproductive Health
RNE	Royal Netherlands Embassy
RPA	Reimbursable Programme Aid
RPIP	Revised Programme Implementation Plan
SACMO	Sub-Assistant Community Medical Officer
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SBTP	Safe Blood Transfusion Programme
SC	Steering Committee / Stakeholders Consultation
SCM	Supply Chain Management
SCR	Stakeholder Consultation Report (by external agency)
SD	Service Delivery
Sida	Swedish International Development Cooperation Agency
SIP	Strategic Investment Plan (2003 – 2010)
SMF	State Medical Faculty
SOE	Statement of Expenditure

SOP	Standard Operating Procedures
SPEMP	Strengthening Public Expenditure Management Programme
SS	Support Systems
ST	Short Term
STD	Sexually Transmitted Disease
SW	Sex Worker
SWAp	Sector-Wide Approach
SWPM	Sector Wide Programme Management
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant (trained and untrained)
TEC	Technical Evaluation Committee
TFR	Total Fertility Rate
TG	Task Group
THE	Total Health Expenditure
THNPP / THP	Tribal HNP Plan / Tribal Health Plan
TIB	Transparency International Bangladesh
Tk	Taka
TL	Team Leader
TOR	Terms of Reference
TWG	Technical Working Group
UAO	Upazila Accounts Office
U5MR	Under Five Mortality Rate
UESDS	Utilisation of Essential Service Delivery Survey (NIPORT)
UFPA	Upazila Family Planning Assistant
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UHDP	Urban Health Development Plan
UHFWC	Union Health and Family Welfare Complex
UHS	Upazila Health System (equivalent to WHO District Health System)
UHFPO	Upazila Health and Family Planning Officer
UHMC	Upazila Health Management Committee
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UP	Upazila Parishad
UPHCP	Urban Primary Health Care Project
USAID	United States Agency for International Development
UZ	Upazila
VAW	Violence Against Women
VAD	Vitamin A Deficiency
VGD	Vulnerable Group Development
WB	World Bank
WID	Women in Development
WHO	World Health Organisation

1 USD = 70 Thaka.

HNPSP Sector Performance Indicators 2004 - 2010

BANGLADESH HEALTH SECTOR 2004 – 2010.

	HNPSP Baseline		MTR 2008	HNPSP APR 2009	PAD	MDG
	2004	2006	2007	2008	2010	2015
				Target	Target	Target
DEMOGRAPHIC						
Total population (million)	**137m** [m]	**141m** [e]	**143m** [e]	**145m** [e]		
Women of reproductive age (15-49 yrs) (%)	**52** [m]					
Life expectancy at birth (male/female)	**64 / 65** [m]	**65 / 68** [e]	**65 / 68** [e]	**67 / 70** [e]		
Annual growth rate (%)	**1.4** [m]		**1.9** [s]			
SOCIO ECONOMIC						
Per capita GDP (USD, 1995/6 constant/current price)		**306** [g]	**312** [g]	**329** [g]		
		447	**487**	**554**		
Literacy rate male / female						
Impact Indicators						
Infant mortality rate*	**65** [a]		**52** [a]	*42*	*37*	*31*
U5 mortality rate*	**88** [a]		**65** [a]	*NS*	*52*	*48*
Neonatal mortality*	**41** [a]		**37** [a]	*NS*	*30*	*20*
% Children U5 (24-59m) stunted*[1]	**48.4** [a]		**42.3** [a]	*NS*	*30*	*25*
% Children U5 (6-59m) stunted*[1,2]	**46.5** [a]		**38.5** [a]	*NA*	*NA*	*NA*
% Children U5 (0-59m) underweight*[1]	**47.5** [a]		**46.3** [a]	*38*	*34*	*33*
% Children U5 (6-59m) underweight*[1]	**51.7** [a]		**49.7** [a]	*38*	*34*	*33*
Maternal mortality ratio (per 100,000 live births)*	**320** [o]		**NA**	*256*	*240*	*147*
% ever married women under 50 with low BMI	**34.3** [a]		**29.7** [a]	*NA*	*NA*	*NA*
Total fertility rate*	**3.0** [a]		**2.7** [a]	*2.5*	*2.2*	*2.2*
Prevalence of HIV among pregnant women (15-24 yrs)	**<1**		**<0.5**	*NA*	*NA*	*NA*
Outcome indicators						
Utilisation rate of ESD (%)	**55** [b]	**NA**	**NA**	*75*	**NA**	*80*	*NA*
TB cure rate (%)*	**85** [d]		**92** [d]	*NS*	**93** [d]	*85*	*NA*
Contraceptive prevalence rate (modern methods)*	**47** [a]	**49** [b]	**48** [a]	*NS*	**50** [b]	*70*	*NA*
% women on long lasting birth control methods*	**7** [a]	**7** [b]	**7** [a]	*NS*	**7** [b]	*9.3*	*NA*
% children (9-59 months) receiving vitamin A capsules*	**82** [a]	**85** [b]	**88** [a]	*90*	**88** [b]	*> 90*	*NS*
% babies exclusively breast fed for 6 months	**42** [a]		**43** [a]	*NS*		*NS*	*NA*
% children (12-23 months) fully imunized	**73** [a]	**76** [b]	**82** [a]	*NS*	**83** [b]		
% children (12-23 months) received DPT3 vacc.	**81** [a]	**87** [b]	**91** [a]	*90*	**91** [b]	*95*	
% children (12-23 months) received Measles vaccine*	**76** [a]		**83** [a]	*NS*		*> 80*	
% pregnant women who had at least one ANC visit from a medically trained provider by 2 lowest quintiles	**48.8** [a] LQ: 24.9 SQ: 38.2	**46.3** [b] LQ: 23.4 SQ: 37.7	**51.7** [a] LQ: 30.8 SQ: 36.3		**51.3** [b] LQ: 30.9 SQ: 40.7		
% births attended by skilled health worker by 2 lowest quintiles (%)*	**13.5** [a] LQ: 3.4 SQ: 4.3	**17.9** [b] LQ: 5.2 SQ: 10.1	**18.0** [a] LQ: 4.8 SQ: 6.7	*34*	**21.4** [b] LQ: 5.1 SQ: 11.1	*43*	*50*
% pregnant women receiving IPT for malaria							
% children under five using bed nets*	**< 15**				**40** [k]	*80*	
Malaria case fatality rate - children <5/ 1000 adm.							
Hospital malaria case fatality rate /1000 admissions							
% population without sustainable access to improved water							
% population without access to imrpoved sanitation							
Output indicators							
TB case detection rate (%)	**46** [d]	**71** [d]	**72** [d]	**-**	**73** [d]	*70*	**-**
DOTTS coverage (%)	**99** [d]	**99** [d]	**100** [d]		**100** [d]		
Leprosy case detection rate (%)	**61** [q]	**71** [q]	**72** [q]		**72.5** [q]		
Caesarean section rate (%)	**3.5** [a]		**7.5** [a]				
% health facilities thata provide quality services according to National Standard[3]							
% health facilities with functional ComEOC/Basic EOC							
% hospitals achieving and maintaining 3-5 star rating under IHMS accreditation scheme							
Bed occupancy rate in Upazilla Health complex (%)	**79** [n]	**73** [n]	**73** [n]				
Bed occupancy rate in District Hospitals (%)							
Average length of stay in District Hospital							
# of women reporting violence to health facilities (rape and other violence)							

	HNPSP Baseline		MTR 2008	HNPSP APR 2009		PAD	MDG
	2004	2006	2007	2008		2010	2015
				Target		Target	Target
Process indicators							
% drugs in stock (UPC / District Hospital)							
% district Hospitals with all Tracer Drugs available							
% Upazila Health Systems with annual Health Bulletin							
Input indicators							
% districts with Disease Surveillance Reports*			**47** [r]	*50*	**85**	*80*	
% share of total GOB budget allocated to MOHFW budget*	**6.5**	**6.7**	**7.0**	*10*	**6.5**	*10*	
% total MOHFW expenditure allocated to the 25% poorest districts*	**NS**	**12** [pr]	**15** [pr]	*NS*		*40*	
Expenditure as % of original budget: revenu and development budget		**rev: 92** **dev: 41**	**rev: 103** **dev: 63**		**rev: 90** **dev: 61**		
Per capita annual GOB expenditure on health (Taka pc, constant 1995/96 prices, adjusted by GDP deflator)		**129** [p]					
Per capita annual DP expenditure on health (Taka pc, constant 1995/96 prices, adjusted by GDP deflator)		**38** [p]					
Per capita GOB and DP budget for health (USD)		**168** [p]					
Out-of-pocket expenditure on health (%)							
% Upazila and below level share in total health expenditure	**46** [pr]	**45** [pr]	**52** [pr]	*50*		*>50*	
Per capita public health spending of poorest districts as % of average district p.c. spending			**0.9**	*110*			
MOHFW expenditure on medical and surgical requisites (constant 2005/6 prices, Taka/pp)							
% audit objections settled within last 12 months							
Proportion of contracts awarded within initial bid validity period*	**92**	**80(DGHS)** **5(DGFP)**	**90(DGHS)** **55 (DGFP)**		***NA (DGHS)*** ***100 (DGFP)***	*> 95%* *in 2006*	
Average number of days between reception indent and reception goods for ICB/NCB procurement (CMSD)							

Notes

Selection of indicators is based on HNPSP Results Framework with additional indicators regarded useful for sector monitoring although data are not available for all; the list is by no means exhaustive.

a Bangladesh Demographic Health Survey (BDHS)
b UESD
c UNAIDS (2006) Report on the global AIDS epidemic. Geneva.
d National Tuberculosis Program (NTP); DOTS coverage % 2004 is from 2005
e Data per 1st of July SVRS Report; Statisical Pocket Book Bangladesh 2008. Bangladesh Bureau of Statistics
g Statisical Pocket Book Bangladesh 2008. Bangladesh Bureau of Statistics
h Voice of MIS-Health Neswletter - Issue 5, February 2009
i News Letter Communicable Diseases, Dec 2008 Source MIS report
k National Malaria Plan
m SVRS 2004
n Health Bulletin 2008, calculated rates from table page 25
o BMMS
p data refer to financial year (FY) that ends July of same year; source not traced
q National Leprosy Control Programme (NLCP); figure for 2004 is from 2005
r APIR 2009, source not stated
s Population Reference Bureau
Remark: figures without a marker are figures for which the original source could not be traced but appeared in reports
Blanks show no data available

* Included in PAD and HNPSP Results Framework 2009 (30 indicators), except for bednets indicator (in PAD, not in current RFW)
1 For nutrition indices WHO has adopted the WHO Child Growth Standards as new reference population in 2006. BDHS 2007 reflects this.
For reasons of comparison all nutrition indicators in the table are based on the previous NCHS/CDC/WHO International Reference Population.
Annex D in BDHS 2007 provides the data for them. BDHS total figures were re-calculated for specific ages in months.
Because different indicators have been used in the PAD and RFW, underweight indicators for both age groups are provided in the table (0-59 months and 6-59 months)
All BDHS data on nutrition for U5 children can be found in Annex 5 of Volume I
2 Indicator is included for comparison with underweight indicator
3 To be measured through implementation of performance assessment/ quality assurance program; per type of service or for all services

NA Not Applicable
NS Not Stated

Note: A detailed comparison of various Nutrition indicators is available in Annex 5.

The health care pyramid: levels of care with facilities

Table Workload at OPD by type of facilities at the various administrative levels (April 2009)

Administrative division	Average population	Type of facility	Number of facilities functional	Average out-patients / month (% female)	Remarks
Divisions: 6 (excl. Dhaka city)	25 million	Tertiary and teaching hospitals			
Districts: 64 (DGHS)	2.3 million	District hospital	60	8,855 (39%)	not in Dhaka; 100-300 beds (average 147 beds)
Districts: 64 (DGFP)	2.3 million	Mother & Child Welfare Centre (MCWC)	97		obstetric care + clinical contraception; (average 14 beds)
Upazilas 481 (DGHS)	270,000	Upazila Health Complex (UHC)	413	4,597 (64%)	30-50 beds (average 40)
Upazila 481 (DGFP)	270.000	Mother and Child Welfare Centre	74 Unclear		0-26 beds (average 15)
Union: 4,403	25,000	health and family welfare centre ("upgraded" if with medical officer)	1,300 (est.)	661 (61%); 704 if upgraded	No beds; 128 not contracted out to NGOs through MSA
Wards (DGHS) (roughly 20,000) Wards (DGFP) (roughly 20,000)	6,000*	Community Clinic (Health Assistant) Community Clinic (FW Assistant)	10,775 (or: 8,000?) approx. 23,000	1,052* (48%) 1.052* (48%)	378 not contracted out (MSA)

* sampled together (both services are provided in the same facility).
Source: Tulane & ACPR, Bangladesh Health Facility Survey, April 2009; various other sources
Note: Some of the available figures are conflicting; MOHFW is requested to update the information provided here before the next APR.

Executive Summary

The Health Nutrition, Population Sector Programme (HNPSP 2003-2010) still has one year before it will be formally closed (June 2010). Various mechanisms have been put in place to monitor its progress, one being the Annual Programme Review (APR) by an Independent Review Team (IRT). This year, the APR 2009 took place in April-May 2009, at a special moment in time, as the elections of December 2008 had brought victory to the Awami League and a new team in the Ministry of Health and Family Welfare (MOHFW) had just taken office. The IRT was thus confronted with a special challenge to review the achievements and constraints of HNPSP implementation over the last 1-2 years, while at the same time being informed about plans and aspirations of the new management in MOHFW. These plans are still on the drawing board, with little detail or reflection how the aspirations can be turned into reality.

This IRT report is a reflection of this situation. It includes both a lot of detailed information about what has been achieved and where weaknesses can still be found, but also presents some suggestions on how the policies of the new Government might be taken forward.

1. Mixed results
In general our observations show mixed results, as highlighted below:

1. Vertical programmes under HNPSP have continued to record good progress, reflected in improved coverage, with reduced gaps between rich and poor, and continued progress in health outcomes – lower child mortality, reduction of some communicable diseases, continued reduction in chronic malnutrition (stunting) and some improvements in maternity services from a low base. Overall contraceptive prevalence has not improved.

2. Little progress has been made in improving utilisation of public sector health services, especially by the poorest segments. Major problems affecting utilisation are lack of sufficient drugs, staff shortages (especially in remote facilities), poor prioritisation of spending, and pervasive problems of management and coordination. MOHFW has not yet tackled the internal reforms to address these problems, nor has it exploited the potential to improve the contribution of non-public sector service providers. These issues now need to be given higher priority, because Bangladesh has already achieved most of the reduction in mortality that can be achieved through vertical programmes; future progress will increasingly depend on more complex interventions requiring a more efficient, effective and equitable health system, able to respond to diverse and unpredictable needs.

2. Dialogue
Based on these findings, we advise the Development Partners (DPs) to agree with an extension of HNPSP to June 2011.This is not costless, because donors with a fixed annual budget will have re-allocated unspent HNPSP funds to other purposes.

A withdrawal at this moment in time would result in an abrupt cut in public health spending, and would be against the harmonisation and alignment agenda, to which all the Pooled Donors have subscribed. The IRT also argues that an extension is essential to give enough time for preparing a follow-on programme and for putting in place the external financing that it will require. Despite the frustrations of lack of progress in some areas, IRT believes a further phase of support is both needed and merited, given the significant progress that has been achieved in other areas.
Some examples are provided in the box below:

Despite the major political changes that have taken place in Bangladesh in the last years, the Government has been able to sustain its level of service provision, continuing its delivery of HNPSP-related programmes to all the people in the country. The MOHFW, being just three months in office, is actively engaged in formulating its new policy directives and priorities;
For the medium-term, the recently approved decentralisation policy is likely to yield important benefits for the delivery of (delegated) care at district and Upazila levels; a scheme for delegation of financial authority has already been agreed and needs to be implemented; a midwifery strategy is in place and the recruitment of Family Welfare Visitors has started again, as suggested by the MTR 2008;
The IRT feels that important changes are possible and that Government can get close to achieving its MDGs, IF the current momentum can be supported and the DPs are willing to continue to provide their active and unconditional support, financially and technically.

Regarding the future of HNPSP, the IRT therefore suggests to improve dialogue among MOHFW **and** the DPs as follows:

The various stakeholders in HNPSP need to strengthen the processes and mechanisms for dialogue and embark upon a more policy-oriented and supportive discussion about important issues that need to be addressed in the remaining two years of HNPSP, being:

1. The elaboration of the new Health Policy and Strategy for the coming 5-10 years, including (i) decentralised planning and budgeting, (ii) setting of local priorities in consultation with local communities and the (iii) development of an Upazila Health System, managed by Upazila Health Management Committees (UHMC);
2. The challenge to mainstream Nutrition and Population related activities in the overall work of the health facilities at the various levels;
3. The challenge to strengthen and expand the various support systems (human resources, procurement, PFM and M&E), as suggested in this report;
4. Addressing the problem of poor efficiency in the provision of health care in the country through a revision of the internal organisation of the MOHFW;
5. Ensure predictability of resources, both from MOHFW and from the DPs

3. The APR process

Compared with the MTR 2008, this year APR showed some notable progress:

- Debriefings were no longer separate, but brought MOHFW senior management and DPs together for the first time;
- Many more Line Directors participated in the various formal debriefing meetings. Discussions were more open and of a technical nature. Civil society and research institutions participated in many of the debriefing sessions;
- Programme managers from DGHS and DGFP sat together and agreed on the need for more integrated services at the Upazila level and below;
- The linkage of Task Groups with the recommendations of the IRT allowed for better coordination of activities among the various Line Directors (LDs), resulting in more comprehensive Action Plans for next year. However, their use in the revision of Operational Plans under the responsibility of the various LDs and Joint Secretaries still needs to be improved. This can only be done, IF the monitoring by the APR is harmonised with the Planning and Budgeting cycle of the Government. The IRT therefore suggests that the next APR (in 2010) be undertaken in September – October 2010, as the financial implications of its recommendations can then be included in the next OP budgets.

4. New aspirations

The IRT found the aspirations of the government, relating to the expansion of primary care facilities at the community level, full of potential, IF they are embedded in a Primary Health Care System that takes the existing structures of the MOHFW as the starting point. For Bangladesh, this would mean the development of an Upazila Health System (UHS). The IRT believe this is necessary because of severe limitations on what could be achieved by expanding the current mode of service delivery. A possible approach to implementing and financing the UHS is therefore discussed in some detail in section 2.8, 'Revival of PHC in Bangladesh'. Some suggested characteristics are summarised below:

Prerequisites for an integrated Upazila Health System are:

1. A management committee composed of all those responsible for the provision of the services and those responsible for the support needed by finance, monitoring, maintenance and other services at that level;
2. This committee is tasked to make annual plans with annual budgets and has the mandate to set their own priorities within the limits set by national policy. They are asked to wisely use the resources at their disposal according to the targets set by themselves in their annual plans;
3. The committee is also tasked to implement their own plans and report quarterly or annually to the higher levels of authority on progress and constraints they have been facing in reaching their stated targets with the resources (personnel, equipment and money) put at their disposal;
4. Update the Essential Services Package for Upazila level and below, e.g. maternal health, nutrition, family planning and treatment of common diseases;
5. Establish linkages with the community including community health committees that take responsibility for developing and sustaining community ownership and active participation in health;
6. Define and agree on management responsibilities to provide oversight and coordination between district, upazila, union and community levels.

5. Overarching issues

Finally, the IRT felt that four issues needed to be highlighted in this Executive Summary, as they are of an 'overarching importance' to the country (and not only to the HNPSP). They are shortly summarised below, as the reader will find the details and the arguments in the various sections of this report (between brackets).

5.1. Nutrition (section 2.9)

Nutrition indicators have improved over a 20 year period, but not fast enough to reach acceptable levels or the targets set by the MDGs. The indicator used for the MDG (underweight for age), shows that moderate malnutrition among children aged 6-59 months has come down from 66% in 1990 to about 50% in 2007. The slow down in the rate of reduction in the MDG indicator reflects a combination of continued improvement in chronic malnutrition (stunting), down from 48% in 2004 to 42% in 2007, but still far away from the MDG target (33%)[1], offset by some indication of an increase in acute malnutrition (wasting) among under fives, which has increased from 10% in 2000 to 15% in 2004 and 17% recorded in 2007. About 30% of women are under-weight, down from 34% in 2004, and many suffer from anaemia. Research shows that these features are difficult to address, as they are passed on from generation to generation. Reducing malnutrition therefore remains a huge and long-term challenge for the nation.

Nutritional status in a country responds to many factors outside the direct influence of MOHFW (living standards, food security, education, gender relations etc). The health sector has been able to contribute its share to these slowly improving indicators through good coverage in Vitamin A and micronutrients distribution, wide-spread use of Oral Rehydration Salts (ORS) and the GOB sponsored activities by the National Nutrition Programme (NNP), covering some 25% of the country.

However, the IRT feels that the downward trend in these nutrition indicators can be accelerated, if the importance of nutrition is recognised and institutionally anchored.
In many health facilities, no nutrition-related activities take place; children are not weighed during consultations in DGHS nor in DGFP run clinics. The NNP suffers from poor stewardship and weak institutional arrangements. In its office in Dhaka, out of 71 staff only 1 is a nutritionist. There is an acute shortage of knowledgeable nutrition workers in the country. Technical supervision and monitoring of nutrition related activities is very weak and undependable.

This report provides five suggestions of what needs to be done:

1. Mainstream nutrition with all DGFP and DGHS interventions as part of the future PHC / UHS and bring the various nutrition activities together at all service points with guidance from nutrition experts and committed professionals;
2. Review the Area Based Community Nutrition (ABCN) of NNP and decide whether to expand or modify its approach; review the technical and programmatic skill mix in the NNP and if needed consider time-bound technical assistance from some DPs;
3. Decide on the institutional home for nutrition in the MOHFW and ensure regular monitoring at the level of Minister/Secretary;
4. Develop a Nutrition policy for the MOHFW that brings all stakeholders working in the health sector together;

[1] See HNPSP Sector Performance Indicators 2003 – 2010 at pages xi and xii.

5. Initiate steps to establish a high-level body for nutrition related policies involving other Ministries and revitalise a mechanism for coordinating interventions capable of synergistic impact on nutrition in the health sector and in other sectors.

5.2. Decentralisation and delegation (section 3.1 and 3.3)

Achieving the required improvements in the efficiency, effectiveness and equity of health services (and sustaining progress towards the MDGs) will need significant reform to decentralise decision-making, reduce fragmentation and increase accountability to users. A fully effective health system is not possible through a system in which management within the 64 districts and nearly 500 Upazilas is split between the two Directorates General and the smallest decisions are taken in Dhaka through a structure involving two budget systems, 38 line directors, numerous projects and programmes, and the involvement of several Ministries. Increased delegation of management and financial responsibility to Upazila and district level will help to alleviate the problems, and will be more effective, if accompanied by some streamlining of management in Dhaka. This change can begin as a process of delegation of authority to MOHFW officers posted at district and upazila levels, combined with strengthened accountability to users, pending resolution of current uncertainties regarding the relationships between local political institutions.

The IRT supports the MOHFW intention to provide budgetary resources for helping to finance local level plans. To ensure the realism of plans, and provide an incentive to take the exercise seriously, Upazilas should be informed in advance of the level of additional resources potentially available to them, if they meet fairly simple criteria. These could include preparation of a joint plan with demonstrable links between the resources requested and the planned targets, together with evidence of joint working across health, family planning, and NNP where relevant. The additional resources should be managed via the Government system with appropriate support to address fiduciary risks. They should initially be focussed on the poorest districts and benefit from flexible and experienced TA where needed.

The preparation of plans and allocation of funds needs to be linked into a structured approach to work-planning, monitoring and supervision, and is therefore complementary to our recommendations for strengthening the Upazila health system as described in section 2.8 of this report.

5.3. Population and fertility (section 4.2)

Over the years, the MOHFW has played a key (and quite successful) role in bringing down the very high fertility rates in the country. The total fertility rate currently stands at 2.7 children per woman (2007). Unfortunately, the official goal of replacement level fertility (meaning a TFR of 2.2) by 2010 will therefore not be met. This will have serious consequences for Bangladesh's socio-economic development in the long term. Therefore, the ultimate aim should be to bring down the fertility rate to replacement level as soon as possible and certainly not later than by 2015.

Every 5 years delay in reaching replacement level will add another 3% to the population projection. With a total fertility rate of 2.2 by 2015, the population of Bangladesh will still grow from the present 150 million to about 250-260 million before stabilisation will be achieved. Even better, if a fertility rate of 1.8 could be achieved by 2015, the population would stabilise at approximately 220, still an enormous challenge.

In view of the above, the IRT suggests MOHFW to urgently review its population and fertility targets and consider a more ambitious goal. A fertility rate below replacement level would require much more than a gradual expansion of the proportion of fertile couples who presently use a modern method of contraception (47%). It would require a drastic revision of the current population policy of the GOB with the following elements:

- A more intensive promotion of contraceptive use (especially free long-lasting / permanent methods), where lack of access and stock-outs would not be tolerated anymore;
- Focus the national family planning programme predominately on hard-to-reach and underperforming districts/divisions of the country;
- Provide (economic) incentives for couples that limit themselves to 1 child;
- Enforce the legal age of marriage for women (18 years);
- Urgently address the unacceptable high level of unmet demand for FP (17-18%);
- Address the high discontinuation rates of contraceptive methods by urgently improving FP counselling and quality of service delivery, particularly post-partum and post-menstrual regulation.

Drastic as some of these measures may seem, one has to consider the alternative population increase that might well prove to be unsustainable for the country.

5.4. Human Resources for Health (section 5.1)

All chapters in this report show that there is a crisis in the human resources of the health sector in the country, both in quantity and in quality. Swift and decisive actions need to be taken. Even actions taken now will bear fruit only after several years.

A systematic approach is essential to assess (i) the capacity development challenges for meeting shortages and (ii) redressing the current skill-mix imbalance, particularly the ratio of doctors to nurses to technologists. A workforce plan for the short-medium term is necessary with a clear strategy to achieve targets within a specified time (2 years), addressing both the public and the private sectors. The plan should also address the needs and motivations of the workers, both women and men, as well as their responsibilities towards their clients. In order to address the critical shortage of nurses, GOB has to rapidly conclude the recruitment exercise of nurses that is currently stalled.

An important question is whether the government can go on creating new posts to absorb the yearly output of doctors and nurses or face the problem of their unemployment. The last one is an imminent possibility. How this problem is to be addressed should be decided urgently.

Given finite resources, steps have to be taken to improve utilization of existing resources through: (a) financial and administrative delegation; (b) increased supervision; (c) strengthening MOHFW's stewardship role in regulation and quality assurance in both the public and private sectors; and d) gradually moving to a more efficient system of polyvalent (multipurpose) health workers in PHC.

Finally, the high turn-over of administrative cadre within MOHFW and its Directorates remains a critical issue, as ownership, leadership and management of many Operational Plans are compromised. The IRT advises the Ministry to initiate urgently high-level discussions with the Ministry of Establishment with the aim to ensure that positions of cadre respond to criteria of professional affinity and periods of service of 2-3 years.

6. Overall appreciation of HNPSP

The IRT finishes the review with modest optimism, as it has the impression that the new leadership is becoming aware of the challenges it is facing and is willing to take bold and far-reaching decisions. It is vital the MOHFW realises that the health delivery system with its vertical structures has reached its limits in achieving the stated (MDG and other) targets. It will have to address the various constraints highlighted in this report and take the decisions that are needed. We realise that the obstacles are enormous. It will need time and creative thinking to address them. Expectations should be realistic as to what can be achieved in the coming two years. The IRT is convinced that addressing these challenges is the only way forward to achieve what the government has vowed to do: improve the health of its population. We sincerely hope that it will be possible for the MOHFW leadership to bring all stakeholders together in this endeavour and in this way mobilise the necessary resources, not only financial but also – and perhaps more importantly – in human capital.

7. A roadmap for reading the IRT report

The IRT report consists of two parts that address different audiences:

1. Volume I, being the Main report, targets senior management of MOHFW and Development Partners. The issues raised are meant as 'food' for the internal and external discussions and eventually decision-making on major policy issues, raised by the IRT. In Volume I you will find:

- The background, methodology and limitations (sections 1.1 and 1.2)
- An update on the progress in the HNPSP itself (sections 2.1 – 2.7)
- A special chapter on the Revival of PHC in Bangladesh (section 2.8)
- The special topic on Nutrition that the IRT was asked to look at (section 2.9)
- In addition chapter 3 brings together all the executive summaries of the technical reports, structured under the three main headings: Stewardship, Service Delivery and Support Systems. These contain also the main recommendations of the IRT for the Task Groups and Line Directors to draft their Action Plans for next year.
- Finally there are the various annexes, as described in the Table of Contents

2. Volume II contains the technical chapters. It targets the technical people of the MOHFW and the various Directorates, responsible for the implementation of programmes and management of resources. The document provides the background analysis on which the conclusions and recommendations are based and is therefore important to understand the rationale of our executive summary. The ten chapters are structured under the same three headings (Stewardship, Service Delivery and Support Systems) and contain a lot of detail, tables and recommendations.

They all start with the same Executive Summary that is also given in the Volume I, including the main recommendations to be used by the Task Groups for the elaboration of their Actions Plans.

Dhaka, 10th May 2009.
Dr Jarl Chabot,
Team Leader APR 2009.

1 INTRODUCTION

1.1 Background to the Annual Programme Review (APR 2009)

The Health, Nutrition and Population Sector Programme (HNPSP 2003-2010) started effectively at the end of 2005. HNPSP focuses on (i) accelerating the achievement of health related MDG and PRSP goals through service delivery; (ii) meeting emerging HNP sector challenges (being long-term policy strategies and initiatives in public health); and (iii) implement key reform areas (like public sector management, health sector diversification, decentralisation and stimulating demand for health services).

Government accounts for only about one third of total health expenditure, with out of pocket spending on pharmacies and on a diverse range of private sector practitioners accounting for most of the rest. MOHFW accounts for over 95% of Government health spending. The 38 HNPSP operational plans account for 91% of budgeted 2008-9 Government development expenditure on health, and about 38% of total Government health expenditure including the revenue budget. While HNPSP is without doubt the largest programme to support the health sector, it is not the only one. There are – according to the Annual Development Programme (ADP 2007-08) – a total of 23 projects included in the MOHFW sector (13 investment and 10 TA projects) of which 4 are under the responsibility of other Ministries, but operate within the HNP sector (e.g. Urban health programme under Ministry of Local Government).

In February 2008, a Mid Term Review (MTR) of HNPSP was conducted by an Independent Review Team (IRT). The IRT concluded for each of its 'components':

1. MDG and PRSP goals: Good progress has been made in extending already high coverage of main interventions for reducing U5 mortality, modest progress in maternal health and nutrition, and stagnation in CPR, despite significant reduction in TFR. There is some improvement in utilisation of health services, but still too little progress in addressing chronic shortages of staff, drugs and equipment. A declining share of the budget is going to ESD services of most benefit to the poor. Disbursement is improving but remains low, procurement related problems being the main cause.

2. Sector challenges: The MTR concluded that action to address these challenges had not been operationalised, as the documents had not indicated who would be responsible or how these challenges were to be addressed.

3. Reform agenda: The MTR report stated that, although some modest pilots are now underway (e.g. voucher scheme), planned reforms under SIP to extend user-centred and effective services through innovations such as DSF, contracting non-public providers, and using less centralised approaches have made little progress.
In general, reviewing the HNPSP period at mid-term, the MTR noted new dynamic, improved coordination and closer monitoring of the annual action plan over the last year. Based on these observations, the MTR advised the MOHFW to initiate the preparations

for a new sector programme, to follow on from the scheduled June 2010 end date of HNPSP.

In December 2008, Bangladesh held Parliamentary elections and a new Government led by the Awami League was installed in the first weeks of January 2009. In the course of the following months, new appointments were made for most of the management positions in the MOHFW. In the meantime, preparations for the current APR continued.

The IRT started its work mid April 2009 with the following overall objectives (annex 1):

- To take stock of the achievements of the implementation of MTR recommendations and progress made on the action plan set out at the MTR;
- To review the implementation of the HNPSP program *vis a vis* the revised results framework thus far. Take stock of quantitative and qualitative achievements of the goals, targets, reforms, fund utilization. Recommend revisions to these for the remaining period of the program.
- To review the financing arrangements and assess how well donor support meets the priorities and requirements of the HNP sector and suggest options for the next HNP support program.

Specific objectives of this review for each of the IRT consultants were prepared and adopted by the APR Steering Committee.

1.2 Methodology and Limitations

The IRT 2009 methodology in conducting the APR 2009 was similar to the one used during the MTR 2008. Preparations were made by the APR Steering Committee. During a visit to Dhaka by the team leader (February 2009), the selection of team members was finalised, a work programme was adopted (annex 2) and an impressive amount of background documentation (annex 4) was collected and shared with all team members.

The IRT visited Bangladesh between the 16th of April and the 9th of May 2009. After 3 days of briefings with all stakeholders (various levels of MOHFW, Line Directors, DPs, NGOs and other Ministries), the team made individual and group interviews with a wide variety of persons and institutions involved in the sector (annex 3). A field visit to 4 Divisions/Districts[2] was undertaken together with representatives of the six Task Groups (TG) from MOHFW and DPs. In each District various Upazilas were visited and interviews were made with the civil surgeon, deputy directors and other health staff at all levels of the service delivery system (District Hospital, MCWC, Upazila Health Complex, Union Health and Family Welfare Centres and Community Clinics).

Back in Dhaka, the IRT drafted an 'issues paper' that was discussed with senior management of the MOHFW and the DPs. This provided the main elements for the first draft of the Technical Report (Volume II) and the Main Report (Volume I) that were discussed during debriefing meetings with the Task Groups, the various levels of the MOHFW and the DPs. Care was taken that the main conclusions and recommendations of the IRT were shared with the six TGs and 4 'working groups' in order to support them in formulating new, relevant and practical Action Plans for the next year.

[2] Sylhet (Sunamganj district); Chittagong (Chittagong district); Dhaka (Jamalpur district) and Khulna (Sathkhira district).

The limitations of conducting sector reviews are evident: to review the many very diverse elements of a large and complex sector like the one in Bangladesh in a period of just three weeks is likely to be incomplete and in some instances superficial. The fact that the new government had just taken office and many of our interviewees were only a few weeks in charge sometimes complicated the information collection. The policy direction and the new priorities of the MOHFW were shared with us, but the new health policy and other strategic documents had not yet been elaborated.

Another limitation for the IRT team was the question whether to review HNPSP, the health sector or the various Operational Plans of the MOHFW and its Directorates. The limited involvement of the private sector (NGO, not-for-profit and for-profit) in the policy direction of the health sector in general and of HNPSP in particular further limited the scope and information collection by the IRT team. We decided to follow the original SIP, PAD and R-PIP documents in order to allow for consistency between (i) the APR 2007, (ii) the MTR 2008 and (iii) this APR 2009. HNPSP thus remains a programme that is not sector-wide and not even MOHFW-wide in scope.

1.3 Acknowledgements

The team is extremely grateful for the time and technical advice provided by the Honourable Minister, Prof A.F.M. Ruhal Haque, the Honourable Advisor to the Prime Minister, Prof Dr. Syed Modasser Ali and the Secretary of the MOHFW, Mr Sheikh Altaf Ali. The special interviews with various team members despite their busy working schedules have been greatly appreciated.

