স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

HEALTH, POPULATION, AND NUTRITION SECTOR DEVELOPMENT PROGRAM (HPNSDP)
JULY 2011 –DECEMBER 2016

ANNUAL PROGRAM IMPLEMENTATION REPORT (APIR) 2016

December 2016

PROGRAM MANAGEMENT AND MONITORING UNIT (PMMU)
PLANNING WING, MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

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PREFACE

This is the fifth and the last Annual Program Implementation Report (APIR) for the Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-16. The Report tries to capture progress of implementation of the Program by tracking performance of 32 Operational Plans during FY 2015-16.

Data contained in the Report is sourced from a template circulated to the Line Directors (LDs) for collecting information on achievement of OP indicators, physical progress, training progress and identification of challenges they faced in the course of program implementation. The financial data like allocation, release and expenditure have been drawn from Ministry of Health and Family Welfare's (MOHFW) monthly ADP review. The Report also sheds light on some of the institutional and service initiatives undertaken by the MOHFW during July, 2015 – June, 2016.

It will be fair to state that the Program achieved substantial progress over the last five years in terms of both financial and physical targets. The challenges identified by the LDs draw attention to a number of issues which need to be addressed for achieving better performance in the next sector program.

I hope that the Report would be found relevant and useful within the Government and by the Development Partners. We would be happy if the Report contributes to focusing on priority issues and adoption of realistic actions for achieving better performance in the coming 4th HNP Sector Program.

I would like to thank the LDs and their supporting teams for their time and involvement in generating the information on which the Report is based. I appreciate the support and hard work of my colleagues in the Planning Wing and the Technical Assistance Support Team (TAST) of Program Management and Monitoring Unit (PMMU) for producing the Report.

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ABBREVIATIONS & ACRONYMS

ADP	Annual Development Program
AMC	Alternative Medical Care
ANC	Antenatal Care
APIR	Annual Program Implementation Report
APR	Annual Program Review
ARH	Adolescent Reproductive Health
AWP	Annual Work Plan
BCC	Behavior Change Communication
BFHI	Baby-Friendly Hospital Initiative
CBHC	Community Based Health Care
CC	Community Clinic
CCSD	Clinical Contraception Service Delivery
CDC	Communicable Disease Control
CHCP	Community Health Care Provider
CPR	Contraceptive Prevalence Rate
CSBA	Community Skilled Birth Attendant
CMSD	Central Medical Stores Depot
DDS	Drugs and Dietary Supplements
DGDA	Directorate General of Drug Administration
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
DH	District Hospital
DNS	Directorate of Nursing Services
DPA	Direct Project Aid
DSF	Demand Side Financing
EDPT	Early Diagnosis and Prompt Treatment
EGV	Equity Gender and Voice
EmOC	Emergency Obstetric Care
ESD	Essential Services Delivery
ESP	Essential Service Package
FMAU	Financial Management and Audit Unit
FP	Family Planning
FPI	Family Planning Inspector
FP-FSD	Family Planning Field Services Delivery
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FY	Financial year
GOB	Government of Bangladesh
HA	Health Assistant
HEF	Health Economics and Financing
HEP	Health Education and Promotion
HIS&eH	Health Information System and e-Health
HIV	Human Immunodeficiency Virus
HNP	Health Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Program
HPSP	Health and Population Sector Program
HPNSDP	Health Population and Nutrition Sector Development Program
HPNSP	Health, Population and Nutrition Sector Program
HRM	Human Resource Management
HSM	Hospital Services Management
HTR	Hard-to-Reach
IDU	Injection Drug User
IEC	Information, Education and Communication
IEDCR	Institute of Epidemiology, Disease Control & Research
IFM	Improved Financial Management
IHS	Improving Health Services
IHT	Institute of Health Technology
IMCI	Integrated Management of Childhood Illnesses
IPHN	Institute of Public Health & Nutrition
IST	In-Service Training
IUD	Intra Uterine Device
IYCF	Infant and Young Child Feeding
JDTAF	Joint Donor Technical Assistance Fund
LAPM	Long Acting and Permanent Methods
LD	Line Director
LLP	Local Level Planning
MARP	Most at Risk Population
MATS	Medical Assistant Training School
MCH	Medical College Hospital
MCRAH	Maternal, Child, Reproductive and Adolescent Health
MCWC	Maternal and Child Welfare Center
MDG	Millennium Development Goal
MDR	Multi-Drug Resistant
M&E	Monitoring and Evaluation
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCAH	Maternal Neonatal, Child and Adolescent Health
MOHFW	Ministry of Health and Family Welfare
MPIR	Mid-term Progress Implementation Report
MPR	Mid-term Program Review
MR	Menstrual Regulation
MSR	Medical and Surgical Requisites
NASP	National AIDS/STD Program
NCDC	Non-communicable Disease Control
NEC	National Eye Care
NES	Nursing Education Services
NGO	Non-Governmental Organization
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
NNS	National Nutrition Services
NSV	No-scalpel Vasectomy
OP	Operational Plan
PA	Project Aid
PAP	Prioritized Action Plan
PFD	Physical Facilities Development
PER	Public Expenditure Review
PIP	Program Implementation Plan
PLMC	Procurement and Logistics Monitoring Cell
PLSM	Procurement, Logistics and Supplies Management
PME	Planning, Monitoring and Evaluation
PMMU	Program Management and Monitoring Unit
PMR	Planning, Monitoring and Research
PSE	Pre-Service Education
PSSM	Procurement, Storage and Supplies Management
PW	Planning Wing
RADP	Revised Annual Development Program
RPA	Reimbursable Project Aid
RFW	Results Framework
SACMO	Sub-Assistant Community Medical Officer
SBA	Skilled Birth Attendant
SDAM	Strengthening of Drug Administration and Management
SHS	Strengthening Health Systems
SmPR	Six-monthly Progress Report
SOP	Standard Operating Procedure
SSK	Shasthyo Shurokhsha Karmasuchi
SWAp	Sector Wide Approach
SWPMM	Sector Wide Program Management and Monitoring
TAST	Technical Assistance Support Team
TFR	Total Fertility Rate
TOT	Training of Trainers
TQM	Total Quality Management
TRD	Training, Research and Development
UHC	Upazila Health Complex
UH&FWC	Union Health and Family Welfare Center
WHO	World Health Organization

EXECUTIVE SUMMARY

This is the fifth Annual Program Implementation Report (APIR) of the Health, Population and Nutrition Sector Development Program (HPNSDP) 2011-16. It has been prepared by the Program Management and Monitoring Unit (PMMU) of the Planning Wing of the Ministry of Health and Family Welfare (MOHFW), to assess progress of implementation of the Operational Plans (OPs). It is a review of progress in program implementation (during 2015-16) accompanied by identification of the areas for improvement.

It may be recalled that the HPNSDP aims at improving health services and service provision, and strengthening the health systems. The sector program functions through 32 OPs, each led by a Line Director (LD). In terms of the number of OPs, 16 OPs are accounted for Improving Health Services (IHS) and the rest for Strengthening Health Systems (SHS). The OPs vary greatly in size of yearly budget allocation with 16 OPs accounting for less than 1% of total budget each, while the Physical Facilities Development (PFD), alone accounted for 21% of the budget of the year under review.

The information for the APIR was collected from the LDs on a structured data reporting template customized for individual OPs. PMMU staff closely liaised with the LDs and their core staff, e.g. Program Managers (PMs), Deputy Program Managers (DPMs), and Accountants, with support from the Technical Assistance Support Team (TAST) members (from MEASURE Evaluation and icddr,b) to collect the data and complete data analysis in time.

MAJOR FINDINGS

Budget Allocation and Spending Patterns: The total fund allocation for FY 2015-16 was Tk. 4,214.7 crore, 44% of which came from GOB (Tk. 1,868.9 crore) and 56% from PA (Tk. 2,345.8 crore). The overall spending rate (against allocation) was 81%, with 94% for GOB and 70% for PA fund. Compared to the average spending rate of the first four years of HPNSDP (87%), the rate of utilization in the fifth year declined. However, in terms of spending rate against released fund, the rate of utilization in the fifth year remained similar to the average spending rate of the first four years of HPNSDP (91%). Even though the rate of utilization of RADP fell from 89% in 2013-14 to 83% in 2014-15 and 81% in 2015-16, the Program was able to spend increasing amount every year – from Tk. 1,993 crore to Tk. 3,404 crore in 2015-16, an increase of 71% over the 5-year period. This shows increasing absorption capacity and improved budget planning and management.

The main reasons of the decline were: (a) non-availability of PA fund, particularly RPA funds from the World Bank (WB); (b) the long time (almost one year) taken to negotiate an additional financing of US $150.0 million with the WB due to the introduction of a new mode of financing, resulting in an unclear understanding of RPA fund release mechanism; and (c) the limited number of procurement packages cleared by the WB during the last part of FY 2015-16. These factors contributed to slowing the pace of program implementation and fund utilization. A summary table is provided at Annex A on both financial and physical progress by OPs during FY 2015-16 and at Annex B on cumulative fund allocation and utilization during FY 2011-16.

Programmatic Achievement Measured by Indicators: Of the 158 OP indicators considered for FY 2015-16, 100 (or 63%) were found to have been fully achieved, and 41 (or 26%) partially achieved. However 17 (11%) indicators were not achieved. The progress in OP-level indicators in FY 2015-16 was lower than the average progress made in the first four years of HPNSDP (65%) in line with slowing pace of program implementation during the FY. An update on progress in OP-level indicators can be seen at Annex D. The assessment of achievement of the RFW indicators also show a comparable picture. Given the fact that the next Sector Program is going to adopt a new financing modality based on disbursement-linked indicators, measures

have to be devised to ensure that its performance in the achievement of indicators improves dramatically, to be able to claim full reimbursement from the WB and other participating DPs.

Training and Workshop: 3.6% of the total annual expenditure for FY 2015-16 was spent on training activities and organizing workshops/seminars/orientations during the FY. Of the total training cost, Tk. 91.5 crore (75%) was spent on training activities and Tk. 30.0 crore (25%) on workshops/seminars/orientations. A total of 558,625 participants took part in trainings and workshop/seminar/orientations during FY 2015-16. Among them 223,806 (40%) participants attended in-country training programs, 448 (0.08%) attended training programs abroad and the rest 334,371 (60%) attended workshops/seminars/orientations. Majority of the local and international training participants were from the SHS OPs (63% and 74% respectively), while among workshop/seminar participants, 95% attended those conducted by IHS OPs. Participants attending 1-2 days' training constitute 70% of the total local-training participants.

Progress in Strengthening Institutions and Services: Some contributing activities undertaken during FY 2015-16 are highlighted below:

- District maternal and neonatal health (MNH) plan was implemented in 11 districts and upazilas including HR support.
- Under the EPI program, 726 volunteers were recruited in 31 districts against the vacant Health Assistant (HA) positions, and 414 MCH and immunization workers were recruited in 13 districts to fill up vacant positions.
- 94 mobile medical teams were engaged to ensure provision of tribal health service.
- Behavior and Sero-surveillance program was conducted among population at risk of HIV in selected areas of Bangladesh.
- Four vision centers were established in Gopalganj and Chapainawabganj.
- Manuals on treatment protocol and eye examination protocol were supplied to all Civil Surgeon's offices and medical colleges.
- Transport, Equipment Maintenance Organization (TEMO) was revitalized through provision of additional financial and human resource.
- The HPN BCC eToolkit for field workers, as a resource for field workers when counseling their clients, was designed and disseminated.
- National Vitamin-A Plus Campaign 2015 was successfully held.
- Memorandum of Understanding was signed with James P. Grant School of Public Health (JPGSPH) of BRAC University for nutrition surveillance.
- Management trainings were conducted by NIPSOM, IEDCR, BCPS, CME, NIPORT and NICVD.
- Chittagong Drug Testing Laboratory was repaired and renovated.

Progress in Formulating Policy/Strategy/Guideline: Following key activities were reported:

- Bangladesh National Strategy for Maternal Health, 2015-2030 was finalized and relevant Standard Operating Procedures (SOP) were approved.
- Draft National Eye Care Strategy was developed and awaits finalization.
- Nutrition Policy 2015, and National Advocacy and Communication Strategy for Nutrition, and Nutrition in Emergency Guideline were approved.
- National Dietary Guideline was developed and awaits approval.

Key challenges faced: The LDs reported following challenges which they experienced during the fifth year of HPNSDP implementation:

- Resource constraints generally;
- Insufficient resources for monitoring and supervision;
- Insufficient skilled manpower; and
- Delay in fund release.

Initiatives to support Program implementation: This being the last APIR under HPNSDP, the Report records 3 different initiatives undertaken during the last 5 years to underpin Program implementation and guide policy-formulation: (a) the issues which were highlighted in periodic review documents to draw attention of the Program management; (b) policy documents and action plans prepared during the Program period and (c) studies conducted as part of comprehensive technical assistance, to support the Program.

Progress in other Issues of Concern: Some issues of concern identified during HPNSDP implementation were (a) the development of a coordinated plan of action by both DGHS and DGFP for acceleration of MNCAH and FP service delivery; (b) non-functioning of completed health facilities due to non-synchronized supply of equipment and HR and the continuing spill-over of unfinished construction of health facilities; and (c) provision of the needed human resources for health. During HPNSDP, MOHFW's efforts in developing the coordinated service delivery plan and the master plan for construction of new health facilities remained as unfinished agenda. But the Health Workforce Strategy (HWS) was approved, which would be translated into action in the 4th Health, Population and Nutrition Sector Program (HPNSP) for 2017-2022. In addition, vigorous attempts were made during the reporting period to address the fiduciary issues by developing an action plan on Integrated Fiduciary Assessment (IFA), by initiating steps for restructuring the FMAU and by developing strategies for restructuring the CMSD. All these steps will need to be followed up in the next Program.

Status of Preparation of the 4th HPNSP: The Concept Paper and the Strategic Investment Plan (SIP) of the 4th HPNSP were developed and approved in May 2015 and April 2016 respectively. By June 2016, the draft updated Essential Service Package (ESP) and the results framework (RFW) of the 4th HPNSP was also formulated and shared for finalization. Preparation of the 4th Sector Program was going on and the first draft PIP would be sent to the Planning Commission shortly. The Government, meanwhile in June 06, 2016 decided to extend the implementation period of HPNSDP up to December 31, 2016.

CHAPTER 1. INTRODUCTION

1.1 COUNTRY AND SECTORAL CONTEXT

Bangladesh has been undergoing steady social and economic changes, more so since 1990. Over the past two decades, the country has registered a significant rise in gross domestic product (GDP) and gross national income (GNI). Per capita GDP was estimated at US $1,384, and the per capita GNI was estimated at $1,465 in 2015-16 (GOB 2016), moving the country up to the lower-middle income group (WB 2015). GDP growth rate has been above 6% over the last decade, at par with some of the best-performing economies in the world, and reached 7.11% in 2015-16 (GOB 2016). However, despite this success, a considerable proportion of the population lives below the poverty line (GOB 2015a).

In the social sector, Bangladesh made remarkable progress in many areas during the last decade, i.e., increase in literacy and life expectancy at birth; sustaining a high level of child immunization coverage resulting in continued decline in infant and child mortality; and achieving a sharp decline of maternal mortality ratio (MMR). In terms of health services delivery, antenatal care visits for pregnant women by medically trained providers nearly doubled from 33% in 1999-2000 to 64% in 2014 and delivery by medically trained providers increased from 12% to 42% during the same period. This increase in skilled delivery is predominantly due to a rise in facility deliveries, which increased from 8% to 37% during 1999-2014 (NIPORT 2015).

Bangladesh also demonstrated substantial progress in implementing an effective family planning program. The decline in total fertility rate (TFR) with increase in contraceptive prevalence rate (CPR) is commendable. TFR declined from 6.3 births per woman in 1975 to 3.4 in 1994, and further decline to the current rate of 2.3 in 2014 (NIPORT 2015). The increase in skilled delivery, coupled with reduction in fertility, resulted in 40% reduction in MMR from 320 in 2001 to 194 in 2010 (NIPORT et al. 2011). Experts have estimated a further fall since then. Gradual improvement of basic health and nutrition services also contributed to a substantial reduction (halving) of under-five mortality (from 94 deaths per 1000 live births in 1999-2000 to 46 in 2014) (NIPORT 2015), and achieving the Millennium Development Goal (MDG) 4 target in advance. Studies indicate that the sector program, with the Government's leadership and continued support from the Development Partners (DPs), contributed to an accelerated improvement in key HNP outcomes in Bangladesh over the last decade (Ahsan et al. 2015). The success of Bangladesh in achieving the targets of MDGs is acclaimed globally and Bangladesh received the 'UN MDG Award' in 2010 for child mortality reduction; the 'South-South Award' in 2011 and 2013 for innovative use of Information and Communication Technology (ICT) for improving health of women and children, and reducing poverty; and the 'Diploma Award' in 2013 from the Food and Agriculture Organization (FAO) for achieving the MDG 1 target well ahead of the deadline.

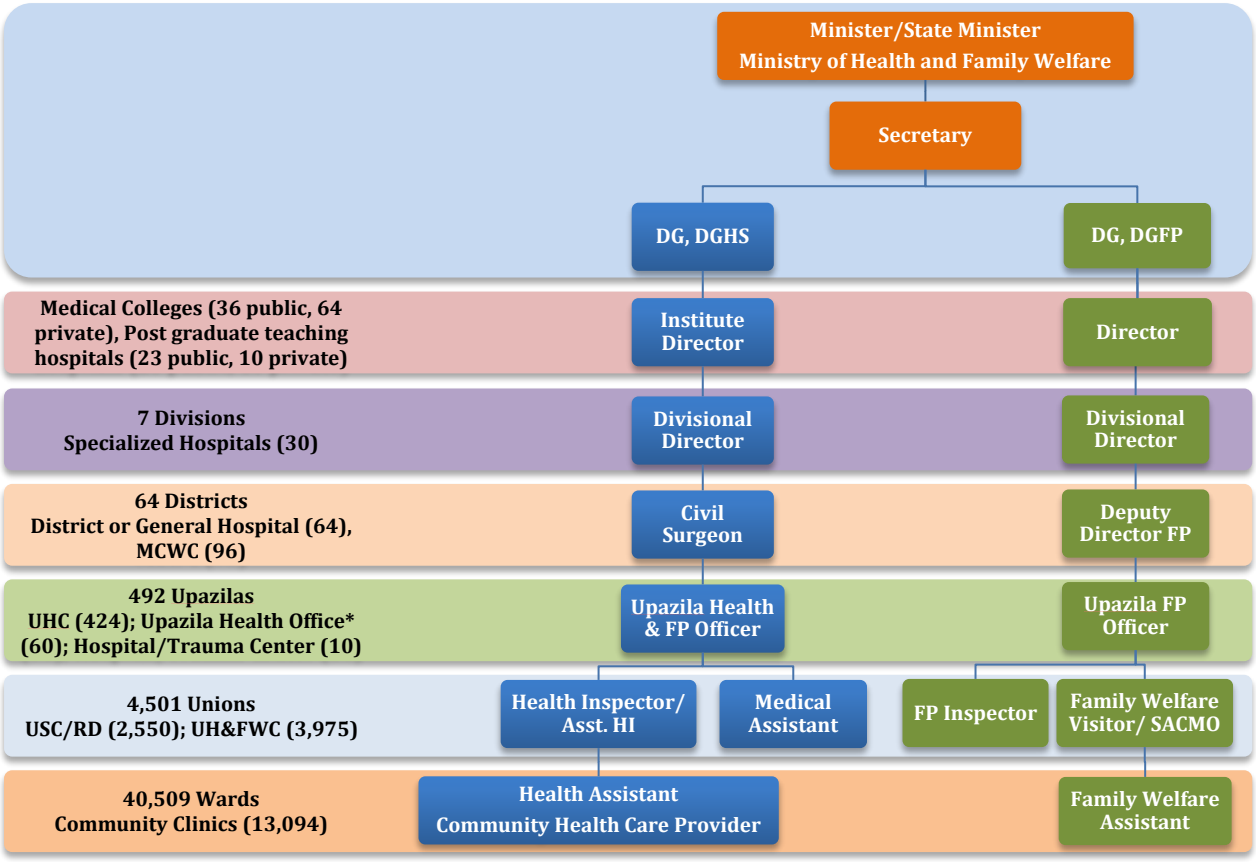
1.2 HEALTH SERVICE DELIVERY SYSTEMS IN BANGLADESH

The Ministry of Health and Family Welfare (MOHFW) is responsible for the implementation, management, coordination, and regulation of national health and family planning related activities, programs, and policies. In line with the general system of public administration in Bangladesh, the MOHFW management structure comprises two main groupings:

- The Secretariat, responsible for policy development and administration comprising eight functional wings and units headed by an Additional Secretary or Joint Secretary/Joint Chief;

- The Directorates, which work as agencies for implementation up to the field level. Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) are the two main service-providing agencies, through which MOHFW implements its programs. Responsibilities for providing services are also shared by the Directorate of Nursing Services (DNS), the Directorate General of Drug Administration (DGDA), Health Engineering Department (HED), National Institute of Preventive and Social Medicine (NIPSOM), Institute of Epidemiology, Disease Control and Research (IEDCR), Institute of Public Health and Nutrition (IPHN), Institute of Public Health (IPH), National Institute of Population Research and Training (NIPORT) and other relevant institutes. Figure 1-1 below illustrates the structure of public sector health services (not the entire organizational structure of MOHFW) following the country's administrative pattern (DGHS 2015; DGFP 2014).

Figure 1-1. MOHFW's Structure of Health Services Delivery



* situated at '*sadar upazila*' which do not have indoor facilities because it's headquarter is co-located at the district town.

1.3 SECTOR-WIDE APPROACH (SWAp) IN THE HEALTH SECTOR

The Health and Population Strategy of 1997 marked the decision to move away from a project-based modality being followed for so long to a sector-wide approach (SWAp) in the health sector of the Fifth Five-Year Plan, which began in 1998 and was known as the Health and Population Sector Program (HPSP) 1998-2003. The main focus of the HPSP was to decentralize the delivery of the essential service package (ESP) using a "one-stop" service model, and deliver basic health and family planning services to the rural community from static community-based Community Clinics (CC). The second health SWAp, titled Bangladesh Health, Nutrition and Population Sector Program (HNPSP), was designed and implemented during 2003-2011. The overall objective of the HNPSP was to increase the availability and utilisation of user-centered,

effective, efficient, equitable, affordable, and accessible quality HNP services. MOHFW adopted the third SWAp titled Health, Population, and Nutrition Sector Development Program (HPNSDP) 2011-16 with the intention to strengthen health systems and improve health services. Table 1-1 below illustrates the duration, size and the government's contribution to SWAp financing of the successive SWAps in Bangladesh's HNP sector – it transpires from the table that GOB contribution to the health SWAp is on a continuous rise and the DPs' share is comparatively declining.

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

Name	Duration	Fund (Billion US$)	GOB contribution	DP contribution
Health and Population Sector Program (HPSP)	1998-2003	2.2	62%	38%
Health, Nutrition and Population Sector Program (HNPSP)	2003-2011	5.4	67%	33%
Health, Population and Nutrition Sector Development Program (HPNSDP)	2011-2016	6.6	78%	22%

1.4 VISION, MISSION, GOAL AND DEVELOPMENT OBJECTIVE OF HPNSDP

VISION: The vision is to see the people healthier, happier and economically productive to make Bangladesh a middle-income country by 2021.

MISSION: The mission is to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health.

GOAL: The goal is to ensure quality and equitable health care for all citizens in Bangladesh by improving access to and utilization of health, population and nutrition services. A number of development activities in other key sectors implemented throughout Bangladesh will contribute to achievement of this goal along with HPNSDP.

DEVELOPMENT OBJECTIVE: The development objective is to "improve access to and utilization of essential health, population and nutrition services, particularly by the poor."

1.5 HPNSDP FINANCIAL OUTLAY

The total estimated financial outlay for the HPNSDP for 2011-16 stands at Tk. 51,082.41 crore (US $6,549.02 million), inclusive of the development and non-development budget in the revised program implementation plan (RPIP). Of the total financial outlay, Tk. 19,571.06 crore (US $2,509.11 million) has been set as the estimated development budget for the 32 OPs. The contribution from the DPs was estimated to be Tk. 11,333.72 crore (US $1,453.04 million), to be provided by World Bank (IDA) and JICA credit, and grants from DFID, JICA, SIDA, CIDA, USAID, WHO, UNICEF, UNFPA, EKN, KFW, GIZ, UNAIDS, GFATM, GAVI-HSS, etc. – this is 58% of the total development budget. As of mid-June 2016, the actual financing position by GOB and the DPs stood at Tk. 5873.90 crore and Tk. 10137.60 crore respectively. However, both KFW and GIZ withdrew from financing the HPNSDP in the midst of its implementation. It is worth mentioning that the DP contribution to the development budget of the SWAp programs of MOHFW has continuously been declining (from 62% in the 1st SWAp to 58% in the 3rd SWAp). Moreover, combining the development and non-development budget of the MOHFW, the GOB share stands at 78% and the DP share is 22% (GOB 2014).

[1] IMED (2003); GOB (2005); GOB (2014)

1.6 PROGRAM COMPONENTS AND STRATEGIES OF HPNSDP

The activities under HPNSDP are implemented by 32 Operational Plans (OPs), each led by a Line Director (LD), which fall under the different directorates and the MOHFW. HPNSDP has two major components: The component on ***improving health services*** aims at improving the delivery of essential health services which seek to improve reproductive, adolescent, maternal, neonatal, infant and child health; family planning (FP); nutrition; communicable and non-communicable diseases; and improving the service provision including primary health care as well as hospital services. The other component aims at ***strengthening health systems*** particularly sector wide program management, health sector planning, human resources, health care financing and improved financial management, development of physical facilities, procurement and supply chain management, pharmaceuticals and M&E, including MIS. The above-mentioned components are being pursued through the implementation of 32 OPs equally divided into two components.