Important administrative and logistic support was provided throughout the presence of the team in the country by Mr Md. Abdul Mannan (Joint Chief Planning Wing) and his team for all appointments with the MOHFW and the various Directorates and by Dr Dinesh Nair (World Bank) and his team for appointments with the Development Partners. Special thanks go to Mr Helal Uddin, Mr Saif Uddin Ahmed (both MOHFW) and Ms Iffat Mahmud (WB), who were essential for making some of our appointments. Through the APR Steering Committee, the IRT received timely the Annual Programme Implementation Report (APIR 2009) and the updated Result Framework (RFW) from the M&E Unit (Mr Helal Uddin, Dr Kamrul Ahsan and his staff).

Special thanks are due to the government officers in the two Directorates General, the NNP executive director, the DDA director, the health and family welfare offices in the four districts, Upazila Health Complexes and all the other facilities that the team has visited. We are grateful for their time and effort in sharing ideas and suggestions with us.

The various individuals working in the civil society, the NGOs, research institutions (IPH, ICDDRB) and other non-public sector organisations are sincerely thanked for their time and patience to respond to our questions and provide us with invaluable information.

Development Partners have been instrumental in providing timely logistics such as the vehicles for the field visits and the organisation of the briefings at the beginning of our stay in the country. Essential support has been provided by the Chair of the HNP Consortium (Mr Arthur Erken), the HNP consortium members and the team in the World

Bank. All DP staff are sincerely thanked for their time and availability to respond and reflect on our questions and ideas.

We hope that this report will contribute to a commitment of the MOHFW and the DPs to initiate as a matter of urgency the development of an operational Strategic Plan that translates the National Health Policy (PRSP II) into achievable targets and outputs that are time-bound through an agreed and realistic road map. There are still more than two years ahead. Much can be achieved in that period if the potential of ALL Bangladeshi stakeholders in the health sectors is brought into the equation.

Being an *independent* review team, the opinions and suggestions mentioned in this report are solely the responsibility of the authors and do not in any way commit or imply the agreement of the various stakeholders operating in the Bangladesh health sector.

1.4 Composition of the Independent Review Team (IRT) 2009

The composition of the IRT with their respective fields of specialisation is given in the table below together with their email addresses that can be used if and when additional information on specific topics is requested.

Table 1-1: Composition of IRT team by technical area

POSITION / NAMES	TECHNICAL AREA / EXPERTISE	EMAIL ADDRESSES
Jarl Chabot	Team leader, Public Health	j.chabot@etcnl.nl
GOVERNANCE AND STEWARDSHIP		
Muhammed Ali	Deputy Team Leader, new policies and priorities	md.ali1955@gmail.com
Kevin Brown	Institutional strengthening	kbrown@btinternet.com
Andy O'Connell	Coordination (and PPP)	chivuna@eircom.net
Ms Maheen Sultan	Gender, Equity and Voice*	sulthuq@bol-online.com
Mick Foster	Health Economics and Finance	mickfoster@btconnect.com
SERVICE DELIVERY		
Kees Schaapveld	Public Health	k.schaapveld@wxs.nl
Ms Indra Pathmanathan	Mother, Neonatal and Child Health	ipathmanathan@gmail.com
Ms Sultana Khannum	Nutrition*	Shona2008@yahoo.com
SUPPORT SYSTEMS		
M.M.Reza	Human Resources for Health*	Rezamm2006@yahoo.com
Ed Vreeke	Procurement*	edvreeke@gmail.com
Ronald Horstman	Monitoring and Evaluation*	r.horstman@phc-amsterdam.nl
Steve Perkins	Public Financial Management*	sperkinspvt@aol.com
Siddiqur Rahman Choudhury	Public Financial Management*	siddiqur_sbc@yahoo.com
A. Waheed Khan	Budget Planning	Waheedkhan_a5w@yahoo.com

* = Task Groups are in existence / operational in these technical areas.

2 Progress in HNPSP / SIP Objectives

2.1 Progress in HNPSP Overall Objectives

The Terms of Reference of the MTR 2008 mentions as overall objective "to review the implementation of the HNPSP program *vis a vis* the revised results framework thus far and take stock of quantitative and qualitative achievement of the goals, targets, reforms, fund utilization and recommend revisions to these for the remaining period of the program". The Overall Objective of HNPSP - being the same as the Strategic Investment Plan (SIP) of the GOB - is to increase the availability and utilisation of user-centred, effective, efficient, equitable, affordable and accessible quality HNP services.

Similar to the MTR 2008, the IRT found that progress in extending already high coverage of main interventions for reducing U5 mortality has continued, some improvements have been made in maternal health. The total fertility rate has continued to come down, although the overall contraceptive prevalence rate has not increased[3]. With regard to malnutrition, Bangladesh has continued to achieve good progress in reducing stunting (the best indicator of chronic malnutrition, and the main cause of long term damage), although the MDG indicator of weight-for-age has made slower progress.
.
Less positively, there has been no improvement in the low utilisation of curative health services, especially by the poor. Utilisation is strongly associated with the availability of drugs, but provision for drugs at lower levels of the system has long been insufficient and even in decline. Low utilisation also reflects lack of staff (especially in the more remote facilities), and absence of basic equipment. There are no plans in place to address these issues. The recently revised PIP implies a reduction in the share of the Essential Services Delivery OP from 20% of actual spending in June 2008 to just 15% in the 2008/9 to 2010/11 period. Patient numbers are assumed to grow in line with population, implying no improvement in access. Geographical allocation of MOHFW spending continues to be biased against the poorest districts.

The reform programme aims to extend user-centred and effective services. The only significant progress has been the scaling up of the maternal voucher scheme, but the contracting of non-public providers and decentralisation has not advanced.

Finally, the programme continues to suffer from low disbursement of available funds. Utilisation of the development budget is low across the whole of Government, but MOHFW continues to spend a lower than average share of the development budget.

[3] Analysis by ICDDR shows that take up of permanent methods has increased in the most fertile younger age groups, but the overall CPR shows no increase, because this is offset by those who were sterilised in earlier campaigns ageing out of the reproductive age group. The actual performance of DGFP in recruiting younger women and men and their net contribution to continued reduction in the TFR is therefore not reflected in the flat CPR numbers. (Dr Kim Streatfield, personal communication to IRT).

The six so-called 'core indicators' to measure the success of HNPSP have been summarised below. They show that only one of them (TB) has been achieved.

Table 2-1: HNPSP: Six 'Core Performance Indicators'.

INDICATORS	Baseline and results over the years				
YEAR	2004/05	2006/07	2007/08	2008/09	2009/10
	Baseline	Results	Results	Results	Target
1. % Share of total govt budget allocated to MOHFW budget	6.5	6.7	7.0	6.5	10
2. % total MOHFW expenditure allocated to 25% poorest districts	17%	16%	NA	NA	40
3. Utilisation rate of ESD among the 2 lowest quintiles.		NA	NA	NA	
4. Proportion contracts awarded within initial bid validity period	DGHS: 91 DGFP: NA	DGHS: 80 DGFP: 05	DGHS: 90 DGFP: 55	DGHS: 90 DGFP: 100	> 95% in 2006
5. Percentage of births attended by skilled health personnel Average Lowest quintile Second quintile	 Av: 13.5 LQ: 3.3 SQ: 4.3	 Av: 18.8 LQ: 5.2 SQ: 10.1	 Av: 18.0 LQ: 4.8 SQ: 6.7	 Av 21.4 LQ: 5.1 SQ:11.1	43
5b. Any ANC from medically trained provider: Average Lowest quintile Second quintile	 48.8 24.9 38.2	 46.3 23.4 37.7	 51.7 30.8 36.3	 51.3 30.9 40.7	ANC not mentioned
6. TB Case Detection Rate /NTP	46	71	723	73	70

Sources and Definitions: See HNPSP Sector performance Indicators, page xi and xii.
NA = Not Available. We are aware of no composite data for ESD utilisation by wealth quintile (e.g. outpatient contacts). See Table 2.3 for data on coverage of major interventions and differences in nutritional status.

2.2 Component 1: Progress in achieving MDGs and PRSP outcomes

A new Utilisation of Essential Service Delivery Survey has become available with data for 2008. Although the figures are broadly comparable with the 2007 DHS, the survey designs were different and progress should not be inferred from comparing 2007 DHS data with 2008 UESD figures. However, comparison with data in the previous UESD survey from 2006 does enable us to infer something about trends up to 2008.

MDG 1: MDG 1A (reduce malnutrition) Bangladesh has continued to make good progress in reducing stunting in children of 6-59 months, an indicator of chronic malnutrition, which fell from 46.5% in 2004 to 38.5% in 2007, an acceleration in the rate of improvement. There was some increase in wasting between the 2004 and 2007 DHS surveys, although this indicator of acute malnutrition may be influenced by the combined impact of the floods and of the 60% increase in food prices in 2007. This would also explain the slower progress in reducing the MDG indicator of weight-for age (underweight), which reflects both chronic and acute effects.

Although some progress is being made, the case study in Nutrition, undertaken as part of this APR 2009, highlights the urgent need for: (i) mainstreaming nutritional activities in all health facilities, (ii) special centres to treat acute malnutrition cases and (iii) gradual merging of nutrition activities undertaken by NNP, IPHN, ICDDR,B under the overall coordination and guidance by the MOHFW.

MDG 4: Reduction in IMR and UFMR has been impressive, most likely due to a combination of health related interventions (like Vitamin A distribution, EPI coverage and diarrhoea management), but also to related developments not assessed during this review (such as improved primary education of girls, water and sanitation etc).

MDG 5: Progress towards reducing Maternal Mortality cannot be measured and is therefore unknown. While it can be reasonably assumed that progress has been made, the planned Maternal Mortality Study should provide the reliable data needed for a good assessment. Like the MTR, the APR 2009 concludes that joint planning, budgeting and monitoring between DGHS, DGFP and NNP could greatly improve focus and efficiency of their respective services.

MDG 6: Reduction in the prevalence and burden of some of the major infectious diseases (TB, Malaria and HIV/AIDS) has continued and the IRT can report progress in the TB Case Detection Rate and progress in the reduction of Malaria cases. For HIV/AIDS, the situation is less clear, as no reliable epidemiological information is available about the prevalence of the virus in the country, assuming to be less that 1%. Specific studies on the various target groups show the prevalence between 1-5%

Table 2-2: Millennium Development Goals Indicators

MDG	Indicators	Progress till 2008	Targets 2015
MDG 1A: Reducing childhood malnutrition	(i) % of underweight children age 6 to 59 months	(i) Declined from 51.7% (2004) to 49.7% (2008)	(i) 33%
	(ii) % of under-five children with moderate or severe stunting (Ht/Age)	(iii) Declined from 46.5% (2004) to 38.5% in 2007	(iii) No target set
MDG 4: Reducing under-five mortality by two thirds	(i) Infant deaths per 1000 live births	(i) Declined from 65 (2004) to 52 (2007)	(i) 31.3 per 1000 live births
	(ii) Deaths in children under 5 over 1000 live births	(ii) Declined from 88 (2004) to 65 (2007)	(ii) 48 per 1000 live births
MDG 5: Reducing maternal mortality by three fourths	(i) Proportion of births attended by skilled staff	(i) Increased from 13.5 (2004) to 18% (2007)	(i) 50%
	(ii) Maternal Deaths per 100.000 live births	(ii) MMR data is not available – survey last done 5 years ago	(ii) 120 per 100.000 live births
PRS and National Population Policy	(i) Total Fertility Rate (TFR) (ii) Contraceptive Prevalence Rate (CPR)	(i) TFR declined from 3.0 (2004) to 2.7 (2007) (ii) CPR (modern methods) 47.3 (2004) to 47.5 (2007)	(i) TFR 2.2 by 2010 (ii) 'Ensure access to reproductive health services' No target figure
MDG 6: Reducing the spread of TB, HIV and Malaria	(i) TB case detection rate (ii) HIV Not specified (iii) Reduction of malaria burden with 50% between 1990 and 2010 ("burden" not defined)	(i) 72% in 2007, 73% in 2008 (ii) Not quantified (iii) Reported malaria mortality reduced by 2/3 between 2000 and 2008	(i) 70% in 2010; reduce incidence of TB from 2015 (ii) Reduce prevalence of HIV/AIDS from 2015 (iii) Reduce incidence of malaria by 2015

Equity: Comparison of the 2004 and 2007 DHS shows that the gap between the richest and the poorest has narrowed considerably with respect to public health interventions, such as immunisation and Vitamin A capsules, both of which have good coverage among the poorest. There has also been some narrowing of the gap in ANC coverage. However, there are severe inequalities in the utilisation of curative services. For example the 2007 DHS data shows that the richest 20% of households are three times more likely than the poorest 20% to seek advice or treatment from a health facility or provider when a child has diarrhoea, fever, or acute respiratory infection; less than 5% of the women from the poorest 20% of households have their babies delivered by a medically trained provider, compared to more than half of women in the richest quintile.

According to the R-PIP, quoting the 2005 Household Income and Expenditure Survey, about 36% of public health services by volume were being used by the bottom 20% of people, but they accounted for only 14% of curative care, with the richest two quintiles having double the rate of utilisation of services. The inequality in utilisation is also reflected in unequal spending patterns, with the poorest districts receiving just Taka 223 per head in public spending on health, compared to a national average of Taka 286[4].

Table 2-3: Coverage basic HNP services by wealth quintile (DHS 2004 / 2007)

RFW	Indicators	**BDHS 2004**		**BDHS 2007**	
No		Wealth Quintile		Wealth Quintile	
		Lowest	Highest	Lowest	Highest
1	% deliveries attended by skilled personnel	3.3	39.4	4.8	50.9
23	% ANC Coverage	10.4	61.1	30.8	83.6
6	CPR (modern Methods)	44.7	50.0	46.9	49.4
21	Total Fertility Rate women 15-49 yrs	4.0	2.5	3.2	2.2
NS	Wasted – 3 SD (Wt/Ht)	1.3	0.7	3.8	2.0
19	Underweight – 3 SD (Wt/Age)	18.2	5.9	15.1	6.5
20	Stunted – 3 SD(Ht/Age)	25.7	5.5	23.2	7.6
2	Percentage of DPT3 coverage	70.7	91.1	92.4	94.7
3	Percentage of Measles immunisation	59.5	90.5	80.2	89.2
NS	Percentage of fully vaccinated children	57.5	85.7	79.9	88.4
4	Percentage of Vit A Coverage	77.2	87.5	88.8	90.0
NS	ORS for Diarrhoea	74.9	94.4	78.7	88.2
NS	ARI treatment	10.8	45.3	23.6	73.0

Note: Wealth quintiles in this table are derived from household ownership of assets (BDHS 2004 and 2007).

[4] Begum et al, PER of the health sector 2006-7, April 2009.

2.3 Component 2: Meeting emerging sector challenges

The objective of component 2 of HNPSP – similar to the Seven Long Term Strategies of the SIP – is: "meeting emerging sector challenges and develop new sector policies".

This objective is rather vaguely defined without any quantitative basis to measure improvements. As has been shown by the indicators in the Result Framework, only one indicator has a measurable value. The share of total GOB expenditure allocated to MOHFW has gone down, as GOB has allocated additional resources to the Ministry of Food and Disaster management budget in 2007-08 in response to floods and high food prices. The high level of acute malnutrition recorded in the 2007 DHS (above the WHO crisis level of 15%) suggests that Government was right to allocate additional funding to coping with the floods and with high food prices, though we are unable to comment on how effectively the funds were spent.

It seems that HNPSP assumed that these challenges were somehow to be operationalised, without indicating who would be responsible and how this was to be achieved. Against the background of the complexities of the internal structure of the MOHFW and the changes in the government at the end of 2008, such an assumption seems now – with hindsight – rather ill-founded. It should therefore not come as a surprise when most of these challenges have hardly been addressed.

Table 2-4: Indicators of component 2: Meeting emerging HNP Challenges

INDICATORS	SIP / HEALTH NUTRITION POPULATION SUPPORT PROGRAMME (HNPSP)						
	Baseline		MTR 2008		APR 2009		HNPSP
YEAR	2005	2005	2007	2007	2008	2008	2010
	Target	Result	Target	Result	Target	Result	Target
% Share of total GOB expenditure allocated to MOHFW expenditure	8%	6.7% 2005/06 Budget/actual	10	7.0% 2007/08 Budget	10%	6.5% 2008/09 Budget	10%
NCD Strategy developed and implemented as per RFW (26)	Developed		Functional	Approved	Functional	Limited implemented	NA
Emergency Health Response Strategy implemented and operational (24)	Strat developed	Not done	Strat functional	Not done	In operation	In operation	NA
Urban HNP Strategy developed and implemented (25)	Developed	Not done	Functional	Not done	Functional	Not done	NA
Waste Management Plan developed for HF(27)	Guidelines	Review done	10% HF	Implemented	30% HF	Implemented, but with delays	100%

Note: Numbers refer to the indicators from the Result Framework (RFW), as mentioned in PAD.

2.4 Component 3: Implementation of key reform areas

The key reform areas in HNPSP are:
1. Strengthening of public health sector management and stewardship capacity, including functions like planning and monitoring, Information management, Reform management, Aid management and the management of contracts.
2. Health Sector Diversification, asking MOHFW to become a purchaser of health services through other (private, NGO) providers;
3. Stimulating Demand for HNP services[5].

These reform areas are major in scope and content and if actively implemented could have made a major difference in the provision of care in the country. However, the PAD does not specify who, how and when these reforms are to be realised. It only states: *"the organisational requirements to embed these functions most effectively require further discussion and – in due course – will be incorporated in the appropriate Operational Plans"*. This has not happened, as the OPs seen by the IRT are very similar to those originally made during the start of HNPSP in 2005.

The APR 2009 therefore concludes that the reform agenda has only partially been addressed during the last year, due to the changes in government (elections in December 2008) and the ambitious but poorly operationalised objectives set out in the PAD. The Table below gives an overview of the current – disappointing – situation.

Table 2-5: Indicators of component 3: Implementing key reform areas

INDICATORS	SIP / HEALTH NUTRITION POPULATION SUPPORT PROGRAMME (HNPSP				
	Baseline	APR 2007	MTR 2008	APR 2009	HNPSP
YEAR	2004	2006	2007	2008	2010
	Target	Result	Result	Result	Target
Decentralisation + Hospital Autonomy expanded + Feasibility study Fin decentralis.	 Legal devt Starting		 Being approved Not started	 Not done Not done	 30 Hospitals Scaling-up
Diversifying Service Provision: + Regulatory framework in place + Accreditation system in place + MSA established + PMA established			 In progress Draft developed In place Selection in progress	 In progress In progress In place Draft contract issued	 Enforced 40% NS
Demand Side Financing (DSF) Maternal Voucher piloted/evaluated	 2 Upazilas		 33 + 9 Upazilas	 Evaluation started	 NS
Budget Management + % Share total GOB expenditure allocated to MOHFW expenditure + Proportion MOHFW budget allocated to 25% poorest districts + 100% audit objections settled within 12 months MTBF in place	 6.7 17 NA NA	 16 18 / 63	 7.0 NA 10 / 58 Done	 6.5 NA NA Done	 10 40 NS NS

[5] The SIP mentions another important reform area, being Decentralisation and Local Level Planning that has been left out of our TOR. However, the IRT has included LLP in its reflections.

INDICATORS	SIP / HEALTH NUTRITION POPULATION SUPPORT PROGRAMME (HNPSP				
	Baseline	APR 2007	MTR 2008	APR 2009	HNPSP
YEAR	2004	2006	2007	2008	2010
	Target	Result	Result	Result	Target
Sector Management + NNP Integrated in SWAp + HIV/AIDS integrated in SWAp + DGHS/DGFP provide Mgmt info + Staff level in Upazilas improved + Performance audits link finance and performance + Community participation in place + Tribal Health plan implemented	 Separate Separate Not done NA Not done Not done Not available		 Done In progress Not yet NA NA Not done Not yet	 Done Partially Minimal/moderate NA; Recruitment underway Not done Insufficient No progress	 In place In place In place % Staff avail. Functional 50% HF NS
Aid Management + MOU agreed and signed + PSO established and functional	 June 2005	 April 2007 Not yet	 April 2008 Functional		 NS NS
% Districts with Disease surveillance reports	NS	NA	47	55	80
Human Resources + HR TG established + Performance Incentive system		 Not yet Not yet	 Available Only Vouchers	 Functional Not yet in place	 NS Functional
Procurement Proportion contracts awarded within initial bid validity period	 DGHS: 91 DGFP: NA	 DGHS: 80 DGFP: 05	 DGHS: 90 DGFP: 55	 DGHS: 90 DGFP: 100	 > 95% in 2006
HMIS: DGHS and DGFP provide mgmt information based on specifications	Not yet done	Not yet done	Coordination in process	In progress	NS

Pooled Fund Financing under HNPSP

Table 2-6 shows total pooled fund (RPA) expenditure by category of spending for HNPSP up to the end of December 2008.

Table 2-6: Disbursements up to December 2008

Category	Category Description	Allocated USD	Disbursed USD	Un-disbursed USD	% of Disbursement
1	Goods, works, services and operating costs	130,626,660.80	0	130,626,661	0
2	Services of NGO and other private and non-public providers	78,313,571.60	30,808,100	47,505,472	39.3%
3	Goods (other than those covered by Category 1)	165,225,531.19	135,392,130	29,833,401	81.9%
4	Works (other than those covered by Category 1)	84,962,582.40	2,457,600	83,575,782	2.9%
5-A	Consultants' Services (other than covered by Category 1)	26,756,152.00	1,386,800	25,369,352	5.2%
5-B	Studies and Training	43,101,372.80	30,491,420	12,609,953	70.7%
DA	Designated Account	0.00			
	Totals	**528,985,870.79**	**200,536,040**	**328,449,831**	**37.9**

Category 1 spending refers to the performance-based element. There has been no expenditure to date. The MTR agreed to release $ 38m based on performance against the defined indicators in 2007-08. This was approved for financing in the following year (i.e. 2008-09), but no expenditure was recorded till the end December 2008.
This reflects the key problem with the timing of the performance based element: it is assessed at the APR that comes too late in the year for inclusion in the budget for the following year. The letter from World Bank approving the proposed use of the funds was not dispatched until June, for a budget starting in the beginning of July!

For the category 1 financing to be paid in 2009-10, five performance indicators have been defined to be assessed during the current review. For the maternity care indicators, the latest available data relates to a period prior to the agreement, and the indicator is strictly speaking not measurable. The other four targets have not yet been complied with. On that basis, and assuming that MOHFW are given the benefit of the doubt on maternity care, based on prior performance, they would receive just 20% of the funding.

Table 2-7: Performance-based financing indicators for 2009

	Indicators	Target 2009	APR 2009 Results
1	Ensure greater financial allocation for the poor: • % of budget going to Upazila and below • APIR captures development budget expenditures for 5 largest OPs at the district level	 3% increase Done	 Not achieved Done
2	Utilization rate for ESD in lowest quintile (LQ): • Delivery attended by skilled provider • Coverage of pregnant women receiving 4 ANC shows	LQ shows: 3% increase 3% increase	 Achieved Achieved
3	MSA issues contracts for 378 community clinics and 138 union facilities	Done	Not done
4	Agreed-upon action plan based on a facility survey, which will include a survey of food for inpatients and medical and surgical requisites (MSR)	Done	Not yet done
5	MOHFW allocates budgets for 2009-10 for THE 6 decentralized districts plans[6]	Done	Not yet done

Turning to the other expenditure categories, there is a need to re-allocate funding from the under-spending works and consultancy services categories in favour of goods.
We repeat the recommendation made last year that there is no merit in specifying the categories of expenditure for which RPA funds can be used in a rigid way, and especially not at the cost of further exacerbating a problem of inability to disburse committed funding. The main purpose of a SWAP approach is to reach agreement on a joint policy, strategy and expenditure programme to be jointly funded. It should be a matter of indifference how the specific RPA funds are used, provided they are financing elements drawn from the agreed expenditure programme. One of the problems with HNPSP has been that the weak dialogue on overall spending priorities has resulted in a low level of trust between the partners, and therefore a restrictive attitude to how funds may be used.

[6] Data will be available by June 2009 and disbursement of this performance-based financing indicator will follow.

The Requested Extension of HNPSP

Although the performance-based financing indicators were not achieved, and the reform agenda made little progress in a year of political transition, the IRT recommends that the requested extension of funding to June 2011 be granted, and that DPs support a new phase of HNPSP to follow on. The arguments are:

1. Although there is a need to address weaknesses in the performance of the health system, the performance to date has many positive features that compare favourably with the experience of other countries. Performance certainly justifies continuing the partnership to support MOHFW in achieving the next stage, which is the difficult task of building an effective health system as opposed to successful vertical programmes;
2. The acronym SWAP refers to a sector wide approach. In terms of the Paris agreement on aid effectiveness, the approach involves a partnership in which there is regular dialogue to sustain agreement on the strategy and expenditure programme to be jointly supported, with the DPs providing predictable long-term funding. It should not be thought of as a project with a distinct end-point, when donors can walk away, particularly not when the level of dependence on DP funding is relatively high. In Bangladesh, the donors are financing around 19% of total Government health budget, and a significantly higher share of the non-salary budget. This is too large a share for Government to quickly substitute these amounts with its own funding in the event of an interruption of donor support. The problem is not just dependence on donor funding, but also a range of logistic support that will take time to build the institutional capacity to replace. The rhythm of the SWAP should be one in which funding decisions are communicated as far in advance as possible, and changes in funding levels are moderated to give Government sufficient time to adapt;
3. Bangladesh has only $ 5 per head to spend from its own resources on health far short of the requirements for meeting the health MDGs. In a global economic crisis, the scope for increasing this will be limited, and Bangladesh will continue to need sustained and preferably increased aid flows;
4. Although some development partners have strong views on health sector priorities, the sustainable way to address them is through dialogue to get them incorporated within the SWAP.

Although the reform agenda has not seen much progress, the new Awami government is just 4 months in power and should be given time to formulate its health policy and its priority interventions for the coming five years.

In summary, the IRT suggests the various stakeholders to strengthen their dialogue structures and embark upon a more policy-oriented and supportive discussion about important issues that need to be addressed in the remaining two years of HNPSP, being:

1. The elaboration of the new Health Policy and Strategy for the coming 5-10 years, including (i) decentralised planning and budgeting, (ii) setting of local priorities in consultation with local communities and the (iii) development of an Upazila Health System, managed by Upazila Health Management Committees (UHMC);
2. The challenge to mainstream Nutrition and Population related activities in the overall work of the health facilities at the various levels;
3. The challenge to strengthen and expand the various support systems (human resources, procurement, PFM and M&E), as suggested in this report;
4. Addressing the problem of poor efficiency in the provision of health care in the country through a revision of the internal organisation of the MOHFW;
5. Ensure predictability of resources, both from MOHFW and from the DPs

2.5 Implementation of Operational Plans (OP)

The operational plans were revised in 2008 and extended to 2010-11. This resulted in some significant changes in percentage shares compared to previous spending patterns (Table 2-8). The percentage share of the essential services OP and of family planning field services delivery were significantly reduced compared to previous actual spending shares, because FP spending was high in the early years before the other OPs started implementation. Physical facilities investments and the spending of improved hospital services management to equip the new facilities increased. It was envisaged to have some catch-up on previous low spending in policy reforms. MCRH was also increased with higher spending on drug kits.

Table 2-8: Percentage shares Spending and Allocations HNPSP Development

	Actual to June 2008	2nd revised PIP allocations 2008-11
Declining Shares		
Essential Service Delivery, DGHS	19.7	15.4
TB & Leprosy Control, DGHS	4.7	2.6
Family Planning Field Services Delivery,	18.2	7.8
Increasing shares		
Communicable Disease Control, DGHS	1.8	5.2
Improved Hospital Services Management, DGHS	6.3	9.1
MCH & Reproductive Health Services Delivery, DGFP	2.9	5.0
Physical Facilities Development, MOHFW	21.2	23.4
Policy Reforms, MOHFW	0.4	3.4

Source: Foster, Dec 2008

The amounts allocated in the R-PIP were 25% higher than the resources available in the MTBF, and actual budgets for 2008-09 had to be reduced. The share of ESD in 2008-09 was 17% whereas physical facilities received 21%, in line with its historic share.

Table 2-9 shows the extent to which the revised OPs contribute to spending at Upazila and below, and comments on the content of the OPs. Overall, the revised PIP allocates around 62% to spending at Upazila and below. However, as we have seen, actual spending patterns may differ from the plans set out in the OP.

A key finding from this analysis is that the OPs are not sufficiently ambitious in planning for the scaling up of the intervention areas that are most critical for achieving further reduction in mortality. There is a particular concern that the budget for drugs, already inadequate, seems to have fallen in real per capita terms between 1999-2000 and 2006-07[7]. What little budget there is for drugs, it is also allocated largely on a per bed basis rather than as per needs. There has been some response to the recommendations of the IRT to increase drug budgets, but less than recommended, and the effectiveness of the response has been limited by procurement delays, with a country wide shortage of DDS kits at present due to a failure to procure timely.

[7] Inference from the PER: The drugs budget appears in several places in both revenue and development budget, and some drugs are procured via DPA. This makes it difficult to get a comprehensive picture.

The share of the Upazila level and below in the recently revised HNPSP operating plans is about 62%. Table 2-9 shows the main programmes contributing to spending at that level. The share of Upazila level and below will increase significantly from 2008-09, when provision will need to be made for the cost of rehabilitation equipping and providing drugs for 10.688 community clinics. The line director ESD estimates the cost of this in 2009-10 at Taka 28,621 Lakhs, likely to be included in a new OP under LD ESD in order to avoid the need to revise the whole ESD OP again to accommodate the change. The cost is equal to about 12.5% of the total ADP allocation for HNPSP in the current year and about 60% of it is for MSR including 45% for medicines. Accommodating these additional costs within a restricted overall spending envelope will be difficult, and reinforces the case for finding ways to improve efficiency.

Table 2-9: Analysis of share Upazila and below in proposed RPIP allocations

	Percentage share in total Expenditure in 2008/9-2010/11		Comments
OPs	% share in Total Expenditure	Upazila and below	
ESD	15.4	13.9	All spent below Upazila level, apart from 8% spending on district hospitals, 3% on ESD management.
Policy reform	3.4	3.1	Over 90% of costs relate to contracting out community clinics (subsequently cancelled), tribal health, the voucher scheme, and related management costs.
FP field services	7.8	7.8	Almost entirely concerned with delivery of services at Upazila and below
MCRH	5.0	4.2	Mostly drugs and MSD for Upazila and below
NNP	7.6	6.1	67% directly at Upazila level via area based community nutrition. Including related commodities, equipment, taxes and training makes 80% at Upazila and below a reasonable assumption.
Physical facilities	23.4	10.1	Percentage below Upazila is based on breakdown given in the OP, with significant spending on upgrading UHCs to 50 beds
CDC	5.2	3.1	CDC finances some national planning work for emergency preparedness and disease reporting and surveillance, some spending on hospital based tests and treatment, but the objectives all relate to grassroots programmes, and the bulk of spending is on programme interventions at Upazila and below to control malaria, kala azar filariasis etc.
Clinical contraception	4.0	3.2	OP analysis shows 79% spent at Upazila and below. Most services provided through DGFP facilities at Upazila and below, main spending is on contraceptives, MSR and payments to clients and those who refer them.
TB and leprosy	2.6	2.1	Estimate seems reasonable given the widespread involvement of public and NGO staff and health facilities at all levels in identifying and treating TB via DOTS.
NASP	3.3	2.0	Assume 40% based on about 30% targeted prevention plus some share of spending on blood safety, BCC etc
Public health and NCD	1.6	0.8	Spending on arsenicosis (48%) and on piloting NCD approaches is mainly at Upazila level and below.
In service training	1.5	0.9	Assumes about 60% of in-service training benefits staff at Upazila and below
Total above	80.8	57.3	
Total 38 OPs	100%	62.2%	Based on the same assumptions as used by PSO in May 2008

Source: Foster December 2008. Analysis from the RPIP ceilings and the Revised OPs; some assumptions repeated from May 2008 analysis by the Programme Support Office

2.6 Follow-up on the MTR/AM 2008 and APR 2007

Table 2-10: Actions AND decisions taken as a follow-up on MTR / AM.

Actions to be undertaken	Immediate	Short term	Comments
	(before June 2008)	(in next OP 2008/09)	
1. Develop Annual Operational Plans with output based budget	Take formal decision to ask the BMC to develop single, MOHFW-wide annual plan and budget for next year. Involve MOF/MOP	Budget Management Committee led by the secretary to develop single, MOHFW-wide annual plan and budget	Little progress: No single MOHFW-wide annual plan with budget has been developed. The elaboration of a development and revenue budget by two different LDs continues. IRT has been told that no authority from MOF is needed to go ahead and bring the two budgets together under MBTF
2. Planning, Budgeting and Monitoring of the health sector	Support relevant LD in drafting their new OP (incl budgets + revised Result Framework).	Include in the next OP the prioritised activities for the next year of each LD	Good progress: Support has been provided to LDs to revise their OPs and budgets, as reported in section 2.5. Many OPs did include suggestions from the IRT team in their 2008 action plan.
3. Target Maternal Mortality to try and reach MDG 5.	Commission study to provide costed options to target maternal mortality. Draft TOR to include all systems!!	Make Maternal Mortality the focus of all OP 2008/09 and 2009/10. Use outcome of study	Little progress: A Terms of Reference for a Maternal Mortality Study has almost been finalised and money is available. Maternal Mortality has not been 'mainstreamed' in most of the revised OPs.
4. Address Human Resource issues	Decide on TOR and composition of task group to develop comprehensive workforce plan.	Coordination and lines of reporting of this multi disciplinary task group is included in relevant OP	Good progress: TG / HRH has been established and is functional. It has produced a HR Strategy with involvement of all relevant LDs. Formal endorsement by the Secretary is awaited.
5. Revise components 2+3 into (i) Systems support and (ii) Governance Strengthening	Take informal decision during Policy Dialogue to shift direction: from components to systems development	Define which LDs are involved in each of these 7 systems; Decide on framework to develop coordinated OP with budget and M&E	Modest progress: Informally the shift from components to systems development has been made, but is not yet reflected in the OPs or in the HNPSP itself. This will need to wait for the formulation of the next sector programme.
6. Develop Health Sector Policy	Decide on TOR and composition of the multi-sectoral policy task-group under the HNPSP Coordinating Committee. Prepare time schedule in OP / Planning. Link with preparations for next sector programme	Present position paper in the first quarter of 2009. Hold broad stakeholders consultations Consensus building is essential	A draft Health Sector Policy was developed by the Caretaker Government. Due the elections in December 2008, it has not been formally endorsed. The current Government has expressed its intention to develop a new policy based on its established political agenda. Some of its main priorities have already informally been stated, but no roadmap yet exists when and how it will be developed. The Planning wing will be charged with its development.
7. Initiate preparations for new comprehensive Sector Programme (on basis of more flexible policy based lending modality)	Decide on TOR and composition of preparatory committee. Link it to sector policy committee and decide in which OP to include	Preparatory Committee to use few consultants for the writing and keep it flexible, as emphasis will change over time	No progress: Due to the changes in government, no steps have been taken to start the process of preparing a new sector programme. If the proposed extension of HNPSP till June 2011 will be accepted, MOHFW and DPs have to elaborate the process of how to get there, taking the development of the new health policy into account.

2.7 Conclusions and Recommendations for HNPSP

The APR 2009 has tried to use the same format that was used by the IRT 2008 to allow for comparison over these two years. There is a subjective element in the way the rating has been defined. However, an impression can be gained in a more or less systematic way of how HNPSP has performed over the last year.

Table 2-11: Is HNPSP achieving its objectives?

IS HNPSP ACHIEVING ITS OBJECTIVES?				
HNPSP Objectives	SIP Objectives	IRT Rating of progress by March 2008 (MTR): HP = High level of progress (= on target); MP = Moderate level of progress; LP = Low level of progress; NP = No Progress; Unclear		Indicators HNPSP / SIP
Overall Objective is to increase the availability and utilisation of user-centred, effective, efficient, equitable, affordable and accessible quality HNP services.	Goal is to increase availability and utilisation of user-centred, effective, efficient, equitable, affordable and accessible quality services, be it the Essential Services Package (ESP), improved hospital services, nutritional services or other selected services.	Vertical programmes under HNPSP have continued to record good progress, reflected in improved coverage, with reduced gaps between rich and poor, and continued progress in health outcomes – lower child mortality, reduction of some communicable diseases, continued reduction in chronic malnutrition (stunting) and some improvements in maternity services from a low base. Overall contraceptive prevalence has not improved. Little progress has been made in improving utilisation of public sector health services, especially by the poorest. Major problems affecting utilisation are lack of sufficient drugs, staff shortages (especially in remote facilities), poor prioritisation of spending, and pervasive problems of management and coordination. MOHFW has not yet tackled the internal reforms to address these problems, nor has it exploited the potential to improve the contribution of non-public sector service providers. These issues now need to be given higher priority because Bangladesh has already achieved most of the reduction in mortality that can be achieved through vertical programmes; future progress will increasingly depend on more complex interventions requiring a more efficient, effective and equitable health system, able to respond to diverse and unpredictable needs.		See Table: Six Core Performance Indicators
Component 1: Accelerating progress towards MDG and PRS Goals	*Five service objectives* to accelerate progress towards MDG Goals	1.1. Reducing maternal mortality; 1.2 Reducing IMR and U5M; 1.3. Improving U5 nutrition; 1.4. Reducing total fertility to replacement levels; 1.5. Reducing the burden of TB, Malaria and other communicable diseases, like the prevention and control of HIV/AIDS.	1.1. MP: training, recruitment and EmOC started; Midwifery Strategy 1.2. MP: IMCI integrated with NNP 1.3. LP: for underweight, MP: for chronic malnutrition (stunting) 1.4. NP: no new initiatives 1.5. TB: HP both for CDR & Cure Rate Malaria: Unclear (but Mortality HP) HIV/AIDS: MP (only target groups)	Proportion of births attended by skilled health personnel: From 13.5 in 2003 till 18.0 in 2007 (target 29.5) TB Case Detection Rate: From 46 in 2004 till 73 in 2008 (target 70 in 2007/08)
Comp. 2A: Meeting emerging sector challenges	Seven Long Term Strategies	2.1. % Share GOB expenditure to health (we will propose to change this indicator) 2.2. Restructuring the way services are provided (free emergencies) 2.3. Improving HNP service efficiencies 2.4. Improving equity through revision of allocations to districts / PHC levels 2.5. Mobilising additional resources	2.1. NP: From 7 to 6.5% 2.2. NP: similar structures 2.3. NP: mainly due to institutional constraints 2.4. NP: no evidence it has gone up 2.5. NP: No additional resources	% Share of total govt expenditure allocated to MOHFW: From 7 in 2006/07 till 6.5 in 2007/08 (target 10 by 2010)

IS HNPSP ACHIEVING ITS OBJECTIVES?				
HNPSP Objectives	SIP Objectives	IRT Rating of progress by March 2008 (MTR): HP = High level of progress (= on target); MP = Moderate level of progress; LP = Low level of progress; NP = No Progress; Unclear		Indicators HNPSP / SIP
		for HNP services 2.6. Stimulating informed demand for HNP services 2.7. Improving the quality and scope of HNP services (regulation, registration and accreditation) 2.8. Improving sector governance and management (organisational and staff), incl gender and voice.	2.6. LP: Nothing other than vouchers 2.7. LP 2.8 LP: No focus on strategic issues	
Comp. 2B: (See AM, p. 11-13 and p. 22, 4F)	Other policy responses and strategies related to the various Line Directors (All Public Health)	3.7. Reducing injuries and implementing improvements in emergency services. 3.8. Strengthen the prevention and control of non-communicable diseases (NCD) and VAW 3.9. Improving health responses to catastrophes 3.10. Urban health service development 3.11. Health Care Waste Management Action Plan 3.12. Improving disease surveillance 3.13. Tribal Health	3.7. No information 3.8. NP: Rethink NCD approach, VAW insufficient attention and coverage 3.9. HP: Appear prepared; reality check with next cyclone. 3.10. Moderate level of progress 3.11. MP: being implemented, but with delays 3.12. MP: initiatives being taken 3.13. No Progress	NCD Strategy developed but cannot be implemented (no baseline and unrealistic targets)
Component 3: Implementing key reform areas. OR: Advancing sector modernisation (see AM, p. 13-15)	Policy responses: A. Public sector management and stewardship B. Decentralisation C. Demand Side Financing (DSF) D. Diversification	3.1. Improving Financial Management (incl. planning, budgeting, accounting and auditing) 3.2. Improving sector management & stewardship 3.3. Decentralisation and local level planning (LLP) 3.4. Improving aid management 3.5. Expanding / stimulating demand-side financing initiatives for ESD (Vouchers etc); 3.6. Diversifying service provision (Institutional / PPP)	3.1. NP: Audit contract delayed, FMAU and LDs not strengthened in reporting 3.2. No focus on strategic issues 3.3. LP: LLP produced for 6 districts 3.4. LP: TGs has broadened the involvement of both MOHFW/DPs 3.5. HP: Vouchers implemented according to plan; showing increased utilisation. Evaluation underway. 3.6. NP: Outsourcing of CC cancelled	+ Proportion of contracts awarded within initial bid validity period: DGHS: XXX% DGFP: 100% + HS, FP and P-MIS delivering mgmt information according to specifications: NO + DSF pilots on schedule as per results framework: FINE
(See AM, p. 15-	E. Other Support Systems	Improve availability of Human Resources (HRH) (4D)	MP: Major recruitment exercise on-going	
		Procurement (4C)	Letter of Credit Mis-procurement: DGFP 0	
		Financial Management (4B)	LP:	
		Monitoring and Evaluation (E)	LP: M&E some gains, initial steps in weak environment	
		Actors outside the public sector cover substantial parts of service delivery. They are not part of the formal sector dialogue and decision making.		

2.8 Revival of PHC in Bangladesh: The Upazila Health System

2.8.1 Background: Limitations in further improving achievements

The Bangladesh health services are characterised by a high degree of vertical organisation, not only in terms of the 'classical' vertical programmes, such as TB Control, Malaria, EPI or Vitamin A distribution, but also in its overall management structures, through the various Directorates (DGHS, DGFP, DNS, DDA, NNP and NIPORT), most of them operating parallel systems for human resources, procurement, monitoring and financial reporting. This way of providing services has been successful in improving infant and child mortality and has been able to substantially reduce the various family planning related indicators. In fact this verticality has allowed for improvements in some of the output indicators presented earlier in this report.

However, Bangladesh is approaching the limits of what can be achieved by means of the types of public health interventions that can be effectively organised through a vertical approach. It is important to sustain the programmes that have delivered the reduction in mortality that has been achieved so far and there is still scope for further progress. However, the next stage of mortality reduction will be achieved through more complex interventions that require the system as a whole to function. Achieving further progress in areas such as neonatal care and maternal mortality – seen as a barometer of the effectiveness of the health system – requires services that have the facilities, staff, resources and management capacity to respond appropriately and quickly to patient needs that are variable in nature. Making progress means overcoming a much more difficult set of challenges than planning well specified vertical interventions.

This APR report shows clear evidence that the current mode of operations is inefficient and less successful in providing the kind of services needed for expanding progress towards the child health MDG and accelerating progress in reducing maternal mortality. MOHFW needs to become more effective in delivering limited curative care and the time-critical emergency obstetric care needed to reduce maternal mortality and neo-natal death. Available data suggests that utilisation of services by the general population is not improving, with outpatient contacts per head of population hardly increasing in the last decade. Progress in improving maternity services is far slower than required.

The reasons for low utilisation are consistent across a number of recent studies and surveys using different approaches: non-availability of staff, lack of access to drugs at lower level facilities most accessible and most used by the poor, high and uncertain out-of-pocket costs for curative care and for deliveries, inconvenient opening times and in some areas difficulty of physical access. The same factors are responsible for low efficiency of services, with failure to ensure timely recruitment, avoidable procurement delays, and poorly informed and over-centralised decision-making, resulting in facilities and staff being idle for lack of critical supplies while poorly supervised staff with little opportunity to use their initiative become de-motivated and at risk of losing their skills.

If nothing changes, Bangladesh can expect a slow down in the reduction of infant and child mortality, very limited progress in the improvement of nutrition indicators and

stagnation in the reduction of fertility. While vertical coordination within the various programmes might still be relatively easy, the horizontal coordination between all these programmes and with the various support systems is not effective. This is not a criticism of individual staff doing their best to make the system work. The IRT doubts whether even the most effective of managers could deliver general health services based on a system that is more centralised and more fragmented than any of us have encountered in any of the many countries in which we have worked. It is little surprise that HNPSP has failed to deliver on the stated objectives of the MOHFW and its various Directorates.

At the level of management within the MOHFW and its various peripheral structures (Divisions, Districts and Upazilas) it is almost impossible to oversee the performance of the sector in its entirety, as reporting is fragmented and incomplete, no reliable information is forthcoming and decisions are implemented with long delays. In fact, management becomes a matter of addressing the many day-to-day problems that come up all the time, be it in Human Resources and training, be it in procurement or be it in the coordination with the Line Directors, the Development Partners and the Civil Surgeons in the Districts.

In short, it appears that the inherent limitations of the fragmentation of the service delivery system have become apparent and the question needs to be asked: How long can MOHFW continue to operate in this way, if GOB is committed to improve the health of the people and achieve (at least to a certain extent) the targets set in the PRSP and the MDG?

2.8.2 PHC in Bangladesh; the Upazila Health System[8]

In 1978, the Conference in Alma Ata, hosted by the World Health Organisation and UNICEF defined Primary Health Care in their final declaration as "health care, based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people's full participation and at a cost that the community and country can afford[9]".

The conference acknowledged that each country has to adapt PHC to its own socio-economic and political environment and that no blue-prints are available to inform a country how to realise these noble intentions. However, there is now some 30 years of experience in efforts to implement PHC in many countries of the world. Among the most important lessons is the generally accepted idea that for the implementation of PHC, an integrated system at peripheral level is needed, capable to plan, budget, implement and monitor the day-to-day activities of service delivery for the people in their catchment area (averaging around 270,000 people)[10]. Generally, a three-tier system, consisting of a Hospital (with 50-200 beds), Health Centres (with or without beds) and Community Clinics define the available service delivery facilities, each with a different staff mix (doctors, nurses and paramedics), most often of a multi-purpose or polyvalent nature.

[8] In this report the "Upazila Health System" is defined as consisting of health providers, working at Upazila, Union and Community levels. Together they provide PHC services
[9] BMJ, 08.03.2008. Stephen Gillam, Is the declaration of Alma Ata still relevant to PHC?
[10] See the Health Care Pyramid in the beginning of this report (page viii)

Prerequisites for an integrated Upazila Health System are:

- A management committee composed of all those responsible for the provision of the services and those responsible for the support needed by finance, monitoring, maintenance and other services at that level;
    - This committee is tasked to make annual plans with annual budgets and has the mandate to set their own priorities within the limits set by national policy. They are asked to wisely use the resources at their disposal according to the targets set by themselves in their annual plans;
    - The committee is also tasked to implement their own plans and report quarterly or annually to the higher levels of authority on progress and constraints they have been facing in reaching their stated targets with the resources (personnel, equipment and money) put at their disposal;
- An update the Essential Services Package for Upazila level and below, e.g. maternal health, nutrition, family planning and treatment of common diseases;
- Establishment of linkages with the community including community health committees that take responsibility for developing and sustaining community ownership and active participation in health;
- Agreement on management responsibilities to provide oversight and coordination between district, upazila, union and community levels.

The concepts underlying the re-vitalisation of the Community Clinics (CC) contain some of the pre-requisite elements. For example, the community clinics are intended to extend static health services from the Union to the Ward level, thereby potentially increasing availability of care. The original concept of the CC had strong elements for promoting community ownership and active participation. These elements might get lost in the current implementation process, since orientation and guidelines on these issues have yet to be resuscitated. However, the CC initiative is not yet integrated into a coherent system at Upazila level that has all the other pre-requisite elements of a functional local level health system. Hence the CC concept is at risk of experiencing all the constraints of other elements of the system and thereby having very little impact.

While in Bangladesh such a system does not yet exist, it could be envisaged to become part of the national health delivery system. It could aptly be called an “Upazila Health System (UHS)” or any other name the MOHFW feels fit. In essence, it should consist of the Upazila Health Complex, the health facilities at Union levels and the Community Clinics at the level of the villages.

Recently, the PHC concept has received increased attention worldwide, as it is considered one of the most effective ways to expand services to the community and thus could be essential for many countries to achieve their stated MDGs.

In Bangladesh, with the political commitment of the new and democratically elected government to bring health to all its citizens, this PHC approach seems to have become one of the pillars of the Health Policy of the MOHFW. The Election Manifesto of the Awami League 2008 explicitly states:

> “In order to ensure health facilities to every citizen of the country, the health policy of the erstwhile Awami League government will be re-evaluated and adjusted according to the demands of the time. In the light of this policy, 18,000 community clinics, established during Awami League rule, will be commissioned”.

Indeed, the political commitment to the expansion of service delivery to the community level through these Community Clinics seems to be fully in line with the recent revival of PHC and appears a necessary and vital condition to make the leap towards reaching the goals of the Bangladesh PRSP and the MDGs.
If the expansion of Community Clinics is taken in its broad sense of being part of the Upazila Health System, it could effectively integrate the former vertical services into one coordination structure (unity of command) and in this way expand services to those that are most difficult to reach. Personnel-wise, some important gains could also be made to solve the HR crisis in the peripheral health facilities.
However, if the focus of the MOHFW will be only on the Community Clinics, the likelihood of becoming another vertical structure is imminent and the objectives will not be reached in the long run, as the system cannot become sustainable. Inefficiencies and waste in service delivery will continue and improvements in health outcomes are unlikely to be made.

2.8.3 Implementation mode: building on what is already there

The IRT recommends building on the work already done in 2000/2001[11] particularly in relation to delegation of authority to district and upazila levels, establishing community linkages and defining responsibilities for community groups. The box below tells us about ideas and suggestions under discussion in 2001 that are remarkably similar to what the IRT proposes now in 2009!

Decentralisation in the Bangladesh Health sector, a discussion document.

In order to achieve decentralisation, the aim is to delegate power as well as responsibility to the level at which health care is provided, the upazila level. For this to occur it is clear that roles and structures throughout the system would need to change. The new role of the Secretariat has been articulated as policy, strategy formulation, regulation and legislation, whilst the Directorates would move from service delivery towards standard setting, performance review, agreeing plans and budgets, supporting districts and hospitals, and overseeing major capital projects. Greater involvement of NGOs and other organisations is also proposed, in addition to greater community involvement in the health services.

Prepared for the MCU by Dr Ken Grant et al, May 2001

The IRT is of the opinion that in order to initiate the implementation of these District and UHS related activities the MOHFW should go slowly and build on the experiences that are currently available in the country. Start with those Upazilas that are interested to initiate this PHC approach and provide them with incentives (staff, finance) to do so. The MOHFW could then concentrate its work on providing the necessary conditions in terms of authority and decentralised resources; develop the various tools that are needed to operate the UHS and initiate the development of adequate training materials, Training of Trainers (TOT) and initiate the refresher courses that will be required.

[11] Ken Grant et al, May 2001. Decentralisation in the Bangladesh Health Sector, a discussion document.

It seems to the IRT that such an incremental approach, - learning from experiences and improving by doing - has a much better chance of a successful implementation than a full roll-out in a centrally planned and operated way. Some relevant issues that need to be decided upon in the beginning are:

- Prepare for and define the composition and tasks / responsibilities of the Upazila Health Management Committee (UHMC) (including planning, budgeting, priority setting, implementation, supervision and reporting) and its various members, notably the Upazila Health and Family Planning Officer (UHFPO); Make the composition of this committee not too small and not too big;
- Develop a Capacity Building Programme that prepares the committee members for their future tasks and responsibilities in managing the various (support) services in the UHC, the Union-level facilities and the Community Clinics. It will be important to have the various management tools (planning format, budgeting format, M&E, supervision and reporting format) in place before the start of this Capacity Building exercise;

Success with the implementation of this new community policy will to a large extent depend on whether the planning and budgeting capacity, coordination and supportive supervision and the ability of the support systems to deliver timely at Upazila level can be improved. Much will depend on the extent to which decentralised planning and decision making by the UHMC is allowed and supported.
In general, it is essential to define the referral and supervision linkages between the various levels of care (District, Upazila, Union and Community) and spell out the responsibilities among all actors in order to ensure the necessary 'unity of command'.

The IRT team suggests MOHFW to elaborate a three year annual rolling plan that allows for flexibility in the implementation. Details on the various steps that need to be taken in the preparation of this new and challenging policy will be made on the way. Such a plan should then become part of the roadmap to implement the revised health policy.

2.8.4 Financing Upazila Health Services

We propose in the Health Sector Financing Technical Report (chapter 3) an approach to financing Upazila and District health services that learns lessons from previous experiences with decentralisation. The main elements can be summarised as follows:

1. Allocate the necessary resources in the budget for financing LLPs, with the funds to be managed and accounted for at District and Upazila level, using existing Government financial management, accounting and audit arrangements.

2. In the meantime, ask Upazilas to prepare LLP's setting out what they hope to achieve in service delivery in the coming budget year and the resources they need in order to achieve it. The plans and budgets will set out in summary form the overall plan for health, family planning and nutrition services. The incentive for preparing the plan in a serious fashion is the prospect of gaining access to some of the additional funds that have been allocated in the budget. To guide the planning process and avoid the preparation of unaffordable 'wish lists', guidance will be provided on the amount of funds potentially available to each Upazila.

3. Additional funding should be focused on the poorest Districts and Upazilas. Ceilings should aim to close the gap between per capita spending in the poorest and richest districts. As suggested in the R-PIP, the additional funding should start with resources for the non-salary budget for current costs and minor items of equipment.

4. Eligibility for funding will not be automatic. In addition to the proposed focus of the scheme on Upazilas that are both poor and have received below average per capita spending in the past, it is suggested that approval of funds should be based on meeting some core criteria. The criteria must not involve the centre in over-riding local priorities, provided that spending proposals conform with fairly general guidance on eligible expenditures (a 'positive list' of eligible expenditures might be proposed). Relevant criteria for assessment might be:
    a. Preparation of a joint plan, covering DGHS, DGFP and (where relevant) NNP, with evidence of willingness to work cooperatively, preferably verified by description of joint planning, coordination, supervision and ideally management arrangements that are already in operation at local level.
    b. The plan should include demonstrable links between the planned targets to be achieved and the resources that are requested. This does not imply detailed activity planning, but fairly high-level linkages, for example between the volume of outpatients and the expenditure on drugs and other MSR.

5. The preparation of plans and allocation of funds will achieve little, if not reflected in effective implementation. It needs to be linked into a structured approach to work-planning, monitoring and supervision. Much of the necessary guidance exists on paper and is reflected in current best practice in the better performing upazilas and districts. However, most upazilas and districts will need technical support and training. Technical assistance to support local level planning, budgeting, and implementation of effective Upazila health services will therefore need to be recruited and mobilised during 2009-10, in time to support preparation of plans for implementation in 2010-11. Past experiences suggest that this timetable for mobilising necessary TA is only likely to be achieved if the TA is recruited through a parallel arrangement. Although the procurement may be done through DPA, there needs to be strong ownership and confidence by MOHFW, other DP, and preferably discussion with district and upazila level staff. The TORs need to be jointly developed. MOHFW and DPs need to select the consultants together.

6. One critical constraint is HR. It will be difficult to make progress in improving services if staff shortages and rapid turnover mean that there is nobody with the time to plan and supervise services, and too few adequately trained staff to deliver them. Various proposals to allow local recruitment of staff in paramedical categories have been proposed in the past but refused by central ministries, for example the DGFP were refused permission in 2008 to use a contractor to recruit 'paid volunteers' to be given basic training in order to fill critical staffing gaps. A necessary condition for success, and one that DPs may wish to emphasise in policy dialogue, is an effective approach to address critical staffing gaps.

2.8.5 Fiduciary risks of implementing the UHS

The fiduciary risk of this approach is arguably no greater than for current centralised approaches, which have seen significant wastage of expenditure, as evidenced by periodic stock-outs due to failure to procure on time, poor utilisation of expensive equipment as revealed by the 2008 equipment survey, and problems of poor coordination between capital works and the provision of necessary staff and equipment. Nevertheless, there are some risks. It is suggested that these can be managed by:

1. Using existing Government financial management systems, with resources for funding LLPs identified by specific budget codes for district and upazila level.

2. Financial Management Reports: Provide TA support as needed to strengthen financial management within the supported districts and upazilas. This should not be a prior condition, but should accompany access to funds. However, continued access by each individual upazila or district should be conditional on compliance with minimum accounting standards, e.g. the availability of financial monitoring reports reconciled to the underlying Government accounts. This should not become a barrier to access, and flexible TA should be available to support district / upazila accounts officers to comply.

3. Timely audit reports: The main auditing will presumably be of district and Upazila accounts as a whole, which would cover but not be limited to health expenditures. Anything more specific required by DPs might need to be contracted out under the authority of the auditor general. An alternative or additional comfort measure could be independent monitoring on a sample basis. This would need to be done with a light touch, to avoid discouraging Districts and Upazilas from applying.

4. Donor funds can flow either through a modified pooled fund or as a form of policy based support. More details on the DP fund-flow arrangements are summarised in Volume 2, in the box on “Alternatives on Investment Lending” (page 111).

The final issue concerns accountability to the community. Formal decentralisation would bring the health services under the control of the Upazila Parishad (UP). Recent legislation and discussion in the Supreme court has resulted in some lack of clarity on the extent to which the UP is beholden to accept the guidance of the local MP. This issue will take time to resolve, but an alternative approach in the short term might be to approach the support of LLP as a form of delegation, rather than decentralisation in the formal sense of shifting responsibility to local-level politicians. The Secretary under this model is delegating some of his authority to be exercised by civil surgeons and Upazila Health and Family Planning Officers (UHFPO), as he is entitled to do under MOF regulations. Accountability to the community might still be feasible through establishing specific health committees in the short term, rather than relying on the formal political structures. As and when the issue is resolved, more formal political accountability could be brought in. It needs to be handled with care if spending is not to be diverted for political purposes, probably implying an initially quite restrictive definition of eligible spending.

2.8.6 The way forward for Upazila Health Systems

Establishment of an Upazila Health Systems (or a similar system with another name) along the lines described in this section would lead to greater effectiveness and efficiency of preventive and curative health services, including specific disease control programmes. The Community Clinics proposed and partially already being established by the present government would be a key element in the UHS, but cannot be a stand-alone level in the national health system. Community Clinics need refurbishment of facilities (or new construction), additional training of existing staff (or hiring or training of new staff), and tools to work with. Nation-wide coverage by the UHS requires a large and lengthy investment in facilities, staff, equipment, pharmaceuticals, logistics and management. It would require delegation of tasks and responsibilities from central, division and district levels to the upazilas, unions and wards, and possibly new methods of financing the services. Such a programme would easily last 10 years and more, as it has done in other countries that opted for a real primary health care system.

The establishment of a PHC model in the form of the UHS needs a decision by the government based on an elaborated proposal taking all factors into account, such as investment costs (facilities, equipment), human resources required, training needs, technical assistance required, and a flexible implementation schedule.

The implementation of an UHS programme could become an important element of the successor to the HNPSP from 2011 onwards, if such a proposal is elaborated and the main decisions are taken before the end of 2009.

2.9 Nutrition: Moving Nutrition from NNP to a decentralised SWAp

2.9.1 Background: Nutrition in BD: overview of the situation

Although good nutrition status is central to the achievement of most of the Millennium Development Goals (MDGs), set by the United Nations, the importance of nutrition as a foundation for health and economic development is often underestimated. A high prevalence of under nutrition has serious impact on quality of life, economic growth and national development. Gillespie and Haddad estimated that Bangladesh loses three billion dollars each year as a result of lower productivity and treatment costs arising from under nutrition. Reduction or sustained elimination of micronutrient deficiencies could increase the country's GDP by 5% at a cost of only 0.3% of GDP by protecting its citizen from malnutrition.

Like other South Asian countries, the prevalence of malnutrition in Bangladesh is one of the highest among the developing countries. However, the indicator used for the MDG (underweight for age), shows that moderate malnutrition among children aged 6-59 months has come down from 66% in 1990 to about 50% in 2007. The current annual rate of reduction of this MDG indicator is 1.27 percent point, whereas an annual rate of reduction of 1.36 percent point is required to achieve MDG 1. In summary, malnutrition rates are improving over the years, but not fast enough to reach the MDG target.

The slow down in the rate of reduction in the MDG indicator reflects a combination of continued improvement in chronic malnutrition (stunting), down from 48% in 2004 to 42% in 2007, but still far away from the MDG target (25%)[12], offset by some indication of an increase in acute malnutrition (wasting) among under fives, which has increased from 10% in 2000 to 15% in 2004 and 17% recorded in 2007. Children with stunting have 20 percent lesser learning scores compared to healthy children. The implications are huge for Bangladesh. This adverse effect on learning is compounded by high levels of anaemia among infants, because anaemia affects their intellectual development

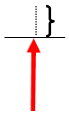
Although there no longer are gender differences in nutrition of children under five, the higher rates of malnutrition among girls and women compared to boys and men is a reflection of gender disparities that still prevail.

About 30% of women are under-weight, down from 34% in 2004, and many suffer from anaemia. Both conditions increase the risk of having babies with low birth weight, which in turn increases the risk of neonatal death and an important cause of poor growth and development in later childhood with consequences for later life. A World Bank study presents evidence that malnutrition during pregnancy and the first two years of life causes irreversible damage to physical and mental development, associated with lower educational attainment, lower productivity in work, and a more than 10% reduction in the lifetime earnings of the individual. It is also a major cause of ill-health and of mortality.

[12] See BDHS and HNPSP Sector Performance Indicators 2004 – 2010 at pages xi and xii.

Micronutrient deficiencies also are prevalent. For example, about 40% of pregnant women are anaemic, increasing risks when they give birth. Deficiencies of other micronutrients of critical concern to children and women are Vitamin A and Iodine.

Figure 2-1: Trend in the prevalence of underweight children 1980-2015.



Source: BDHS 2004 and 2007;MDG Goals; Bangladesh Progress report-2005

Economic growth alone will not solve the problem. If past rates of economic growth in Bangladesh are sustained, it will take 20 years to double income per head. However, the World Bank study estimates that this would reduce malnutrition rates by less than a third, leaving them still far higher than existing rates in Sub-Saharan Africa. The World Bank describes improvements in economic growth, food security and women's education as the 'long route' to reducing malnutrition. They point to the need to scale up 'short-route' interventions, such as feeding practices, ANC, behaviour change and communication, demand side measures, undertake affirmative action to promote gender equity in the household and community, micronutrient supplementation and fortification. Together, these are effective in reducing malnutrition and excellent investments, with high benefit-cost ratios. These types of 'short-route' interventions are addressed within the NNP. Cumulative international evidence shows that if such interventions cover 70-80% of the population, significant impact on nutritional status can be achieved.

2.9.2 The National Nutrition Policy and the NNP

The cumulative effect of malnutrition puts Bangladesh in a disadvantaged position during this time of global economic crisis. Bangladesh endorsed and finalised the National Plan of Action for Nutrition (NPAN) in 1995. It is high time to revise the out-dated NPAN which was formulated in 1992. A recent National Food Policy (2008) is focussed only on food.

At the moment there is no National Nutrition Policy, which explicitly puts nutrition interventions high on the national agenda.

Recent scientific evidence has confirmed that there are nutrition interventions that would be cost-effective in poor countries such as Bangladesh (Lancet, 2008). Most of these interventions have been introduced in the country. They include:

- Micronutrient supplementation for pregnant women and under- five children;
- Growth monitoring and nutrition counselling;
- Promotion of exclusive breastfeeding[13].

However, the scientific evidence also illustrates that such interventions need to reach at least 70% of the population in order to reduce malnutrition levels effectively. For example, with 70% coverage it is possible to avert 17% deaths, 27% stunting and 17% DALYS (Lancet, 2008:371).

To deliver these interventions, two approaches have been adopted.
First, some of the micronutrient interventions (Vitamin A, Iron Folic-Acid (IFA) are delivered through the public sector mainstream health services, namely the Health and Family Welfare services managed by the DGHS and DGFP.
The second approach which is used for delivering growth monitoring and nutritional counseling as well as micronutrients and promotion of exclusive breastfeeding is delivered through NGOs using an Area Based Community Nutrition (ABCN) approach, managed by the National Nutrition Programme (NNP). This second approach, though 'large scale' in comparison with efforts in other countries, operates currently in 109 of the 481 upazilas. It covers only 25% of the population. The NNP is still a long way from the 70-80% coverage that is needed. It is unrealistic to expect a rapid extension of this coverage, as the approach is essentially 'area based' and dependant on the NGO sector which is much smaller than the public sector in Bangladesh.

Therefore, a critical issue needs to be addressed: is the ABCN approach an alternative to the main stream public sector health services or should it be regarded as complementary?

- The IRT recommends that the community based approach should be regarded as complementary to the main stream public sector services and not as an alternative.

The rationale for this recommendation is elaborated in the next sections.

The area-based National Nutrition Programme (NNP)
Several issues affect the NNP programme, such as:

1. Although entitled 'National' there is limited potential for rapid scaling-up and national coverage.
2. It is implemented through several NGOs and has fragile or no links with the mainstream health system. One consequence is that children with severe acute malnutrition (SAM), who need referral and intensive treatment, are not managed adequately. The nutrition supplement which is given to these children lacks essential micronutrients which are necessary to correct iron deficiency anaemia.
3. Although NNP claims to have achieved better results compared to non-NNP areas, those claims are not substantiated with robust analysis of evidence, because the

[13] This is a list of illustrative examples, and is not intended to be a comprehensive list of interventions provided through NNP.

available data is of questionable quality and validity. The components of the NNP programme and their impact need to be evaluated as a matter of urgency.
4. It has not reached the poor nor special areas most in need of nutrition support.
5. NNP has insufficient technical leadership, a limited skilled workforce and lacks rigorous supervision and monitoring.

Limitations of community nutrition approach:
The poorest of the poor generally are not reached by the community approaches. They do not have the time or opportunity to participate in community level activities (See Chronic Poverty reports). They need to be reached by more targeted activities.

Nutrition, education is supposed to be given to the women who attend community clinics, but BDHS 2004 and the World Bank maternal health and nutrition impact study data show that the majority of women on their own cannot make the food choices, as this is the privilege of the family elderly who are often not included in health education. In short, there is a behaviour-knowledge gap. Women may know what they should do, but they do not practice it, as they are not the ultimate decision makers. Use of such information is critical in guiding the design of behaviour change programmes of NNP. It emphasizes the persistence of gender discrimination and inequality and the barrier they create in removing nutritional differences between women and men.

The original design of the NNP programme included household vegetable gardens and poultry farms; the earlier experience from Helen Keller International had shown that people have problems buying the fruits and vegetables they need and that animal proteins had to be included, if one wanted an impact on nutrition. Implementation difficulties distorted this component which was discontinued in 2006.

Nutrition interventions in the Health and Family Welfare services
Micronutrient interventions are delivered also by the Health and Family Welfare services. Vitamin A supplementation is delivered through the EPI programme and has reached a commendable 88% of the population. It effectively reaches the poor.
Iron Folic Acid (IFA) supplementation is a part of antenatal care for pregnancy, but only about 50% of women make one visit and reportedly often do not receive IFA. Hence the IFA coverage is inadequate. Similarly postnatal Vitamin A supplementation is part of the prescribed postnatal care, but since only about 21% of pregnant women have a postnatal visit, coverage is very low.
Growth monitoring and nutrition counselling are not done in the Health and Family Welfare clinics. There is no provision for management of severe acute malnutrition.

2.9.3 The need for change

The only feasible option for rapid expansion of key nutrition interventions to the entire country is **to mainstream nutrition within the health services**, viz integrate as many interventions as possible within the services of DGHS or DGFP. This would be a first step to making nutrition an integral part of HNPSP rather than a stand-alone component. It would then be possible to achieve close links between the community approaches and the health services. Where possible, they could be integrated with those services that are already reaching the poor. Options and steps for doing this are discussed in the section entitled ‘Options for the Future’.

Missed opportunities for inter-sector coordination

Nutrition is not the sole purview of the health sector. Several other sectors have responsibilities and interventions that address directly or indirectly, the problem of malnutrition. There are missed opportunities for coordination between health sector interventions and those of other sectors. A number of food security interventions are undertaken by various government agencies with which MOH FW could coordinate to strengthen its nutrition programmes. Some illustrative examples are cited.

- The World Food Programme (WFP) and other food donors support the government's Vulnerable Group Development programme (VGD) by which monthly rations are given to poor women, particularly pregnant and lactating mothers.
- The Department of Agriculture Assistance implements a number of projects with Danida and FAO assistance, in which increased family food security is an important component.
- The Helen Keller Programme used to be on the cutting edge of nutrition activities, but they are not involved in these discussions anymore.
- Various NGOs are implementing community health programmes. Many do include nutrition education. MOHFW could treat them as part of its extension services and encourage them to include nutrition as one of their community health components.

These experiences are not brought together in one place. There is a need for lesson learning across sectors, across NGOs and government agencies. NNP is in an advantageous position to link these food security opportunity for the vulnerable families.
In order to reduce such missed opportunities, effective coordinating mechanisms are needed. This issue is further elaborated in the section on 'Institutional Arrangements'.

Neglected Communities

Hard to reach areas such as 'haors' and 'chars' (river islands) have particular food security problems. The poor in those areas are particularly vulnerable. In the haors they are cut off from the mainland and are living on virtual islands 4-6 months of the year. Although there is water all around they are not allowed to fish ("Water lords" control the fishing rights). Families in the char areas are isolated and cut off. Food production is poor because of soil conditions. When the water levels rise they are cut off from the mainland and during certain seasons even those with money cannot buy the food they need. The Char Livelihood Program (CLP) interventions target the extreme poor char islands, they are a hard to reach, asset less, landless and jobless population in five districts in Northern Bangladesh. The objective of CLP is to help the targeted households lift themselves out of extreme poverty and hardship. In three years, 55,000 extreme poor households, approximately 250,000 people, have been selected and have received the CLP package of support. This is proving to be successful in terms of improving health and nutrition status though a sustainable livelihood programme.
This is another example in which coordination could be strengthened between the nutrition programme and poverty programmes

2.9.4 Stakeholders in the Nutrition landscape

NNP was originally a standalone project which merged into the HNPSP in 2006. NNP is one of 38 line directorates and is one of those that report directly to the Secretary, as opposed to through DGHS or DGFP. The main activities of the NNP are currently being implemented through competitively contracted NGOs at community level. NNP supports

the NGOs with training, procurement of iron foliate, de-worming tablets, and behaviour change material. National-level NNP activities consist of communication support, for breastfeeding promotion. Support is being contracted to the private sector and Iodine fortification of salt is managed by the Ministry of Industries.
The Institute of Public Health Nutrition (IPHN), also the LD for micronutrients, under the DGHD, coordinates micronutrient supplementation with Vitamin A through the national immunization days (NID).