The HPNSDP's strategic priorities have been formulated by taking into account the strengths, lessons learned, and challenges of the last two health sector programs. Sector specific strategies for HPNSDP include (GOB 2011):

- Streamline, expand the access and quality of MNCH services (MDG 4 and MDG 5).
- Revitalize various family planning interventions to attain replacement level fertility.
- Mainstreaming nutrition within the regular DGHS and DGFP services (MDG 1).
- Strengthen preventive and control programs to communicable diseases (MDG 6).
- Expand NCD control efforts at all levels by streamlining referral systems.
- Strengthen the various support systems by increasing the health workforce at upazila and CC levels, including their capacity building and enhanced focus on coordinated implementation of OPs, MIS and M&E functions.
- Increase coverage and quality of services by strengthening coordination with other intra and inter-sectoral and private sector service providers.
- Pursue priority institutional and policy reforms, such as decentralization and local level planning (LLP), incentives for service providers in hard-to-reach (HTR) areas, public-private partnership (PPP), single annual work plan, etc.

The HPNSDP priority indicators along with targets are shown in the table below. An assessment as to whether the current status is on track to achieve targets is also given in Table 1-2.

Table 1-2: Targets and Assessment of HPNSDP Priority Indicators

Indicator	Baseline (as in PIP)	Updated as of 2014	Target 2016	On track
Infant Mortality Rate (IMR)	52 BDHS 2007	38 BDHS 2014	31	On track
Under 5 mortality rate	65 BDHS 2007	46 BDHS 2014	48	Already achieved
Neonatal mortality rate	37 BDHS 2007	28 BDHS 2014	21	Challenging
Maternal mortality ratio	194 BMMS 2010	176 MMEIG 2015	<143	Challenging
Total fertility rate (TFR)	2.7 BDHS 2007	2.3 BDHS 2014	2.00	Challenging
Prevalence of stunting among children under 5 years of age	43.2% BDHS 2007	36.1% BDHS 2014	38%	Already achieved
Prevalence of underweight among children under 5 years	41.0% BDHS 2007	32.6% BDHS 2014	33%	Already achieved
Prevalence of HIV in MARP	<1% SS 2007	0.7% SS 2011	<1%	Already achieved

The MDG Progress Report 2015 by the Planning Commission shows that Bangladesh registered remarkable progresses in achieving a number of MDG targets, including lowering the infant and under-five mortality rate and maternal mortality ratio; improving immunization coverage; and reducing the incidence of communicable diseases (GOB 2015a).

The Report highlighted that contributing factors for success of achieving the MDGs, along with sustained economic growth, include: consistent policy and committed leadership for reducing poverty, backed by improving implementation capacity and human capital; long-term institutional reform aimed at making the public sector accountable to citizens, and devolution of responsibility and accountability to local levels; and determined social policy and innovation.

1.7 ANNUAL PROGRAM IMPLEMENTATION REPORT (APIR) 2016

The Annual Program Implementation Report (APIR) – prepared by the Planning Wing, MOHFW with technical support from the PMMU Technical Assistance Support Team (TAST) – provides implementation progress of the OPs covering the financial year 2015-16. The MOHFW uses performance information not only to assess program progress but also to utilize the information as the basis of its resource request for subsequent years. The lessons of implementation also form the basis for future program planning and for fine-tuning of investment decisions in the health sector.

1.8 METHODOLOGY FOR PREPARATION OF THE APIR

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

Data collection

The HPNSDP has 32 OPs wherein each OP document lays out the goal (General Objective), specific objectives, priority activities/strategies, financial and administrative management details specific to that OP. It also specifies the indicators on which the OP progress will be measured. To collect data for the APIR and capture information for FY 2015-16, a structured data-reporting template was designed. The reporting template was customized for each OP by providing information within the template specific to the relevant OP taken from its original document (as approved in the PIP). Annex C includes a blank data collection template used for APIR 2016.

The APIR data collection template contains five sections covering the areas of objectives of the OP; the indicators of the OP; information on physical progress of the OP during FY 2015-16; information on training, including training topic and the number of participants; and finally information on the challenges faced by the OPs during the reporting period and mitigation measures. The template is based on the Six-monthly Progress Report (SmPR) 2014, which had been rigorously tested.

The softcopies of data collection templates were sent to each of the LDs with a request to return the filled in templates by a specific time. PMMU staff and the Planning Wing officials closely liaised with the LDs along with their Program Managers (PMs), Deputy Program Managers (DPMs), and Accountants as necessary to complete the data collection templates in time.

Data processing

Each filled-in template was checked for completion, accuracy, and consistency of information by the PMMU TAST with support from a technical group comprising MEASURE Evaluation and

icddr,b. The LDs or their representatives were contacted over phone to get further information when required, after checking data in the templates and, accordingly, the information was updated to make the final data set.

Data analysis

Data analysis for APIR 2016 involved the analysis of performance of the OPs measured by (a) the respective indicators and (b) the rate of fund utilization. Whether an indicator is treated as "achieved" is determined in two ways. First, if the indicator is numerical, its 2016 target is considered "achieved" if the reported achievement is at least 80% of the FY 2016 target. For example, an indicator "total number of upazilas with DSF program" has a target of 100 in mid-2016 and, the baseline number is, say, 10, i.e., 10 upazilas already have DSF program. Now this indicator is considered as "achieved" if the FY 2016 progress is 80 upazilas or more. The category "not achieved" refers to 20% or less progress (of the FY 2016 target) in the OP-level indicators. The "partially achieved" category is lying in between "achieved" and "not achieved." Second, for qualitative indicators, progress is determined based on the indicator definition and the description of the achievement.

The quantitative analysis also included financial progress, by calculating the percentage of expenditure disaggregated by funding source and items of expenditure, whereas the qualitative analysis described the achievement, synthesizes the findings, and identifies factors associated with achievement as well as challenges faced by the OPs during FY 2014-15.

A document on information provided in the templates by the LDs is archived at PMMU under the Planning Wing of MOHFW, which can be accessed upon request. The compiled and analyzed data are presented in the APIR. As mentioned in the methodology sub-section, the data was reviewed with the LDs and the PMs.

Finalization of APIR

On the basis of the analyses, the initial draft of the report was prepared and shared with the Planning Wing and the LDs for their review and feedback. PMMU staff and the PMMU Technical Assistance Support Team (TAST) members also met – as needed – with the LDs for update and clarification of different data points. The Report was finalized after discussion with PW officials, the LDs and concerned DPs.

Organization of the Report

This Report highlights the achievements of HPNSDP as well as includes an overview of the problems faced by the LDs during implementation of their OPs In this Report, Chapter 1 describes the country and sectoral contexts, and methodology used for collecting information from the 32 OPs for the APIR. It also explains how the categories for performance for each OP are determined. In Chapter 2, financial progress of HPNSDP for FY 2015-16 is presented. Chapter 3 presents information on the performance of the 32 OPs in terms of OP indicator progress in FY 2015-16. Consolidated physical progress made by 32 OPs during FY 2015-16 is presented in Chapter 4. Chapter 5 discusses progress made in training under HPNSDP during FY 2015-16. Chapter 6 highlights the key challenges in program implementation as reported by the LDs. Finally, Chapter 7 reports on other Program highlights.

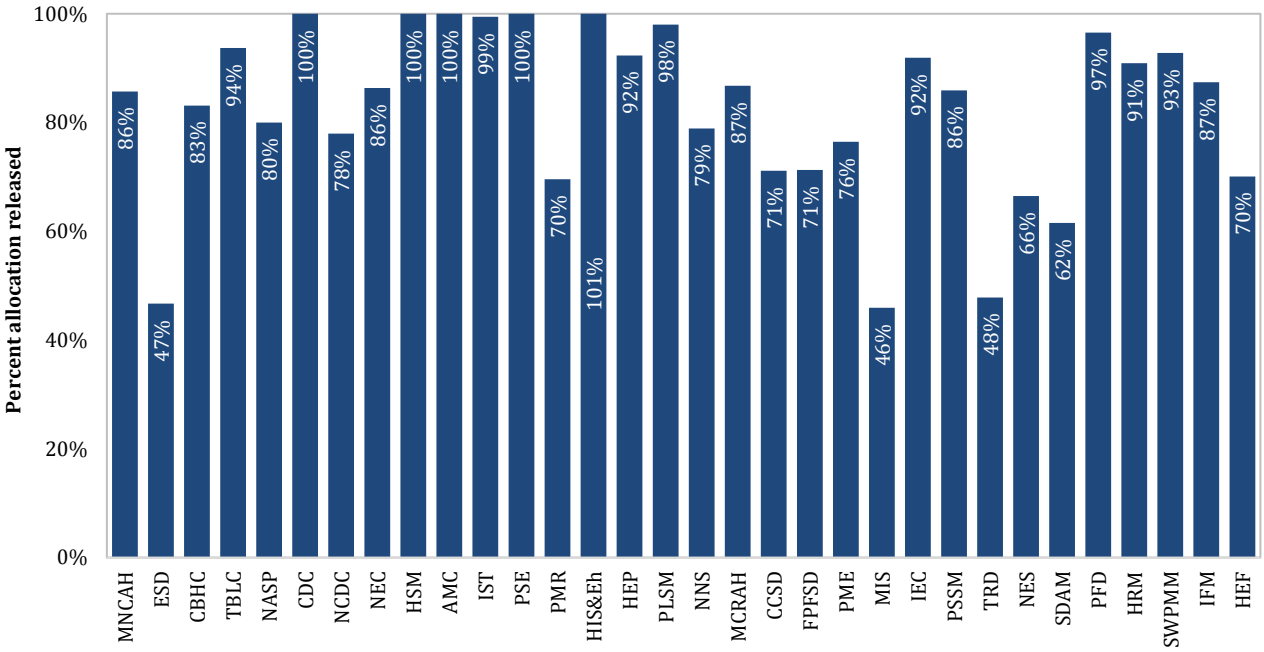
CHAPTER 2. FINANCIAL PROGRESS DURING FY 2015-16

2.1 FUND RELEASE AGAINST BUDGET ALLOCATION

The total revised Annual Development Program (ADP) fund allocation for HPNSDP in FY 2015-16 was Tk. 4,214.7 crore, out of which Tk. 1,868.9 crore (44%) was from GOB and Tk.2,345.8 crore (56%) was from PA. Total RPA allocation for FY 2015-16 was Tk. 1,871.7 crore, which is 80% of the total PA and 44% of the total ADP allocation. DPA allocation for FY 2015-16 was Tk. 474.5 crore, which is 20% of the PA and 11% of the total ADP allocation.

In FY 2015-16, Tk. 3732.4 crore was released, which is 89% of the allocated fund for the financial year. The proportions of allocated fund released were 98% for GOB and 81% for PA. Figure 2-1 below illustrates the distribution of the proportion of release of ADP allocation among the OPs. Overall, the release of funds for MIS-FP OP was the lowest (46%) followed by ESD (47%) and TRD (48%). The main reasons for low fund release for these OPs are: (i) long time (almost one year) was taken to negotiate an additional financing of US $150.0 million with the WB due to the imposition of a new financing operation, resulting in an unclear understanding on RPA fund release mechanism; (ii) Though RPA allocation was reflected in the ADP, however, RPA fund was not available before approval of additional financing by the World Bank Board in June 2016; (iii) revision of some OPs was needed to change the mode of financing of certain activities from RPA to GOB due to uncertainty of additional RPA funding.

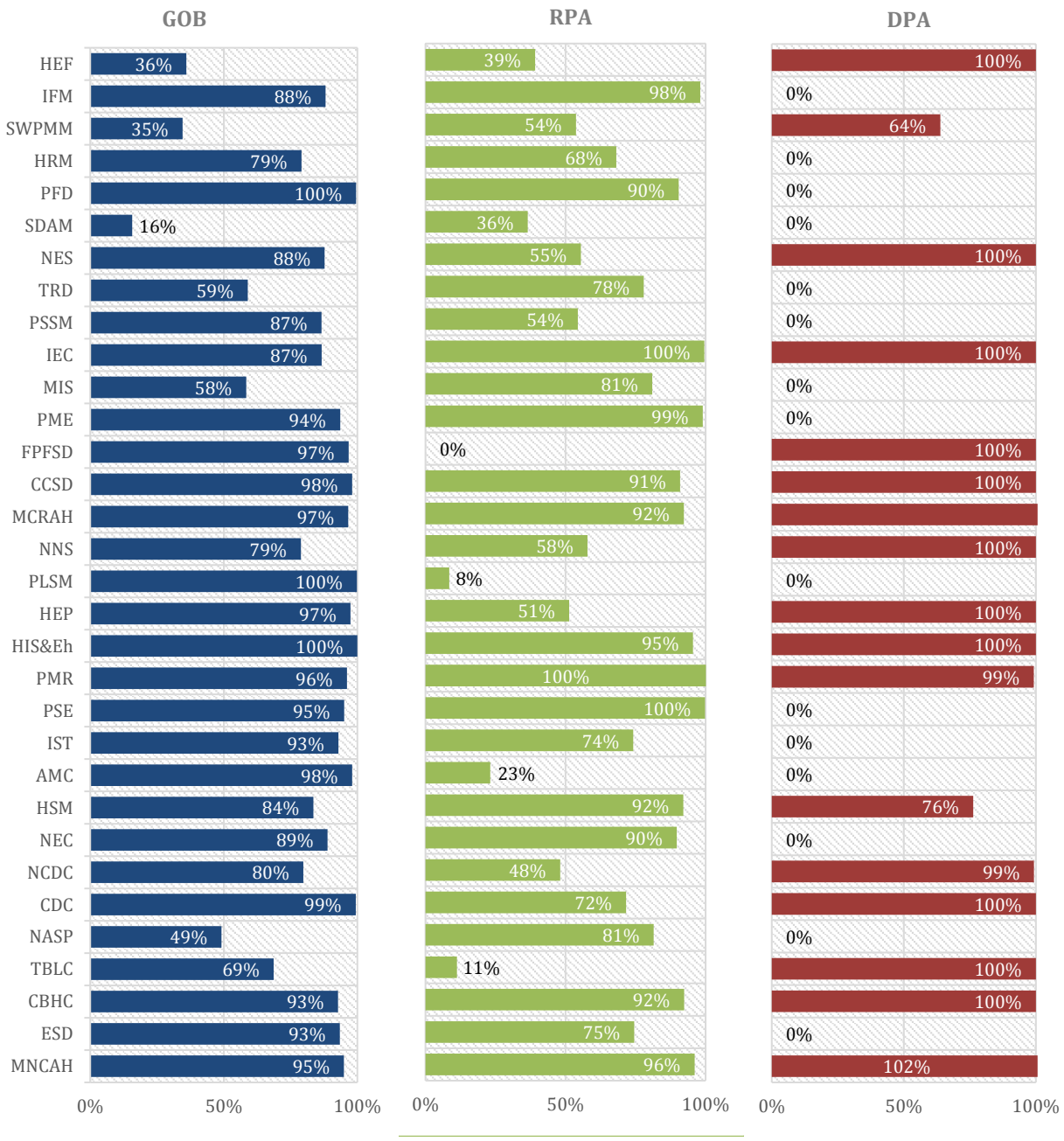
Figure 2-1: Proportion of total ADP allocation released during FY 2015-16



2.2 EXPENDITURE PATTERN AGAINST RELEASED FUND

Tk. 3,404.1 crore was spent in total, which is 91% of the released fund during 2015-16 financial year. The spending rate was higher for GOB fund (96%) than for PA fund (87%). RPA expenditure was Tk. 1,233.1 crore, which is 83% of released amount (Figure 2-2) and 65.88% of the total ADP allocation.

Figure 2-2: Spending rate by OPs during FY 2015-16



Among the administrative units of MOHFW, the spending rate was the highest for the OPs under the MOHFW (97%), followed by the OPs under DGHS (91%) and DGFP (83%). The lowest was by the OP under DGDA (30%), followed by the OP under NIPORT (75%).

2.3 COMPONENT-WISE FINANCIAL PERFORMANCE

The OPs are divided into two components – those referring to "improving health services (IHS)" and those relating to "strengthening health systems (SHS)." Nearly two-thirds (65%) of funds were allocated to IHS OPs and one-third (35%) to SHS OPs, which is more or less in line with the design of HPNSDP to 'enable provision of quality of care and ensure program performance' (the ratio of 70:30) (WB 2011). Of the PA funds allocated for FY 2015-16, 81% were for IHS OPs and 19% for SHS OPs. In contrast, of the GOB funds allocated for FY 2015-16, 45% were for IHS OPs

and 55% for SHS OPs. Table 2-1 shows budget allocation, release and spending patterns, by source of fund (GOB vs. PA) and the OP types.

Table 2-1: Overall financial performance: IHS and SHS OPs during FY 2015-16

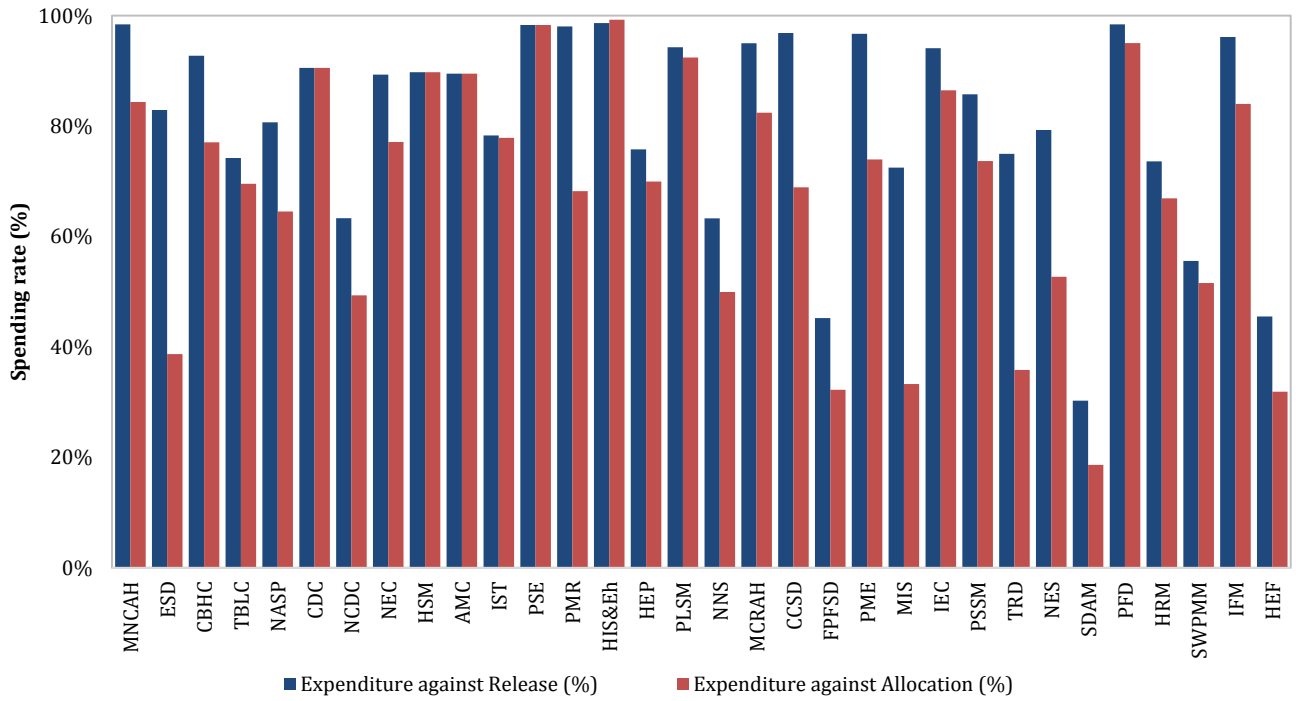
(Tk. in Crore)

OP Type	Improving Health Services (IHS)	Strengthening Health Systems (SHS)	Total
Fund allocation			
Total	2,735.1 (65%)	1,479.6 (35%)	4,214.7 (100%)
GOB	832.5 (45%)	1,036.3 (55%)	1,868.9 (100%)
PA	1,902.6 (81%)	443.3 (19%)	2,345.8 (100%)
Fund released			
Total	2,345.9 (63%)	1,386.4 (37%)	3,732.4 (100%)
GOB	813.3 (44%)	1,027.2 (56%)	1,840.5 (100%)
PA	1,532.6 (81%)	359.3 (19%)	1,891.9 (100%)
Expenditure			
Total	2,080.6 (61%)	1,323.5 (39%)	3,404.1 (100%)
GOB	750.2 (43%)	1,010.7 (57%)	1,760.9 (100%)
PA	1,330.4 (81%)	312.8 (19%)	1,643.2 (100%)
Number of OPs	***16***	***16***	***32***

2.4 SUMMARY OF FINANCIAL PERFORMANCE

The spending rate is a good indicator of program performance. From a 51% spending rate during the first half of the FY 2015-16, to 91% spending at the end of the FY indicates a massive acceleration in the pace of implementation, particularly by the large OPs. Figure 2-3 below presents the OP-wise spending rates both against allocation and released fund for FY 2015-16.

Figure 2-3: Spending rate by OPs during FY 2015-16



2.5 TRENDS IN FINANCIAL PERFORMANCE

The overall economy of Bangladesh is currently growing at around 7% per year leading to increasing funding in health in absolute terms, despite the fact that health spending comprises less than 1% of the Gross Domestic Product (GDP) and total health expenditure (THE) is 3.5% of GDP (GOB 2015b). The budget of the MOHFW as a percentage of the national budget is on a continuous decline. However, there has been an average annual growth of 12.6% in the total Annual Development Program (ADP) allocations during the last five years (FYs 2011/12-2015/16). Utilization of the development budget has also increased from an average rate of 70-72% in the pre-SWAp period to around 80-85% during the three SWAp periods.

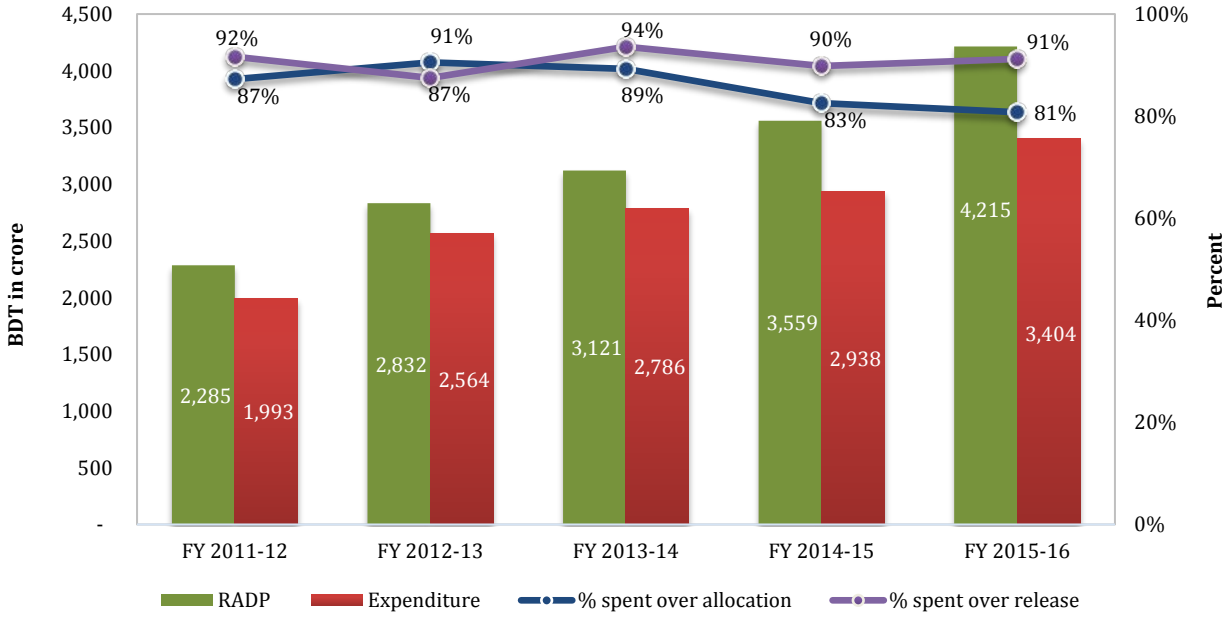
In ADP of MOHFW, the allocation for 32 OPs was 54% in 2012/13, which increased to 78% in 2015/16. The allocation for the parallel projects under the development budget was Tk. 4592.87 Crore (95% GOB and 5% PA) in the previous five years (2011/12 - 2015/16). In addition, in the last five years (2011/12 - 2015/16), Tk. 1,003.7 Crore had been allocated as 'Grants-in Aid' to nearly 42 organizations under the revenue budget (Khan et al. 2015).

ADP utilization rate during FY 2015-16 was the lowest of the past five years' implementation of HPNSDP. Main identified reasons for lower ADP utilization were (a) non-availability of PA fund, particularly RPA funds from the World Bank (WB); (b) long time (almost one year) was taken to negotiate an additional financing of US $150.0 million with the WB due to the imposition of a new financing operation, resulting in an unclear understanding on RPA fund release mechanism; and (c) few procurement packages were cleared by the WB during the last part of FY 2015-16. All these reasons seem to have contributed to slowing the pace of program implementation, and the fund utilization.

Figure 2-4 shows that even though the rate of utilization fell from the high of 89% in 2013-14 to 83% in 2014-15 and 81% in 2015-16, HPNSDP was able to spend increasing amount every year – from Tk. 1,993 crore in 2011-12 to Tk. 3,404 crore in 2015-16, an increase of 71% over the 5-year period. This shows an increase in capacity of MOHFW for absorption of funds, which largely reflects better budget planning and re-appropriation of funds by the Planning Wing.