Nutritional surveillance is particularly important in Bangladesh where malnutrition is high, there is geographic diversity (ie monga areas, chars, etc) and there is a high prevalence of disasters. This ensures a speedy response in crisis to the most vulnerable groups. In the Sidr response there was no real ability to roll out food-aid in a strategic way to the most vulnerable and these were at the highest risk of mortality. Helen Keller International undertook nutritional surveillance for a number of years, initially for their program areas, and subsequently at a national level with a capacity building component with IPHN. However, lack of donor funding for HKI meant this surveillance ended in 2006. MOHFW failed to take up this crucial activity. HKI is due to start again soon but again without significant commitment from MOHFW. Funding is provided by the European Commission, with implementation being done by BRAC and HKI and with capacity building being done in the Bangladesh Bureau of Statistics (BBS). While sample design and protocols should be done together with BBS to ensure compatibility with other statistical exercises, it is not clear where nutritional analysis capacity should be established: in the BBS; in MOHFW, or under the current organization in IPHN?

Coordination of implementation within the MOHFW starts with a national steering committee, chaired by the Hon. Minister for Health and Family Welfare, and the programme should have coordination mechanisms right down to community level. External coordination is partly through representation of other stakeholders in these coordination committees and through NNP linkages with nutrition related programmes in other ministries and previously some sub-projects e.g. household food security interventions to be implemented through the Ministries of Agriculture and Fisheries and Livestock and through the Vulnerable Group Development (VGD) programme of the Ministry of Women and Children's Affairs. In the past a National Nutrition Council was established, but this has rarely met in recent years.

A Nutrition Task Group (NTG), chaired by the Joint Secretary Public Health and WHO, exists as the policy dialogue group between the MOHFW and the donors with regard to implementation of nutrition programming under HNPSP. Unlike other task groups within HNPSP, the NTG also has external representation including the co-chair of the Nutrition Working Group (NWG), an NGO dominated informal working group on nutrition and with representation from ICDDR,B. However, this group was convened only 3 times in 2008, generally with very little notice, and without a pre-announced agenda. Going forward this group needs to meet on a regular basis, with an announced agenda that allows members to prepare for the meeting. Discussion items should include progress under NNP, IPHN and nutrition programming under other LDs, as well as driving the dialogue on policy and strategy.

Community nutrition activities are organised around community-donated Community Nutrition Centres (CNC), established for a population of 1250 households and run by part-time female contract-workers, called Community Nutrition Promoters (CNPs) appointed by the NGOs. CNPs are supervised by Community Nutrition Organisers

(CNO). In addition, Village, Union and Upazila Nutrition Management Committees are established for community mobilisation and inter-sectoral co-ordination. Originally NGOs were contracted directly by the NNP, but this moved to competitive contracting in 2007, and subsequently in 2008 this contracting responsibility was transferred to the new Management Support Agency (MSA).

In short: Nutrition is currently implemented in 'silos' in the MOHFW with little linkage to other line directorates There appears to be no relationship between IPHN, NNP and IEC line directorate; explanations for the slow roll out of community-based IMCI were given as the lack of community workers, yet the line directorate had never considered using the community nutrition promoters; NNP targets pregnant women who are ultra poor with BMIs potentially below 17.5 and therefore at risk of poor maternal outcomes. The maternal voucher pilot programme was not linked to or targeted to high-risk pregnant women identified in the NNP programme.

2.9.5 Options for the future: Nutrition in an Upazila Health System

Once the policy decision is taken to mainstream nutrition within the health services, several options should be considered to implement it effectively:

First, the design of an integrated health and nutrition service needs to be developed. This would include decisions on:

1. What would be the most cost-effective modality(ies) for nutrition counselling to reach key decision makers in the family?
2. Would it be feasible to aim for growth monitoring of all children, or to develop interim measures such as 'sentinel' approaches?
3. What would be the most cost effective and feasible modality(ies) for management of acute severe malnutrition?
4. Would the food supplementation component of NNP be continued, modified or discontinued? What about the non-NNP upazilas?
5. Would micronutrient supplementation powder (sprinkles) for home food for children be included in the programme? Through what delivery modality?
6. How could adolescents, especially girls, be reached?
7. Would the food security (home garden) component be continued? If yes, in what form and where?
8. What measures are needed to improve the impact of the exclusive breastfeeding initiative?
9. What measures are needed to improve the implementation of micronutrient supplementation for pregnant and postpartum women?
10. How would national nutritional surveillance be established?

In making decisions, it is necessary to consider questions like who should do what and select the best combinations. Every contact of clients with the health system needs to be considered. Opportunities for integration into services have to be identified, e.g. at EPI sessions, ANC and PNC visits, satellite and community clinics, union and upazila level institutions etc. An example would be detection of severe malnutrition and provision of nutrition counselling. There are several opportunities to improving the coverage of ANC with better counselling and support for iron folic acid supplementation and improving postnatal coverage, so as to improve postpartum Vitamin A supplementation.

Management of severe acute malnutrition could be integrated into upazila, and district level institutions. Zinc supplementation could be included with ORS during diarrhoea. For interventions such as exclusive breast feeding, a multi-pronged approach would be needed. The capacity of the IEC division to design or contract out the development of such an approach needs to be assessed.

Second, what organizational restructuring within MOHFW is needed to make nutrition an integral part of the Health and Family Welfare services?

Third, what would be the relationship between the current area-based community nutrition (ABCN) approach of NNP to the proposed Upazila Health System?
Once more, several options or combinations of options are possible:

- In NNP upazilas, build referral and supervision linkages between the area based community nutrition approach (ABCN) and the Health and FW services, and define responsibilities and reporting lines;
- In upazilas not currently served by NNP, decide whether or not to continue phased expansion of the ABCN approach.
- In upazilas where the NNP type of ABCN has not been implemented, decide whether other community mobilization initiatives can be utilized: either piggy-backing on existing initiatives or introducing alternative approaches such as using the community clinic as the focus point.

Fourth, what mechanisms are needed (or need to be revitalised) to strengthen coordination between health and other sectors on nutrition-related issues?

Moving from policy to implementation
Once the design issues have been resolved, operational implementation issues would need to be planned. It would be necessary to have a clear definition of roles and responsibilities. Some critical interventions are already within the responsibility list of health care providers, although implementation is inadequate, while for others, the new responsibilities would need to be developed.

In particular, clarity would be needed regarding managerial and supervisory lines and responsibilities. Managerial responsibilities would need to be specified and where relevant, capacity developed. For example, the responsibilities would include developing implementation plans that integrate nutrition interventions, ensuring finance, supply of materials and logistic support, mobilising community support or linking with existing community based initiatives, supervising both technical and managerial aspects, and monitoring and evaluating progress.

For upazilas that face special challenges, such as the ‘Monga’ prone areas, natural calamity-prone coastal belt and the hill tracts, additional responsibilities might be required to ensure there are community-based efforts and safety nets.

Planning a transition phase
Since the existing NNP is delivered through contracts to NGOs, and some contracts are on-going while others are in the process of being awarded, a time-based transition phase would be needed to move from the current to the new model of service delivery.

Addressing resistance to change
Appropriate training or orientation efforts are required for upazila level managers, supervisors and service providers. It would be important to recognise that resistance to change is very likely, particularly to a change that brings an expanded list of responsibilities. This cannot be managed merely through directives from the centre. Motivational inputs to address the anticipated resistance to change would be needed to facilitate rapid and effective implementation.

2.9.6 The Human Resource Situation in Nutrition

Health workforce shortage is a chronic problem in Bangladesh. In considering mainstreaming of nutrition interventions, issues arise in relation to (a) whether there are adequate number available workers at the front-line to provide nutrition interventions in addition to their other functions, their immediate supervisors and those that would provide technical guidance and (b) the technical competence of each category to provide that intervention effectively.

Number of front line workers and their immediate supervisors
Since several micronutrient interventions are already included in the responsibilities of existing cadres of workers, the issue of achieving better coverage is part of the available numbers and the planning and management of their time. HR initiatives are being developed to address these issues (see section on Human Resources). Growth monitoring and nutrition counselling would be an additional responsibility. An assessment is needed on how and where this activity could be integrated. Currently there is no system for regular contact between the health system and under-five children except at NNP community nutrition centres. The options are:

- Initiate under-five clinics at outreach services and/or community clinics;
- Start weighing of children as and when they have contact with any health facility. This would enable detection of SAM, but not moderate malnutrition.

The first option would require significant increase in community workers, since it implies that efforts would be needed to locate eligible children and also to recall drop outs. The second option might be possible with current staffing patterns but would be less effective in detecting malnutrition and providing adequate nutrition counselling.

In upazilas where there is ABCN through NNP, it is possible to 'piggy-back' on other initiatives through which community workers have regular community contact. Linkages could be made, where community workers conduct the under-five clinics using health and family welfare facilities and outreach sessions. In upazilas where such opportunities do not exist, suitable strategies need to be developed.

Special nutrition cadre
Absence of technical expertise in nutrition is one of the serious shortcomings of the system. Not only NNP but also the health system requires such expertise to guide and provide advice on technical aspects. Provision of community nutrition experts at national, district (and eventually at upazila level) is essential for providing leadership and technical guidance, and for orientation and on the job training of workers and their supervisors.

Technical competence:
Health care providers as well as community workers would need initial as well as on-going training geared to the nutrition functions expected of them. The training provided in the successful EPI programme is one example of a model that could be emulated.

It would also be necessary to have skilled and knowledgeable health personnel for managing SAM. Options to be considered for providing appropriate care would include training some of the existing categories of health workers such as Sub Assistant Community Medical Officers (SACMO), medical assistants, FWVs or community paramedics to be trained in managing (mal)nutrition or creating an entirely new public health oriented cadre.

Policies need to be developed after the options are considered and discussed with key stakeholders with a view to feasibility, cost and effectiveness of each option.

2.9.7 Support from M&E, Research, Procurement and PFM

Monitoring and evaluation
M&E is an important part of NNP and other nutrition projects and programmes in order to track measurable progress to facilitate evidence-based decision making for policy makers. This is to be linked with other indicators within the HNPSP integrated umbrella. Making use of existing information systems within MOHFW contributes to synergy and efficiency of the whole system, especially for nutrition, while the identity of nutrition interventions can be maintained. The integrated nutrition management information system should be led by a core qualified team (Nutrition, Statistics, ICT) that ensures built-in quality assessment of the information system. A formative evaluation and operational research should guide the scaling-up process. This external quality control of M&E is to be incorporated in the NNP technical monitoring policy.

Besides the routine information system that provides important management information on the performance of the nutrition programme, time series of data indicate that more profound investigations are required. Whereas key nutrition indicators do not show major improvements over time, mortality rates are dropping. Research on the determinants of health is justified in order to provide answers to the dynamic of nutrition and malnutrition in the country. Results would certainly add to informed and evidence-based decision making on the impact of the National Nutrition Programme.

Logistics / Procurement
Currently all procurement for NNP goods and services is done centrally in Dhaka. The number of products procured is limited. The NNP service procurement has been taken over by MSA who is finalising the 49 packages for a total of 233 Upazilas. The contracts of the 63 upazilas in Phase 2 have already been signed.

In light of the decentralisation of authorities to district level, it is possible to consider decentralising the procurement of the two medicines. Currently, the Civil Surgeon already procures the NNP medicines as part of the MSR. Although procurement experience does exist at district level, it may be worthwhile to compare prices for the two medicines at district and national level. Current distribution is done through the NGO's who collect the medicines from the NNP offices in Dhaka. This would have to change.

Nutrition Research

Bangladesh has a tradition of leadership in nutrition research. There is a need to disseminate existing research results on nutrition problems and their solutions among policy makers, including Members of Parliament (MP), MOHFW senior managers and the media for evidence-based policy decision.

Further, research could address key problems identified by the programme. For example: What dietary intervention can improve the situation, at what cost? Why are levels of anemia still unacceptably high in young infants and women, what cost-effective intervention might improve the situation? The answers to these questions can be obtained through analysis of existing survey data and from prospective nationally representative, well designed studies. Suggested topics include:

- What are the most cost-effective interventions to reduce low birth weight prevalence
- How can food security interventions, targeting the ultra poor be improved
- How to improve the current suboptimal rates of exclusive breast feeding;
- Identification of 'malnutrition hot spots' to target future interventions.

Also in-depth qualitative studies are needed to better understand gender discrimination and how it affects nutrition. This should help identify what could be the possible entry points to change nutrition care and practices for children, girls and women.

Financial support in a decentralised system

Financial provision relating to Nutrition is included in two OPs:

- The National Nutrition Programme (NNP) which falls under the MOHFW and
- Micronutrient Supplementation (MS) under the DGHS.

The Revision of the PIP in 2008 resulted in a 13% increase in the budget for NNP and a small reduction (2%) in MS. Both programmes are supported substantially by external funding (NNP approx 90% and MS approx 75%). The financial provision for MS has been well utilised (40% of the R-PIP budget expended at 31.12.2008) but expenditure on NNP is low in comparison to the budget: only 16.6% of the R-PIP provision having been spent at 31 December 2008.

If nutrition support is to be mainstreamed and scaled up, it needs to be coordinated with, and preferably integrated within, health and family planning services. The proposed approach to financing district and upazila local level plans would provide an entry point to bring nutrition within the mainstream of day-to-day service provision, initially by joint planning at local level by health, family planning, and NNP staff. Mainstreaming nutrition within MOHFW will include the need to consider the appropriate distribution of budget provisions across both revenue and development budgets to support the changes in the mode of service delivery.

Table 2-12: Financial Provision for Nutrition in HNPSP

	NNP Tk Crore	Micronutrients Tk Crore	Total Tk Crore
Revised PIP 2005	1347	98	1445
Revised PIP 2008	1520	96	1616
ADP : RPA	1082	57	1139
ADP: DPA	14	17	31
ADP: GOB	104	24	128

ADP Total	1200	98	1298
Budget 2007/08	115	21	136
[14]Actual Exp 2007/08	110	15	125
Budget 2008/09	133	16	149
[15]Cumulative Exp to 30/6/08	490	30	520
Exp as % Revised PIP	32.2%	31.2%	31.3%

2.9.8 Conclusions

In summary, the key challenges are to scale up the critical nutrition interventions and improve their implementation, particularly in vulnerable high risk groups. For this purpose, actions are needed at the policy, programme and service delivery levels.
To scale up these interventions, the best option is to mainstream the nutrition into the services provided through DGHS, DGFP and NNP facilities and staff.
To improve the capacity and effectiveness of the delivery mechanisms, it needs to be reviewed and specific strategies need to be adopted and monitored regularly.

At the policy level.
First, agreement is needed on mainstreaming nutrition within MOHFW activities. It is also necessary to define which critical interventions should be scaled up and the time frame within which this should be achieved.
An important question is whether there is sufficient capacity for rapid scale up for example in areas like referral and management of severe acute malnutrition, promotion of exclusive breastfeeding, micronutrient supplementation during pregnancy and post partum period, and zinc with ORT for diarrhoea treatment.

Second, a decision is needed on the institutional home for Nutrition and which institution will be responsible for providing leadership. It is necessary to expand the responsibilities and capacity of the selected institution accordingly, while simultaneously specifying the responsibilities of all stakeholders in relation to nutrition interventions. There is need for a formal coordination mechanism.

Third, a decision is required on the future of the NNP and the ABCN approach. For this purpose, it is necessary to review the NNP and decide on its future in relation to the programme content, its approach and institutional arrangements.

Fourth, in order to make the inter-sectoral activities functional, a high-level body headed by the Prime Minister or her nominee is required. Perhaps the National Nutrition Council needs to be reactivated.

At the Programme level, a phased approach is needed.
First it is necessary to identify opportunities within the existing services for immediate mainstreaming and to prepare and implement time-bound plans to integrate nutrition into on-going activities.

[14] APIR 2009
[15] R-PIP 2008

Second, the plans should include measures to address deficiencies in implementation of the critical nutrition interventions, such as improving Vitamin A supplementation during the post-natal period.
Third, a strategic plan is needed to specify how services need to be strengthened in order to expand the range of interventions that are to become mainstreamed. The plans should include not only time-bound activities, but also estimates for the required human resources, equipment and financial means.

Operational level
At the operational PHC level, (i.e. community, union and upazila levels), each upazila and district will need to develop an implementation plan for integrating the selected nutrition interventions. Special strategies are needed for community groups that are at high risk. The resources required for such strategies need to be assessed and provided.

2.9.9 Recommendations

The delivery of nutrition interventions in Bangladesh need an overhaul in order to respond to the challenge of the high rate of malnutrition in the country.
Therefore it is necessary to**:**

1. Mainstream nutrition within Health and Family Welfare services;
2. Decide on the organizational re-arrangements needed to provide an appropriate institutional home for nutrition;
3. Decide on the design of the mainstreamed service and its relationship with the ABCN approach implemented by NNP;
4. Strengthen health/nutrition education and BCC to address the socio-cultural determinants (including gender discrimination) of food distribution at household level;
5. Establish high level national nutritional policy advisory bodies and establish or re-vitalise inter-sector coordination mechanisms;
6. Establish mechanisms for national nutritional surveillance.
7. Develop a phased implementation plan for the transition from the current to the future design of nutrition services.

3 Technical Reports: Stewardship of HNPSP

3.1 Sector Management

Findings

Table 3-1: Findings in overall sector Management since the start of HNPSP

Area	Targets		Comments
Dates	June 2008	June 2009	
1. Publicise HNPSP	Start July		HNPSP branding is being used at all workshops. GTZ consultant has been contracted to develop a communications strategy.
2. Coalitions with non-public actors (+ TA)	Start July		There has been a lot of discussion but little action because senior managers are not convinced of the value of coalition building with non-public actors
3. Monthly review of HNPSP with DGHS/DGFP	Start April		The DG Health Services and Family Planning are chairing monthly reviews to review progress against OPs. The Secretary is also reviewing progress on the ADP on a monthly basis.
4. Continue HNP Forum and Coordination TGs	Start April		HNP forum has not met for over 6 months, but the intention is to start meeting on a more regular basis. HNP Coordination has met 4 times in last year. Some TGs are meeting on a regular basis but others are less active.
5. Regulatory and Accreditation systems reviewed	December		Not yet done, routine work ongoing but no overview done.
6. Sector reviewed by Health Policy Group		April	The new government intends to develop a long-term national health policy. The Secretary proposes to establish a health policy committee lead by the Joint Chief Planning which will include representatives from the Directorates of Health Services and Family Planning.
7. PMA established	Established	Operational	Draft contract has been issued to selected company
8. MSA Inception report discussed	Done May		Done
9. NGO contracting agreed	Done May		The MSA presented its inception report at a DSP Steering Committee meeting in October 2008, NGO contracting ongoing
10. MSA contracted: 138 Union RD/FWC 378 Community Clinics	Sept 2008		MSA contract signed 1st April 2008. Contracting out of management of UHC and Community Clinics to NGOs cancelled. NGO contracting for NNP and NASP is in progress

Note: Outputs and Indicators taken from PAD and R-PIP.

Results and achievements

The MOHFW revised the PIP and OPs to incorporate the recommendations of the Aide Memoire following the MTR and policy dialogue. The production of an annual performance implementation report (APIR) and annual stakeholder consultation review have now become standard parts of the annual performance review. The implementation of OP is done routinely through the different executing wings of the MOHFW and

reported monthly at different levels, including as part of the overall reporting on the MOHFW annual development plan (ADP).

The establishment of Task Groups (TG) to support the implementation of OPs is a positive move, though still at early stages. It needs further institutionalisation, working groups in some key areas need to be re-designated and included in the TG structure.
A number of inter- and intra- directorate committees have been set up and are functioning to take forward sector initiatives, e.g. local level planning.

Some minor steps have been made in the area of strengthening regulation. MOHFW has approved a new organisational structure to strengthen the Directorate of Drug Administration (DDA), as a strengthened DDA is essential if the growing pharmaceutical sector is to be appropriately regulated.

Work is on-going to contract NGOs to delivery specific packages of the essential service delivery under the HNPSP. A range of public-private partnerships are being established within the health sector, with support through the HNPSP, supported directly and indirectly through pooled and non-pooled donor funding.

There is discipline of regular monthly coordination meetings to review service delivery which take place at the division and district levels, although there are separate meetings for health and family planning. In addition, monthly meetings are taking place in the Secretariat to review progress of the ADP and the HNPSP Operational Plans.

Constraints and challenges

1. Policy frame-work: The HNP sector at the moment is being managed without an up-to-date policy frame-work and clearly-defined priorities. It is necessary that a comprehensive Health Policy outlining the objectives, goals and priorities of the sector should be adopted through a detailed consultative process so that the sector works with a clear Policy direction and its performance is evaluated with reference to the goals and objectives enunciated in the National Policy.
2. Sector boundary: At present the HNPSP sector boundary is not well defined. It does not contain all the programs/projects in the sector and not even within the MOHFW. Urban health Care is outside the ministry, while a number of infrastructure projects within the Ministry are outside the HNPSP. A number of vertical programs like TB, Malaria and HIV/AIDS as well as the numerous other NGO programs, are being implemented under separate financing arrangements. This hampers sector-wide monitoring and evaluation and also makes it difficult to attribute outcomes to different segments or interventions in the sector. The GOB and DP's may consider bringing all these activities under one programme through better alignment and harmonisation.
3. Programme awareness: Understanding of and awareness of HNPSP, particularly among district and upazila levels is unsatisfactory. Lack of awareness diminishes ownership of the programme, while it fails to create the desired impact on service delivery and achievement of results. Steps should be taken by way of extensive orientation programmes, seminars and workshops to create better awareness of HNPSP, its goals and objectives with a view to ensuring better implementation.
4. Problems of management: HNPSP has been plagued with a number of deficiencies and weaknesses since its inception. The most frustrating problem is the acute shortage of professional staff namely doctors, nurses and paramedics. This is further

complicated by frequent transfers and absenteeism, resulting from weak personnel management. Management also suffers from existing structural anomalies which in turn adversely affect efficient, cost effective, intergraded and client-friendly service delivery.

5. Strengthening Capacity and Role of Support agencies: Two support agencies, namely the Program Support Office (PSO) and the Management Support Agency (MSA) have been created to strengthen the public sector capacity. PSO is in operation since mid-2007. It seems there is a huge disconnect between these agencies and the Ministry/DGs whom they are supposed to support. The PSO/MSA do not take any proactive actions, either to improve their relationship with the government agencies or to strengthen their implementation capabilities. The government agencies consider them as rank outsiders and interlopers whose only job is to find fault with government agencies and officials. This situation certainly calls for improvement so that the government receives the desired inputs and support from these organizations leading to better programme implementation.
6. Planning and Implementation: The number of OP's may be reduced by amalgamating those dealing with allied subjects or sub-sectors which will make planning and implementation somewhat easier. LD's need intensive formal orientation and training to improve their knowledge of the programme and implementation capability. Officials of the Ministry and Directorates must be allowed to continue in their positions for a minimum appropriate tenure in the interest of smooth and uninterrupted implementation of OP's. The identification of some LD's/senior officials as 'anchors' has shown results and the system should continue.
7. Coordination and Monitoring: The Programme being complex and challenging in nature calls for effective co-ordination and monitoring within the GOB, as well as with DP's. The Coordination Committee, the Steering Committee and the Task Groups have to sit regularly with participation at appropriate level and try to remove any bottlenecks in implementing the programme. Much better sector performance can be expected if these committees/groups function at regular intervals. Currently, the APR is one of the few opportunities for reviewing the key sector components, this means that the APR agenda has become very crowded in recent years, resulting in the APR being requested to identify sector priorities rather than addressing issues around sector priorities that have already been agreed. The quality of MIS needs to be upgraded if better monitoring is to be achieved. The currently bifurcated MIS also affects decision-making and may be amalgamated. Since the program is entering a critical stage, it may be advisable that coordination and monitoring is occasionally done at higher levels of the government which may remove inter-ministerial and inter-sectoral bottle-necks and expedite programme implementation.
8. Reform management: The HNPSP envisaged a number reform activities considered necessary for modernizing the sector and to ensure improved service delivery. These included sector management, decentralization and local level planning, service diversification and stimulating demand for HNP services. Progress in achieving these reforms has been poor, except in the area of the Voucher scheme. Renewed attempts should be made to put the reform agenda on track, however difficult and unpleasant the task may be. The HNPSP has great potential and much of it depends on the careful implementation of the reform agenda.

Table 3-2: Recommendations for Sector Management

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1. Capacity for policy and strategy development	Government to agree HNP policy statement by June 2009. Ministry to lead Government owned process to develop new sector strategy aligned with the GOB planning and budget calendar Design the strategy development process as an experiential learning project for Ministry managers and professionals (a learning by doing approach facilitated by a trained mentor)		
2. Strengthen regulation	Establish a committee to co-ordinate the approval and continuing accreditation of medical teaching hospitals, adopting a system of provisional approval and accreditation MOHFW to immediately follow-up on release of funds to DDA to implement their OPs.	Establish a taskforce to coordinate a review of the legal framework, support the taskforce with appropriate short-term TA; Support DDA to develop a long-term strategic plan for the regulation of the pharmaceutical sector in Bangladesh	Carryout periodic reviews of how regulations are being adhered to in the health sector, including how quality is being assured and recommend changes to the regulatory framework and arrangements for its implementation
3. Enhanced performance management	Create a senior management team (Secretariat + DGs) to review sector performance on quarterly basis with 5 identified priorities on the agenda (e.g. MNCH, nutrition, population, HR reform, decentralization).	Create balanced set of performance indicators, which also reflect equity and gender, aligned with the new sector strategy. Increase discretion over HR and budgets at district and Upazila levels	Strengthen accountability of providers to elected representatives Strengthen horizontal accountability to users through citizen charters and report cards.
4. Improved programme management	All national programmes and support systems to carry out their own annual internal reviews and report on progress. Cluster OPs to promote cooperation between departments with accountability to the closest direct report in the structure Decongest the agenda for the APR through intermittent sub-sector reviews on key issues	Strengthen Annual Sector reporting by building on sub-sectoral reporting on strategic areas, e.g. such as the essential services delivery. Establish annual planning, budgeting and review cycle in line with GOB annual cycle as outlined in R-PIP	
5. Better aid relations	GoB and DPs agree on new institutional architecture for SWAp with clearly agreed responsibilities, membership and meeting schedules	Gradually integrate HNP Coordinating Committee into existing MOHFW monthly meetings which	

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
	for the different fora The HNP forum is activated as the forum for policy dialogue between GOB, DPs and representatives of implementing agencies with priority setting and annual reviews aligned with GOB budget calendar HNP consortium develops a harmonisation and alignment plan acceptable to government GoB provides quarterly reports to DPs on progress in 5 key priorities	review progress on ADP and OPs GOB and DPs jointly monitor progress on the agreed harmonisation and alignment plan	
6. Diversification of service provision	Revise the Terms of Reference of the DSP Steering Committee to broaden the scope to PPP, and appoint a co-chair to facilitate regular meetings. Commission a study to review all the current ways partnerships are supporting the diversification of service provision (outside of the current out-sourcing). Review the need for establishing a stand-alone PMA and explore the integration of the PMA functions within existing structures, if contractual arrangements allow. Review the working arrangements for the MSA and their reporting arrangement within the MOHFW, including the possibility of full-time placement of key technical assistance from the MSA to work full- or part- time with their counterparts.	Establish a NGO and Private Sector desk within the MOHFW	
7. More effective internal structures	Start work to revise the vertical and horizontal division of responsibility at key points within the structure Create a senior management team responsible for deciding policy and strategy, as well as reviewing sector performance (see 3 above) Establish a full-time SWAp Secretariat to support the senior management team headed by a	Create a multi-disciplinary policy unit to support the senior management team Create permanent cross-departmental teams for key priorities (e.g. maternal mortality) reporting to the Secretary	Staff the policy unit with staff who have worked effectively on the preparation of the new sector strategy

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
	senior government official and staffed with members of the PSO team.		
8. Improved coordination	Develop a calendar for all routine meetings, ensuring that TGs (& steering committees), HNP Forum and HNPSP CC are coordinated to feed into each other. Appoint Co-Chairs so as to ensure calendar is not interrupted. Review and revise if necessary the range of Task Groups, their terms of reference and participation (if necessary set up a HNPSP CC taskforce for this purpose), identify what secretariat support is needed and provide, establish communication system for information sharing.		

3.2 Gender, Equity and Voice (GEV)

Findings
Gender, Equity and Voice are recognized as key areas to be addressed by the HNPSP programme. A number of interventions and activities were foreseen and a number of institutional mechanisms were in place in order to ensure sufficient attention was paid to these issues. However the priority given to gender and voice was effectively reduced and the institutional mechanisms for gender mainstreaming became somewhat inactive, while the institutional mechanisms for voice were not set into place (user forums).

There are a number of areas where there is progress in reducing the disparity between girls and boys and between women and men. Under-five mortality rates and malnutrition rates are virtually the same for girls and boys. While in some health care areas there is still disparity of treatment (ARI for example), in others it is reduced.

There are a number of areas of inequality in access to health services in terms of availability of hospital beds, restrictions in women's independent access to health care facilities, not having access to EmOC (Emergency Obstetric Care) facilities, and not having facilities which can be considered to be women friendly (ensuring privacy, addressing violence against women (VAW), providing space for breastfeeding, minimum cleanliness, having adequate human resources, etc). The shortage of staff at rural and lower levels affect the quality of care women and the poor can receive, as they are the ones who go most to the local public facilities.

The support systems such as HR, M&E, and PFM have not fully supported the importance given to gender mainstreaming. The reviews and strategies formulated do not take gender fully into account. There is a need to address the huge number of women who are part of the health workforce to ensure that they are not discriminated against. While there is a lack of available data to do a thorough analysis, we do know that more than 50% of the new doctors who join are women but that their drop-out rate is very high and only a small percentage of women doctors carry on in public service.

There has been progress at the national level on gender responsive budgeting as part of the MTBF process by which budget submissions have to be justified by the pro-poor and gender sensitivity as well as by the relevance to the PRSP. This has still to be translated into budget allocations at the project level and to the monitoring of the budgets.

A stock-taking exercise of the Gender equity strategy has already been done by the consultants hired by task group GEV and a workshop was held in February 2009 organised by the GEV Task group. A report is available on the stock-taking exercise including a proposed action plan. The GEV group is now preparing a more focussed action plan based on the stock-taking.

With regard to Voice, there has been no progress on the institutional arrangements for Health Service Users Forum. There are a number of committees at various levels both under DGHS and DGFP to involve community stakeholders in health or family planning activities and these are more or less active. A Citizen's Charter of Health (CCH) was formulated and later revised in 2007, which is displayed in health facilities nation-wide.

The LLP process and tool kit envisages involvement of the local community in the local level planning process. Orientation on this has been given to those who are/were to be involved in the process. This is also an important mechanism to institutionalise the opportunity to give voice to the local community.

As part of the action plan for Governance and Planning for the Future, an action agreed upon was "coalition building with non-public actors (with TA assistance on communication strategy), e.g. the Health Service Users Forum and stakeholder workshops. HEU was to take the necessary steps to implement the above action, receiving help from DGFP and DGHS. This has not been done.

Table 3-3: Findings in Gender Equity and Voice since the start of HNPSP

Major expected outputs and results in HNPSP	Indicators, Targets and Activities	Progress during 2005 – 2008
Gender		
1. "Core" health services provision are improved at the margin to cost effective, equitable and accessible levels (no 3 in Log frame in PAD)	Gender (All Public Health facilities offer Gender sensitive services by 2010)	In the period July 2007 to June 2008 8 district hospitals were provided extra budget for MCH services; 10 district hospitals monitored for EOC activities and orientation workshop on gender were held at 4 district hospitals. 112 of upazila health facilities and 59 of the district hospitals have functioning EmOC facilities. In the period July 2007 to June 2008, as part of the Strengthening of Baby and Women Friendly Hospital, a number of hospitals have been selected and assessed; orientation has been provided to the service providers and community; additional monitoring carried out and supply of medicine, instrument & equipment for strengthening of the Women Friendly Hospital activities at district hospital has been provided. A national accreditation committee has already been approved by MOHFW. Breast Feeding refresher workshops were held at 8 district hospitals. There are plans to scale up to 28 Women Friendly Hospitals by 2010. According to the Citizens Charter all Medical College Hospitals are to have breastfeeding corners, required confidentiality to be maintained regarding examination and treatment of patients especially for women, and well cleaned and separate toilets are to be maintained for male and females. District hospitals and Upazila Health Centres are to provide Emergency Obstetric Care (EmOC) services round the clock.
2. Reducing injuries and implementing improvements in emergency services (1.5 in LF in PAD)	VAW (% of women who receive counseling after injury disaggregated by age and socioeconomic status)	One Stop Crisis Centres have been established in 8 Medical College Hospitals under the Multi sectoral Project on Violence Against Women. Women victims of violence receive health, legal, and mental counselling in these OCCs. The organogramme of the medical college hospitals include the post of a clinical psychologist but there has not been any recruitment to these posts. In the women friendly hospitals there are separate protocols for the treatment of women victims of violence.
3. Violence and Injury (3.6. in LF in PAD)	Awareness Campaigns Awareness campaign for the prevention of accidents and injuries are annually	Ministry of Women and Children's Affairs (Multi sectoral Project on Violence Against Women) has implemented some awareness campaigns.

Major expected outputs and results in HNPSP	Indicators, Targets and Activities	Progress during 2005 – 2008
	implemented; scaling up of One-Stop-Crisis centers	
Equity		
4. Utilization of ESP(ESD?) services by the poor (LF PAD 1a)	Utilization of ESP (ESD?) services at all service levels in public and NGO facilities, by the two lowest quintiles	The poor receive disproportionate benefit from public health programmes, but for the reasons we have discussed they make much less use of curative care. About 36% of public health services by volume are being used by the bottom quintile, but they account for only 14% of the utilization of curative care, slightly more than half as much as the two richest quintiles. Women account for more in- and outpatient consultations, but this is largely accounted for by their use of reproductive health services, particularly family planning. For all other services, men benefit more than women (women to men ratio of 0.86). This is particularly strong at tertiary level. (see Section 3.3.2 of the report)
5. Improved Budget Management (2.8 LF PAD)	Proportion of total MOHFW expenditure allocated to the 25% poorest districts	The public expenditure review estimated the historic share of Upazila and below up to 2006-07, and found that it increased to about 52% in 2006-07 from about 45% in the two previous years. For the APIR, the PSO produced estimates that the Upazila and below share was 54.5% in 2007-8 budget and 54.1% in 2008-9[16].(Section 3.3.1 of the report)
Voice		
6. Improved Sector Management (2.9 LF PAD)	Institutional arrangements for community and stakeholder participation safeguard indicator (Institutional arrangements for Health Service users Forum agreed BY 2004, HSUF secretariat in place, 50% coverage by 2010)	There has been no progress on the institutional arrangements for Health Service users Forum. There are a number of committees at various levels both under DGHS and DGFP to involve community stakeholders in health or family planning activities and these are more or less active. A Citizen's Charter on Health was reformulated in 2004 and revised in 2007, which is displayed in health facilities nation-wide
7. LLP (2.5 LF PAD)	Strategy for Local level planning developed	The LLP process and tool kit envisages involvement of the local community in the local level planning process. Orientation on this has been given to those who are/were to be involved in the process. This is also an important mechanism to institutionalise the opportunity to give voice to the local community.

Outputs and Indicators taken from PAD and R-PIP.