OP-wise cumulative financial progress during the five years of HPNSDP (i.e. FYs 2011–16) can be seen from Annex B.

Figure 2-4: Trends in program financing and spending rate of HPNSDP, 2011-2016



The average rate of expenditure over RADP allocation during the 5-year period was 85% and 12 OPs including 7 of the largest 11 OPs – achieved above-average utilization; e.g. PFD, HSM, CCSD, PSE, CDC, PLSM, and HIS&eH. Below average utilization by the larges OPs include FPFSD (75%), CBHC (75%), MCRAH (80%) and MNCAH (83%).

The 11 OPs with the largest allocation mentioned above, together accounted for 82% of the HPNSDP's RADP budget between 2011 and 2016! This left a large number of OPs (16 OPs) with relatively small share of RADP allocation (i.e. 1% and below). It may be noted that even though the skewed pattern of fund allocation among the OPs follows the scheme in PIP, the inter-OP share of the Program budget varied during program implementation, e.g., PFD which was estimated to get an allocation of 22% in the PIP budget-estimate received 17% during actual program implementation, while MNCAH received the highest allocation (18%) compared to PIP estimate of 14%.

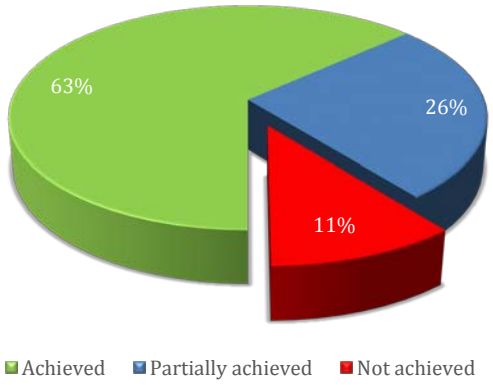
Among the large OPs, distinct gains in actual allocation, viz-a-viz the PIP estimate, were made by HSM (12% vs. 8%), PSE (5% vs. 2.68%), PLSM (3% vs. 2%) and HIS&eH (3% vs. 2.75%). The losers – in addition to PFD – were FPFSD (6% vs. 7%), CBHC (6% vs. 7.5%), CCSD (5% vs. 6%), and most dramatically NNS (2% vs. 6.7%). Two of the large OPs retained their planned share allocation: MCRAH (4%) and CDC (3%). The change of share in cumulative allocation among the OPs reflects the perception and priority of the MOHFW as interpreted by the Planning Wing for achieving HPNSDP goals and targets.

CHAPTER 3. PROGRESS IN INDICATORS DURING FY 2015-16

3.1 OVERALL PROGRESS MEASURED BY OP-LEVEL INDICATORS

The overall program achievement during FY 2015-16, measured by OP-level indicators, was found to be 63%. Out of the 158 indicators used at the OP-level, 100 indicators (63%) were fully achieved and 41 indicators (26%) were partially achieved against the targets set for mid-2016. Seventeen indicators (11%) were found "not achieved", meaning 20% or less progress made in FY 2015-16 compared with the mid-2016 target (Figure 3-1).

Figure 3-1: Overall achievement measured by OP-level indicators during FY 2015-16



In terms of individual OPs, four (TB-LC, HIS&eH, FP-FSD and SDAM) out of 32 OPs were able to fully achieve their targets of the OP-level indicators during the FY 2015-16 (Table 3-1). OPs with weak progress are PFD, PME, HRM and HEF with 25% or less OP-level indicators fully achieved.

Figure 3-2: Distribution of progress in OP-level indicators during FY 2015-16

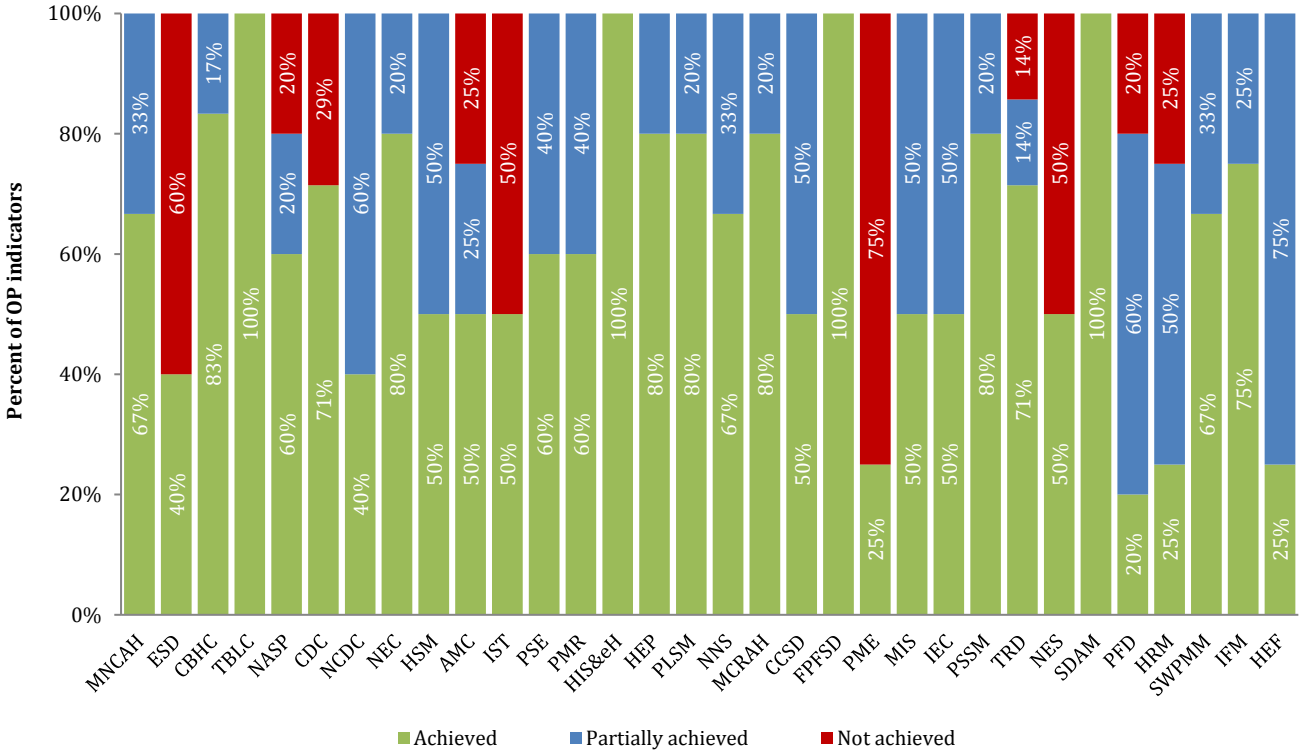


Table 3-1: Distribution of OPs by progress in OP-level indicators during FY 2015-16

Category of Progress (% of OP-indicators achieved)	Name of OPs	Number of OPs
<25%	PFD	1
25%-49%	ESD, NCDC, PME, HRM, HEF	5
50%-74%	MNCAH, NASP, CDC, AMC, HSM, IST, PSE, PMR, NNS, CCSD, MIS, IEC, TRD, NES, SWPMM	15
75%+	CBHC, TBLC, NEC, HIS&eH, HEP, PLSM, MCRAH, FPFSD, PSSM, SDAM, IFM	11

Fund Utilization and Achievement of Indicators by an OP

The rate of achievement of OP-level indicators bears no predictable or no systematic relationship with the size of OP budget or the rate of utilization of its funds. Four types of relationship have been noticed between fund utilization and the achievement of the OP indicators (see Table 3-2):

Table 3-2: Relationship between fund utilization and the achievement of the OP indicators

(a) Low Indicator achievement but high fund utilization	Some OPs achieved 50% or less indicators, while their spending level was more than 90% against their RADP allocation, e.g. HSM, PFD, AMC.
(b) High indicator achievement but low fund utilization	These are OPs like FP-FSD and SDAM which achieved 100% of their indicators, whereas their spending level remained low (32% and 19% respectively).
(c) High fund utilization and indicators achievement	There are also OPs which scored high on both fund utilization and indicator achievement, e.g. HIS & e-Health and PLSM.
(d) Low fund utilization and achievement	On the contrary, there are a number of OPs which performed poorly in both fund utilization and indicator achievement, e.g. ESD, NCDC, MIS-FP, HEF etc.

It may be reckoned that rationale of allocation of budget to an OP is guided by the size of its activities; so bigger the OP, bigger is its budget allocation for carrying out those activities. The number of OP indicators varied between 5 and 7 for all OPs irrespective of OP size or budget. An indicator intends to capture achievement of a key result/activity/process in an OP, indicators need not cover all major activities of an OP. Moreover, OP indicators were set prior to the beginning of Program implementation for the whole of the Program period and underwent revision following the first annual review of the Program. Whereas, the budget allocation for the OP, is decided every year and varies on a yearly basis, with no direct relationship to the number and or complexity of the OP indicators.

Moreover, it may be kept in view that different indicators have different levels of difficulty in achieving those, even though for reporting purpose, each indicator is assumed to be of equal value to the others – which in reality is not the case. For example, some (quantitative) indicators may be comparatively easier to achieve than those relating to system reform! Further, an indicator of an OP does not get revised every year unlike the allocated budget for it.

It is also to be noted that failure to utilize the fund allocation by an OP usually results during the ADP revision process (in the 9th month of the financial year) - in its re-appropriation and reallocation to other OP(s) to accelerate full fund utilization, but in the case of failure of

indicator achievements a step to change/amend the pre-set target of the OP indicator cannot be taken.

In the final analysis, budget expenditure and achievement indicators do not necessarily bear any linear relationship in the current shape of the sector programs. However, in the changed financing modality of Program for Results (PforR) in the 4th HNP Sector Program, the relationship between the indicators and budget of an OP may have to be reassessed, particularly for indicators relating to service provision.

3.2 INDICATOR PROGRESS BY MAJOR OP TYPES

Table 3-3 shows that the performance of improving health system (IHS) related OPs in terms of achievement measured by the OP-level indicators is higher than strengthening health services (SHS) related OPs (64% vs. 60%). Progress in OP level indicators till 2016 is appended as Annex-D.

Table 3-3: Overall OP-level indicator progress: IHS and SHS OPs during FY 2015-16

Indicator Progress	Improving Health Services (IHS)	Strengthening Health Systems (SHS)	All OPs
Achieved	64%	60%	62%
Partially achieved	27%	24%	25%
Not achieved	10%	16%	13%
Number of Indicators	***83***	***75***	***158***

3.3 UPDATE IN RESULTS FRAMEWORK (RFW) INDICATORS

In order to update the RFW indicators for 2016, data from the 2014 Bangladesh Demographic Health Survey (BDHS), the 2014 Bangladesh Health Facility Survey and MOHFW's administrative sources were used. Table 3-4 below shows the updated RFW for 2016.

Table 3-4: Update of HPNSDP Results Framework (RFW) Indicators

Sl #	Performance Indicator	Means of Verification & Timing	Baseline & Source	Update 2016	Target 2016
Goal: Ensure quality and equitable health care for all citizens of Bangladesh.					
GI 1	Infant mortality rate (IMR)	BDHS, every 3 yrs	52, BDHS 2007	38, BDHS 2014	31
GI 2	Under 5 mortality rate (U5MR)	BDHS, every 3 yrs	65, BDHS 2007	46, BDHS 2014	48
GI 3	Neonatal mortality rate (NMR)	BDHS, every 3 yrs	37, BDHS 2007	28, BDHS 2014	21
GI 4	Maternal mortality ratio (MMR)	BMMS, every 5 yrs	194, BMMS 2010	170, MMEIG[2] 2013	<143
GI 5	Total fertility rate (TFR)	BDHS, every 3 yrs	2.7, BDHS 2007	2.3, BDHS 2014	2.00
GI 6	Prevalence of stunting among under-5 children	BDHS, every 3 yrs	43.2%, BDHS 2007	36.1%, BDHS 2014	38%
GI 7	Prevalence of underweight among under-5 children	BDHS, every 3 yrs	41.0%, BDHS 2007	32.6%, BDHS 2014	33%
GI 8	Prevalence of HIV in MARP	Sero-Surveillance (SS), every 2 yrs	<1%, SS 2007	0.7%, SS 2011	<1%
Program Development Objective: Increase availability and utilization of user-centered, effective, efficient, equitable, affordable and accessible quality HPN services. **Strategic Objective:** To improve access to and utilization of essential health, population and nutrition services, particularly by the poor.					
Component 1: Service delivery improved					
Result 1.1: Increased utilization of essential HPN services					
1.1.1.	Proportion of delivery by skilled birth attendant	BDHS, every 3 yrs UESD, every 2 yrs	26.%, UESD 2010 18%, BDHS 2007	42.1%, BDHS 2014	50%
1.1.2.	Antenatal care coverage (at least 4 visits)	BDHS, every 3 yrs UESD, every 2 yrs	19.9%, UESD 2010 20.6%, BDHS 2007	31.2%, BDHS 2014	50%
1.1.3.	Postnatal care within 48 hours (at least 1 visit)	BDHS, every 3 yrs UESD, every 2 yrs	20.9%, UESD 2010 18.5%, BDHS 2007	33.9%, BDHS 2014	30%
1.1.4.	Contraceptive prevalence rate (CPR)	BDHS, every 3 yrs UESD, every 2 yrs	61.7%, UESD 2010 55.8%, BDHS 2007	62.4%, BDHS 2014	72%
1.1.5.	Unmet need for FP	BDHS, every 3 yrs	17.1%. BDHS 2007	12.0%, BDHS 2014	9.0%
1.1.6.	Measles immunization coverage by 12 months	CES, annual	82.4%, CES 2009	86.6%, CES 2014	87%
1.1.7.	Proportion of under-5 children with pneumonia receiving antibiotics	BDHS, every 3 yrs UESD, every 2 yrs	38.0%, UESD 2010 37.1%, BDHS 2007	87.9 UESD 2013 34.2%, BDHS 2014[3]	87%
1.1.8.	Proportion of children (6-59 months) receiving Vit-A supplementation in the last 6 months	BDHS, every 3 yrs UESD, every 2 yrs	82.6%, UESD 2010 88.3%, BDHS 2007[4]	62.1%, BDHS 2014[5]	90%
*1.1.9.	TB case detection rate	NT Program, annual	74%, NTP 2009	53%, GTBR 2014[6]	75%
Result 1.2: Improved equity in essential HPN service utilization (MDGs 1,4,5 and 6)					
1.2.1.	Proportion of births in health facilities by wealth quintiles	BDHS, every 3 yrs UESD, every 2 yrs	Q1:Q5 = 8.0:59.5, UESD 2010 Q1:Q5 = 4.4:43.4, BDHS 2007[7]	15.0:69.5=1.0:4.6 BDHS 2014	Q1:Q5 = <1:4

[2] Maternal Mortality Estimation Inter-agency Group by WHO, UNICEF, UNFPA, UN-PD and WB (www.maternalmortalitydata.org)
[3] Methods and tools used in BDHS 2011 and 2014 were different.
[4] BDHS 2007 and UESD 2010 collected information from children age 9-59 months.
[5] CES 2014 reports that 85.4 percent of infants aged 6-11 months and 93.7 percent of children aged 12-59 months received Vitamin A capsules
[6] Global Tuberculosis Report 2014 by the World Health Organization (WHO)
[7] Q1: bottom 20% and Q5: top 20% of wealth quintiles to represent socioeconomic status of households

Sl #	Performance Indicator	Means of Verification & Timing	Baseline & Source	Update 2016	Target 2016
1.2.2.	Use of modern contraceptives in low performing areas	BDHS, every 3 yrs UESD, every 2 yrs	Syl: 35.7%, Ctg: 46.8%, UESD 2010 Syl: 24.7%, Ctg: 38.2%, BDHS 2007	Syl: 40.9%, Ctg: 47.2%, BDHS 2014	Sylhet: 40.0%, Chittagong: 45.0%
1.2.3.	Number of upazilas with women targeted by improved voucher scheme[8] for having institutional deliveries	DSF Monitoring Reports, annual	31 DSF upazilas (+9 universal), DSF Monitoring Report 2010	53, APIR 2015	50 DSF upazilas
Result 1.3: Improved awareness of healthy behavior (MDG 1,4,5)					
1.3.1.	Rate of exclusive breastfeeding in infants up to 6 months	BDHS, every 3 yrs UESD, every 2 yrs	43.0%, BDHS 2007	55.3%, BDHS 2014	50%
1.3.2.	Proportion of children 6-23 months fed with appropriate IYCF[9] practices	BDHS, every 3 yrs UESD, every 2 yrs	41.5%, BDHS 2007	22.8%, BDHS 2014	45%
Result 1.4: Improved PHC-CC systems					
1.4.1.	Number of functional Community Clinics (CC) providing basic HNP services	CC Project/ MIS/MOHFW, annual	Registers and forms supplied to CCs in June 2012	13,006, CC MIS 2015	13,500
1.4.2.	Proportion of upgraded union-level facilities able to provide normal deliveries (NVD)	Health Facility Survey (BHFS), every 2 yrs	15.5%[10], BHFS 2009	47.2%, BHFS 2014	50%
Component 2: Strengthened Health Systems					
Result 2.1: Strengthened planning and budgeting procedures					
2.1.1.	Proportion of MOHFW budget allocated to upazila level or below	Public expenditure review (PER), annual	52%, PER 2006/2007	47%, PER 2008/2009	60%
2.1.2.	Proportion of annual work plans with budgets submitted by LDs by defined time period (July/Aug)	Planning Wing, annual	NA	100%, Planning Wing 2015	100% (target by 2013)
Result 2.2: Strengthened monitoring and evaluation systems					
2.2.1.	MIS reports on service delivery published and disseminated[11] annually	HIS & eHealth and MIS-FP, annual	NA[12]	Both MISs have published and disseminated; APIR 2015	100%
2.2.2.	Performance report of OPs reviewed with policy makers, MOHFW, Directorates and DPs, six months and annually	Planning Wing, six monthly (Jul-Dec->Feb), (Jul-Jun->Aug)	NA	100%, Planning Wing 2015	100% (achieved by 2013)
Result 2.3: Improved human resources – planning, development and management					
2.3.1.	Proportion of service provider positions functionally vacant at district level and below, by category	DGHS/DGFP MIS, annual BHFS, every 2 yrs	Physicians: 45.7%; Nurses: 24.7%; FWV/SACMO/MA: 16.9%, BHFS 2009	Physicians[13]: 37.8%, Nurses: 19.3%, FWV/SACMO/MA: 9.0%, BHFS 2014	Physicians: 22.8%; Nurses: 15.0%; FWV/SACMO/MA: 8.5%
2.3.2.	Number of additional providers	HRD/MOHFW,	NA	2025, APIR 2015[14]	3,000

*TB-LC OP are using a different indicator: "case detection rate of all forms (new and relapse) of TB cases' – Baseline (source): 48% (NTP, 2009), 2016 update: 61.7 % against target 62%.

[8] Improved refers DSF upazilas that are "means-tested," i.e. women need to meet specific criteria to be eligible for the voucher program.

[9] Infant and Young Child Feeding

[10] % of UH&FWC (upgraded) able to provide vacuum and forceps delivery only.

[11] 'Disseminated' is defined as distributed to, and discussed with relevant stakeholders.

[12] Baseline set as 'Not Applicable' as the current practice by MISs is publication on time and distribution (no stakeholder discussion)

[13] Physicians includes consultants and general physicians

[14] Diploma midwives produced by DNES

Sl #	Performance Indicator	Means of Verification & Timing	Baseline & Source	Update 2016	Target 2016
	trained in midwifery at upazila health facilities	annual			
2.3.3.	Number of comprehensive EmOC facilities with functional 24/7 services covering all districts	MIS/EmOC BHFS, every 2 yrs	132, MIS/DGHS 2009	82 UHCs (164 in total), APIR 2015	204[15]
Result 2.4: Strengthened quality assurance and supervision systems					
2.4.1.	Case fatality rate among admitted children with pneumonia in Upazila Health Complex	DGHS MIS, annual	8%,[16] Health Bulletin 2009	0.31%, MIS/DGHS 2015	<1.0%
Result 2.5: Sustainable and responsive procurement and logistic system					
2.5.1.	Proportion of health facilities, by type, without stock-outs of essential medicines	BHFS, every 2 yrs	66.1%,[17] BHFS 2009	78.7[18]%, BHFS 2014	75%
2.5.2.	Proportion of facilities without stock-outs of contraceptives	BHFS, every 2 yrs	58.1%,[19] BHFS 2009	54.3%, BHFS 2014	70%
Result 2.6: Improved infrastructure and maintenance					
2.6.1.	Proportion of facilities (excluding CCs) having separate, improved toilets for female clients	BHFS, every 2 yrs	51.0%, BHFS 2009	47.6%, BHFS 2014	75%
Result 2.7: Sector management and legal framework					
2.7.1.	Regulatory framework for accreditation of health facilities including hospitals (both in the public and private sectors) reviewed and updated	MOHFW	1982 Regulatory Act	Accreditation document finalized by HEU, APIR 2015	Accreditation document with an Action Plan developed
Result 2.8: SWAp and improved DP coordination (deliver on the Paris Declaration)					
2.8.1.	Number of non-pool DPs submitting quarterly expenditure reports	Planning Wing/FMAU, annual	Irregular	88% (14 out of 16 DPs), Planning Wing 2014	100%
Result 2.9: Strengthened Financial Management Systems (funding and reporting)					
2.9.1.	Utilization rate of Reimbursable Project Aid (RPA) against RADP	Planning Wing/FMAU, annual	85.0%,[20], APIR 2012	66%[21], APIR 2016	100%
2.9.2.	Proportion of OPs with spending >80% of ADP allocation (annually)	Planning Wing/ FMAU, annual	44.7%,[22] FMAU 2003-2011	34%[23], APIR 2016	100% (by 2013)
2.9.3.	Proportion of serious audit objections settled within the last 12 months	FMAU, annual	7%, FMAU 2007/2008[24]	68%, World Bank 2015	>80%

Analysis of Progress in RFW Indicators

Goal-level indicators: Note on the achievement of the 8 goal-level indicators (which are of the nature of impact indicators) may be seen at Table 1-2 of this report. 3 goal-level indicators were

[15] DGHS Voice of MIS Feb, 2009
[16] Calculated from deaths in each age cluster of children who attended outpatient and emergency departments of IMCI facilities.
[17] Defined as at least 75% of union level essential drug kit (10 drugs) available in the facilities at district level and below.
[18] Defined as at least 6 out of 8 essential medicines of a DDS kit available in the facilities at district level and below (including CCs)
[19] Defined as four family planning supplies (condom, oral pill, DMPA, IUD) available in the facilities at district level and below.
[20] Baseline taken from the HPSDP Strategic Document, p.57
[21] ADP review figure of 2016
[22] Baseline taken from HPSDP Strategic Document, p.71-72
[23] ADP review figure of 2016
[24] Baseline from APIR 2009

off-track and require to be pursued vigorously in the next Program. These are: (i) neonatal mortality rate, (ii) maternal mortality ratio, and (iii) total fertility rate. Two other goal-level indicators related to stunting and underweight among under-5 children – even though these achieved targets – need coordinated inter-sectoral interventions to bring down their unacceptable levels.

Intermediate indicators at process and outcome level: The RFW contains 32 intermediate indicators, divided equally between the 2 components of the Program – Component 1: Improving Health Services, and Component 2: Strengthened Health Systems. A little less than half of targets of the indicators (15 indicators) were achieved as per the above update (Table 3-4), while 7 more indicators showed impressive progress over the baseline even though these failed to reach their targets. These include the gains made in delivery by SBA (indicator 1.1.1), ante-natal care coverage (indicator 1.1.2), unmet need for FP (indicator 1.1.5), the upgraded union-level facilities able to provide normal deliveries (indicator 1.4.2), the regulatory framework for accreditation (indicator 2.7.1), non-pool DPs submitting quarterly expenditure reports (indicator 2.8.1), and the proportion of serious audit objections settled (indicator 2.9.3). Some of the targets of the indicators were clearly ambitious compared to their baseline like those related to SBA, ANC coverage, unmet need for FP, union facilities providing normal deliveries and the proportion of settled audit objections.

It may be noted that the RFW includes downward revision of target for an indicator (1.2.2) – after MTR – relating to use of contraceptives in low performing areas, which was achieved, even though the figures for Sylhet and Chittagong were considerably below the national coverage.

The off-track indicators include 8 indicators, for which the 2016 update show their achievement as being even below their baseline figures. This includes 2 service-related indicators: (i) TB case detection rate (indicator 1.1.9), and (ii) children fed with approximate IYCF practices (indicator 1.3.2). 6 indicators in this category which failed even to maintain their baseline figures relate to system-strengthening component of the Program, e.g. indicators numbering 2.1.1, 2.3.3, 2.5.2, 2.9.1, and 2.9.2. This should work as a wake-up call when 25% of the results indicators (8 out of 32) could not even maintain their baseline.

A contrasting positive picture is worth noting: all 3 indicators relating to improved equity in essential service utilization (Result 1.2) relating to MDGs 1, 4, 5 and 6 were achieved before the target date. Similarly the target of training in midwifery has been achieved, even though all 3,000 midwives had not yet graduated. In addition, the indicators relating to strengthened planning and budgeting procedures (Result 2.1) as well as the result relating to strengthened quality assurance (Result 2.4) were also achieved.