Results and achievements

- 4 District Hospitals and 3 Upazila Health Complexes have been accredited under the women friendly hospitals scheme.
- 8 of One-stop Crisis Centres providing comprehensive care to women victims of Violence
- "Stock-take of Gender Strategy and Gender Action Plan carried out in February 2009;
- Workshop on voice and accountability was held on 23-24 Feb. 2009 where all the issues of health user forum, stakeholder participation etc. discussed.
- LLP process started which includes local level consultations
- About 8000 community clinics set up with local committees

[16] Dr. Azaher Ali Molla and Dr. Muhammod Abdus Sabur, Proportion of MOHFW Budget Going to Upazila and Below: An Analysis of FYs 2007-08 and 2008-09.

Constraints and challenges

For gender, equity and voice the responsibilities to take forward the issues are scattered and the approaches are fragmented. Since all three are cross-cutting issues they need to be addressed throughout the programme and in/by all the support systems. However there is no champion or focal point to ensure that these are adequately addressed. The TG GEV is one body where they come together but the TG is itself an ad-hoc body for coordination, set up in response to an APR recommendation.

All three issues need strong political will to take them forward, since they challenge the status quo. They need long-term processes to take them forward and there are no easy solutions. The benefits are important but not always obvious. With shortages of human resources, turn-over of staff (both in Government and within donors), the time and attention required for such issues is insufficient.

The scale at which the HNP programme functions is also a challenge for the operationalisation and rolling-out of qualitative and process intensive interventions.

Recommendations

Table 3-4: Recommendations for GEV

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
Voice			
1. Strengthening and promoting of voice and accountability mechanisms	Identification of best practices, review TOR and membership HACs, formulate guidelines, contract out facilitation Formation of committee to develop and monitor the process of institutionalisation of the CCH. Ensure that local level planning integrates local stakeholder consultations Promotion of NGO health service programme accountability to local clients.	Finalise TOR, composition and procedures of HACS, expand number. Ensure CCLs from local community committees. Involvement of various stakeholder groups in the process of planning of the future programme. Identification of institutional responsibility for the promotion of voice and accountability mechanisms as part of sectoral governance	New programme to ensure that outputs, outcomes and indicators address voice and accountability issues across the programme Training of health care providers to include clients rights, Allocate adequate budget to V&A interventions.
Equity			
2. Closing the large gap in utilization of services between the poorest and the non-poor	Formulate budget to allocate a larger amount to upazilas and below, and explore options to minimise costs	Explore options for addressing more pro-poor measures Piloting of approaches to staffing and supervising services in remote areas.	
3. Develop guidelines so disadvantaged and marginal groups are taken into consideration in planning, implementation and monitoring of service delivery	Development of guidelines	Dissemination and follow-up of guidelines. Ensure that the situation and interests of disadvantaged and marginal groups are taken into account in formulation of the new programme.	
4. Disadvantaged regions need to have diversified	Review special interventions proposed for hard to reach and	Review implementation of the special interventions and adjust as necessary	Integrate region specific programme in the new

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
approaches to address their specific problems.	backward regions. Begin implementation of these special interventions	Identify the region specific strategies that will need to be taken for the future programme	plan in order to address various types of disparities
Gender			
5.Strong follow-up and monitoring of specific measures so that gender sensitivity in all public health facilities is ensured	Follow-up and monitoring on a priority basis of the roll-out of EmOC at upazila level; of referrals of complicated deliveries. Introduce measures to ensure privacy and develop guidelines for the allocation of hospital beds according to sex and type of care needed	Formulation of proposals by the relevant sections and departments to address gender issues; stakeholder studies commissioned should explore what are women's priorities and constraints with regard to nutrition, maternal health care, family planning. Information should be collected on disease patterns among men and women.	
6.Identification of outputs, activities and indicators relevant to the promotion of gender equity across the programme that need to be monitored	Engage with the process of the finalisation of the new Health Policy to ensure that gender equity is adequately addressed. GEV to prepare action plan. Follow-up with DMIS preparations, TA on M&E and DGFP and DGHS to ensure that sex disaggregated data is produced Training on gender analysis Include representative of the TG GEV in the TG M&E		The new programme documents should ensure that gender relevant outputs, activities and indicators are incorporated across all the parts of the programme.
7. Strengthening attention to gender and equity concerns in HR planning, development and management	Authorities should be provided regular statements to monitor recruitment, postings, transfer, training of different categories of staff by sex Include representative of the TG GEV in the TG HR. Bangladesh Health Workforce Master Plan should incorporate gender affirmative measured to address the differential needs of the women and men. The principle of equity should be operationalised in HR plans and include in the Bangladesh Health Workforce Master Plan		
8. VAW identification, treatment and carrying out of medico-legal examinations to be ensured at upazila and district levels.	Review of the experiences of the OCCs and Women Friendly Hospitals, identify what general district hospitals, upazila Health complexes and union health centres can do to deal with VAW, revise existing protocols on VAW accordingly. Monitoring and follow-up of	Integrate training and orientation on VAW identification counselling and treatment in the curriculum and courses of health care providers at all levels, including FWAs, FWVs, HA, nurses and doctors Prepare strategic plan for how the health system can address needs for	Medical and nursing education curricula to include courses on violence against women (causes, consequences, manifestations, treatment, etc).

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
	carrying out of medico-legal examination at Upazila and District level.	psychological counselling for girls, boy and women affected by violence.	
9. Review and revise TOR and membership of institutional mechanisms for gender mainstreaming in the MOHFW. Proposals to be developed by TG GEV and submitted to Gender Advisory Committee (GAC) for approval	Review/revise TOR, functions, membership of the GEV Task Group and the Gender Advisory Committee. Emphasize policy making and decision-making role of GAC and coordination and follow-up role of GEV/TG. Review and revise TOR of the GNSP Unit to emphasize its policy role, the TOR of the GIO to emphasize its operational role and their links to the GAC and the TG GEV. WID Sub-focal points in DG HS, DGFP and Directorate of Nursing Services (DNS) should be revived and reassigned and made members of GEV TG. PSO Gender Advisor role of support to the above should be decided and annual work plan agreed with GEV TG.		

3.3 Health Sector Financing

Results and achievements
Government and donor spending of $ 5 per head accounts for 30% of health spending; the rest largely consists of out of pocket expenditure on a diverse range of mostly small scale private providers of modern and alternative services of variable efficacy. Direct household expenditure on purchasing drugs from pharmacies accounts for private spending of $ 4 per head – dwarfing public expenditure of much less than $1 per head on drugs.

Public health interventions such as immunisation are approaching universal coverage and have good equity characteristics. However, curative services offered by MOHFW reach a far lower proportion of the population, they are little used by the poor and coverage is not improving. If current plans are left unchanged, there will be little improvement in coverage of curative care or in equity by 2010-11. The recently revised OPs are not planning for an increase.

The main barriers to improving access by the poor are high and uncertain costs for a low quality service, with lack of drugs a major cause of low utilisation of public services, together with lack of staff, especially in remote areas. The Government budget for drugs has been in long-term decline; availability continues to be interrupted by procurement problems. Recent increases are welcome, but fall far short of what is required to support the rapid growth in utilisation that will be needed to sustain continued progress towards the MDGs.

A resource group on health financing has been established, and has begun to define a work plan. A number of important studies have been recently completed or are in preparation, including the public expenditure review, health facility and facility efficiency surveys, and Sida stock takes, while new national health accounts are being prepared. There is little other progress to report on health financing in this year of political transition: no new pilots of alternative financing were started, local level planning has not been linked to budget provision and remains split between DGHS and DGFP, no movement on hospital autonomy, and contracting out of community clinics has been halted by the new Government.

MOHFW has so far met one of the five performance measures for receiving Category 1 financing, based on performance on maternal health before the agreement was made.

Constraints and challenges
The financial resources available to the health sector are far short of what is needed to reach the MDGs, and future growth in the budget is likely to be slower due to the global recession. Achieving better health outcomes will require MOHFW to make fuller and more effective use of the funds that are available by improving efficiency and equity of access, and by ensuring that available budgets are fully utilised.

Some of the decisions in the revised PIP may be worth revisiting. The physical facilities investments stretch beyond HNPSP, and have long-term financial and human resources

implications that may prove difficult to meet while also introducing an Upazila health system with rehabilitated community clinics.

Major improvements in efficiency are also needed because Bangladesh has achieved most of the reductions in mortality that can be realised by scaling up relatively simple stand-alone public health interventions. Future progress in reducing mortality will increasingly depend on more complex interventions that require an efficient health system, able to respond in a timely and appropriate way to diverse and unpredictable demands. Achieving the required improvements in the efficiency effectiveness and equity of health services (and sustaining progress towards the MDGs) will need significant reform to decentralise decision-making and reduce fragmentation. A fully effective health system is not possible via a system in which management within the 64 districts and nearly 500 Upazilas is split between the two DGs, and the smallest decisions are taken in Dhaka through a structure involving two budget systems, 38 line directors, numerous projects and programmes, and the involvement of several Ministries. Increased delegation of management and financial responsibility to Upazila and District level will help to alleviate the problems, and will be more effective if accompanied by some streamlining of management in Dhaka.

Government is not the only actor able to contribute to improved health outcomes, and with limited resources it needs to define its role carefully. There is scope to develop insurance and risk-pooling mechanisms that will relieve Government of responsibility for financing services to the better off, enabling it to concentrate on serving those who can not afford to pay. There is also scope to use public private partnerships and contracting out to provide services to urban and remote populations where public sector primary health care is not presently available.

Bangladesh has considerable experience of alternative ways to finance health services, but almost none of it is in Government, the maternal voucher scheme being the only exception, though a significant one. The constraints on introducing innovative approaches within a bureaucratic and rule-bound culture have proved formidable, and there is little reason to be confident that this will change sufficiently to enable alternative financing via MOHFW to make a significant contribution to health outcomes within the next 6-7 years spanned by HNPSP and a possible successor programme. This raises an issue of priority for action within MOHFW. Government has a formidable agenda of internal reforms to address the problems of the public sector system for which it is responsible. There is a strong case for focusing attention and available capacity on those internal reforms.

Alternative financing mechanisms should be pursued, but the main channels for developing and supporting them can be, and probably should be, outside the health ministry, although Government will need to have some role in regulation. Because private sector services are not available everywhere, MOHFW will also need to ensure that public sector health facilities are able to respond to increased patient demand stimulated by alternative financing mechanisms. This is likely to require increased budget flexibility and more local management discretion. However, there is no reason why MOHFW needs to be directly responsible for developing and implementing alternative financing arrangements. These may be easier to develop and scale up by working outside the HNPSP through non-Government institutions, able to draw on experience with both financial innovation and service delivery.

An effective approach to decentralised planning, budgeting and service delivery is essential, but it needs to learn from past problems. Local integration of services should be encouraged but not imposed; real results need to be seen before motivation sags. Local plans need to be informed by realistic expectations of additional resources to implement them, and should focus on reducing the current geographical inequity in financing. We recommend an approach to supporting local level plans based on allocating additional funds in the budget to support Upazila and District plans. The amounts each is eligible to receive should be communicated in advance in order to guide planning and realistic budgeting. The scheme should initially be targeted in the poorest districts and upazilas. Access to funding would not be automatic but would be subject to conditions related to joint working across health and population, a plan with clear links between targets and the resources to achieve them, and conforming with guidance on the purposes for which additional resources can be used (see section 2.8.4 of main report). Technical assistance will be needed to support the process. This needs to be mobilised in 2009-10 to permit the start of the scheme in 2010-11, which means using DPA to recruit. Fiduciary risks can be tackled by using the Government system, but with technical assistance to support district and upazila capacity.

The current indicators for measuring progress towards improving the poverty focus of expenditure are not routinely monitored or targeted in budget preparation. The implications of budget decisions for the share of spending at upazila and below can and should be monitored during the course of budget preparation, as was done successfully by the PSO during the revision of the R-PIP. The indicator for the share of the budget going to the 25% poorest districts cannot at present be measured. We propose an alternative target and indicator: MOHFW to achieve an annual increase in the share of budgeted and actual total expenditure that is identifiably within the poorest 25% of districts. This has the advantage that it encourages both a stronger poverty focus, and a more poverty conscious approach in preparing / monitoring the budget, moving away from the current approach where it is largely accidental, whether the target is reached or not.

Aid effectiveness can be improved by better integrating the programming of DP support with the annual budget calendar, as the R-PIP proposes. The timing of the APR should be brought forward to October each year to facilitate this.

Harmonised and aligned mechanisms for supporting the health sector need to be retained beyond the HNPSP, but modified to facilitate full disbursement while retaining a sufficient focus on managing fiduciary risk. A review of the various options should be undertaken in 2009-10, with the objective of having revised financing agreements in place to start from July 2011.

Table 3-5: Recommendations for Health Sector Financing

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1. Review the workplan of the HFRG	1. Review the work plans of the financing resource group, ensuring that Government and HNPSP avoid taking on roles that could be more effectively pursued via non-Government routes		
2. Introduce upazila and	Mobilise TA, allocate funds for	Disburse funds,	Implement, monitor and

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
district level planning and budgeting in the poorest districts	financing districts and upazilas plans in 2010-11 budget, develop and issue guidelines and budget ceilings , support interested poor upazilas and districts in preparing 3 year rolling plans, allocate funds in 2010-11 budget for those meeting the criteria	Upazilas and Districts start implementation, support monitor and review progress, approve funds for year 2 where progress justifies, invite applications from additional Upazilas	review, modify and extend as justified
Improve the pro-poor targeting and monitoring of the budget	Keep spending at upazila and below under review during budget preparation, and target a year on year increase	Keep spending at Upazila and below under review during budget preparation, and target a year on year increase	Keep spending at Upazila and below under review during budget preparation, and target a year on year increase
Develop new indicators for baseline	Calculate a 2007-08 baseline for a new indicator: achieve an annual increase in the share of budgeted and actual total expenditure that is identifiably within the poorest 25% of districts. Set a target for 2010-11.	Monitor the target during budget preparation to ensure a year on year increase is achieved	Monitor the target during budget preparation to ensure a year on year increase is achieved.
Review the rationale of the physical Facilities OP			
Improve coordination of dialogue around the annual budget cycle, as recommended in R-PIP	DPs indicate financing intentions for 2010-2011by end December		
Change the APR to September/October – with the next one scheduled for 2010, to launch the successor programme		September-October APR	
Agree DP financing options for a successor programme, maintaining the objectives of harmonisation and predictability	Review alternatives to current arrangements	Negotiate new Joint Financing Agreements to commence July 2011	

4 Technical Reports: Service Delivery

4.1 Disease Control and Medical Services

The priority objectives of the HNPSP in the field of Public Health and Disease Control according to the revised Programme Implementation Plan are presented in Table 4.1 below. Other objectives and an overview of the results of the programmes are described in Section 4.2 of the Technical Report. Mother & Child Health and Nutrition are key elements of Public Health but are organised and discussed separately in the Technical Report (chapters 5 and 6).

Table 4-1: Findings in Public Health since the start of HNPSP

Major expected outputs and results in HNPSP	Indicators, Targets and Activities	Progress during 2005 – 2008
1. Reduce the burden of HIV/AIDS	HIV prevalence among pregnant women 15-24 years in high-risk groups (except IDU) and in the general population to be below 1% in 2011.	No data available.
2. Reduce the burden of tuberculosis	Case detection rate to reach 70% by 2011. Cure rate of new cases of TB to reach 85% by 2011.	Case detection rate already reached 72% in 2007 and further increased to 73% in 2008. Cure rate already reached 92% in 2008.
3.Reduce the burden of malaria	Reduce malaria morbidity and mortality by 50% in 2011 (compared to 1990).	*Recorded* malaria mortality reduced from 478 in 2000 to 154 in 2008. Most cases of malaria do not enter the statistics. Number of confirmed cases increased in 2008 due to better case detection.
4. Reduce the use of tobacco	Prevalence of smoking and use of smokeless tobacco below 20% in 2011	Baseline was 31% and 32%, respectively, in 2005; no new data available.
5. Early detection of breast and cervical cancer	Screening by self-examination to reach 30% of eligible women by 2011.	Cervical cancer cannot be detected by self-examination. Cancer screening objective is not realistic.
6. Early detection of hypertension	Awareness activities for the eligible population leading to 20% screened in 2011.	No data available.

Source: Revised PIP.

During the Annual Programme Review of April-May 2009, the Independent Review Team was able to analyse disease control programmes (malaria, HIV/AIDS, tuberculosis and leprosy, avian influenza, kala-azar, filariasis, non-communicable diseases) and other public health programmes (arsenic mitigation, emergency preparedness and response, medical waste management, and health education).
Some other programmes could not be analysed due to time constraint, e.g. blood safety, dengue control, (re-)emerging diseases, and injury prevention (the operational plan of which includes violence against women).

Results and achievements
Most of these public health programmes have produced good results, especially the tuberculosis and leprosy programme. The programmes for malaria, filariasis, kala-azar, avian influenza, arsenicosis, emergency preparedness, and medical waste management can also point to achievements. Health Education and HIV/AIDS carried out their

activities according to the operational plans as best as they could, but results are difficult to measure.

Constraints and challenges

Usual problems such as delays in procurement, frequently changing officials, and shortage of field staff will not be presented here, as national staff knows them all too well, and are dealing with them as they occur. These problems are being discussed in a more general way in other parts of this report. Minor challenges to the various public health programmes are described in chapter 4.2 (Vol II). There are, however, challenges worth to mention in this executive summary:

1. The management of the National AIDS and STD Programme (NASP) should be the spider in the web of HIV/AIDS control activities, but has been weak for a long time, because of too frequent changes in staff positions. There is also insufficient insight into the long-term risk of spreading of HIV from high-risk groups to the general population of Bangladesh.
2. The filariasis programme appears to be running a bit out of steam, so that the Mass Drug Administration is not reaching the coverage required for elimination of the disease.
3. The strategy against non-communicable diseases (NCD) needs a reality check, especially on the subject of population screening. The NCD programme is under-funded and understaffed, and is unlikely to deliver results.
4. Health education and promotion is a key weapon in most public health programmes and should be strengthened and especially more concentrated in one organisation.
5. Public health programmes need primary health care providers for the continuity and sustainability of their activities in the field. Therefore, the possible revival of primary health care in Bangladesh - through community clinics or otherwise - is strongly recommended, also for better meeting the demand for medical care.

Table 4-2: Recommendations for Public Health

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1. Strengthen NASP management and activities.	Adopt new strategy. Strengthen NASP management and ensure continuity of competent staff. Collect epidemiological data.	Collect epidemiological data.	Continue activities according to the new strategy.
2. Strengthen filariasis control.	Improve Mass Drug Administration. Consider vector control.	Improve Mass Drug Administration.	Reschedule elimination target (also for kala-azar).
3. Rethink NCD control.	Collect baseline data. Rethink NCD strategy.	Collect baseline data. Decide on NCD strategy for the coming decade.	Implement new NCD strategy with sufficient resources.
4. Centralise health education & promotion.	Establish links between health education cells/departments, including tobacco control.	Strengthen health education and promotion in all relevant programmes.	Strong health education and promotion element to remain in public health programmes.
5. Establish real PHC (through Upazila Health Systems, UHS).	Elaborate UHS vision/policy and long-term strategy/action plan.	Implement UHS strategy.	Implement UHS strategy.

4.2 Mother, Neonatal and Child Health and Family Planning

Findings

Table 4-3: Findings in MNCH and Family Planning since the start of HNPSP

Major expected outputs and results in HNPSP	Indicators and Targets	Progress during 2005 – 2008
1. Reducing IMR and U5M to achieve MDG 4	IMR 33.1/1000 and U5M of 48/1000 by 2015	1. Bangladesh is on track to achieve MDG 4 with impressive declines in infant and under-five mortality). 2. IMR declined from 65 (2004) to 52 (2007); 3. U5M declined from 88 (2004) to 65 (2007)
2. Reducing maternal mortality to achieve MDG 5. (reduction by three fourths of the 1990 level to reach 120 per 100,000 live births by 2015)	1. To increase the proportion of births by skilled attendants from 13% (2004, BDHS) to 43% by 2011 (APIR, 2009) 2. To decrease Maternal Mortality Ratio from 320 per 100,000 live births (BMMS, 2001) to 270/100,000 in 2011.	1. Births with skilled attendance has increased from 13% (2004) to 18% (2007).. 2. An accurate estimate of progress on maternal mortality is possible only with a MMR survey, and this has been commissioned to be done in the next year.
3. Reducing fertility in line with the Population Policy which is to achieve replacement level of fertility i.e. Total Fertility Rate (TFR) of 2.2 by 2010	1. To reduce TFR to 2.2 by 2011 (APIR) 2. To increase contraceptive prevalence rate for modern methods (CPR) and increase access to reproductive health services.	1. TFR declined from 3.0 (2004) to 2.7 (2007) 2. CPR (modern methods) remained stagnant. It was 47.3 in 2004 and 47.5 in 2007.

Note: Targets from Aide Memoire 2008.

Results, achievements, constraints and challenges

Since the MTR 2008, significant steps have been taken to implement the agreed recommendations. These should be regarded an important first steps toward achieving the desired outcomes for MNCH in HNPSP. They include (a) expression of commitment to improving nursing (and midwifery) at the highest political level, (b) a massive recruitment exercise including filling vacancies for doctors and FWAs, (c) adoption of a National Neonatal Strategy, (d) acceptance of a proposed Midwifery Strategy to increase midwifery skills in the country, (e) steps to train pairs of doctors (obstetric and anaesthesia) to provide EmOC and incentives to place them in upgraded upazila level facilities, (f) improved monitoring of EmOC facilities (g) steps to expand IMCI through NGOs working at the community level under NNP.

Availability of the final report from BDHS has enabled this APR to focus more attention on the how effectively programmes are reaching the poor, and identify gaps and refine recommendations accordingly.

Child health: Children are being protected effectively against vaccine preventable diseases in childhood (for example, 81% coverage of measles immunisation, and the country has maintained polio-free status). There is no gender or wealth disparity in immunization rates. There is good quality surveillance and outbreaks are promptly and well investigated. The number of vaccines in the routine programme is being expanded with GAVI support. The EPI programme also delivers Vitamin A and achieves good

coverage. Also, use of oral re-hydration for diarrhoeal disease has wide coverage and reaches the poor.

Expansion of the facility based IMCI is progressing well, but expanding the implementation of IMCI at community level and including pharmacies and 'village doctors' is relatively slow. The BDHS 2007 indicates that only about 37% of sick children receive care from a trained provider, with girl children and the poor having lower rates. The challenge is to expand community IMCI to more upazilas and begin the training of traditional and informal providers. Collaboration with the successful social marketing approach used by the family planning programme that trains private sector pharmacists and tradition and informal providers could be a way forward.

Anther critical challenge is neonatal mortality which remains high – it was 42 in 1999-2000, 41 in 2004 and 37 in 2007. Only 22% of children receive appropriate care within 24 hours of birth. The challenge is that 82% of births occur in the home. It is necessary to educate communities and care-givers who attend new-born children at home on simple life-saving measures for the newborn. Nutrition and breastfeeding are intricately connected to child health. Issues on these topics and covered in the section on Nutrition. Implementation of the newly adopted Neonatal Strategy would address several key issues.

Maternal Health: ANC coverage is 51% (target 55%) but wealth disparity is marked (31% in LQ1 compared to 83% in LQ5). Since coverage is much lower than for EPI which reaches more than 80% of children, it should be possible to increase coverage rapidly for ANC by closer collaboration between EPI and ANC. Also, the quality of ANC (Iron Folic Acid, birth counselling) needs improvement.

Skilled attendance at birth has increased slightly since 2004, largely due to increased use of private sector by the wealthier quintiles. The gap between the highest and lowest quintiles has increased. About 82% of women deliver at home, and the programme has tried to increase access through trained community skilled birth attendants (CSBAs). As yet, available data does not enable an analysis of how effective this intervention has been. Only about 43% of the estimated requirement of 15,000 CSBA has been trained, but the pool of eligible candidates from the public sector is almost exhausted. It is currently proposed to expand the CSBA training by taking in candidates from the private sector. This is a desirable direction, but should be accompanied with an evaluation of the competence and effectiveness of the existing CSBAs.

The recently completed massive recruitment of staff including doctors and FWAs did not include nurses and FWVs. The nurse recruitment was stalled, and efforts underway to revive the process require urgent attention. The position regarding renewing the aging FWVs workforce is unclear, and policy decisions are needed urgently since this is the category that is expected to have a significant role in increasing contraceptive use and also has a good potential for providing skilled birth attendance.

Severe inadequacy of midwifery trained persons is a major constraint to increasing skilled attendance for births both at home and in facilities. A strategy for increasing midwifery skills in the country has been outlined and accepted. This is an important milestone. It now needs to move rapidly into implementation phases. Several issues need attention. These include (a) administrative, legal and financial measures to enable the creation of the proposed new cadre of Junior Nurse-Midwives, (b) coordination of the

Junior Nurse-Midwife proposal with other parallel proposals such as training of Community Paramedics, (c) empowering the private sector to provide skilled attendance for childbirth by enabling the proposed new category(ies) as well as CSBAs to work as employees or be self-employed.

The expanded nurse-midwifery workforce has the potential to provide the backbone for services provided through the community clinic and related structures, as has been the experience of several countries in South and South East Asia.

HNPSP also aims to manage complications of childbirth and 164 of the target 190 facilities at district and upazila level have been upgraded to become functional EmOC centres. Monitoring whether these centres are providing EmOC has improved, and the APIR reports that such facilities are providing for 27% (target 30%) of 'met need for emergency obstetric care'.

The upward trend in use of emergency obstetric care is encouraging, but the gap between poor and rich is very great (Caesarean rate in LQ1 is 1.8% compared to LQ5 which is 25%). Since the expected rate for caesareans is 10-15%, it demonstrates that the poor are not receiving care they need while the wealthier are being subjected to 'over-medicalisation' during childbirth. Postnatal care for women and neonatal care is low at 19%. Several reports both quantitative and anecdotal, testify to the poor quality of care in institutional facilities.

Potential synergy between improvement quality, voice and accountability. Quality is poor with respect to physical aspects, cleanliness, interpersonal communication, privacy and gender sensitivity, and medical (technical) aspects such as outmoded clinical practices. Current approaches to quality assurance are reported to be ineffective. New approaches are needed. For example, a system could be tested that would involve facilities and their communities and use the existing MIS to provide regular feedback on the relative performance of facilities.

Maternal Voucher scheme has been implemented in 33 upazilas, of which 9 poor upazilas have universal eligibility, while the others use defined poverty criteria. Initial reports indicate improved utilization of services. Percentage of one ANC visit 46% (National 16%), ANC 3: 44%, Safe delivery 48% (National 18%), Caesarean Section 5% (National 5%), PNC 87% (National 22%). Several rapid assessments have identified implementation issues and these are being addressed.

Concerns about the voucher scheme relate to whether the poor are benefiting, collaboration with NGO and private providers, whether the scheme has created unforeseen undesirable changes in the behaviour of public and private providers, bureaucratic obstacles such as restricting EmOC use to the particular upazila when EmOC in a neighbouring upazila might be more accessible. Another issue is whether the proposed expansion of the scheme is sustainable at affordable cost. There is an on-going evaluation of the scheme, and its results should be able to provide information on all these aspects

Population and Family Planning. The PRSP II 2008 recognises the urgency of stabilising population growth, for which a fundamental requirement is early achievement of replacement fertility (TFR 2.2). In response, the HNPSP strategy aims to increasingly use permanent and long-lasting methods (PLTM) and reduce drop-out rates. There has

been little progress in increasing contraceptive prevalence which is stagnant at 47.5% for modern methods.

Addressing population issues cannot be the responsibility solely of the DGFP and MOHFW. With a young population, and large cohorts entering the childbearing age group, measures are urgently needed to delay childbearing, encourage spacing and limit family size. The entire nation needs to be energized to contribute to the effort.

Inter-sector efforts are needed to increase the retention of girls in secondary school and provide employment opportunities for young women. Similarly, nationwide efforts are needed to promote small family norms such as 'one child family' and incentives for limiting the number of children. BCC by the MOHFW alone will not be sufficient.

Family Planning. There has been intensive analysis of fertility and contraception patterns in the country and the programme has taken account of such information in planning strategies. There is 17% unmet need for contraception. Use of oral contraceptives has probably reached saturation levels. Only 13% use permanent and long term methods (PLTM); this has declined from the 1993-94 level of 26%. Different regions of the county have differing patterns of fertility, contraceptive use and age at marriage. One encouraging feature is that although overall prevalence of male and female permanent methods seems to be flat or declining a little, actually there are two simultaneous trends. Analysis of age specific trends indicates that younger men and women (15-34), being the most fertile age group, are getting sterilized in increasing numbers, but the trend is concealed by the loss of the oldest group who had high proportions sterilised during the campaigns of the 1980s. (Streatfield and Feisel, personal communication)

The programme needs to develop and implement strategies adapted to the different challenges in different parts of the country. The focus on increasing the use of PLTM implies the need for a higher skilled workforce. MOHFW needs to energise its entire skilled workforce including doctors and nurses under DGHS to provide counselling and services particularly for PLTM, and use every contact with the health service as an opportunity to promote family planning.

APIR 2009 reports achievement of internally set targets for PLTM and cites stock-outs of IUD for 1 year and implants for 2 year as major contributor to low performance (APIR 2009). Special efforts are need to ensure no future stock-out situations.

Key messages for Population and Family Planning

- Energise the entire nation toward rapid population stabilisation
- Make family planning the concern of all arms of MOHFW – not confined to DGFP
- Adapt implementation strategies to the needs of different regions
- Increase innovative approaches to address hard to serve communities

Table 4-4: Recommendations for MNCH and FP

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1. Expand use of CEmOC	1 Improve coverage and use of ANC, EmOC and PNC (1) 2. Establish, implement and monitor quality standards. (2) 3. Evaluate the voucher scheme and revise (3)	Expand quality standards and monitoring, (2) Decide on future of voucher scheme (5)	
2. Increase C-SBA/midwifery for improving skilled attendance	1. Mainstream, and expand CSBA training, re-start FWV training, and implement recruitment of nurses (7) 2 Establish time targets for making the midwifery strategy operational. (7) 3. Complete the review of MH strategy including acceptable roles for TBAs, CSBA and junior nurse-midwives. (3)	1. Establish CSBA practice in public & private sectors.(7) 2. Implement new midwifery strategy.(7)	Rapid increase of midwifery trained personnel in public and private sectors
2. Expand IMCI and improve postnatal and neonatal care	1. Set time targets to expand each aspect of community IMCI and extend F-IMCI to District Hospitals (.5) 2. Draft and implement action plan with time targets for the Neonatal Strategy.(5)	Further expansion of IMCI (5) Implement action plan with time targets for the Neonatal Strategy.(5)	
3. Promote inter-sectoral measures to support population stabilization	1. Promote awareness of population issues among policy makers 2. Participate in inter-sectoral mechanisms to support measures to support fertility reduction		
4. Increase permanent and long term contraceptive use and reduce drop out rates	1. Prepare district/upazila specific strategies and begin implementation. (6) 2. Develop a time bound plan to integrate family planning into all services offered by MOHFW	Evaluate impact of district strategies and refine accordingly. (6)	
4. Reduce unmet need and increase CPR	Develop and implement BCC suited to each district. (6)	Assess impact of BCC and develop strategies.(6)	

Note: the numbers in brackets after each recommendation refer to numbered recommendations in Volume II, Sections 5.3 – 5.6.

4.3 Nutrition

Findings

Table 4-5: Some findings in Nutrition since the start of HNPSP

Major expected outputs and results in HNPSP	Indicators, Targets and Activities	Progress during 2005 – 2008
1. Reduce prevalence of LBW	Prevalence of LBW should be below 20% in 2011	Prevalence of LBW not reduced, 40% in 2009
2. Reduce prevalence of underweight < 5 years	Prevalence of underweight in < 5 yrs should be 36% in 2011	Prevalence of underweight < 5 yrs was 46% in 2009
3. Reduce prevalence of anaemia in pregnant women	Prevalence of anaemia in pregnant women should be below 30% in 2011	Prevalence of anaemia in pregnant women was 46% in 2009
4. Prevalence of iodine deficiency in school children	Prevalence of iodine deficiency in school children should be below 23% in 2011	92% of households in NNP areas use iodised salt in 2009

Note: Outputs and Indicators taken from R-PIP.

Results and achievements

- Since HNPSP in 2005 the Vitamin A supplementation for children aged 9-59 months, implemented through the EPI programme, and IPHN has achieved an admirable 88% coverage.
- Nutrition status among children in BDHS indicates that the gap between boys and girls is narrowing.
- A Nutrition Task Group was formed to support the line Director of NNP to implement the operational plan.
- Expansion of NNP has been planned to 64 more upazilas by June 2009 to make it a total of 168;
- In NNP areas, 92% of households were using iodized table salt.
- Food security interventions: 96.5% of very poor VGD families received direct food aid from WFP and more than 42% VGD families received nutrition services from CNCs.
- Looking back over the past 20 years, despite several Natural calamities and financial crisis, Bangladesh has achieved slow but sustained reduction in the prevalence of underweight and stunting,

Constraints and challenges

According to Millennium Development Goal 1, the prevalence of childhood malnutrition should be reduced from 66 % in1990 to 33% in 2015. Although childhood malnutrition rates have been declining, the improvement is not fast enough to reach the targets of MDGs by the fact that:

- About 49% of children 6-59 months of age are still underweight and 38% are stunted (details in annex 5), reflecting the cumulative effect of failure to receive adequate nutrition over a long period of time.
- 40% percent of babies are born with low birth weight and have a higher risk of dying at birth or growing up underweight or stunted.
- 64% of children aged 6-24 months of age and 46% of pregnant women were anaemic Iodine deficiency disorders still persist.

- The coverage of two priority interventions - iron folic acid in pregnancy and vitamin A supplementation after childbirth - is insufficient: only 20% of women receive vitamin A supplementation following childbirth. Since 82% of births occur in the home, the health system needs to reach postnatal women and their babies within 6 weeks of childbirth in order to deliver this intervention.
- Anaemia in children draws special attention for appropriate micronutrient intervention
- Although a very high proportion of children are breast fed, only 43% of children below six months are exclusively breast fed, and the rate has not improved.
- For the older infant and young child, timely and adequate complementary feeding remains low.
- Zinc supplementation with ORT as treatment of diarrhoea has reached only 23% of children.

The large scale area based community based National Nutrition Programme (NNP) is currently operational in only 109 Upazilas with a coverage of only 25% of the population. It has planned to expand to further 64 Upazilas by June 2009.

Several issues affect the NNP programme:
1. Coverage is a long way from the 70% to 80% coverage that is needed to have impact on national nutrition levels.
2. The potential for scaling up is limited both by availability of NGOs in areas that most require interventions and capacity of the public sector to award and manage contracts.
3. The NNP is contracted to several NGOs and has fragile or no links with the mainstream health system. Referral and intensive management for children with severe acute malnutrition is very inadequate.
4. Although NNP claims to have achieved better results compared to non-NNP areas, those claims are not substantiated with robust analysis of evidence, and the quality and validity of the available data is questionable. The components of the programme and their impact need to be evaluated.
5. Although NNP appears to be strategically a commendable programme, it needs technical leadership and skilled health workforce and rigorous supervision and monitoring. There is no nutrition leadership in the country from the highest level to the operational grass root level.

There are several other nutrition projects and programmes run by government institutions, supported by development partners and international and national NGOs, but their activities are not well monitored.

Recommendations
In summary, the key challenges are to scale up (mainstream) the critical nutrition interventions and improve their implementation particularly in vulnerable high risk groups. For this purpose, actions are needed at the policy, program and service delivery levels:

Policy level
1. To scale up critical interventions, the only option is to **mainstream** the critical nutrition interventions into the services provided through DGHS and DGFP facilities and staff. Some interventions are needed urgently if there is sufficient capacity for rapid scale up. Examples include referral and management of severe acute malnutrition, promotion of exclusive breastfeeding, micronutrient supplementation

during pregnancy and post partum period, and zinc with ORT for diarrhoea treatment. For others, it would be necessary to build capacity. Examples are integration of growth monitoring and nutrition counselling and micronutrient powder for children.

2. A decision is needed on an institutional home for Nutrition and be responsible for providing leadership in Nutrition related activities. It would be necessary to expand the responsibilities and capacity of the institutional home, while simultaneously specifying the responsibilities of all other Directorates in relation to nutrition interventions.
3. A decision is required on the future of the NNP and the area-based community nutrition approach. For this purpose, it is necessary to review and agree on the best option in relation to the programme content, its approach and institutional arrangements. Decisions would include the future of activities in the upazilas currently under the NNP as well as criteria for future expansion, if any.
4. In order to make the inter-sectoral activities functional, a high-level body headed by the Prime Minister or her nominee is required. In order to take the nutrition agenda forward a nutrition policy linked to food policy with time bound strategic focus is urgently required. In order to do this a greater collaboration and harmonisation is necessary among related ministries under an overarching body.

Programme level

1. It is necessary to identify opportunities within the existing services for immediate mainstreaming and to prepare and implement time bound plans for utilising such opportunities to integrate nutrition into on-going activities.
2. The plans should include measures to address deficiencies in effectiveness of implementation of the critical nutrition interventions, such as improving vitamin A supplementation during the post-natal period.
3. A strategic plan is needed to specify how services need to be strengthened in order to expand the range of interventions that are to become mainstreamed. The plans should include not only time bound activities, but also estimates for developing human resources, and additional, material and financial that would be required.

Operational level

1. Each district would need to develop an implementation plan for integrating the selected critical nutrition interventions at community, ward, union and upazila levels. Special strategies are needed for areas and community groups that are at high risk, and the resources required for such strategies need to be assessed and provided.
2. The capacity and effectiveness of the delivery mechanisms selected for each intervention need to be reviewed and specific strategies for improved effectiveness need to be adopted and monitored regularly.
3. Evidence shows that large scale well designed programmes can be effective in improving exclusive breast feeding rates. However, it would require a well designed program using multiple approaches, including approaches designed for adolescent girls, counselling for pregnant women and support during lactation, and approaches intended to change community beliefs and perceptions.
4. A major effort is required to counsel mothers and families on the introduction of energy dense local foods. A feasible strategy is needed for detecting children with severe acute malnutrition, and promptly referring and managing them in facilities that have the capacity to provide such treatment. Such capacity has to be created at upazila and district levels.

5. The widespread deficiency of micronutrients in children can be addressed through a powder containing a mixture of essential micronutrients mixed with home food.

Table 4-6: Recommendations for Nutrition

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1. Mainstream nutrition within HNPSP	1. Agree on critical nutrition interventions to be scaled up. 2. Decide on the 'institutional home' for scaling up mainstreamed interventions 3, Initiate organizational restructuring in accordance with the decision on the institutional home 4. Define responsibilities of all Directorates for mainstreamed nutrition interventions.	1. Review, and where necessary modify coordination mechanisms between nutrition and health services at each level for scaled up interventions.	Integrate nutrition in other related interventions.
2. Develop the design of the integrated nutrition and health service	1. Decide on all the issues listed in Vol I, Section 2.9. Take into account scientific evidence and health system capacity and limitations in Bangladesh. 2. Prepare a time bound implementation plan for the integrating nutrition and obtain approval from relevant authorities.	1. Initiate implementation in accordance with agreed plans. 2. Set achievement targets for micronutrient implementation through heath services and adopt measures to strengthen implementation. 3. Establish mechanisms for implementing new activities (example - nutritional surveillance)	
3. Decide on the desired future for the ABCN	1. Evaluate impact and effectiveness of ABCN approach and decide on its future. 2. Select options for smooth transition from current to desired role for ABCN	1. For the ABCN approach, implement the transition modalities. 2. Implement specific strategies for areas and communities that are at higher risk	
3. Build capacity for those interventions selected for subsequent scale up	1. Prepare plans for strengthening human resource capacity, programme modifications and linkages, and estimate material and financial requirements (existing staff and new staff). 2. Initiate where possible, implementation of the capacity building requirements. 3. Initiate steps for limited expansion of nutrition posts to provide technical leadership at national/district level	1. Implement capacity building plans 2. Where possible begin implementation and monitor closely to identify bottlenecks and constraints. 3 Develop strategies to address constraints	Apply lessons learnt and expand the scaling up of all the critical interventions.
4. Establish or revitalise coordinating and policy making bodies	1. Initiate steps to establish a high level body for nutrition related policies involving other Ministries. 2. Establish and revitalise a mechanism for coordinating interventions capable of synergistic impact on nutrition in the health sector and in other sectors	Develop appropriate policies. Develop mechanisms to promote synergy.	

5 Technical Reports: Support Systems

5.1 Human Resources for Health

A service delivery programme involving as sensitive and fundamental an area as human health critically depends on the availability of adequate number of quality manpower. Unfortunately, the HR issue failed to receive priority in HNPSP. However since the MTR 2008, attempts have been made to recover lost ground and pay more attention to addressing the crisis facing HR. The Project Appraisal Document (PAD) does not have specified outputs for HR nor has the R-PIP a set of indicators, targets, and activities to achieve the (non-existing) targets.

Results & achievements
Positive changes are taking place:
(1) A dedicated Task Group on HR was set up following the MTR, which has a large number of interested DPs as members. The TG is working as a forum for co-ordinating different HR initiatives: e.g. preparatory study on a Health Master Plan, launching of the incentive study for retention of HR in hard-to-reach areas;

(2) Personnel management authorities seem to be making moves for overcoming long-pending personnel issues e.g. DGHS has completed the graduation list of doctors and put the list on a website; Personal Data Sheets have been updated and are accessible online for addition/alterations by the employees. Improved system and software in MIS is yielding better access to HR data, including gender-disaggregated ones;

(3) Energetic steps have been taken to meet critical shortages both in DGHS and DGFP involving doctors, paramedics, technologists and field-level workers. Moves are towards successful resolution of the problem around appointment of some 2000 nurses. The Government has also announced its intention to recruit more doctors and create additional post for nurses;

(4) A new transfer and posting policy for doctors has been issued which provides a rational instrument for needs-based deployment and offers career path – which are necessary conditions for improved retentions.

(5) A recent study showed that large training investments being made under HNPSP funds are being managed better with evidence of good practices across the training spectrum;

(6) A Midwifery Strategy has been developed and approved, a step in the right direction towards filling the serious gap in addressing MNH problems;

(7) A policy on training Community Paramedics in the private sector with curricula developed and supervised by NIPORT has been developed for service in the community and in the private sector. This is also a rare initiative to fulfil the public sectors stewardship role.

Constraints & Challenges

The challenges are diverse and daunting. Some of these are highlighted below to generate recognition and action for intervention:

(1) Mapping attempts to assess the scale of shortages show that under the best-case scenarios, the shortages in the case of doctors and medical technologists cannot be met within the next decade and that for the nurses within a decade and a half.

(2) OPs covering different HR issues remain uncoordinated and segmented as ever, their implementation lower than earlier.

(3) Leadership remains unstable with large changes across the spectrum. The anchor system, which was devised to insulate the large and critical OPs, has failed to salvage the LDs.

(4) MIS system remains splintered and highly centralized as does the decision-making system as a whole. The Health and Family Planning divide continues to obstruct maximization of human resources for service provision.

(5) There is realistic possibility that amid severe shortage of manpower, unless new posts are sanctioned to match the yearly output, doctors would face unemployment in increasing numbers every year. Nurses had reached that position already.

(6) Weak monitoring and supervision of HR-performance at UZ-level and below show little signs of improvement.

(7) Politicization of professional associations poses a systematic challenge and governance problems contribute to client dissatisfaction with public service.

(8) Absence of management training handicaps service potentiality; this may pose serious difficulty to the possible introduction of district-wise budget allocation and its utilization and may further expose the managers to audit risks.

(9) Finalization of the organizational location of NNP within the Government still remains pending.

Table 5-1: Recommendations for HRH

Summary Actions to be Undertaken	Next year HNPSP July 2009 – June 2010	Last Year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1. Develop a medium term workforce plan with time bound strategy	Prepare the plan	Begin implementation	
2. Develop a plan to avoid potential unemployment of doctors and nurses after the present vacancies are filled.	Prepare a time bound plan initiate implementation	Continue implementation	
3. Improve resource utilization through delegation, quality assurance and supervision and strengthen stewardship role.	Delegate administrative and financial powers. Improve supervision. Set up arrangements for handling patient complaints	Strengthen stewardship by MOHFW, engage Professional Association, energise regulatory functions of DGHS,	

Summary Actions to be Undertaken	Next year HNPSP July 2009 – June 2010	Last Year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
	and train facility doctors	BMDC, DNS, State Medical Faculty Pilot Quality Assurance (SOP) in a premier hospital and scale up	
4. Forge alliance with ongoing e-health initiatives and introduce good practice	Introduce tele-health.	Explore introducing e-health specially designed for remote and hard to reach areas.	
5. Ensure that gender issues are considered in recruitment, posting, training, transfer etc. to ensure that maximum use is made of human resources both male and female at all levels	In co-operation with MOWA: - Issue code of conduct to avoid work-place harassment - Guidelines may be given to providers for gender sensitive handling of patients		Mainstream gender awareness issues into medical curriculum
6. Arrange orientation training for providers, supervision and committee members of Community Clinics	Initiate training	Continue	
7. Strengthen MOHFW leadership in HR	Re-arrange chairmanship of 3 HRM-OPs and 2 MIS-OPs under same officer	Demonstrate progress in coordination of different HR activities	

5.2 Procurement and Supply Chain Management

Results and achievements

Various important developments have taken place since the MTR 2008. A computerised procurement tracking software has been installed at CMSD while the MOHFW has initiated the development of a web-based procurement tracking system. Training sessions have been organised for procurement officers, Line Directors and members of the TEC and BEC. This training covered important aspects and was organised internally, in-country and abroad.

Another positive development are the standardised tables of equipment and organisations which been developed and are accessible through the MOHFW website. Some of the recommendations of the medical equipment survey have been implemented or are under way. The MOHFW has also reiterated its need for reinforcement of its procurement capacity and has produced a short list of candidates for PLMC candidates. A procurement status review meeting has been initiated to address procurement issues on a regular basis. The communication between the procurement agencies and the World Bank has clearly improved and another year has gone by without post-review issues.

Implicitly the PAD and the R-PIP's procurement objective is an increase in efficiency of the procurement process. The procurement improvement plan in the PAD lists a number of activities that are expected to strengthen the system and therefore increase efficiency. Although the timeline has changed, some of the seven conditions are in process of implementation (PLMC, TA, MIS, training, QC laboratory). However, the DDA capacity

study has not yet been initiated and others are yet to start (pre-qualification, pre-shipment inspections).

Although there has been a considerable delay in the implementation of these actions, due the fact that the PLMC has not yet been created, the performance of the procurement agencies has improved. This is measured using the three result frame work indicators as mentioned in the PAD:

- Percentage of the contracts awarded within bid validity: this has increased,
- Mis-procurements: there have been zero mis-procurements;
- Only the opening of L/C's within 14 days still poses a problem.

Whether the performance of the sector procurement has improved in terms of value for money or expediency in processing packages (in other words, whether the client has benefited) has not been monitored. However, this is unlikely, as the functioning of the MOHFW has not improved and they play an important role in the overall procurement process.

Table 5-2: Results in Procurement from Action Plan Aide Memoire

Area	Targets		Comments
Dates	June 2008	June 2009	
1. PLMC functional	August 2008	No	A short list with candidates exists. PLMC is expected to be operational before the end of the fiscal year. The need for this TA has been repeatedly reiterated by the MOHFW.
2. Procurement tracking operational + TA	June 2008	No	Although a format for procurement tracking does exist, it cannot be considered as operational as analysis is hardly done.
3. Training Plan ready	June 2008	No	A training curriculum was developed but the function of the MOHFW is not developing a curriculum but rather an overall plan to ensure sufficient procurement capacity in the sector. However, sufficient training has taken place over the past fiscal year.
4. LT/TA in place	July 2008	Yes/No	For DGFP TA has been in place since two months. For CMSD TA has been accepted by the Government and is pending
5. Agreement on complaint processes (PPA /WB /GOB)	June 2008	?	
6. Review threshold value	Sept 2008	Not yet	Not all necessary conditions have been fulfilled. However, there is progress on most of them. Also: no mis-procurement has been declared since more then 2 years on post review tenders.
7. Monthly Procurement Review Meetings	April 2008	Yes	The procurement status review committee exists and meets although not every month
8. Focal points appointed	May 2008	Yes	Focal points are member of the procurement status review committee.
9. Follow-up on Medical Equipment Study	July 2008	Yes	Although responsibilities have been distributed to different actors to follow-up on the recommendations, not all have been implemented or finalised.
10. Revise Procurement Plan	April 2009	Yes	

Note: From Aide Memoire 2008 (p. 30).

Constraints and challenges

A serious constraint has been the continuing absence of PLMC. Fiduciary risks are also still there, less so in the technical procurement process but certainly in the selection of the inputs and the use of the outputs of the procurement process. Too little coordination exists: no "turn-key" approach (with designated project coordinator with sufficient authority) for infrastructure projects has been adopted. Decentralisation or delegation of authority to Line Directors and to district level has not sufficiently taken place. The lump sums for the Upazila health complex and Union centres have not been revised. Stock-outs still occur at DGFP although they are no longer the results of poor planning or the technical capacity of the procurement staff, but rather caused by the length of the authorisation process.

Another important issue is that the MOHFW's role of coordination and monitoring has not yet materialized nor does it yet have the tools to assure that role. Forward thinking about the development of the procurement configuration is absent.

Reinforcement of the technical procurement agencies is a continuing process. Technical tools, technical assistance and training are the main elements used and this should continue and where possible accelerated. However, if the MOHFW is not reinforced the continuing investments in the procurement agencies will yield limited results. The technical procurement process is improving but only MOHFW can ensure improvement on the issues outside the technical procurement process (coordination inputs-outputs, delegation of authority, revision lump sums, efficiency of approval authority process).

One of the main constraints remains the no-objection and authorisation processes that are bureaucratic and therefore time consuming. Whether it is the WB, MOHFW or the CCGP, these procedures cannot be short circuited without significant changes in the DCA (in case of WB no-objection) or decentralisation of authority (in case of MOHFW). Both of which are not immediate solutions.

In the case of decentralisation or delegation of authority to Line Directors or further down to districts, it is indispensable to reinforce the MOHFW internal audit function. Decentralisation should only be done when the MOHFW has indeed the capacity to monitor on-going procurement and has the capacity to support technical procurement at all levels if and when necessary.

Additional procurement related manpower could help the process at MOHFW level. Despite this expressed need, and despite it being conditional in the PAD, the MOHFW has not been able (or willing?) to create the PLMC.

A technical challenge is the implementation of the web-based procurement tracking system. Although the principle is straight forward, technical implementation and the necessary routine activities to maintain the system are not (development/configuration of the database, maintenance of the website, generation of web-based reports).

Table 5-3: Recommendations for Procurement

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1. Creation of PLMC	Immediate		
2. Increase threshold for	Conditional on PLMC creation		

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
post review			
3. Develop terms of reference of the Procurement Status Review Committee	ToR developed and adopted		
4. Define status of Procurement Task Group	ToR developed and adopted. Relationship with PSCC defined		
5. Strategic procurement configuration development plan	Plan developed and adopted	Plan basis for coordination of support to procurement activities at all levels and for decentralisation	
6. On-line procurement tracking system	System fully developed	System fully operation and producing monthly reports with routine standardised information	
7. Procurement indicators	Definition of procurement indicators to be monitored	Monthly reporting of indicators	
8. Decentralisation of authority to lower levels	Decentralisation of procurement authority defined	Decentralisation operational	
9. Central medical equipment database	Database configured and institutionalised	All medical equipment entered in database. Database actively managed	
10. Technical assistance CMSD	Technical assistance as agreed between CMSD and CIDA operational	Standard technical specifications manuals available	
11. Introduce risk management in MOHFW training curriculum as a separate section	Training curriculum adapted		

5.3 Budget Planning and Public Financial Management

There is scope for significant improvement in the planning and budgeting processes. This includes adopting a coordinated approach to the revenue and development budgets, linking operational plans (OP) more clearly to the budget, synchronising their review and updating with the budget cycle, and providing MOHFW with flexibility to reallocate resources within the overall programme. Resolving the shortage of planning staff in the Planning Wing of MOHFW and within the Line Directorates will also contribute to improved planning processes.

Many of the comments made regarding the weaknesses in financial management at the Mid-Term Review (MTR 2008) remain true one year further on. Some action has been taken in response to the action plans arising from both the Annual Programme Review (APR) and MTR processes, but gains have been offset by continued shortages of staff, frequent staff transfers and delays in progressing contractual arrangements.

Results and achievements
The Programme Implementation Plan (PIP) for HNPSP was revised in 2008 to provide a better allocation of resources between the various OPs.

MOHFW has adopted a creative approach to perceived skill shortages by contracting internal audit services and proposing to contract financial support staff for Line Directors (LD) and the Financial Management and Audit Unit (FMAU). The first two phases of the contracted internal audit services were completed and an audit report produced together with a proposed strategy and audit training plan.

The Audit Committee has been active in managing the resolution of observations arising from both internal and external audit. Tripartite meetings have been held to discuss the finding of the Foreign Aided Projects Audit Directorate (FAPAD) and task groups in both MOHFW and FAPAD have been constituted to assist in this process.

MOHFW has continued to meet its target for production of claims for reimbursement through preparation of Financial Monitoring Reports (FMR) within 45 days of the end of each quarter.

Constraints and challenges
Flexibility to manage funds within the overall HNPSP has been constrained by the requirement to show each OP separately within the ADP, and the consequent restrictions imposed on moving funds between these.

There are weaknesses in the OPs themselves, arising from the frequent transfer of Line Directors, shortage of planning staff, duplication of information in the plans and poor linkage between objectives, activities and resource requirements relating to the plans.

Preparation of the revenue and development budgets is not coordinated, giving rise to the risk of inefficiency in the allocation of resources.

There has been no progress on hospital autonomy.

There have been frequent changes in the position of JS (Financial Management and Development) and the FMAU has a number of key vacancies, including those that are due to be appointed under the MOHFW Improved Financial Management OP.

The shortage of financial staff and frequent staff transfers at all levels has continued. Many staff undertaking financial duties at LD and District/Upazila level are not qualified or adequately trained for this purpose.

Change in funding arrangements for the final phase of the internal audit contract, (internal audit over the remaining period of the current programme) has resulted in a discontinuity in internal audit coverage as the contract has had to be re-tendered. The independent post of Chief Internal Auditor (CIA) recommended in the MTR 2008 report has not been created, leaving the FMAU with dual responsibilities for financial reporting and audit.

There have been no noticeable improvements in budget preparation and execution. Notwithstanding the implementation of the Medium Term Budget Framework (MTBF) which aims to facilitate a coordinated budget, the revenue and development budgets

continue to be prepared and monitored separately, though achievement of health service objectives is dependent on effective and coordinated use of both of these.

There remains a disconnect between planning and budgeting. Review of the OPs is not synchronised with the budget cycle and the costing of the OPs is not consistent with the MTBF resource envelopes, resulting in significant differences between planned expenditure for a fiscal year and the allocation in the ADP. Development budget proposals are subject to further review and approval by the Planning Commission when it finalises the ADP, even though the MOHFW has produced these within the agreed MTBF ceiling.

Utilisation of the budget has not improved, hampering any claim for additional funding to move toward the target for an increased share for health in the GOB budget. The overall share fell from 7.0% in 2007/08 to 6.5% in 2008/09 and the share of the development budget from 9.7% to 8.9%.

Extension of the Management Accounting Consolidation System (MACS) beyond the FMAU has stalled due to lack of finance staff at LD offices and may even not be sustainable in the FMAU at present without the support of Technical Assistance (TA). In the context of this delay and the continued development of the Controller General of Accounts (CGA) system, the strategy for MACS now needs to be reconsidered.

Table 5-4: Recommendations for Budget Planning and PFM

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1 SWAp arrangements	Commence preparations for next HNP	Prepare next HNP Programme	Commence new HNP Programme
2 Hospital Autonomy	Finalise hospital autonomy bill	Enact legislation Commence autonomous arrangements	Continue autonomous arrangements
3. Operational Planning	Fill vacant planning posts Empower MOHFW to reallocate funds between OPs within programme total Synchronise update of OP with annual budget cycle	Retain planning staff Develop improved format OPs for next HNP Programme	Retain planning staff Implement new OPs
4 Budget Coordination	Establish institutional framework for coordination of revenue and development budget preparation	Bring revenue and development budget preparation under one wing of MOHFW	Move towards unification of revenue and development budgets
5. Financial Staff	Fill vacant positions in FMAU Contract support staff for LDS Commence deployment of permanent staff to LDs	Transition to LD finance staff from Contract staff	Sustain staff in Financial Positions
6. Budgeting	Prepare for decentralised budgeting (coordinated rev and dev budgets) Identify processes and TA support	Pilot decentralised budgeting Provide TA support Review pilot experiences	Roll out decentralised budgeting with TA support as necessary
7. Financial Reporting	Review need for roll-out of	FMAU to maintain central	Establish reporting system

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
	MACs and train FMAU to manage central system	system Review future reporting requirements and CGA system capability	utilising CGA system
8. Internal Audit	Appoint Chief Internal Auditor Contract internal audit services Review strategy for audit services beyond 2011 Opt (a) Contracted services Opt (b) MOHFW staff	Continue internal audit contract Opt (a) n/a Opt (b) recruit and train MOHFW staff	Opt (a) continue contracted services Opt (b) transition to MOHFW audit staff

5.4 Monitoring and Evaluation

Monitoring and evaluation of HNPSP has gained some ground, but there is scope for significant improvements, especially with respect to the effectiveness - the use of quality health information at peripheral and central levels for planning and decision making, and the efficiency and reliability of the system.

At the outset of HNPSP it was expected to build a strong M&E system that enables analysis of the data from routine and non-routine information systems. In addition, private sector information would be collected. The PAD, R-PIP and OP indicate the targets and activities. Table 5-5 provides an overview of these.

Table 5-5: Results for M&E in HNPSP

Major expected results	Targets and Activities
1. strong M&E mechanism with clearly laid-out input, process, output and outcome indicators to track implementation progress for the duration of the program	MOHFW MEU (source: revised OP SWAP-MOHFW) M&E Unit established under Planning Wing and made functional Results framework for HNSP updated and used for monitoring and reporting purposes; OP indicators linked to Results Framework Data Management and Information System established and operational at MOHFW level
2. enhanced and linked HNP MIS that collects and analysis data from DGHS, DGFP, NNP and Urban Health	APIR report prepared each year; BDHS or UESD Survey conducted Service delivery reports conducted MIS DGHS (source: R-PIP p158) Reports for monitoring progress of child health programs and main CD and NCD formulated. Periodical reports on EmOC status, SBA programs and perinatal deaths published. PMIS publication updated.
3. independent external evaluation on the basis of the Results Framework, and operational research as relevant	Record keeping and reporting mechanism developed. GR updated and used. Capacity built-up of MIS personnel. Computer networking established MIS DGFP (source: R-PIP p219)
4. collect data from private sector in a systemic fashion in order to exercise its public responsibilities	MIS established in all family planning offices; Operational staff trained; manuals developed Data on programme performance available for planning, monitoring and evaluation of the RHFP- MCH programmes. NNP MIS not specifically formulated in R-PIP (no MIS OP)

Outputs and indicators taken from PAD (pp.15 - 36) and R-PIP and OP (MOHFW)

Table 5-6: Status on Action Plan Aide Memoire 2008 for M&E

Area	Targets 2009	Status
1. Revise results framework with mini assessment of data sources (together with DGHS, DGFP, NNP, NIPORT, HEU, BBS)	June	Done and shared with LDs, DPs and concerned stakeholders. Revised RFW was finally discussed in the M&E Task Group June 2008 and included in the RPIP and HNPS
2. Link OP to results framework with specific time bound indicators		A 2-day workshop was conducted May 2008 for this purpose: Linking Results Framework with Operational Plans of HNPSP under the responsibility of the JC (Planning) and carried out with technical support from M&E Unit. Report with the same title is available. Main OPs have RFW indicators included.
3. Comprehensive Plan for M&E system, including coordination of MIS for DGFP, DGHS, NNP, Urban Health and others, which outlines roles and responsibilities of different actors with time bound activities is endorsed by GOB and started to be implemented. Put in place transitional arrangements including data management centre	March	A comprehensive plan for M&E system has not been prepared yet. First steps have been taken to strengthen the M&E Unit (MEU) of MOHFW: the MEU was provided with renovated premises in a new location. Except for 1 staff member who seconded from DGFP no other government personnel operates the MEU. The rest of staff is hired by GTZ. Also support staff is not paid by the government. First design steps for DMIS have been made. In addition, a workshop was held July 2008 on DMIS.
4. Facility Survey for HF outputs and pro-poor performance		Done. Preliminary findings shared
5. Maternal Mortality Survey	April	NIPORT initiated, outsourcing for data collection is in process
6. UESD Survey	April	Conducted by NIPORT, ACPR with support from GTZ. Provisional findings already available and shared

Note: From Aide Memoire 2008, (p. 32).

Results and achievements

Since its inception HNPSP is having its fourth independent review. Most of the recommendations from the last evaluation (MTR 2008) were followed up promptly. Two surveys (health facilities and essential service delivery survey) were conducted, with a third one (maternal mortality) in preparation. With the continued strengthening of the M&E Unit that operates under the Planning Wing of MOHFW, the momentum has been created to further build the M&E capacity for health in the country. The HNPSP Results Framework was revised, now having fewer indicators, and all Operational Plans were more or less linked to the Results Framework. MEU produced two other major outputs. The Annual Programme Implementation Report was compiled with help from all Line Directorates and a start has been made with the very important Data Management Information System (DMIS).

The three management information systems under HNPSP (DGFP, DGHS and NNP) have each produced new outputs. DGHS produced 'Voice of MIS-Health' Newsletters on the performance of EmOC Facility, and a new Health Bulletin (2008). DGFP issued their Annual Report 2008 and Monthly Reports, and NNP disseminates monthly Monitoring Reports.

Regarding information technology, both DGFP and DGHS increased the number of operational computers in the periphery and WAN/LAN systems were installed at upazila and district level. Three main types of management information systems are now in

operation in both DGFP and DGHS: service statistics, personal and logistics. Training has been conducted in computer skills.

During the last year, DGHS MIS improved their offices and their connectivity via internet with district and upazila health offices, with the intention to use web-based applications for data transfer.

Constraints and challenges

Despite these achievements in HNPSP there is scope for further development. The main constraints are related to institutional and structural MOHFW issues and the HNPSP program design. In general, and these features have been reported in earlier evaluation documents. The M&E system relies for an important part on the results of surveys, with routine collection systems much hampered by fragmentation, duplication, centralisation, delays, unreliability, blocked dissemination and under-resourcing.

M&E system, general constraints:

- Fragmentation: In the absence of an overall M&E strategy, each directorate or program concentrates on its own interests. Therefore no overview can be obtained. Issues like cost-effectiveness cannot be monitored.
- Duplication: Different programmes or directorates are interested in the same type of information and use different forms and formats for reporting. The health institutions are overburdened with report forms. A multitude of routine data collection systems (MIS) operate in parallel.
- centralized: Health facilities, union, upazila and district health offices report aggregated data to central level. The systems do not provide tools for analysis at the periphery and are hardly geared towards the needs of the local health management and hospital management.
- Delays and unreliability: Overburdened by reporting requirements, and demoralized because of lack of feed-back, reporting is incomplete (sometimes even fake), too late, contradictory and often not processed or analyzed at national level. The routine information proves to be hardly useful for decision making at either central or peripheral levels. Ad hoc surveys are relied on to fill the gaps.
- blocked: data that has been collected is not easily or not at all accessible by others.
- under-resourced: M&E offices are short-staffed and lack highly skilled personnel (e.g. information technology, epidemiology, etc), financial and human resources are spread over the fragmented M&E systems, and job responsibilities are not always designated to the most appropriate people.

For example, it has taken MEU about 3 months to compile the APIR 2009 due the labour intensive communication on and collection of information that was already in the health system. Highly aggregated information of DGFP and DGHS exists but is not of much use to planners and decision makers. Disaggregated data lies idle at offices in the periphery, and the reliability of, for example, nutritional data is likely to be poor, due to underreporting but this cannot be verified.

Recommendations

In order to overcome some of these constraints in a phased manner a summary of recommended actions is provided in Table 5-7.

Table 5-7: Recommended Actions for Monitoring and Evaluation

Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
1. Provide guidance to M&E and prepare	Prepare Health Information Policy and Strategy, preferably assisted by	Prepare M&E Workplan for next cycle in close relation to	Implementation of Health Information Policy, Strategy

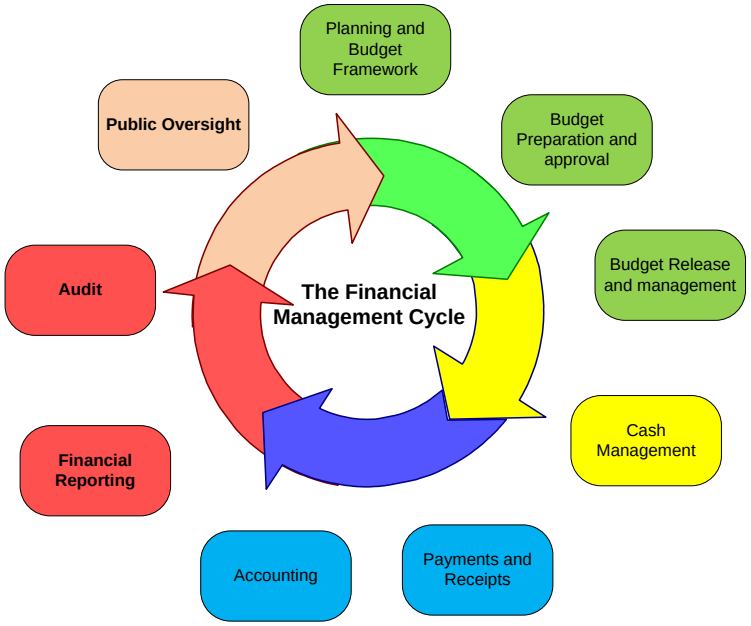
Summary Actions to be undertaken	Next year HNPSP July 2009 – June 2010	Last year HNPSP July 2010 – June 2011	Beyond HNPSP July 2011 – June 2015
for next cycle	Health Metrics Network (WHO)	the Programme	& M&E Workplan
2. Strengthen M&E coordination and capacity	Strengthen MEU, provide mandate higher in MOHFW hierarchy, improve capacity, increase permanent staff, make DMIS operational at Nat'l level, assess needs and prepare M&E training plan	Position MEU closer to senior management MOHFW, carry out mandate, steer M&E reform process on basis of Health Information Strategy; extend DMIS	Concentrate on decentralised integration of management information systems
3. Monitor HNPSP	Revise HNPSP Results Framework and Operational Plan indicators	Prepare next cycle HNPSP PIP and OPs against standard (logframe format)	Produce Sector Performance Monitoring Framework that builds on the HNPSP Results Framework
4. Build capacity at MOHFW, District and Upazila	Ensure regular Logical Framework , M&E, statistics training for LD staff	Ensure Logical Framework, planning and M&E training for District and Upazila staff	Refresher training M&E Develop in-service M&E training curriculum
5. Boost capacity of MIS-HS, MIS-FP and NNP	Provide full support to required upgrade MIS Directorates, incl. recruitment skilled staff, appropriate job descriptions, 'open source' flexible database software, training Link NNP with existing main MIS, link UHCP MIS (see further detailed roadmap)	Prioritize MIS: commence collecting outpatient service statistics from ALL facilities Install built-in quality assurance mechanisms in MIS Organise and conduct integrated Quality Assurance from District level downwards (on pilot basis, see text)	100% outpatient registration, start with collecting from private sector Integrated Quality Assurance expanded (see text)

Initiatives should be taken in a spirit of moving towards a more integrated M&E system while maintaining the parallel structure for the time being. Given that the new administration has created the momentum for new ideas and concepts pertaining to delegated management, the M&E system should gradually move away from being centralised. A bottom-up approach should assure timely available, complete and consistent quality data for disease, health services and support systems that is of use at health facilities, upazilas, districts and central levels.

6 Risk Assessment & Mitigation: a 2009 update

An approach to assessment of fiduciary risk is to examine the effectiveness of controls at each stage of the financial management cycle illustrated in Figure 6-1. This takes account of all processes for internal control of the allocation and utilisation of funds.

Figure 6-1: The Financial Management Cycle



While there was not time within the APR to undertake a comprehensive fiduciary risk assessment, some of the key issues that have to be considered at each stage of the cycle are summarised in Table 6-1 together with comments on the current processes within GOB/MOHFW.

Cross-cutting issues, such as the availability of appropriate numbers of qualified and trained staff to operate systems also have to be taken into consideration.

The quick assessment in Table 6-1 shows that there are some areas for concern but that risk is mitigated through the involvement of the CGA accounts offices that scrutinise claims for payment and through the prior review procurement procedures for major purchasing which apply through the pooled fund arrangements.

Table 6-1: Fiduciary Risk

Stage	Issue	Risk	MOHFW
Planning and Budget Framework	Plans and budgets aligned	Inappropriate budget provision to implement plans	OPs not prepared within resource envelope constraints
	Resource envelopes include all funding sources	Fragmented budgets resulting in inefficient resource utilisation	Revenue and development budgets prepared separately
Budget preparation and approval	Budgets prepared on assessment of needs	Ineffective budgets, funds not allocated where needed	Development budget mainly top-down
	Budgets approved at appropriate levels within MOHFW	Budgets not set in accordance with agreed policies and priorities of MOHFW	Approval by BMC with Secretary as Chair
Budget Release and Management	Timely release of budget in accordance with requirements	Delays in spending, non-utilisation of budgets	Generally good but bottleneck with central purchasing
	Ability to move budget allocations within agreed limits (virement)	Inability to respond to changes in need during budget execution	Virement within OP budgets Movement between OPs not flexible
Cash Management	Management of cash releases within available resources	Increased aggregate fiscal deficit (mainly of concern to MOF)	N/A
Payment s and Receipts	Effective procurement procedures operational	Fraud or loss	PPA and PPR in place Evidence of non-compliance in some cases Major purchases controlled via WB procedures
	Effective authorisation of expenditure procedures operational	Fraud or loss	Payments processed via CAO, DAO and UAO subject to check by CGA staff
	Controls on collection of revenue operational	Fraud or loss	Not a significant issue for HNPSP
Accounting	Accounting system captures all transactions	Fraud or loss Incomplete data for financial reports	CGA system captures all transactions at CAO, DAO and UAO offices
Financial Reporting	Reports produced with right information for right person at right time	Decisions taken without adequate information	CGA reports not utilised Multiple reporting systems
Audit	Effective internal audit	Ineffective systems of control leading to fraud or loss	Contract arrangements good but delayed No independent CIA
	Effective external audit	Unable to demonstrate accountability to elected body and citizens	Annual audit by FAPAD
	Effective arrangements to follow up audit findings	Ineffective systems and non-compliance continue	Audit Committee operational
Public Oversight	Publication of information on budgets and accounts	Lack of accountability to citizens	MOF website provides details of budget and monthly fiscal reports

ANNEXES.