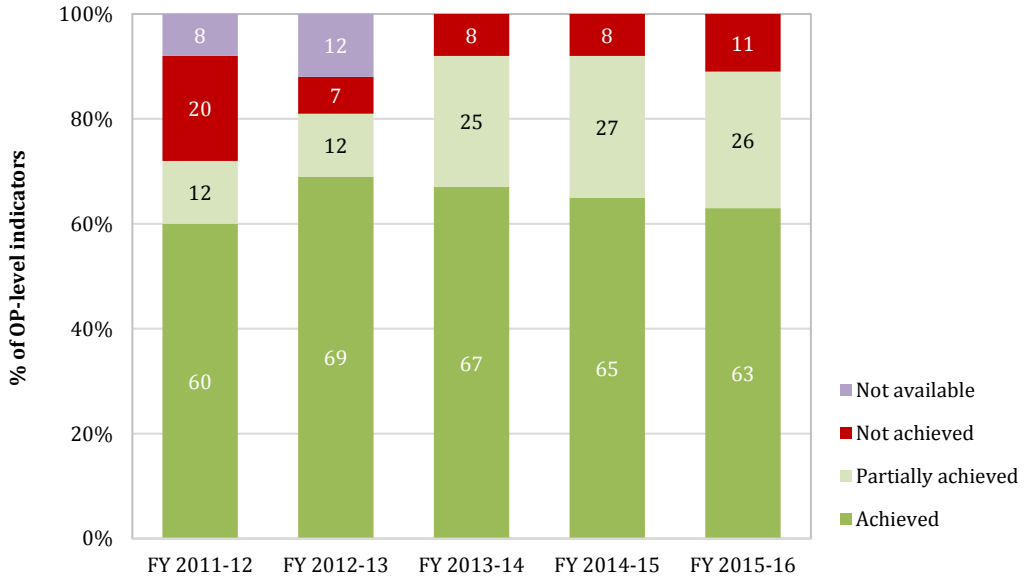
3.4 TRENDS IN OP-LEVEL INDICATOR PROGRESS

Compared to the progress in OP-level indicators during the first four years of HPNSDP, progress observed in FY 2015-16 was slightly lower (see Figure 3-3).

OP level indicators were first ever introduced in the third SWAp – HPNSDP. Initially there were 316 indicators to evaluate progress of 32 OPs of HPNSDP. APR 2012, the first APR of HPNSDP, noted some problems with OP level indicators, including lack of baselines, unclear targets and/or ambitious targets, and sometimes confusing recording of achievements. The great majority of OP level indicators was quantitative and largely measured numbers. Moreover, achievement of some indicators depended on other OPs. Following recommendation of the Independent Review Team (IRT), a priority action to revise the current set of indicators in OPs as necessary for measuring OP progress was included in the Prioritized Action Plan (PAP) of APR 2012. Accordingly, OP level indicators were reviewed and revised by the PMMU in

consultation with all LDs, DPs and others relevant which resulted in reduction in the number of OP level indicators to 158. The MOHFW had put continuous efforts to aware the LDs about OP indicator achievements through the production and dissemination of SmPRs, APIRs/MPIR and APRs/MTR. However, insufficient managerial skill of the LDs; frequent transfer of LDs/PMs/DPMs; inadequate knowledge of LDs and others on OP indicator seem to have added to the difficulty in achieving a number of OP indicators.

Figure 3-3: Trends in progress in OP-level indicators of HPNSDP, 2011-2016



Indicator-based Performance Assessment: Lesson for the Future

However, the lesson of the first experience of having OP indicators in the history of Bangladesh health SWAp is that the achievement of the indicators ranged between lowest 60% (in the first year) and highest 69% (in the second year), with the 5-years average being 65%. 10% of the indicators were not achieved on average, while 25% were in the partially- achieved category.

The performance in the achievement of indicators in both categories – RFW for HPNSDP as well as those for the 32 OPs combined – presents a serious challenge for MOHFW in future as it adopts disbursement-linked indicators as a financing mode for the ambitious 4th HPN Sector program.

Given the fact that the next Sector Program is going to adopt a new financing modality based on disbursement-linked indicators, MOHFW has to devise measures to ensure that its performance in the achievement of indicators improves dramatically, to be able to claim full reimbursement from the WB and other participating DPs.

CHAPTER 4. PHYSICAL PROGRESS DURING FY 2015-16

4.1 REPORTING OF PHYSICAL PROGRESS BY LDs

The LDs were requested to report on their physical progress of work made during July 2015 - June 2016, which called for highlighting progress in major physical activities. In this chapter, OP-wise progress in selected areas and major activities of HPNSDP are highlighted. Progress is reported under two categories, viz., IHS and SHS related OPs.

4.2 IMPROVING HEALTH SERVICES (IHS) RELATED OPERATIONAL PLANS

OP 01: Maternal, Neonatal, Child and Adolescent Health (MNCAH): With a view to improve maternal, newborn and child health (MNCH) status of the population of Bangladesh, MNCAH OP has contributed to increase coverage and utilization of the quality MNCH services at the facility and community levels.

Maternal and neonatal health (MNH)

Annual work plan (AWP) and procurement plan were developed and approved for MNH. The draft of 'Bangladesh National Strategy for Maternal Health, Revised 2015-2030' was finalized and SOP was approved. District MNH plan was implemented in 11 districts and upazilas including required human resources support. A total of 44 doctors (28 in Obstetrics-Gynecology and 16 in anesthesia) received six months EmOC training from four medical college hospitals (MCH). To strengthen and scale-up Community Skilled Birth Attendant (CSBA) Program, 1,106 participants from public sector received six-month CSBA training. A total of 107,082 vouchers were distributed among poor pregnant women in 53 upazilas under DSF program. 18,690 upazila and union DSF committee members participated in a one-day orientation program on DSF activities. A 2-days performance appraisal workshop for 841 private CSBA was completed in 29 districts.

Expanded Program of Immunization (EPI)

The MOHFW approved AWP and procurement plan for EPI. Annual Micro Plan 2016 has been developed at all levels (district, upazila, City Corporations and municipalities). 726 volunteers were recruited in 31 districts against the vacant Health Assistant (HA) positions. Additional support was provided for 621 porters for vaccine distribution from UHC to distribution points in 30 districts. 414 maternal and child health, and immunization workers were recruited in vacant positions for 13 districts. For Oral Polio Vaccine (OPV) to prevent importation of wild polio virus, 12 volunteers were recruited in 9 districts. Renovation of 9 EPI stores in 9 districts and construction of 6 new EPI stores in 6 districts was underway. For strengthening of routine EPI and MNCH activities, 32 District MCH and Immunization Officers (DMCHIOs) were working in 32 districts. Post Introduction Evaluation (PIE) of Pneumococcal Conjugate Vaccine (PCV) and Injectable Polio Vaccine (IPV) was conducted by national and international observers in November-December, 2015. Mid-level Managers' Training was provided to 153 personnel to improve the quality of field services. Data collection for Data Quality Self-Assessment (DQSA) was conducted in 16 upazilas of 8 districts and in 2 City Corporations. HPV demonstration program has been introduced in Gazipur to reduce the incidence of cervical cancer in April, 2016. Switch program from trivalent oral polio vaccine (tOPV) to bivalent oral polio vaccine (bOPV) organized in April 2016 for prevention of vaccine-derived polio virus. Coverage Evaluation Survey 2015 was completed. Procurement of 15 walk-in-cooler (WIC), generator and

AVS was completed. For supervision and monitoring of routine EPI activities at field level, 562 motorcycles were procured.

Integrated Management of Childhood Illness (IMCI)

AWP and procurement plan were approved for IMCI. Trainings were provided to: 3 batches on clinical management on facility IMCI; 6 batches of doctors and paramedics on Emergency Triage & Treatment (ETAT); 121 batches of Basic Health Workers on community IMCI; 109 batches on IMCI Revised Protocol (focusing pneumonia and diarrhea); 10 batches on district evidence based planning and budgeting (orientation and workshop); 9 batches on coordination and performance appraisal for the district and upazila mangers at national level (workshop).

Adolescent Reproductive Health (ARH)

MOHFW approved AWP and procurement plan for ARH. A total of 1,530 service providers and secondary school teachers were trained. Orientation of 660 gatekeepers and training of trainers (TOT) for 55 personnel were also completed.

School Health Program (SHP)

MOHFW approved AWP and procurement plan for SHP. A total of 1,020 primary school teachers were trained and TOT was completed for 99 personnel. Three workshops were conducted on school health where total participants were 78.

OP 02: Essential Service Delivery (ESD): Medical equipment and furniture were procured and supplied to 34 UHCs. 50 jeeps and 50 ambulances were procured and distributed to 50 UHCs. Procurement and supply of medicine have been completed for 20 UHCs. TOT on medical waste management was provided to 143 personnel from 92 UHCs. A foreign training has been completed on medical waste management in Thailand for 18 persons. Another foreign training in Sri Lanka was organized for 18 persons on tribal health. 94 mobile medical teams were formed for tribal health improvement. 532 persons were trained on SOP. With a view to strengthening upazila health system, Upazila Health System (UHS) piloting was introduced in 7 upazilas. All staff and officers of 92 upazilas were trained on MWM.

OP 03: Community Based Health Care (CBHC): 28,000 CC management committee meetings were held. The average number of patients in CCs was 38/CC/day and the performance of ANC in CCs was 11/month. The proportion of CC referrals was 2.1%. 12,895 Community Management Groups and 39,105 Community Support Groups were trained. 606 CHCPs received 3-month basic training.

Medicine, medical and surgical requisites were procured and supplied to CCs. CC activities are being telecasted by airing TV spot and TV scroll. Electric line has been installed at 997 CCs. Birthing room was constructed in 57 CCs and delivery equipment was supplied to 83 CCs with GAVI-HSS support.

OP 04: Tuberculosis and Leprosy Control (TB-LC): Several trainings, seminars and conferences on TB were conducted for 35,594 participants in 566 batches. Above 100% achievement was gained in notifying all forms of TB cases; in detecting new smear positive TB including relapse; in treating new smear TB; and in detecting new smear negative and extra pulmonary TB. 904 Multi Drug Resistance (MDR) patients have been identified and managed. 8,213 child TB cases were detected. In addition, the leprosy elimination at the national level has been sustained at 0.23/10,000 population.

OP 05: National AIDs and STD Program (NASP): NASP OP aims to halt and reverse the spread of HIV and minimize the impact of AIDS on the individual, family, community and society. 100% achievement was gained in covering 6,000 Injectable Drug Users (IDUs), 3,800 brothel-based sex workers, 1,500 street-based sex workers, 1,500 hotel- and residence-based sex workers and 1,000 men who have sex with men (MSM) and Hijra sex workers during the reporting period. Prevalence of HIV was sustained among IDUs. ARV drug has been procured for all service points. In addition, 300 IDUs have been covered with Opioid Substitution Therapy (OST). A function was organized on World AIDS Day in 2015 with a view to raising awareness on HIV/AIDS prevention. HIV testing centers provided regular service updates during the period. Comprehensive Care, Support and Treatment (CST-1, 2, 3) were provided for 1,702 people living with HIV. Prevalence of active syphilis among sex workers was sustained (<2%). Behavior and Sero-surveillance program was conducted among key population at risk of HIV in selected areas of Bangladesh.

OP 06: Communicable Disease Control (CDC): CDC OP deals with reduction in mortality and morbidity of communicable diseases such as malaria, filariasis, etc. This OP also works on helminthiasis, rabies, avian flu and pandemic influenza disease control. In the malaria program, training on Early Diagnosis and Prompt Treatment (EDPT) for field staff, training on severe malaria management for nurses, orientation on malaria management for private practitioners, training of newly appointed doctors on management of severe malaria in the hospital, training of community volunteers on malaria pre-elimination in the four pre-elimination districts, and training on strengthening surveillance system of malaria control program were conducted. Malaria Microscopy Olympiads were also conducted for malaria microscopists of malaria endemic districts. Upazila level advocacy meeting was held with different stakeholders on malaria pre-elimination in the 4 hypo-endemic districts. Malaria mortality rate was 0.0279 per 10,000 people in FY 2015-16. The coverage of EDPT was 92% for severe malaria patients.

For the Filaria program, several advocacy, training, workshop and orientation programs for managers, doctors, professionals, nurses, paramedics, field workers, school teacher volunteers were conducted in 1,148 batches where total participants were 46,010. MDA conduction and household registration have been done successfully with volunteers and supervision in 168 batches with a total of 1,622 participants. A total of 1,500 doctors, nurses, health personnel, paramedics etc. were trained on morbidity control in 36 batches. Stool surveys have been conducted in different districts in 32 batches with 1,120 attendees. According to the Transmission Assessment Survey (TAS), three Filariasis endemic districts stopped Mass Drug Administration (MDA). De-worming among school children age 5-12 years was conducted with 99.43% coverage.

Kala-azar incidence rate achieved the target (<1 per 10,000 population) and the rate was 0.34 per 10,000 population. Indoor Residual Spraying (IRS) has been conducted in all 99 endemic upazilas to control kala-azar. A total of 600 doctors and senior staff nurses from 100 endemic and 19 newly reported upazilas received training on Kala-azar Management including Inj. AmBisome administration. Moreover, 120 doctors and senior staff nurses have been trained on AmBisome administration and Kala-azar management under WHO support. “Active Case Search” (through “Camp Approach”) was conducted in 15 endemic upazilas and 5 moderate-endemic upazilas under WHO’s support in VL elimination in Bangladesh. LLNs were distributed to the old and new kala-azar cases to prevent transmission of kala-azar in 8 hyper-endemic upazilas. For 8 hyper-endemic upazilas, a protocol on “Active Case Search” has been prepared and developed and Kala-azar Search Volunteer (KSV) organized and conducted house-to-house active kala-azar case search. Kala-azar diagnosis and treatment services to all 100 endemic upazilas have been made available. Training on “No Kala-azar Transmission” activity to ten endemic upazilas has been organized. All the preparatory works for web-based disease surveillance have been completed and training for relevant staff was ongoing by MIS/DGHS.

OP 07: Non-Communicable Diseases Control (NCDC): This OP completed printing of IEC materials on NCDs, and making a documentary on drowning and blindness. Printing of training module for NCDC was carried over through Central Medical Stores Department (CMSD). With a view to observe World Tobacco Day, NCDC OP published a supplementary to daily newspaper, developed and distributed festoons, posters and banners to different important places of Dhaka City to publicize the negative effects of tobacco, and organized seminars and rallies for public awareness about the bad effects of tobacco. This OP also developed 'Lighting of the Lights' to all health complexes, Civil Surgeon offices, medical college hospitals and other important health facilities to create the awareness about autism on World Autism Day. Billboards on NCDs were set up through CMSD for awareness.

A three-day training program on clinical algorithm for management of major NCDs was completed for 1500 physicians in 50 batches. A 3-day training on injury/trauma prevention and care was conducted for doctors in 45 batches. A training program was completed on health emergency preparedness and response. A post disaster health management training program was conducted for doctors in 17 batches. NIPSOM arranged two 3-day training programs on climate change and occupational health safety. Three 3-day training programs were conducted in 100 batches on diabetes, hypertension, heart disease, COPD, cancer, arsenicosis, thalassemia etc. for doctors, nurses and paramedics. A 3-day training was also conducted on road safety, snake bite, drowning etc. for health service providers in 21 batches. A training program on occupational safety was completed in 37 batches for ship-building, garments and industrial workers. Another 3-day training program was conducted in 17 batches for service providers on EPR, post disaster health and EMS.

Two seminars have been completed on conventional and non-conventional NCDs in 95 and 104 batches respectively. A workshop was held on updating and formulating a strategic plan and an operational plan on oral health. A workshop was conducted for the development and formulation of a National Guideline for Stroke. Additionally, an orientation workshop was completed for stroke. Another workshop was conducted on development of NCDs screening tools at central, district and upazila levels. Seven seminars were completed on snake bite and other common poisoning in rural community of Bangladesh. An advocacy meeting was held on autism and World Hypertension Day was observed. 300 UHCs were providing hypertension and diabetes screening service. A total of 40,230 service providers (physicians, nurses, MA/SACMO, HI/AHI, HA, FWV/FWA, etc.) were trained on NCDs during the reporting period. Awareness campaign on injury (traffic and childhood injuries, including drowning) was conducted in 140 upazilas. The number of factories providing occupational health and safety training was increased to 165. Total 65,910 arsenicosis patients were treated during the period. With a view to observe World Health Day, this OP published a supplementary piece to daily newspapers, and organized rallies for public awareness about World Health Day 2016 through Civil Surgeons in the whole country. Diabetic screening camps were held in 64 districts and 200 patients from each district were screened. Procured furniture was distributed to NCD corner at 10 UHCs.

OP 08: National Eye Care (NEC): With a view to create awareness on blindness and its prevention, the NEC OP has done scientific seminars, free cataract screening camps, discussions, during celebration of World Sight Day October every year. Vision 2020 district committees have been formed with sharing among the stakeholders at 24 district in Bangladesh to achieve the goal of Vision 2020. Screening program on diabetic retinopathy patients was ongoing at NIO&H, Dhaka, CEITC, Chittagong and Feni Diabetic Hospital. Total 25,332 patients with diabetic retinopathy were screened and managed. A sharing meeting was held in Khulna between NEC and Sight Savers for better coordination and improvement of progress of assigned activities regarding eye diseases. Eye care equipment has been supplied in 42 different district hospitals. Training was given to 58 Ophthalmologists for Microsurgery, 29 Orientation/short term fellowship on Retina/Paediatric Ophthalmology, 87 Nurses for OT and ward management, 650 Govt. field level health workers of different district for Primary Eye Care. 42 number of cataract

screening and surgical camps were conducted at different medical college, district hospital, upazila health complex to increase country Cataract Surgery Rate (CSR). As a result CSR rate has increased from 1172 per million population to 1950 per million population. 14222 cataract operations were done at districts during the reporting period. 5,000 child cataract surgeries were performed. School Sight Testing Programs were held at the Autism Welfare Foundation, Dhaka and 20 primary schools around the Dhaka city and also at Madaripur. Medical and Surgical Requisites (MSR) have been supplied to 42 district hospitals and 5 private hospitals. For finalization of NEC strategy, a draft copy of the National Eye Care Strategy was discussed in the Planning Wing (PW), MOHFW. In Gopalganj and Chapainawabganj 4 vision centers have been established. Primary eye care manuals have been distributed to district Civil Surgeon's offices, different high school and primary school's offices of Dhaka city for mass awareness development of eye care. Treatment protocol and examination protocol books were supplied to district Civil Surgeon's offices all over the country and medical colleges. The number of hospitals that followed standard protocols was increased to 220.

OP 09: Hospital Service Management (HSM): The HSM OP has supported financing salary, diet, cleaning service, security service, medicine and MSR to related secondary and tertiary level hospitals. With the intention of strengthening and upgrading secondary and tertiary level hospital services for improvement of patient care and accessibility, during the period (July '15-June '16), the HSM OP spent taka 45,026.39 lac. Medical Waste Management (MWM) was introduced at 6 medical college hospitals, 10 specialized hospitals and 4 district hospitals, and conducted foreign training among 12 participants and local workshop among 1,000 participants on MWM. TQM concept was introduced in 8 medical college hospitals, 14 district hospitals, 3 maternal and child welfare centers (MCWCs) and 32 UHCs. In addition, 7 participants received a foreign training and 998 persons attended in workshop on TQM concept.

With a view to ensure safe blood transfusion, Tk.45.60 lac was spent to supply blood bags, reagents, and kits at blood transfusion centers and training was conducted among 400 persons regarding safe blood transfusion. Nonetheless, 10 participants were trained on safe blood transfusion in a foreign training. For safe blood transfusion service, number of facilities increased to 219. Tk. 74.49 lac was spent for accrediting hospitals as women and baby friendly hospitals so far 14 district hospitals and 3 UHCs were declared as women friendly hospitals (WFH). And total 2,060 persons were trained on WFH. Shishu Bikash Kendras were established in 15 medical college hospitals. Total 45 persons were oriented on Shishu Bikash Kendra. In order to strengthen NITOR, Sher-E-Bangla Nagar, Dhaka, Tk. 94.85 lac has been spent.

In addition, this OP also revitalized Transport, Equipment Maintenance Organization (TEMO) in Mohakhali, Dhaka and established Shishu Bikash Kendro at secondary and tertiary level hospitals. This OP also strengthened Clinical Services Delivery through infection prevention at secondary and tertiary level hospital. Structured referral system was introduced in 1 medical college hospital, 24 district hospitals and 17 UHCs. 45 persons attended a workshop on structural referral system. Moreover, 10 persons received foreign training on emergency management. Another foreign training was held on infection prevention where total participants were 10 persons. Along with this, 663 persons attended a workshop held on biosafety/ patient safety.

OP 10: Alternative Medical Care (AMC): AMC OP provides Unani, Ayurvedic and Homeopathic medical services throughout the country. 2% patient load was increased to previous 28% of patients who received AMC services out of total OPD patients at the selected district hospitals. AMC facilities was introduced in 2 UHCs, 1 DGHS, 2 Govt. Homeopathic College and Hospitals and 10 Govt. Tibbia Colleges. Four Unani, Ayurvedic and Homeopathic Pharmacopoeia and Formularies were prepared. Two new herbal garden plantations were initiated during the reporting period. Seven officials received a seven-day foreign training on management of Unani/Ayurvedic/Homeopathic system of medicine. Two orientation programs were held on

Unani/Ayurvedic/Homeopathic system of medicine and use of Herbs in herbal garden for 181 officials and 183 staff separately.

OP 15: Health, Education and Promotion (HEP): 1,700 personnel from Bureau of Health Education (BHE) were trained locally for capacity building and logistic support. 15 HEP packages were completed during the reporting period for health awareness, sensitization and motivation. 500,000 IEC materials have been produced and distributed. 95 inter-sectoral and multi-coordination meetings were conducted. 185 model villages on HEP were established. Intensive modules were used in two health facilities to train doctors, nurses and HAs.

OP 17: National Nutrition Services (NNS): NNS OP aims to deliver the nutrition services country wide through the existing DGHS and DGFP mechanism to reduce the prevalence of malnutrition in Bangladesh. During 2011-16, NNS established 200 Severe Acute Malnutrition (SAM) management unit at DHs and UHCs. With coordination of MIS/DGHS, online reporting from SAM unit has been started. To reduce child malnutrition nutrition services were incorporated with total 395 IMCI and Nutrition corners. Total 592 BFHI units were established at various health facilities at district and upazila levels. NNS providing nutrition services in urban and hard to reach areas in joint collaboration with respective ministries, departments and NGOs.

The Public Health Laboratory (PHL) is established and the Steering Committee recommended renaming PHL to National Food Safety Laboratory (NFSL). The goal of the project, "An efficient and well-functioning food safety control system in Bangladesh that leads to improved public health and enhanced trade in food commodities", and the project framework for the cost extension remains with outputs. The project is focusing on women as a force to achieve behavioral change. An estimated 2 million women have been reached through food safety awareness campaigns. 640 personnel were trained on food safety (food inspection). Nutrition based SBCC related 14 Workshop conducted with GO, NGOs and INGOs participants where different messages were developed and finalized TV spot, folk song, drama, talk show, etc. These are broadcasting both in Bangladesh Television and Bangladesh Beter regularly. Bangladesh Television telecasting program every Wednesday and Thursday at 11:30 am. Five court yard meetings on balanced diet and maternal nutrition already been aired by Bangladesh Television. Five posters developed and utilized in the field on exclusive breastfeeding, complementary feeding, growth monitoring and promotion (GMP), iron supplementation to prevent nutritional anemia of the pregnant mothers and nutritional care during pregnancy.

IPHN-NNS and Health and FP related personnel were trained in financial management and office management. Total 38,541 field level workers trained in essential nutrition services delivery. In order to control iodine deficiency disorder, technical support was provided to Control of Iodine Deficiency Disorder (CIDD) project of Ministry of Industry (MOI) by various activities. The National Vitamin-A Plus campaign 2015 was launched. The coverage of the campaign was 99% in 6-11 month children and 100% in 12-59 month children. Food fortification module and food fortification booklet were developed. In addition, food safety program was included to NNS OP. Modules on M&E was developed and training programs were provided to district- and upazila-level health and FP officials. Contract was signed with Partners in Social Sector Management Research Training and Development (PSSMRTD) for low birth weight (LBW) survey. Initiatives have been taken to harmonize Nutrition Information System (NIS) for urban partners and also for NGOs working on nutrition through bilateral funding.

A Memorandum of Understanding (MOU) was signed with James P. Grant School of Public Health (JPGSPH) of BRAC University for nutrition surveillance and a draft report was submitted during the period. Regular stakeholders' coordination meetings have been conducted named "Partners forum for Nutrition" where, each stakeholder shared their program update and also alignment with NNS activities. A national nutrition related training database has been

developed and being updated, which will be a resource for next training plan or program implementation. An online format for Logistic MIS has been developed and implemented as a Demo version into national HMIS. Once, this LMIS will be live then logistic supply gap and distribution will be smooth and recorded electronically at web.

Each quarter nutrition indicators performance and reporting status analysis have been shared with divisional and district level health officials. That contributes a lot to gap analysis and future recommendation step to improve the situation of the facility. In addition, a Divisional review meeting has been conducted for each division with the support of UNICEF with divisional level health officials, where a brief discussion been done on DNIs and the performance of that division on these indicators. Several recommendations and feedback been shared with them to improve the status through these divisional workshops. Quarterly NNS newsletters have been published and shared with different stakeholders. Moreover, to emphasis on IYCF a bulletin on IYCF been published and shared on quarter basis. These technical inputs been done in joint collaboration between government and Development Partners.

OP 18: Maternal, Child, Reproductive and Adolescent Health (MCRAH): The MCRAH OP is mainly responsible for ensuring healthy reproductive life of women and adolescents during pregnancy and child birth, and throughout the whole span of reproductive life through services by skilled service providers at home and at facilities to achieve MDGs 4 and 5.