Annex 1. Terms of Reference of HNPSP / APR 2009

Bangladesh Health, Nutrition Population Sector Program (HNPSP)
Annual Program Review (APR) 2009.

1. Background

The Annual Program Review (APR) of the Health, Nutrition and Population Sector Program (HNPSP) is a management instrument, designed for both the Government of Bangladesh (GOB) and the Development Partners (DPs), to monitor progress in the implementation of the program and to verify that management and policy responsibilities are met. It will focus on implementation of service delivery and reform objectives and suggest course of actions to the HNPSP goals, objectives, risk management strategies and financing of the program.

The APR will be carried out under the guidance of a joint GOB / DPs APR Steering Committee (SC), headed by the Joint Chief Planning, MOHFW, and comprising of the following members: (i) DGHS (Planning, MOHFW); (ii) DGFP (Planning, MOHFW); (iii) WB Task Team Leader; (iv) HNP Consortium Chair; (v) Two representatives from the HNP Consortium; (vi) Civil Society Representative (vii) One representative of Economic Relations Division of the Ministry of Finance; (viii) One representative of Implementation, Monitoring and Evaluation Division of the Ministry of Finance and (ix) One representative from Health Users' Forum.

This APR Steering Committee will be primarily responsible for the following: (i) to oversee/ facilitate the APR planning and implementation process; (ii) to ensure the timely submission of key reports requested for the APR; (iii) to agree on Terms of Reference for the APR Consultancy Team; (iv) to facilitate the Field Visits and agree on criteria for selection of locations; (iv) to organize the Policy Dialogue and agree on selection of Moderator; and (v) ensure that the wrap up discussions on the aide memoir are carried out in the spirit of partnership.

As HNPSP (2003–2010) moves to its final few years of implementation, the need to consolidate the gains becomes paramount. In this light the APR provides an opportunity to reassess progress and focus on key priorities. Further with the new Government it is an opportunity to reaffirm shared objectives. The Mid Term Review (MTR) of HNPSP, held in March 2008, was an extensive process that reviewed all aspects of HNPSP at great depth. Therefore, while building on the MTR 2008 *the APR will aim to (i) be more focused on key program initiatives in the HNPSP where early results / or the lack thereof are evident; (ii) develop shared problem analysis and solutions using existing institutional structures, i.e. the joint GOB–DP task groups and other working committees; (iii) focus on implementation level realities – with focus on HNP outcomes specifically HNP service utilization and nutrition issues.*

2. Objectives of the APR 2009

The overall objectives of this APR are:

- To take stock of the achievements of the implementation of the MTR recommendations and progress made on the action plan set out at the MTR;

- To review the implementation of the HNPSP program *vis a vis* the revised results framework thus far and take stock of quantitative and qualitative achievement of the goals, targets, reforms, fund utilization and recommend revisions to these for the remaining period of the program.

- Review the financing arrangements and assess how well donor support meets the priorities and requirements of the HNP sector and suggest options for the next HNP support program.

The specific objectives of the APR 2009 include:

- To review the progress in service delivery focusing on implementation of operational plans (OPs) and progress towards the strategic objectives as laid out in the Strategic Investment Plan (2003 -2010) and the Poverty Reduction Strategy.

- To assess the progress in implementation of the key reform areas in HNPSP especially (i) Strengthening of the public health sector management and stewardship capacity (ii) Diversification of Services Provision (iii) Stimulating Demand. To recommend any revisions in the reform objectives and targets of the program.

- To assess the effectiveness of the monitoring arrangement of HNPSP especially the effectiveness of the technical assistance available to MOHFW and identify institutional constraints.

- To review the actions taken or deemed necessary to broaden understanding of the program for the line directors, program managers, Ministry officials and the new decision makers and leadership of the sector.

- To review the financing of the sector in the previous year in terms of commitment and contributions of GOB and DPs (including parallel support), fund utilization, reporting, and overall efficiency achieved. To map funding sources, needs and gaps to meet the full implementation requirement of the revised PIP.

- To highlight health system issues and challenges in delivering on HNP outcomes, and review the capacity building measures initiated.

- To assess progress on the performance based financing targets.

- To analyze procurement performance (goods and services) and to assess the progress MOHFW has made in this regard. Provide recommendation on how to improve procurement performance.

- To review the working arrangement between development partners and government and how well DP support (including parallel support) is presently supporting the HNPSP 2003-2010.

- To arrive at a road map and a menu of options for the preparation and agreement of support beyond HNPSP.

3. Description of APR Process

The APR process will include several steps (technical work, field visits, stakeholder consultation and policy dialogue), as detailed below.

a. The Technical Review will be carried out by an Independent Review Team (IRT) of international and national consultants that will collect review and analyze data generated routinely within the health delivery system as well as additional analytical studies, qualitative data, conduct fact-finding activities and review of components and sub-components.

   - The IRT will review available information and assist the Task Groups in analyzing data and recommend next steps. The IRT will prepare a report that will be discussed in the Task Groups and based on these discussions, an action plan will be prepared that will be followed up in the next year.
   - The IRT will assess implementation of the HNPSP and provide a detailed analysis of a selected core objective of the program to assess how technical strategies have been backed by human resources, political economy, procurement, financing, institutional and monitoring and evaluation strategies. This APR will use the Health Service Utilisation and Nutrition goal to study this in depth and highlight the challenges to achieving the objectives and targets of HNPSP (including relating to reducing inequities) and the possibility of meeting the same.
   - The IRT will make recommendations for strategies, implementation, and financing for the remaining part of the program. The IRT will assess the need for extending the program and provide an opinion if such extension would enhance chances for achieving the development objective of the program. It will suggest options as what to do differently in the coming years in order to make sure that the intended reforms of the program are indeed implemented.

b. Annual Program Implementation Report and Status of Performance Indicators Report will be prepared by the MOHFW and made available to IRT prior to the Technical Review.

c. This APR aims to provide forums for **field level discussions on implementation realities. Seven task groups (Gend**er Equity Voice, Monitoring and Evaluation, Procurement, Diversification of Services Provision[17], Financial Management, Human Resources, Coordination Committee[18]) and with its technical subgroups will form 7

[17] This group will include the Health Financing Resource Groups

[18] To avoid duplication with the Task Group, the Coordination Committee will follow up on the policy reform and service delivery objectives, covering activities of DGHS, DGFP and NNP

member groups (3 MOHFW, 3 DPs and 1 IRT) consisting of senior level policy makers, development partners and IRT. The visits will focus on services to understand bottlenecks and identify solutions to health service delivery and utilization issues. Specific focus will also be given on improving utilization and strategies to improve the nutritional status of poor women and children. The process is to be managed by the APR SC. Brief reports of issues identified in the visit will be included in the IRT Report.

d. Stakeholder Consultation Process: To elicit views of various stakeholder groups an agency will be contracted to conduct focus group discussions with HNP related users and providers. Stakeholder consultations will be conducted in six divisions feeding into a discussion at the division level. The field visit team (comprised of DP, GOB and IRT members) will be observers at the stakeholder discussion at the Divisional level. This year the Stakeholder review while focusing on health service utilization will have an additional schedule on issues related to nutrition and will elicit views of stakeholders including poor pregnant women, users of public, private and NGO services, and service providers including NGOs, public sector health providers, private sector health providers. Based on these FGDs, the agency will prepare a Stakeholder Consultation Report that will be an important input into the APR process.

e. Independent Risk Assessment and Management Report will be prepared by the Team Leader, IRT. This year the risk assessment will focus on fiduciary risks and the strategies for managing them.

f. The Team Leader, IRT will prepare the Independent Technical Report drawing on various inputs including the reports mentioned in (b), (c), and (d) and from the other sources of information as described in section 4 below.

g. The issues identified in the technical work and field visits will form the agenda for discussion in the task groups and the coordination committees. Each task group will identify a set of actions with time lines and responsibilities. These actions will be consolidated for further discussion and endorsement at a high level Policy Dialogue to take place in between senior representatives of MOHFW and the DPs. Key Objectives of the Policy Dialogue will be defined by the APR SC:

   - To discuss key findings and recommendations proposed by the IRT report;
   - To discuss MOHFW's and Donor Comments on IRT's report;
   - To prioritize HNPSP Issues; and
   - To agree on Proposed Actions required for moving the HNPSP program forward and reach consensus regarding the next HNP Program.

h. The Aide Mémoire for the APR 2009 will be jointly written by GOB and DP. A drafting committee will deliver the first draft for discussions in the Task Groups. The final Aide Mémoire will be discussed and agreed upon by the Coordination Committee.

i. Following the policy dialogue and agreed aide Memoire, the Program Implementation Plan, Operational Plan, budget and procurement plan for the following year are revised. This will be reviewed at the HNP Forum Meeting following the APR.

4. Information available for the APR 2009

The following reports/sources of information will be available during the APR[19]:

i) Annual Program Implementation Report 2009
ii) Bangladesh Demographic and Health Survey 2007
iii) Utilization of Essential Delivery Services Survey 2008
iv) National Health Accounts 2007–08
v) Health Facility Survey 2008
vi) Public Expenditure Review 2007
vii) Facility Efficiency Survey 2007
viii) Joint Assessment of the Implementation of HIV/AIDS Targeted Interventions in Bangladesh 2008
ix) Review of Health Care Waste Management 2009
x) Improving Returns to Capacity Building Investments 2008
xi) Health Watch Report 2008
xii) Review Missions / Evaluation reports of GFATM /GAVI / DP Support program (where available)
xiii) Review of Maternal Voucher Scheme 2008
xiv) Review of Avian Flu Activities 2008
xv) Rapid Assessment of Demand Side Financing Scheme 2008

5. Deliverables

The TL of IRT will submit a written report to the APR SC. The final version of the report will include:

- A summary of lessons learned and concise information on the key issues to be discussed during the policy dialogue in a main report of maximum 20 pages. This will include: (a) progress against objectives; (b) institutional constraints in implementation; (c) priority actions for follow-up for the remainder of HNPSP; (d) financial framework for donor funding; and (e) a roadmap for the period after HNPSP.
- The background reports of all consultants and key findings from the stakeholder consultation meeting will be attached in an annex to the main report.

[19] Following the first visit of the Team Leader additional areas of analytical work will be initiated in consultation with the APR SC and respective Task Group as an input into the APR process – this may involve follow up on specific aspects of HNPSP e.g. review of Technical Assistance, Health Care Waste Management and Tribal plans.

6. APR Schedule

The timetable will be as follows:

Deliverable/Activity	To be Completed By
Finalization of APR TOR	November 30, 2008
Finalization of TOR for the Team Leader (TL)	November 30, 2008
Selection of Team Leader	November 30, 2008
Team Leader Visit	January 07, 2008
Finalization of TORs, Shortlist of Team Members	January 15, 2009
APIR ready	January 30, 2009
Availability of programmatic monitoring indicators of the Results Framework	February 20, 2009
HIV Mission	February 28, 2009
Stakeholder Consultation Report	April 25, 2009
Independent Review[20]	**April 15 to May 8, 2009**
Field visits	April 21 to 23, 2009
Draft Report FEASIBLE???	May 02, 2009
Task Group meetings, consultation meeting with Line Directors	May 05 to 07, 2009
Finalization of Action Plan, Donor Financing 09-10 and PBF Indicators for 2010	May 07, 2009
Policy Dialogue (The TL will present salient features of the Report in the Policy Dialogue)	**May 11 to 12, 2009**
Final IRT report and Draft Aide Memoire distributed	May 17, 2009
Wrap-Up Meeting	May 18, 2009
Finalization of Aide-Memoir	May 24, 2009

7. Independent Review Team (IRT) – to be decided

a. Team Leader
b. Gender Equity Voice Specialist and M&E Specialist
c. Health Economist and Financial Management Specialist
d. Health Governance and Procurement Specialist
e. Health Management Specialist / Institutional Specialist & HR
f. Public Health, Maternal and Child Health and Nutrition Specialist

(Assess how technical strategies have been backed by human resources, political economy, procurement, financing, institutional and monitoring and evaluation strategies. This APR will use the Health Service Utilisation and Nutrition goal to study this in depth.)

8. Reporting

The Team Leader (TL) of the Independent Review Team (IRT) will work under the guidance of the Chair of the APR Steering Committee (APR SC). The TL will report for all purposes to the APR SC.

9. APR Secretariat

MOHFW Planning Wing/ M&E Unit will act as the secretariat for the APR 2009.

[20] Draft Detailed Work Plan is included as Annex 1

10. Support Team:

The support team will facilitate the APR process.

- MOHFW: Two officials from Planning Wing
- World Bank Bangladesh HNP team

Annex 1

Bangladesh Health, Nutrition and Population Sector Program
Annual Program Review, April–May, 2009
Tentative Schedule

Date	Day	Activity
April 15, 2009	Wednesday	IRT arrives
April 16, 2009	Thursday	Coordination Committee briefs IRT
April 17 to 18, 2009	Friday Saturday	Weekend
April 19 to 21, 2009	Sunday to Tuesday	Task Groups brief IRT
April 21 to 23, 2009	Tuesday to Thursday	▪ Field visit (IRT and Task Group members) ▪ Stakeholder Consultation at the Divisional Levels
April 24 to 30, 2009	Friday to Thursday	▪ IRT has individual meetings as required ▪ IRT report gets drafted
May 02, 2009	Saturday	DRAFT report distributed
May 05 to 07, 2009	Tuesday to Thursday	Task groups discuss draft report and prepares action plan
May 08, 2009	Friday	IRT leaves
May 11 and 12, 2009	Monday to Tuesday	Policy Dialogue
May 13 to 14, 2009	Wednesday to Thursday	Preparation of Aide Memoire
May 17, 2009	Sunday	▪ FINAL IRT report distributed ▪ DRAFT Aide Memoire distributed
May 18, 2009	Monday	Wrap-up meeting
May 24, 2009	Sunday	Aide Memoire and Management Letter sent out

Annex 2. Overall work programme APR 2009

DAY	MORNING	AFTERNOON
Tuesday, 14.04	TL travels to Dhaka	
Wednesday, 15.04	Team members to travel to Dhaka 08.40 TL arrives in Dhaka (EK 582)	12.30 TL to meet WB team (Update, TG, field visit and other issues)
Thursday, 16.04	Arrival Team members; Book in Sheraton Hotel	15.00 APR Steering Committee; TL+Deputy to attend.
Friday, 17.04	*09.00 Internal Team meeting: work programme, TOC* *09.00 Hotel Dahlia Room, 2nd floor*	*14.00 Continuation of morning meeting* *14.00 Hotel Dahlia Room, 2nd floor*
Saturday, 18.04	*10.00 Meeting with J.Chief Planning, PSO and M&E*	*15.00 Debriefing WB team and member DP Consortium* *15.00 Hotel Dahlia Room, 2nd floor*
Sunday, 19.04	10.00 Meeting Secretary + 9 J. Secretaries / J. Chiefs 11.30-13.30 Meetings with Task Groups: new developments, prepare field visits and action plans. 11.30-12.30 TGs Nutrition and FM (+GEV in HEU)	12.30-13.30 TGs Procurement and M&E 15.00 Meeting DPs: each DP to select 2 topics among the various thematic groups. Lake Shore Hotel
Monday, 20.04	09.00 Meeting DGHS and 19 LDs 10.30 Meeting DGFP and 09 LDs 12.30 Meeting on EmOC (EPI Conference room) (11.00-12.30 TGs: HRH) 12.30 Meeting on EmOC at EPI room in DGHS	15.00 JC/Ali: Meeting Minister of Health / Secretary 15.00 Meeting J. Chief + 11 LD Anchors (MOHFW) Tania with Steve and Waheed 18.00 Hotel Dahlia Room, 2nd floor
Tuesday, 21.04	08.30 Tania with Ronald; 10.00 Tania with Indra 10.00 Meeting with LD/Med Ed of DGFP 11.30 Meeting Health Advisor to Prime Minister	16.00 GK with Maheen/Indra 18.00 Hotel Dahlia Room, 2nd floor Arrival Joe Martin (GAVI)
Wednesday, 22.04	09.30 M&E workshop (EPOS), DGHS, IPH room 10.30 MNCH meeting (GTZ office)	14.30 ICDDRB presentation DHS/UESD/HFSurvey (all) 18.00 Hotel Dahlia Room, 2nd floor
Thursday, 23.04	09.00 DFID Seminar MNCH (ICDDRB) 11.00 TG / HR Meeting MOHFW (mini conference) Interviews in Dhaka (prepare for issue paper)	Interviews in Dhaka 18.00 Hotel Dahlia Room, 2nd floor
Friday, 24.04.09	*Field Visit to 4 Divisions: Sylhet, Chittagong, Jamalpur and Khulna (APR team with Task Groups)*	*Field Visit to 4 Divisions: Sylhet, Chittagong, Jamalpur and Khulna (APR team with Task Groups)*
Saturday, 25.04	*Field visit*	*Field Visit*
Sunday 26.04	Debriefing at the District Health level (field) Return from the field	15.00 Coordination Ctee (Kevin, Andy, Waheed) 17.30 Hotel Dahlia Room, 2nd floor: Internal debriefing
Monday 27-04	Draft individual contributions to 'Issues Paper' (on the basis of TOC) (09.00 Internal meeting pooled DP + WB	15.00 Output 1: Team members submit their contributions to 'Issues Paper' to TL (see TOC) 18.00 Dahlia room only for ad hoc joint meetings
Tuesday 28-04	09.00 RTM Stakeholder Consultation Workshop: presentation of results on Nutrition, GEV; Venue: Int Jute Study Group (145 Monipuripara) Final interviews in Dhaka (if needed)	TL brings issue paper together 16.00 Meeting Nutrition support group 18.00 Hotel Dahlia Room, 2nd floor: Discuss Issue Paper
Wednesday 29-04	09.00 Meeting Health Watch (WaterAid Office) Continue individual writing technical reports (on the basis of TOC / Vol II)	14.00 TL submits issue paper to MOHFW and DPs Continue individual writing technical reports (on the basis of TOC / Vol II)
Thursday 30-04	08.30 IRT&Pooled donors (Mick, Steve, Andy, Kevin) Continue individual writing technical reports (Vol II) AND make the contributions to Chapter 2 of Vol I. TL to start on Volume I, main report	Continue individual writing technical reports (Vol II) AND make the contributions to Chapter 2 of Vol I. TL continue on Volume I, main report.
Friday *01-05.2009*	*12.00 Output 2 and 3: Team members to submit technical sections of Volume II AND contributions to chapter 2, Vol I*	*TL finalises Zero Draft Vol II (all technical reports).*
Saturday 02.05	*TL finalises Zero draft Vol I. Main report (all summaries AND Chapter 2 of Vol I)*	*14.00 WB to print Vol II (Technical report) and Vol I (Main report) (at WB 15x)*

DAY	MORNING	AFTERNOON
Sunday 03.05	Team reads Zero draft Vol I and Vol II (internal) 08.15 DPs discuss Issue paper (EC)	Team reads Zero draft Vol I and Vol II (internal) 15.00 Additional Secretary: Issues paper & Extension: with all J.S. DGHS/DGFP, Pooled DPs, Chairs TGs
Monday 04.05	09.00 Team discusses Zero draft Vol II technical reports (internal). Hotel Dahlia room, 2nd floor Core Team MOHFW/DPs (Start preparations Action Plans & Policy Dialogue	14.00 Team discusses Zero draft Vol I Main Report. Hotel Dahlia Room, 2nd floor
Tuesday, 05-05	TL to finalise first drafts Vol II & Vol I. Team members to prepare ppt for debriefing Senior Management and DPs (next day)	14.00 TL submit first draft Vol I&II to MOHFW/DPs Copying Vol I (150x) and Vol II (50x) 12.00 Output 4: Team members to submit ppt for debriefing Senior Management and DPs
Wednesday 06-05	09.30 Debriefing with Secretary DGs, DPs (all HNP Forum members, with ppt) Task Groups to read first draft APR (Vol II)	Debriefings TG/PFM; TG/Procurement; HFWG + Coord WG (on basis of format) 19.00 Hotel Dahlia Room, 2nd floor
Thursday 07-05	10.00 Debriefings: TG/MNCH; TG/PH-DC; TG/HRH; TG/GEV; TG/M&E; TG/Nutrition (on basis of format)	Teams to revise Vol I&II with comments MOHFW/DPs 18.00 Hotel Dahlia Room, 2nd floor 18.30 Reception Sheraton (drinks and snacks)
Friday 08-05	Team to revise Vol I&II with comments MOHFW/DPs *Team members prepare ppt for Policy Dialogue*	*14.00 Output 5: Team members submit final versions of Vol I & Vol II.* *17.00 Hotel Dahlia Room, 2nd floor (Wrapping up)* *19.30 Non-APR Party at Hilary's; Road 118, Hs 4.*
Saturday, 09-05 National Holiday	*Team members depart* *MOHFW Internal meeting with LD (Recs IRT-Vol II)*	*Team members depart*
Sunday 10.05	TL to work on final draft APR reports (Vol I & II) TL to prepare presentation Policy Dialogue Core Team MOHFW/DPs brings TG reports together, being the various Action Plans for MOHFW	Internal meeting DPs to discuss their position regarding the IRT recommendations TL to work on final draft APR reports (Vol I & II) TL to finalise presentation Policy Dialogue
Monday 11.05	08.15 WB to meet with Heads of Agencies TL to finalise final draft APR 2009 reports	14.00 TL submit final draft APR 2009 reports to MOHFW and DPs
Tuesday 12-05	Policy Dialogue between MOH and DP and NGOs	Policy Dialogue between MOH and DP and NGOs
Wednesday 13-05	Start preparations for the Aide Memoire MOHFW/DP 19.10 TL departs (EK 587)	00.05 Dubai – Ams (05.20, KL 428)
Thursday 14-05	Start preparations for the Aide Memoire MOHFW/DP	

Logistics MOHFW:
Mr Saif Uddin Ahmed is in charge for appointments at MOHFW and MEU;
Mob: 01720-279 616. < bsaif2000@yahoo.com >

Logistics DPs and NGOs:
WB / Ms Iffat Mahmud, Mob: 01715 496 825
WB / Mr Shahadat Chowdhury, Mob: 01817 520 116
UNFPA (Ms/Mr Touhid Alam), Mob: 01713 046 975
Email < touhid@unfpa-bangladesh.org >

Annex 3. Persons interviewed

MINISTRY OF HEALTH AND FAMILY WELFARE (MOHFW)	
Prof Dr. AFM Ruhal Haque MP	Minister of Health and Family Welfare (MOHFW)
Prof Dr. Syed Modasser Ali	Prime Minister's Office
Sheikh Altaf Ali (LD)	Secretary MOHFW
MD Abdul Mannan	Joint Chief Planning
Helal Uddin	Deputy Chief FW
MD Nazrul Islam Sarker	Deputy Chief (Planning Wing)
Mohd. Monirul Islam	SAC Planning Dept
MD Said Udin Ahmed	SAC Planning Dept
Nargie Khanum	Senior Assistant Chief Planning Wing
Ms Ummea Saima	AC Planning Dept
Saif Uddin Ahmed	Senior Assistant Chief (SAC)
ABM Kamrul Islam	MOHFW / M&E Unit (Technical Team Leader)
Muhammed Emranul Haq	MOHFW / MEU Adviser
Dr. Monika Krengel	Data Management and Information support, MEU
Md Zahidul Islam	MOHFW / MEU
Dr Khaled Shamsul Islam	MOHFW, HRDU
Mr Probhash Chandra Roy	Sr Assistant Chief, SEI, Planning Commission
Dr. Shamim Ara	Joint Chief HEU
Balizur Rahman	Deputy Chief GNSP/HEU
Abdul Hamid Moral	Assistant Chief, HEU
Mahbubur Rahman	Deputy Secretary GNSP/HEU
Mr Masum	Assistant Secretary GNSP/HEU
Mr Mahtab	GTRZ Consultant GNSP/GTZ
Tahmina Begum,	Freelance consultant
MD Abdul Kalam Azad	Additional Secretary (LLP)
1. AKM Manzurul Hauque	JS Admin and Personnel Mgmt (PM)
2. Dr. M.A. Jalil	JS Hospital and Nursing (GI)
3. Dr Md Anwar Hossain Munshi	JS PH and WHO
4. Mr A.K.M. Amir Hossain	JS Physical Facilities, Med Educ. (Coordination)
Md. Nazrul Islam	Deputy Secretary development and medical education
5. Dr. Rebeka Sultana	JS Financial Mgmt (FMD)
6. Quamrun Nahar Khanam	JS Development & Family Welfare
Zulfiqur and others ask for feedback on the website: < www.mohfw.gov.bd >	
Md Nazrul Islam	Deputy Secretary JS Coordination and M&E
Dr Mohd. Abdus Sabur	PSO / TL and PH Policy
Ms Shahana Begum	PSO / Gender & Equity
Anisuz Chowdhury	PSO / PFM & Audit
Dr. Azaher Ali Molla	PSO / Health economist & poverty analysis Specialist
DIRECTORATE GENERAL OF HEALTH SERVICES (DGHS)	
Prof Shah Monir Hossain	Director General DGHS
Prof Dr Hasan Asa Tahmin	DGHS Admin (QA & HRM)
Dr Khaleda Begum	DD HR and Admin
Dr. Rokeya Sultana	DGHS Dir Planning/Res (SWPM & R&D)
Dr. Faruk Ahmed Bhuiyan	Deputy Programme Manager (Planning Unit)
Dr. Bazlur Rahman	Assistant Director (Planning Unit)

Dr. Md. Shajedul Hasan	Deputy Programme Manager (Planning Unit)
Dr MD Shajedul Hasan (contact person)	DGHS DPM (SWPM)
Prof. Dr. Abul Kalam Azad	DGHS Dir MIS (MIS & Pers)
MR Akhtar Hussain Bhiya	DGHS Dir Hospital Improvement
Dr Jahangir Alam	DGHS PHC (ESD)
Prof Pravat Bara	DGHS MBDC (TBLC)
Dr MD Ishaque Khan	DGHS NASP
Dr. Md. Akhtor Hossain Bhuiyan	Director and LD IHSM
Dr. A.K.M. Saideu Rahman	DGHS Hosp+Clinic (IHSM) (desk officer)
Sabina	DGHS, PSSM
Brigadir General Quaddar	DGHS, LD CMSD
Dr. Mohd. Ali Belal,	Deputy Director CMSD
Dr Yasmin Rahman	Deputy PM, MCH
Dr A.N.Md Jainal Abedu	DGHS ADG/Admin (IST)
Dr. Asharfi Ahmad	DGHS Deput Program Manager IHSM
Dr. S.M. Abu Zahid	WHO consultant procurement & supplies NTCP
Dr. Md Ishaque Ali	Deputy Director NTCP
Programme Managers and Deputy Managers responsible for Maternal Health services	DGHS and DGFP: FP-MCH Service Delivery, EmOC at Upazila level and below, EmOC in District Hospital & MC, CSBA training & voucher Scheme
Dr Mosaddeque Ahmed and staff) and NNP	DGHS: Responsible for IMCI + Coordination with NNP

DIRECTORATE GENERAL OF FAMILY PLANNING (DGFP)	
Mr Mohammad Abdul Qayyum	Director General DGFP (Additional Secretary)
Md Shahadat Hossain	DGFP Dir Admin (HRM)
Md Matiur Rahman (contact person)	DGFP Dir Planning (SWPM & LLP)
Md Jahiruddin	DGFP Dir MIS
Rezaul Islam	DGFP Dep Dir MIS
Ganesh Chandra Sarker	DGFP Dir IEM (IEC/FP)
Abdullah Al M. Chowdhury	DGFP Dir Finance (FSD)
Md Hossain Mollah	DGFP Dir Logistic (PS&SM)
Abu Taher	DGFP Dir Audit (IFM)
Dr Md Aminul Islam	DGFP Dir MCH-S (MCH/RH services)
Dr Md Abdul Kh. Chakder	DGFP Services (CCSD)
DIRECTORATE OF NURSING SERVICES (DNS)	
Ms Azizun Nahar	DNS / LD Nursing education and services (reports to Secretary)
Arjuna Begum	P.O DNS
Farida Khatun	Asst Director (Admin)
Sufia Begum	Asst Director (Education)
Rahima Jamal Akhtar	Nursing Supervisor
DIRECTORATE OF DRUG ADMINISTRATION (DDA)	
Md. Ismail Hossain	Director DDA / LD Strengthening Drug Admin (SDA) (reports to Secretary)
NATIONAL INSTITUTE FOR RESEARCH (NIPORT)	
Dr K.C. Mondal	NIPORT, Director General(Additional Secretary
Dr. M. Akhter Hossain	NIPORT, Dir Training
Dr. Ahmed Al- Sabir	NIPORT, Director Research

NATIONAL NUTRITION PROGRAMME (NNP)	
Biman Kumar Saha	Joint Secretary and Executive Dir NNP
M.K. Chakiaborty	Director Programme
Parveen Akhter	Deputy Secretary (Dir M&E)
Dr. Md. Bashasat Ali Aarkes	Programme Director
Mr Nigar Sultana,	Assistant Director, Procurement Goods NNP
Kamalesh Chandra Roy,	Deputy Director Finance, Accounts and Procurement officer
Md. Anwar Hossain	Team Leader (Bangladesh Extension Education Service)
Dr. S.M. Mustafizis Rahman	Assistant Director BCC (also on field visit)
Dr. Tahmina Hossain Talukdu	Assistant Director M&E
Md. Mohsin Mia	Assistant Director
Ms Josephine XX	Unicef, Nutrition officer
Indrani Chakma	Unicef, Nutrition officer
Dr. Z.H. Basunia	Registrar, Bangladesh Medical and Dental Council
Dr. Badiuzzaman	National consultant WHO
PWD	
Md. Hahabub Hassan	Executive Engineer PWD
Kazi Md. Firoze Hassan	Sub-divisional Engineer PWD
MSA	
Dr John Xavier Sosa	MSA / EPOS TL
Dr A.B.Siddique	MSA / PH specialist
Mr Ziauddin Ahmed Khan	MSA / contract Mgmt spec.
Md Aman Ullah	MSA / MIS adviser
Mohammed Ali	Procurement specialist
CMMU	
Colonel Gazi Ashrafuddin Ahmed	Chief Engineer
Md. Shafi Uddin	Superintending Engineer
Luffur Rahman	JS, O&M Wing, Ministry of Establishment
Dr Lucy Riffat	CCM Secretary, Global Fund
John Wallace	Team leader, MATT 2

OTHER ORGANISATIONS	
Ministry of Finance	
Ranjit Kumar Chakrawbarthty	Joint Secretary (Budget)
Planning Commission	
Dr Md Idris Ali Dewan	Member Socio-Economic Development Group
FAPAD	
Md Shahabuddin Patwary	Director General
Hoda Vasa Chowdhury Ltd	
M Munjurul Hassan	Partner
Masud Hossain Rizvi	Consultant

HB Consultants Ltd	
Saiful Islam	Managing Director
Md Abdul Hannan Khan	IT Consultant

NON-GOVERNMENTAL ORGANISATIONS (NGOs)	
Ms Kaosar Afsana	BRAC, Programme Head
Dr Kader	Director Gonoshasthaya Kendra (GK)
Dr Rezual Huq	Gonoshasthaya Kendra (GK) Director Rural Health
Dr Lenin Azad	Gonoshasthaya Kendra (GK) Director Research and M&E
Iftekar Zaman	ED TIB
Dr Khairul Islam	ED Water Aid and Member Health Watch
Dr Rebecca Milton	Member Naripokkho and Coordinator WFH project
ACADEMIA	
M Sekandre Hayat Khan	Head ISRT, University of Dhaka
Tahmeed Ahmed	ICDDR-B Nutrition
Tracey Lynn Koehlmoos	ICDDRB / BRAC (Training and Health / FP Systems
Dr Abdul Quaiym	ICDDR-B / Nursing study
Shams El Arifeen	ICDDR-B / Child health
Peter Kim Streatfield	ICDDR-B / Population, FP
Dr Abbas Bhuiya	ICDDR-B/Behavioural Sciences
DEVELOPMENT PARTNERS (DPs)	
Mr Dinesh Nair	WB, Team Leader Health
Ms Tania Dmytraczenko	WB, Sr Health Economist
Ms Lynn R. Brown	WB, Nutrition Economist
Raziq Hossain	WB, Procurement specialist
Marghoob B. Hussein	WB Procurement specialist
Syed Ahmed Ali	WB Procurement team
Ms Suraiya Zannath	Financial Management Specialist
Ms Iffat Mahmud	Research
Mr Karar Zunaid Ahsan	Monitoring and Evaluation
Shahadat Chowdhury	Administration
Sultana Nazma	Secretary
Arthur Erken	UNFPA Representative; Chair HNP Consortium
Tahera Ahmed	UNFPA assistant Repr
Shammin Sultana	UNFPA, PO-Gender
Touhid Alam	UNFPA
Zaman Ara	UNFPA / RH
Saramma Thomas Mathai	Regional Team Coordinator, Maternal Health
Zaman Ara	National Programme Officer (RH & SM)
Atef Hussein El Maghraby	MNH Programme Coordinator
Rafique Sultan	Strengthening RH Services for the Urban Poor
Taheera Ahmed	UNFPA Expert on Population, RH and MH
Peter Duncan Jones	AusAid
Jenny Finch	AusAid

Shahrukh Safi	AusAid
Hilary Syme	CIDA, First Secretary Development
Ms Momena Khatun	CIDA, Health Officer
Fran McConville	DFID / Health coordinator
David Osborne	DFID / Governance
Sheila Ryan	DFID / Secretary
Tom Crowards	DFID
Judith Oulton	DFID/Nursing study
Benedict David	DFIF/HQ Senior Health Advisor South Asia
Tom Crowards	DFID, Senior Economic adviser,
Adam Jackson	DFID, Economic adviser
Dr Hilary Standing	Institute of Development Studies, Sussex University, UK
Dr Stefan Frowein	EU Ambassador
Peter Herzig	EU / Health Advisor
Nadia Rashid	EU / Programme officer
Jean–Olivier Schmidt	GTZ / Coordinator health
ABM Kamrul Ahsan	GTZ, Technical TL, MEU
Dr. Md. Emranul Haq	GTZ Advisor MEU
Atia Hossain	GTZ, Sr Advisor H. Economics Unit
Mir Rashed Sohel	GTZ, Urban Governance
Dirk Gehl	KfW / project manager
Mr. Habibur Rahman	KfW / HNP Vice chair
Ms Saeda Makimoto	JICA, Representative(in charge of Health)
Ms. Yukie Yoshimura	JICA , Safe Motherhood Promotion Project
Mr. Katsumi Ishii	JICA, Project Formulation Advisor(Health)
Dr. Mamoru Hanzawa	JICA, Field Coordinator (Infectious Disease Control)
Theo Oltheten	RNE / Health and Education Sector
Britta Nordstrom	Sida
Syed Khaled Ahsan	Sida
Ms Khadijat Mojidi	USAID / Office Director
Krishnapada Chakraborty	USAID, Bangladesh (Project Mgmt Specialist)
Kanta Jamil	USAID / Program Coordinator
Iyorlumun Uhaa	UNICEF
Dr Birthe Locatelli-Rossi	UNICEF/Chief Hlth Division
Richard Johnston	UNICEF/Arsenicosis
Midori	UNICEF
Jucy Merina Adhikari	UNICEF Immunization Officer
Shelina Ahmed	Health and Nutrition Specialist
Atef ElMagrhabi	UNFPA/Coord/MNH Progr
Dan Odallo	UNAIDS
Rokshana Reza	UNAIDS
Mr. Mahbub	UNAIDS