2,411,242 ANCs (1st visit) were provided by SBAs during the reporting period. A total of 245 doctors, FWVs and CSBAs were trained on neonatal asphyxia. To ensure services to provide safe delivery at home, 519,068 Tab. Misoprostol were distributed for prevention of postpartum hemorrhage. 631,792 deliveries were conducted by SBAs at facilities and 188,398 menstrual regulations (MR) were done. 608.59 million pieces of drugs and MSR were procured from RPA fund. This OP also procured 8,000 BP machines, 8,000 stethoscopes, 66,000 registers, 1,400,000 forms and cards, and 2,500 books of birth certificates. To ensure logistic/MSR supplies to service delivery point and the community, 3,600 drugs and dietary supplement (DDS) kits were procured. To support service delivery, Tk. 1,681 lac has been allocated to district and upazila levels for procurement of medicine, MSR, pay utility bills, and repair and maintenance of service centers at local level. For capacity development, TOT and basic training on Tab. Misoprostol was conducted at seven districts. Recruitment of 140 Ansar/VDP members was completed for 70 EmOC facilities/MCWCs.

OP 19: Clinical Contraception Service Delivery (CCSD): CCSD OP aims to shift contraceptive use patterns to more effective long acting and permanent methods (LAPMs) on the basis of informed choice. During the reporting period, the following LAPM services were provided: 93,963 tubectomies; 69,068 NSVs; 233,557 IUDs; and 353,239 Implants. Procurement of contraceptives, medicine, MSR, bedding, clothing and printing materials was completed. Besides, funds were placed to Bangladesh Association for VSterilization (BAVS) and Marie Stopes Clinic Society, Bangladesh to provide support to NGOs for LAPM services. TOT was conducted in 81 batches on Post-Partum Family Planning (PPFP) separately for doctors and paramedics to develop practical skills. A basic training on LAPM methods was also conducted for 1,929 paramedics. To develop counseling and practical skills on FP method, one basic training was conducted for 1,095 paid peer volunteers. 908 persons participated in customized web-based online software data entry training. 12 persons received overseas TOT on Post-Partum Intra Uterine Device (PP-IUD) and Post-Partum Tubal Ligation (PPTL). Total 141 workshops were performed on NSV, IUD, bottom up projection, LAPM and FPCST QAT during the reporting period, where total participants were 10,129.

OP 20: Family Planning Field Service Delivery (FP-FSD): The OP is mandated to provide family planning and MCH services. Under the FP-FSD OP, 334,000 satellite clinics were held during the reporting period. Orientation programs on FP were held in 28 upazilas for the field

providers (FWAs, FWVs, FPIs and SACMOs). Orientation programs on Progesterone Only Pills (POP) were held at the headquarters for the district- and upazila-level managers. An orientation program was conducted for the newlywed couples in 23 upazilas. To reactivate upazila and union FP committees, a workshop was conducted in a district. GO-NGO coordination meetings were held in 22 districts. Orientation programs on related laws were held in all 64 districts for the district managers. Orientation on second and subsequent injection dose has been completed in 23 upazilas for FWAs and CHCPs. Monitoring workshop was held in 64 districts for the district and headquarter managers. 75 volunteers were recruited in 5 upazilas. Besides, this OP procured motor cycles, jeeps, bags and umbrellas for FWAs, registers, injection cards and diaries.

OP 23: Information, Education and Communication (IEC): The IEC OP organized two major events – World Population Day and Campaign and Service Week. Messages were disseminated on FP-MCH through hoardings/bill boards at upazila/union level in Sylhet and Chittagong districts. 2 short films, 10 TV spots and TV scrolls have been produced and telecasted on short-acting FP methods, LAPMs, early marriage prevention, PPFP, 5 danger signs during pregnancy, 3 delays in care seeking during childbirth, birth planning, and promoting facility delivery through Bangladesh Television and private TV channels. Two documentary films on best practice have been produced on different issues (FP, MCH, ARH and consequences of early marriage). One TV Magazine was produced and telecast through Bangladesh Television and 2 private TV channels. This OP also advertised through well-circulated daily newspapers on increasing male participation and awareness building on LAPM. Media campaigns were held on ARH and LAPM through Bangladesh Television and private TV channels addressing regional service package. An impact survey was conducted on IEC activities. 400 advertisements on FP, MCH and RH through daily newspapers were circulated and 50,000 copies of Porikroma were distributed. The IEC OP completed 10,080 radio programs through Bangladesh Betar. 5,750 radio programs were broadcasted in all private FM radio channels and community radio. 336 TV programs were transmitted through Bangladesh Television. 920 media campaigns organized through all private TV channels. 5,185 film shows were also organized throughout the country. 264 motivational programs on early marriage, FP, MCH, RH and gender issues through folk songs, jarigans and pot singing (regional focused and LLP area based) were also organized. One Campaign through road show across the country was organized. 200 motivational programs were organized on FP, MCH, RH and gender issues through street drama in 3 hill districts and in all upazilas of Chittagong and Sylhet divisions. Procurement of 3 jeeps was completed.

4.3 STRENGTHENING HEALTH SYSTEMS (SHS) RELATED OPERATIONAL PLANS

OP 11: In Service Training (IST): IST OP is working on capacity building of health service providers through quality training in the areas of ESP, clinical, non-clinical and management at home and in abroad. A total of 1,150 doctors and nurses participated in a 2-day orientation on early detection of breast and cervical cancers. Four 1-day orientation programs were held on violence against women for 2,075 health workers, autism awareness for 8,300 health personnel and opinion leaders at upazila level, fistula prevention and care for 2,500 field service providers and social representatives for awareness building, and cervical and breast cancer awareness for 4,150 opinion leaders. A 2-day joint simulation exercise (multi-sectoral approach) was organized with Bangladesh Red Crescent Society (BDRCS) at the cyclone prone districts on emergency preparedness and response, where 4,225 persons participated. A 2-day training program was held for 3,550 medical officers (MOs) and field staffs on disaster mitigation/post-disaster hazards. 5,125 field service providers participated in a 6-day ESD refresher training at upazila level. A 3-day orientation training was conducted on kidney and urological diseases for 2,875 health workers. A 3-day breast-feeding counseling training was completed for 3,850 health care providers. 1,900 field staff participated in a 3-day training program on gender

issues. A total of 1,600 senior staff nurses, staff nurses, assistant staff nurses, medical technologists and others participated in a 3-day training program on proper use and preventive maintenance of medical equipment.

Eight training programs of different ESDs were conducted for 10,225 personnel during the reporting period. The training programs conducted on: mass causality management for 3,550 hospital-level staff; office management for 925 office staff; basic management service for 3,375 doctors; medical and surgical emergency management for 675 support staff; improved financial management for 675 personnel working at division, district, upazila and specialized institutions; primary management of burn for 175 doctors and 550 nurses and paramedics; and basic computer training for 300 health personnel.

Management trainings were implemented by ICMH, IPH, NIPSOM, IEDCR, BCPS, CME, NIPORT and NICVD. ICMH implemented 6 training programs for 308 personnel on research methodology, complementary feeding, breast-feeding counseling, computer, TOT for doctors, and HIV. The only training arranged by IPH was on GLP and lab management for 200 personnel. NIPSOM implemented 7 training programs for 558 personnel on occupational safety, emerging issues, research methodology, nutritional anthropometric study, hospital acquired infection lab diagnosis, control and prevention for doctors and nurses, and epidemiological survey of health status. IEDCR implemented 3 trainings for 310 personnel on laboratory diagnosis of emerging and re-emerging diseases, diseases surveillance, and outbreak investigation. BCPS implemented 2 trainings for 593 personnel on communication skill development and IT, basic surgical skill development, faculty development, and basic surgical skill development. Two trainings were implemented by CME for 88 teachers of postgraduate medical institutes, medical colleges, nursing colleges, paramedical institutes and Medical Assistant Training School (MATS), and for educational management. NIPORT conducted a 7 days' basic service management training for 1,307 doctors. NICVD also organized management training on cardiac emergency for 393 health personnel of division-, district- and upazila-level.

Moreover, 11 specialized overseas trainings were organized for 226 personnel under this OP. The trainings were on rhinoplasty and functional endoscopic sinus surgery, operative gynae-oncology, video assisted thoracic surgery, retinopathy of prematurity, arthroplasty and spine surgery, prosthodontics conservative dentistry and endodontics, allo-geneic bone-marrow transplantation, vitreo-rational disease, rectograde intra-renal surgery and infertility.

OP 12: Pre-Service Education (PSE): 23 batches of 4th-year medical students and 9 batches of 2nd-year dental students received Residential Field Site Training (RFST) under Community Medicine Departments of all government medical colleges, dental colleges and dental units. 1,500 teachers of medical and dental colleges were trained on Quality Medical Education. Workshops on Quality Assurance Scheme were conducted for the different faculty members to improve quality in teaching in all public medical colleges, dental colleges/units, Institute of Health Technology (IHT), MATS. Medical education unit was established in 30 medical colleges and 3 dental colleges. Laboratory and library facilities were improved in 30 medical colleges and 9 dental colleges. Supplies and services were provided for existing and new government medical colleges, and dental colleges and units for further improvement of medical education. This OP also provided support for post-graduate medical education development in selected medical colleges and different post-graduate institutes including support in research and library facilities. Academic facilities, educational facilities and the Centre for Medical Education were strengthened for institute of health technologies, medical assistant training schools and curriculum development. Moreover, National Health Library and Documentation Center was also strengthened through provision of books. Machines and equipment were procured for medical colleges, post-graduate medical institutes through CMSD. Monitoring, supervision and evaluation system has been established in medical colleges and other cost centers. English language training was arranged for medical and dental students. Annual reports containing the

academic performances of medical colleges have been published. Security and cleaning services were provided through outsourcing for new government medical college, IHT and MATS.

OP 13: Planning, Monitoring and Research (PMR): PMR OP has trained 580 personnel on management and performance appraisal in 29 batches for capacity development from district level and below. 400 health personnel in 20 batches were trained on research methodology. 21 research studies were conducted by Planning Unit, DGHS and 20 research studies were conducted by Bangladesh Medical Research Council (BMRC). 12 progress monitoring meetings were held with the LDs and PDs in the DGHS. 600 persons in 30 batches attended in a workshop on evidence-based health planning. In addition, 600 personnel in 30 batches participated in a workshop on research activities.

OP 14: HIS & e-health (HIS&eH): HIS&eH OP has done some major activities according to AWP to improve health information system (HIS) and e-health and to introduce newer technologies. Total 21,354 health workers were trained on HIS & eHealth inclusive of use of mobile phone devices in 482 upazilas. A total of 2,068 doctors and staff received computer training. 13,712 CHCPs were trained in 2-day training program on HIS & eHealth in 482 upazilas. A hands-on training was conducted for 31 medical teachers and scientists. 1,571 participants received TOT training in 64 districts. A foreign training on Medical Biotechnology (MBT) was held for 10 personnel in India. 14 persons received a foreign training on HIS in Thailand. 12 persons participated in a foreign training on e-Health Telemedicine in Vietnam. A one-day consultative workshop on HIS & e-Health was held for 48 personnel. Two other consultative workshops were conducted at district- and upazila-levels. National-level Annual MIS Conference was held in Dhaka with 212 participants and division-level Annual MIS Conferences were held in all divisions with 1,961 participants. A two-day training workshop was arranged where 97 medical teachers were trained. The major expenditure of this OP was on computer accessories, internet services, consultancy, machinery and other equipment, and local training.

OP 16: Procurement, Logistics and Supplies Management (PLSM): PLSM OP has done some major activities to improve operational capability of CMSD for procurement, storage and proper distribution of goods to all LDs. The OP has also done activities for implementation of e-procurement. An online storage and distribution system was established to track all goods procured in CMSD. 75% of the packages were captured by the procurement web portal. All contracts were awarded within initial bid validity period. All items were monitored from receiving to distribution through the Electronic Inventory System at CMSD. According to AWP 2015-16, a total of 55 computers, laptops, UPSs and printers were procured. 31 other necessary items of office equipment were also procured during the reporting period.

OP 21: Planning, Monitoring and Evaluation (PME): The PME OP's objective is to assist different OPs of DGFP through effective coordination, monitoring, evaluation and implementation of LLP. 7 AWPs with budgets of DGFP OPs were submitted to MOHFW. Total 103 divisional and district level workshops were conducted on program performance monitoring where total participants were 4,113. 62 personnel participated in a one-day workshop on HPNSDP extended period's financing and implementation of OPs. 55 personnel attended a workshop on project completion report (PCR). A central workshop was also held on field performance monitoring with 61 attendees. Procurement of motor vehicles and computers was completed.

OP 22: Management Information System (MIS-FP): The OP is mandated to establish a management information system up to the upazila level by introducing web-based system for improving data quality for recording and reporting. MIS-FP OP collected FP-MCH performance data through a web-based system at upazila level. Total 488 upazilas were providing monthly report electronically for web-based MIS. 17 data quality reports were submitted by sending 4 teams in each month. The FWA Register (8^{th} edition) has been introduced in the field and

31,033 persons were trained on this register. Twelve reports have been published separately on service statistics (SS) and logistics. Seven workshops have been completed to give the idea about the change in new FWA Register in each division. Procurement of 200 Tablet PCs has been completed by logistic unit of DGFP.

OP 24: Procurement, Storage and Supply Management (PSSM): PSSM OP's objective is to ensure continuous availability and accessibility of contraceptives and reproductive health commodities at the Service Delivery Points (SDPs) for the millions of consumers. Ansar/VDP members have been deployed to ensure security of warehouses and stores. Contraceptives and RH commodities have been supplied to warehouses and upazila stores using GOB and private transports. Carrying and Forwarding (C&F) agent has been appointed to clear commodities from sea/air ports. Physical Inventories and Commodity Audit of Contraceptives and MSRs were conducted at the selected points of the DGFP supply chain systems ranging from central warehouse to community levels. Total 902 supply and service delivery points have been covered through this commodity audits. 7,500 Inventory Control Registers (ICRs) have been printed for the good inventory practices at the warehouse level. Total 16 persons received foreign training on different topic such as: selection and recruitment procedure of consultants for World Bank funded projects; procurement and inventory management; procurement management course and import/export documentations and shipping procedures. One person received CIPS training on Supply Chain Management. Training was conducted on logistics management, computer course eGP procurement and L/C for 200 persons.

86 persons attended a workshop on Supply Chain Management. Vehicle, computer and accessories, equipment, furniture, etc. were procured. Post-shipment verification about procured goods was carried out by standing board without any cost implication; however one lab test was carried out by an independent firm.

OP 25: Training, Research and Development (TRD): Imparting pre-service and in-service training to service providers and conducting research, evaluation and surveys for providing up-to-date information for improvement of HNP programs are the key activities of TRD OP. During the reporting period, basic training, induction training, refresher training, reproductive and child health training, and instructional system design training were held. Training was provided to 128 persons on reproductive and child health (IUD and IP, ENC, ELCD). A basic training was conducted for 460 FWVs, FWAs and FPIs. Refresher training was conducted for 1,649 FWVs, SACMOs, HAs, FPIs and FWAs. Two national surveys were conducted and two surveys were ongoing. A program focused research study was conducted and six were ongoing. A total of 11 annotated bibliography/ research-policy briefs and newsletter were published during the reporting period. A collaborative training and other activity was conducted. Five curriculum and instructional materials were developed. Twenty-one research dissemination programs have been conducted. Two collaborative research activities including national surveys and one research methodology training course were conducted during the reporting period.

OP 26: Nursing Education and Services (NES): With a view to develop and strengthen human resources in nursing and midwifery, the NES OP completed different types of specialized training courses (pediatric, oncology, trauma and emergency, mental health, geriatric, ICU, cardiac, disaster, English language for Nursing Officers, HIV, BCC, computer training). An orientation program for newly appointed senior staff nurses was completed in 9 batches. Procurement of furniture has been done. 975 nurses completed long term diploma in midwifery and 1,950 nurses were trained on specialized courses.

OP 27: Strengthening of Drug Administration and Management (SDAM): The SDAM OP's objective is to ensure quality, efficacy and safety of pharmaceutical products and thus contribute to improving the health of the people. 10,800 drug samples were tested and 1,552 inspections on Drug Manufacturing Units were completed during the reporting period. 72 staff

received training on Good Manufacturing Practice (GMP). During the reporting period, 72 persons attended training – local (51) and foreign (21). Repair and renovation of Chittagong Drug Testing Laboratory was completed. Procurement of laboratory equipment and construction of DGDA head office building have also been completed.

OP 28: Physical Facilities Development (PFD): According to the AWP 2015-16, upgradation of 37 existing UH&FWCs, upgradation of 13 UHCs from 31 to 50 beds, remodeling and renovation of 3 existing family planning stores were completed. Besides, upgradation of 110 existing UH&FWCs, upgradation of 2 UHCs from 10/50 to 50/100 beds, upgradation of 1 nurses training institute into nursing college were ongoing. Expansion of 41 UHCs were ongoing (26% progress) to accommodate Upazila Family Planning Offices, stores and services. The construction works of (i) four UH&FWCs, (ii) one ladies hostel, (iii) two 31/50 bed hospitals for new upazilas, (iv) one Deputy Director (FP) office, (v) fifteen 10 bed MCWCs, (vi) one nursing college, (vii) one fifty bed diabetic hospital, (viii) one twenty bed hospital, (ix) one 20 bed MCWC, (x) one 20-50 bed hospital and (xi) three Family Planning Offices were ongoing. The remaining works of four UHC from 31 to 50 beds and four UH&FWCs were also ongoing. Reconstruction works of 4 UHCs and upgradation of RD into UH&FWC were also ongoing (39% progress). Establishment of 5 IHTs achieved 34% progress. 42% progress achieved in physical facilities development of 9 Homeopathic Medical College and Hospitals. Physical facilities development of Unani Ayurvedic College was ongoing (40% progress). 45 staff was trained in the basic course of procurement management.

OP 29: Human Resources Management (HRM): During the reporting period, one international consultant was working with the support from JDTAF to implement the HR Plan. Recruitment rules for non-medical and nursing have been sent to Ministry of Public Administration (MOPA) for approval. System design for Central Human Resources Information System (CHRIS) was established and agency level training of CHRIS was ongoing. 396 participants were trained in a 3-day training program on IPM. NIPORT arranged a refresher training program for 100 FWAs. Training on HM and HRM was conducted by NIPSOM for 113 UHFPO/RMO/MO/nurse/others. 11 personnel completed EMBA/EMPH from BRAC and North South University. 23 personnel attended a 9-day foreign training program on leadership skill and governance in human resources for health in Mahidol University, Thailand. An APA workshop was conducted with 52 attendees. 252 persons participated in Health Workforce Strategy 2015 workshop. A workshop was conducted on standardization of organogram matching with TO&E. In addition, 125 personnel participated in a workshop on CHRIS. This OP has paid officers' allowances and payments.

OP 30: Sector Wide Program Management and Monitoring (SWPMM): During the reporting period, the Mid-term Program Implementation Report (MPIR) 2014 and the Six-monthly Progress Report (SmPR) 2015 of HPNSDP were finalized. An M&E Task Group (METG) and a Local Consultative Group (LCG) meeting were held. 8 personnel participated in a 10-day foreign training on health system strengthening and sustainable financing, which was held in Malaysia. 7 personnel participated in another foreign training program held in India on health system management and planning. Training on "Exchanging ideas with other implementing countries and gain practical knowledge to develop more effective strategies in Bangladesh" was held in two batches – one batch in India and another in Vietnam. Total 7 workshops were conducted and total participants were 452.

OP 31: Improved Financial Management (IFM): The IFM OP is responsible for improving financial as well as fund management and audit system. During the reporting period, four financial reports were prepared on time. Internal audits were completed for 32 OPs. Total 1,355 financial management personnel were trained on financial management in separate training program. A workshop was also held on financial management for 1,042 account personnel. To

make IFM more efficient, outsourcing of FM personnel and audit firm for internal audit have been done. This OP also arranged workshops, seminars and conferences.

OP 32: Health Economics and Financing (HEF): With a view to conducting policy oriented research on health economics, 17 local trainings and 37 workshops, seminars and conference were held during the reporting period. Four EGV training programs were implemented for field officials. Three research studies received World Bank (WB) clearance and the studies were ongoing. Piloting of *Shasthyo Shurokhsha Karmasuchi* (SSK) was going on. Public Expenditure Review (PER) 1997-2014 was conducted and disseminated. Data collection for Bangladesh National Health Accounts-V was started. During the reporting period, the developed drafts were (i) work undertaken for benefit package development, (ii) Health care standards for primary and secondary level health facilities and (iii) SSK Manual.

CHAPTER 5. PROGRESS IN TRAINING DURING FY 2015-16

5.1 TRAINING PORTFOLIO COMPARED TO TOTAL EXPENDITURE

HPNSDP promotes considerable effort to improve HR capacity through trainings (local and foreign) and workshops/seminars/orientations. Out of the total expenditure of FY 2015-16, Tk. 121.5 crore (or 3.6%) was spent on trainings and workshops/seminars/orientations (Figure 5-1). Of the total training cost, Tk. 91.5 crore (75%) was spent on training activities and Tk. 30.0 crore (25%) was spent on workshops/seminars/orientations.

Figure 5-1: Share of training and workshop/seminar in relation to expenditure in FY 2015-16

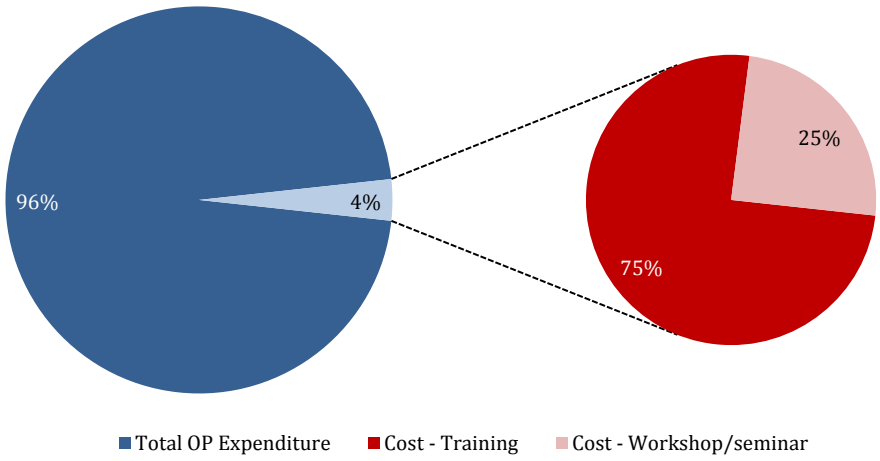


Table 5-1 shows the distribution of OPs by the cost of training. Out of 32 OPs, 29 conducted any training/workshop during FY 2015-16, and IST spent the most on training (Tk. 23.0 crore) followed by MNCAH (Tk. 13.2 crore), NNS (Tk. 13.1 crore) and HIS&eH (Tk. 13.0 crore). In terms of share of training out of the total OP expenditure, IST spent 95% of the total OP expenditure for capacity building activities followed by HRM (59%), MIS-FP (50%), PME (40%), TRD (39%) and SWPMM (38%).

Table 5.1: Distribution of training cost by Operational Plan, FY 2015-16

(Tk. in crore)

OP	Total OP expenditure	Total cost for training and workshop	Training as % of total OP expenditure
All OPs	***3404.1***	***121.5***	***3.6%***
MNCAH	487.4	13.2	3%
ESD	44.5	1.6	4%
CBHC	423.8	2.5	1%
TBLC	92.1	3.2	4%
NASP	25.5	0.0	0%
CDC	126.7	2.5	2%
NCDC	27.1	7.9	29%
NEC	3.3	0.3	9%
HSM	464.0	5.0	1%
AMC	31.3	0.5	2%
IST	24.1	23.0	95%
PSE	172.0	5.7	3%

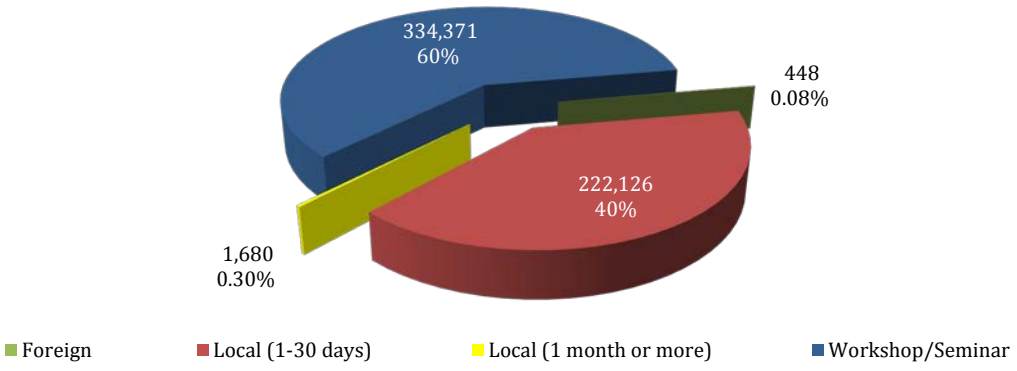
OP	Total OP expenditure	Total cost for training and workshop	Training as % of total OP expenditure
PMR	3.9	1.2	31%
HIS&eH	65.5	13.0	20%
HEP	22.4	1.4	6%
PLSM	116.4	0.0	0%
NNS	44.4	13.1	30%
MCRAH	111.3	1.8	2%
CCSDP	113.4	3.9	3%
FPFSD	38.7	1.3	3%
PME	2.5	1.0	40%
MIS-FP	3.6	1.8	50%
IEC	24.6	3.7	15%
PSSM	16.7	0.5	3%
TRD	8.5	3.3	39%
NES	40.4	6.1	15%
SDAM	1.5	0.0	0%
PFD	852.7	0.0*	0%
HRM	2.2	1.3	59%
SWPMM	2.7	1.0	38%
IFM	4.5	0.9	19%
HEF	6.1	0.8	13%

* Cost of training for PFD was not available

5.2 DISTRIBUTION OF PARTICIPANTS BY TRAINING AND OP TYPES

A total of 558,587 participants took part in training and workshop/seminar/orientation during FY 2015-16; among them 223,768 (40.1%) participants attended in-country training programs, 448 (0.08%) attended training programs abroad and the rest 334,371 (59.9%) attended workshops/seminars/orientation (see Figure 5-2).

Figure 5-2: Participants of training and workshops in FY 2015-16



Most of the local and foreign trainings were from the SHS OPs (63% and 74% respectively), the rest were from IHS OPs. In terms of workshop participants, IHS OPs conducted 95% (Table 5-2).

Table 5-2: Training and workshop participants in FY 2015-16 by type of OPs

OP	Number of training participants (Local)	Number of training participants (Foreign)	Number of workshop/seminar participants
All OPs	***223,806***	***448***	***334,371***
Improving Health Services (IHS)			
MNCAH	20,363	0	29,686
ESD	675	36	0
CBHC	606	0	0
TBLC	1,746	0	49,830
NASP	0	0	0
CDC	11,954	0	0
NCDC	8,180	0	32,050
NEC	90	0	320
HSM	0	49	5,899
AMC	0	7	364
HEP	1,700	0	2,020
NNS	29,376	0	161,944
MCRAH	4,129	0	1,370
CCSD	2,825	12	10,129
FP-FSDP	0	0	6,066
IEC	72	12	16,880
IHS total	*81,716*	*116*	*316,558*
Strengthening Health Systems (SHS)			
IST	55,282	226	0
PSE	6,544	0	680
PMR	980	0	1,200
HIS & e-Health	40,913	36	4,533
PLSM	0	0	0
PME-FP	0	0	4,291
MIS-FP	31,033	0	572
PSSM	201	16	95
TRD-NIPORT	2,907	7	1,700
NES	1,650	0	270
SDAM	51	21	0
PFD	38	0	0
HRM	615	23	465
SWPMM	33	0	452
IFM	313	3	1,042
HEF	1,530	0	2,513
SHS Total	*142,090*	*332*	*17,813*

5.3 DISTRIBUTION OF LOCAL TRAINING BY DURATION

There were 223,806 in-country training participants during the FY 2015-16, and almost the entirety of them, 222,128 (or 99%) participants received the 1-30 days of training. There were 1,213 (0.5%) participants who received training of 1-6 months and only 467 (0.2%) participants received six or more months of training. Table 5-3 shows the distribution of local training by duration in FY 2015-16.

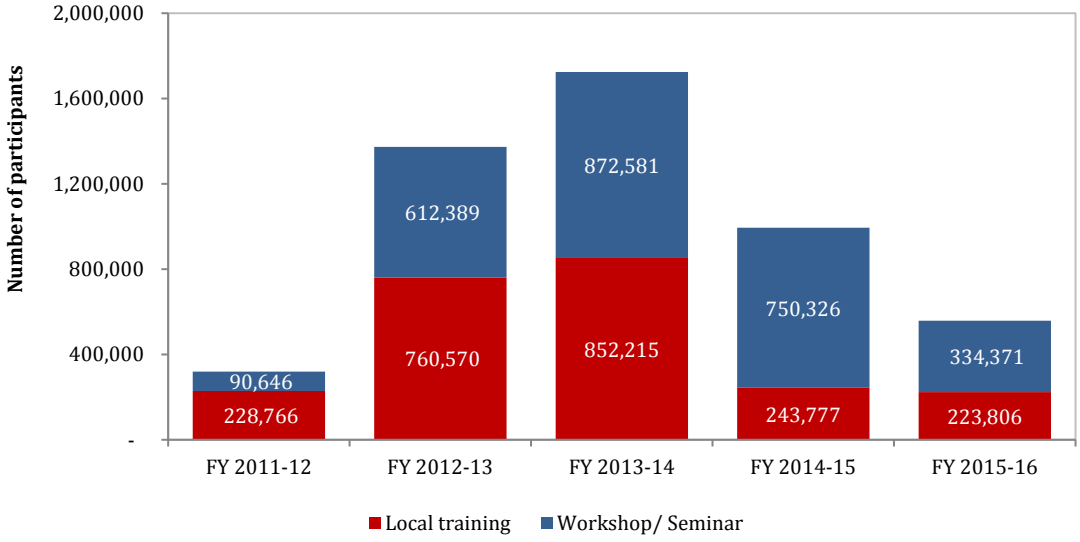
Table 5-3: Distribution of local training by duration during FY 2015-16

Training duration	Training participants		Cost of training (Tk. in crore)	
	Number	*%*	*Total*	*%*
1 day	64,011	28.6	10.0	11.9
2 days	93,329	41.7	14.7	17.6
3-30 days	64,786	28.9	49.6	59.2
1-6 months	1,213	0.5	8.7	10.4
6+ months	467	0.2	0.7	0.8
Total	***223,806***	***100.0***	***83.7***	***100.0***

5.4 TRENDS IN TRAINING PROGRESS

Trends in training figures during the first five years of HPNSDP, i.e. between FY 2011-12 and 2015-16, indicate that the number of participants steadily decreased in FY 2015-16 after a massive increase in FY 2013-14 (Figure 5-3).

Figure 5-3: Trends in participants of training and workshops during FY 2011-16



It is worth mentioning that activities related to training and workshops are an integral part of the HPNSDP, though expenditure on training and workshops was only 3.6% of the total HPNSDP expenditure for FY 2015-16. HR capacity development through skill-based and other forms of training is important for regular activities of HPNSDP implementation. Similarly, orientation, advocacy, technical and other forms of workshops, etc., are conducted on a regular basis under all the OPs. All these are expected to contribute to improving service efficiency and strengthening support systems.

From the APIR 2013, the predominance of 1-2 days training among local training activities was highlighted with the suggestion that the quality and contents of such type of training need to be assessed. Between FY 2012-13 and FY 2015-16, the proportion of all local training participants receiving 1-2 days of training declined from 92% to 70%, which reflects better planning in capacity development and possibly management efficiency.

CHAPTER 6. CHALLENGES IN IMPLEMENTATION DURING FY 2015-16

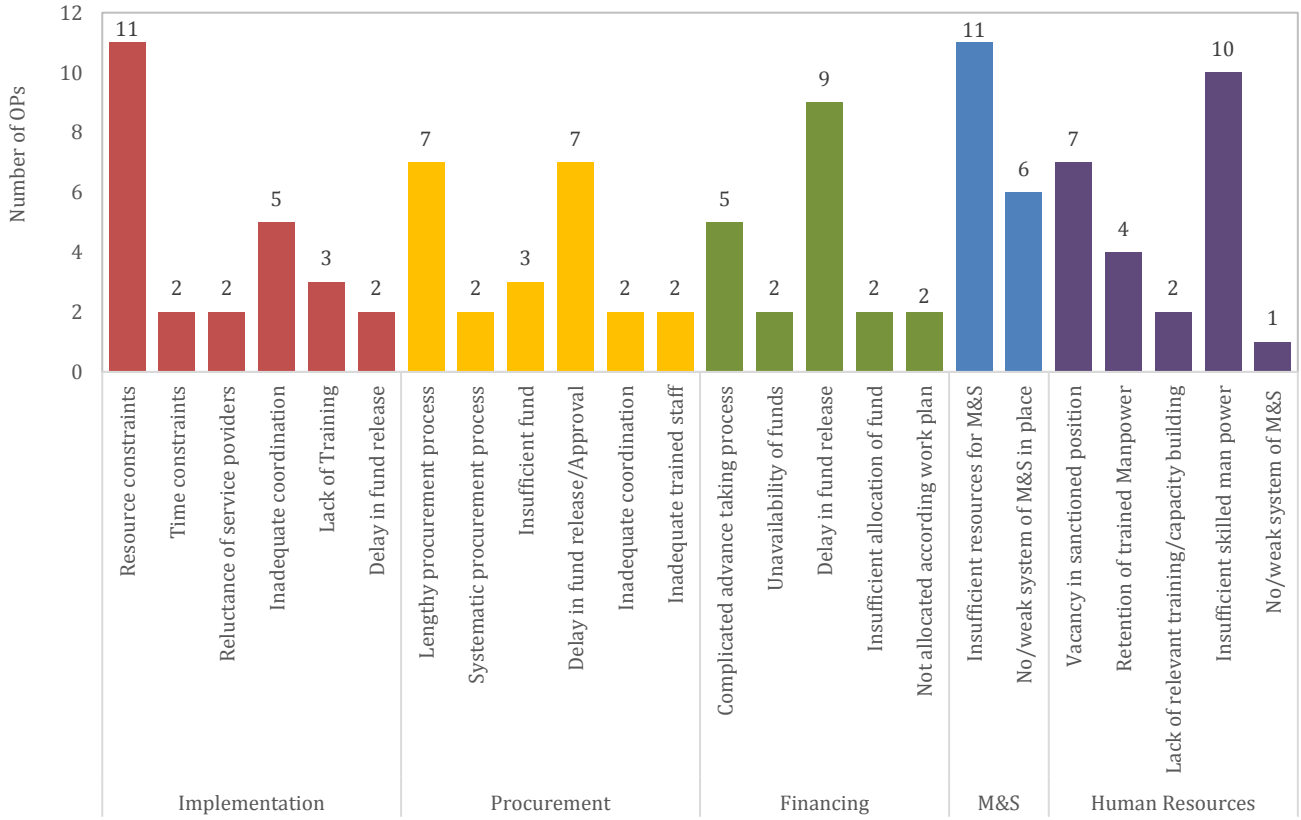
The reporting template used for obtaining information on the implementation progress of the OPs, also collected information on the major challenges faced by the LDs during the fifth year of HPNSDP implementation. This chapter summarizes the challenges reported by the LDs, which have been classified under five categories viz., implementation, procurement, financing, human resources, and monitoring and supervision. Table 6-1 below provides a summary of the major challenges faced by the LDs during FY 2015-16.

Table 6-1: Summary of the key challenges faced by the LDs of HPNSDP during FY 2015-16

Areas	Key Challenges	Reported by the number of LDs
Implementation	Resource constraints	11
	Time constraints	2
	Reluctance of service provider's	2
	Inadequate coordination	5
	Lack of Training	3
	Delay in fund release	2
Procurement	Lengthy procurement process	7
	Systematic procurement process	2
	Insufficient fund	3
	Delay in fund release/approval	7
	Inadequate coordination	1
	Inadequate trained staff	2
Financing	Complicated advance taking process	5
	Unavailability of funds	2
	Delay in fund release	9
	Insufficient allocation of fund	2
	Not allocated according work plan	2
Monitoring & Supervision	Insufficient resources for M&S	11
	No/weak system of M&S in place	6
Human Resources	Vacancy in sanctioned position	7
	Retention of trained Manpower	4
	Lack of relevant training/capacity building	2
	Insufficient skilled man power	10
	No/weak system of M&S	1

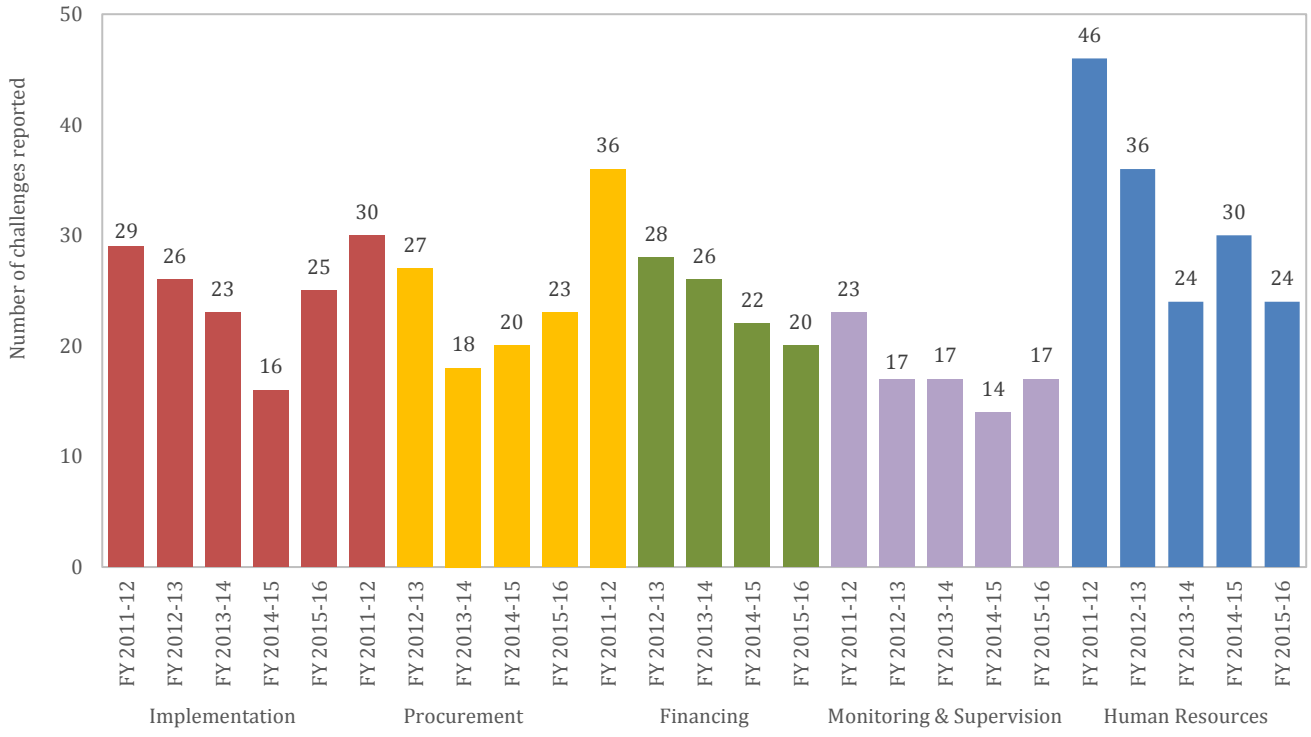
Among the key challenges, 11 LDs reported resource constraint to be the main challenge which-they had faced during the fifth year of HPNSDP implementation. Similar number of LDs also reported insufficient resources for monitoring and supervision to be a challenge. Insufficiency of fund was also mentioned as one of the key challenges for procurement and financing. Delay in fund release posed a challenge to a considerable number of the LDs in the areas of financing, procurement and implementation. On the other hand, inadequate co-ordination was identified as a challenge by one-fifth of the reporting LDs while some of them mentioned insufficiency of skilled manpower as a key challenge. Figure 6-1 shows the key challenges reported by LDs for FY 2015-16.

Figure 6-1: Key challenges faced by the LDs of HPNSDP during FY 2015-16



In terms of trends in number of challenges reported by LDs during the first five years of HPNSDP, the number of challenges reported by LDs went down steadily in most categories (see Figure 6-2) except for implementation.

Figure 6-2: Trends in the number of challenges reported by LDs, July 2011 – June 2016



The number of OPs reporting no challenges increased from zero OP in FY 2011-12 to 3 OPs in FY 2012-13 to 8 OPs in 2013-14 and 2014-15, and decreased to 6 OPs in FY 2015-16, indicating efficiency improvement in the management of OP implementation (see Table 6-2 below).

Table 6-2: OPs reporting zero challenges during FY 2011-16

Financial Year	Improving Health Services (IHS)	Strengthening Health Systems (SHS)
2011-12	-	-
2012-13	AMC; TB/LC	PSSM
2013-14	HSM; NASP; TB/LC;	MIS-FP; SWPMM; PFD; PSSM; TRD
2014-15	NASP; NCDC; HSM; IEC	PSE; PMR; TRD; SWPMM
2015-16	NASP; HSM; AMC	PSE; PMR; MIS-FP

CHAPTER 7. HIGHLIGHTING OTHER PROGRAM INITIATIVES

This chapter highlights three different kinds of activities in support of implementation of HPNSDP during the program period: Table 7-1 lists the issues raised in various Six-monthly/Annual Program Implementation Reports to draw attention of the Program Managers while Table 7-2 mentions various legal and policy instruments developed by MOHFW and Table 7-3 records the large variety of subjects/areas studied and analyzed to underpin program implementation and guide policy formulation.

7.1 ISSUES HIGHLIGHTED IN PERIODIC PROGRAM REVIEWS

The PMMU introduced for the first time in the history of the Bangladesh health sector program a bi-annual program performance review system and produced APIR and SmPR to facilitate holding APRs. Based on LDs' reporting and periodic discussions with program implementers and relevant stakeholders, both the Reports – in addition to regular coverage of progress achieved in fund utilization, physical progress, achievement of the indicators and focus in training, etc. – highlighted a number of issues for consideration of the MOHFW management during July 2012–June 2016. Table 7-1, collates the issues highlighted in different program implementation reports. Some of these issues found place in the PAP, following Policy Dialogue between MOHFW and the DPs which were held every year post-APR.

Table 7-1: Issues for consideration highlighted in periodic program review documents

No.	Issues	Documents highlighting the issues	Whether Considered as PAP
1.	Adequacy and sufficiency of the OP indicators to reflect the wide range of activities of the sector program	APIR, 2012	Yes
2.	Appropriateness and adequacy of the resource plan	APIR, 2012	Yes
3.	Structure of OPs in connection with the thematic areas	APIR, 2012	
4.	Integration of Community Clinics into existing upazila-based Primary Health Care (PHC) system	APIR, 2012	
5.	Expansion of DSF as planned	SmPR, 2012	Yes
6.	Required skill mix retention in selected UHCs to provide comprehensive EmOC services	SmPR, 2012	
7.	Prioritization of activities in nutrition area and scaling those up	SmPR, 2012	
8.	Develop and activate a roll-out plan for providing integrated nutrition services at facilities within upazila level and below, with priority to HTR areas and areas with concentration of nutritionally vulnerable population	SmPR, 2012	Yes
9.	Capacity enhancement of NNS as the institutional home for nutrition	SmPR, 2012	
10.	Establishing/strengthen multi-sectoral linkage and coordination for nutrition interventions	SmPR, 2012; APIR, 2013	Yes
11.	Improved co-ordination between CHCPs and the other two categories of service providers at the CC	SmPR, 2012	
12.	Job uncertainty of the CHCPs need to be allayed to maximize their potentiality	SmPR, 2012	
13.	Mainstreaming of CCs facilitated by the adoption of single reporting format	SmPR, 2012	
14.	Capacity development for procurement planning, management, storage, distribution and supervision at various levels of MOHFW and simplification of routine procurement procedures	SmPR, 2012	Yes
15.	Reducing procurement lead time	SmPR, 2012	

No.	Issues	Documents highlighting the issues	Whether Considered as PAP
16.	Development of a standard framework contract	SmPR, 2012	Yes
17.	Recruitment of a biomedical engineer to help developing standardized specifications for medical equipment	SmPR, 2012	Yes
18.	Harmonization of HIS-EH and MIS-FP to ensure interoperability of the routine data systems from DGHS and DGFP	SmPR, 2012	
19.	Speed up the process of identifying and clearing TAs for smooth implementation of different OP activities	SmPR, 2012	
20.	Review of JDTAF principles and guidelines for proper utilization of the TA funds effectively	SmPR, 2012	
21.	Introducing hospital autonomy in public sector hospitals	SmPR, 2012/2013; APIR, 2013	
22.	New Private Health Care Act	SmPR, 2012/2013; APIR, 2013	
23.	Resource allocation formula	SmPR, 2012/2013; APIR, 2013	
24.	Development of EGV and NGO participation strategies	SmPR, 2012; APIR, 2013	
25.	Health insurance and health care financing framework	SmPR, 2012; APIR, 2013	
26.	Matching expansion of physical facilities with supply of equipment and manpower	APIR, 2013; MPIR, 2014	
27.	Inter-ministerial coordination in nutrition interventions	APIR, 2013	
28.	Improving visibility of NNS	SmPR, 2012; APIR, 2013	
29.	Policy guidance on mental health, urban health and tribal health	SmPR, 2012/2013; APIR, 2013; MPIR, 2014	
30.	Development of IEC package to support the delivery of key health and family planning services	SmPR, 2012/2013; APIR, 2013	
31.	Developing and implementing HR Plan	SmPR, 2012/2013; APIR, 2013	
32.	Upgrading and implementing recruitment rules	SmPR, 2012/2013; APIR, 2013	
33.	Implementing performance management system	SmPR, 2012/2013; APIR, 2013	
34.	Establishing HR Information System	SmPR, 2012/2013; APIR, 2013	
35.	Mapping out the need for new construction and facility upgradation	SmPR, 2013	
36.	Preparing a comprehensive maintenance plan	SmPR, 2013	
37.	Strengthening Pharmacovigilance	MPIR, 2014	
38.	Finalized Maternal Health Strategy and SOPs need to be approved and actions initiated for implementation	SmPR, 2015	Yes
39.	Sharing status of implementation of the regional service package for strengthening FP services in low performing areas by both DGHS and DGFP	SmPR, 2015	Yes
40.	Formal training on LAPM activities to the field level doctors of DGHS and nurses of DNS (who are posted in the divisions of Chittagong and Sylhet) is to be provided urgently	SmPR, 2015	Yes
41.	Mechanism needs to be worked out for delivery of Post-partum FP and empowering the DGHS delivery points with authority of drawing and disbursing from the Imprest Account	SmPR, 2015	Yes
42.	The current recruitment rules of FWVs in the context of their existing educational qualification along with training are to be	SmPR, 2015	Yes

No.	Issues	Documents highlighting the issues	Whether Considered as PAP
	reviewed		
43.	Availability of anesthetists is to be increased through a) expediting the training on anesthesiology to medical officers and b) contracting out the service	SmPR, 2015	Yes
44.	Review and strengthen the structure of IPHN with proper mandate and institutional capacity to effectively implement NNS	SmPR, 2015	Yes
45.	Capacity building of the community health workers for providing quality nutrition service through competency based training and orientation on revised job descriptions	SmPR, 2015	Yes
46.	Scale up screening activities and strengthen referrals for the diagnosed hypertension and diabetes cases to the targeted UHCs	SmPR, 2015	Yes
47.	Existing co-ordination mechanism between Ministry of Local Government, Rural Development and Cooperative (MOLGRDC) and MOHFW has to be strengthened for improving urban primary health care services	SmPR, 2015	
48.	Policy for regulating private medical and dental colleges needs to be prepared and finalized in consultation with all stakeholders.	SmPR, 2015	Yes
49.	Accounting Software needs to be developed and process for its operationalization initiated	SmPR, 2015	Yes
50.	A timeframe to respond to audit clarifications for settlement needs to be agreed upon and a framework for getting response from the LDs on FAPAD - led audit objections is to be developed. The agreed Action Plan on Integrated Financial Assessment Action Plan (IFA) needs to be monitored for implementation	SmPR, 2015	Yes
51.	The review for restructuring of CMSD needs to be completed soon and follow-up actions initiated	SmPR, 2015	Yes
52.	An action plan is to be developed for implementation of the approved HR Work Force Strategy	SmPR, 2015	Yes
53.	HRIS is to be fast-tracked and completed incorporating different HR MISs	SmPR, 2015	Yes
54.	Actions are to be initiated for implementation of the Monitoring and Evaluation Strategy and Action Plan (MESAP)	SmPR, 2015	Yes

7.2 POLICY DOCUMENTS AND ACTION PLANS PREPARED DURING HPNSDP

During HPNSDP period, a number of policy documents and action plans (laws and acts, policies and strategies, guidelines, and action plans) were developed to guide and support effective implementation of the SWAp. Table 7-2 lists the policy documents developed during July 2011 – June 2016.

Table 7-2: List of policy documents and actin plans prepared during HPNSDP (2011-16)

Year	Title of Document	Status as of 30 June 2016
Laws and Acts		
2013	Breast milk Substitute, supplementary food for babies prepared on commercial basis and its tool for use (Regulation of Marketing) Act	Approved
2013	Bangladesh Food Safety Act	Approved
2013	Vitamin "A" Fortification in Edible Oil Act	Approved
2014	National Health Protection Act	Draft

Year	Title of Document	Status as of 30 June 2016
2014	Patient Protection Act	Draft
2014	Health Care Service Provider Protection Act	Draft
2015	Drug Act	Draft
2016	Mental Health Act	Draft
2016	Organ Transplantation Act	Draft
Strategies and Policies		
2011	National Health Policy	Approved
2011	National Strategy for Improving Uptake of Long Acting and Permanent Method (LAPM)	Approved
2011	Private Medical College Establishment and Management Policy, (Revised)	Approved
2012	Health Care Financing Strategy	Approved
2012	Bangladesh Population Policy	Approved
2013	National Immunization Policy	Draft
2014	Gender Equity Strategy	Approved
2014	National Urban Health Strategy	Approved
2014	Audit and Financial Management Strategy	Approved*
2014	National Communication Strategy and Action Plan for Reduction of NCD High Risk Behaviors in Bangladesh	Draft
2015	Monitoring and Evaluation Strategy and Action Plan (MESAP)	Approved
2015	Health Workforce Strategy	Approved
2015	National Strategy for Obstetric Fistula	Approved
2015	National Nutrition Policy	Approved
2015	Strategic Planning on Quality of Care for Health Service Delivery in Bangladesh	Approved
2015	National Advocacy and Communication Strategy on Nutrition (merged with SBCC strategy)	Final
2015	Health Education Strategy	Final
2015	Alternative Medical Care Strategy	Approved
2015	Urban Immunization Strategy	Draft
2015	Comprehensive Social and Behavioral Change Communications (SBCC) Strategy	Approved
2015	Malaria National Strategic Plan	Draft
2016	Bangladesh National Strategy for Maternal Health 2015-2030 (revised)	Final
2016	SOPs related to revised National Strategy for Maternal Health 2015-2030	Approved
2016	National Drug Policy	Draft
Guidelines and Action Plans		
2011	Strategy and guideline for prevention, control and management of Nipah and other encephalitis	Final
2012	Guidelines on emerging infectious diseases and outbreak investigation	Final
2013	National MR Guideline	Approved
2013	National Plan of Action on Adolescent Sexual Reproductive Health (ASRH)	Approved
2014	Action Plan on ARH	Approved
2015	National Guidelines for Management of Clubfoot	Draft
2015	National Strategy and Action Plan for Autism and Neurodevelopmental Disorders	Final
2015	National Post-partum Family Planning Action Plan	Draft
2015	Nutrition in Emergency Guideline	Approved
2015	National Dietary Guideline	Draft

* Approved by the MOHFW, but not the Office of the Comptroller and Auditor General of Bangladesh

7.3 STUDIES CONDUCTED UNDER COMPREHENSIVE TECHNICAL ASSISTANCE

Based on past experience, an institutional mechanism was established under HPNSDP for technical assistance (TA) by pooling both pool and non-pool DP funds to make the TAs more effective and responsive. The TA fund was titled as "Joint Donor Technical Assistance Fund (JDTAF)" to enhance achievement of the goal and objectives of HPNSDP. The Technical Assistance Committee (TAC) constituted by the MOHFW identifies TA requirements based on demand received from the LDs. Part of the TA consisted of studies on issues related to different aspects of program implementation. During July 2011 – June 2016, 37 studies were conducted under JDTAF to facilitate informed decision-making under HPNSDP (Table 7-3).