Dr Duangvadee Sungkhobol	WHO Representative
Mr Frank Paulin	WHO consultant
Dr Khaled Hassan	WHO / HRH
	WHO / PH
Dr Mannan Bangali	WHO (NPO and NTD)
Dr Kamruzzaman Biswas	WHO (NPO / surveillance)
Dr Andrew Trevett	WHO (Environmental Hlth)
Mr Raja Gupta	Board Chairman Global Fund
Sylhet / Sunamganj District	(Mick, Indra, Muhammed, Zakir, Khaled, Fran, Khaled Syed)
Sylhet Civil Surgeons office	Civil Surgeon, Sylhet
Dr Jazal Uddin Ahmed	Deputy Civil Surgeon, Sylhet
Sunamganj District Hospital	Chief Obstetrician, Key ObGy staff and EmOC trainees
Osmania Medical College and Nursing Training School	Acting Head of Nursing School and nursing tutors and Hospital Director and key staff
Sylhet, RHSTEP centre for RH training	Key staff
Jamalgonj Upazila	Upazila Health and Family Planning Officer (UHFPO)
Upazila Health Centre	Key staff
Health & FW Centre (Union level),	Key staff
Community Clinic	Key staff
Sunamgunj Sadar Upazila	Upazila Health and Family Planning Officer (UHFPO)
Upazila Health Centre	
Health & FW Centre (Union level),	
Community Clinic	
Sulla Upazila (Voucher Scheme)	Upazila Health and Family Planning Officer (UHFPO)
Upazila Health Centre	Upazila and WHO Officers responsible for Maternal Voucher Scheme
Health & FW Centre (Union level),	Key staff
Community Clinic	Key staff
Sunamgunj Sadar	Key staff
Chittagong / Chittagong District	(Andy, Steve, Ed, Jarl, Maheen, Mahboob, Ireen, Hillary)
Dr Md Abu Tayab	Civil Surgeon
Dr H.M. Ahsanul Hoque	Medical Officer
Dr K.M. Ashik Aman	Medical Officer
M.M. Ershad	Deputy Director, DGFP
Ferdoes Ara Begum	Principal Nursing Institute Chittagong
A.K.M. Rafiqul Islan	Coordinator Division Continuing Education
CMSD Chittagong	
Mohammaded ABul Kalam	Assistant Director Port Clearance CMSD
A.K.M. Shahaat Hossain	Clearance Officer Port Clearance CMSD
Mohammed Abul Khan	Assistant Director Port Clearance, DGFP
Kirean Chandra Meitha	Port clearance officer, DGFP
Md. Sayeedurz Rahman	LSO coordinator USAID/DELIVER project
Mr. Shah Alam	Regional supply officer DGFP
Mirershorai Upazila	

Dr Tabarukullah Coundhury	Upazila Health and Family Planning Officer (UHFPO)
Wahidpur Union	union and family welfare sub-centre,
Durgapur Community Clinic	1 Health Assistant and 1 Family Welfare Assistant
Abu Nagar Community Clinic	1 Health Assistant (female)
Mirershorai	Matrika, private maternity centre,
Sitakundu Upazila	
Dr M Abu Taher	Upazila Health and Family Planning Officer (UHFPO)
Fatikchari Upazila	Upazila Health and Family Planning Officer (UHFPO)
Babunagar Community Clinic	Staff
Dawlatpur Union staff NNP staff (TL, CNO and CNP)	Assistant Health Inspector, HA, Chairperson of CC Management Ctee, Union Parishad Chairman.
Rangamatia Union (20 beds)	Medical Officer and Family Welfare Visitor (FWV)
Jamalpur District	(Ronald, Mustafizur, Raziq, Touhid)
Dr. Dabiril Islam	Civil Surgeon and team
Dr. Sushil	Deputy Director Family Planning and team
Jamalpur District Hospital	Director and team
Jamalpur Community Clinic	1 Health Assistant, 1 Family Welfare Assistant, 1 Community Nutritional Practitioner
NGO for NNP Jamalpur	Director
Mother and Child Welfare Centre, Jamalpur	Director
Khulna / Sathkhira District	(Siddique, Kees, Kevin, Olivier, Saeda)
Dr. P.K. Paul	Deputy Director Family Planning, Sathkhira District
Dr. Muhammed Ebadullah	Civil Surgeon, Satkhira District
Tala Upazila	
Dr Shyamal Krishna Saha	Upazila Health and Family Planning Officer (UHFPO)
Kalaroa Upazila	Upazila Health and Family Planning Officer (UHFPO)
Shunabaria UHFWC	family welfare visitor
Domdom Community Clinic	health assistant and family welfare assistant
Debhata Upazila	Upazila Health and Family Planning Officer and staff
Debhata Union Sub-Centre	pharmacist
Eidgah Model Community Clinic	family welfare assistant
private clinic	manager and nursing staff
model village	health education volunteers

Annex 4. Documents consulted

Author, Year	Title
00 GENERAL DOCUMENTATION FOR ALL	
MOH / DP, April 2008	Aide Memoire MTR 2008
MOH / DP, April 2007	Aide Memoire Supervision mission 2007.
MOH / DP, 2006	Aide Memoire Supervision Mission 2006
MOHFW – DP, Nov 2007.	HNPSP Mid Year Stock-take, Nov 2007.
IRT, April 2007	APR 2007 Main report
IRT, April 2007	APR 2007 Technical reports
IRT, March 2008	MTR 2008 Main report (Vol I)
IRT, March 2008	MTR 2008 Technical reports (Vol II)
IRT, March 2008	MTR 2008, presentation for the Policy Dialogue (ppt)
MOHFW, Planning Wing, Feb 07	Annual Programme Implementation Report (APIR – 2007)
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MOHFW, April 2009	Annual Programme Implementation Report (APIR – 2009)
MOHFW / MEU, Jan. 2008	Programme Implementation Report (PIR – 2008)
DHS, 2007 final BD - website	DHS final report (and specific tables) and web-site address: http://www.measuredhs.com/pubs/pub_details.cfm?id=890&srchTp=home
DHS, 2007, March 2009.	Power point presentations by staff NIPORT on specific tables: Overview, Maternal Health, Child Health, Fertility and Nutrition
UESD, 2008	UESD Tables tabulation 2008 study, final
DP, Jan 2009	LCG Summary
DP, Dec 2008	LCG Policy Brief Health
DP, Jan 2009.	LCG Policy Brief Health (2 pages): Moving forward
DP, Jan 2009	LCG Policy Brief Health (WB ppt)
DP, Jan 2009	LCG Health
DP, Jan 2009	LCG Macroeconomic Policy
DP, Jan 2009	LCG Governance
DP, Jan 2009	LCG Aid Effectiveness
Foster Mick, Dec 2008	Operational Plans Analysis, final
Health Watch, Undated (Mahmood)	PH Care system in BD, the role of Public Administration
GOB, Dec 2008.	Election Manifesto Awami League
GOB, Planning Commission, undated	MDG Needs Assessment and Costing: Thematic area Health.
GOB, Planning Commission, July 2005	Unlocking the potential, National Strategy for accelerated Poverty Reduction (PRSP).
IHP+, Geneva, Febr 2009	Communique Ministers of Health
IHP+, (DFID), Nov 2008	Country Health Sector Teams in IHP, background literature review
M&E Unit, 12.04.2009	Reports available for the APR 2009.
MOHFW, March 2009	Letter from MOHFW to DPs concerning timely SOE.
MOHFW / GOB, Nov 2008	National Health Policy (draft)

DP, 28.09.2008	Comments on National Health Policy by HNP Consortium
MOHFW, Undated	Action Plans for all Line Directors
MOHFW, Febr 2009	GEV in HNPSP stock take and way forward
MOHFW, March 2008	GAVI application for HSS
MOHFW / DGHS, 2008	Health Bulletin (DGHS/MIS)
MOHFW / GOB, Nov 2004	SIP / Strategic Investment Plan (SIP July 2003 – June 2010)
MOHFW, Nov 28, 2005	HNPSP Implementation Manual
MOHFW, Planning Wing, Nov 2005	Revised Programme Implementation Plan (R-PIP July 2003 – June 2010)
MOHFW, Planning Wing, July 2008	Revised PIP Final (July 2003 – June 2011)
MOHFW, Planning Wing, July 2008	Revised PIP Final (July 2003 – June 2011 with 38 OPs, Tables and with Expenditure up to June 2008 and budget till June 2011)
MCU, May 2001 (Draft)	Decentralisation in the Bangladesh health Sector, a discussion document.
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BD Institute of Development Studies (BIDS), March 2008	MTR 2008; Stakeholders' Consultation Report on MNCH. Dr. Sharifa Begum, Senior Research Fellow & Dr. S. M. Zulfiqar Ali, Research Fellow.
NIPORT, IEDCR, April 2007	Utilisation of Essential Service Delivery (UESD) Survey 2006
SIDA, 2008	Reality Check, listening to poor people's realities
World Bank, March 1999	Fourth Population and Health Project (End of Project Evaluation)
World Bank, March 2005.	PAD / Project Appraisal Document
World Bank, June 2005 / Dec 2005	Implementation Completion Report (ICR)
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World Bank, May 2007	Implementation Status Report
World Bank, Jan 2004.	MDG Needs assessment (Bangladesh case study)
World Bank, Dhaka. Jan 2007	To the MDGs and beyond: accountability and institutional innovation in Bangladesh. Paper No. 14.
WB, Jan 2007	To the MDGs and beyond: Chapter on health Chapter 5. Creating Human Capital – health
World Bank, May 2007 (ppt)	Trends in health outcomes and service delivery in BD
WB, Febr. 2009	APR 2009: Information Sources (to be compiled)
Minutes HNP Donor Consortium	Minutes of meetings: 21.05.2008; 25.06.2008; 24.08.2008; 07.10.2008; 23.09.2008; 15.01.2009; 03.03.2009.
Minutes DP Retreat, 14.12.2008	Proceedings DP Retreat – HNP Consortium, 14.12.2008
Minutes HNP Coordination Ctee	Minutes of meetings: 07.10.2008; 03.03.09;
Minutes HNP Forum	Minutes of meetings: 01.09.2008 (to be issued probably next week)
Minutes GOB-DP, July 2008	Minutes GOB – DP working groups
Minutes CCM	Minutes of CCM Meetings: 10.06.2008;
Minutes Steering Ctee APR 2009	Minutes of Meetings by Steering Ctee APR: 05.02.2009;
Minutes DPs on GAVI August 2008	Minutes of meeting of DPs on GAVI / HSS support: 14.08.2008
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DFID, Pearson Marc, Jan 2006	Global Health partnerships and Health Systems Strengthening (HSS)
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FMRP, Jan 2007.	Governance, Management and Performance in Health and Education facilities in Bangladesh

	(draft) (Social Sector Performance Qualitative Study)
MOHFW, Nov 2004	Institutional & Management Capacity Assessment
01B. INTERNAL AND EXTERNAL COORDINATION AND PPP	
GAVI, 2009.	Correspondence on Coordination for the APR between GAVI and HNPSP
Loevinsohn, Lancet 2005	Buying results? Contracting for health service delivery in developing countries
MSA, June 2008	Work plan and Inception report (April 2008 – March 2009)
MSA, June 2008	Policy Options Paper
MSA, Febr 2009	Background information on MSA (confidential)
DP Comments on MSA, Oct 2008	DPs comments on the MSA Inception Report & Work plan (Oct 2008) and its Policy Option Paper (July 2008)
Cortez R., May 2005	NGO Contracting Evaluation for the HNP Sector in BD
MOHFW, 2003 (Verulam)	End of Programme Evaluation of the PPP component of HPSP
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Allison CJ, June 2000	"Technical Assistance to MOHFW to assist in developing processes for NGO involvement in HPSP"
WB, Dhaka, December 2005	"Comparative Advantage of Public and Private Health Care Providers in Bangladesh", Bangladesh Development Series – paper No. 4
WB, March 2009	"A review of NGO Contracting in the Urban Primary Health Care Project II", Benjamin Loevinsohn
Asian Development Bank, November 2008	"Framework for Public-Private Partnerships (PPP) in the Social Sectors & Experiences from the Bangladesh Urban Primary Health Care PPP Project in Reaching the Poor", Sekhar Bonu
Health Policy and Planning 2008 :23:465-475	"Does an expansion in private sector contraceptive supply increase inequality in modern contraceptive use?", Sohail Agha and Mal Do
Government of the People's Republic of Bangladesh, October 2008	"Moving Ahead- National Strategy for Accelerated Poverty Reduction II (FY2009-11), Planning Commission
NIPORT 2006	Slums of urban Bangladesh, Mapping and Census 2005
02. GENDER, EQUITY AND VOICE	
JHPN, Sept 2008	Articles in JHPN: Achieving the MDGs in Bangladesh", Vol 26, No 3.
MOHFW, Febr 2009	GEV in HNPSP stock take and way forward: getting the basics in place
MOHFW / HEU / WHO, August 2008 (Workshop)	Integrating Rights Based Approach (RBA) in addressing health consequences of Gender Based Violence (Gender NGO Stakeholder Participation Unit (GNSP)
Health Watch, Dec 2006.	Bangladesh State of Health Report: challenges of achieving equity
GTZ, April 2008	Rights Based Approach (RBA) in Health (Brown Bag lunch)
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CIDA, February 2009	MOHFW Gender Equity in HNPSP, stock take and way forward: getting the basics in place, building on success
WB, August 2003	Voices of stakeholders in the health sector reform in BD
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DSF Pop Council, April 2008	DSF, Update on Voucher Scheme for poor rural women to utilise pregnancy care
DSF Pop Council, July 2008	DSF, Update on experiences from implementation of maternal voucher scheme
DSF, Oct 2008, ICDDRB	Rapid Assessment on the status of the DSF, final report (by ICDDRB and GTZ)
DSF, Oct 2008, HEU	Rapid Assessment of DSF pilot 2008.
DSF, May 2008 (ppt)	Some 09 power point presentations on the status of the DSF (various authors)
European Commission, June 2008 (Conseil Sante)	Innovative approaches to health financing in BD: identification of options for project support HNPSP (draft)
Abt Associates, Nov 2008	Review, analysis and assessment of issues related to HCF and Health Economics in BD (Technical Proposal prepared for GTZ)
HCF Task Group, Dec 2008	Various TORs from the HCF Task Group (zipped)
HCF, Oct 2007	Two TORs to study a Health Financing Package by HEU
MOHFW/HEU, Sept 2008	HEU Work Plan (Excel sheet)
MOHFW/HEU/Tim Ensor, 11.1999	Economic Indicators for monitoring the HPSP (Research Note 16)
MOHFW/HEU, Sept 2000	Strategies for developing health insurance in BD (Research Note 20)
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MOHFW/HEU, Jan 2003	PER / Public Expenditure Review HPSP 2001-2002
MOHFW, June 2006	PER / Public Expenditure Review HNPSP 2003-2004
MOHFW. March 2009	PER / Public Expenditure Review HNPSP XXX
MOHFW, XXX	Health Chapter on Poverty Assessment
CGAP, Sept 2005	Health Micro Insurance (three case studies). (Case Study No 13)
GOB, MFA, Dec 2005	Macroeconomic Management of Bangladesh
ODI, Sept 2008 Briefing paper 40	Is water lagging behind in aid effectiveness? Lessons from BD, Ethiopia and Uganda.
Verulam, Febr. 2007	Review of Parallel Funding by DPs
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Bull WHO, 2009, 87. 130-138	Neonatal Mortality risk factors and causes (Pakistan Study)
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KIT, Febr 2009	Joint Assessment of targeted interventions for HIV in BD

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ICDDRB, March 2009.	20 years of HIV in BD: experiences and way forward (submitted to WB/UNAIDS)
DGHS / NASP, Sept 2005	National HIV Serological Surveillance 2004-2005. (6th Round Technical Report)
UNGASS, Dec 2005	UNGASS Country report 2003-2005
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Malaria	
DGHS, Malaria and Parasitic Disease Control Unit	Malaria Annual Report June 2007 – June 2008
DGHS, M&PDC Unit, Jan 2009.	Strategic Plan for Malaria Control Programme in BD 2008 – 2015.
MSF, Holland, 2002	Two Malaria Studies Chittagong Hill Tract (Mal Studies MSF Holland)
Tuberculosis	
WHO, August 2007 (TUB-01)	Rapid Assessment of TB Control activities in refugee camps in Cox Bazar district
WHO, Sept 2007 (TUB-02)	Planning and implementation of Advocacy and Social Mobilisation
WHO Sept 2007 (TUB-03)	Feasibility assessment for establishing Regional TB Reference Labs
WHO, Nov 2007 (TUB-04)	Report on a Training Course in Tuberculine testing in BD
WHO Dec 2007 (TUB-05)	Assessment of TB control activities in workplaces in Chittagong and Dhaka
WHO, NTCP, Oct 2007 (TUB-06)	Report of the Fourth Joint Review (JRM4)
WHO, Jan 2008 (TUB-08)	Training on DOTS-plus and management of drug resistant TB
WHO, Febr 2008 (TUB-09)	Rapid assessment of drugs and logistic storage systems within network of NTCP
WHO, April 2008 TUB-14)	TB / HIV Collaborative activities
WHO, Oct 2007 (TUB-15)	Estimation of the prevalence of HIV infection among TB patients in Dhaka
WHO, Jan 2009 (TUB-19)	Assessment of involvement of private health care providers in the programmatic management of drug resistant TB in BD.
DGHS / NTCP, 2008	Tuberculosis control in Bangladesh - Annual report 2008.
Arsenicosis	
MOHFW, undated	National Policy for Arsenic Mitigation, 2004.
World Bank, Oct 2007	Policy Advisory Note for Arsenic Mitigation
FAO, 2006	Arsenic contamination of irrigation water, soil and crops in BD
Howard Guy, Undated	Social aspects of access to health care for Arsenic patients
SANDEE, Nov 2007 (Zakir Hossain Khan)	Managing the Arsenic Disaster in water supply: risk measurement, cost of illness and Policy choices for BD
No Author, Undated	Implementation plan for Arsenic Mitigation in BD
UNICEF, 2008	Arsenic Primer, Guidance for UNICEF country offices on the investigation and mitigation of Arsenic contamination
Authors various, March 2006	Research Paper on mortality and Arsenic exposure in utero
Chen et al, 2004	Cancer burden from Arsenic in drinking water in BD
Avian Flu	
Woirld Bank, Sept. 2008	Aide Memoire (final): Implementation review Mission for the Avian Flu Preparedness and response project
World Bank, Febr 2009.	Aide Memoire (final): Implementation review Mission for the Avian Flu Preparedness and response project
Ostroff, April 2008	Avian Flu: key issues and way forward
GOB/WHO / FAO, Undated	National Avian Influenza and Human Pandemic Influenza Preparedness and Response in BD, 2006-2008.
WHO, August 2007	Guidelines for Clinical Management of Avian Flu Cases
MOHFW/DGHS, Oct 2008	Standard Operating Procedures (SOP) Avian Influenza in Humans

Non Communicable Diseases	
MOHFW/DGHS, undated	National Policy, Strategy and Plan of Action for NCD Surveillance and Prevention
HNPSP, June 2008	Review of NCD Component of the HNPSP (2 reports in June)
HNPSP, Bot Report, March 2009.	NCD Component in HNPSP
WHO, April 2007	Impact of Tobacco-related illnesses in Bangladesh (SEARO)
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Diabetes Information	See Bangladesh Med Res Counc Bull. 2007 Apr;33(1):1-12.
B Med Res Council, April 2007	Prevalence of Diabetes and impaired fasting glucose in urban populations in BD (Bulletin)
Dr Mudgal., March 2007	Review of Health Care Waste Management (HCWM) Plan of BD, HNPSP/HAPP
EPI	
WHO, August 2008	WHO Weekly Epid Record: Neonatal Tetanus elimination
05A. MATERNAL, NEONATAL AND CHILD HEALTH (MNCH)	
Authors various, undated	12 (scientific) articles on MNCH (zipped)
Author unknown	Recommended recent documents on MNH in BD
Author unknown	Concept Paper on 2008 Bangladesh Maternal Mortality Survey
JHPN, Sept 2008	Achieving the MDGs in Bangladesh", Vol 26, No 3.
BRAC, ICDDRB, Oct 2008	Manoshi, Community health solutions in BD (Scientific Report 104) (Dhaka)
BRAC, ICDDRB, Febr 2009	Research brief Manoshi (Dhaka)
A.B. Bhuiyan Focal Point on CSBA Training	Community Based Skilled Birth Attendant Training Program. Progress Report 2008
CIDA, Oct 2008	MNH in Bangladesh: preliminary overview of funding options for CIDA
CIDA, Dec 2008	MNH Situational Analysis and programmatic response
DNS & Bangladesh Nursing Council, September 2008	Proposed Strategic Directions. Enhancing Contribution of Nurse-Midwives for Midwifery Services to contribute to the attainment of MDG 4 and 5
ITG, 2008	Reducing financial barriers to Obstetric Care in low-income countries
Joint GOB-UN MNH Initiative	Accelerating Progress towards Maternal Neonatal Mortality and Morbidity Reduction
HEU MOHFW Bangladesh, Oct 2008	A Rapid Assessment of the DSF Pilot
MNH Stakeholders Consultation	Minutes of Meeting on 15 April 2009
Population Council DBRHCP Research Update no 5 July 2008	Experiences fro implementing the Maternal Voucher Scheme in Rural Bangladesh
GTZ, ICDDR,B Data International. October 2008	Report of Rapid Assessment of the DSF Pilot. Research Paper No 36
World Health Organization	Activities of the Demand Side Financing at Sulla Upazila by Masum Al Jaki
JICA	Operational Guidelines on Community Support System (CSS) in Bangladesh
MOHFW/DGHS, XX	Verbal Autopsy on Maternal Deaths
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MOHFW EPI, DGHS	Immunization Programme,Comprehensive Multi-year Plan, (2006-2015). Based on the Global Immunization Mission and Strategies
Author unknown	NGO profiles (draft) (BRAC, CARE etc)
PRMA Leslie Patykewich, Oct 2008	A case study of RH supplies in BD
READ, April 2004	Performance evaluation of piloting the SBA training Programme
RH Services Training and Education Program RHSTEP	At A Glance July 200 – March 2008
World Bank, March 2005	MNCH and Nutrition Impact Evaluation
WHO Bull, 2009, 87. 130-138	Neonatal Mortality risk factors and causes (Pakistan Study)
WHO, undated	MNH Funding overview 2008-2009 (excel sheet)
UNFPA, Martz, Febr 2008	MNH Mapping, a mapping of Maternal and Neonatal health interventions in BD

USAID, NIPORT, ICDDR, B	Bangladesh Demographic and Health Survey 2007: Policy Briefs
GTZ, undated	TOR BD Maternal Mortality Survey (BMMS) (concept paper)
GTZ, 16.03.09	Minutes BMMS Taskgroup
DFID XXX	MNCH review
DFID, XXX	MNCH Project Proposal
DFID, April 2009	Mid term Review of the ADB supported Urban Health Programme (Andy)
05B. POPULATION AND FAMILY PLANNING (FP)	
HPP, Sept 2008, Suhail Aga (hard copy with Jarl)	Does an expansion in private sector contraceptive supply increase inequality in modern contraceptive use? (case study BD, p. 472)
JHPN, Sept 2008	Achieving the MDGs in Bangladesh", Vol 26, No 3. (see MNCH)
FMRP / SSPS, June 2005	Health and Family Planning, social sector performance qualitative survey
NIPORT, UNFPA, 2007	Bangladesh Population Profile 2006
FMRP, Social Sector Performance Survey, Sept 2005	Primary Health and Family Planning in Bangladesh, assessing service delivery/
06. NUTRITION	
JHPN, Sept 2008	Achieving the MDGs in Bangladesh", Vol 26, No 3.
CIDA, Febr 2006	Review of organisational options for delivery of Nutrition services through HNPSP
World Bank, March 2005	MNCH and Nutrition Impact Evaluation
WB, May 2005	The Nutrition MDG indicator: interpreting progress
III. SUPPORT SYSTEMS	
07. HUMAN RESOURCES FOR HEALTH	
Author Unknown, Undated	HRH Master Plan for BD, 2010-2040, Concept Paper (Lorenzo?)
Author unknown, Undated (ppt)	Status on HR in MNH districts (ppt)
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ICDDRB, Parveen, Undated	Enabling environment and scope of nurses in Maternal and Neonatal health care programmes in BD (2 pages)
MOHFW, Sept 2008	Health Workforce Strategy 2008 in BD
MOHFW/DGHS, Sept. 2007	A report on Expansion of Medical Education for a balance production of health workforce
Task Group HRH, Oct 2008	Feedback on the draft Bangladesh Health Workforce Strategy 2008 and the Roadmap for the development of a HRH Master Plan
Task Group HRH, Undated	HRH Development Road Map Matrix and activities, timeline and budget 2008-09
Task Group HRH, Undated	Action Plan for Human resources (1 page, Table 6.6)
Task Group HRH, Sept 2008	Incentives for HR
Social Science and Medicine, 2007	Why Bangladeshi nurses avoid nursing: social and structural factors in hospital wards in BD
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OPM, March 2009	Improving returns from Capacity-Building investment Bangladesh
Health Watch, March 2008 (ppt)	Presentation of Health Care Providers (HCP) in Bangladesh: density, skills, motivation and challenges (ppt)
Bhuiya, Abbas (ed.), 2009	Health for the Rural Masses (Insights from Chakaria)
D. Peters and R Kayne, 2003	Bangladesh Health Labour Market Study – Final Report
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MIS, DGHS	Health Bulletin 2008
Mahmood, S. S., 2009	'Are Village Doctors a Curse or a Blessing?' 12th Annual Scientific Conference, ICDDR,B.
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Dr. A M Zakir Hossain etc., 2009	Study on HRD in Bangladesh as a Prelude to the HRH Master Plan 2010 - 2040
08. PROCUREMENT AND SUPPLY CHAIN MANAGEMENT	
CIDA, Sept 2008	Project Summary Proposal: CIDA-MOHFW Procurement systems training and equipment project and pre-project bridging TA assistance
DFID, April 2001	Development of administrative and financial management capacity for SWAp: the experience of the BD health sector
MOHFW/HEU, Jan 1997	An assessment of flow of funds in the health and population sector in BD
PRMA Leslie Patykewich, Oct 2008	A case study of RH supplies in BD
09. PUBLIC FINANCIAL MANAGEMENT (PFM)	
Author Unknown, Undated	TOR for the Internal Audit of the HNPSP
Internal Audit report	Internal Audit of HNPSP (hard copy made available to Steve Perkins, Mick Foster and Ed Vreeke)
GAVI (undated)	TOR for Financial Management Assessment in BD (27.04 – 07.05.2009)
GAVI, March 2009	Coordination with GAVI on FMA (correspondence)
GAVI, Febr. 2009	GAVI Financial Management Assessment (FMA) (draft guidance note)
GAVI, Undated	GAVI Transparency and Accountability Policy (TAP) (Q&A for GAVI eligible countries)
MOHFW / FMAU, Sept 2008	Minutes of the meeting on the Internal Audit and to draft an Action Plan
MOHFW / FMAU, Nov 2008	Action Plan re Internal Audit irregularities
MOHFW, undated	Summary of serious irregularities
MOHFW, undated	Initial response Internal Audit
WB, 23.02.2009	Observations and comments re Audit reports (7 audit observations)
WB, 01.02.2009	FAPAD, Final Audit Report FY 2007-2008
MOHFW01, 27.05.2008	USD 38 M for PBF
MOHFW02, 03.06.2008	USD 38 M for PBF
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EU, 23.11.2008	Verification mission report on the WB HNPSP (draft)
10. MONITORING AND EVALUATION (M&E)	
HNPSP, undated ?2006	Updated HNPSP M&E Result Framework (appendix 4)
Chabot, Febr. 2008	MDG and HNPSP Indicators Tables (all together)
MOHFW/MEU, XXX	Results Framework (Updated 2009)
GTZ01, August 2005	M&E Plans for the HNPSP (final)

GTZ02,	TOR Data Management
GTZ, undated	TOR BD Maternal Mortality Survey (BMMS)
Hornetz Klaus, March 2007	M&E in the BD health sector SWAp (ppt)
IMED / Ministry of Planning 2003	HPSP Evaluation 2003
11. DEVELOPING PARTNERS	
ADB, April 2009, MTR/UPHCP II	Report of the MTR of the Urban Primary Health Care Project (UPHCP II) (Independent Consultant Team)
EC01, Lot 8, Nov 2008	TOR to support the development of innovative options for health care financing in HNPSP
EC02, Lot 8, Nov 2008	TOR to support the preparation of a successor to the HNPSP in BD.
EC03, Lot 8, Febr 2009	TOR for M&E of an EC funded project to strengthen health services in Chittagong Hill Tracts
EC04, Lot 8, Febr 2009	TOR to support M&E of a EC funded project to reduce Maternal and Neonatal Mortality and Morbidity
EC05, Febr 2009	Correspondence Herzig
EC06, February 2008 (Conseil Sante)	Assessment of a project proposal and development of alternative options for Chittagong Hill Tracts programme (UN Collaborative Health Initiative)
GTZ, undated	TOR BD Maternal Mortality Survey (BMMS) (concept paper) (see soft copy in MNCH)
GTZ01, Febr 2009	Correspondence GTZ (Olivier)
GTZ02, Undated	TOR for strengthening M&E within HNPSP
GTZ03, XXX	TOR Incentive Study
RNE, Nov 2008	Draft EKN Strategic interventions 2009-2012.
RNE, Nov 2008 (ETC Crystal)	BOOM, SRHR and advocacy framework for action
DFID/BD, 2007	DFID Bangladesh, Briefing Note on Health
DFID, UPHCP II, ??2008	Urban Primary Health Care Project (UPHCP): an analysis of service delivery to the poorest.
DFID, UPHCP II, April 2009	Review of access by the poorest to Skilled Births Attendants (SBA) through UPHCP II.

Annex 5. Table comparing various weight indicators 2004-2007.

Percentages and numbers for moderate and severe stunting, wasting and underweight for children under 5, 2004 and 2007 (BDHS)[21].

[21] **Note:** figures are based on standard deviations (SD) from the median of two different reference populations. The BDHS 2004 report used the NCHS/CDC/WHO standard (top panel), the BDHS 2007 report used the WHO Child Growth standard (bottom panel). Due to the difference in these standard populations the figures in the reports from both surveys cannot be compared straight away. However, in Annex D of the 2007 BDHS report the 2007 data have been recalculated using the reference population that was used in 2004. While using these figures (middle panel) a comparison can be made between 2004 and 2007.

BDHS 2004 (Reference Population NCHS/CDC/WHO)

Age group	STUNTING height-for-age				WASTING weight-for-height				UNDERWEIGHT weight-for-age				Number of children in survey
(months)	severe (- 3SD)	N	moderate or severe (-2SD)	N	severe (- 3SD)	N	moderate or severe (-2SD)	N	severe (- 3SD)	N	moderate or severe (-2SD)	N	
<6	1.5	9	10.4	60	0.6	3	3.1	18	0.9	5	8.3	48	581
6-9	6.5	25	23.5	89	1.3	5	8.3	31	7.1	27	29.4	111	378
10-11	5.0	9	28.3	51	1.3	2	12.9	23	13.3	24	42.9	78	181
12-23	20.4	239	50.9	596	2.8	33	24.0	281	17.8	208	58.5	684	1170
24-35	16.0	196	44.7	546	1.9	23	13.4	164	16.8	205	54.6	667	1222
36-47	21.0	262	49.2	615	0.4	5	10.6	132	13.4	167	51.1	638	1249
48-59	22.5	275	51.2	627	0.4	5	10.0	122	10.8	132	51.1	625	1224
0-59	**16.9**	1014	**43.0**	2583	**1.3**	77	**12.9**	772	**12.8**	769	**47.5**	2852	6005
6-59	**18.5**	1006	**42.0**	2523	**1.2**	73	**12.6**	754	**12.7**	764	**46.7**	2804	5424
24-59	**19.8**	733	**29.8**	1787	**0.6**	33	**7.0**	419	**8.4**	505	**32.2**	1931	3695

BDHS 2007 (Reference Population NCHS/CDC/WHO, see Annex D)

Age group	STUNTING height-for-age				WASTING weight-for-height				UNDERWEIGHT weight-for-age				Number of children in survey
(months)	severe (- 3SD)	N	moderate or severe (-2SD)	N	severe (- 3SD)	N	moderate or severe (-2SD)	N	severe (- 3SD)	N	moderate or severe (-2SD)	N	
<6	2.3	10	9.2	40	0.3	1	2.6	11	1.3	6	7.8	34	430
6-9	4.0	17	17.6	73	0.6	2	6.3	26	2.6	11	20.8	87	416
10-11	1.7	3	21.9	37	2.1	4	19.6	34	9.2	16	37.6	64	171
12-23	11.8	127	38.0	409	2.9	31	29.1	313	13.8	149	55.0	592	1077
24-35	13.1	142	37.2	404	0.9	10	16.9	184	15.5	168	53.6	582	1086
36-47	18.4	193	47.3	496	1.0	10	13.9	146	13.5	142	52.1	547	1049
48-59	14.7	155	42.7	451	0.6	6	13.5	143	8.3	88	51.4	543	1057
0-59	**12.2**	647	**36.2**	1911	**1.2**	65	**16.2**	856	**10.9**	578	**46.3**	2449	5286
6-59	**13.1**	637	**38.5**	1871	**1.3**	64	**17.4**	845	**11.8**	573	**49.7**	2415	4856
24-59	**15.4**	491	**42.3**	1352	**0.8**	27	**14.8**	472	**12.5**	398	**52.4**	1672	3192

BDHS 2007 (Reference Population WHO Child Growth Standard)

Age group (months)	STUNTING height-for-age				WASTING weight-for-height				UNDERWEIGHT weight-for-age				Number of children in survey
	severe (- 3SD)	N	moderate or severe (-2SD)	N	severe (- 3SD)	N	moderate or severe (-2SD)	N	severe (- 3SD)	N	moderate or severe (-2SD)	N	
<6	5.7	26	19.0	86	4.6	21	17.9	81	9.0	41	29.1	132	455
6-9	9.3	39	24.8	104	4.6	19	13.3	56	5.9	25	25.2	106	419
10-11	2.8	5	25.0	43	4.0	7	25.9	45	7.3	13	33.0	57	173
12-17	10.4	51	32.5	161	3.5	17	22.8	113	9.1	45	36.2	179	495
18-23	16.4	96	47.3	276	4.4	26	23.5	137	13.8	81	41.5	242	584
24-35	21.3	231	53.2	576	1.9	21	16.1	174	14.0	152	44.5	482	1083
36-47	23.1	242	54.0	565	2.4	25	15.1	158	14.9	156	46.8	490	1046
48-59	15.9	168	45.6	482	1.4	15	15.3	162	10.9	115	46.3	490	1058
0-59	**16.1**	858	**43.2**	2294	**2.8**	151	**17.4**	926	**11.8**	627	**41.0**	2178	5313
6-59	**17.1**	832	**45.4**	2208	**2.7**	130	**17.4**	845	**12.1**	586	**42.1**	2046	4858
24-59	**20.1**	641	**50.9**	1623	**1.9**	60	**15.5**	494	**13.3**	423	**45.9**	1461	3187