Table 7-3: Studies Conducted under JDTAF during HPNSDP (2011-16)

No.	Study Title	Conducted By	Period
1	Program Evaluation for Demand Side Financing	HERA	April-August, 2013
2	Development of Health Workforce Strategy	Soyapi Lungu	May, 2013 to May, 2014
3	Feasibility Study of NEMEMW&TC and TEMO	Foyzul Bari Himel	July-September, 2013
4	Study on Restructuring of FMAU	Golam Mustafa	December, 2013 to January, 2014
5	Fire Safety Assessment of DGDA	Anisur Rahman	July-November, 2013
6	Feasibility Study on Repair and Maintenance of Bio-medical equipment	Project Hope	Mar-July, 2014
7	Development of Concept Note for GFATM for CDC	Shampa Nag	April-June, 2014
8	Development of a National Strategy on Alternative Medical Care in Bangladesh	Imperial Health	July, 2014 to June, 2015
9	Updating National Malaria Strategic Plan	Dr. Mannan Bangali	April-July, 2014
10	Assessment of Implementation Status of TA under HPNSDP	Dr. Wahidul Islam	May-August, 2014
11	Tribal Health Plan Review	Ahmed Al Sabir	May-July, 2014
12	Assessment of Strengthening Stewardship functions of the Regulatory Bodies	Humayun Kabir, Dr. M A Sabur and Mohammad Hussain	May-July, 2014
13	Assessment for Gender, Equity, Voice and Accountability (GEVA) situation of Community Groups	Ladly K Faiz	June-August, 2014
14	Performance Assessment of Local Level Planning of Directorate General of Health Services (DGHS) and Directorate General of Financial Planning (DGFP)	Md. Abdullah	May-July, 2014
15	Midterm Review of HPNSDP	David Daniels and Humayun Kabir	July-September, 2014
16	Situation assessment of Health, Nutrition and Family Planning (HNFP) Services among Tribal Population in Bangladesh	RTM	November, 2014 to August, 2015
17	Review and Assess Status and Capacity of NIPORT and Develop Strategic Plan for NIPORT under its existing Mandate under TRD-NIPORT	Dr. Yasmin Ahmed and Dr. Khandaker Rashedul Haque	August-December, 2015
18	Asseessment of risks and developing a fire prevention system in the recently established Expanded Program on Immunisation (EPI) of DGHS	Anisur Rahman	December, 2015 to February, 2016

No.	Study Title	Conducted By	Period
19	Technical Review of Kala-azar Elimination Program (KEP)	Dr. Golam Mustafa	February-May, 2015
20	Scoping Study for Strategy Recommendation to develop HRIS in HRM unit, MoHFW	ThoughtWorks	January-March, 2015
21	Devising Cash Transfer Modality of DSF	Dr. M A Sabur	July-August, 2015
22	Situation Assessment of New Medical Colleges in Bangladesh	Md. Abdullah and Dr. M A Sabur	September, 2015 to February, 2016
23	Training Needs Assessment for Personnel from the Directorates and Offices under MoHFW	RTM	May-September, 2015
24	Assessment of Contribution of MoHFW to Urban Health Services	icddr,b	June-October, 2015
25	Development of Strategic Investment Plan for 4th HNP Sector Program	David Daniels	June-October, 2015
26	Situation Assessment of Autism and Neurodevelopment Disorders in Bangladesh	Boston University	October – November, 2015
27	Developing National Strategy and Action Plan for Autism and Neurodevelopmental Disorders	Boston University	February-March, 2016
28	Rapid Assessment of Sector Financial Management Information Systems	Tarun Kumar	March-April, 2016
29	Operational Research on "Strengthening Union Health and Family Welfare Centres for providing round-the-clock normal delivery services"	Population Council	September, 2014 – November, 2016
30	Revision and Standardization of Table of Organization	Dr. Mizanur Rahman and Dr. Faruque Khan	May, 2015 to September, 2016
31	Developing Strategic Tools/Guideline on the basis of QI strategic plan to Strengthen Quality Improvement (QI) Secretariat	Dr. Shayema Khorshed	June, 2015 to June, 2016
32	Assessment of Stakeholder Perception of public Health Services	icddr,b	June, 2015 to February, 2016
33	Developing Strategy for Restructuring CMSD to Match its Capacity in Performing Activities to Strengthen the Health System of Bangladesh	HERA	December, 2015 to March, 2016
34	Designing Implementation Strategy for Accredited Drug Seller Model in Bangladesh	MSH	November, 2015 to November, 2016
35	Assessing the Impact of Mobile Phone Technology to Improve HNP Service Utilization in Rural Bangladesh through Pilot Intervention	icddr,b	July-December, 2016
36	Revision and Standardization of Table of Organization (Senior Consultant)	Dr. Khaleda Begum	January-June, 2016
37	Understanding disease burden among the garment workers and establish an effective linkage between the in-house clinics and nearby state and non-state health facilities with the aim of achieving universal health coverage and improvement of urban primary healthcare	Brown University	August-November, 2016

CHAPTER 8. WAY FORWARD FOR THE 4TH HPNSP

The progress in RFW goal-level indicators of HPNSDP indicate that four out of the 8 indicators were achieved, i.e., U5MR, childhood stunting and underweight, and prevalence of HIV in MARP, while IMR was found to be on track. Although the rates of childhood stunting and underweight have declined, yet their declining rates are not acceptable in the context of Bangladesh approaching a middle income country status. Therefore, the stunting and underweight among under-five children need coordinated inter-sectoral interventions to bring down their unacceptable levels. However, the rest of the goal-level indicators, e.g., NMR, MMR and TFR fell short of target and need vigorous persuasion in the 4th HPNSP.

Three other important issues of concern identified during HPNSDP implementation were (a) the development of a coordinated plan of action by both DGHS and DGFP for acceleration of MNCAH & FP service delivery; (b) non-functioning of completed health facilities due to non-synchronized supply of equipment and HR and the continuing spill-over of unfinished construction of health facilities; and (c) provision of the needed human resources for health. During HPNSDP, MOHFW's efforts in developing the coordinated service delivery plan and the master plan for construction of new health facilities along with repair & maintenance of existing facilities remained as unfinished agenda. However, MOHFW developed and approved the Health Workforce Strategy (HWS) during HPNSDP, which would be translated into action in the 4th HPNSP through implementation of the human resources action plan (HRAP) under preparation.

During the 4th HPNSP both DGHS and DGFP, through the relevant OPs, would adopt and implement the coordinated service delivery plan for MNCAH & FP activities. Moreover, development and implementation of the master plan for construction of health facilities has also been planned for the 4th HPNSP. In addition, vigorous attempts were made during the reporting period to address the fiduciary issues by developing an action plan on Integrated Fiduciary Assessment (IFA) and by initiating steps for restructuring the FMAU. Both these steps will need to be followed up in the 4th HPNSP. Similarly, a study was completed during the period for 'developing strategies for restructuring CMSD' to improve the procurement system, which also calls for policy decision and administrative action as a way forward in the 4th HPNSP.

Preparation of the 4th sector program titled "4th Health, Population and Nutrition Sector Program (HPNSP) started with the launching workshop held in January 2015. This workshop provided the platform for GOB-DP dialogue for preparation of the next sector program. The High Level Committee (HLC) headed by Secretary, MOHFW and the Planning Working Committee (PWC) headed by Joint Chief, Planning Wing, MOHFW were formed for necessary guidance and supervision in connection with the preparation of the 4th HPNSP. DPs were represented in both the committees. The Government, meanwhile in June 06, 2016 decided to extend the implementation period of HPNSDP by six months, i.e., up to December 31, 2016.

Through extensive consultations among GOB-DP, Civil Society and other stakeholders, the Concept Paper of the 4th HPNSP was developed and approved in May 2015 highlighting the broad areas of concerns and their mitigation measures. Following the Concept Paper, the Strategic Investment Plan (SIP) of the 4th HPNSP was prepared in consultation with all concerned stakeholders including the DP representatives. The SIP was approved by MOHFW and circulated in April 2016. The SIP describes the intentions of the Government that it wants to pursue during the next five years and has also identified three distinct components of the 4th HPNSP along with a set of eight strategic objectives against which the interventions are to be made.

The ESP in practice since 1998 – as the tool of focusing on PHC and pro-poor strategy – was updated and finalized through extensive consultations with concerned stakeholders. By June 2016, the draft upgraded ESP was formulated and shared for finalization. The RFW of the 4th

HPNSP was also drafted and shared with all concerned by the RFW preparation committee headed by Joint Chief, Planning Wing, MOHFW. A Program Preparation Team (PPT) was formed to assist the preparation of Program Implementation Plan (PIP) of the 4th HPNSP. As part of the divisional stakeholder consultation exercise on the next sector program, one workshop was conducted by the Planning Wing in Khulna in May 2006, two other divisional-level workshops followed later, held in Sylhet and Chittagong. By June 2016, the Planning Wing of MOHFW conducted series of consultation meetings/workshops in association with the DPs, required for preparation of the 4th HPNSP.

A roadmap in connection with the preparation of the 4th HPNSP was developed and finalized through sharing with all concerned including the DPs in the Planning Working Committee meeting. Preparation work of the 4th HPNSP was going on and MOHFW decided to engage some national/international consultants for development of the PIP. It was also decided that the full draft PIP consisting of the narrative part, OP summaries and budget would be prepared and the first draft PIP would be shared with the DPs by 30 September, 2016 (but actually shared in the first week of October 2016).

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ANNEX A: SUMMARY OF FINANCIAL AND PHYSICAL PROGRESS OF HPNSDP IN FY 2015-16

(Tk. in crore)

OP	RADP allocation	Released fund	Amount spent	% expenditure of released fund			% spent of RADP allocation	% of physical progress measured by OP indicators
				GOB	*PA*	*Total*		
All 32 OPs	***4,214.7***	***3,732.4***	***3,404.7***	***96%***	***87%***	***91%***	***81%***	***62%***
MNCAH	577.9	495.3	487.4	95%	99%	98%	84%	67%
ESD	115.0	53.7	45. 09	93%	75%	83%	39%	40%
CBHC	550.0	457.1	423.8	93%	93%	93%	77%	83%
TBLC	132.5	124.2	92.1	69%	74%	74%	70%	100%
NASP	39.5	31.6	25.5	49%	81%	81%	65%	60%
CDC	140.0	140.0	126.7	99%	88%	91%	91%	71%
NCDC	55.0	42.9	27.1	80%	49%	63%	49%	40%
NEC	4.3	3.7	3.3	89%	90%	89%	77%	80%
HSM	517.0	517.0	464.0	84%	92%	90%	90%	50%
AMC	35.0	35.0	31.3	98%	23%	90%	90%	0%
IST	31.0	30.8	24.1	93%	74%	78%	78%	50%
PSE	175.0	175.0	172.0	95%	100%	98%	98%	60%
PMR	5.8	4.0	3.9	96%	100%	98%	68%	60%
HIS&eH	66.0	66.4	65.5	100%	96%	99%	99%	100%
HEP	32.0	29.5	22.4	97%	60%	76%	70%	80%
PLSM	126.0	123.5	116.4	100%	8%	94%	92%	80%
NNS	89.0	70.2	44.4	79%	61%	63%	50%	67%
MCRAH	135.0	117.1	111.3	97%	94%	95%	82%	80%
CCSD	164.5	117.0	113.4	98%	93%	97%	69%	50%
FPFSD	120.0	85.5	38.7	97%	4%	45%	32%	100%
PME	3.4	2.6	2.5	94%	99%	97%	74%	25%
MIS	10.8	5.0	3.6	58%	81%	72%	33%	50%
IEC	28.4	26.1	24.6	87%	100%	94%	86%	50%
PSSM	22.7	19.5	16.7	87%	54%	86%	74%	80%
TRD	23.8	11.4	8.5	59%	78%	75%	36%	71%
NES	76.7	51.0	40.4	88%	77%	79%	53%	50%
SDAM	8.1	5.0	1.5	16%	36%	30%	19%	100%
PFD	897.4	866.4	852.7	100%	90%	98%	95%	20%
HRM	3.3	3.0	2.2	79%	68%	74%	67%	25%
SWPMM	5.3	4.9	2.7	35%	57%	56%	52%	67%
IFM	5.4	4.7	4.5	88%	98%	96%	84%	75%
HEF	19.0	13.3	6.1	36%	49%	46%	32%	25%

ANNEX B: SUMMARY OF OP-WISE CUMULATIVE RADP ALLOCATION AND UTILIZATION DURING 2011-16

(Tk. in crore)

OP	Cumulative RADP Allocation	Rate of Utilization (%)	Percentage of Total Allocation (%)	Estimated Allocation (%) in PIP
All 32 OPs	16,010.7	85%	-	-
MNCAH	2,881.2	83%	18%	13.61%
PFD	2,681.4	96%	17%	21.71%
HSM	1,948.2	95%	12%	8.40%
FPFSD	1,018.9	75%	6%	7.28%
CBHC	993.5	75%	6%	7.47%
CCSD	766.2	85%	5%	6.12%
PSE	765.9	97%	5%	2.68%
MCRAH	666.3	80%	4%	3.96%
CDC	556.8	96%	3%	2.72%
PLSM	433.7	95%	3%	1.97%
HIS&eH	405.8	89%	3%	2.75%
TBLC	398.4	80%	2%	1.45%
NNS	381.9	67%	2%	6.72%
NCDC	377.8	77%	2%	2.34%
ESD	304.2	55%	2%	2.01%
NES	280.7	79%	2%	1.35%
IST	191.9	77%	1%	1.52%
NASP	175.7	67%	1%	1.23%
IEC	121.8	85%	1%	0.61%
HEP	111.5	88%	1%	0.66%
TRD	101.2	71%	1%	0.50%
AMC	81.90	91%	1%	0.36%
PSSM	68.8	87%	0%	0.36%
HEF	58.0	44%	0%	0.26%
MIS	55.3	66%	0%	0.26%
PMR	42.3	79%	0%	0.24%
SDAM	37.2	58%	0%	0.14%
HRM	33.0	57%	0%	0.66%
NEC	20.5	83%	0%	0.10%
SWPMM	20.4	66%	0%	0.32%
IFM	19.8	84%	0%	0.16%
PME	10.5	90%	0%	0.05%

ANNEX C: APIR 2016 DATA COLLECTION TEMPLATE

ANNUAL PROGRAM IMPLEMENTATION REPORT (APIR) 2016

July 2015-June 2016

OP XX: OP Title: ……

A. OBJECTIVE(S) OF THE OP

General objective: ……
The specific objectives are ……

B. ACTIVITY-WISE PHYSICAL PROGRESS

In column 1, please insert major activities undertaken during FY 2015-16.
In column 2, please identify progress of each activity performed during July, 2015 – June, 2016.

Major Activities undertaken during July 2015 – June 2016	Progress made during July 2015 – June 2016
(1)	(2)

C. **PROGRESS ON THE OP-LEVEL INDICATORS AS OF JUNE 30, 2016:**

Indicators of the OP are given in the following table with baseline and target for 2016.
Only column 6 is required to be completed:

Sl #	OP Indicators	Unit of Measurement/ Means of verification	Baseline	APIR 2015 (Achievement reported upto June 2015)	Target Mid-2016	Achievement (July 2015 - June 2016)
	(1)	(2)	(3)	(4)	(5)	(6)
1.						
2.						
3.						
4.						

D. TRAINING PROGRESS DURING FY 2015-2016

Instructions:

2. Specify unit of duration – day/week/month in column (3)
3. Please provide the number of training participants who are not MOHFW officials/staff (e.g. community management group, community support group, school teachers/students, garment workers, …… etc.) in column (6).

Category of training	Area/subject of the training/ workshop/ seminar	Duration of training	Total number of participants	Cost of Training (Tk. in Lac)	Remarks
(1)	(2)	(3)	(4)	(5)	(6)
Local Training					
Short-term					
Medium-term					
Long-term					
Subtotal (a)					
Foreign Training					
Short-term					
Medium-term					
Long-term					
Subtotal (b)					
Workshop/ Seminar/ Orientation					
Workshop					
Seminar					
Orientation					
Advocacy					
Subtotal (c)					
Grand Total (a+b+c)					

E. BRIEFLY DESCRIBE THE CHALLENGES FACED DURING FY 2015-16, AND MEASURES TAKEN TO OVERCOME THOSE:

Areas	Challenges	*Actions already taken by LDs*	*Additional measures suggested by LDs*
(1)	(2)	(3)	(4)
Implementation			
Procurement			
Fund availability/ disbursement			
Monitoring and supervision			
Human Resources			
Others (please specify)			

F. FINANCIAL PROGRESS: (no need to provide information on financial progress)

OP wise ADP allocation, release, and utilization figures will be used from ADP software of MOHFW.

ANNEX D: UPDATE ON PROGRESS IN OP-LEVEL INDICATORS, 2016

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
OP 01: Maternal, Neonatal and Child, Adolescent Health Care (MNCAH)							
1	Number of health facilities providing 24/7 C-EmOC	Number of MCH, DH and UHCs (HIS/ Admin records)	78	204	183 (101 UHCs, 59 DH & 23 MCH)	132	170 (88 UHC, 59 DH & 23 MCH)
2	Number of CSBA trained	Number of persons (OGSB/ Admin record)	7,089 (2012)	13,500	8,932	10,224	11330 (1106 this FY)
3	Number of Upazilas having DSF program	Number of Upazila (DSF Monitoring Report)	53 (2012)	133	53	53	53
4	Proportion of women age 15-49 yrs received TT-5 doses of TT during their last pregnancy	Percent (Coverage Evaluation Survey - CES)	42.3% (2011)	70%	43.6% (CES 2013)	53.2%	57.1% Crude 46.1% Valid (CES 2015)
5	Proportion of children aged 12-23 months vaccinated by all scheduled vaccines by 12 months of age	Percent (Coverage Evaluation Survey - CES)	80.2 % (2011)	90%	80.7% (CES report 2013)	81.6%	89.8% Crude 82.5% Valid (by 12 months) (CES 2015)
6	Number of UHCs having an IMCI with Nutrition Corner	Number of UHCs (Admin record/ IMCI MIS)	350	480	150	480	487 (07 this FY)
OP 02: Essential Services Delivery (ESD)							
7	Number of Upazila under Upazila Health System (UHS) piloting	Number (Admin record)	N/A	7 upazilas	3 upazilas	7 Upazila introduces with UHS strengthening	7 upazilas
8	Number of UHCs with personnel trained on MWM	Number (Admin record)	206 Upazila (OP report)	421 upazilas	260 upazilas	363 upazilas	455 upazilas
9	Number of Urban Dispensaries functional with HR and supplies	Number (Admin record)	17 (2012)	33	17	10	-
10	Update of National Protocol for Mental Health Care	Protocol updated and available	N/A	Protocol Updated	Not done (It is premature to update as the protocol was developed very recently)		Not done
11	Satellite clinics taking place in Chittagong Hill Tracts (CHT) as per workplan	Number of satellite clinics/ medical camps – 1 in each Upazila per month (Admin record)	N/A	200 /year	68 satellite clinics conducted	210	0
OP 03: Community Based Health Care (CBHC)							
12	Patients per CCs per day	Average number of patients in CC (Monthly monitoring report)	19/CC/ day (2010)	40/CC/day	38/CC/day	4051.02 Lac visits were made to CCs by service seekers	38/CC/day
13	Number of CC referrals	Number of patients referred (Monthly monitoring report)	1.85% of total patients attended (2010)	3.00% of total patients attended	2.08% of total patients attended	87.03 Lac emergency & complicated cases were referred from CCs to higher facilities	1.31%
14	Number of community clinic management committee meeting held	Number of meetings per quarter (Monthly monitoring report)	5,000 (2010)	30,000	28,860/ Quarter		28,000
15	Number of CHCPs provided Basic training	Number of person (Monthly monitoring report)	8,848 (2012)	13,500 (Cumulative)	Basic training have been provided all CHCPs	The existing 13,011 CHCPs have already been trained.	606 new recruited CHCPs Basic training (3

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
						The recently recruited 850 CHCPs will be trained in 2015-2016	month) completed in 28 batches.
16	Number of a) Community Management groups (CG) and b) Community Support Groups trained	Number of groups (Monthly monitoring report / Admin report)	CG: 2,900(Mid-2012) CSG: 6,141 (Mid-2012)	CG: 16,000 (Cumulative) CSG: 48,000 (Cumulative)	CG:12,577 CSG: 37,731	CG: 12,895 CSG: 39,105	CG: 12895 CSG: 39105
17	Number of ANCs in CCs (including nutrition counseling)	Number per month (HIS/ CC Monitoring report)	2/ month	10/month	10/month		11/month
OP 04: TB and Leprosy Control (TB-LC)							
18	TB case notification rate (all forms)	Cases per 100,000 population/year (NTP Annual Report)	99/100,000 (2011)	120/100,000	119/100,000	126.8	131.3
19	Treatment success rate among detected New Smear Positive (NSP) TB cases	% (NTP Annual Report)	92%	Sustain	93%	94% (July 2013-June2014)	94% (July 2014-June 2015)
20	Multi Drug Resistance (MDR) patients identified and managed	Number (NTP Annual Report)	390	2,300	748	928	904
21	Sustaining Leprosy Elimination at the national level and reducing the new cases at least 10% per year	Rate (new cases per 10,000 population) (Admin record)	0.20/10,000	<=0.10 per 10,000	0.18 per 10,000	0.21/10000	0.23/10000
OP 05: National AIDS/STD Program (NASP)							
22	Prevalence of HIV among Injecting Drug Users	% (Sero-surveillance/IBBS)	1.05%, SS (2011)	Sustained	Sustained	Sustained	Sustained
23	Prevalence of active syphilis among sex workers	% (Sero-surveillance/IBBS)	>5%, SS (2011)	<2%	Sustained	Sustained	Sustained
24	Number of medical personnel trained in HIV	Number (Admin record)	400	1600	625	2,550	0
25	% of service points having stock of ARV drugs	% (Admin record)	100%	100%	100%	100%	100%
26	Number of HIV testing centers providing regular service updates	% (Admin record)	76	100	Nil	69%	100%
OP 06: Communicable Disease Control (CDC)							
27	Malaria mortality	Rate - Deaths per 10,000 people	0.0034 (2010)	0.0025	0.0136	0.0279 (37deaths)	0.0279 (37 deaths)
28	Proportion of patients under coverage of EDPT for severe malaria	Percent (NMCP MIS)	70% (2011)	90%	90.0%	92%	92%
29	Number of filariasis endemic districts stopped Mass Drug Administration(MDA)	Number of districts (TAS)	10 (2012)	19	17	3	3
30	Number of school children of age 5-12 years administered with deworming drugs	Number of children (6 monthly report on MDA coverage)	68% (2010)	90%	84.3%	99.43%	99.4%
31	Kala-azar incidence	Rate – new cases per 10,000 people (CDC Annual Report)	2.15 (2012)	<1	0.99 per 10,000	0.34 Per 10,000 Populations	0.34 Per 10,000 Population
32	Proportion of dog bite victims managed with Post Exposure Prophylaxis (PEP)	Percent (CDC Monthly Report)	25% (2012)	90%	57.0%		

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
33	Number of diseases under intensive surveillance	Number of diseases (IEDCR Website/ Admin record)	3 (HIV, Flu, NIPAH)	8	7		
OP 07: Non-Communicable Disease Control (NCDC)							
34	Number of UHCs providing a) hypertension and b) diabetes screening	Number of UHCs (NCD InfoBase/ Admin record)	1 (2012)	482	142	236	300
35	Number of service providers trained on NCD screening and management	Number of service providers, viz. physician, nurse, MA/SACMO, HI/AHI, HA, FWV/FWA (NCD InfoBase/ Admin record)	34,250 (2012)	120,000	73,205	119,231	40,230
36	Number of Upazilas covered by awareness campaigns on injury (traffic and childhood injuries, including drowning)	Number of Upazilas (NCD InfoBase/ Admin record)	60 (2012)	300	140 upazilas	140 upazila	140 upazilla
37	Number of factories providing occupational health and safety training	Number of factories (NCD InfoBase/ Admin record)	80	280	150	165	165
38	Number of arsenicosis patients treated	Number of persons screened by H-H Active Surveillance (NCD InfoBase/ Admin record)	56,758	65,000	65,910	65,910	65,910
OP 08: National Eye Care (NEC)							
39	Adult cataract patients undergone surgery	Rate (Admin record)	1,206/million people	1,600/million people	1,475/million people	1,500/million people	1,950/million people
40	Number of patients with diabetic retinopathy screened and managed	Number (Admin record)	N/A	3,000	1,900	2,200	10,886
41	Number of hospitals following standard protocols	Number (Admin record)	45	59	195	200	220
42	Number of Child Cataract Surgery performed	Number (Admin record)	4,500/year	5,000	5,000	5,400	5,000
43	Cataract patients undergone surgery by receiving DSF/Cash Voucher	Number (Admin record)	N/A	1,000/year	951/year	1,831/year	1,551
OP 09: Hospital Services Management (HSM)							
44	Number of hospitals (DH and above) introduced standard in-house medical waste management	Number of hospitals (Admin report)	14 (2012)	14 MCH; 8 SH; 28 DH	9-MCH; 8-Spec. Hosp; 8-DH	14 MCH; 8 Spec. Hosp; 8 DH	6 MCH; 10 Spec. Hosp; 4 DH
45	Number of facilities (UHC and above) introduced safe blood transfusion services	Number of health care facilities (Admin report)	191 (2012)	317	217	219	219
46	Number of hospitals introduced TQM concept (5s-CQI-TQM)	Number of hospitals (Admin/ Status report)	3 DH (2012)	8 MCH (Gyn. & Ped); 10 DH; 8 UHC	4-MCH; 8-DH; 4-UHC	3 MCH (Gyn. & Ped); 14 DH; 3 MCWC; 32 UHC	8 MCH (Gyn. & Ped); 14 DH; 3 MCWC; 32 UHC
47	Number of hospitals declared as women friendly	Number of hospitals (Admin/ Status report)	6 DH; 3 UHC (2012)	25 DH; 5 UHC	1-MCH, 22-DH, 2-UHC	21 DH; 5 UHC	14 DH; 3 UHC
48	Number of *Shishu Bikash Kendra* established	Number of hospitals (Admin/ Status report)	10 MCH (2012)	18 MCH; 17 DH	15-MCH	15 MCHs	15 MCHs

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
49	Number of hospitals introduced structured referral system	Number of hospitals (Admin/ Status report)	6 MCH, 24 DH and all corresp. UHCs (2012)	20 MCH, 64 DH and all corresp. UHCs	11-MCH; 41-DH and all corresp. UHCs	21 DH, 5 UHC	1 MCH; 24 DH; 17 UHC
OP 10: Alternative Medical Care (AMC)							
50	Patient received AMC services out of total OPD patients at the selected district hospitals	% (Admin record, reported by MO-AMC)	23%	30%	26%	28%	30%
51	Number of facilities introduced AMC	Number (Admin record)	45 DHs, Govt. Unani & Ayurvedic Colleges, Govt. Homeopatic College and Govt. Tibbia College	All District Hospitals, all medical colleges, & all UHCs	45 DHs, Govt. Unani & Ayurvedic Colleges, Govt. Homeopatic College and Govt. Tibbia College	51 DHs, 05 MCHs & 143 UHCs, DGHS-02, Govt. Unani & Ayurvedic Colleges & Hospital-27, Govt. Homeopatic College & Hospital-19 and Govt. Tibbia College-01	51 DHs, 05 MCHs and 145 UHCs (also 3 DGHS, 27 Unani & Ayurvedic Colleges & Hospitals, 21 Homeopatic College & Hospital. 11 Tibbia Colleges
52	Prepared Unani, Ayurvedic & Homeopathic Pharmacopoeia & Formularies	Number (Admin record)	2	6	0	0	5
53	Prepared herbal garden (plantation of medical plants)	Number (Admin record)	470	500	0	0	472
OP 11: In-Service Training (IST)							
54	Number of health personnel trained in the area of Essential Service Delivery (ESD)	Number of batches of size 25 persons (Admin record)	1030+345 batches	2,829	1,309 (cumulative)	2,384 batches	1,653 batches
55	Number of health personnel trained in management, including Monitoring & Supervision	Number of batches of size 25 persons (Admin record)	938+324 batches	1,489	1,807 (cumulative)	1,327 batches	571 batches
56	Number of health personnel trained in different clinical specialties	Number of persons (Admin record)	474+72 persons	1,011	787 (cumulative)	198 persons	0
57	Number of health personnel trained in Public Health	Number of persons (Admin record)	231+26 persons	551	397 (cumulative)	75 persons	0
OP 12: Pre-Service Education (PSE)							
58	Number of batches of fourth year Medical and Dental students received Residential Field Site (RFST) Training	Number of batches (Admin record)	Medical-17; Dental-3	Medical-42; Dental-16	Medical-54 & Dental-9 (cumulative)	Medical-77 Dental-18	Medical-23; Dental-9
59	Number of teachers (Medical and Dental College) trained on Quality Medical Education	Number of teachers (Admin record)	350	2,000	1,100 (cumulative)	1,360	1,500
60	Establish Medical Education Unit in Medical Colleges	Number of institutes (Admin record)	Medical-22; Dental-3	Medical-21; Dental-45	Medical-23; Dental-9	Medical-29 Dental -3	Medical - 30; Dental - 3
61	Improvement of Laboratory & Library facilities at Govt. Medical and Dental	Number of institutes (Admin record)	Medical-22; Dental-3	Medical-21; Dental-45	Medical-22; Dental-9	Medical-29 Dental -09	Medical -30; Dental - 9

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
	College						
62	Review and update medical, dental, paramedical and other curricula	Number of curriculum (updated curricula available)	MBBS curriculum updated	IHT & MATS curriculum updated	Medical curricula updated; BSC G141in health technology (Laboratory) curricula updated	Curriculum updated MBBS-1 Dental: 1 IHT: 1 MATS: 1	Diploma in cardiac Perfusion technology Curriculum
OP 13: Planning, Monitoring and Research (PMR)							
63	Number of Upazilas (including Hard-to-reach & low performing areas) prepared Local Level Plan (LLP)	Number of Upazila (Plans available)	14	48	28 upazilas	28	-
64	Number of doctors and supporting staff of district-level and below facilities trained in Management and Performance Appraisal	Number of batches with 20-25 person each (Admin record)	11 batches	100 batches	25 (cumulative)	100%	29 Batches
65	Number of health personnel trained in Research Methodology	Number of batches with 20 person each (Admin record)	5	111	44 (cumulative)	67 batch 100%	20 Batches
66	Number of research studies conducted and findings disseminated	Number (Reports available, preferably in the form of a compendium)	N/A	20	101 (cumulative)	40 (100%) 59 (100%)	21 studies conducted by Planning Unit, DGHS; 20 by BMRC
67	Number of progress monitoring meeting conducted with the LDs in the DGHS	Number (Meeting minute)	12	60	37 (cumulative)	12 (100%)	12 (One in each month)
OP 14: Health Information System and e-Health (HIS&e-H)							
68	Proportion of government health facilities submitting timely and adequate report as specified by HIS	Percent (Admin record)	82%	95%	90%	91%	95% for Community Clinic, 100% up to Upazilla level
69	MIS reports on health service delivery published and disseminated	Number of report per year (Printed report available)	1	1	1	1	1
70	Number of health facilities having specially designed telemedicine centers	Number of facilities (Admin record)	18	34	28	43	59
71	Documented evidence of public awareness articles and radio or television shows on MBT	Number of articles/shows per year (Admin record)	5	10	5	8	14
72	Annual MIS Conference held to improve data quality	Number of conference per year (Admin record)	1	1	1	8 (7 at divisional level & 1 at national Level)	8 (7 at divisional level & 1 at national level)
OP 15: Health Education and Promotion (HEP)							
73	Number of BHE personnel trained	Number (Admin record)	2,502	10,008	2,060	6,376	1,700
74	Number of awareness campaigns conducted on a) health, and b) nutrition	Number (Admin record)	5	26	11	15	15
75	Number of IEC materials printed and	Number (Admin record)	4,00,000	8,00,000	5,00,000	9,00,000	5,00,000

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
	disseminated						
76	Number of inter-OP and multi-sectoral coordination meetings conducted	Number of meetings (Meeting minute)	33	225	7	47	95
77	Number of facility (doctor, nurses) and field staff (HA) trained using an intensive module to train both	Number (Admin record)	N/A	Training initiated	1 developed (out of 2)	02 Developed	2 (Reviewed & Finalized)
OP 16: Procurement, Logistics and Supplies Management (PLSM)							
78	Online storage and distribution system established to track all goods procured in CMSD	Activity completed (Admin record)	N/A	System established	On-line logistics tracking system district & upazila level stores under process	Milestone (% of procure goods tracked)	System established
79	Number of trainings on procurement management conducted	Number (Admin record)	N/A	32	16	23 Nos.	No training
80	Percentage of contracts awarded within initial bid validity period a) ICB; b) NCB	Number (Admin record)	100%	100%	80%	91%	100%
81	Percentage of procurement packages (goods) captured by the procurement web portal	% (Admin record, PLMC)	N/A	75% of the packages	Portal entry started on trial basis	100%	100%
82	Proportion of items monitored (from receiving to distribution) through the Electronic Inventory System at CMSD	% (Admin record)	100%	100%	100%	100%	100%
OP 17: National Nutrition Services (NNS)							
83	Number of CC workers (CHCP, HA, FWA) trained in nutrition services delivery	Number of service providers (NNS Training/ Admin record)	7,000 (2012)	35,500	26,382	11,763 IYCF and other micro-nutrient issues	38,541
84	Number of Upazilas having a) trained personnel and b) forms to report on nutrition services (i.e. GMP, Counseling)	Number of Upazilas (HIS/ Admin report)	0 (2012)	459	482 Upazilas has Reporting forms integrated in DHIS-2 of HMIS (IMCI&N reporting form)	a) Training on basic nutrition provided b) 482 upazilas has reporting forms integrated in DHIS-2	a) 440 Upazila's covered (Basic Nutrition, IYCF & SAM) b) 482 Upazilas has forms integrated in DHIS-2
85	Steering Committee for Nutrition Implementation (SCNI) and Nutrition Implementation Coordination Committee (NICC) have meetings held to coordinate nutrition activities	Number of meetings (Meeting minutes)	2 SC; 2 NICC meetings	4+6 meetings/ year	8 SCNI meetings; 6 NICC meetings conducted (cumulative)	3 NICC and 4 SCNI/NTG meetings conducted	12 NICC and 12 NTG meeting were held
86	Number of personnel trained on food safety (Food Inspection)	Number of persons from DGHS, BSTI, Municipalities, City Corporations, DAE, Food and others (Admin record)	N/A	300	640	-	640 (the Program Closed in June 2015)

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
87	Number of hospitals under Revitalization of BFHI	Number of hospitals (Admin record)	63	499	150	188	592
88	Number of NVAC+ campaigns in a year	Number of national campaigns (Admin report)	2	2	2	1	6
OP 18: Mater5nal, Child, Reproductive and Adolescent Health (MCRAH)							
89	No. of ANC (1st.visit) provided by SBAs in DGFP.	Number(DGFP MIS)	18,00,000 (2012);	60,00,000	24,95,460 (cumulative)	22,21,109	24,11,242
90	Number of program personnel trained on Neonatal Asphyxia.	Number of Doctors, FWVs & CSBAs (Admin record)	4,847 (2012)	14,000	6,482 (cumulative)	84	245
91	Number of Tab. Misoprostol distributed	Number(DGFP MIS)	60,000 (2012)	25,00,000	21,84,032 (cumulative)	4,05,864	5,19,068
92	Number of deliveries conducted by SBAs in DGFP	Number(DGFP MIS)	3,50,000 (2012)	12,50,000	10,08,333 (cumulative)	3,64,110	6,31,792
***93**	No. of reported MR done.	Number(DGFP MIS)	2,50,000 (2012)	4,40,000	4,67,691 (cumulative)	2,22,606	1,88,398
OP 19: Clinical Contraception Service Delivery (CCSD)							
***94**	Number of VSC/NSV performed	Number of operations per year (DGFP-MIS)	3,05,775 (2012)	4,00,000	4,65,719 (cumulative)	193,726	1,63,031
***95**	Number of IUDs inserted	Number of insertions per year (DGFP-MIS)	2,61,699 (2012)	4,50,000	5,21,710 (cumulative)	2,44,027	233,557
***96**	Number of Implants inserted	Number of insertions per year (DGFP-MIS)	2,15,736 (2012)	4,50,000	564,427 (cumulative)	3,33,379	353,239
***97**	% of eligible couples at national level accepted LAPMs (LAPM as % of CAR)	% of eligible couples (DGFP-MIS)	15% (2012)	20%	16.55% (up to May-2014)	17.45%	16.53%
98	Number of personnel trained in clinical contraception	Number of staff (Admin record)	332 (2009-10)	3560	11,227 (cumulative)	340	1,929
99	Availability of , long acting FP methods in Upazila stores in Sylhet and Chittagong divisions	% of Upazila stores having no stock-out (FP-LMIS)	100% (2012)	100%	100%	100%	100%
OP 20: Family Planning Field Service Delivery (FP-FSD)							
***100**	Percentage of eligible couples at national level accepted Injectables (Injectables as % of ELCO)	% (FP-MIS)	15.4% (2012)	85%	16%	16.34%	20.35%
***101**	Percentage of eligible couples at national level accepted temporary methods (oral pills and condoms as% of ELCO)	% (FP-MIS)	46.7%	65%	45.48%	45.36%	55.70%
102	No. of Satellite Clinic conducted	Number (Admin record)	2,85,000	18,00,000	3,28,000	3,20,000	1,630,000
103	Number of upazilas covered under refreshers' trainings to fieldworkers	Number of Upazila with trained FWA/FWV/ FPI/ SACMO (Admin record)	82	100%	302 (cumulative)	107	92%
OP 21: Planning, Monitoring and Evaluation (PME)							
104	Number of Upazilas (including Hard-to-Reach & low performing areas) prepared Local Level Plan (LLP)	Number of Upazila (Plans available)	100	376	188 Upazila Plans, including 14 pilot upazilas (3 years planning cycle)	45 Upazila Plans, including 6 pilot upazilas (3 years planning cycle)	-

* The reported figures refer to informed choice exercised by eligible couples/clients. The targets represent projections at (national) aggregate level used for planning, budgeting and monitoring purposes.

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
105	Number of Community Clinics incorporated with LLP activities.	Number of motivational workshops and meetings held at CC level (Admin record)	923	6,320	3,476 meetings & workshops held at CC level (cumulative)	323 meetings & workshops held at CC level	-
106	Number of *Uthan Boithak* (yard meetings) Organized.	Number of meetings (Admin record)	6,872	25,640	19,878 (cumulative)	498	-
107	Number of annual work plans (AWP) with budgets of DGFP operational plans submitted to MoHFW by defined time period (July/August).	% (AWPs available)	07 OPs	07 OPs /Year	100% (07 OPs /Year)	100% (07 OPs/Year)	7 OPs/Year
OP 22: Management Information System (MIS-FP)							
108	Number of upazilas providing monthly report electronically for web-based MIS	Number of upazila (MIS report)	N/A	488	487	488	488
109	Number of field workers and supervisors trained on FWA register and reporting forms	Number (Admin record)	NA	65,000	30,500 (cumulative)	30,500 (cumulative)	31,033 (cumulative)
110	Check validity of data by sending 4 teams in each month	Number (Data Quality report submitted)	66	216	52	38	17
111	MIS reports on service delivery published and disseminated annually	Number (MIS Report available)	1/year	5	3 (Not Disseminated) (cumulative)	1	1
OP 23: Information, Education and Communication (IEC)							
112	Number of FP, MCH & Nutrition campaign organized	Number (Admin record)	N/A	2,069	1,211 (cumulative)	156	127
113	Number of workshop organized for awareness building of community leaders, professionals and religious leaders on FP, MCH & Nutrition at upazila level	Number (Admin record)	708	5,372	1,130 (cumulative)	5	280
114	Number of IEC materials (audio and video) produced, and broadcasted in mass media	Number (Admin record)	Video produce: 08; Video telecasted: 698; Audio broadcasted: 1,200	Video produce: 24; Video telecasted: 3,226; Audio broadcasted: 6,000	Video produced: 22; Video telecasted: 4,695; Audio broadcasted: 37,640 (cumulative)	Video produced: 23; Video telecasted: 1,754 Audio broadcasted: 17,080	Video produced: 15; Video telecasted: 1,784 Audio broadcasted: 15,830
115	Number of advertisements a) displayed and b) published in the National Dailies	Number (Admin record)	a) 240; b)250;	a) 373; b) 1,458;	a) 408; b) 1,334 (cumulative)	a) 135; b) 400	a) 144; b) 520
OP 24: Procurement, Storage and Supply Management (PSSM)							
116	Percentage of contracts awarded within initial Bid Validity period	% (Admin record)	100%	100%	95%	94%	95%
117	Availability of selected FP methods in SDPs in a) all divisions, particularly in b) the lagging regions of Sylhet and Chittagong	% (Admin record; SCIP/LMIS)	a) 80%; b) 65%	a) 100%; b) 100%	a) 98.35%; b) 99.64%	a) 98.40% b) 98.00%	a) 98.60%; b) 98.53%
118	Percentage of a) Warehouse Inventory	% (Admin record; SCIP/LMIS)	a) 100%; b) 90%;	a) 100%; b) 100%;	a) 100%; b) 96%;	a) 100% b) 100%	a) 100%; b) 100%;

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
	Management System (WIMS) and b) Upazila Inventory Management System (UIMS) functional						
119	Quarterly review meeting of Logistic Coordination Forum taking place on regular basis	Number (Meeting minutes)	4 /year	4 /year	3/year	3/year	2 /year
120	Percentage of Upazilas having no 'unusables'	% (Admin record/ Upazila survey & condemnation report)	N/A	80%	45%	70%	78%
OP 25: Training, Research and Development (TRD)							
121	Reproductive and Child Health Training - (IUD & IP, ENC, ELCD)	Number of persons (Admin record)	9,425 persons	9,626 persons	5,804 persons (cumulative)	128 persons	128 persons
122	Basic Training (for FWV, FWA, FPI)	Number of persons (Admin record)	4,971 persons	7,634 persons	3,831 persons (cumulative)	1,618 persons	460 persons
123	Refresher Training (for FWV, SACMO, HA, FPI, FWA)	Number of persons (Admin record)	25,230 persons	9,625 persons	3,946 persons (cumulative)	2,115 persons	1649 persons
124	Conduct national surveys (including BDHS, BMMS, UESD surveys, facility survey, Urban Health Survey, etc.)	Number (published and reports available)	2 nos.	8 nos.	4 nos. (cumulative)	2 nos.	2 nos. & (2 survey ongoing)
125	Number of program focused research studies conducted	Number (disseminated and published reports available)	14 nos.	64 nos.	35 nos. (cumulative)	-	1 nos. & (6 studies ongoing)
126	Publish annotated bibliography/ research-policy briefs/ newsletter	Number (report available)	10 nos.	50 nos.	33 nos. (cumulative)	9 nos.	11 nos.
127	Conducted Research Methodology Training Course (Local)	Number (Admin record/ Training feedback report)	-	10 batches	Nil	Not reported	Not reported
OP 26: Nursing Education and Services (NES)							
128	Number of diploma midwives produced	Number of students admitted (Admin record)	525	2,100	1,225	800	975
129	Number of nurses trained on specialized courses	Number of nurses trained (Admin record)	80	500	340 (cumulative)	180	1,950
130	Newsletter and Nursing Journal published annually	Number (Report available)	N/A	2/year	2	2	-
131	Number of nursing institutes inspected	Number of Institutes inspected (Inspection record from BNC)	15/year	15/year	56 (cumulative)	44	-
OP 27: Strengthening of Drug Administration and Management (SDAM)							
132	Number of drug samples tested every year	Number (Annual report)	2,681	10,000	5,815	7,455	10,800
133	Number of inspections on Drug Manufacturing Units	Number of companies (Admin report)	310	4,000	1,085	1,199	1,552
134	% of positions capable of conducting drug inspection filled	% (Annual report)	33%	80%	62.1%	69.35%	73.00%
135	Number of staff received training on GMP	Number (Admin report)	N/A	60	64 Persons	110	72
OP 28: Physical Facilities Development (PFD)							

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
136	Percentage of contracts awarded within initial bid validity period	% (Admin record)	N/A	85%	68%	70%	97%
137	Number of existing FWC physically upgraded to UH&FWCs for improved MCH services	Number of facilities (Admin record)	1,441	800	130	69	Completed: 37 Nos Ongoing: 110 Nos. Average Progress: 45%
138	Number of UHC upgraded from 31-50/50 to 100 bed hospitals	Number (Admin record)	251	161	49	10	Completed: 13 Nos. Ongoing: 25 Nos. Average Progress: 68%
139	Develop a comprehensive plan for repair and maintenance of facilities	Plan available and implemented (Divisional Inspection Report)	Plan drafted	Maintenance/ work in progress as per the plan	Nil	0	Average progress of routine and periodical maintenance works: 87.2%
140	Staff provided training in the basic course of Procurement Management	Number of staff (Admin record)	205+25=230	800	467		45
OP 29: Human Resources Management (HRM)							
141	HR Plan developed on the basis of HR gap	Done (Admin report)	N/A	HR Plan implemented	Draft HR plan developed and under review; TOR developed for a study on capacity of the pre-service training institutions	Consultant recruitment process to finalize the HR implementation is in final stage.	An international consultant under JDTAF is working to develop draft HR plan by 31 August
142	Recruitment rules for a) health, b) non-medical, c) FP and d) nursing cadres upgraded/revised.	Number (Upgraded recruitment rules available; Revised job descriptions available)	a) under review; c) awaits finalization; d) drafting ongoing	Recruitment Rule upgraded for (a) and (c); Job description for (a), (b), (c) and (d) updated and oriented	Draft recruitment rules (Non-medical – EPI, Physiotherapy, Medical physics) sent to the MOPA	Two consultants are recruited and updating of Recruitment Rules for b) non- medical and c) FP are ongoing.	Recruitment rules on medical and nursing has sent to MOPA for approval
143	Policy on introducing incentive packages (financial and non-financial) for hard-to-reach/rural areas are developed and implemented.	Done (Policy available)	Study on incentive package completed	Pilot initiated based on inter-ministerial decision on introducing incentive packages	Incentive packages developed, TA support requested for initiation piloting.	Report prepared with recommendations	EOI published by August, study will be carried out
144	Central Human Resources Information System (HRIS) established.	Done (Admin report)	N/A	Systems design finalized	Requirement analysis under process, TA support requested and TOR developed	A scoping study for establishing central HRIS carried out under JDTAF. Based on the results, a consulting firm is being contracted.	System design CHRIS finalized Agency level training of CHRIS is going on. By October the training program will be completed
OP 30: Sector-Wide Program Management and Monitoring (SWPMM)							
145	% OPs submitted Annual Work Plan with quarterly budget breakdown on time	% (Admin record)	97%	100%	90%	100%	100%
146	% of PAP actions	% (Admin record)	N/A	100%	90%	100%	100%

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
	followed up on time						
147	Prepare OP progress report (including information from ADP) for Annual Program Review (APR)	Number (Progress report available)	a) N/A; b) 1 APIR	a) 4 six-monthly reports b) 5 APIRs	2 SmPRs, 2 APIRs (cumulative)	1 APIR, 1 SmPR	1 APIR, 1 SmPR
148	METG meetings taking place quarterly	Number (Meeting minute)	4/year	4/year	3	3 MESAP TWG, 2 METG meetings took place	1 METG meeting took place in December 2015
149	LCG Health meetings organized quarterly and decisions followed up	Number (Meeting minutes available)	4/year	4/year	2	4 LCG meetings took place in Nov'14; Jan, Jun and Sep '15	1 LCG meeting took place in September 2015
150	Developing M&E Strategy and Work Plan	Done (Strategy and Work plan available)	Older versions of M&E Strategy available	Work plan developed and Strategy implemented	Strategy drafted with short- and medium-term work plans	MESAP approved	
OP 31: Improved Financial Management (IFM)							
151	Number of financial reports prepared on time	Number of reports prepared every year (Admin record)	N/A	5	4	4	4 Report Completed
152	Number of internal audits completed	Number (Audit report)	4	32	Final report of (outsourced) Audit firm not yet received; Conducted Internal audit by Internal core audit team	32	Audit completed for 32 OPs
153	Number of FM personnel trained at OP level	Number (Admin record)	500	3,000	2,334 (cumulative)	1,019	1,355 Person. Completed.
154	% of audit observations resolved in last one year	% of audit observations (Admin record)	0%	>80%	25%	30	113 observations settled out of 222, which is 51% of total.
OP 32: Health Economics and Financing (HEF)							
155	Number of study/ research conducted and disseminated	Number (Report available)	07 policy relevant studies conducted	20 Studies reports	01 study	01 study/ research conducted and disseminated	After WB clearance, 3 studies started
156	Number of NHA and PER conducted	Number (Report available)	01 PER	03 PER; 01 NHA; 01 RMNCHA; 01 DSA;	National Health Accounts estimates (analysis in the final stage) but estimates not yet available	01 NHA disseminated and 1 PER on going; Preliminary estimates of Urban Health Expenditure-disseminated in IUCH	PER 1997-2014 disseminated. BNHA-V data collection started and expected to be completed by October 2016.
157	Number of training conducted (EGVNP)	Number (Admin record)	02 batches local training on EGV held (70 persons trained)	10 local batches (300 participants); Foreign training (10 participants)	02 batches training conducted (71 participants attended)	04 Field training on EGV held	04 batches local training on EGV held
158	Implementation of Health Care Financing Strategy	Number (Implementation Plan available)	Strategy developed and approved	Implementation of specific interventions initiated	Implementation Plan formulated and is available	Preparatory work for SSK Piloting has almost been completed;	Piloting ongoing; following Cabinet Division's

Sl.	OP Indicator (Revised)	Unit of measurement (means of verification)	Baseline	Target Mid 2016	MPIR 2014	APIR 2015	APIR 2016
						Baseline Survey and Household Survey have been conducted; Concept Paper for Formal Sector Health Insurance has finalized	recommendations Draft Health Protection Act is being revised